

Running head: DISSERTATION – S.G. MARSHALL

**Social Context Matters: A Focused Ethnography of Talwin and Ritalin Injection in
Winnipeg, Manitoba**

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Abstract

BACKGROUND: The non-medical injection use of Talwin and Ritalin (Ts and Rs) is uniquely prevalent in urban centres of the Canadian Prairie Provinces. However, the experiences of people who inject Ts and Rs have remained largely unexplored. By positioning people who inject Ts and Rs as keepers of situated knowledge regarding local drug use trends and the social conditions for drug-related harms and benefits, this focused ethnography explored the social context surrounding the injection of Ts and Rs in Winnipeg. Drawing from the sociology of Pierre Bourdieu, attention was focused on the relations of power at the macro/structural, meso/institutional, and micro/individual levels that shape lived-experience, and conditions for drug-related harms and benefits.

METHODS: Semi-structured interviews were undertaken with 36 people who inject drugs. In phase I of the research, 24 people who inject Ts and Rs were interviewed. To further explore the nature of spaces in which drugs were consumed, phase II of the research involved semi-structured interviews with 12 people who inject drugs and had no permanent residence.

FINDINGS: The broad social context was shaped by racialized, classed, and gendered relations of power that manifested in institutional practices and mainstream systems of meaning.

Medicalization, drug-prohibition, systemic racism, and neoliberal governance were principal influences in the social and material conditions of the local setting. Lived experiences were characterized by structurally disadvantaged social location, high institutional interactions, and elements of habitus and everyday life that influenced drug-related benefits and harms. Key factors involved in these influences included: reproduction and impacts of family separation;

social, material, and symbolic aspects of drug consumption spaces; and everyday practices of harm reduction arising from community membership as a significant enabling resource.

CONCLUSION: Relations of power in the social context surrounding Ts and Rs injection emerged as significant sources of everyday oppression and harm. Findings reveal the need for public health to work toward significant shifts in the distribution of power and material resources, and the decriminalization of drug use in order to mitigate social, symbolic, and material conditions for drug-related harms. Locally tailored, Indigenous and community-led, culturally safe, and gender-sensitive programs and practices are imperative.

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Preface

Researching the social world of drug use is an act of power, and inevitably shaped by the history, experience, and position of the researcher. I am a middle-aged, white, English-speaking, Western-educated, heterosexual woman. This social location affords me privileges as a member of several dominant and normalized groups. I am also a third generation descendent of Eastern European ancestors who migrated and settled in central Canada in the early 1900s. I have lived most of my life in Manitoba, Canada, on Treaty 1 Territory where this research took place, the ancestral lands of the Anishinaabeg, Cree, Dakota, Oji-Cree, and Dene peoples, and the homeland of the Métis Nation. Therefore, I am implicated in the colonial history of Canada and have benefited from the appropriation of Indigenous land and resources, and the oppression of Indigenous peoples. I acknowledge that I do not represent Indigenous peoples or their knowledge or worldviews. I approach this project with humility and in hope of contributing to the disruption of colonial relations through critical engagement in health research.

I was a street nurse in Winnipeg for many years and I have had hundreds of conversations with people who inject Talwin and Ritalin (Ts and Rs). Much of what I have learned in this research project I hadn't made space for in my street nurse conversations. My research interests are local, practical, action-oriented, and positioned in the field of public health and the privileged social location that afforded me a career in this field. It is from these perspectives and my own observations in urban public health that I set out to study the experiences of people who inject Ts and Rs—not with a specific interest in the drugs themselves or the route of their consumption, but because I believed that following the injection of Ts and Rs would bring me to a network of situated keepers of knowledge on the social context that shapes urban injection drug use in Winnipeg.

About 15 years ago, when I was working as a street nurse, I received a mid-afternoon call from a client I saw regularly. She was a woman in her twenties who hung around with a slightly older crowd and regularly injected Ts and Rs. She told me she had shared a needle the night before. As usual I asked, “Can you tell me what happened?”

She had been out late with her boyfriend and two older male friends. One of the men had a “set” of Ts and Rs (two Talwin, one Ritalin: enough for four shots) but there was only one new needle among them. She described the conversation that would inform their decisions around the shared use of that one needle. One of the older men disclosed that he had HIV and hepatitis C, stating he would take “last shot.” The other older man stated he had hepatitis C and would take second last. My client and her boyfriend both shared that they had hepatitis C, but both had tested negative for HIV in the last year. The group decided that my client would use the needle first as she was the youngest, was female, and least likely to have HIV. Her boyfriend would go second. She wasn’t sure if she was at risk for HIV having used the needle first.

This type of sero-status disclosure and subsequent sero-sorting in the context of needle sharing challenged some naïve assumptions I had. Specifically, needle-sharing was not uninformed and reckless, but rather considerate and strategic based on the resources available. The process my client described was an apt example of the type of protective harm-reducing resources that exist among networks of people who use drugs. Asking if people have shared injection equipment and offering a binary set of “yes” and “no” responses will never reveal the intricate sociality of drug use practices. My preference for qualitative methods and what they could uncover grew out of observations of this type.

This research project involved a range of activities I am privileged to have experienced. I was taken on walks of back alleys, parks, and indoor spaces where people congregate to inject drugs, people shared deeply private and painful stories with me, and a group of regulars on Main Street cleverly and mockingly nicknamed me “Pan Handling Degree” (PhD). Most of my research participants were referred by their friends or family. I managed to reach a close network of people who wanted me to hear from others they considered to be knowledgeable. I am immensely grateful to be trusted with their stories. Whether or not these local experts would share their knowledge with me, and whether I could adequately hear it, understand it, and construct a picture of it are difficult and humbling questions that cannot be fully answered. I am very thankful that I have had the opportunity to do my best.

Chapter 1: Introduction

Approximately 5% of the global adult population—or about a quarter of a billion people—reported using a drug in 2015, yet only a small proportion of this drug use is harmful or problematic (United Nations Office on Drugs and Crime [UNODC], 2017). Drug-related harms and problematic drug use are more often experienced by those impacted by structural disadvantage, and these harms take shape along axes of power such as race, social class, and gender (Global Commission on Drug Policy [GCDP], 2017, UNODC, 2017; Rhodes, 2002; 2009). Yet, all too often drugs are construed as the “problem,” rather than the social context that surrounds and shapes the lives and opportunities of people who use drugs. If social context is the problem, social context ought to be the subject of research. Focusing on the environments of drug use can produce insights for meaningful action on the social determinants of drug-related harms and inform locally-tailored and community-informed harm reduction policies, programs, and practices.

Talwin and Ritalin (Ts and Rs) injection use in Winnipeg is a starting place for a local exploration into how social conditions shape drug use practices, benefits, and harms. Throughout this dissertation, the terms “Ts and Rs injection” and “injection of Ts and Rs” are used in reference to the non-medical injection use of Talwin and Ritalin, or in some instances Ritalin alone, primarily but not exclusively by intravenous route. This introductory chapter provides a summary of the epidemiological research on the scope and characteristics of Ts and Rs injection in Winnipeg, the challenges of studying social context, the benefits of qualitative approaches to studying drug use, and an overview of this dissertation.

Epidemiology of Ts and Rs Injection

Talwin (a mild narcotic analgesic) and Ritalin (a synthetic stimulant) injection, although generally uncommon across Canada, is uniquely prevalent in urban centres of the Prairie Provinces and Northwestern Ontario (Hennink et al., 2007; Public Health Agency of Canada [PHAC], 2006, 2014a, 2014b; Schoedel & Shram, 2014; Wild, Wolfe, Newton-Taylor, & Kand, 2008). Surveillance among a convenience sample of 245 people who inject drugs (PWID) in Winnipeg revealed that Ts and Rs were the most commonly injected drug by participants in the six months prior to the survey, followed by cocaine, crack cocaine, and morphine (PHAC, 2006). However, the drug-related harms and benefits, and experiences of people who inject Ts and Rs, have remained largely unexplored.

The PHAC *I-Track* surveillance project is a cross-sectional survey of PWID across Canada. One of the goals of the *I-Track* studies is to describe the changing patterns in drug injection trends and practices among PWID at national and regional levels. Three phases of the *I-Track* studies have taken place since 2003, with Winnipeg participating in only phase 1 (PHAC, 2006). Across all sites, on average, cocaine, morphine, and hydromorphone were the most commonly reported drugs injected in the past six months (PHAC, 2006, 2014a, 2014b), however, there were regional variations in the use of some substances. Heroin injection was commonly reported in British Columbia and Toronto, but rarely at other sites, and the injection of Ts and Rs and Ritalin alone were rarely reported outside of the Prairie Provinces and Northwestern Ontario (PHAC, 2006, 2014a, 2014b). Table 1 below provides a summary of all three phases of PHAC *I-Track* surveillance of people reporting the injection of Ts and Rs and Ritalin alone in the last six months across sites where these substances were commonly (over 10%) reported. The use of Ts

and Rs did not consistently pattern the use of Ritalin alone, suggesting that these are distinct trends.

Table 1

Reported Injection of Ts and Rs and Ritalin (%) in the Last 6 months at Select Sites: I-Track

<i>I-Track Study</i>	<i>Drugs</i>	<i>Edmonton</i>	<i>Regina</i>	<i>Winnipeg</i>	<i>Thunder Bay</i>	<i>Average across all sites</i>
Phase 1: PHAC, 2006	Ts and Rs	23.6%	61.2%	46.4%	-	8.9%
	Ritalin	5.4%	66.8%	10%	-	3.9%
Phase 2: PHAC, 2014a	Ts and Rs	14.9%	40.8%	-	12.1%	6.0%
	Ritalin	1.6%	49.6%	-	40.9%	9.4%
Phase 3: PHAC, 2014b	Ts and Rs	6.8%	38.2%	-	15.2%	6.9%
	Ritalin	2.2%	70.1%	-	55.1%	19.3%

Note. Phase 1 included seven sites, Phase 2 included 10 sites, Phase 3 included 11 sites

Another large survey of PWID in Winnipeg, the Social Network Study II (Wylie, 2005), took place in 2003/2004, in which 435 PWID were surveyed. This research sought to gain insight into the social networks of PWID in Winnipeg and the effects networks had on an individual's risk of blood borne pathogen infection, risk behaviours, and harm reduction activities (Wylie, 2005). In this sample of PWID, cocaine (63%), morphine (36%), and Ts and Rs (32%) were the most commonly reported drugs injected in the last six months (Wylie, 2005). Analyses of this dataset provide insight into the social location and conditions experienced by people who inject Ts and Rs. People who reported most commonly injecting Ts and Rs were more likely than other PWID networks to report Indigenous¹ self-identification, needle-sharing, difficulty accessing injection supplies, residential instability, injection in downtown hotels and

¹ The term Indigenous is used throughout this document in reference to the First Peoples of the lands now known as Canada, and recognition of First Nations, Métis, and Inuit as peoples, and the international legal rights expressed in the 2008 *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP). http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

outdoors, higher rates of hepatitis B and C infection, and solvent inhalation (Shaw, Deering, Jolly, & Wylie, 2010; Shaw, Jolly, & Wylie, 2014; Shaw, Shah, Jolly, & Wylie, 2007; Shaw, Shah, Jolly, & Wylie, 2008; Wylie, 2005; Wylie, Shah, & Jolly, 2006; Wylie, Shah, & Jolly, 2007).

Reports of high blood-borne infection rates among people who inject Ts and Rs in Winnipeg have been contested and deemed low compared to other injection drug use networks with similar rates of needle sharing (Des Jarlais, 2007). This finding suggests that some protective factors or enabling resources may be at work within the practices and broader context surrounding the injection of Ts and Rs in Winnipeg. Nut, King, Saulsbury, and Blakemore (2007) assessed Ts and Rs as drugs of relatively low potential for harm and misuse. However, in Winnipeg these drugs appear to be used by a population embedded within harmful and inequitable social conditions. Thus, people who inject Ts and Rs in Winnipeg are likely to have unique insights into the relationships between social context, drugs, and individual practices. Nevertheless, the available surveillance data on injection drug use in Winnipeg is over a decade old and no qualitative studies exploring the injection of Ts and Rs have been found in the literature, highlighting the need for further exploration.

The non-medical use of prescription drugs, such as Ts and Rs, occupies a borderland between legal and illegal use. There are numerous modes through which prescription drugs can be diverted for non-medical use, including procurement from family and friends, doctors' prescriptions, drug thefts, prescription forgery or fraud, Internet purchases, illegal manufacturing, and other supply chain breaks (Fischer, Bibby & Bouchard, 2010). There is some evidence that the market source and acquisition of Ts and Rs is distinct from other illegal prescription drug markets. Haydon, Rhem, Fischer, Monga, and Adalf (2005) reported on results

from the Canadian Multisite Cohort of Illicit Opioid Users (OPICAN) study in which the acquisition patterns of prescription drugs for non-medical use were explored. Respondents who used Ts and Rs reported acquiring them from a regular dealer (50%), a friend (47.6%), a partner (7.1%), or irregular dealer (4.8%), but never from a doctor. Conversely, all other prescription drugs were acquired from a doctor to some degree, including benzodiazepines (28%), Tylenol 3s and 4s (32%), Demerol (32%), OxyContin (40%), and Percocet (37%). These findings suggest, at least for the *OPICAN* study respondents, that the market source of Ts and Rs was not diverted prescriptions.

Three emerging drug use trends have raised concerns in Manitoba in recent years: bootleg fentanyl use and harms, a rise in injection drug use, and a growing prevalence of crystal methamphetamine use. According to a 2017 opioid surveillance report from Manitoba Health, Seniors and Active Living (MHSAL), from the first quarter of 2016 to the same period in 2017 the number of opioid-related deaths in Manitoba increased by 87.5%. Among fentanyl-related deaths in 2017, 40% were found to have carfentanil present, an analogue considered 50 to 100 times stronger than fentanyl. In suspected opioid overdose events where take-home naloxone kits were used, blotter tabs of bootleg fentanyl (36.6%) and carfentanil (23.7%) were the most commonly reported drugs on board (MHSAL, 2017). Further, injection drug use in Winnipeg is on the rise, evidenced by a nearly three-fold increase in the numbers of needles/syringes distributed annually over the last few years (Ross, 2017). Crystal methamphetamine use is reported to be increasing and associated with a 17-fold rise from 2013 to 2017 in emergency room visits related to amphetamines (Addictions Foundation of Manitoba, 2017). Such rapid shifts in drug markets and trends are often accompanied by harms to people who use drugs, as new sources must be procured, product reliability is lost, and new methods of drug consumption

are tested (Grund, Latypov, & Harris, 2013; Harris, Forseth, & Rhodes, 2015; Horyniak et al., 2014). Nonetheless, the ways in which these changes in drug use trends and markets impact the use of Ts and Rs is unknown.

Researching the Social Context of Drugs

Drug-related harms are largely derived from the social context surrounding drug use, such as access to housing, punitive drug polices, differential policing, economic deprivation, racialized discourses and practices, and socially produced pain and trauma (Rhodes, 2002, 2009; Rhodes et al., 2003; Rhodes et al., 2006). In many circumstances, society's response to drug use is more harmful than the drugs themselves, and harms take on particular forms across axes of power, such as race, social class, ability, and gender (Duff, 2007, 2011, 2012, 2013; National Advisory Committee on Prescription Drug Misuse, 2013; Rhodes, 2002, 2009). Regardless, individual drug use behaviours remain the primary focus of drug use research. A systematic review by Strathdee et al. (2010) found that only one-quarter of epidemiological studies of human immunodeficiency virus (HIV) risk among PWID in the last decade looked outside of individual behavioural risk factors. Such oversights tend to make socially produced problems appear to be problems of individual conduct.

Although surveillance and survey research can capture and quantify the scope of drug use and harms among certain populations, there are significant limitations to the knowledge produced through survey methods. Research priorities are determined by the survey researcher *a priori* in order to construct a survey, limiting opportunity for discovery outside of predetermined questions and responses. Survey methods lack the capacity to capture the continually shifting and non-linear relationships between historical, policy, social, and material environments and human

life (Rhodes, 2009). Multiple perspectives, situated knowledge, alternate voices, and what is acceptable, accessible, appropriate, and safe for people of different social locations are not captured in drug use survey research. Without locally specific and situated knowledge it is difficult to determine how drug-related harms are shaped and magnified, and thus it is difficult to inform interventions that may redress drug-related harms.

Ts and Rs are a trend of smaller urban centres of the Prairie Provinces and Northwestern Ontario, where less drug use research is done. The generalizability or transferability of research findings from large Canadian urban centres to Winnipeg is weak because the urban contexts, drug markets, and trends are regionally distinct. Similarly, interventions designed to redress harms in other contexts are often not transferable. These factors highlight the need for research that not only captures locally specific drug use trends and practices but situates practices within the local context that shapes the conditions for drug-related benefits and harms.

Moreover, the peer-reviewed addictions, harm reduction, and drug use research literature is predominantly derived from quantitative methods (Neale, Allen, & Coombes, 2005; Rhodes, Stimson, Moore, & Bourgois, 2010). This tendency is more pronounced in journals with impact factors higher than 2.0 (Rhodes et al. 2010), with the highest impact journal, *Addictions*, publishing only 2% qualitative research in 2004 (Neale et al. 2005). The impact of this quantitative/qualitative imbalance is difficult to estimate but may shape the way drug use and PWID are understood amongst health actors. Methodological choices result in certain representations of the subject and the problem. Large sample survey studies are critiqued for foregrounding variables of risk and harm and massing individuals into a distant and undifferentiated cast of thousands (Keane, 2011). However, problems of representation are not

unique to quantitative research as qualitative research can also produce representations of the drug-using subject that reinforce problematic stereotypes (Sterk, 2003).

The Research Question

The central question of this research project is: *What is happening with the injection of Ts and Rs in Winnipeg, and what powers shape this phenomenon and the experiences of people within it?* Supplementary questions include:

- What powers (symbolic, structural, and material) are operating to produce and reproduce the injection use of Ts and Rs injection in Winnipeg? How does power shape drug use practices and lived experience?
- What institutional, agency, or organizational services, practices, or policies have a significant impact on the lives of people who inject Ts and Rs? What do those impacts look like?
- What intersecting systems of oppression (e.g. race, social class, gender) are at work within the lived experience of people who use Ts and Rs? How do they operate and intersect to shape identity and lived experience?
- How are Ts and Rs perceived related to other drug trends that are shaping the current market?
- In what ways have people who inject Ts and Rs avoided or mitigated drug-related harms?
- What is the nature of places and spaces in which Ts and Rs are used, and how does the nature of these spaces impact the conditions for drug-related harms and benefits?

These questions are well suited for exploration through qualitative research methods, discussed further in the following section.

Qualitative Research Methods

Adopting qualitative and ethnographic approaches to studying drug use brings with it certain benefits. Emerging drug trends are constantly in motion, and a significant amount of *a priori* information is required to generate meaningful survey questions. Intrusive lines of questions about hidden and stigmatized practices are unlikely to be answered without rapport and trust (Agar, 2002, 2008). Qualitative methods can provide the basis for relations of trust and discovery, and allow rapport to be developed with participants in order to explore the areas that participants find important and meaningful (Page & Singer, 2010). Ethnographically, by taking the researcher into the world(s) of people who use drugs, interpretations grounded in the social, cultural, and experiential realities of the participants can be sought (Bourgois, 1998a, 1998b, 2002). Research starting from the lived experiences of people who use drugs has illuminated the significance of relations with institutional agents (such as housing/shelter, law enforcement, and health services workers) in shaping everyday lives and social practices (Bourgois & Schonberg, 2007; Campbell, 2000; Fraser & Valentine, 2009). Moreover, qualitative research can inform conceptual and theoretical development, which bring a critical examination to extant orthodoxy and assumptions driving harm reduction and substance use research and practice (Davis, 2003; Moore & Rhodes, 2004).

As health system actors, our concerns over drugs and the people who use them have shifted over time. There appears to be consensus that drug-related harms and markets are more complex than ever before (United Nations Office on Drugs and Crime [UNODC], 2016, 2017).

Drug markets are changing more rapidly today in terms of the number, type, and availability of new psychoactive drugs being produced, and the use of new underground technologies for marketing and distribution (Seddon, 2014; UNODC, 2016). The changing nature of drug markets remains a vital area of ethnographic inquiry and significantly shapes the lived experience of drug use. While the health system has its knowledges based in program evaluations, health assessment, surveillance, and tacit knowledge, the people who use drugs possess valuable, hidden knowledges about drug trends, how trends take shape, and how they are experienced. Indeed, these individuals have been observing the same changes over decades while navigating harms every day, giving rise to unique situated knowledge that can be shared through qualitative research approaches.

The Present Study

This focused ethnography is informed by a critical poststructuralism perspective and the sociology of Pierre Bourdieu. The purpose of this undertaking is to explore the social context surrounding the injection of Ts and Rs in Winnipeg, and the conditions for drug-related benefits and harms. The main foci of the study include: the historic, economic, structural, and symbolic factors that have contributed to the social location of people who inject Ts and Rs (macro); institutional and agency practices and policies, neighbourhood characteristics, and social network practices and dispositions that impact the everyday lives of people who inject Ts and Rs (meso); and the nature of spaces in which drug use occurs and how these spaces shape drug use as a social practice (meso/micro). As drugs are generally consumed in the pursuit of benefits, this research makes space to explore both benefits and harms of drug use from the perspective of those with lived experience.

The research took place in two phases in which a total of 36 semi-structured interviews were conducted. In phase I of the research, 24 in-depth, semi-structured interviews were undertaken with people who inject Ts and Rs. In phase II, 12 PWID who lack stable residence were recruited for semi-structured interviews that were focused specifically on spaces of drug consumption. Semi-structured interview findings were coded into a framework, then built into a map that represents the social context surrounding the injection of Ts and Rs in Winnipeg.

Significance of the Study

The injection of Ts and Rs is not considered a “problem” — rather, the “problem” is the social context surrounding it. The experts on this social context are those navigating these conditions every day. Nevertheless, exploring the social context surrounding Ts and Rs injection can result in harm magnification, whereby shedding light on a social phenomenon makes it appear to be a problem and can increase interference into the already highly regulated lives of people who use drugs (Keane, 2011). Thus, it is important to mindfully articulate the “problem” at the outset. Focusing on social context can serve to shift the burden of blame for drug-related harms off of PWID and toward unjust social processes.

This project set out to produce a thorough account of the context surrounding the injection of Ts and Rs in Winnipeg by foregrounding situated knowledge contextualized within relevant histories, macro systems of power, institutional relations of power, systems of meaning, and manifestations at the local level that shape lived experience. Drawing from the expertise of people who use drugs helps build an understanding of everyday social and material conditions, the effects these conditions produce, and the leverage points for redressing drug-related harms and promoting social justice. Contextual understandings of drug use practices can reveal

opportunities to interrupt drug-related harms at structural and spatial levels, which are considered more effective and sustainable than models that aim to change individual behaviours (Des Jarlais, 2000; Rhodes et al., 2006). Further, adopting this approach has the potential to produce actionable knowledge that can inform policy, built environment, harm reduction programming, addictions treatment, and other social services such as shelter/housing, community monitoring/security, law enforcement, and primary care that serve and interact with PWID. Locally tailored approaches are required to identify the interplay between determinants of health and actual living conditions and address those conditions that shape drug-related harms.

Dissertation Overview

This dissertation begins with an extensive look into the evidence and the gaps in knowledge related to the injection of Ts and Rs in Winnipeg. Two broad bodies of knowledge are drawn from to summarize the existing literature on the injection of Ts and Rs; research on the non-medical use of prescription drugs, and research on injection drug use. The literature reviewed in Chapter 2 provides insight into scope, trends, and epidemiology of the non-medical use of prescription drugs. A brief history of the emergence of the injection of Ts and Rs is provided, as well as a summary of the pharmacology, contemporary scope, and harms associated with this drug use trend. However, the ways in which social context contributes to drug use practices are rarely illuminated within the extant drug use literature. A number of contextual factors that contribute to the social conditions for non-medical use of prescription drugs are explained. The injection of Ts and Rs in Winnipeg unfolds as a largely unexplored phenomenon and an appropriate social site from which to examine the relationships between the environment, human life, and drugs.

The theoretical foundation of this research project, grounded in critical poststructuralism and the sociology of Pierre Bourdieu, is introduced in Chapter 3. Bourdieu recognized power as central to social life and believed that the core task of social research is to unveil hidden dimensions of power relations. Bourdieu's concept of field is introduced as a model for understanding the social context of drug use. Bourdieu's concept of habitus is adopted in the place of culture, and the concept of capital is introduced as an essential building block of power within the field. Together these concepts assist in exploring and explaining the salient relations of power that reproduce and shape the injection of Ts and Rs in Winnipeg.

The research methodology and methods utilized in the study are outlined in Chapter 4. This includes an overview of the key features of a focused ethnography, and a description of all data sources, participant recruitment, data analysis and interpretation, and how ethical issues were addressed in this study. As an exploratory focused ethnography, the fieldwork for this research took place in two phases. Themes arising from interviews with participants who inject Ts and Rs in phase I informed the direction of the inquiry. Phase II focused on the nature of spaces in which drugs were consumed and the relationships between social context, space, and drug use practices. All 36 interviews were coded and analyzed and themes were mapped out visually and considered for relations of power in the research setting that shape lived experiences. Systems of power at the structural and institutional levels that shape the local research context are more deeply explored in Chapter 5.

Chapter 5 is focused on constructing a comprehensive picture of the local research setting and a critical engagement and elaboration of the powers at work in the social context of Ts and Rs injection in Winnipeg. This discussion provides a broad view at how patriarchy, capitalism, and settler colonialism shape the institutional infrastructure and mainstream notions of gender,

social class, and race in Canada. Systemic racism, medicalization, neoliberal governance, and drug-prohibition are discussed for their impacts on institutional practices and everyday access to power and resources in the research setting. These systems of power contribute to the production of Ts and Rs injection as a social phenomenon, and the social location and opportunities available to participants in this research.

In Chapter 6 the situated knowledge and stories told by research participants are shared. Themes from these narratives are arranged across five broad categories: social location and biographies, everyday institutional relations, drug market characteristics, habitus and everyday life, and individual drug use practices. Everyday life for participants was found to be characterized by high institutional entanglement, skilled navigation in the exchange of resources, taking care of community, and maneuvering through conditions that maximize drug-related benefits and minimize harms.

In Chapter 7, the three key research findings—family separation, spaces of drug consumption, and harm reduction as everyday practice—are interpreted theoretically and located within the contemporary research and policy context. Family separation emerged as a significant condition for drug-related harms and collective habitus shaped by settler colonialism, drug enforcement, and the combined impacts of the criminal justice and child protection systems. Spaces of drug consumption emerged as locales with intricate sociality and economics that shaped drug use practices, benefits, and harms. Everyday acts of taking care within the community mitigated drug-related harms and maximized benefits. These social practices generally arose from membership and belonging within a community and were limited by access to material and social resources that enable them. Finally, limitations of this research, lessons

learned, and ways forward in research, policy, programming, and practice are discussed in Chapter 8.

Chapter 2: Literature Review

Canadians are among the highest per capita consumers of prescription drugs in the world (International Narcotics Control Board [INAC], 2016). Higher rates of prescribing and dispensing prescription drugs expand opportunities for their diversion and non-medical use (Fischer, Rehm, & Gittins, 2009). The injection of Ts and Rs is one manifestation of these opportunities. Within the extant literature, the non-medical use of prescription drugs (NMUPD) refers to pharmaceutical drug use without a practitioner's prescription, in greater amounts than prescribed, greater frequencies than prescribed, by another route than prescribed, or for other reasons than what the drug was prescribed for (Haydon et al., 2005; Wild et al., 2008). It is noteworthy that harmful pharmaceutical industry practices and inappropriate prescribing practices are not put into view under this definition; only the person using the drug non-medically is problematized. This definition also implies that the use of prescription drugs outside of medical orders is not therapeutic or helpful, which undermines much of the therapeutic use of diverted prescription drugs that occurs by people who are failed or excluded by health systems. Further, throughout the peer-reviewed and grey literature, the terms "prescription drug misuse," "abuse," and "non-medical use of prescription drugs" occur widely and sometimes interchangeably with either varying definitions or no clear definition.

Acknowledging the limitations of the concept of NMUPD, this review begins with a summary of the available evidence on the scope and nature of NMUPD across Canada, and in Manitoba, in order to provide an overview of major trends. As much of the large-scale survey research on NMUPD across Canada derives from non-Indigenous worldviews and tends to exclude Indigenous peoples living on-reserve, a summary of NMUPD among Indigenous peoples in Canada is included. The discussion then turns to an examination of the pharmaceutical

properties of Talwin and Ritalin, the scope of the non-medical use of prescription stimulants, and the history of Ts and Rs injection. A detailed summary of the literature on the scope, nature, and harms of Ts and Rs injection in the Prairie Provinces of Canada follows. In order to expose some aspects of social context that shape NMUPD, prescribing and dispensing in North America, legal and professional regulation of prescription drugs in Canada, the under-treatment of pain and mental health conditions, and criminal justice issues related to NMUPD are discussed. Finally, some of the limitations of the state of knowledge regarding NMUPD and injection drug use are discussed with implications for the current research project.

Scope of NMUPD in Canada, Manitoba, and Among Indigenous Peoples

Some national surveys provide insight into the scope of NMUPD in the general Canadian population. Although many of these data sources are more than five years old, they provide some insight into national trends. Health Canada's most recently available (2012) *Canadian Alcohol and Drug Use Monitoring Survey (CADUMS)*, a telephone survey of adults across Canada, found females more likely to report the use of psychoactive prescription drugs than males (25.5% and 20.2% respectively), with sedatives and tranquilizers more common among females than males. Psychosocial distress, grief, and role strain among women is suggested to be related to the high reliance on benzodiazepines by prescribers (British Columbia Ministry of Health, 2008; Dell et al., 2012). Conversely, the reported use of stimulant prescription drugs among males was higher, at 1.2% for males and 0.5% for females (National Advisory Committee on Prescription Drug Misuse, 2013). There is also evidence that consumers—youth in particular—perceive prescription drugs to be safer and more reliable than illegal street drugs (McCarthy, 2007; Twombly, & Holtz, 2008).

Using telephone survey methods similar to the *CADUMS* survey, the Canadian Addiction and Mental Health (CAMH) *Monitor* in Ontario is the longest running survey of adult substance use in Canada. The 2015 *CAMH Monitor* separates prescribed opioid use among males (21.1%), and females (24.1%), from non-medical use of prescription opioids among males (3.8%), and females (4.4%), providing a better estimation of non-medical prescription opioid use (Ialomiteanu, Hamilton, Adlaf, & Mann, 2016). However, this is the only indicator of NMUPD contained within the *CAMH Monitor*.

NMUPD in Manitoba. It is noteworthy that most of the studies informing the scope and harms of NMUPD in the province of Manitoba are outdated and not likely to represent contemporary trends. Regardless, insights can be estimated from several publicly available data sources such as: high-school student surveys, data collected from people entering drug treatment programs, drug dispensing monitoring systems, and data drawn from fatal overdose events. The most recent *2012-2013 Manitoba Youth Health Survey Report* (2014) found that 6% of students in grades 7 through 12 reported the use of pharmaceutical drugs “to get high” in the last year (including prescription and over-the-counter drugs). Data on the types of prescription drugs used were not gathered. Prescription drugs were the second most commonly reported type of drug used, next to cannabis (21%). Reported use of any drugs among high school students increased steadily from grade 7 through grade 12 respondents, with males slightly exceeding females in use until grade 11, after which females reported slightly higher use.

The Canadian Community Epidemiology Network on Drug Use (CCENDU) report from 2015 provides information on drugs that people entering addictions treatment programs in Manitoba reported ever using. Among youth entering addictions programs in 2011/2012, marijuana (94.5%), ecstasy (47.9%), and cocaine (37.6%) were the substances youth most

commonly reported ever using. Youth also reported having used a range of prescription substances, including opioids (32.1%), over-the-counter drugs (21.2%), barbiturates (20.1%), benzodiazepines (14.3%), and Ritalin (13.6%) (CCENDU, 2015). There were no significant changes in the rate of youth reporting Ritalin use from 2007/2008 to 2011/2012. In 2011/2012, adults entering addictions treatment more commonly reported using prescription drugs than youth (CCENDU, 2015). Opioids (60.2%) were the most prevalent, including OxyContin (20.3%), followed by over-the-counter drugs (59.8%), benzodiazepines (49%), and Ritalin (9.7%) (CCENDU, 2015). The use of Ts and Rs was not assessed and the report does not distinguish between medical and non-medical use of prescription drugs. This has implications for the higher reported rates of Ritalin use among youth as it is a commonly prescribed for youth diagnosed with Attention Deficit and Hyperactivity Disorder (ADHD). It is also noteworthy that addictions program entry assessments inquire about lifetime use of drugs, and these responses are not necessarily relevant to the drugs for which people are seeking treatment. Thus, these assessments provide some indication of the scope of substance use, but not the harms.

Manitoba Health, Seniors, and Active Living (MHSAL) produces quarterly opioid surveillance reports in which prescription opioid dispensing information is collated. Although this report does not capture NMUPD specifically, it provides information on local trends in opioid prescribing and dispensing. Data are drawn from the Drug Program Information Network (DPIN) in Manitoba, an electronic, on-line, point-of-sale prescription drug database that is connected to all community pharmacies to track out-of-hospital drug dispensing. The number of Manitobans to whom a prescription opioid from a community pharmacy was dispensed increased by 15% from 2012 to 2017, with females dispensed prescription opioids in a greater proportion than males (MHSAL, 2018). The report also provides information on dispensing of opioids in

amounts over 50 morphine milligram equivalents (MME) per day, which is associated with increased risk of opioid overdose (Centres for Disease Control and Prevention, 2016), thus providing a measure of the scope of problematic opioid prescribing/dispensing in Manitoba. There was a gradual 29% increase in the number of people prescribed a prescription opioid in amounts greater than 50 MME in Manitoba from 2012 to 2017 (MHSAL, 2018). Post-dispensing diversion is considered a key source of prescription opioids that reach the illegal market (National Advisory Committee on Prescription Drug Misuse, 2013).

Looking at prescription drug use indicators among people who died of apparent opioid-related overdose in Manitoba provides some insight into the harms of prescription drug use, whether the drugs were used medically or non-medically. Data from the Office of the Chief Medical Examiner indicates the top substances other than opioids detected in toxicology screens among people who died of apparent opioid-related deaths from January 2014 to September 2017 were benzodiazepines and antidepressants (MHSAL, 2018). Further, from 2014 to 2017, opioids, followed by antidepressants and benzodiazepines, were the drugs most frequently prescribed to those who died, and opioid prescriptions in the six months prior to an apparent opioid-related overdose death in Manitoba increased from 57% in 2014 to 72% in 2017 (MHSAL, 2018). While bootleg illegal fentanyl has emerged in the Manitoba drug market and is implicated in a growing proportion of apparent opioid-related overdose deaths, prescription opioid drugs are implicated in most overdose fatalities (MHSAL, 2018).

NMUPD and Indigenous peoples. There is growing evidence that NMUPD and associated harms among Indigenous peoples are a significant concern (Assembly of First Nations, 2010, 2011; Firestone, Fischer & Tyndall, 2015; First Nations Governance Centre [FNIGC], 2010, 2012). There are approximately 88,000 people in Manitoba living on-reserve

(Government of Canada, 2014), and the NMUPD among on-reserve Indigenous people are often not captured in the data systems reviewed in the previous section. Russell, Firestone, Kelly, Mushquash, and Fischer (2016) found that data regarding prescription opioid use and harms among Indigenous Canadians are limited, although available data suggest that prescription opioid dispensing and use among Indigenous populations are on the rise in select settings compared to the non-Indigenous Canadian population.

Where some research has suggested that NMUPD is much higher among Indigenous people living off-reserve than non-Indigenous people (Currie & Wild, 2012; Currie, Wild, Schopflocher, & Laing, 2015), the *First Nations Regional Health Survey 2008/10* found that fewer than 5% of youth living on-reserve reported illicit drug use of any kind, which is lower than the national average (First Nations Information Governance Centre [FNIGC], 2012). Further, among adults living on-reserve, the *First Nations Regional Health Survey 2008/10* found sedatives to be the most commonly used prescription drug (non-medically) among both male (5.6%) and female (5.9%) respondents, followed by opioids (4.1% for females, 5.2% for males) and stimulants. Use of prescription and non-prescription stimulants (cocaine, crack cocaine, crystal methamphetamine, ecstasy) was combined in this survey; and male (3.5%) respondents were more likely to report stimulant use than female (2.1%) respondents (FNIGC, 2012).

In most contexts where racialized inequalities exist, the scope of drug use between populations can be comparable, but the burden of drug-related harms falls upon those who experience colonial oppression, racial discrimination, and other forms of structural disadvantage (GCDP, 2016). In Northern Ontario, prescription opioid harms, including dependence, mortality, and pregnancy-related harms, appear higher among Indigenous than non-Indigenous populations.

For example, in 2012, Cat Lake First Nation in Ontario declared a community crisis due to the widespread use and harms associated with NMUPD (Chiefs of Ontario, 2010; Dell et al., 2012). Moreover, addictions and harm reduction services are rarely available in First Nations, Métis, and Inuit communities, and often are not culturally appropriate (Carter & McPherson, 2013; Loppie Reading & Wien, 2009; National Advisory Committee on Prescription Drug Misuse, 2013; Russell, et al., 2016).

The pathways to NMUPD and problematic substance use among Indigenous peoples can be linked to settler colonialism and the resultant social dislocation, economic exclusion, and health inequities. Many First Nations people link their psychological pain and trauma, and associated prescription drug use, to their experience in Indian residential schools and foster care placement (Health Canada, 2011). Chronic health diseases—such as arthritis and rheumatism, diabetes, asthma, heart disease, chronic bronchitis, and cancer—are more prevalent among Indigenous people than non-Indigenous people in Canada (FNIGC, 2010). The higher presence of these illnesses results in higher prescribing, dispensing, and general availability of prescription analgesic drugs in First Nations communities (National Advisory Committee on Prescription Drug Misuse, 2013). In a study by Currie et al. (2015) in Edmonton, Alberta, 80% of Indigenous study respondents reported experiences of racial discrimination, and these experiences were associated with symptoms of Post-Traumatic Stress Disorder and NMUPD. Further, the authors found that participation in Indigenous cultural traditions was associated with increased racial discrimination. Meanwhile, cultural continuity and culture-based programs for and by Indigenous people have been found beneficial to all areas of well-being, including managing trauma and problematic drug use (Rowan et al., 2014).

Where epidemiological data and media representations tend to portray Indigenous peoples in Canada as generally unhealthy and unable to manage their own affairs, these representations can have a disempowering effect on Indigenous communities and interfere with efforts toward Indigenous self-determination and governance (National Advisory Committee on Prescription Drug Misuse, 2013; Nelson, Browne, & Lavoie, 2016). The state of substance-use knowledge, to date, is largely grounded in Western knowledge and scientific worldviews, which lack an understanding and acceptance of cultural beliefs and the spiritual influence in everyday life and tend to overlook the historic and structural production of the conditions for problematic substance use (Native Addictions and Mental Health Regional Research Consultation/Forum, 2011; Nelson et al., 2016). The creation of “population pathology” is a pervasive and subtle form of structural racism and discrimination that can set up mainstream bias toward Indigenous peoples (Reading, Kmetz, & Gideon, 2007). The causes of problematic substance use among Indigenous peoples should be understood to arise from the highly racially stratified and discriminatory ways in which daily life and broader opportunities are systematically and historically unequally organized (Reading et al., 2007).

The Non-Medical Use of Talwin and Ritalin

The non-medical use of Talwin alone does not arise as a concern in the literature, thus this overview focuses more specifically on non-medical prescription stimulant use and the use of Ts and Rs in combination. This section begins with a synopsis of pharmaceutical properties of Talwin and Ritalin, followed by a brief overview of the literature on the non-medical use of prescription stimulants, a summary of the history and contemporary state of the injection use of Ts and Rs, and a review of the evidence of harms associated with Ts and Rs injection.

Talwin and Ritalin as pharmacological agents. Talwin (pentazocine) is an agonist/antagonist opioid analgesic, not commonly associated with overdose (Challoner, McCarron, & Newton, 1990). The most common formulation of Talwin (pentazocine) dispensed is the round, flat, white, 50 mg tablet. According to the product monograph (Sanofi-Aventis, 2011), when administered orally it is equivalent to approximately 60 mg codeine or 5 mg intramuscular morphine in analgesic effect. The onset of effect occurs within 15-30 minutes, with duration of three to four hours. Common side effects include miosis (constriction of the pupils), mild respiratory depression, increased biliary pressure (which can lead to gastric reflux), decreased intestinal motility (which can lead to constipation), and sedation.

Prolonged consistent use of Talwin can lead to dependence and subsequent withdrawal symptoms on cessation, which are generally simple to manage compared to other narcotic analgesics (Brogden, Speight, & Avery, 1973). Where most narcotic analgesics such as morphine have increased effect with increased dose, Talwin appears to have a ceiling effect on its analgesic properties (Brogden et al., 1973). Unlike other narcotic analgesics known to cause significant respiratory depression and subsequent fatal overdose, Talwin has not been associated with these classic opioid overdose symptoms (Brogden et al., 1973; Challoner et al., 1990). The singular non-medical use of Talwin is rare and reports of harms derived from injection are limited to older case studies. Reported harms include dermatological complications, especially among people with diabetes mellitus (Palestine, Millns, Spigel, & Schroeter, 1980), venous complications (Padilla, Becker, & Hoffman, 1979), and fibrosis of muscular tissue if injected into the muscle (Oh, Rollins, & Lewis, 1975).

Ritalin (methylphenidate) is a synthetic stimulant drug commonly used in the treatment of ADHD (Sherzada, 2012). In 1956, Health Canada approved short-acting methylphenidate

(Ritalin®) in 5, 10, and 20 mg tablets. Long-acting formulations were approved later, including Ritalin sustained release in 20 mg tablets in 1984; Concerta® in 18, 27, 36, and 54 mg tablets was approved in 2003; and Biphentin® was approved in 2006 in a range of strengths from 10-80 mg tablets (Schoedel & Shram, 2014). Immediate release formations have effects that last for three to five hours, where sustained release formations can last from eight to 12 hours (Sherzada, 2012). No studies were found that compared long-acting versus short-acting stimulant preparations for their potential for diversion and non-medical use in Canada. However, a review of non-medical prescription stimulant use in the United States (U.S) indicated that 80% of respondents reported the use of short-acting preparations, 17% used long-acting, and 3% used both (Bright, 2008).

Ritalin exerts a potent stimulant effect on the cardiovascular and central nervous systems and has been shown to increase systolic blood pressure by about 5 mm Hg, which in long-term therapy is known to increase morbidity and mortality (Nissen, 2006). Volkow et al. (1995) found that despite similarities between cocaine and Ritalin in their affinity for the dopamine transporter binding site and their rapid uptake in the brain, these drugs differ significantly in the rate at which they clear from the brain, with Ritalin clearing much more slowly. These differences in clearance were not found to be associated with differences in onset, duration, and decline of the “high” associated with the drugs. This finding implies that it is the initial inhibition of the dopamine transporter that is associated with the high. Volkow et al. (1995) suggest that the relatively slow clearance of Ritalin from the brain may serve as a limiting factor for frequent self-administration, and thus may prevent the use of Ritalin for the type of drug bingeing associated with cocaine and crack cocaine. The effects of Ritalin may be limited by the relatively slow uptake, especially if taken orally (Darredeau, Barrett, Jardin, & Pihl, 2007). If used

intravenously, or if taken orally in conjunction with alcohol, Ritalin produces more cocaine-like effects (Volkow et al., 1995). Although reports of fatal overdose are relatively rare, Ritalin when used with alcohol can produce the metabolite, ethylphenidate, which has been implicated as a potential contributing factor in fatal overdose among people using this combination (Markowitz et al., 2000).

Non-medical use of prescription stimulants. The emergence of ADHD as a diagnostic category and subsequent growth in ADHD diagnosis throughout the 1980s and 1990s resulted in a rapid expansion of prescription stimulant products. Particularly, various formulations of methylphenidate (Ritalin®) and amphetamine (Adderall®) were approved for use by many high-income countries' national prescription regulating bodies during the 1990s (Rafnar, & Bjarnadottir, 2016). Today, the worldwide prevalence of ADHD is estimated to be 5.3% (Brault & Lacourse, 2012); however, diagnosis of ADHD and the resultant treatment with long-term stimulant use are much more common in North America than in Europe (Nissen, 2006). The rise in prescription stimulant dispensing in North America, and more recently Iceland (Rafnar, & Bjarnadottir, 2016), has been associated with a general rise in the non-medical use of prescription stimulants through increased access to diverted pharmaceuticals (Kroutil et al., 2006). Accordingly, health researchers have demonstrated interest in tracking and exploring the non-medical use of prescription stimulant drugs.

The majority of studies exploring the non-medical use of prescription stimulants are focused on high school and college students (Wilens et al., 2008). Kaye and Darke (2012) found that 71% of the studies done on the non-medical use of prescription stimulants were based on high school and college student populations in North America. Although the use of prescription stimulants among high school and college students is a distinct trend from the injection of Ts and

Rs in most respects, this body of literature provides valuable insight into the use of these drugs under different social contexts.

Rates of prescription stimulant use among college students have been found to vary from 5 to 35% across different studies (Wilens et al., 2008). The vast majority of college students report the purpose of their non-medical prescription stimulant use to be the pursuit of cognitive enhancement, to assist with studying (Carroll, McLaughlin, & Blake, 2006; Darredeau et al., 2007; Lookatch, Dunne, & Katz, 2012; Schoedel & Shram, 2014; Wilens et al., 2008) and/or to prolong alcohol drinking sessions (Babcock & Byrne, 2000; Barrett & Phil, 2002). In one study, 60% of respondents reported their non-medical stimulant use to be helpful and not harmful (Carroll et al., 2006). Studies that explored acquisition among college students have found diverted prescriptions from peers to be the primary source of prescription stimulants (Darredeau et al., 2007; Wilens et al., 2008). College students who used prescription stimulants non-medically were found more likely to be white, from middle- to high-income backgrounds, and attending college in Northeast U.S. (McCabe, Cranford, Morales, & Young, 2006).

Despite wide recognition of the potential for prescription stimulants to be used non-medically, little is known about patterns of use and harms. In a large U.S. study, Kroutil et al. (2006) found that less than 13% of people who reported non-medical use of prescription stimulants met diagnostic criteria (DSM-IV) for stimulant dependence. A rapid assessment by Wild et al. (2008) of the non-medical use of prescription stimulants in Edmonton, Alberta found that among emergency room (ER) visits from 2003-3006 related to prescription drug use, disorders due to stimulants were the leading cause at 16.64/100,000 ER visits, followed by drug withdrawal syndrome at 15.22/100,000 ER visits. Few people, however, were hospitalized for stimulant-related ER visits. Evidence of harms related to the non-medical use of prescription

stimulants is mostly limited to case reports and small studies of clinical populations (Kaye & Darke, 2012). Further, these case studies have focused nearly exclusively on biomedical harms as a direct result of drug consumption, not on the complex interactions between substance, person, and social context.

The literature on the non-medical use of prescription stimulants among high school and college students fosters a robust understanding of this trend by providing insight into the scope of use, characteristics of people who use, reasons for use, benefits, and harms of use. Exploring the reasons that people use drugs helps uncover the relationship between social context and drug use. For instance, if college students are using stimulants to enhance academic performance, the pressures arising from the academic institutional setting emerge as part of the context shaping use. By extending the exploration of drug use into these areas, a broader range of interventions to reduce harms can come into view for consideration.

The history of Ts and Rs injection. The injection of Ts and Rs appears to have evolved out of two separate drug trends, Ts and blues, and Ritalin injection, both dating back to the U.S. in the 1970s. Pentazocine, marketed by the Sterling-Winthrop company as Talwin, was approved for use in the U.S. in 1967 (Baum, Hsu, & Nelson, 1987). As pentazocine was evaluated to have low potential for harm and misuse, narcotic controls on Talwin were not applied internationally, or in the U.S. (Polkis, 1982). By the late 1970s, there were accounts of the intravenous use of a combination of Talwin and the antihistamine tripeleennamine, which was a 50 mg blue-coloured pill (Polkis, 1982; Showalter, 1980). The combination was referred to as “Ts and blues,” and when used by injection reportedly produced a euphoric high, similar to heroin (Baum, et al., 1987; Polkis, 1982; Showalter, 1980).

By the mid to late 1970s, reports of Ts and blues became particularly high in some U.S. cities, with initial concerns raised in mid-west cities including Chicago, St. Louis, Cincinnati, Detroit, and New Orleans, and later eastern cities such as Newark, Buffalo, and Philadelphia (Polkis, 1982). Three reasons were posited for the emergence of this trend: declined quality of available heroin; low cost of Ts and blues; and low regulatory controls over Ts and blues, enabling diversion to the illegal market (Polkis, 1982; Showalter, 1980). Ts and blues tended to be used by urban, marginalized, African-American men (Polkis, 1982), and occasionally associated with a volatile and violent drug market in some U.S. cities (Polkis, 1982).

The harms associated with Ts and blues were not negligible, particularly for the era. Emergency room visits rose, and coroners' offices reported a significant growth in the number of deaths with pentazocine and tripeleminamine on toxicology reports (Polkis, 1982). The most common adverse reaction was tonic-clonic seizures, primarily from tripeleminamine, reported by nearly 20% of people who used these drugs in one study (Lahmeyer & Steingold, 1980). However, life-threatening overdose was considered rare (Polkis, 1982). Injection-related cutaneous problems and cardio-respiratory diseases were noted in relation to the pulmonary build-up of fillers within the pills (Butch, Yoken, & Sigell, 1979; Polkis, 1982; Showalter, 1980; Tomashefski, Hirsch, & Jolly, 1982).

Several interventions were implemented to deter the use of Ts and blues. In 1979 the U.S. Drug Enforcement Administration rescheduled Talwin under the *Controlled Substance Act*, enabling harsher punishments for trafficking Ts and blues (Polkis, 1982). The original Sterling-Winthrop tablets were amenable to injection as they readily dissolved in water when crushed (Polkis, 1982). The formulation was changed in 1981 because of concerns around abuse and diversion. Talwin NX©, with 0.5 mg of naloxone, was added to the formulation to prevent it

from being injected (Baum et al., 1987; Griffin & Spillane, 2012). Naloxone has no effect if taken orally, but if injected the naloxone binds to opioid receptors blocking the effects of Talwin (Sanofi-Aventis U.S., 2011). This change in formulation largely diminished the use of Talwin for non-medical use (Griffin & Spillane, 2012), although occasional accounts of intravenous use of Talwin NX© were still reported in combination with tripeleminamine (Reed & Schnoll, 1986).

Likewise, during the 1970s the intravenous use of Ritalin became a concern in the U.S. North West (Rasmussen, 2008). Ritalin was reported to provide effects similar to cocaine when used by injection and resulted in a range of harms related to the intravenous use of crushed pills (Rasmussen, 2008; Volkow et al., 1995). Consequently, the U.S. Task Force on Drug Abuse called for stricter scheduling of Ritalin due to abuse concerns in metropolitan areas, specifically Seattle where it was considered the primary drug of injection (Schmeck, 1971). Although the injection of Ts and blues declined significantly in the U.S. after the introduction of Talwin NX (Griffin & Spillane, 2012), concerns about the injection Ts and Rs arose in the U.S. Midwest in the 1990s (Carter & Watson, 1994), suggesting that Ritalin supplanted tripeleminamine in the 1980s or early 1990s.

Conversely, in Canada, Talwin PX© (50 mg pentazocine HCL without naloxone) was never removed and remains on the market (Canadian Drug Products Database, 2018), and is still manufactured by Sanofi-Aventis Canada in Quebec. In the 1990s, patterns of injection drug use varied across urban centres in Canada with cocaine more common in Montreal and Toronto, heroin dominant in Vancouver, and Ts and Rs second to cocaine in the Prairies (Hankins, 1998; Riley & Nolin, 1998). In Winnipeg in the late 1980s, Ts and Rs were reported the most common drug of injection followed by cocaine and heroin (Hammond et al., 1991). The use of Ts and Rs across the Prairies in the 90s appears to have fluctuated in response to the price and availability

of cocaine in the illegal market (Gold, 1990). In older studies of PWID presenting to emergency rooms, Ritalin injection was associated with typical symptoms of stimulant toxicity, including hallucinations, paranoia, seizures, and depressive symptoms post-bingeing (Parran & Jasinski, 1991). Where some have reported injecting Ritalin slow release (20 mg), this preparation contains water insoluble constituents, which are suggested to be linked to vascular sclerosis (scarring) and pulmonary fibrosis (Parran & Jasinski, 1991).

Contemporary research on Ts and Rs injection. Currently, the injection of Ts and Rs is not a wide concern in Canada as other drugs, such as cocaine, crystal methamphetamine, heroin, and prescription opioids, tend to be more widely used (PHAC, 2006, 2014a, 2014b). However, outside of Canada there are certain geographies and populations in which the injection of Ritalin alone is prevalent. A study with PWID in Iceland found Ritalin to be the most commonly injected drug, with 85% of one sample reporting intravenous use in the last three months (Bjarnodattir et al., 2013). The mass emergence of Ritalin injection in Iceland is posited to be enabled by lifted restrictions on prescription stimulants in concert with a significant growth in Ritalin prescribing (Rafnar, & Bjarnadottir, 2016). Similarly, a resurgence of Ritalin injection in France has been noted, with up to 20% of PWID reporting use, particularly among low-income men in central Marseille (Djezzar, Courneé, & Richard, 2014; Frauger et al., 2013).

Trends in the non-medical use of Ritalin alone and Ts and Rs have been studied across seven different Canadian urban centres, including Winnipeg, among three distinct drug using populations: street-involved youth, street-involved adults, and recreational drug users (Canadian Center for Substance Abuse [CCSA], 2016). This report does not specify the route of consumption for these drugs, so ostensibly includes all routes including injection use. Rates were found to vary more by age group than by urban centre. Among adults who use drugs and have no

permanent residence, Winnipeg (25%) and Regina (32.5%) had the highest rates of past year use of Ts and Rs, yet lower rates of Ritalin use among street-involved youth and recreational drug users than other urban centres (CCSA, 2016). The variability in trends of prescription stimulant use across different demographic groups suggests that the uptake and use of prescription stimulants is regulated by social factors beyond drug availability.

Within Canada, the intravenous use of Ts and Rs appears to be low in general. Phase 2 of the PHAC *I-Track* study found that 9.4% of the national sample of PWID reported the injection use of Ritalin alone in the last six months, and 6% reported injecting Ts and Rs (PHAC, 2014a). The most recent *I-Track* phase 3 study (PHAC, 2014b) found that 19.3% of the national sample reported the injection use of Ritalin alone in the last six months, and 6.9% of the respondents reported the injection use of Ts and Rs. However, higher reported injection use of these products is found among populations in the Prairie Provinces and North Western Ontario (PHAC, 2006, 2014a; 2014b; Schoedel & Shram, 2014).

Regina is the urban centre with the highest reported injection use of Ts and Rs in Canada. In a survey of 250 PWID from Regina in 2005, 87.2% of this sample identified as First Nations, Métis, or Inuit (Hennink et al., 2007). From that study, cocaine was the most common drug injected in the previous six months (33 % for females, 34% for males), followed by Ts and Rs (26% for females, 19% for males), and Ritalin alone (25% for females, 22% for males). Most respondents reported using injection drugs in their own home, rather than outdoors or in “shooting galleries.” A small proportion of these respondents tested positive for human immunodeficiency virus (HIV) (2.9%), and 63.7% tested positive for the hepatitis C virus, with a small number co-infected with both viruses. In the most recent PHAC (2014a) *I-Track* phase 3 report, among Regina respondents, Ritalin alone was the most commonly reported drug injected

(49.6%) in the last six months, followed by Ts and Rs (40.8%). Among the cities included in this most recent *I-Track* study, Thunder Bay respondents also reported high use of Ritalin by injection (40.9%) but lower use of Ts and Rs (12.1%) in the last six months.

Edmonton, Alberta has experienced moderate rates of reported Ts and Rs injection in recent decades. According to *I-Track*, Ts and Rs were reported injected in the last six months by 23.6% of respondents in phase 1 (PHAC, 2006), and 14.9% in phase 2 (PHAC, 2014a). Schoedel and Shram (2014) suggest that the prevalence of Ts and Rs injection in Alberta has been related to the low street cost of Ritalin products. Ritalin® (immediate release) and Ritalin SR® are among the cheapest stimulant medications at approximately \$9.00 and \$14.50 respectively when dispensed from pharmacies (Schoedel & Shram, 2014). However, the street prices of prescription drugs were found to be considerably higher than pharmacy prices (Wild et al., 2008).

Drawing from results of the Canadian multi-city *OPICAN* study of inner-city drug users in Edmonton, Wild et al. (2008) found that the price of Ts and Rs ranged from \$2 to \$25 for a single pill, and \$50 for a “set” (one of each Talwin and Ritalin in this study). These street prices were comparable to that of Dilaudid (8 mg hydromorphone) and morphine (price varied by strength), where Tylenol 3 and Tylenol 4 were relatively inexpensive at \$0.5 to \$2 per pill. People who reported injecting Ts and Rs indicated having higher drug expenditures than those who used street methadone, demerol, valium, or codeine (Wild et al., 2008). However, quantities of daily drugs were not specified in the study, so it is possible that people who use Ts and Rs use greater quantities of drugs in general than other drug users. Among all these studies, a high prevalence of polysubstance use was reported among PWID including drugs used by injection and non-injection methods. Although true rates cannot be known, Schoedel and Shram (2014) suggest that the injection use of Ts and Rs is decreasing in Western Canada based on

convenience survey results from 2002 and 2007. This finding is not supported by PHAC (2014a) *I-Track* results, especially for cities like Thunder Bay and Regina where reported rates remain high. Further, it is noteworthy that all samples of PWID are convenience samples, and subject to great variability.

Only one study was located that explored the acquisition of Ts and Rs for injection in Canada. Drawing from the *OPICAN* study, Haydon et al., (2005) found that people who injected Ts and Rs mostly reported getting their drugs from a regular dealer (50%) or from a friend (48%), while none reported prescriptions from a doctor or from theft. This profile of acquisition was markedly different from all other prescription drugs being used non-medically, where drugs like benzodiazepines and prescription opioids were primarily acquired from doctors' prescriptions (Haydon et al., 2005). Currently in the U.S., injectable liquid Talwin is available on the market but oral tablets, although approved, have been discontinued (U.S. Food & Drug Administration, 2017). In Canada Talwin PX© (a 50 mg tablet without naloxone) is still being manufactured, suggesting the source of Talwin for the Ts and Rs market is likely from within Canada.

Most of what is known of Ts and Rs injection in Winnipeg, Manitoba is drawn from a large dataset collected in 2003-2004 (Wylie, 2005). Of the 435 Winnipeg respondents, the most frequently injected drug was cocaine (63%), followed by morphine (36%), and Ts and Rs (32.3%), where Ritalin alone was reported by only 5.3%. People who inject Ts and Rs in Winnipeg were found to have higher than average rates of hepatitis B and C infection (Shaw et al., 2010; Wylie et al., 2006), high rates of syringe and injection equipment sharing, core area residency, unstable housing, entrenched poverty, Indigenous self-identification, injection within downtown Winnipeg hotels, and some association with solvent inhalation (Shaw et al., 2007;

Shaw et al., 2010; Shaw et al., 2014; Wylie et al., 2006; Wylie et al., 2007). Although people who inject Ts and Rs in Winnipeg often live in inner-city neighbourhoods where needle exchange programs are situated, many report having difficulty accessing sterile injection supplies (Shaw et al., 2007). These findings suggest that the network of people who inject Ts and Rs experience a greater burden of drug-related harms, barriers to service, and structural violence than other networks of PWID in Winnipeg. What is known of the relationship between social context and the injection use of Ts and Rs is limited to associations between demographic characteristics and drug use behaviours drawn from survey derived datasets. There have been no qualitative studies to date exploring this phenomenon.

Harms associated with Ts and Rs injection. Ts and Rs have been evaluated to have relatively low harms associated with their use when compared to other drugs on the illegal market (Nut et al., 2007). However, pulmonary talcosis, infective endocarditis, and blood borne infections are important to discuss. Pulmonary talcosis and infective endocarditis arise from the injection of crushed and solubilized pills. Although of different etiology they present with similar symptoms. Conversely, blood borne infections, primarily HIV, hepatitis C and hepatitis B, can arise from the use of contaminated injection equipment.

Infective endocarditis can result from several injection drug use related causes, including the intravenous injection of fillers within the pills, which can damage the cardiac valves (Cooper et al., 2007). Other related causes include: injection of high bacterial loads (primarily staphylococcal bacteria) related to unsterile injection practice or drugs contaminated with bacteria; and spasm of the heart vessels leading to cardiac tissue damage related to the use of cocaine or other stimulant drugs (Cooper et al., 2007; Moss & Munt, 2003). The symptoms can present differently depending on which valves are affected, but generally fever, chest pain,

difficulty breathing, and cough are common manifestations (Moss & Munt, 2003). Imbert, Cohen, and Simon (2013) found low incidence of coronary disease and endocarditis among people who inject Ritalin in France and suggested this may be due to use of 10 µm filters (Sterifilt®) used to remove particulate matter in the preparation of the pills for injection. These filters are regularly made available through harm reduction supply distribution programs in France (Imbert et al., 2013).

Often referred to as “chalk lung,” pulmonary talcosis, or filler-induced pulmonary granulomatosis, is a harm that can arise from the intravenous use of pills designed for oral use. Fillers, including talc, micro-crystalline cellulose, or cornstarch (Polkis, 1987), are binding ingredients in pills manufactured for oral use, including Ts and Rs. When Ts and Rs are crushed, dissolved, and injected intravenously, filler particles can become lodged in the tiny pulmonary vessels and migrate to the spaces around the air sacs of the lungs (Marchiori et al., 2010). The body will recognize these particles as foreign, and macrophages from the immune system will attack them, resulting in an inflammatory mass, or granuloma (Marchiori et al., 2010; Sussman, Pentz, Spruijt-Metz, & Miller, 2006; Ward et al., 2000). Symptoms include progressive shortness of breath or difficulty breathing, weight loss, wheezing of the chest, cough, and emphysema (Marchiori et al., 2010; Stern et al., 1994).

Blood borne infections (e.g. hepatitis B, hepatitis C, and HIV) can be easily transmitted by shared injection drug use equipment (PHAC, 2014b). In some parts of the world injection drug use has been associated with significant epidemics of HIV and hepatitis C (UNODC et al., 2017). HIV rates in Manitoba are considered high compared to other Canadian provinces and territories (Government of Canada, 2015). However, new HIV infections in Manitoba are primarily driven by sexual transmission, with infections related to injection drug use at

approximately 12% (Manitoba HIV Program, 2015). This is markedly different from trends in Saskatchewan, where new HIV infections have been primarily driven by injection drug use (Government of Saskatchewan, 2016). Wylie et al. (2006) explored rates of blood borne infections among different networks of PWID in Winnipeg, finding that the use of Ts and Rs was associated with increased rates of hepatitis B and C, but not HIV.

Contextual Factors Shaping NMUPD

There are several contextual factors shaping NMUPD that are not often captured in studies exploring the scope and nature of NMUPD, and thus require further explanation. This section focuses primarily on health system influences on NMUPD, including: prescribing and dispensing, the structure of health delivery, the under-treatment of pain and mental health conditions, and the legal and professional regulation of prescription drugs in Canada. Criminal justice issues related to NMUPD are also briefly outlined.

Prescribing and dispensing. High rates of NMUPD in North America have been linked to prescribing and dispensing practices. The use of psychotropic medications in the U.S. and Canada is higher than other high-income countries, although diagnostic rates of pain and psychiatric conditions are comparable (Fischer, Keates, Buhringer, Riemer, & Rhem, 2013; National Advisory Committee on Prescription Drug Misuse, 2013). North American prescribers demonstrate higher reliance on opioids for pain conditions than European prescribers (Fischer et al., 2013; Manchikanti, 2007). Canada is the world's second largest per capita dispenser of prescription opioids, second to the U.S. where up to 80% of the world's supply of prescription opioids is dispensed (Fischer et al., 2013; International Narcotics Control Board [INCB], 2013, 2015, 2016; Manchikanti, 2007). Further, Canadian prescribers demonstrate a markedly high

reliance on benzodiazepines for a range of health complaints, at 15 times the dispensing rates as the U.S. (Haydon et al., 2005; Murphy, Wilson, Goldner, & Fischer, 2016; National Advisory Committee on Prescription Drug Misuse, 2013; Werb, 2006). Benzodiazepines continue to be associated with substantial morbidity and mortality in Canada (Murphy et al., 2016).

In terms of pharmaceutical dispensing, North American health care systems have less strict regulatory mechanisms for pharmaceutical drugs by relying more heavily (80%) on community-based pharmacies with few post-dispensing control mechanisms, resulting in a higher capacity for diversion (Fischer et al., 2013). The differences in prescribing practices between North American and European prescribers (physicians and nurse practitioners) may be due to a range of factors, including the structure of the health delivery system, medicalization of historically non-medical conditions (discussed further in Chapter 5), and preparation and education of practitioners, which varies considerably across Canada (Fischer et al., 2013).

Structure of health delivery. What the health care system publicly funds and makes available ultimately shapes the conditions for NMUPD. Fee-for-service is the foundational remuneration model for physicians in Canada (MD Physicians Services, 2012). The use of fee-for-service rather than contract or salary physician systems appears to have a significant impact on prescribing practices. In Saskatchewan, the level of NMUPD has been found to be higher in the south where more fee-for-service practitioners operate, versus the north where more physicians are on contract and salary (Dell et al., 2012). Similarly, health care systems that fund non-medical health services—such as counselling, physiotherapy, massage, and acupuncture—provide practitioners with options other than pharmacotherapy. Most of these types of treatments are not covered in Canadian provincial health care systems even with substantial evidence of their benefits (Lewis, 2015).

Undertreated pain and mental health conditions. Underscoring the issue of NMUPD is the simultaneous debate around the under-use of prescription drugs, such as the under-treatment of pain and psychiatric conditions (Amari, Rehm, Goldner, & Fischer, 2011; Fischer et al., 2013; Haydon et al., 2005; Manchikanti, 2007). In a systematic review by Lusted, Roerecke, Goldner, Rehm, and Fischer (2013), over 50% of people in substance use treatment who reported non-medical use of prescription opioids experienced pain that was not medically treated. The under-treatment of pain is particularly problematic among PWID (Voon et al., 2015). The extent to which NMUPD takes place in the context of self-management of pain and mental health conditions is unknown. Without a better understanding of this problem, interventions that seek to decrease prescriptions of psychotropic drugs may increase barriers to medication access, contribute to health inequities, and as such foster conditions for NMUPD in the context of self-treatment. Thus, prescribing practitioners need to balance the dual concerns of under-prescribing and over-prescribing of psychotropic medications.

Legal and professional regulation of prescription drugs in Canada. Enforcing tighter controls on prescribing practitioners through prescription monitoring programs is widely recommended (Carter & Graham, 2013; Fischer et al., 2009; National Advisory Committee on Prescription Drug Misuse, 2013). These systems are associated with lower dispensing of controlled substances although evidence is lacking that these reductions have prevented diversion, misuse, or drug-related harms (Fischer et al., 2009). In Canada, the federal system of prescription drug monitoring and reporting to Health Canada was dismantled in the 1990s, leaving this responsibility to the provinces (National Advisory Committee on Prescription Drug Misuse, 2013). Consequently, Canada has a fragmented and inconsistent system of monitoring the rates and characteristics of prescription drug dispensing and other modes of prescription drug

release into the community (Fischer et al., 2009; National Advisory Committee on Prescription Drug Misuse, 2013). Discrete data systems exist at different jurisdictional levels—such as, coroners’ reports, drug program monitoring systems, losses and thefts, post-market adverse events, and law enforcement records—without a comprehensive initiative or body to collate this information (National Advisory Committee on Prescription Drug Misuse, 2013).

In Manitoba, the DPIN system (discussed earlier in this chapter) allows prescribers and dispensers to check the medications clients have had dispensed to them. In 2011, the Manitoba Government launched the Improving Medication Prescribing and Outcomes via Education (IMPROVE) program, which uses the DPIN system to incorporate and monitor quality indicators for potentially inappropriate prescribing practices for a range of monitored drugs (Chateau et al., 2015). Notably, prescription stimulants are not among the categories of monitored drugs established by the Manitoba Monitored Drugs Review Committee (Chateau et al., 2015).

Criminal justice issues related to NMUPD. Canada is still in an early state of criminal justice policy formation around the NMUPD. What makes this area of policy complex is that NMUPD is not exclusively illegal (Fischer et al., 2009). Under the *Controlled Drugs and Substances Act* many Canadians could be subject to criminal drug charges for NMUPD although this path does not promise to be fruitful for redressing the causes of NMUPD or the associated harms (Fischer et al., 2009). Very few cases of NMUPD lead to legal charges because of the many complications involved in gathering evidence and legal case building (Fischer et al., 2009). Approaching NMUPD as a criminal justice issue would likely produce similar detrimental effects on the health and social well-being of people who use drugs as do current drug policies (Fischer et al., 2009), including the racialized and class-based characteristics already evident drug law enforcement (Khenti, 2014; Marshall, 2015). Criminalization of people who use

prescription drugs non-medically can put sanctions on people experiencing social and material inequities and stigmatize further through criminal labels, ultimately doing more harm than good.

Although prescription drugs tend to be found in most drug markets, they historically have dominated drug markets in land-locked regions that are far from major entry points, such as shipping ports, where heroin and cocaine would generally enter the market (UNODC, 2016). Recent developments in the Dark Net (systems that route internet traffic through relays to disguise users and locations) are transforming the shape of new drug markets (Bancroft & Reid, 2016; Broséus et al., 2016). Meanwhile, Ts and Rs have managed to persist in local drug markets since the 1970s or 1980s.

As discussed in Chapter 1, the ways prescription drugs are diverted for non-medical use is heterogeneous, including: procurement from family and friends, doctor's prescriptions, drug thefts, prescription forgery or fraud, Internet purchases, illegal manufacturing, and other supply chain breaks (Fischer et al., 2010). Theft of prescription drugs from pharmacies, hospitals, delivery trucks, and other locations along the supply chain are considered a significant source of diversion that goes largely untracked (Fischer et al., 2010; Kuehn, 2007; National Advisory Committee on Prescription Drug Misuse, 2013). The degree to which Talwin and Ritalin enter the illegal market through theft along the supply chain has not been well explored, although theft has not emerged as a source of acquisition from people who inject Ritalin (Haydon et al., 2005; Wild et al., 2008). The CCENDU (2011) report found relatively few instances of drugs diverted from Manitoba pharmacies between 2005 and 2009. The two main sources of diversion included forged prescriptions and unexplained losses of drugs from pharmacies, both of which were reduced by more than one half from 2005 to 2009. Diversion through theft from other places along the supply chain or procurement through Internet pharmacies or the Dark Net is unknown.

According to the *Controlled Drugs and Substances Act*, possession and multiple doctoring for methylphenidate (Ritalin) is an indictable offence subject to a maximum penalty of up to three years' incarceration, and up to ten years for trafficking or possession for the purpose of trafficking. Similarly, importing, exporting, and production of methylphenidate are indictable offences with a maximum penalty of ten years. In Winnipeg, the number of drug charges grew from 1054 to 1471 annually between 2005 and 2009, representing a 40% increase, with the greatest number of charges related to cannabis and cocaine, and negligible drug charges related to prescription drug trafficking (CCENDU, 2011). This general trend appears to have continued through 2013 (Cotter, Greenland, & Karam, 2015), indicating that prescription drug trafficking is not a significant source of criminal justice encounters.

Blind-Spots in the Drug Use Literature

Various definitions and systems of meaning emerge from the literature on NMUPD and injection drug use with distinct underlying assumptions regarding the nature of the issue (Racine & Forlini, 2010). Naturally, different ways of understanding NMUPD have a bearing on research questions, the outcomes of studies, and thus the overall state of the knowledge on NMUPD. Literature in the area of NMUPD employs multiple ways of defining and measuring NMUPD—including any non-prescribed use, abuse, recreational use, use to get high, or meeting diagnostic criteria for a substance use disorder—likely because these criteria are simple and amenable to dichotomous classification (Barrett, Meisner, & Stewart, 2008). Sproule and Zhang (2017) explored the quality of NMUPD survey questions by recruiting people involved in NMUPD to answer five drug-related questions drawn from common population surveys. The authors found that 44% of participants had misinterpreted the questions referring to particular medications and

their pharmaceutical categories (e.g. opioids, benzodiazepines, stimulants). Different definitions used to characterize NMUPD across different survey questions were found to result in large discrepancies in NMUPD reporting (Sproule & Zhang, 2017). Thus, the lack of consistent and well-defined definitions and measurement tools creates challenges for estimating the scope and nature of NMUPD.

A large proportion of the literature on NMUPD reviewed in this chapter does not distinguish between problematic and non-problematic drug use. Problematic substance use has been defined as “use that has become habitual and compulsive despite negative health and social effects” (Carter & MacPherson, 2013, p.16). If NMUPD is considered problematic in and of itself, research tends to be limited to exploring the scope of use alone, and may overlook harms, benefits of use, and the social context that shapes use. Knowing the scope of NMUPD alone does not help inform public health interventions that redress harms. As most drug use is not harmful or problematic (UNODC, 2017), there may be much to learn from exploring non-problematic use and the benefits people experience from drug use. This perspective can help destigmatize drug use and shed light on the natural resources people draw from to mitigate drug-related harms.

The reasons that people use drugs provide important information for understanding the context surrounding use. If people report NMUPD in pursuit of therapeutic benefits, this can indicate important gaps in the availability, accessibility, or acceptability of existing health services. While some people use prescription drugs non-medically to treat underlying conditions, others use drugs to manage side effects of another drug or to treat unmanaged somatic or socially produced pain. There is a wide body of literature demonstrating the high prevalence of key comorbidities of chronic pain and psychiatric conditions among people who use prescription drugs non-medically (Leeies, Pagura, Sareen, & Bolton, 2010; Novak, Herman-Stahl, Flannery, &

Zimmerman, 2009; Rosenblum et al., 2007). Thus, many people likely derive therapeutic benefits from NMUPD that are not captured in research.

Finally, the primary drug-related harms explored in research are often identified by the researcher rather than those who use drugs. Research into injection drug use is often centred on concerns of blood borne infection transmission, specifically injection equipment lending and borrowing, and sexual practices related to potential transmission. Although HIV and viral hepatitis are a significant public health issues, these concerns tend to waylay other concerns that PWID may have about their drug use. For instance, the PHAC *I-Track* project is an enhanced surveillance system that monitors HIV and hepatitis C and the associated risk behaviours among PWID in Canada by combining behavioural and biological surveillance. Accordingly, *I-Track* core survey questions focus on modes of potential infection transmission, and do not capture experiences of stigma, discrimination, criminal justice encounters, or tap into the strengths or perspectives of participants and their communities (PHAC, 2006; 2014a; 2014b).

Summary of Literature Review

The non-medical use of Ts and Rs across Canada and in Manitoba does not arise as a prevalent trend except within the research specific to injection drug use. One important conclusion to draw from the literature is that concerns are focused primarily on micro level issues such as the properties of the drugs, the behaviours of consumption, and the characteristics of individuals who use the drugs. The ways in which historic, physical, social, economic, political, and symbolic environments shape lived experience, pathways to different drug markets, and drug use practices remain obscure. There is little space within the dominant research purview to capture the strengths, coping strategies, priorities, situated knowledge, and expertise

of people who use drugs. Further, there is little focus on the social context that gives rise to drug markets and shapes the conditions for drug-related benefits and harms.

The second conclusion drawn from the literature is that the injection of Ts and Rs is a pertinent phenomenon in which to explore the relationship between social context and drug use practices. The injection of Ts and Rs has historically been prevalent in Winnipeg and taken up by a network of people who experience structural disadvantage although there does not appear to be a substantive burden of harms arising from the consumption of Ts and Rs. The prominence of this drug use trend in Canadian Prairie Provinces has been demonstrated through survey research that is largely outdated and tends to raise additional questions that cannot be answered through survey methods. Further, much of harm reduction programming and best practice recommendations for PWID are based on research done in large urban centres (Strike et al., 2013) where Ts and Rs use is rarely reported. The injection of Ts and Rs emerged from a specific regional context and requires a locally tailored approach to explore, presenting an opportunity to learn about the relationship between social context, everyday life, and local drug use practices from a Winnipeg-based network of people with situated expertise.

With the limitations of the current literature in mind, this research project seeks to make space to discover the reasons people use Ts and Rs, the benefits and harms associated with use from the perspectives of PWID, and how the social context surrounding the injection of Ts and Rs in Winnipeg creates conditions for benefits and harms. People who use Ts and Rs are considered to hold valuable situated knowledge of shifting drug use trends and the conditions that shape the lives of PWID in core area Winnipeg. An enhanced understanding of local drug use issues is imperative in order to develop locally tailored and community-informed programs and services. The injection of Ts and Rs are explored not as a problem of individual conduct, but

a field of exploration from which much can be learned about local drug trends, and the complex relationship between social power, human life, drugs, and health.

Chapter 3: Theoretical Background

How we come to know drugs, the people who use them, and the spaces and practices of consumption matters to how people who use drugs are governed, served, constructed, helped, respected, and regulated. Research into drug use often fails to identify how social, structural, and organizational context shapes the actualities of drug use practice (Duff, 2007), which serves to reinforce stigma against people who use drugs (Keane, 2011). Drugs and drug users are often ascribed responsibility for a range of harms that arise from the interrelations of social, political, economic, material, affective, and symbolic conditions (Rhodes, 2009). This research seeks to make visible the connections between social context, lived experiences, and social practices of people who inject Ts and Rs in Winnipeg, and honour the situated knowledge and voices of people who use drugs.

Theoretical perspectives provide distinct ways of understanding the social context of drug use. According to Duff (2011), social context is generally defined as “a distinctive structural or cultural ‘environment’ that frames and situates human behaviour and the diverse cultural practices that sustain it” (p. 404). In this chapter, the theoretical perspective and sociological concepts of Pierre Bourdieu are described as tools for understanding the social context of drug use. In order to explain the theoretical basis of this research, Crotty’s (1998) scaffolding framework is applied, in which the theoretical components are discussed in order of ontology, epistemology, theoretical perspective, and a description of the fundamental concepts that shaped the research processes and product. In addition to the conceptual tools of Pierre Bourdieu, the concepts of enabling environments, enabling places, and enabling resources are introduced to augment Bourdieu’s concept of capital and make space for exploring strength and resilience.

Finally, intersectionality and anti-oppressive perspectives are discussed in terms of their influence on and theoretical congruence with this research project.

Introduction to Pierre Bourdieu

Bourdieu was a French sociologist, anthropologist, and philosopher whose major works were produced in the 1960s through the 1990s (Jenkins, 1992). He is regarded as a logician of poststructuralism who provided conceptual tools that make social context available for critical analysis (Harker, Mahar, & Wilkes, 1990; Swartz, 1997; Wacquant, 2008). Although poststructuralism reflects many views, there are some key commonalities across poststructuralism theorists, including ways of understanding the nature of language, subjectivity, and power (Weedon, 1997).

Consistent with poststructuralism perspectives, Bourdieu considered language a contested site of meaning making where our subjectivity, or sense of ourselves, is constructed (Bourdieu, 1991). Bourdieu (1977) argued that there is symbolic domination present in every linguistic exchange, as linguistic “signs” are cultural symbols that require the speaker to be believed or obeyed. Similarly, human subjectivity is understood to be socially acquired through the impacts of history and structures and is in constant flux and conflict (Bourdieu, 1998). Bourdieu’s concept of habitus, described later in this chapter, provides a conceptual frame for understanding the links between social structures and human subjectivity. Finally, Bourdieu (1991) offered a way to understand how power becomes widely dispersed in society and more complex in operation than power embedded in individual agents or social structures. Symbolic power is seen to derive from those who have accumulated cultural capital, providing the ability to impose a “legitimate” vision of the social world (Bourdieu, 1989, 1991). Once recognized as legitimate,

symbolic power can be exercised upon people with their own complicity and used to reinforce social divisions (Bourdieu, 1991).

Ontology

Ontology refers to the theory of reality, existence, and the nature of being (Crotty, 1998; McEwan, 2011; Strega, 2005). Bourdieu had an ontological interest in the nature of social practice, and the relationship between language and power. The core of Bourdieu's social ontology is the relationship between field, capital, and habitus, which together constitute social practice (Bourdieu, 1985; Bourdieu, 1990; Harker et al., 1990; Swartz, 1997). Power is seen to work through the creation of distinctions or divisions, where one concept generates its binary or polar opposite, and one becomes subordinated by the other (Swartz, 1997). Generating distinction is central to symbolic functions and discourse (Bourdieu, 1990), and the examination of discourse (systems of meaning) is considered integral to understanding how domination is achieved (Bourdieu, 1991; Jenkins, 1992). Bourdieu incorporated language into his theory of social practice in which social actors order, advise, or persuade, and to which people listen, obey, or resist (Snook, 1990). Categorization and distinction between groups of people, practices, or things can be described as the process of "othering" (Bourassa, McKay-McNabb, & Hampton, 2004). Accordingly, Bourdieu was interested in language and discourse as systems of power and oppression.

Epistemology

Epistemology refers to the study and theory of knowledge, and how knowledge comes about (Crotty, 1998; McEwan 2011; Strega, 2005). According to Bourdieu, people are born into

historically and socially constituted systems of meaning that are continually shaped, contested, and re-shaped (Swartz, 1997). Thus, there is no reality that can be known independent of one's historically constituted position and standpoint. This notion of socially constructed knowledge and subjectivity can be traced back to the early writings of Marx (1963, p. 67): "it is not the consciousness of man that determines their being, but on the contrary, their social being determines their consciousness." The critical turn associated with social constructionism refocuses aspects of epistemology to address how power and domination in the social world affect our knowledges (Crotty, 1998). As Bourdieu positioned himself against the practice of theory development and was interested in relations of power and collective meaning making of social actors (Bourdieu, 1990; Swartz, 1997; Harker et al., 1990), he was epistemologically aligned with social constructionism. Bourdieu is considered a critical thinker in that he was critical of socially produced categories, critical of the practice of theory itself, and critical of power relations that invade everyday life and solidify structures of inequality (Swartz, 1997).

According to Bourdieu (1990), all of social reality are objects of cognition and construction. The objective (external structures) and subjective (internal sense of oneself and the world) are seen to exist in knowledge at the same time. In recognizing that our knowledges of the natural and social worlds are constructions (frames of meaning), we also recognize that the researcher must work with social actors' constructions in understanding social life (Crotty, 1998). Bourdieu (1990) described accounts produced by researchers as intrinsically two-fold in that the social world has already been interpreted before the researcher enters the field. According to Bourdieu (1989), the task of the social scientist is to build an "account of the accounts" of social actors. Thus, as the social world in which participants live is already

interpreted by them, the research product is a co-construction as it contains interpretation from both the participants and researcher.

Bourdieuian Theoretical Lens

According to Crotty (1998), a theoretical perspective is the philosophical stance that informs methodology and grounds the logic and criteria of the research process. For Bourdieu, the goal of social research is “to dissect the social mechanisms and meanings that govern social practices, contribute to subjectivity, and explain their strategies and trajectories” (Wacquant, 2002a, p. 1470). Bourdieu’s conceptual framework of practice is described as a “generative structuralism” (Vandenberghe, 1999; Harker et al., 1990) in that it allows the social picture to arise inductively from the data (Wacquant, 2002b). When used in this generative manner, social theories are put to use as tools in empirical inquiry, open to expansion and rejection based on how well they work in the real world (Wacquant, 2002b, 2011). Bourdieu considered knowledge to develop from the rational (theoretical) to the real, acknowledging that some conceptual account always guides inquiry in the field (Wacquant, 2011). As such, bringing the conceptual tools of Bourdieu into the field can prevent the researcher from falling back on lay or folk theories, or the researcher’s own spontaneous sociology (Wacquant, 2011).

Wacquant (2008) describes two major bodies of social theory or readings of the social world. The structuralist reading (objectivist) seeks out power relations and patterns unbeknownst to agents. The constructivist reading (subjectivist) is concerned with the internal perceptions and actions of individuals. Bourdieu (1990; Bourdieu & Wacquant, 1992) criticizes this divide as false and mutilating of the nature of the social world. The objectivist and subjectivist worlds are considered relational as objective structures prescribe certain available paths of action and

perception. Similarly, subjectivities and perceptions guide action and struggle to conserve or transform objective external structures of power (Wacquant, 2008). Bourdieu developed the concept of habitus (discussed in the following section), which is both *structured* by social forces, and *structuring* as it shapes various social activities of a habitus-sharing group (Bourdieu, 1990; Wacquant, 2008). In this way, Bourdieu remained critical of social structures, but rejected that structures fully determine action and subjectivity (Bourdieu, 1990; Harker et al., 1992; Swartz, 1997). Finally, Bourdieu’s work intersects with critical theory by viewing research as a mode of political intervention (Harker et al., 1992). Bourdieu believed public disclosure of embedded power relations revealed through research would destroy their legitimacy. Thus, social research is viewed as an instrument of struggle (Swartz, 1997).

Theoretical Concepts of Bourdieu

Bourdieu’s conceptual tools are offered for use in “socioanalysis”—analogous to psychoanalysis, where the researcher seeks to unveil the powers that shape unconscious practices and interests of social actors as they produce and reproduce social order (Swartz, 1997).

Bourdieu was largely concerned with the manner in which the actions of individuals are shaped by the history and structure of their social world, and how those social practices can contribute to the maintenance of existing power relations (Bourdieu, 1990; Jenkins, 1992; Wacquant, 2008).

As such, he sought to develop a theory of social practice that connects individual action to structure, history, and power. Bourdieu’s concepts of field, habitus, and capital provide a conceptual framework for exploring aspects of social context without losing sight of the relational aspects between structure and agency (Bourdieu & Wacquant, 1992). Together, these concepts constitute the elements of social practice, with the goal of unveiling covert dimensions

of power relations (Swartz, 1997). In relation to exploring lived experience, Bourdieu's concepts of field, habitus, and capital are essential conceptual tools informing this research project. Symbolic power and symbolic violence are also introduced as fundamental concepts in this research.

Field. Fields are historically constituted arenas in which social practices take place, and agents (individuals or institutions) struggle and strategize to attain resources and positions of power (Jenkins, 1992; Swartz, 1997). Fields are likened to games, with their own explicit and implicit regulations (Harker et al., 1990). Positions in the field are determined by actors' access to different kinds of capital or goods, which are unequally distributed throughout (Bourdieu & Wacquant, 1992). Thus, a field is characterized by power relations between actors in different positions, and actors can strive to maintain their position, attain a new position, or transform the field or game (Bourdieu & Wacquant, 1992).

The limits or boundaries of a field are poorly defined and continually shifting (Bourdieu & Wacquant, 1992). Boundaries can only be determined through investigation, and the social space where an object or agent is no longer impacted by the effects of the field marks the field's border (Bourdieu, 1992; Bourdieu & Wacquant, 1992). Bourdieu (1990) describes fields as having "relative autonomy" in relation to other fields, as fields are seen to influence or "colonize" each other, with the field of economic production being the most dominant in most societies (Bourdieu, 1985; Bourdieu & Wacquant, 1992). The concept of field enables macro social analysis, such as Wacquant's (2009) *Punishing the Poor*, where Bourdieu's concept of bureaucratic field provided a framework to explore both the material/socio-economic and discursive/symbolic dynamics at work in U.S. penal and welfare policies. For this research project, the social context surrounding the injection of Ts and Rs in Winnipeg is considered the

field, comprised of drug market dynamics, histories, institutions, discourses, and lived experiences. Thus, the social context, or field, comprises the unit of analysis for this research.

Habitus. The concept of habitus allows for an account of how macro systems, such as legal structures, political economic forces, and discourses, can become ascribed on the body in a dynamic way (Jenkins, 1992). Bourdieu understood social practice to be relatively unconscious. Habitus involves an internalized sense of how to act in the world, which generally functions without insight of its principles (Bourdieu & Wacquant, 1992). Shared histories among people can translate into a shared body of cognitive and behavioural dispositions (shared habitus) and ways of classifying and doing things (Swartz, 1997). Harker et al. (1990) describe habitus as one's "comfort zone" in terms of actions, skills, habits, and perceived possibilities, which includes many embodied characteristics such as style of speech, gait, manner of dress, drug use practices, tastes, and preferences. Habitus includes the acquisition of an intuitive sense of the "game," like a system of motivating structures or sense of one's possibilities, where the practices of social actors are largely unconscious and based on an internalized sense from past experiences (Bourdieu, 1990).

As positions in the field change, so do dispositions (habitus); as such, field and habitus are always in flux (Swartz, 1997). Bourdieu (1990) describes habitus as transposable because it travels with us and forms the basis of our point of view as we move through space and time. Habitus shapes our actions because it guides our behaviour, but it is not deterministic because individuals still possess agency to act in ways that are not always consistent with their habitus. Drugs have been widely used historically across all sectors of human societies (GCDP, 2016), but vary in terms of what drug are used, how they are consumed, and what may be considered

normal, appropriate, or problematic use. Thus, the concept of habitus is particularly productive for exploring drug use trends and practices at the local level.

Habitus can be explored through observation and personal interviews without embedding oneself in the social practice of interest, as was done by Bourgois and Schonberg (2007) in exploring the social practices of homeless men in San Francisco who inject heroin. Habitus is a central concept in this research as it relates to everyday shared dispositions and practices of people who inject Ts and Rs, shaped by histories and social structures. The concept of culture, which is historically central to ethnography, is defined by the concept of habitus in this research, as discussed further in Chapter 4.

Capital. Capital is a broad concept that includes any goods or resources in society worth being sought after. Access to capital enables actors to attain positions of power — with power understood as both an oppressive and productive force (Harker et al., 1990). Bourdieu (1990) identified four main types of capital over which competition occurs: economic capital (material goods), social capital (valued relationships, membership, trust, reciprocity), cultural capital (legitimate knowledge of some kind, institutional recognition, manner of conduct or speech), and symbolic capital (prestige and social honour, influence). Symbolic capital is a concept that provides a way of understanding the wide dispersal of power throughout society. Actors in powerful positions are seen to have symbolic capital in their authority to name or categorize things (groups, people, actions), often through processes of distinction, thereby creating an “official” version of social reality (Bourdieu, 1991; Snook, 1990). Symbolic capital exists in the perceptions of others who misrecognize symbols as legitimate and natural aspects of the social world (Bourdieu, 1990, 1991). Forms of capital are central to defining and attaining positions and delimiting possibilities of actors in a given field, and some types of capital have the capacity

to transform into other types (Jenkins, 1992). Therefore, capital is an essential building block for exploring practices in everyday life and relations of power in the field.

Using field, capital, and habitus as a methodological toolset has important implications for what counts as data. In constructing a picture of social relations and habitus, all important elements must be accounted for and conceptually linked (Harker et al., 1992). Bourdieu's framework encourages a broad net to be cast in terms of admissible and relevant data in social exploration, including interview data, statistics, photography, field notes, institutional and government policies, lived experience, and symbolic aspects of text, policy, and history.

Symbolic power and symbolic violence. Symbolic power and symbolic violence draw directly from the sociology of Pierre Bourdieu and are important concepts for exploring power relations in this research project. Symbolic capital is antecedent to the development of symbolic power, which can be wielded to produce symbolic violence. The power to represent is rooted in symbolic power: "The power to impose upon other minds a vision, old or new, of social divisions depends on the social authority acquired in previous struggles" (Bourdieu, 1989, p. 23). Symbolic systems contribute to the reproduction of social order by acting as instruments of knowledge and domination, making possible a consensus within a community as to the nature of the social world (Harker et al., 1990). Race, social class, gender, and drugs are all systems of symbolic power created by social actors, with particular influence and relevance in this research project. Speech and other forms of discourse are to be seen as practical interventions that shape social life through symbolic power. Discourse enables beliefs and ideas to become legitimized through their seemingly universal and natural appearance (Jenkins, 1992). Symbolic power can take on a life of its own, enacted by those whose power is ambiguous, or in the form of internalized oppression (Wacquant, 2008). Bourdieu understood linguistic relations to be

historically produced relations of power, and language as a strategy of symbolic violence (Jenkins, 1992; Snook, 1990).

Symbolic violence is harm caused by symbolic power; “the subtle impositions of systems of meaning that legitimize and thus solidify inequality” (Wacquant, 2008, p. 264). Symbolic violence refers to forms of social coercion, oppression, and harm derived from these systems of meaning that are imposed on others (Wacquant, 2008). Those who do not have the means to speak or be heard can see themselves in the words or discourses of legitimate authorities, although these labels may also be contested and challenged (Snook, 1990). Therefore, the examination of discourse is seen as integral to an understanding of how domination is achieved through the manipulation of symbolic capital and power (Harker et al., 1990; Jenkins, 1992). Finally, structural violence, as a related and applicable concept, is human suffering that is structured by historical and economic forces that conspire in complex ways to constrain the agency of individuals (Farmer, 2005). Symbolic power, symbolic violence, and structural violence are important conceptual tools for this research for examining relations of power within the field of Ts and Rs injection in Winnipeg.

In addition to Bourdieu’s conceptual tools described above, this research draws from the conceptual developments offered by Tim Rhodes and Cameron Duff that help describe drug use contexts, and from intersectionality and anti-oppressive methodologies for informing the analytic perspective.

Risk and Enabling Environments, Enabling Places, and Enabling Resources

The most widely adopted contemporary framework for understanding and exploring the social context that surrounds drug use is the “risk environment,” attributed to the work of Rhodes

(Rhodes, 2002, 2009; Rhodes et al., 2003, Rhodes, Singer, Bourgois, Friedman, & Strathdee 2005). Rhodes, as a scholar critical of risk, sought to re-conceptualize the notion of drug-related risk as socially situated within a micro to macro environment to help account for the unequal distribution of drug-related harms across different populations (Rhodes, 2002, 2009). Rhodes' framework is cited as a piece among the resurgence of ecological approaches in public health (Moore & Dietze, 2005) aimed at providing a framework for balancing individualistic public health efforts with collective action for the reduction of inequalities in drug-related harms. Rhodes (2002, 2009) calls for greater engagement with ethnographic and other qualitative approaches in the epidemiologically dominated field of public health and suggests the risk environment as a promising tool to guide this work.

The risk environment (Rhodes, 2002, 2009) is concerned with two broad, intersecting, and interacting levels of influence: the macro (public policy, legal structures, economy, cultural organization, race, social class, gender) and micro (peer and social relations, immediate settings, individual practices, properties of drugs), occasionally addressing the meso (institutional practices, neighbourhood characteristics, built environment) level of influence (Rhodes et al., 2005). Four broad types of environments are conceptualized—physical, social, economic, and policy—which can occur at micro or macro levels (Rhodes, 2002). These levels of influence are seen to interact with each other in inextricable ways. The framework is suggested as an analytical device for practical use rather than a theoretical model (Rhodes, 2002, 2009).

Rhodes (2009) suggests that Bourdieu's concepts of field, habitus, and capital present important opportunities for exploring the risk environment through lived experiences. However, it is important to note that the terms "macro," "meso" and "micro," while commonly used across many academic disciplines in reference to aspects of social context, are not used within the

language of Bourdieu. These terms are employed in this research as they help translate and summarize concepts in a common language. It is important to note that these levels of social context are not clearly delineated and the relationships between them are multidirectional and continually shifting within the field.

The other element of drug use context described by Rhodes (2002, 2009) is “enabling environments,” in which drug-related harms can be mitigated, navigated, reduced, and avoided. While essentially the same concept as the risk environment, much less empirical or theoretical attention has been given to studying enabling environments. These concepts were drawn upon in this research to inform the analysis and interpretation of the social context surrounding the injection of Ts and Rs, making space to explore structural, community, and individual level power relations and situated knowledge.

Duff (2010, 2011) built conceptually on the idea of enabling environments for the reduction of drug-related harms with his work on “enabling places.” Enabling places are seen to be active environments comprised of diverse social, material, and affective resources that shape practices, interactions, and ground human experience (Duff, 2011). Duff posited that enabling places are comprised of three types of enabling resources: social, material, and affective. Duff (2010, 2011) describes social resources as processes and relationships that support the creation and maintenance of social networks, including social bonds, trust, reciprocity, cooperation, and belonging. Material resources include commodities such as, income, gifts, barter, and housing, and services such as health, community food, and transportation. Affective resources arise from the lived and felt dimensions of everyday life, including “attitudes, practices, processes and relations that sustain (or undermine) the capacity or preparedness to act in pursuit of one’s health” (Duff, 2010, p. 342). Hope is an example of an enabling resource that can motivate social

practices that enable health (Duff, 2010). However, enabling resources are not inherently beneficial to health. These resources need not only to be present, but they must be deployed in ways that achieve beneficial results (Duff, 2010).

There are three reasons this research draws from the concept of enabling places and resources in addition to Bourdieu's concept of capital. First, according to Bourdieu (1986) capital derives from the accumulation of goods and resources. Participants in this study tended to access, exchange, and use resources daily but rarely accumulated them in a manner consistent with capital, with the exception of social resources. Using the term "capital" in this sense may undermine the profoundly disadvantaged conditions of research participants in terms of access to social and material opportunities, resources, and power. Second, where Bourdieu's concept of capital does not address affect or emotion in detail, the concept of enabling resources (particularly affective resources) helps to augment this interpretation. Third, enabling places and enabling resources create theoretical space for exploring strength and resilience, and are used as heuristic devices for exploring structural, spatial, and community resources that enable a range of benefits and mitigate harms within the social context of Ts and Rs injection in Winnipeg.

Perspectives from Intersectionality and Anti-Oppressive Methodologies

According to Yuval-Davis (2011), Bourdieu's triad of field, capital, and habitus provides an analytic tool for intersectional analysis—the exploration of multiple categories and forms of domination simultaneously (gender, race, sexuality, class, ability). Social processes that create and maintain power relations along axes of socially constructed categories have distinct ontological foundations. Intersectional exploration focuses on how categories are created, resisted, maintained, and socially organized (Dhamoon & Hankivsky, 2011). A dominant male

gender order is recognized as a product of habitus and a form of symbolic domination often misrecognized as legitimate (Bourdieu & Wacquant, 1992). Bourdieu (1990) recognized that privileging gendered power relations over other forms of power (such as social class and race) would be naïve. All salient dimensions of power must be discovered empirically and included in a social analysis. Bourdieu's method helps fix categories, such as race and gender, as verbs rather than nouns in order to shift the focus toward the social strategies that create and maintain categories (Henry, Tator, Mattis, & Rees, 2009). Drug use and its related harms are shaped differently across social categories, and understanding these categories as being socially engineered shifts the focus onto their production and reproduction through material and symbolic power relations. Thus, drawing from Bourdieu is consistent with intersectionality perspectives.

Additionally, a number of key perspectives from anti-oppressive research methodologies (Brown & Strega, 2005; Dei, 1999; Dei & Johal 2005; L.T. Smith, 2012) are drawn from in this research project. In anti-oppressive research approaches, differences between people (e.g. race, class, gender, sexuality) are centred and honoured (Dei, 1999; Graveline, 1998; Okolie, 2005). People with unique standpoints, insights, and experiential knowledge of power relations are seen to hold valuable expertise (L.T. Smith, 2012). Knowledge production is relational; that is, it occurs through interaction and relationships in a research environment where both researcher and participants have agency and power to create knowledge (Max, 2005). The purpose of research is not only to uncover power relations in the social world, but to destabilize power relations in the process of knowledge production, interrogation, validation, and dissemination (Gormley, 2005). Participants are creators of knowledge and subjects that resist oppression. Thus, the research product is a co-construction in which all parties make substantial contributions (Dei, 2005).

Summary of Theoretical Background

A theoretical lens refines the research question and empirical focus. Drawing from a critical poststructuralism perspective, the injection of Ts and Rs provides a doorway into a social context highly imbued by historical and structural power relations and lived experiences highly shaped by complex intersecting axes of power. Social context can be conceptualized in many ways, but through the theoretical lens of this study the focus becomes the operations of power within the field, and how these power relations shape the conditions for drug-related benefits and harms. The sociology of Pierre Bourdieu provides a critical lens and conceptual tools with which to bring together lived experience and agency with social structure and history and to incorporate symbolic power and discourse. Drawing further from the concept of enabling environments and perspectives from anti-oppressive methodologies helps create space for exploring emotional and affective states, community strengths, and honouring the situated knowledge derived from life experiences.

Chapter 4: Methodology and Methods

The critical poststructuralist perspective described in the previous chapter was animated empirically through a focused ethnographic methodology articulated in this chapter.

Methodology is the strategy, process, or design lying behind the choice and use of particular research methods, and guides and justifies the ways in which research data are produced and analyzed in response to a research question (Crotty, 1998). Methods are the tools through which the research project is put into effect. In this chapter, the core methodological components of focused ethnography are outlined, followed by a detailed description of the research methods, processes for establishing trustworthiness, considerations for representation, and ethical processes engaged in this project.

Methodology: Focused Ethnography

Research and, indeed, ethnography has historically been a colonizing practice, making authoritative claims on the knowledge, customs, and values of other peoples, particularly colonized peoples (Bourgois, 1998a; L.T. Smith, 2012). Ethnography has enabled the re-writing of Indigenous histories and appropriation of Indigenous knowledge and produced damaging and incorrect representations of Indigenous peoples (Agar, 2008; Graveline 1998; L.T. Smith, 2012; Wahab, 2005). Debate regarding the nature of knowledge itself and the problematic practices of ethnography have enabled a range of new developments in ethnography over recent decades, including interpretive ethnography (Denzin, 1996; Kirkham & Anderson, 2002), critical ethnography (Carspecken, 1996), post-critical ethnography (Lather, 2001; Noblit, Flores, & Murillo, 2004), and institutional ethnography (Smith, 2005, 2006). These developments recognize the need to build an ethical space where colonial (and other) relations are disrupted

(Jamal, 2005). What remains consistent among various contemporary ethnographic approaches are the methods of engagement through immersed fieldwork, in-depth interviews, observation, and thick description (Creswell, 2007).

Ethnography refers to both a set of research processes and a product of research in which culture is described and interpreted (Spradley, 1979; Wolcott, 1990). The process of ethnography refers to the methods of data collection, with fieldwork being a key component. Traditional ethnography involved deep immersion into societies unknown to the ethnographer that were small and isolated, where the ethnographer would live for a year or more and participate in local life. The ethnographer would produce an account of social practices and customs based on the idea of a single shared traditionally constituted culture (Agar, 2006). The ethnographic product is described by Wolcott (1990) as a cultural analysis and interpretation of the social practices of a group of people in a setting. According to Wolcott (1990), in order for something to be claimed an ethnography, the study must not only employ ethnographic methods, but do so with the intent of producing an ethnographic account of social action.

In focused ethnography, also referred to by Wolcott (1990) as micro ethnography, selected aspects of daily life in particular settings or scenes are examined, rather than attempting to build an account of an entire cultural system. The goal of focused ethnography is to understand and describe the interrelationships between people and their environments in the society in which they live, often within a discrete community or contextualized scene (Cruz & Higginbottom, 2013; Muecke, 1994). The methodology is well suited for studies of contemporary or urban society, which is highly differentiated and fragmented (Knoblauch, 2005). Ethnography, through its focus on social and cultural context, has been described as the link between the micro everyday interactions and the macro wider societal formations (Savage,

2000). The way the setting is contextualized will depend on the researcher's theoretical perspective. When a critical lens is applied, the ethnographic product is less focused on cultural description and more so on power relations that shape lived-experience, including subjugated and contrary voices, thereby revealing hidden power dynamics (Muecke 1994, Mayan 2009; Wall, 2014). In this study, the focus is on the social context surrounding the injection use of Ts and Rs in Winnipeg, and how these conditions and the power-relations therein shape drug use practices.

Focused ethnographies are distinguished from traditional ethnographies in their scope and intent. Focused ethnographies derive from specific and pragmatic objectives to efficiently inform policy, programs, or practices, and are common among practice professions such as education, nursing, and engineering (Cruz & Higginbottom, 2013; Higginbottom, Pillay, & Boadu, 2013; Roper & Shapira, 2000; Wolcott, 1990). Focused ethnographies are often the work of one researcher in the field with a pre-determined question or focus (Cruz & Higginbottom, 2013; Muecke, 1994). Further, the researcher in a focused ethnography often has expertise and intimate knowledge in the field of study that has informed the research question (Knoblauch, 2005; Muecke, 1994; Roper & Shapira, 2000). Thus, prior engagement in the field generally replaces the prolonged immersion of traditional ethnography (Knoblauch, 2005; Muecke, 1994).

The key methods of data collection differ between focused and tradition ethnographies. Formal and informal ethnographic interviews are often the key data source in focused ethnography (Cruz & Higginbottom, 2013), and fieldwork tends to be of short duration and involve intensive data collection, as opposed to the one-to-two-year field immersion typical of traditional ethnography (Muecke, 1994; Roper & Shapira, 2000; Wolcott, 1990). Participant observation in a focused ethnography is often limited to selected times and events, and often

secondary to data derived from interviews (Muecke, 1994). However, the data collection phase is intense as a large amount of data is produced in a short time, enabled by audio recordings of interviews (Cruz & Higginbottom, 2013; Muecke, 1994). Finally, research participants in focused ethnography are often people with expert knowledge and experience relevant to the phenomenon of study, rather than those who have developed close and trusting relationships with the researcher through prolonged field engagement (Knoblauch, 2005; Muecke, 1994).

Regardless of the type of ethnography being undertaken, it is important to address the concept of culture as a historically central concept in ethnography. The word “culture” has been defined and re-defined so many times that the term conjures multiple and often conflicting meanings (Harker et al., 1990). Classic definitions tended to assume homogeneity across societies and did not recognize that belonging or non-belonging to a cultural group lays across multiple axes of socially constructed categories, complicating processes of cultural belonging (Agar, 2006). Wolcott (1990) describes culture as something that is created by the ethnographer and imposed upon the subjects, rather than something “out there” to be discovered. According to Harker et al. (1990), Bourdieu recognized the problems associated with the word “culture” and developed the concept of habitus to resolve some of these difficulties of belonging and maintain a focus on relations of power in social practice.

This focused ethnography draws from a number of these perspectives and centres the concepts of field, habitus, and capital in exploring social practice. Consistent with a critical poststructuralism perspective, the research focus is on relations of power. Social practices that may have traditionally been described as culture are only of interest as they are shaped by histories, structures, institutions, and symbols. Thus, the social practices and dispositions, or habitus, are to be explored and explained as they relate to the broader social context in which

they were constituted. The product of the research is an interpretation, or co-construction, of the social context surrounding the injection use of Ts and Rs in Winnipeg, including a highly contextualized account of social practices within this field.

Research Methods

Little is known about the use of Ts and Rs and the salient elements of the social context that surrounds this practice. The study therefore sought to explore lived experience, situated meanings, and social location, and reveal larger meso (institutional practices and neighbourhood characteristics) and macro (structural) influences that shape the conditions for drug-related benefits and harms. The research design was open-ended allowing the focus to emerge as the study progressed.

Fieldwork is a critical component of ethnographic studies and refers to the data collection phase of the research (Muecke, 1994). Fieldwork and data collection was conducted in two phases with different participant recruitment processes and eligibility criteria used in each phase. Phase I of the study set out with the broad research question: *What is happening with the injection use of Ts and Rs in Winnipeg, and what powers shape this phenomenon and the experiences of people within it?* Preliminary data analysis and interpretation from phase I informed the sampling and recruitment for phase II, which explored more specifically the nature of spaces in which drugs were used, what powers configure drug use spaces, and how spaces shape drug use practices. Data from both phases were analyzed and organized into a coding framework. The coding framework was then built into a social context map, or a visual representation of the field in terms of salient systems of power and players. Interpretation of the field enabled key findings to emerge. The study setting, data sources, data collection processes of

phase I and phase II, data storage and safeguarding, and data analysis and interpretation processes are described in this section. Finally, processes for establishing trustworthiness, issues of representation, and ethical considerations are explained.

Participant observation is a research strategy in which the researcher actively becomes engaged in community life or the participants' natural setting, observing and listening as the researcher gathers participants' accounts of their reality (Agar, 2008; Spradley, 1979). Typical of a focused ethnography, the researcher had significant prior involvement in the field of inner-city Winnipeg drug use (nearly two decades), specifically in public health and harm reduction programming, rather than long-term immersion typical of traditional ethnography. Formal structured observations of research participants were not a source of data in this research project. However, observations were made during several fieldwork processes, including recruitment of participants while walking through the neighbourhood and engaging in informal conversations. Observations also occurred around and during participant interviews in various settings, and other observatory opportunities that arose during fieldwork.

Bourdieu was highly critical of the knowledge gained through participant observation since, in his view, no amount of immersion in a field can erase the privileges of the researcher's social location (Bourdieu, 1990, 1991; Cole & Dumas, 2010). Rather, Bourdieu (1990) promoted reflexivity that includes: identifying the researcher's social location; identifying the researcher's location in the academic field and the field of study; and analyzing the researcher's motivation to study the object. The researcher's process of reflexivity is discussed later in this chapter, including implications arising from significant prior engagement in the field that can generate both meaningful insights and connections, and deeply rooted blind-spots.

Study setting. This study took place in the Downtown and Point Douglas/North End areas of Winnipeg, Manitoba. A thorough description of the study setting, and its historic and institutional constitution follows in Chapter 5. Interviews and field notes were recorded at private locations within the Downtown area of Winnipeg (one office on Hargrave Street, one on Main Street). Home visits were offered for interviews if participants preferred, and an inner-city office space was procured for interviews as privacy was expected to be compromised in single-room occupancy settings or unstable housing situations. Although individual interviews were encouraged, participants were welcome to interview in couples if they preferred, particularly if this facilitated comfort, rapport, and trust between the participants and interviewer.

Data sources. The key sources of data utilized in the study were: socio-demographic questionnaires; in-depth, semi-structured interviews; informal interviews; and field notes. A total of 36 semi-structured interviews took place.

Socio-demographic questionnaires. All participants recruited for in-depth, semi-structured interviews were asked for basic demographic information by means of a brief socio-demographic questionnaire (see Appendix A). These questionnaires provided additional information for thick description and to provide an overview of participant characteristics (Agar, 2008; Polit & Beck, 2012).

Semi-structured in-depth interviews. In phase I, 24 in-depth, semi-structured interviews of 20-90 minutes long (45 minutes was average) were conducted with people who inject Ts and Rs. Phase II involved similar interviews with 12 homeless people (no permanent residence) who inject drugs. Detailed information about each phase is in the following sections. All 36 interviews were digitally audio-recorded, transcribed verbatim, and checked for accuracy

(Bailey, 2008; Davidson, 2009). Appendices B and C provide the semi-structured interview guides for phases I and II.

Semi-structured interview guides were informed by Bourdieu's conceptual triad of field, habitus, and capital. Biographical lines of questioning provided opportunities to draw narrative lines between history, social structure, and the social location of participants. Everyday lived experience was tapped in interview guides to specifically seek out relations of power, capital exchange, and elements of habitus and environment. Questions related to individual drug use practices and related benefits and harms were structured to capture how the broad social context surrounding use influenced practices.

Informal interviews. Informal conversations and interviews are not audio-recorded and are a natural process of ethnographic fieldwork. They occur in spontaneous conversations that arise during recruitment, while arranging interviews, and spending time in the neighborhood or setting of the research. They cannot be predicted, are often brief, and are not part of a formal data collection process that receives approval from a Research Ethics Board. In this study, approximately 20 to 30 informal interviews occurred during fieldwork phases (October through December 2015 and April through May 2016), providing information that fed into field notes and analytic memos.

Walking the North Main Street area and engaging in informal interviews/conversations with people encountered on the street facilitated recruitment and tapped into neighbourhood perceptions about drugs and drug use. Conversations revolved around daily events in the community, a description of the study and purpose, and what participation in the study entailed. Questions arose in informal interviews in response to the researcher's focus on Ts and Rs, and

regarding the motivations and social location of the interviewer. From these conversations emerged community member observations about local drugs trends and markets, particularly around the growing prevalence of crystal methamphetamine use, the growth of injection drug use, and the emergence of strong illicit opioids such as fentanyl. Familiarity grew between the researcher and neighbourhood regulars, and encounters were often marked with humour.

Field notes. Observations in the field are captured in field notes to provide data on what people do, augmenting data on what people say in interviews. Field notes can assist with processes of reflexivity by capturing early assumptions and constructions of the researcher in detail (Agar, 2008). Raw observations and reflections were captured around recruitment processes and participant interviews and from observations in other spaces where people use services or consume drugs (Agar, 2008; Page & Singer, 2010; Spradley, 1979). Emerging themes, insights, contradictions, and divergence were recorded in thick description (Spradley, 1979, 1980; Wolfinger, 2002). Field notes inspired analytic memos, analytic themes, and alternative voices and meanings which augmented the analysis and interpretation of the data.

Phase I. The first phase of this research took place from October 2015 through December 2015, during which 24 semi-structured interviews took place with people who had injected Ts and Rs (including Ritalin alone) in the last 6 months, who were over the age of 18, and able to provide informed consent.

Recruitment. Participants were recruited by three key methods; directly by the researcher, by staff at a local needle exchange program, and referred to the researcher by other participants. The researcher distributed handbills and engaged in conversations about the research while walking the neighbourhood and talking with potential participants. Handbills

were also distributed to potential participants through the Street Connections program, a mobile outreach and harm reduction program that serves PWID (Appendix D provides a staff script and sample handbill used to inform potential participants of the research project). Participants were also provided handbills to pass onto others they know who met the research eligibility criteria. Several potential participants contacted the researcher as a result of these methods. The first five participants interviewed were sampled purposively, which is “a non-probability sampling method in which the researcher selects participants based on personal judgment about which ones will be the most informative” (Polit & Beck, 2012, p. 739). Specifically, efforts were made to interview participants of various gender, age group, and housing status in order to facilitate a robust coding framework from the first five interview transcripts. The remainder of the participants entered into the study as they contacted the researcher, met eligibility criteria, and had interviews successfully arranged and undertaken.

The majority of phase I interviews (n=17) took place in participants’ homes or the homes of friends or partners. Seven interviews were held in an office space in the Exchange District of Downtown Winnipeg. Five interviews were conducted with couples, the rest with individuals.

Participant characteristics. Three of the phase I participants injected Ritalin alone (not with Talwin), each of whom were male and had acquired Ritalin through diverted prescriptions. The rest of the participants (n=21) injected Talwin and Ritalin in combination, acquired from regular dealers or friends, although the main substance used by participants varied. Seventeen participants reported polysubstance use, with crystal methamphetamine, morphine, cocaine, crack, and alcohol among the most commonly used substances. Twelve participants identified as First Nations, eight identified as Caucasian, two identified as Métis, one as First Nations and Caucasian, and one as First Nations and African. Fourteen participants identified as male and 10

as female; none identified as another gender. In terms of housing, five lived in single room occupancy hotels, 16 in their own apartment, one was homeless, one stayed in shelter, and one lived in a partially owned property. No participants reported income from legal employment at the time of the interview; 19 received income assistance with or without disability benefit, two received a pension, two received unemployment insurance, and one reported no income source. In addition, most participants reported some other form of income generation such as boosting (selling stolen goods), odd jobs, scrap metal collecting/returning, barter, transactional sex, taking drugs in return for sharing their space for drug consumption, scoring drugs for others in return for a cut of drugs, or theft (see Appendix E, Table 2. of participant characteristics).

As the majority of phase I participants had access to stable housing, the voice of unhoused PWID emerged as a problematic site of silence; specifically, because spaces of drug consumption would be expected to be different for unhoused people. Accordingly, phase II sampling was purposively undertaken to reach unhoused PWID in order to expand inquiry into an important emerging theme (Agar, 2008; Spradley, 1979, 1980; Page & Singer, 2010).

Phase II. The second phase of the research took place from April through May 2016. Twelve semi-structured interviews were conducted with participants who self-reported the injection of any drug in the last six months and were over the age of 18, able to provide informed consent, and had no permanent address.

Eligibility criteria were altered from phase I to include unhoused participants who inject any drug, rather than specifically Ts and Rs. The original purpose of the study was to explore the social context surrounding the injection use of Ts and Rs, a largely core area phenomenon in Winnipeg. However, thematic saturation on the nature of Ts and Rs injection had largely been

reached from phase I data, whereas spaces of consumption required further exploration, especially given that most of the participants in phase I were housed. As unhoused PWID are a significant part of the social context of Core Area Winnipeg injection drug use, they were expected to have relevant insights into the social and physical nature of spaces of drug consumption and the injection of Ts and Rs whether or not they used these drugs. Thus, the specific drug injected was not considered necessary to include in eligibility criteria and limiting eligibility to one type of drug was likely to make recruitment challenging and potentially unfeasible.

To facilitate further exploration into spaces of consumption, the interview guide was modified slightly to focus more on the benefits and harms of spaces of drug consumption—what makes a good space, what creates the conditions for harms—rather than a focus on the harms and benefits of Talwin and Ritalin (see Appendix C).

Recruitment. Recruitment for phase II was more challenging because of the lack of resources among potential participants; for example, access to phone or transportation. Recruitment was accomplished by walking the Main Street neighbourhood early during the day (6:00 am – 11:00 am) in the area around three housing shelters. Main Street Project, a housing shelter grounded in Housing First (Main Street Project, 2016) and harm reduction perspectives, was engaged as a potential recruitment partner. Support for the study and recruitment was provided by the Executive Director of Main Street Project, who had the ability to leave posters and handbills in the facility, explain the study to staff, and inform the staff that the researcher would be recruiting around the centre. While study information was shared with staff at Main Street Project, fieldwork by the researcher turned out to be a very effective method of recruitment, thus no further support was required. Early morning recruitment around Winnipeg's

Main Street Project was found to be more conducive to informed consent as participants who use drugs or alcohol every day had not yet consumed substances. Appendix D includes a script used to explain the study to staff and potential participants, as well as the handbill used for recruitment. One participant interview was held in an office space in the Exchange District of Downtown Winnipeg; the other 11 were held in an office space procured within Main Street Project. All interviews were conducted with individuals (not couples).

Participant characteristics. Most phase II participants (9 of 12) reported poly-substance use, including non-beverage alcohol products such as hand sanitizer. Five identified Ts and Rs as their main drug used, three reported crystal methamphetamine, two reported alcohol, one reported crack cocaine, and one reported morphine. All 12 participants in phase II identified as First Nations. Nine identified as male, three as female. In terms of housing, five participants reported usually sleeping at a friend or family's home ("couch surfing"), four reported usually sleeping outdoors, and three reported usually sleeping in a shelter. In terms of income, three participants had paid casual or term employment, seven received income assistance, one reported no income, and one reported only illegal income. Other income generating practices included panhandling, scrap metal collecting/returning, collecting/returning aluminum cans (canning), theft, barter, and odd jobs (see Appendix E).

Of all 36 participants recruited in both phases, the age ranged from 28 to 66 years with an average age of 41. Most of the participants (22 of 26) first injected a drug in their teens, and 12 in their early 20s. Thus, participants had decades of experience with the inner-city Winnipeg injection drug use scene, and valuable knowledge and insights about the social context surrounding the injection of Ts and Rs in Winnipeg.

Data storage and safeguarding. Personal interview data were anonymized (personal identifiers removed from transcripts) and kept in accordance with the Personal Health Information Act (password protected on a secure drive with an audit trail to digital data). On transcription, identifiers of people or places named by participants during interviews were also removed, as well as any segments that participants wished to have removed or which the researcher deemed potentially harmful (e.g. information regarding specific drug trafficking organizations or venues). Audio recordings were deleted once transcribed. NVivo11 for Mac, a software program designed for qualitative data organization, was the primary tool for managing the textual interview data. Demographic questionnaires were entered into NVivo as classification/attribute data in order to assist with queries. Once demographic information was entered the original paper demographic questionnaires were destroyed by shredding. Field notes and analytic memos were not entered into NVivo but informed thematic analysis and interpretation, and were coded by hand and entered into nodes/codes where appropriate. Only anonymized data were entered into NVivo on a password protected computer, with the password accessible only to the primary researcher. Access to long-term storage of identifying material (consent forms) was provided through the Manitoba Centre for Nursing and Health Research (MCNHR) at the University of Manitoba.

Data analysis and interpretation process. Data analysis and interpretation occurred in three stages that moved from analytic through interpretive processes. Analysis involved first and second cycle coding during and after the data collection phases. Emerging themes from the data were organized into codes, which were organized into hierarchal categories. Codes and categories were continually revised with ongoing analysis and the addition of new data throughout the research. This process produced a coding framework that was incorporated into a

social context map. The map was used as an interpretive tool to visually organize the salient elements of the field and to help interpret the key findings arising from the field. These three phases of coding framework, social context mapping, and interpretation of the field are explained in further detail.

Coding framework. Ethnographic interview data and field notes were organized into codes and categories of codes, which comprised the coding framework. Interview transcripts and field notes from phase I and phase II of the research simultaneously shaped the coding framework and were coded into it.

First cycle coding. The analysis of qualitative data involves searching for patterns to condense a large amount of information into smaller pieces, and many methods are available for this. The preliminary coding framework emerged from coding the first five interviews. Transcripts were coded line-by-line (also known as open coding) in this initial stage (Charmaz, 2006; Saldana, 2009). In initial coding, data are coded into discrete elements, with all codes being tentative and provisional as the analyst reflects upon coded segments and searches for analytic leads, supported by analytic memo writing (Saldana, 2009). This method is appropriate for emergent research designs and projects with multiple data sources (Saldana, 2009).

The coding framework development was supported by the use Bourdieu's concepts of field and habitus to organize codes into provisional categories. Drawing from Bourdieu, relations of power within the social context surrounding the injection use of Ts and Rs in Winnipeg were the focus of this analysis. Pre-established sociological concepts, such as habitus, informed the initial coding process, and the coded data segments were grouped in a hierarchal scheme of codes and categories. According to Bourdieu, analysis is never truly inductive as the researcher

always enters the field with some scholarly or folk ideas about the structure of the social world (Wacquant, 2002b, 2011). For these reasons Bourdieu offers up his concepts of field, habitus, and capital as conceptual tools which may be rejected or expanded upon if they do not fit with what is empirically captured in social research (Wacquant, 2011). Further, axes of power, such as race, class, and gender, were examined as fundamental building blocks of social organization and social stratification (Dhamoon & Hankivsky, 2011).

Most segments of text fell into a single code. However, some fell into more than one code, but generally only into one category. The remaining 19 interviews from phase I were coded through first cycle coding with continual revision and reflection on existing codes and categories. Saturation was considered reached when new codes were no longer arising from the data, and further exploration was warranted when new codes were arising but not well defined.

Second cycle coding. Second cycle coding involves reorganizing and reanalyzing data with the goal of developing a categorical, conceptual organization from the first cycle of codes (Saldana, 2009). Focused coding is a refining process (Saldana, 2009), used to search for the most salient and robust themes emerging from the data, organized into codes and categories. Through this process themes become broader and robust codes were fed into emerging categories. The nature of spaces in which drugs are consumed and the impact of spaces on drug use practices was a robust theme that emerged from phase I data.

The coding framework developed from the first phase of interviews was used to code interviews from phase II, although the data sets (interview transcripts) from phase I and II were kept in separate NVivo files. Field notes and analytic memos served as a code and category generating process. Some new codes emerged in this process, such as valuing toughness,

community monitoring, reclamation, alcohol and solvent use, taking drug breaks, and stigma. New codes were combined into existing categories of codes and the coding framework evolved through the coding process. The new codes were put into the NVivo file that contained phase I interview transcripts, and the transcripts read over again to see if the new codes resonated with the first set of interviews.

The coding framework was continually reorganized through analysis and interpretation. Five categories unfolded from this process; social location and biographies, everyday institutional relations, drug market characteristics, habitus and everyday life, and individual drug use practices. The strength of codes emerging from data analysis was determined by the density of their coding as well as the complexity of their dimensions. Appendix G (Table 3, Coding Density) provides a list of categories, codes, the number of references to each code, and number of participants referencing each code. Table 3 is intended to make explicit how the researcher decided upon the salient elements. The codes and categories of findings arising from participant interviews are discussed in Chapter 6.

Social context mapping. Social context mapping is both a process and a product of research. It is used to help visualize and understand the environment and social organization of human practice and experience (Canadian Centre for Substance Abuse [CCSA], 2014; Ethnographic Research Inc., 2018). In this study, social context mapping helped lay out the physical, social, economic, political, historic, and symbolic aspects of the environment that shape drug use practices and the conditions for harms and benefits. In addition to identifying the important aspects of the social context, mapping also enhances interpretation by helping the researcher systematically identify components of a system and explore relationships between them. As a product of research, social context mapping can make complex systems more approachable

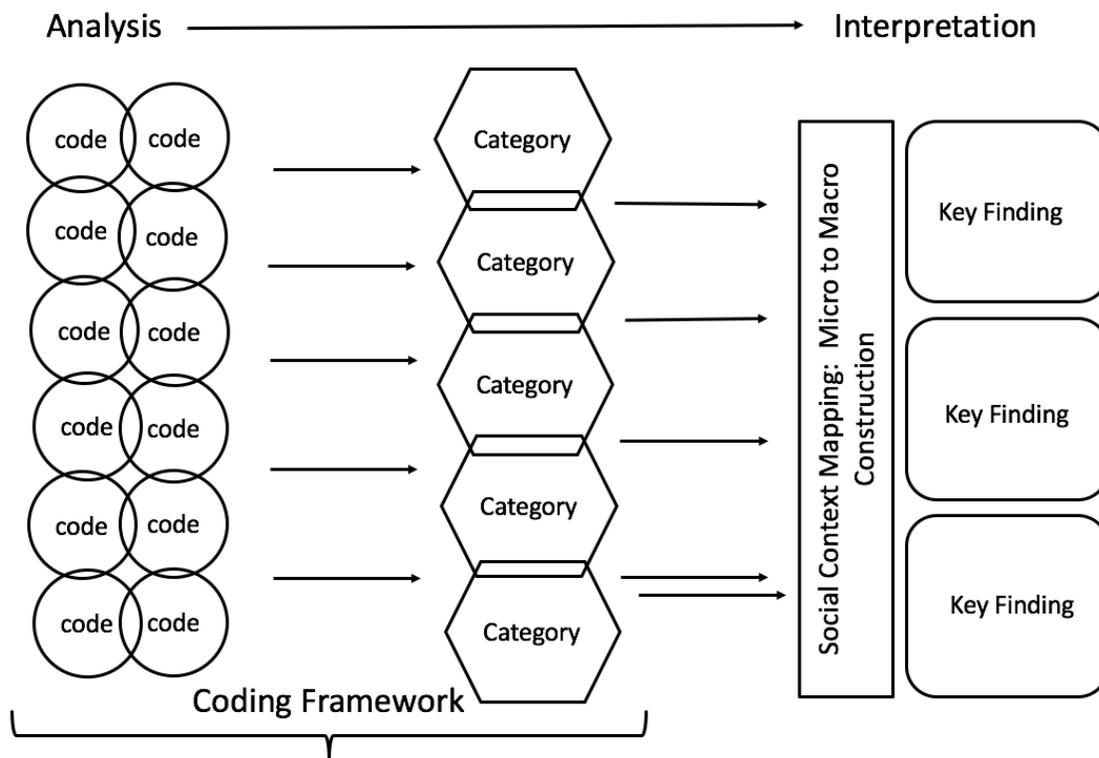
(CCSA, 2014) and can help translate the researcher's analysis to the reader especially in a project with multiple layers of findings.

The Health Officers of British Columbia (2011) framework for determinants of benefits and harms of psychoactive substances informed the development of the social context map. This framework depicts psychoactive drug use as a set of social practices arising from interactions between physical, social, economic and political environments, and complex drug market dynamics (Canadian Public Health Association, 2014), and was unique from other examples in the literature in that benefits of drug use were considered.

Once the interview data had been roughly organized into a coding framework, a map was constructed as a means to incorporate ethnographic field data with other elements that constitute the social context surrounding the injection use of Ts and Rs in Winnipeg. With the construction of the social context map, the researcher's process moves from analysis toward interpretation, with higher abstraction of meaning. Mapping served to reveal and explore elements of the social context that were robust and silent, and to enhance analysis and interpretation during the data organizing and analysis phase. There were important systems of power in the field that did not arise significantly from the interview data but contributed to the social location of participants, constitution of the institutions that shape daily life, and the drug market, discussed in Chapter 5. By locating the researcher within the map, the process fostered reflexivity and helped make explicit the tacit knowledge and assumptions that the researcher brought with her into research process. The social context map also serves as a research product that can help the reader understand how the interview data were organized and situated in context, and to visually lay out the salient micro to macro elements of the field. The social context map is presented in Chapter 6.

Interpretation of field. The social context map enhanced interpretation of the field to expose key findings, which are discussed in Chapter 7. Drawing from Bourdieu, the interpretation of power relations focused on forms of capital transition and exchange (economic, social, cultural, and symbolic) and resources used by players within the field, including strategies for wielding power. Power relations were found particularly salient to the high level of institutional interactions that participants in this research experienced, enabling places and resources, and symbolic power and discourse that shaped the field. Finally, the way that relations of power shaped the conditions for drug-related benefits and harms were centred in the interpretation. Key findings were considered salient if they appeared to capture significant relations of power in the situation, overlap with multiple categories and codes, and significantly reflect lived experiences and knowledge shared by participants. Figure 1, Data Analysis and Interpretation Process, below provides a visual representation of how the ethnographic data were organized into codes and categories, mapped, and interpreted for salient findings.

Figure 1. Data Analysis and Interpretation Process



Establishing Trustworthiness

Lincoln and Guba (1985) describe four key evaluative criteria for the trustworthiness of a qualitative research study: credibility, transferability, dependability, and confirmability.

Credibility. Credibility refers to confidence in the “truth” of the research findings, which was enhanced by prior and prolonged engagement in the field, persistent observation, data triangulation, and peer debriefing. Prolonged engagement is a central feature of ethnographic work and involves spending enough time in the field to understand the phenomenon of interest. The researcher has nearly 20 years of nursing experience in Winnipeg’s core area serving street-involved populations and people who use drugs, building relationships across systems, and

personal involvement with participatory projects with people who use drugs. Although an asset for credibility, this historical engagement in a professional capacity created some assumptions and blind spots that required unpacking and challenging over the six months of data collection by way of active listening and reflexivity. For the most part, participants appeared to be forthcoming in their conversations and interviews, and several times told the researcher when they did not wish to share parts of their lives or experience. The challenge for the researcher was being open to what was said, implied, and potentially not spoken.

While engagement in the natural research setting helps the researcher be attentive to the multiple influences and contextual factors that shape the phenomenon of interest, persistent observation helps the researcher develop a depth of knowledge and identify these contextual elements at play. Social context mapping was used as a method to augment data analysis and interpretation. Visually laying out the research findings can help articulate the contextual elements of the field and identify which elements required further data or interrogation (Lincoln & Guba, 1985; Morse, Barrett, Mayan, Olson, & Spiers, 2002).

Triangulation is the use of multiple sources of data to ensure that the analysis and interpretation is rich, penetrating, and comprehensive. Triangulation of data sources was a primary means of enhancing trustworthiness by examining the consistency of findings from different data sources; specifically, from interviews with people who have different viewpoints and from different social locations, and to some degree at different points in time over the data collection period (Creswell, 2007). Analyst triangulation was also employed, where the primary researcher's academic advisor reviewed preliminary findings, and discussed alternate interpretations and potential blind-spots (Angen, 2000). This method supported the development of the initial coding framework. All codes and categories that arose from the data were

constantly challenged and revised as more data were added and analyzed. The primary researcher also engaged in analytic sessions with doctoral student colleagues to uncover researcher bias and assumptions and to test emergent hypotheses (Lincoln & Guba, 1985).

Transferability. The degree that the findings of research can be applicable to other settings or populations is the transferability. Qualitative research is not intended to produce generalizable findings however, by providing thick analysis and description, the reader has sufficient information to determine if the conclusions drawn from the context and situation may be applicable to other times, settings, and people (Lincoln & Guba, 1985). Thick analysis and description can also address complexity, contradiction, and heterogeneity in research findings (Agar, 2008). By providing a thorough description of the study setting and robust direct quotes to exemplify findings and themes, readers may see salient differences, similarities, and multiple truths that may resonate with their own experiences and observations.

Dependability. The degree to which research findings are consistent and could be repeated is the dependability. The external examination, required for the defence of a doctoral dissertation project, or external inquiry audit, enhances the dependability of research findings. This process provides a means to assess the adequacy of data analysis and interpretation and receive important information to develop a stronger and more articulated analysis (Creswell, 2007). Providing a robust description of the data enables the dependability to be assessed.

Confirmability. The degree to which the research findings and product arise from the participant data, rather than from researcher bias, is referred to as confirmability. The primary means of establishing confirmability are an audit trail and reflexivity. An audit trail provides an account of analytic decisions and assumptions made by the primary researcher throughout the

course of data collection and analysis (Morse et al., 2002; Streubert Speziale & Carpenter, 2003), and was maintained in this study through recorded analytic memos and the evolving coding framework and social context map. This strategy allowed committee members to see what steps the researcher had made in drawing conclusions from the data.

Reflexivity is another means to establish confirmability, and a significant portion of Pierre Bourdieu's work revolved around reflexivity. The primary target of Bourdieu's epistemic reflexivity is not the individual analyst but the unconscious ways of knowing embedded in research tools and practices, which are a product of the collective field of academia (Bourdieu & Wacquant, 1992; Maton, 2003). Bourdieu did not deny the importance of the individual researcher uncovering her own personal motivations invested in social analysis. However, Bourdieu argued that the main impediment to knowledge is the collective unconscious of social science methods, which causes the analyst to project a fallacy onto the object of research (Bourdieu & Wacquant, 1992). The social scientist is understood to be predisposed to false projection: "intellectuals have a much greater than average capacity to transform their spontaneous sociology, that is, their self-interested vision of the social world, into the appearance of a scientific sociology" (Bourdieu & Wacquant, 1992, p. 66).

According to Wacquant (2011), epistemic reflexivity is intended to prevent the researcher from falling back on common sense, lay/folk or scholarly pre-constructions of what is being observed. Taking the point of view of research participants seriously is integral to reflexivity, which can manifest in various forms of collaboration with research participants (Wacquant, 2011). Social context mapping as an analytic and interpretive tool can facilitate epistemic reflexivity by enhancing the researcher's ability to consider disparate elements and symbolic power within the field, including the academic institution and researcher as an element of the

field. The researcher and the research project may be placed into the map to make transparent the position of the researcher and project within the field of interest.

The researcher's social location as a Caucasian female, middle-aged and middle-class female is typical in the field of nursing. All major institutions (education, academia, health care, law enforcement) in the field are informed by non-Indigenous, primarily Eurocentric, ways of knowing and doing. It is therefore not only a problem of a researcher from a different social location than research participants, but also a researcher practicing in a social world where it is commonplace to perpetuate colonial relations by way of a social world set up to privilege non-Indigenous peoples, practices, knowledges, and ways of doing. Thus, colonial relations are often perpetuated through any practices within institutions, including research. As well, the research is informed by critical poststructuralism, derived from Western academia. The work of the researcher is to keep these problematic power relations in view during in the inception, process, and product of this research, to capture the voice of participants, contextualize data in a critical social analysis, and expose problematic power relations.

Reflexivity was operationalized in the study design and methods. Talwin and Ritalin injection as a drug use trend is not considered a "problem" but rather a field to explore from multiple standpoints with a focus on power relations and action, with knowledge construction understood as an act of power. By allowing data and analysis to point the way toward further exploration, there is less inclination for the researcher to impose her own construction onto the data. Using Bourdieu's conceptual tools made space for multiple truths, instability, and negotiation in the research process. In addition to data from participant interviews, field notes, and informal interviews, the researcher incorporated a range of other data including relevant histories, institutional and policy data, and previous research on Talwin and Ritalin injection as

contributions to the discourse. In this way, the researcher's own dataset was positioned within a body of other work as a contribution to the construction of the field.

Finally, a research product informed by a critical lens should be useful and lead to further action. The usefulness of this study was enhanced by paying close attention to the needs of potential knowledge users, including harm reduction programs, community services, addictions agencies, shelters, and others involved in serving people who use drugs. As the primary researcher has longstanding, close, collegial relationships with these key community partners, consultation for the purpose of developing relevant research questions and useful results was an ongoing process throughout the study.

Representation

Making the private lives of stigmatized and structurally disadvantaged people public through ethnography has serious ethical implications. Ethnographic products can be acts of symbolic violence by way of distorting and exploiting the people they represent. Trust is difficult to establish in the context of publicizing the private. Ethnographic products should honour the presence and humanity of drug users, while remaining critical of structural power relations (Bourgois, 2002; Keane, 2011). Exploring the social context surrounding Ts and Rs injection can result in harm magnification, where shedding light on a social phenomenon makes it appear to be a problem and can increase interference into the already highly regulated lives of people who use drugs (Keane, 2011).

This study dealt with representation by focusing on the field, or social context surrounding the injection of Ts and Rs, as the unit of analysis. All social practices were framed within their social, economic, and historical context as it was understood. This was especially

true for information or practices that may not reflect favourably on participants, such as illegal income-generating practices or violence. By positioning social practices within a larger social and historical context, they can be read as an extension of a social world that limits options for obtaining the capital necessary to survive. Omitting unfavourable practices can lead to a truncated and distorted account of the urban social world (Wacquant, 2002a). Concealing the morally unsanctioned conduct of social actors in order to produce positive representations leads to poor quality social research and disservice to research participants and can underplay the structural relations of lived experience and drug use practices (Wacquant, 2002a).

Quotes were selected judiciously to demonstrate and exemplify findings from the ethnographic interviews. According to Bourdieu (1993), much of what participants communicate in oral interviews is lost once recorded, transcribed, and translated into text. To respect participants' voices, Bourdieu (1993) suggests that the transcribed text should be edited to remove certain add-ons, confused or partial phrases, expletives, or linguistic tics (such as "like" and "uh"). While these play a role in oral conversation they confuse and obscure the message to the reader. Bringing the transcribed and translated oral voice closer to the written language of the reader can make the knowledge and perspectives of the participants more accessible. Accordingly, participant quotes were edited post verbatim-transcription in a manner consistent with the written voice, without altering the substance of what was said.

Ethical Considerations

Research ethics approval was granted by the Education/Nursing Research Ethics Board at the University of Manitoba, and research access approval to engage Street Connections in recruitment was granted by the Winnipeg Regional Health Authority Research Access

Committee. As the study was an emergent design, approval of a revision to the study protocol prior to phase II was required as purposive sampling was used to explore emerging findings that may differ by participant characteristics, which could not be anticipated at the study outset. The ethical principles of respect for persons, concern for welfare, and justice, as set out in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERCC], Social Sciences and Humanities Research Council of Canada [SSHRC], 2014), were given due consideration in the design of the study and formed the basis of the ethics protocol. Ethical implications related to research with Indigenous peoples are also acknowledged and discussed.

Respect for persons. Free and informed consent is an important component of respect for persons and autonomy. Informed consent means that “participants have adequate information about the study, comprehend the information, and have the power of free choice, enabling them to consent to or decline participation voluntarily” (Polit & Beck, 2012, p. 157). Potential participants were provided with both a verbal and a written explanation of the purpose of the study and had the opportunity to ask questions. The following ethical considerations were addressed: participation is voluntary and declining to participate would not impact any care services the individual may receive; participants have the right to refuse to answer any questions; and participants have the right to withdraw from the study at any time with no impact on services. All participants signed a consent form for participation (see Appendix F for phase I and II consent forms). Contact information for the researchers (primary researcher and academic advisor) was provided should participants take interest in further information about the study results.

People who use drugs are often perceived to have impaired capacity to consent to participate in research because of intoxication and chronic effects of drug use, and as a consequence of drug withdrawal (Bell & Salmon, 2012). Although acute withdrawal symptoms have been associated with compromised decision-making abilities and concentration (Bell & Salmon, 2012), there is little empirical evidence of impaired informed-consent-making abilities among people who use drugs. In fact, studies have found people who use drugs to have no significant differences in consent comprehension than people who do not use drugs (Harrison, Vlahov, Jones, Charron, & Clements, 1995; MacQueen et al., 1999).

Intoxication was considered an exclusion criterion and was assessed by the primary researcher, a nurse with extensive experience working with people who use drugs. Potential participants who met the eligibility criteria were told that informed consent depended on their being free of intoxicating substances during the interview —although if intoxicating substances were on board, rendering the person ineligible, the interview could be rescheduled to another time. The researcher asked if any intoxicating substances had been used in the last five hours (“have you taken any drugs, alcohol, or things to get high in the last five hours?”). All substances listed were considered for dose and duration of intoxicating effect. Short acting stimulants, such as cocaine and crack cocaine, have a relatively short effect (30 minutes), where abstinence for three hours before an interview would be considered acceptable. Longer acting central nervous system depressants such as alcohol, toluene, and opiate drugs (except for prescribed methadone) would require a period of four to five hours of abstinence prior to the interview (Smith, Marks & Lieberman, 2005). Physical symptoms of intoxication were also observed for, such as slurred speech, unsteady gait, altered consciousness, or symptoms of acute drug withdrawal —with these symptoms resulting in exclusion at that time. As discussed under the recruitment section,

locating and interviewing people early in the morning proved to be a good method for avoiding intoxication as a barrier to participation.

Free and informed consent further requires the participant to be free of coercion or perceived coercion to participate in research (as perceived coercion has the same social effects as actual coercion). Issues of “double agency” often arise when health and social research is conducted by people who provide care and service to research participants (Edwards & Chalmers, 2002). In this context, coercion to participate in research may occur if the participants perceive that their non-participation may result in compromised care or service. Recruiting research participants from Street Connections, Winnipeg’s largest harm reduction supply distribution program, may be considered problematic in this context. However, Street Connections provides safe injection supplies to clients anonymously, and the proposed recruitment was passive (i.e. the contact information of the researcher was provided to the client, rather than client information passed onto the researcher). It would be evident to clients that there would be no way for staff to know whether a client participated in the research, and thus no ability for care to be altered as a result. Further, Street Connections does not provide primary care, in-depth counselling, or specialized care (such as HIV treatment or prenatal care) that could be perceived as difficult to access elsewhere. To further ameliorate this issue, the consent process used plain language to explain that participation in the research in no way alters access or quality of care received. Although a number of partnering harm reduction supply distribution sites exist in Winnipeg, they are primarily connected to smaller service areas where clients are already known to providers by name; thus, a perceived or actual pressure to participate in the research is more likely in those settings.

People who inject Ts and Rs lack existing formal infrastructure by which community engagement can take place; however, this should not deprive this community of the opportunity to participate in research (CIHR, NSERCC, SSHRCC, 2014). Community engagement inherent to ethnographic research seeks to tilt the imbalance of power between researcher and community by sharing and shaping results as a co-construction (Agar, 2008), and drawing from experiential expertise provides favourable balance of inclusion and respect for the autonomy of the participants.

Concern for welfare. The principle of beneficence addresses the researcher's responsibility to minimize harm and maximize benefits for research participants. Participants have a right to freedom from harm, discomfort, and exploitation, and an assessment to determine if the risk-benefit ratio is acceptable is important to protect participants (Polit & Beck, 2012). This study posed minimal risks to participants, and the primary discomfort was time and inconvenience associated with attending the interview with the researcher. However, as issues were expected to arise in interviews that may warrant referral for support or services, the researcher had a general resource guide on hand to facilitate access to appropriate services such as addictions, shelter, income, food security, counselling, and health care.

In order to offset the burden of participation, each participant was provided a small honorarium in compensation for his or her time. Phase I participants received \$25 gift cards for Superstore/No Frills as honoraria, as well as bus tickets to travel to and from the grocery store. Gift cards were considered pragmatic in the field and a standard practice for the academic institution under which the study was conducted. However, phase II was changed to allow for a \$25 cash honouraria. Cash is the preferred honouraria for this population as gift cards for groceries are of little practical use if a person is unable to store groceries. In keeping with the

ethical principal of respect of autonomy, cash honouraria pays recognition to the ability of research participants to know best how they should spend their money. The honouraria were considered reasonable compensation for the participants' time and effort, and not enough to exert coercion to participate in the study (Grant & Sugarman, 2004; Ulrich & Grady, 2004). The benefits of the study should also be considered, and participants may benefit from involvement in the research study as it may increase their understanding of the social context in which they live; the interview provided a venue to speak about their experiences candidly to an active listener.

To protect confidentiality, participant names were replaced with pseudonyms of their choice. In cases where participants did not want to use a pseudonym, or when participants interviewed under a street name that would be recognizable to others, the researcher assigned a pseudonym. Two participants chose the pseudonym Tina, and two participants chose the pseudonym Brian, thus there is a "Tina Two" and a "Brian Two."

There is a risk of harm when a hidden social practice is highlighted through studying, asking questions about, and writing findings about the phenomenon of Ts and Rs injection in Winnipeg. Documents arising from the research contribute to the constitution of this social phenomenon by putting forth a type of knowledge and discourse about this phenomenon and the people involved with it. For this reason, issues of representation in research, discussed earlier in this chapter, are taken very seriously. The study sought to problematize the social context that positions people for involvement with different types of substances, rather than making problematic those who use substances and their social practices.

Acquisition of pharmaceutical drugs and diversion to the market is an extremely important element of the field of interest, but one of the more potentially harmful areas of exploration. As drug dealers are often arrested, such a disclosure could lead to a participant thinking the researcher leaked information to police. The collection of this type of information was largely avoided by clearly stating the nature of confidentiality and identity protection in the research process. Illegal activities discussed are protected under these confidentiality processes with the exception of a disclosure of abuse involving a child or vulnerable adult, in which case the researcher is legally obligated to report it to the appropriate authorities. Four interviews had information on specific drug sources, such as names of dealers or trafficking venues. The primary researcher transcribed these interviews herself and removed the incriminating information from the transcripts.

Justice. The third ethical principle of concern is justice, which involves the research participants' right to fair treatment and privacy (Polit & Beck, 2012; CIHR, NSERCC, SSHRCC, 2014). Although complete anonymity is not possible in the context of face-to-face interviews, confidentiality procedures were explained to participants; specifically, that collected data would only be made available to those for whom the participants had consented to give access (the research team), and findings would not be reported in a way that identifies individual participants. The collected data were made anonymous during the transcription process by using a pseudonym of the participants' choice. Participants were also assigned a code that was linked to their name on a separate electronic document that was encrypted and password protected on a password-locked computer in the primary researcher's home for audit purposes. The researcher had full access to the data; however, her advisor and research team only had access to the anonymized data. Immediately following the interviews, participants were asked if there was

anything they wanted to remove from the transcript, and the primary researcher/interviewer made a note any time an identifier was used in interviews to remove it. The confidentiality procedures were explained to the transcriptionist, who agreed to the conditions and signed a confidentiality pledge requiring safekeeping of the data. Materials used for knowledge translation will be free of identifying information on any kind. As ethnographic products often contain some thick description, careful attention was paid to narratives that may contain identifying events or details, regardless of the lack of unique individual identifiers used.

Research with Indigenous peoples. The majority of participants in this study identified as Indigenous. When conducting research involving Indigenous peoples, there are specific implications for the ethical principles of respect for persons, concern for welfare, and justice that extend beyond the consideration of individual participants. Research should consider Indigenous ways of knowing and being, the land, and communities, and should enhance Indigenous peoples' capacity to maintain their cultures, languages, and identities as First Nations, Inuit or Métis peoples, and to support their full participation in, and contributions to, Canadian society (CIHR, NSERCC, SSHRCC, 2014). This research derived from a poststructuralist critical perspective, not an Indigenous lens or worldview, but with a view to making hidden voices and perspectives heard, expose power relations that hold structural inequities in place, and build relationships based on trust and reciprocity.

People who inject Ts and Rs in Winnipeg may be understood to be a community of interest comprised of a significant proportion of Indigenous peoples. A community of interest is defined as an informal community who share common interests, and whose boundaries, organization, and leadership may be fluid and not well defined (CIHR, NSERCC, SSHRCC, 2014). Communities of interest may be temporary or long term, existing within or outside of

territorial or organizational communities, and characterized by diverse interests and perspectives. Although the research did not intend to make analyses or conclusions specific to Indigenous peoples, it is recommended that communities of interest, Indigenous service agencies, or Indigenous organizations be engaged pre-research to help secure community representation in research oversight and to ensure cultural safety in collecting and interpreting data when a sizeable proportion of research participants are expected to be Indigenous (CIHR, NSERCC, SSHRCC, 2014). Engagement and relationship building promotes mutual trust and communication and mutually beneficial research objectives.

This project was only weakly informed by pre-research engagement with the community of interest. There was no clearly available infrastructure to support pre-research engagement, nor Indigenous harm reduction organizations within the research setting. However, some informal engagement with the researcher and the community of interest was established through a community-based musical project, JD and the Sunshine Band, that the researcher has been a part of since 2013. The project is a band that evolved out of a drop-in centre, Sunshine House, often frequented by people who use solvents. Many of those who use solvents currently or historically injected drugs (most commonly Ts and Rs) and retained close connections to people who inject Ts and Rs. The musical project is a non-hierarchical and non-professional space where the researcher made close connections with community members while playing local shows, concerts, and festivals, and recording albums. This engagement provided opportunities to discuss plans to explore Ts and Rs, the purpose of the research, and the questions that were to be asked of participants. Community members generally considered Ts and Rs to be drugs of low harm and suggested that those who injected Ts and Rs would have excellent knowledge of inner-city drug use and daily hurdles involved in street life. Carrying out the research project also fostered

engagement and trust with participants to serve as a starting place for collaborative projects in research, policy, and programming going forward.

Finally, ownership, control, access, and possession (OCAP) of research data comprise a set of principles that reflect First Nations commitments to use and share information in a way that brings benefit to the community being researched while minimizing harm that may arise from research (First Nations Information Governance Centre, 2014). OCAP is an expression of First Nations jurisdiction over information about the First Nations peoples and communities. Although there was a willingness to honour OCAP principles, they could not be honoured or applied in this project with the raw interview data. There was no clear representative body to whom the data could be provided. However, rich contextualization of participant characteristics, thick description of interview findings, and presentation of multiple perspectives and voices in this research are used to make much of the raw material available for alternative analyses and interpretation by the reader.

Summary of Methodology and Methods

Bringing together the critical sociology of Pierre Bourdieu with focused ethnography methods produced a valuable conceptual/methods package. Laying out the important aspects of a social context can be unwieldy without a defined focus, yet determining a focus *a priori* can create analytic blind spots. Centralizing power relations and capital proved helpful in mapping aspects of the social context, and particularly the relationships between institutions and daily life. The social location of the researcher shaped all aspects of the study. Trust and rapport between researcher and participants was variable. Many interviews stimulated robust conversation and the researcher was entrusted with deeply personal and painful life stories, however some participants

were not willing to share their experiences and insights in detail. Analysis and interpretation of data is always partial and limited by the standpoint of the analyst, thus space was made for multiple voices, interpretations, and perspectives.

Through these methods, evidence to shed light on the social context surrounding Talwin and Ritalin injection in Winnipeg was constructed. The presentation of research findings unfolds over the next three chapters. The macro and meso aspects of the social context are explored in Chapter 5, presenting the reader with a critical view of systems of power and privilege that shape the existence of Ts and Rs injection and characteristics of daily life for participants within the local study setting. Chapter 6 is set up to provide readers with the opportunity to hear the voices of participants by way of a primarily descriptive presentation of participant narratives, albeit framed in a micro to macro disposition of context. The discussion put forth in Chapter 7 provides a deeper interpretation of the most salient findings emerging through the social context constructed in the previous two chapters. This presentation of findings is intended to produce a highly contextualized account of the situated knowledge and lived experiences of participants, as well as the researcher's theoretical exploration into the key elements of the social context that emerged in this study.

Chapter 5: Constructing the Social Context as a Field of Power Relations

In this chapter, systems of power and oppression are explored for their constitution of Ts and Rs injection as a social phenomenon, and their influence on the local study context and social location of participants. Providing insight into the social context of an ethnographic research project is essential in order to understand how social practices are shaped and situated (Page & Singer 2010; Agar, 2008). Drawing from Bourdieu (Bourdieu & Wacquant, 1992), the social context, or “field,” is characterized by historically, structurally, and symbolically produced relations of power that shape habitus and lived experience. Accordingly, some of the relevant histories that gave rise to the field of Ts and Rs injection are foregrounded in this chapter. Similarly, manifestations of power are explored for the ways in which they play out in institutional policies and practices, and shape access to social and material resources among people involved with Ts and Rs injection in Winnipeg.

Situated knowledge shared through participant interviews drew attention to antecedent systems of power that shaped the social context, drug market, habitus, and participants’ lived experiences. However, social context cannot be pieced together solely from accounts from within it. Specifically, macro (structural, political, economic, mainstream systems of meaning) and meso (institutional practices, neighbourhood characteristics) social systems can fail to arise in interviews with people about everyday life, as individuals generally cannot experience life outside of these systems. This applies to structural systems, such as policies that determine the distribution of power and resources in society, as well as symbolic systems such as race, social class, gender, and drugs, that act as instruments of knowledge and domination. Powers within the field shape the habitus of participants: a shared set of dispositions, practices, and ways of being that affect life opportunities and well-being in significant and enduring ways.

In all, 36 individuals who inject drugs and reside in inner-city Winnipeg participated in this research and their social locations reflect marginalization on a number of intersectional axes. Twenty-three of the 36 participants identified as First Nations, two identified as Métis, eight as Caucasian, one as First Nations and Caucasian, one as Métis and First Nations, and one as First Nations and African. Settler colonialism emerged as the most evident axis of structural power in the field and its operations are examined throughout this chapter, Chapter 6, and Chapter 7. Several layers of structural disadvantage positioned participants for low income. Only ten of the 36 participants had completed high school (grade 12), which limited their opportunities for employment. Most participants received provincial Income Assistance as their primary income, supplemented by some form of informal economy in order to meet basic needs. Twenty-three of the participants identified as male and 13 as female; none of the participants identified as other genders. The participant characteristic data are described throughout this chapter and framed within the relevant historical, social, political, economic, and institutional dynamics that comprise the social context surrounding the injection use of Ts and Rs in Winnipeg.

This chapter begins with a description of the local study setting and the key services arising from participant interviews. Next, the macro power systems of patriarchy, capitalism, and settler colonialism are introduced as tools to critically examine the formation of the Canadian nation and ideas of race, social class, and gender. Finally, macro and meso systems of power manifesting within Canadian institutions and mainstream symbolic systems are discussed with specific links to the local study setting and participant characteristics.

Local Study Setting

This study took place in the Downtown and Point Douglas/North End areas of Winnipeg, Manitoba. Poverty, homelessness, and street involvement are visible and racially stratified in these places, and access to resources and opportunities are systematically and historically unequally organized as a result of ongoing colonial and discriminatory processes and practices (Comack, Deane, Morrissette, & Silver, 2013). The buildings along Main Street are a mix of corporate business and health and social services, such as community-based food services, walk-in clinics and pharmacies, faith organizations, Indigenous organizations, and temporary shelters. While there is vibrant growth in Indigenous community development, organizations, and services (Maton, 2016; Silver, 2006), the neighbourhoods are heavily policed and monitored by patrol organizations (Comack, 2012).

All participants in this study were recruited from and resided in the neighbourhoods of Point Douglas and Downtown Winnipeg, with almost all of the participants residing in the North End, or Census Tract 34 (as designated by Statistics Canada). Silver (2015) undertook a detailed analysis of Statistics Canada *2011 National Household Survey* data to find that 56% of the residents in this area self-identified as Aboriginal, compared to 11% of Winnipeg as a whole. Approximately 52% of families in these areas identified as lone parent (primarily female) families, compared to 18% of Winnipeg families. The median after-tax household income in this census tract was \$26, 000, less than half that of the median after-tax household income for Winnipeg as a whole. Youth and child poverty rates in Census Tract 34 are more disparate, with 70% of children under 18 years of age and 67% of children under age 6 living in low income (after-tax Low Income Measure), compared with 25% of Winnipeg as a whole (Silver, 2015).

There are many agencies, programs, and services in and around this neighbourhood that seek to serve street-involved people, people experiencing residential instability, Indigenous people, people who use drugs, people who are sexually exploited or involved in transactional sex, or others who may experience barriers to material and social resources due to structural disadvantage and discrimination. A handful of these agencies arose frequently in conversation with participants as they play a role in shaping the everyday experiences. Thus, a brief description of these services follows.

Key services arising from interviews. The most common types of services discussed during participant interviews were housing/shelter and community-based food services. Main Street Project (just off of Main Street at 75 Martha Street) provides shelter services using harm reduction and Housing First approaches, as well as addictions support, integrated health, and a chemical detox unit (Main Street Project, 2016). The main shelter at 75 Martha Street is the only Winnipeg shelter that does not prohibit intoxication or drug paraphernalia and accordingly tends to serve many people who use drugs and lack stable housing (Main Street Project, 2016). Across the street from Main Street Project is the Salvation Army/Booth Centre, a faith organization that operates temporary and transitional shelter and the Anchorage residential addictions treatment centre (Booth Centre Ministries, n.d.). Around the corner is the Lighthouse Mission, which is an Evangelistic organization that serves breakfast and lunch daily. Across Main Street is the Bell Hotel, a Housing First single-room occupancy, multi-dwelling housing unit with meals and supportive services, operated by Main Street Project and other partners (Main Street Project, 2016). Half a block behind the Bell Hotel is Siloam Mission, a faith-based charitable organization that provides temporary shelter, meals, clothing, employment assistance, mental

health services, and supplementary health services such as dentistry, podiatry, and physiotherapy (Siloam Mission, n.d.).

Two main health services were discussed by participants. Street Connections is a harm reduction program of the Winnipeg Regional Health Authority with a fixed site and mobile van, providing safer sex and drug use supplies, system navigation, referral, nursing services, outreach, community engagement in various projects, and advocacy. The mobile van operates from 5 pm until 1 am six nights a week (Street Connections, n.d.). Nine Circles Community Health Centre, located in the Downtown/West Broadway neighbourhood, provides comprehensive primary care, social support, education, and prevention services to people affected by HIV or hepatitis C, people with problematic substance use, those at risk of poor outcomes due to discrimination, and those living in the Downtown or Point Douglas neighbourhoods (Nine Circles Community Health Centre, n.d.). There are dozens of other community-based organizations and services, many of them Indigenous-led, that likely interfaced with participants in the study; however, only those agencies and services that arose frequently in conversation with participants have been outlined.

Critically exploring the constitution of this research setting and constructing a meso to macro picture of the social context surrounding the injection of Ts and Rs in Winnipeg involves taking a few steps back to explore systems of power that are antecedent to the formation of Canada as a nation.

Macro Systems of Power

Patriarchy, capitalism, and colonialism emerged as macro systems of domination that organize the privilege of some social norms and manifest in the institutional and symbolic

environment of the field. Further, these macro systems contribute to systems of meaning about gender, social class, and race, which shape the distribution of power, resources, opportunities, and help solidify structures of inequality (Dhamoon & Hankivsky, 2011).

Patriarchy, capitalism, and colonialism. Patriarchy is a macro system of social structures, practices, and symbols in which men dominate, oppress, and exploit women (Walby, 1999). The concept of a binary male and female gender system is itself a system of power that excludes and oppresses other genders, therefore gender inequality is too complex to relegate entirely to patriarchy. However, the concept of patriarchy remains an essential tool in examining gender relations. Industrialized states have historically had patriarchal relations manifest in the public and private spheres of society in modes such as paid work, state power, sexuality, violence, and cultural institutions (Walby, 1999). As social institutions formed among industrialized states, they were shaped primarily by men who had already learned the techniques of hierarchical organization (Hartmann, 2006). Women and other genders of different social class, race, ability, and sexual orientation have historically been subjected to different forms and degrees of patriarchal power (Hartmann, 2006).

Capitalism is an economic macro system that developed in a patriarchal context, and so has manifestations that reproduce patriarchal relations of power (Walby, 1999). According to Marx (1867), capitalism is an economic system characterized by social relations of production that create dominant and subordinate classes, whereby the dominant capitalist class appropriates surplus and the subordinate working class is exploited for labour power. The relations between the two classes is therefore one of conflict and struggle (Marx, 1867). As capitalism developed in industrialized nations, patriarchal power relations have been reproduced within societal structures. Such manifestations include men's historical control over women's (domestic) labour

power, the development of gender-segregated job markets, and gendered dynamics that limit female leadership in the workplace (Hartmann, 2006).

Colonialism is an ongoing system of exogenous domination over Indigenous peoples, generally in pursuit of economic interests fuelled by European capitalism. Settler colonialism is characterized by the appropriation of land and resources, and attempts to eliminate Indigenous societies (Veracini, 2011; Wolfe, 1999). Settler colonialism is distinguished from other forms of colonialism (e.g. imperial colonialism) by two features: the nature of the relationship between the colonizers and colonized; and the relationship between the colonizers and the homeland(s) they left (Veracini, 2010, 2011, 2013; Wolfe, 1999). In settler colonialism, the settling populations seek to overrule the local Indigenous peoples, which is accomplished primarily through dispossession from their lands (Harris, 2004). In the interest of capital and profit, Indigenous peoples may be relegated to small reservations, and the rest of the land opened for settler development (Harris, 2004). The new settled nation builds an identity based on the idea of fleeing an oppressive metropolis, and alienation from the homeland (Veracini, 2010; Wolfe, 1999).

Colonialism cannot be said to derive solely from capitalism, but evolved in a capitalist context, enabling capitalist economic relations to manifest in colonial institutions, processes, and practices. Laying claim to territories through settler colonialism is often accomplished through the pretense of settlers discovering an uninhabited land (or “terra nullius”), as is the case in Canada (Pacquette, Beauregard, & Gunter, 2015). Settlers become the founders of the political order in colonized lands, providing sovereign entitlements (Veracini, 2010). Along with the new political order, settling involves the destruction of old and construction of a new society, including all institutions such as economy, criminal justice, politics, education, child welfare,

social welfare, and health (Veracini, 2010; Wolfe, 2006). Settlers come to stay and forge a new social order.

In sum, power relations inherent in patriarchy, capitalism, and settler colonialism are reproduced within Canadian society and its institutions, and contribute to ideas of gender, social class, race, and other socially constructed categories. While Canadian history is characterized by movements of resistance to the problematic power relations that manifest in society, the trails of patriarchy, capitalism, and colonialism are apparent in the everyday living conditions and opportunities that are historically and enduringly unequally organized.

Macro and Meso Manifestations of Power in Institutions and Symbolic Systems

Institutions refer to mechanisms of social order and organization within society, including structures such as economics, politics, social welfare, education, child protection, criminal justice, and health. Institutions are sites where macro systems of power manifest in policies, laws, regulations, structures, programs, and systems of meaning, and play out in the meso level of the research study context. Specifically, macro systems shape structures and policies that determine the nature and distribution of social and material resources available in society, and shape interactions between institutional agents, mainstream society, and participants. Where macro systems of power can become taken for granted as a natural part of the social world, the institutional manifestations of meso level power relations are more readily captured empirically in the everyday institutional practices and neighbourhood living conditions experienced by participants. Systemic racism, health system manifestations, neoliberal governance, criminal justice manifestations, and drug prohibition are the key institutional systems of power discussed in this chapter for their impact on the field of study and participants' everyday lives.

Systemic racism. In concert with the idea of settling an uninhabited land, settlers operate under the supposition that there were no legitimate forms of government, education, economy, justice, etc. prior to settlement (Wolfe, 2006). Institutional systems are constructed under the white settler (European) systems of meaning, and are created to reproduce settler interests, although the settler agenda is forwarded outside of formal institutions “from the metropolitan centre to the frontier encampment” (Wolfe, 2006, p. 393). The institutions, practices, and policies that arise from settler colonialism combine to undermine Indigenous peoples’ access to and control over a range of resources and power (de Leeuw, Greenwood, & Cameron, 2010). White supremacy is a system that assumes that the practices of whiteness are the right way of organizing human life (National Collaborating Centre for Determinants of Health [NCCDH], 2017). In this way, white supremacy and systemic racism are embedded in the structure of Canadian institutions and social practices of society, influencing how material and social resources for well-being are distributed in white settler society (NCCDH, 2017).

Elimination of Indigenous peoples and societies was a necessary strategy for settlers’ appropriation of land, and this goal benefits from the false assumption that non-Indigenous cultures are superior to Indigenous cultures (Silver, 2015; Wolfe, 1999). Settler colonial systems tend to represent Indigenous peoples as frail and vulnerable, constituting a particular shape of racism that resonates with mainstream discourse (Veracini, 2011). A salient example, articulated by de Leeuw et al. (2010), is the 1869 *Act for the Gradual Enfranchisement of Indians*, which emphasized Indigenous vulnerability to mental health conditions and addictions. This discourse legitimizes settler colonial domination as agents of care and protection over “vulnerable” Indigenous peoples (de Leeuw et al., 2010). These racist and false beliefs in Indigenous inferiority continue to manifest widely in Canadian society, and can become internalized by

Indigenous people, leading to a range of psychosocial and spiritual manifestations of hopelessness and low self-esteem (Silver, 2015).

As a result of their social locations, participants in the study tended to be dependent upon institutions for access to basic resources such as food, shelter, and income. Thus, institutional relations were part of the fabric of their everyday life, and systemic racism is evident among various institutions in Manitoba that participants interface with regularly, such as education, criminal justice, and health. For instance, Ilyniak (2014) found racist representations of Indigenous peoples in Manitoba public elementary school history and social studies texts published between 1960 and 2013. Overt racist representations were found in textbooks published in the 1960s through 80s, referring to Indigenous peoples as “barbarians” and “savages.” More recent textbooks displayed subtle racism with implications that settlers arrived in uninhabited lands, and cultural and social traits of Indigenous peoples were implied to be biological traits (Ilyniak, 2014). This education system regulates how Manitobans are taught to understand Indigenous peoples, thereby reproducing conditions for white supremacy inside institutions and in mainstream society.

Comack and Balfour (2004) examined legal cases heard by Manitoba Court of Queen’s Bench and describe how racist ideological representations of Indigenous offenders, victims, criminal acts, and the spaces in which they occur make their way into legal case-building strategies. Alcohol and drug use among Indigenous people was presented as chaotic and reckless, and these racist representations were seen to affect sentencing decisions by non-Indigenous juries and judges (Comack & Balfour, 2004). Finally, systemic racism in the health system was seen as a major contributing factor in the death of a 45-year-old Indigenous man, Brian Sinclair (College of Physicians of Canada, 2016). Mr. Sinclair died of a treatable bladder infection after spending

34 hours unattended to in a Winnipeg emergency room while hospital staff assumed he was intoxicated and homeless (College of Physicians of Canada, 2016; Lett, 2013). The victim's family and Indigenous leaders called for an inquest to consider the ways in which race, disability, and social class may have contributed to the man's lack of treatment. The participants' experiences of everyday institutional relations are shared in detail in Chapter 6.

Elimination through family separation. Indigenous family separation is one of the most salient manifestations of systemic racism in Canadian institutional history that impacts the social location of participants in this research. In Canada, the settling British government gained control over the land and resources, disrupted Indigenous communities, economies, and ways of being, and sought to “civilize,” Christianize, and assimilate Indigenous peoples into white settler society (Truth and Reconciliation Commission of Canada [TRCC], 2015a). Breaking the bonds between parents and their children was considered an effective means to destroy Indigenous cultural beliefs and ways of being within and between generations (Royal Commission on Aboriginal Peoples [RCAP], 1996; TRCC, 2015b). The Indian residential school system and the Sixties Scoop were two colonial projects instrumental in the destruction of Indigenous family units, the legacy of which is witnessed today among participants in this study. The social location of participants cannot be fully explained without discussing the Indian residential school system and the Sixties Scoop.

The Indian residential school system, which operated in Canada from 1883 until 1996, was a “civilizing” project between the Canadian government and the major religious bodies of the time (Department of Indian and Northern Affairs Canada, 2003; TRCC, 2015b). Some 150,000 Indigenous children were removed from their homes, often by force or threat, and placed into these schools. Within these institutions, traditional dress, language, and customs were

banned, and abhorrent rates of neglect and abuse were experienced by the children (RCAP, 1996; TRCC, 2015b). On returning to their communities, survivors of Indian residential schools felt isolated and disconnected from family and community, and unequipped to contribute to community and traditional economic life; parents and children had lost generations of experience parenting (Chansonneuve, 2005; RCAP, 1996; TRCC, 2015a).

Child and family service policies and practices impacting Indigenous peoples in Canada took stride in the 1950s through 1960s, reproducing the legacy of Indian residential schools. In 1951, an amendment to the *Indian Act* brought child welfare of Indigenous children under provincial jurisdiction, and transfer of federal funds to provinces was based on the number of children in care (Clarkson et al., 2015). Subsequently, the number of Indigenous children apprehended by child protection services increased by 40 times; many of those apprehended children were adopted out to non-Indigenous families in Canada, the U.S., and overseas, in an era referred to as the “Sixties Scoop” (Fournier & Crey, 1997; Sinclair, 2007). Today, Manitoba has some of the highest rates of children in state custody in the world, and roughly 90% of those children are Indigenous (Brownell et al., 2015; Gough, Trocmé, Brown, Knoke, & Blackstock, 2005; Milward, 2016). The legacy of Indigenous family separation should be understood as various levels of harms, including harms against individual children and primary caregivers, harms against families, harms against community, and attacks on the cultural integrity of Indigenous peoples (Star & Brilmayer, 2003).

Many of the participants in this research had firsthand experience with the Sixties Scoop and/or parents who had been forced into Indian residential schools. Twenty-nine of the 36 participants discussed issues of family separation in their upbringing and/or daily lives, often by way of being raised by child protection services or other family members. Family separation was

related to early independence and street involvement for many participants. Almost half of the participants were living independently without parental support before the age of 18. All of the women in this research who had children were non-custodial parents, with the majority reporting their children were being or had been raised in the child protection system. Thus, the legacy of colonial attacks on Indigenous family integrity and culture was extremely apparent in the histories and everyday lives of people involved in this research.

Health system manifestations: Medicalization, abstinence, and harm reduction. Ts and Rs are pharmaceutical drugs that owe their existence for medical and non-medical use to the expansion of medical practice and pharmaceutical industries. Medicalization is an institutional manifestation in which medical practice reaches into areas of human life not historically treated or pathologized by health professions, including mood, social conduct, and socially produced pain (Conrad, 2007; Rose, 2003, 2006). Over the last 40 years, psychiatry, medicine, and the pharmaceutical industry have co-expanded their reach into a range of human conditions (for example, ADHD, sleep, menopause, problematic drug use, appetite, and mood), all rendered diagnosable and pharmacologically treatable (Rose, 2001). Therefore, medicalization has created the conditions for the expansion of psychotropic pharmaceutical products and their mass diversion for uses outside of prescribed purposes.

Medicalization is a structural and symbolic system of social control that transforms aspects of everyday life into pathologies, thereby narrowing the range of what is considered normal (Conrad, 2007). It is a process that can symbolically transform problems of the social world (for instance, intergenerational trauma) into individual pathologies arising from biochemical abnormalities that are treatable with pharmacological remedies (Conrad, 2007; Rose 2003). In this way medicalization works to underplay problematic social conditions and to

pathologize subjects or citizens who are not economically productive (Conrad, 2007; Rose 2003). Rose (2001, 2003, 2006) argues that in neoliberal societies where individual initiative and autonomy are understood to be responsible for fulfillment, the lack of energy to fulfill tasks required for work and economic growth comprise symptoms of what is now pathologized as “depression.” Societal expectations of the individual act as the norm, and behaviour contrary to these norms is pathologized. In this way neoliberal governance (discussed further in this chapter) ideologically works in concert with medicalization. Moreover, medicalization is shaped by ideas of gender. Women’s experiences have been disproportionately medicalized, including: contraception, childbirth, infertility, premenstrual syndrome, menopause, eating disorders, sexuality, aesthetics, and post-partum depression (Conrad, 2007).

The mass emergence of Ritalin. Ritalin emerged during the post-1950 era of medicalization, and the history of its development, marketing, and medical and non-medical use is a relevant story in the making of the social context surrounding Ts and Rs injection in Winnipeg. Ritalin was originally approved for use in 1955 and marketed for a range of adult ailments, including depression, obesity, fatigue, senility, narcolepsy, and schizophrenia (M. Smith, 2012). Although stimulant drugs were found to help institutionalized children focus academically in the 1930s, Ritalin was not marketed for use with hyperactive children until 1961 (M. Smith, 2012).

Rose (2003) describes the U.S. as a pharmacological society in which modification of mood, thought, and conduct through pharmacological means has become relatively routine. The 1990s were marked by the emergence of ADHD as a psychiatric condition treated primarily with pharmaceutical stimulants such as methylphenidate (Ritalin). Stimulant prescriptions in the U.S. rose by five times between 1990 and 2000 with Ritalin accounting for two-thirds of this growth

(Rose, 2003). In Canada, between 2005 and 2015, there was a 2.6-fold increase in the prescribing of ADHD medication to preschoolers, a 2.5-fold increase in prescribing to school-aged children, and a fourfold increase in prescribing to adults (Morkem, Patten, Queenan, & Barber, 2017), demonstrating the persistence of this medical trend in Canada. Prescription stimulants are used specifically to improve self-discipline and self-regulation, and the diversion of these drugs for the use of pleasure is said to be a central anxiety in medical discourse, as pleasure can be seen to be the antithesis of self-discipline (Keane, 2002, 2008).

The non-medical use of pharmaceutical products was common among participants in this research. Of the 36 participants, 25 identified a prescription drug product as their main drug used. Although most reported the use of more than one substance, Ts and Rs were the main drug used by 17 participants; six reported morphine, one reported Dexedrine, and one reported Percocet (oxycodone). For those participants whose primary drug used was not pharmaceutical, five reported crystal meth, three reported crack cocaine, one reported solvent, and two used a mix of substances with no stated preference. Most participants described the drug scene as dominated by crystal meth, crack cocaine, morphine, Ts and Rs, and a mix of other prescription drugs. The proliferation of pharmaceutical drug production, prescribing, and dispensing enables diversion of these products for non-medical use. Trafficking of prescription medications, in turn, becomes a source of economy for a population largely excluded from living wages and employment opportunities, an issue explored further in Chapter 6.

Abstinence and harm reduction. The ideas and practices of drug-prohibition, discussed later in this chapter, have shaped the nature of health services for people who use drugs. Drug treatment remains widely dominated by the goals of abstinence and the idea of drugs as inherently harmful (Boyd, 1984). If there are no legal means by which drugs can be acquired for

use, the state cannot legitimately condone their use. Abstinence is the goal most consistent with the logics of drug prohibition, whereby services for people who use drugs are designed to help people abstain from drug use. Despite its weak evidence base, drug treatment has historically been punitive and abstinence-based, with mild shifts since the 1990s with the emergence of harm reduction (Frank, 2011).

Harm reduction refers to “policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in [by] people unable or unwilling to stop” (Harm Reduction International, 2017, para 1). The beginnings of harm reduction can be traced back to grassroots activist movements primarily led by people who use drugs and politicized front-line service providers in the 1960s and 70s (Riley, Pates, Monaghan & O’Hare, 2012; Roe, 2005). In the wake of the 1980s’ global HIV epidemic and shift of infection to urban PWID and the sharing of injection equipment, needle/syringe distribution programs were increasingly adopted by the public health sector as a strategy to interrupt HIV transmission (Riley et al., 2012; Fischer, 1997). Needle/syringe distribution programs have since become the most widely known harm reduction intervention, and the effectiveness of these programs for reducing HIV among PWID has been established by systematic reviews (Abdul-Quader et al., 2013; Gibson, Flynn, & Perales, 2001; Hurley, Jolley, & Kaldor, 1997; Ksobiech, 2003). Public funding of syringe exchange is associated with lower rates of HIV infection and an increase in health and social services accessed (Bramson et al., 2015).

Harm reduction is a perspective that grew out of opposition to abstinence ideology, but not necessarily in opposition to neoliberal or conservative governance. In the 1980s in the U.K., the first needle exchange programs were supported by the Thatcher Conservative government, and vehemently opposed by the Labour Party of the time (Riley et al., 2012). As needle/syringe

distribution services are cost-saving by way of preventing HIV infection (Wilson, Donald, Shattock, Wilson, & Fraser-Hurt, 2015), harm reduction can resonate with neoliberal goals of reducing government expenditures in health. In Canada, opposition to harm reduction from the Harper Conservative government (Hyshka, Butler-McPhee, Elliott, Wood, & Kerr, 2012) ostensibly derived from the ideological investment in drug prohibition and “tough on crime” policies, rather than from neoliberal economic interests. As evidenced by Comack, Fabre, & Burgher (2015), the Harper government “tough on crime” strategies were tremendously expensive to provincial/territorial and federal governments.

Unlike many other provinces, Manitoba does not have a provincial harm reduction supply distribution program. Although there are several needle distribution sites in Winnipeg, the funding that supports them is insufficient to meet the demand (Ross, 2017). Other types of harm reduction services, such as supervised consumption services, peer-run harm reduction organizations, managed alcohol programs, naloxone distribution, or expedient access to opioid replacement therapy that exist in other provinces, were not accessible to participants in Winnipeg at the time of the research. The lack of these resources and services were tangible gaps that arose in participant interviews, shared in Chapter 6.

Neoliberal governance. Although governance can feel distant from everyday lived experience, modes of governance ultimately shape the distribution of power and resources in society, which play out at every level of the social world. Neoliberalism is a form of capitalist governance and is characterized by the state’s retreat from social welfare, deregulation of the market economy, and emphasis on individual responsibility for well-being through responsible choices (Broad & Antony, 2006; Rose, 2000). Neoliberal economic governance is premised on the extension of markets and is tied to political projects that emerged out of a range of economic

tensions that developed over the postwar era (Stanford & Vosko, 2004). Its aim is to reinvigorate the dominance of private business and investors in the economy (Larner, 2000).

In the 1980s and 90s in Canada, markets were restored through deregulation of industry and restricting labour/union organization (Broad & Antony, 2006; Stanford & Vosko, 2004). This shift toward neoliberal governance has resulted in widening income polarization as the economy favours those in the highest income categories, contributing to marked social classes (Curry-Stevens, 2008; Gaetz, O’Grady, Buccieri, Karabanow, & Marsolais, 2013). As well, the state’s retreat from the provision of social welfare has created a neoliberal policy climate that tends toward producing responsible, market-involved citizens who are encouraged to not burden the state (Rhodes, 2002).

Market fundamentalism. One important manifestation of neoliberal governance is market fundamentalism, which shapes the nature of markets, including the drug market. Capitalist interests have been reproduced in the neoliberal era in the field of pharmacology, contributing to a public health crisis in opioid-related harms. Griffin and Miller (2011) described the case of Purdue Pharma as an apt example of how industry re-regulation in the neoliberal era enabled the proliferation of pharmaceutical drugs and drug-related harms in the community. In the U.S., pharmaceutical advertising regulations were relaxed to allow for direct “to consumer” marketing (Griffin & Miller, 2011). At the same time, OxyContin© (a formulation of oxycodone) was aggressively advertised to prescribing practitioners as a non-addictive form of chronic pain control (Griffin & Miller, 2011). Demand and use of OxyContin© proliferated. Between 1996 and 2000, sales increased 20 times, with annual sales of over \$1 billion (Griffin & Miller, 2011). From 1991 to 2007, prescriptions for oxycodone increased over eight-fold, and deaths related to oxycodone increased five-fold in Canada (Dhalla et al., 2009). In 2009, Purdue

Pharma pled guilty to fraudulent advertising that misled the public and prescribers about the addictive properties and risk for misuse of the drug, and was ordered to pay over \$600 million in fines (a small proportion of annual OxyContin© profits) to the U.S. federal government and the Commonwealth of Virginia (Griffin & Miller, 2011). This case exemplifies how affording great power to industry through deregulation enables corporate crimes of great social and public health harms that tend to slip past harsh punishments.

Neoliberalism is associated with a minimalist government, allowing market competition to organize economic activity and the provision of basic needs. However, smaller government does not mean less governance (Larner, 2000). Rose (2000) describes how neoliberal governance operates by depending on shame, guilt, responsibility, obligation, fidelity, and good choices of its citizens. Public order and risk management are central goals of neoliberalism, accomplished through regulation, surveillance, and control through public institutions, and citizen responsibility (Rose, 2000). This system of meaning portrays crime, poor health, poverty, and other socially marginalized outcomes as the result of “failed citizens” that lack the entrepreneurial skills required in a competitive market (Rose, 2000). Thus, neoliberal economic rationalities shape the policies, programs, and practices of other institutions, including income and employment assistance, health, criminal justice, education, and others. The following discussion is focused specifically on employment, income, and welfare, and housing and shelter, and their relationship to the study setting.

Impacts on employment, income, and welfare. Social welfare systems expanded rapidly in Canada after the Second World War, but shifts toward neoliberal governance since the 1980s have resulted in a scaling back of these services (McKeen & Porter, 2003). There has been a shift in responsibility for social welfare provision from the state to the market and the family,

coinciding with greater dependence on benevolent and faith-based organizations for basic needs (McKeen & Porter, 2003).

Neoliberal welfare systems emphasize re-entry into the workforce and increasingly punitive social welfare provisions that result in increased poverty, homelessness, food insecurity, and wealth inequity (Gaetz et al., 2013; McKeen & Porter 2003). Systematic exclusion of Indigenous peoples from the economy, education, and other social determinants of health is evidenced by the disparities between Indigenous and non-Indigenous people in Canada. Across Canada, Indigenous people are more likely than non-Indigenous people to have annual household incomes below \$20,000 (Statistics Canada, 2013), to receive social assistance, to be unemployed, to live in unsafe housing, to not attend university, and to not vote in federal, provincial, or municipal elections (Canadian Human Rights Commission, 2010). In Manitoba, 40% of the province's Indigenous population live in Winnipeg (Statistics Canada, 2013), where the life expectancy is 10 years less in racialized neighbourhoods with the lowest median household income (Point Douglas and Downtown), compared to neighbourhoods with the highest household income (City of Winnipeg, 2015).

Silver (2015) locates the spatially concentrated, racialized poverty of Winnipeg's inner-city to have derived from suburbanization, de-industrialization, in-migration, and colonialism. Suburbanization of wealthier residents resulted in a "hollowing out" of the inner-city, driving inner-city housing prices down and ownership into the hands of absentee landlords who tended to invest little into the maintenance of this primarily low-rent housing stock. Urban de-industrialization over the last 50 years has negatively affected employment opportunities for people with low levels of formal education. Living-wage, full-time, industrial/factory work has slowly been replaced with part-time, low-wage, and non-unionized jobs. During this economic

shift between the early 1960s and present day, in-migration of Indigenous peoples from First Nations communities into Winnipeg increased approximately sixty-fold. Today, Winnipeg has the largest Indigenous population (92,810) in the census metropolitan area of all urban centres in Canada followed by Edmonton, Alberta (76, 205), and Vancouver, British Columbia (61, 460) (Statistics Canada, 2016). These socioeconomic influences have compounded with the ongoing legacy of settler colonialism to shape the spatially concentrated, racialized poverty of the neighbourhoods where this research took place, and the social location and everyday living conditions of the participants in this study.

Participants in this study were generally dependent upon income assistance or casual employment for their income. Structural disadvantages in youth, combined with histories of mistrust and maltreatment in the education system, impacted their access to education in early life. Three participants reported paid casual employment; 26 received income assistance with or without disability benefit; two received a pension; two received unemployment insurance; two reported no income source; and one reported only illegal income. In addition, most participants reported some other form of income generation, such as boosting (selling stolen goods), odd jobs, scrap metal and can collecting/returning, panhandling, barter, transactional sex, theft, odd jobs, taking drugs in return for sharing their space for drug consumption, or scoring drugs for others in return for a cut of drugs. There were gendered differences in the types of income-generating practices participants engaged in (which are discussed in Chapter 6). Nearly all the participants reported regularly accessing free community-based food services, such as foodbanks and free meals.

Impacts on housing and shelter. The rise of neoliberal governance coincided with cuts to social housing, which has significantly contributed to increased homelessness across Canada

(Gaetz et al., 2013). In the early 1990s, the federal government withdrew federal subsidies for public housing construction, resulting in a dramatic decrease in access to social housing for the decades to come (Brandon, 2015a). In the context of inner-city Winnipeg, inadequate housing and shelter have been identified as particularly problematic, with high rates of disrepair, insect and rodent infestations, and overcrowding in the public and private housing stock (Brandon, 2015b). Advocacy for improved low-income housing from local organizations helped to bolster a commitment from the New Democratic Party provincial government to improve the public housing stock in 2012, although conditions have not improved for many inner-city residents (Brandon, 2015b), and investment in social housing remains a contested policy terrain. A report contracted by the Manitoba Conservative provincial government, elected in 2016, suggests moving away from social housing investment by selling Manitoba Housing units to the private sector and raising rent for the lowest-income tenants (Silver, 2017).

Homelessness in Winnipeg was estimated by the *Winnipeg Street Census, 2015*, in which at least 1400 people were found to be experiencing homelessness on October 25th, 2015 (Maes Nino et al., 2016). A gender-based analysis of the data collected at that point-in-time was undertaken by Drabble and McInnes (2017), who found that: 84% of the women surveyed identified as Indigenous; 32% grew up in a First Nations community; 60% of women reported growing up in foster care or group homes; 18% of women identified as part of the lesbian, gay, bisexual, transgender, two-spirited, queer (LGBTQ) community, compared to only 6.4% of the males; and 6% of the women surveyed were pregnant. Women were also found to report more frequent but shorter episodes of homelessness than men. Thus, homelessness for women in Winnipeg was found to be unique, and LGBTQ and racialized women faced distinct barriers,

often as a result of discriminatory practices in housing and shelter services, and mainstream society (Drabble & McInnes, 2017).

Housing shapes not only the physical and psychological dimensions of health (Brandon, 2015b), but also the nature of all social practices, including drug use. Housing and shelter was challenging for participants in this study. Among the 36 participants, 16 lived in their own apartment, one lived in a partially owned property, five lived in single-room occupancy hotels, six participants reported usually sleeping at a friend or family's home ("couch surfing"), four reported usually sleeping outdoors, and four reported usually sleeping in a shelter. The high rate of dependence on community-based food, shelter, and income assistance exemplifies the way neoliberal welfare policy shifts have impacted access to basic needs among research participants in this study. Homelessness, Housing First, and spaces of drug consumption are discussed further in Chapter 6 and Chapter 7.

Criminal justice and drug prohibition. Research participants shared everyday concerns and experiences of harm arising from relations with the criminal justice system and forms of drug prohibition. Although history of arrest or incarceration was not asked specifically, 15 of the 36 participants shared their histories of incarceration, many of whom cited their criminal records as the reason they could not get a job, and drug involvement was often reason for their criminal records. High neighbourhood police presence and drug law enforcement shaped many aspects of participants' social location and everyday lives, and was the most important consideration in finding spaces for drug consumption. Punitive approaches to crime, racialized criminal justice, and drug prohibition are explored further in this section as pertinent manifestations of power in field of Ts and Rs injection in Winnipeg.

Punitive approaches to crime. While federal governments in Canada have taken harsh and punitive approaches to crime, the most significant in recent decades is the Harper Conservative government's (2006 to 2015) "tough on crime" strategy, which was driven by the mandate to tackle crime with harsher sentences, thereby deterring crime and making communities safer. This strategy manifested in significant Criminal Code amendments, enabling minimum mandatory sentences of a range of offences (including illegal drug offences), reduced eligibility for conditional (served in community) sentences, harsher sentences for young offenders, and other sanctions on offenders. The "tough on crime" strategy also resulted in overcrowding and violence in prisons and jails, making these spaces more dangerous for prisoners and staff, and a shift from rehabilitation to the warehousing of prisoners (Comack et al., 2015).

Manitoba has the highest adult incarceration rate and the highest rate of adult offenders under community supervision among the Canadian provinces (Office of the Auditor General of Manitoba, 2014). Two-thirds (66%) of prisoners in Manitoba being held in custody are on remand, awaiting their trial in overcrowded conditions (Office of the Auditor General of Manitoba, 2014). Time spent in remand custody historically garnered a two-for-one credit toward time served as remand conditions are generally harsher and with less access to programming (Comack et al., 2015). This credit system was reduced in 2009 with changes made under the Harper government's "tough on crime" strategy (Comack et al., 2015).

Racialized criminal justice. A "tough on crime" policy agenda tends to be tough on those at the brunt of policing and criminal justice surveillance, which in Manitoba tends to be Indigenous people (Comack, 2012). An increase in poverty and income inequality tends to coincide with an increase in crime (Silver, 2015). In Winnipeg, the incidence of property and violent crime are

higher in the inner-city communities where this research took place (City of Winnipeg, 2017). As the inner-city of Winnipeg faces complex poverty and is home to a high proportion of Indigenous residents, place, race, poverty, and crime become associated. Racialized places commonly become conflated with violence and crime (Razack, 2007), and can in turn become heavily policed. Comack (2012) explored the experiences of Indigenous young men in Winnipeg's inner-city who were frequently stopped by police, questioned, detained, or searched because they "fit the description" of a suspect. This research exemplifies one of the ways through which racialization can bring Indigenous peoples under high institutional surveillance and regulation.

From 2015 through 2016, Indigenous adults comprised approximately 3% of the Canadian population, yet accounted for one-quarter of all admissions to provincial and territorial correctional centres (Reitano, 2017). Over-incarceration is more acute for Indigenous females, who accounted for 38% and 31% of female admissions in provincial/territorial and federal institutions respectively in 2015 (Reitano, 2017). Over-incarceration of Indigenous peoples is most pronounced in the Prairie Provinces. At the federal Stony Mountain Institution in Manitoba, 65.3% of the population in 2013 was Indigenous (Government of Canada, 2013). Further, the Prairie Region had Canada's highest rates of double-bunking (overcrowding), lock-down incidents, inmate self-harm incidents, and inmate homicides and assaults (Government of Canada, 2013). The high rate of incarceration of Indigenous peoples has been linked to systemic racial and cultural discrimination, economic and social disadvantage, intergenerational loss, violence, trauma, and substance use (Government of Canada, 2013).

Drug prohibition. Drug prohibition may be considered a macro system of power that gives rise to institutional practices of governance and the cultural meaning of drugs. Drugs

themselves are a concept constituted by moral and political evaluations that shape how they are permitted and prohibited (Derrida, 2002). In neoliberal societies, drugs are often perceived as “criminogenic” or crime producing (Moore, 2007). The structural and symbolic elements of drug prohibition are further shaped by axes of race, social class, and gender (Campbell, 2000). The injection of Ts and Rs in Winnipeg cannot be considered outside of drug prohibition, which shapes the drug market and the social and symbolic conditions of everyday life and drug use.

Law enforcement has been the primary shape of drug policy in Canada, and the history of Canadian drugs laws are racialized, class-based, and gendered (Boyd, 1984; Boyd, 2015). Late 19th and early 20th century drug prohibition laws in Canada were shaped by tensions in the international opium trade between the British and Chinese controlled markets, as well as white-Asian racial tensions in the labour market in British Columbia (Boyd, 1984). For instance, in British Columbia, white producers of pharmaceutical opium products (e.g. tonics, elixirs, cough syrups) were exempt from the opium licensing fees that Chinese opium factories had to pay for producing opium designed to be smoked (Boyd, 1984). Moreover, white producers were seen to produce therapeutic products, whereas Chinese producers were seen to create products for leisure and pleasure (Boyd, 1984). From the early days of drug regulation, therefore, the practices and perceived purpose of drug consumption were based on distinctions of what was acceptable or deviant, and drug policies were shaped by settler economic interests.

In recent decades, Canadian drug policy has become a highly contested arena. Under the Harper government’s “tough on crime” approach, drug laws became harsher with the instatement of mandatory minimum sentences for a range of drug-related offences (Comack et al., 2015), the removal of harm reduction from the national Anti-Drug Strategy, and governmental interference in the operation of supervised drug consumption services (Hyshka et al., 2012; Marshall, 2015).

The outlawing of harm reduction and reduced federal funding for such programs demonstrate the political reach into modes of health care delivery. The Harper legacy is now being slowly dismantled by the current Liberal government, with the reinstatement of harm reduction as a “legitimate” response to drug use and the pending legalization of cannabis (DeVillaeer, 2017).

Impacts of drug prohibition on the drug market. Prohibition has various effects on the drug market. Of note, prohibition favours concentrated substances that can be imported in smaller, less noticeable volumes. This preference was evidenced historically when narcotics laws were applied to opium, morphine, and heroin, a move that coincided with a shift toward the use of more powerful heroin, and the weaker predecessor, opium, declined in prevalence altogether (Boyd, 1984). During alcohol prohibition, low ethanol spirits (e.g. beer and wine) were generally replaced on the market with high-ethanol liquors and products adulterated with poisons (Brecher, 1972).

Currently, the proliferation of bootleg fentanyl, a synthetic opioid drug approximately 50-100 times stronger than morphine (Therapeutic Research Centre, 2012), on the illegal market has been posited as a logical result of drug prohibition (MacPherson, 2017), resulting in a national overdose crisis affecting urban centres across Canada (Carter & Graham, 2013, Government of Canada, 2016). Carfentanil, an analogue approximately 100 times more toxic than fentanyl, is related to a rise in fatal overdose in Manitoba (MHSAL, 2017). Werb, Kerr, and Nosyk (2013) explored the longitudinal impact of drug law enforcement on drug pricing and purity, concluding that the global supply of opiates, cocaine, and marijuana has not been reduced by drug law enforcement. Rather, it appears that drug purity has gone up, price has gone down, and seizures have either remained stable or increased slightly in recent decades.

Comack et al. (2013) used participatory methods to explore Indigenous street gangs in Winnipeg. Crack cocaine was the key business of gangs at the time as it was a high price and large volume commodity. Prisons emerged as a central site of street gang and illegal drug business activity, serving to advance the illegal careers of prisoners, while contributing to the isolation of individuals and separation of families. As such, efforts to enforce drug prohibition were found to support the development of illegal drug business gang structures. Concerns over crack cocaine in Winnipeg have subsided in recent years as crystal methamphetamine (Addictions Foundation of Manitoba, 2017) and fentanyl derivatives (MHSAL, 2018) have been associated with increased drug-related harms.

Drug-related charges and incarceration. Since 1991, the police-reported crime rate in Canada has decreased by half, while police-reported drug offences have doubled (Cotter et al., 2015). Two-thirds of all police-reported drug offences involved cannabis, more than half of which were possession charges (Cotter et al., 2015). Nearly 30% of incarcerated women, compared to about 16% of incarcerated men, were imprisoned for drug offences (Cotter et al., 2015). Time in correctional institutions for drug-related crimes contributes significantly to racial stratification and the creation of single-parent families, lost family connections, lost employment opportunities for those marked with a criminal record, and caregiver resource strain (Carter & McPherson, 2013; Moore & Elkavich, 2008).

Extralegal manifestations of drug prohibition. Ideas and practices arising from drug prohibition are not contained within the criminal justice system, but have reached beyond into health, child protection, housing, and mainstream ideas of how drugs should be managed in society. Racialized and poor women have struggled for control over their bodies and their children, and have been held individually responsible for pregnancy and birth outcomes (Boyd,

2015). Campbell (2000) argues that women's drug use becomes conflated with social decay and deviance, and the birth of a drug-affected child is positioned as a crime against humanity. Moreover, people living in poverty are judged more harshly for their drug use as it tends to be considered financial mismanagement, playing into mainstream cultural notions of the poor being individually flawed, lazy, and ultimately responsible for their poverty (Amundson, 2015). Rules and regulations around drug use and paraphernalia in housing/shelter, child protection, and health services arose throughout the narratives of participants, shared in Chapter 6.

Women who use drugs are regulated through various spheres of formal and informal systems such as criminal justice, family law, social services policy, and medical policy (Boyd, 2015). Reproduction has been a specifically regulated area of women's lives under drug prohibition systems. For instance, the historic Supreme Court of Canada case of *Winnipeg Child and Family Services (Northwest Area) v. G. (D. F.)* centred around a teenaged Indigenous pregnant woman who was placed by child protection services into mandatory custody and treatment for glue sniffing for the course of her pregnancy (Collier & Haliburton, 2015). The Supreme Court held that the state did not have the authority to detain a woman in custody to rectify her conduct because of three reasons: only the rights of born persons are recognized; the life of a fetus and the pregnant woman are intimately connected and cannot be treated separately; and treating a woman and pregnancy as a dichotomy would deprive mothers of control of their bodies and autonomy (Collier & Haliburton, 2015).

It is imperative to consider both child welfare and criminal justice systems when considering the reproduction of family separation among Indigenous peoples in Canada, and the complicity of drug prohibition. As described earlier in this chapter, all of the women participants in this research who had children were non-custodial parents. Most of these women cited alcohol

or drug use as the reason their children were apprehended by child protection services. The powerful reach of drug prohibition ideology into the institution of child protection was tangible in the lives of participants.

Drug prohibition similarly shapes drug use practices and access to health care. In a systematic review by DeBeck et al. (2017), drug law enforcement was found to have a negative impact on HIV prevention and treatment outcomes for PWID. Criminalization and enforcement resulted in poor access to sterile injection supplies, increased needle sharing, and subsequent increases in rates of HIV among PWID. A Vancouver-based study by Werb et al. (2008) found that that 28% of PWID surveyed had been stopped and detained by police without arrest in the last six months. Those most affected by street-level policing tended to have characteristics that placed them at heightened risk for various adverse health outcomes, including homelessness, recent incarceration, and required assisted injection. The authors suggest that the confiscation of drugs and/or needles and syringes through discretionary policing practices has the potential to exacerbate drug market activity or prompt increased syringe borrowing.

Drug prohibition efforts have been found to interfere with access to harm reduction services in inner-city Winnipeg. Safer crack-use kits are a harm reduction resource provided to people who smoke crack cocaine in order to support safer smoking practices, increase service engagement, and discourage migration from crack smoking to injection drug use (Backé, Bailey, Heywood, Marshall, & Plourde, 2012). A 2014 survey of 136 people who accessed safer crack-use kits from Street Connections in Winnipeg (Ross, 2015) found that one in five of the respondents reported a run-in with police related to their crack-use equipment, many of whom had their kits confiscated or destroyed by police. Several individuals felt they were prevented by police from obtaining the harm reduction supplies they needed. Moreover, some individuals had

their kits either taken or smashed by staff at an overnight shelter, demonstrating the everyday reach of drug prohibition outside of law enforcement.

In sum, participants were found to occupy social locations that made entry into illegal drug use and income generating practices more plausible. In recent decades there has been a shift toward more punitive approaches to drug offences and street crimes, and the application of these punitive policies are differentially applied in low-income and racialized neighbourhoods, including the setting of this research. Moreover, drug prohibition is a powerful discourse with power extending into other institutions the research participants interface with such as health, housing, and child protection. These systems of power converge to shape the lives and resources available to people involved with the injection of Ts and Rs.

Summary of Macro and Meso Social Context

The social context surrounding the injection use of Ts and Rs in Winnipeg is comprised of macro and meso systems of power. Patriarchy, capitalism, and settler colonialism were prominent macro structures at play in the formation of Canadian white settler society, which manifest in institutional policies and processes, and in systems of meaning that determine how social and material resources are distributed. The intergenerational impacts of settler colonialism and systemic racism, chasms in state provision, and the high institutional encounters and regulation in everyday life shaped opportunities for education, employment, income, shelter, and food security for research participants in this study. The drug market and lived experiences of using drugs were shaped by pharmaceutical products made possible by various power manifestations, including medicalization, and regulated by various modes of drug prohibition. Institutional regulation, surveillance, monitoring, and punishment are differentially applied

across axes of race (particularly Indigeneity), social class, and gender in this social context, contributing to the reproduction of inequities in social and material resources. With this backdrop in place, the situated knowledge that emerged from the participant interviews can now be explored.

Chapter 6: Situated Knowledge, Experiences, and Participant Stories

The experiences, stories, and knowledge that participants shared during ethnographic interviews are presented in this chapter, as well as some of the context that shaped those conversations. The thematic findings arising from participant interviews were arranged in a macro to micro coding framework comprised of five broad categories: social location and biographies, everyday institutional relations, drug market characteristics, habitus and everyday life, and individual drug use practices. These five categories are not mutually exclusive but rather overlap and shape other elements of the social context. Each thematic category and code is explained in detail throughout this chapter.

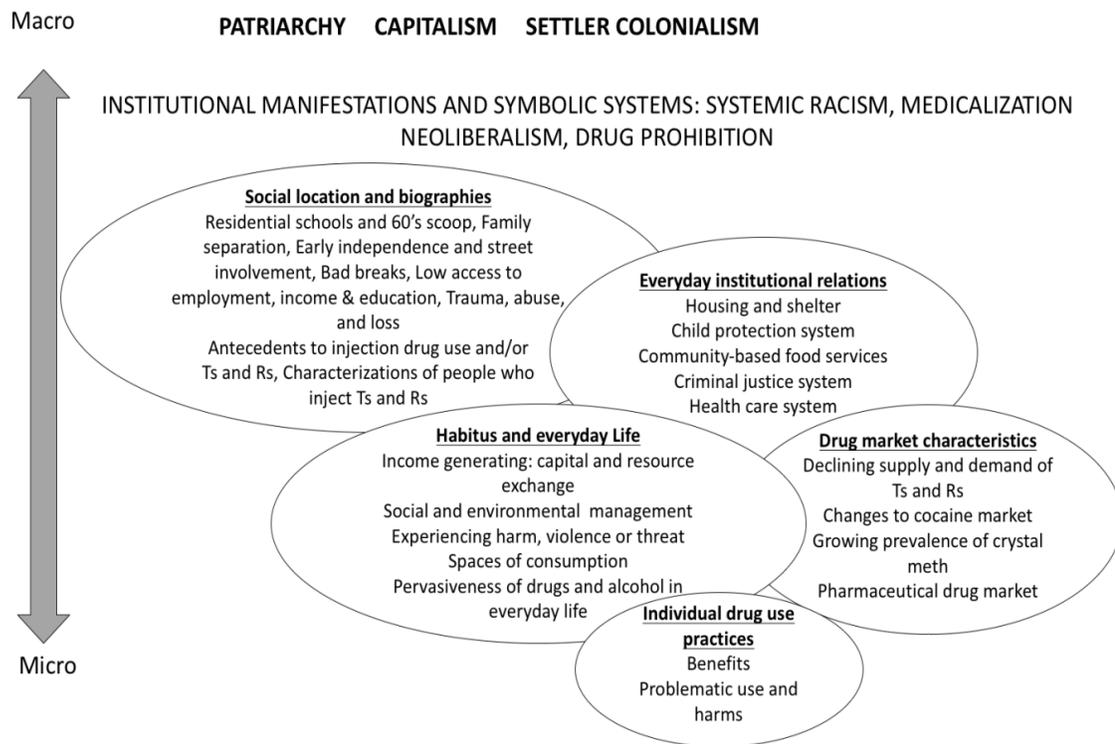
Bourdieu's concept of field informed the coding framework as well as the social context map presented in this chapter. Fields are arenas constituted by history, structures, and relations of power in which social practices take place, and individuals, groups, or institutions strategize to attain resources and positions of power (Jenkins, 1992; Swartz, 1997). Accordingly, aspects of the field that arose from interviews included structures and historical processes that shaped social location, everyday institutional relations, drug market characteristics, and habitus. Other significant elements of the field that did not become fully expressed in interviews were discussed in the previous chapter (Chapter 5).

Habitus was a central concept that informed the organization of findings emerging from participant interviews and emerged as a category of codes that captured social practices such as the exchange of capital (accumulated social, economic, cultural, and symbolic resources), common experiences and dispositions, and ways of doing and being in everyday life. Capital was a significant thematic concept, referring to accumulated resources wielded by players in all levels

of the field to struggle and strategize for power. Individual drug use practices comprise the micro level of the coding framework and are shaped by the field and habitus. However, collective and individual agency has the ability to alter and transform habitus and the field itself.

Figure 2 (Social Context Map) is a visual depiction of the social context that surrounds the injection of Ts and Rs in Winnipeg, or the field, as it emerges from this research. The social context map includes the coding framework of themes arising from participant interviews (represented by overlapping oval shapes), and the macro and meso systems of power described in Chapter 5. Elements of the field are arranged from macro (top), to micro (bottom).

Figure 2. Social Context Map



The intent of this social cartography is to provide the reader with a visual, highly contextualized account of the social life of participants who shared their knowledge in this research. The discussion that follows is organized according to the five thematic categories depicted in the map: social location and biographies, everyday institutional relations, drug market characteristics, habitus and everyday life, and individual drug use practices.

Social Location and Biographies

Social location is often considered to be defined by gender, race, social class, age, ability, religion, sexual orientation, or other socially constructed categories deemed important by society. In addition, participants' biographical histories tended to be characterized by events or situations that led to their involvement in the inner-city Winnipeg injection drug use scene. While participant demographics are summarized in Chapter 5 and in Appendix E, the focus here is on the participants' narratives. Participants were asked "Can you tell me about yourself, where you grew up, what that was like for you?" "What should I know about who you are?" Responses to these questions provided insight into the histories, events, institutions, and conditions that shaped participants' paths and social locations, which are organized here according to a number of themes: Indian residential schools and the Sixties Scoop; family separation; early independence and/or street involvement; bad breaks; low access to employment, income, and educational attainment; abuse, trauma, and loss; antecedents to injection drug use and/or use of Ts and Rs; and characterizations of people who use Ts and Rs.

Indian residential schools and Sixties Scoop. Settler colonialism shaped the social location of participants in ways more complex than this research was capable of capturing. Several participants shared stories of parents or other family members forced into Indian

residential schools or adopted out during the Sixties Scoop, which structured family and individual trajectories.

Tina Two, a Métis woman in her 30s, described her family history as being shaped by the Sixties Scoop and Indian residential schools, and shared her own experiences of family separation and the institutional impacts of Child and Family Services (CFS), as well as multiple experiences of abuse, trauma, and loss, leading to early independence and street involvement.

I grew up here in Winnipeg and I wasn't raised by my family. My dad died when I was six, my mom was a [solvent] sniffer and I have other siblings that I've never seen. I met one sister only twice and she was adopted out to London, England. She [my mom] called them [CFS] and told them that she didn't want me. She used to be a bad alcoholic and she used to beat me and my other cousin and she was always drunk. I found out recently she was brought up in residential school. My auntie raised me until I was six – my dad's sister, and her one son used to sexually abuse me from [age] three to six. I was brought up in CFS until I was sixteen, but all through that time I did different kinds of drugs. I started smoking cigarettes, drinking, coke [cocaine], sniff [solvent], weed, hash, and I even started working the streets when I was 12 and I still do.

Tina Two's background captures shared elements of structural disadvantage that intersected in many of the participant's histories.

B is a First Nations man in his 50s who was adopted out in childhood to the U.S. during the Sixties Scoop, which resulted in experiences of alienation and lost identity. As a young adult in the U.S. he was involved in an incident that resulted in him being deported back to Canada.

He was not returned to his birth community but rather to a town in Manitoba where he had no known family or friends.

I ended up with white families [in the U.S] and I'm an Indian boy. I got shipped back to The Pas of all places. They should have shipped me to Alabama. I had Cree people talking to me in Cree, "Where are you from?" I didn't even know – I couldn't answer them. They thought I was Mexican [laughs].

Brian, a First Nations man in his 30s, grew up in the U.S. where some of his family had settled in an attempt to avoid the Sixties Scoop. *"I was born in Saskatchewan, raised in Minnesota, in the States. My mother brought me down there, because my mom was raised down there by her family to avoid the Sixties Sweep."*

Although often considered historic practices, the impacts of Indian residential schools and the Sixties Scoop arose tangibly in the biographies of some participants and played a large role in shaping individual trajectories and limiting opportunities.

Family separation. Most participants shared personal histories of family separation, upbringing in foster homes or adopted families, abandonment, loss of family members, and lost family connections. This was one of the most pervasive and complex themes, often overlapping with institutional impacts (child protection and criminal justice) and shaping individual drug use practices. Family separation was often reproduced in everyday lives when participants' own children were in the charge of others. This theme is apparent in quotes throughout this chapter.

Carl is a First Nations man in his 40s who shared his history of being raised in child protective services, separated from all but one sibling through the foster care system.

I was born in Teulon, Manitoba. And I grew up mostly in foster homes and group homes until I was about 17. All my siblings were scooped up and put in the foster homes. There's only two of us in that foster home. They placed my younger brother and I together, and the two youngest siblings grew up in different foster homes because they were smaller. But now I talk with them every day, all of them. My dad and the oldest sister live out in the country and I stay connected with them. He's (my dad is) coming to pick me up today.

Although raised apart from his siblings, Carl was able to reconnect with his siblings and father as an adult.

Tina Two's mother was a survivor of an Indian residential school, which contributed to the separation of her family. Tina Two expressed her resistance to her mother's attempts to rekindle a relationship with her, demonstrating a complex response that can reproduce family separation intergenerationally.

It's become like a routine to me because I don't know much of my family. My mom now tries to get me to know her family now and I tell her, "I don't need to know them because where were they when I needed them?" That's how I look at it and I say, "I don't need them in my life, I'm doing good where I'm at." (Female, Métis, 30s)

Not all participants were able or interested in re-kindling family relationships, but most participants expressed a deep appreciation for the family they had in their lives, including belonging to a "street family." This value in caretaking and family generation was expressed by Celina, a First Nations woman in her 30s who grew up in Northwestern Ontario and had lost touch with the family she was raised in. *"I do have relatives but I don't visit them. Actually I'm pretty much adopted by a street family, and I've taken in street kids, taken them into my life."*

Early Independence and/or street involvement. Many participants shared histories of being on their own, often with little social support, and involved in street economy, street drug use, or street life/homelessness before the age of 18. Kim is a Caucasian woman in her 40s who shared her history of entry into street involvement in adolescence.

I was born North of Winnipeg and moved to the city when I was 12 and have basically been on the street using drugs and everything since I was 12 or 13 years old. We were pretty much running away from home, not listening, and getting into drugs. Powdered cocaine was on the scene. I was into that at 12 and 13 and working on the street. I've had a pretty rough life, but I'm doing okay now, better than I was. Throughout my life I've had my ups and downs – got good here and screwed up there, but other than that, I'm still here. I've been here [in this apartment] a year now so it's great.

Brian Two, a First Nations man in his 30s, was raised by child protective services. Even in the foster home where he stayed the longest and felt most at home, the care he received was conditional. *“I'd say guidance is what they gave me – not support. That ended because they found out about what I was doing and they just tossed me aside.”* Brian Two was kicked out of his foster home before his 18th birthday and had no further contact with the family that raised him.

Bad breaks. For a minority of participants, a bad break, bad luck, or unfortunate event launched the person toward a less privileged social location, regardless of privilege experienced in upbringing. Participants often recalled a bad break as a turning point in life. These instances were more likely to arise in conversation from participants who were non-Indigenous and born into middle-income families.

Bill, a Caucasian man in his 60s, grew up with his family in Northwestern Ontario. As a young adult he visited Winnipeg for a rock concert and ended up caught in an apartment fire that left him hospitalized for nearly two years. Bill has lived in inner-city Winnipeg ever since.

I spent the last three months in hospital just for them to wean me off drugs, because I spent two years in – in the hospital that is, with all the grafting, and they had to reconstruct my hands. I had nothing to do during the days. I was well enough to go home but it was for them to wean me off drugs: down to morphine, down to Demerol, down to codeine So I was disabled, and pretty much from there I wasn't working. After a year or two I got into the drug scene.

Sam, a Caucasian male in his 40s, shared his appreciation for the family stability and privilege he experienced growing up, and recalls a bad break as the turning point that changed his trajectory.

I grew up in [suburbs] on the same street where my mom still lives to this day. I went to elementary school, junior high, and high school all within eight blocks of my home. I played community hockey. I played community soccer. My parents were very involved in coaching soccer for youth and adults. I was asked to leave home on my 18th birthday because I was doing criminal things, property crimes, drinking. So I got a 30-day notice on my 18th birthday. I moved in with some friends. I started committing more serious crimes right away to pay my rent. I got sentenced to jail time on my first adult charge, when the Crown attorney wasn't even seeking an incarceration period. The judge deemed it that he should give me a sentence. You usually go with the Crown, especially on a joint recommendation where both lawyers are asking for a fine. For him [the judge] to

disregard that on my first ever charge. That in itself I blame for [my turning point] because essentially what they did is send me to con[vict] college and I learned from master criminals. I learned how to do time from older men and I also learned how to get away with crimes by older, more sophisticated criminals.

Low access to employment, income, and educational attainment. Low educational attainment and a history of criminal charges often were cited by participants as reasons for poor access to gainful employment. Lack of employment positioned most participants for greater dependency or interface with social institutions, such as income assistance, public housing and shelter, and the criminal justice system (explored further under a discussion of everyday institutional relations). Male participants were more likely to express challenges related to seeking and attaining employment, and often referenced temporary or casual manual labour. There were no female participants who reported actively seeking legal employment, which may reflect fewer employment opportunities for women with low educational attainment.

Eli, a Caucasian man in his 60s, found that his employable skills and experience are overridden by his criminal record.

I'm a really good cook. I worked for a lot of years cooking in 16 daycare centres, old age homes, people's restaurants, stuff like that. I'm a very organized person so I can go into anybody's kitchen, never having been there, follow the menu on-time every single day. I booked my calendar year round so I'd work for one daycare two weeks, and the next one two weeks, and the next one two weeks. People would phone me up and line up their calendars for holidays. Then they passed a law where they were going to screen for sex offenders, so even though I'm not a sex offender I can't go to the board of directors with 55 convictions of a criminal past.

Trauma, abuse, and loss. Many participants discussed traumatic experiences, abuse, or major loss in their upbringing or early adult lives that contributed to their social location, individual trajectory, or sense of themselves. There was great depth and complexity to the pain, loss, and trauma that participants shared when discussing their individual biographies. These stories tended to arise as defining periods or events in people's biographical histories.

Kendra is a First Nations woman in her 30s, originally from a community in Northern Manitoba. She was raised in and out of foster homes, which resulted in disconnection from her home community. Growing up in group homes in inner-city Winnipeg, she found her way to crack cocaine and alcohol as a teenager. Kendra had a few children by the time she was 20 years old, the time at which her daughter died. The loss of her child was compounded by her being evicted from her home, and she dealt with her grief in a state of homelessness. She stayed with friends where she could, most of whom injected Ts and Rs, and she started injecting drugs.

I was eight years old when I became a permanent ward [of CFS], but from age four to eight I was in and out of foster homes. I should have stayed out there [her First Nations community] actually but came here [to Winnipeg] and I started drinking young. I didn't start shooting up until I was 20. I just lost my daughter, she died. I got evicted from my house and I had nowhere to go, so I was staying at a friend's, and all they did was shoot up. I was still just smoking crack, and I figured one day, "Fuck it, get me a half [set of Ts and Rs]."

Linda is a First Nations woman in her 40s who experienced severe abuse from her ex-husband. The injuries remain a part of her everyday life.

I was badly abused by my ex-spouse. He shattered my pelvis, broke five ribs, and punctured a lung. So, I had a problem – I had to learn to walk again. I went from a wheelchair to a walker to canes, so that was a process. It was painful and I still have pains because of it.

Trauma was also experienced as a result of participants' own actions. Gino, a First Nations man in his 30s, told of his chronic nightmares in which he would recall images from police photos of a violent murder he was involved with in his youth.

I recently got home from Stony [Penitentiary], too, meth got me a little bit of trouble. Well, actually, I think it was my 16th birthday.... Bad action, and I don't even remember doing it. I was high on crystal meth that time. They [police] showed me pictures of that dead guy.... They said I burnt the body and I still have memories of that picture. I have nightmares about it sometimes. I still take night terror meds so I won't dream about it. Every morning I think about that, what I did, and I just can't wrap my head around it. I don't even go back there [home community]. I don't even talk to my family anymore.

Antecedents to injection drug use and/or Ts and Rs. Several events, conditions, or situations enabled participants' entry into intravenous drug use and Ts and Rs in particular. Although Ritalin alone was occasionally reported to be taken orally, or crushed and snorted, the Ts and Rs combination was only reported to be injected. Thus, becoming involved with the injection of Ts and Rs required experience or social normalization with injection drug use, Ts and Rs use among social relations, and, for some participants, prescription Ritalin.

Experience or social normalization with injection drug use. Drug use practices are facilitated by social norms among families and friends, thus the type of drug use a person is

introduced to and involved with is influenced by their social location. As Ts and Rs were solely used by injection, a person needed to be willing to inject a drug prior to engaging in this practice. The majority of participants first injected a drug in their teens. Two participants shared that their first injection drug use experience was at age 12. Many had injected cocaine or morphine before trying Ts and Rs and learned how to inject drugs from watching or being injected by friends or family.

Tina Two, shared her experience with initiation to injecting cocaine.

Yeah, then we moved into a different place and they were shooting up. I said, "What's that?" And they said "It's coke." So I said, "Let me try some of that, I've got money." So they gave it to me. I didn't know how to mix it or anything, so they did it for me and hit me [injected it for me], and I said, "Okay, here, go buy me some more." (Female, Métis, 30s)

Eli's first experience with injecting drugs was in high school, where injection drug use was common.

At my high school they had a 24 hour [craps] game. It started at eight in the morning and went until five, outside the principal's office. A lot of people didn't go to school, they played craps. Half the people in my grade nine class were shooting speed, and I started shooting speed at 14, in grade nine. (Male, Caucasian, 60s)

Ts and Rs use among social relations. Access to Ts and Rs at the time of this study was fairly limited, and presumably controlled by a fairly small number of sources. Unlike drugs such as cannabis and crystal methamphetamine, which are widely available from many sources, a

person needs to know insiders to the Ts and Rs market to access them, which is often facilitated by social relations.

For those participants who had used Ts and Rs, instances were shared where Ts and Rs were being used by social relations prior to the participant trying them. Jupiter, a First Nations and Caucasian woman in her 30s, shared her first experience witnessing the injection of Ts and Rs by her aunt who became her caretaker.

I was born and raised here in Winnipeg, and I grew up in a family home with my married parents. It went okay until I was about age 12, then my mom took me to my auntie's place for a visit. I didn't know I was going to get dumped off there to live forever. That's when I first saw my auntie using needles in the kitchen, she was injecting Ts and Rs. Before I turned 15 we were pretty much allowed to do anything because my auntie did everything: weed, Ts and Rs, alcohol, and sniffing. Not crack, though, I never saw them do crack.

Charles is a First Nations man in his 40s who grew up in the custody of child protective services in Winnipeg. He learned to prepare and inject Ts and Rs from watching his foster parents.

So I was looking at them [my foster parents]. I just watched how they were doing it, then I decided to take one [set of Ts and Rs]. I mixed it up and did the way they were doing it.

Some participants were engaged in intravenous drug use, including Talwin or Ritalin alone, but not connected to the source of Ts and Rs. Sam shared his experience injecting Talwin and later Ritalin, but never the combination.

I just did Talwin, I didn't know about Ritalin yet. I knew about Ts and Rs, but never really had the chance to make that happen.... The three of us friends in Stony Mountain [Penitentiary] had gotten released on day parole. We didn't know how to set up a clean environment, or a sterile area if you will, with a clean paper towel, a clean spoon, washed hands. He [one friend] taught us all about that. The Talwin later led to Ritalin. I'd buy a prescription from this grandma that was in care and control of her grandson who had Ritalin. When I would shoot Ritalin, it mimicked cocaine for me and I liked it.

(Caucasian, Male, 40s)

Prescription Ritalin. For the few that injected Ritalin but not Ts and Rs, the intravenous use of Ritalin was facilitated by access to prescription Ritalin. Patrick, a Caucasian male in his 30s, first accessed Ritalin through prescription, and eventually started injecting the drug. *“I got them prescribed. They're just dispensed weekly now, versus getting 90 a month. I was originally trying to stop because my girlfriend wanted me to stop doing those.”*

Characterizations of people who inject Ts and Rs. Several participants offered perspectives on the Ts and Rs injection scene, including characterizations of people that inject Ts and Rs and the environments of use. Ts and Rs were generally described as an “old school” dwindling trend, characteristic of older experienced PWID, and of poor or cheap quality compared to a speedball (cocaine and heroin) or heroin alone. Some participants identified with this network of people and others did not. Jim, a First Nations man in his 30s, was familiar with people who inject Ts and Rs but considered himself an outsider to the scene.

I think of it like an old school drug I guess you could say. I noticed a lot of people that are doing it around me were in a different age group, say 44, 43, like 10 years ahead of

my age, so I think of it as an old school drug. These are people I see around less and less. I think they're actually dying out.

Some negative characterizations were shared by participants who did not identify with Ts and Rs users. While views of participants concerning people who inject Ts and Rs cannot be deemed representative of the wider community, they should be understood in the context of the participants' own lived experiences, and the potential impact of mainstream racism and classism in the social setting. Day Late, a Caucasian man in his 50s, described the use of Ts and Rs as “dirty,” suggesting some local level stigma attached to the people who use Ts and Rs, their practices, and spaces of consumption.

Now I'm doing the meth because the meth's cleaner than Ts and Rs are. With Ts and Rs you're in dirty houses, you're doing it with ... At least you have the clean needles but you're in dirty places.

In summary of social location and histories shared by participants, some commonalities exist among participants in the drivers of structural disadvantages that shaped their shared histories, dispositions, and perceptions of opportunities, and introduced participants to the core area of Winnipeg and the drug scene therein. Among these shared histories are the intergenerational impacts of colonial processes that interrupted family integrity, which resulted for many in early independence and introduction to street life and economies at a young age. There was significant pain and loss in participant biographies, intergenerational forms of trauma, and severance from family and community support, sometimes as a result of a bad break. For most participants, injection drug use was part of a shared disposition and habitus among social relations, relatives, and friends, which participants were introduced to in early life as a means to cope with pain and hardship, and to experience pleasure and recreation. Within this habitus,

initiating injection drug use was not unusual. However, reaching other milestones of mainstream youth development, such as high-school completion, were less common and the path was not well resourced.

This reading of participant biographies and histories is not to underplay the significant strengths and agency amongst participants to set their own unique trajectories and challenge systems of oppression. Rather, this interpretation demonstrates how structures and history can ascribe on the person a shared set of perceived possibilities, norms, and social practices that come to be carried forward amongst many within a shared habitus.

Everyday Institutional Relations

Most participants in this study experienced systematic exclusion from gainful and meaningful modes of engagement in mainstream society, largely because of ongoing colonial impacts, institutional racism, few opportunities for education and employment, family separation, and criminal records. As a result, participants discussed regular contact with social service institutions to access basic needs. Other institutional relations arose from differential surveillance of communities and people, such as high police presence, child protection surveillance, and community monitoring in the racialized North Main and Downtown neighbourhoods. These institutional relations had profound impacts on everyday lived experience.

This category of research findings focuses primarily on institutional relations in the current everyday lives of participants, rather than institutional relations that shape social location (as discussed in Chapter 5). The institutions most commonly discussed include: housing and shelter, child protection, community-based food services, criminal justice, and health care.

Housing and shelter. Access to stable housing and shelter was a challenge for participants, as discussed in Chapter 5. Difficulties obtaining housing on Income Assistance allowance arose in conversations. According to Bill *“they give you extra money for housing, and every place just jacks up the rent.”*

Housing challenges extended even to basic shelter, where participants often could not access a mat to sleep on at Main Street Project. As Lee, a First Nations man in his 40s, noted: *“Yeah, like they open the doors at seven in the evening and by nine, two hours, they're full already.”* Lee also experienced challenges accessing shelter due to the drug, paraphernalia, and intoxication prohibition policies held by shelters. *“I went there [Siloam Mission] once and I smelled like beer and they wouldn't let me in.”* Jupiter lived regularly at the Salvation Army and had to navigate the prohibition policy which applied to all paraphernalia, used or unused.

There's no drug paraphernalia allowed, and you can't be intoxicated. I had that [safer crack use kit] in my room and even though it's still in the bag and never been used yet, another resident said I couldn't have that in my room. So I took it out. I follow rules, I don't want to ruin that because I have nowhere else to stay. (Female, First Nations and Caucasian, 30s)

There were participant accounts of abandoning shelter and housing systems due to drug and alcohol prohibition policies. Brian, for instance, sometimes chose to sleep outside rather than navigate prohibition rules.

When I was homeless, the Main Street Project was a big part of my life. Being homeless, you had to follow certain rules, and you had to be sober enough to get in there. So we just choose to sleep outside in the summertime. (Male, First Nations, 30s)

Some participants also raised concerns about safety and theft inside shelters. Gino experienced multiple episodes of theft inside shelters until he started sleeping on roof tops to avoid his losses.

My mom sends them [clothes and gifts] all the time and I have to go and pick them up at the airport. Every time I get new stuff and stay at the Project they [other patrons] steal my stuff when I sleep. The next morning I'll see somebody else wearing my new shirt. I even got my shoes stolen that one time while I was sleeping, and I had my shoes on. They don't protect us. They give like a piece of paper to sign that they're not responsible for your property. I can't say anything. I lost over two hundred dollars of stuff there before and I stopped going. (Male, First Nations, 30s)

Celina told of challenges she experienced in the shelter system when she stood up for herself or other women.

I got kicked out twice during the wintertime, and that was because I got into a fight inside the Project because girls were mouthing off on me, or guys would be fighting their girlfriends and then I'd step in and protect them. Guys were using a weapon so I had to use a technique to try and get their weapon and toss it. Anyways, I had to defend a few women in there and upon that I ended up getting kicked out. (Female, First Nations, 30s)

Chris, a First Nations male in his 40s, shared his experience of living on the river bank for four months with a group of co-workers. Living outside of the housing and shelter system was not a financial necessity in this situation but a choice that provided greater autonomy for people who used drugs.

There were about six of us that worked for a paving company, we all were employed, we are all into drinking and drugs, and we all partied together after work [laughs]. We had tarps to keep the wind away, and over it to keep the rain out. We even had mattresses there [laughs], we made it like a camp, like a bush camp, and it was comfortable. I had my cell phone, and I had the alarm set. We'd have to be up at six in the morning. I'd plug it in at work in the truck to charge. The only thing is we were making about 200 bucks a day cash, we were paid every day, and they bought us lunches every day so for eight of us, we would throw 20 bucks each, 160 dollars. For being homeless we ate very well. We had a grate down there for a grill, open fire, we would actually throw in 160 dollars together every day. We had pots for making potatoes, corn on the cob, and we would eat steaks every night. New York strip loins – those 35-dollar cuts. We did that every night, all summer, four months straight.

Child protection system. The colonial legacy of Indigenous family separation arose in participants' biographical histories and was reproduced in everyday life, often by way of further contact with the child protection system. Of the 24 participants who reported having children of their own, most shared that their children were raised in the custody of child protection services. However, of the 11 women interviewed who had children of their own, all their children had either been apprehended or relinquished to family or child protection. Not surprisingly, female participants were more likely to discuss contact with child protection agencies than male participants. There may have been other participants with this experience who did not offer this information in the interviews. This finding is focused on the experiences of non-custodial parents with child protection agencies.

Jupiter shared her feelings of frustration, anger, and pain arising from experiences with child protection when she was denied access to her children.

They [child protection] are not abiding by their rules either. I haven't seen my kids in over a month and I've been going to my visits and they haven't come [crying]. It's an agency, I don't know why they don't do what they are supposed to do. (Female, First Nations and Caucasian, 30s)

Robin, a First Nations woman in her 30s, shared that her children were taken away because of her alcohol use, regardless of her separation of alcohol use from her children. “*They [my children] were taken away because I was drinking too much. But I didn't drink beside them. I always had a sitter, and I would go drinking somewhere else.*”

Terry, a First Nations woman, and her partner Jeff, a Caucasian man in his 30s, experienced frustration with child protection. They were not informed where their two-year-old twins were being raised and were granted limited information or visitation.

When we had a phone I talked to that service worker. He talks about my other [older] kids, but not about my twins and my girls. I want to see my small ones, that's who I want to see. I don't know where they are. I tried telling them to make a visit, to get pictures. We may have visited once with my twins.

Not everyone expressed dissatisfaction with child protection. Tina, a First Nations woman in her 30s shared: “*No, they don't give me trouble. When I did my parenting [program] I got my certificate.*”

Community-based food services. Many of the participants in this study reported regularly accessing free community-based food services, including free meals and/or food banks

from a variety of organizations. One participant, however, primarily stole his food. Participants often accessed meal services based on whether they felt at home or comfortable with the service. This identification was shaped by a sense of belonging with others who accessed the service, as much as by those who deliver the service. Day Late would walk from the North End of Winnipeg to Osborne Village, approximately 10 km, to access free meals there, although the North End has more free meals than any other neighbourhood.

I like to go to that one in Osborne because I feel more welcome there than at the ones on Main Street, because I don't fit the part. It [Osborne] seems to be more welcoming than the other ones. It's a bit far away from the North End but... (Male, Caucasian, 50s)

Eli recalled his history navigating community food services.

For years here I was stuck going to the soup kitchen. That was my whole life. If you go to Lighthouse you'd have to get there at six in the morning to get a cake or something good. The sniffers [solvent users] would take over all those line-ups. (Male, Caucasian, 60s)

Some participants, including Hezus, felt that access to food on the Main Street strip of Winnipeg was abundant. *"Yeah, Siloam, Lighthouse, the [Main Street] Project, and there's Austin, the Vineyard. No, can't starve here [laughs]."* (Hezus: Male, First Nations, 40s)

Similarly, Bill accessed community food services and often took home leftovers in a container.

I have my own small fridge and microwave. I'm at the [name omitted] hotel, so I had lunch at Siloam's before I came here. If you live in the [name omitted], another hotel on Main, or the Salvation Army, you can get 11 meals a day within a two-block radius.

(Male, Caucasian, 60s)

Food banks were less often accessed and reported to be more cumbersome as recipients have to register, show identification, make an appointment, deal with transporting the food, and have a place to store the food. As Jim noted:

Sometimes I'll go to food banks but I haven't had a chance yet to make an appointment and find somewhere close. You have to call and register, show them your health card, and if you don't make it you have to register again. (Male, First Nations, 30s)

Max, a Caucasian man in his 30s, felt that he shouldn't access food banks if he could afford food.

I haven't really used the food banks that much. I used this one about two months ago but I don't call it all the time. Usually I try to buy my own food and try not to use the food banks. I try to take care of my own because I know there are a lot of people out there that need the food banks. If I can afford my own food then I'll do that instead of spending it all on drugs, alcohol, or just foolishly.

Criminal justice system. Participants were not directly asked if they had experience with criminal justice, arrest, or incarceration, although about half of the participants shared their history of incarceration. In addition, participants shared experiences of community-based sentences, general police questioning, probation, or other impacts of criminal justice. Both male and female participants discussed relations with the criminal justice system, and shared experiences which ranged from intentional arrest, negative impacts of incarceration, positive impacts of correctional programming, and observations of criminal justice being differentially applied according to neighbourhood and nature of offence.

Barbie, a First Nations woman in her 30s, shared her history of being intentionally arrested.

I purposely got caught because it was way too much. I was just getting sick of it [drugs and theft]. I thought “I’m just going to end up killing myself or something.” So I went to jail, then I came back out and started [using drugs] again but not as heavy.

Some participants commented on how incarceration was disruptive to social connections and belonging. Chris recalled feeling useless when he was in jail because he couldn’t connect to or contribute to his family.

I don’t want to end up back in jail. I can’t be a provider for my family if I’m in jail. When my kids were young, the triplets, and I was in jail, I felt useless in there because I couldn’t support them. I took a kitchen job in jail which paid me 65 dollars every two weeks just to make myself feel better by signing the money out to her. That would get a case of formula and a case of diapers. It’s not a lot but I felt better about myself doing that. (Male, First Nations, 40s)

Eli spent a number of years incarcerated in solitary confinement and struggled with complex responses to being excluded from a social world.

You’re in a little five by nine and you can only pace five little steps back and forth. You want to kill people when you get out. I couldn’t go to sleep without dreaming of killing people. When you’re locked up for a long time you go over every conversation you ever had, what you should have said, what you didn’t say, what you could have said. When you’re in a little world like that and you get out, the people don’t remember any of that because they’ve been living their life. (Male, Caucasian, 60s)

Max also experienced the feeling of stagnation while he was incarcerated.

Doing time, you get time to think about your life. Once you enter that place your life is on hold until you get out. You can try to set things up for when you get out but time stands still in there. (Male, Caucasian, 30s)

Other participants commented on the differential application of policing to individuals, groups, neighbourhoods, and types of offences. Bill shared his perceptions of differential policing on the Main Street strip.

A hundred and fifty-five dollars they're charging people for writing on the sidewalk. I don't think that happens anywhere other than up on the [Main Street] strip. You hear of anyone being charged for that in your neighbourhood? [laughs] For drawing on the sidewalk? I don't think they [police] even bother anybody who's doing Ts and Rs nowadays, maybe with morphine, sniffing it or whatever. I think people are mostly getting bothered because they're drinking outside. (Male, Caucasian, 60s)

Patrick felt that drug-related charges were being handled more harshly than violent crimes.

It's a revolving door right now with certain crimes. It's almost like you can get away with murder and only do three or five years, but if you sell cocaine you're going away for seven. People are doing more time for drug offences than serious assaults and murder charges. (Male, Caucasian, 30s)

Lee shared an example of a police officer catching him injecting drugs outdoors and, rather than charging or fining him, made him collect the discarded needles in the area.

I went by the riverbank alone and did a half [set of Ts and Rs] to myself. Then I saw this tire come right in front of me, and I looked and it was a police car. “What are you doing?” I had the needle in my arm already. He made me clean up that whole [area]. I guess people left needles before me in that place. I cleaned that whole thing up. He said “Clean it up or you're going to get a fine” [laughs]. (Male, First Nations, 40s)

Robin shared a story about a time she was picked up by police and told they were doing a survey on Ts and Rs, and subsequently questioned about drug procurement and access.

I was standing outside and they said “Excuse me,” and I said, “Yeah, what? Am I being arrested?” “We’re not arresting you. Can you come?” Then I said, “Yeah, okay.” So I went with them, “Oh, we’re just doing a survey. I’ll buy you a pack of smokes after you’re done.” They bought me pack of smokes [laughs] and I thought I was being arrested for something. They asked me where I got it [Ts and Rs] from but I didn’t tell. I just made up another story. (Female, First Nations, 30s)

Tina Two had a positive experience with a program she was connected with through the criminal justice system.

I was [incarcerated] in Edmonton for a couple months and then I went to Okimaw Ohci Healing Lodge. I was glad I went there because I learned a lot. Before I used to let people walk all over me and I couldn’t talk for myself. It's a federal institution and we lived out in cottages there. My teacher said that when I first started I was at a Grade 3 level, and when I finished I had my Grade 10. This one [program] called Warrior Women was a three-month program and it was really in depth with yourself. That was hard. (Female, Métis, 30s)

Health care system. Participants shared instances of everyday encounters with the health care system and discussed a range of experiences regarding access to prescription drugs, mistrust and differential treatment from health care providers, difficulty accessing addictions treatment, and tensions relating to addiction treatment ideology. Some shared positive experiences with health care programs, particularly Assertive Community Treatment (ACT), a mental health and housing support program, and Nine Circles Community Health Centre, which provides volunteer opportunities for people living with HIV.

Navigating access to prescription and non-prescription substances through the health care system. Participants shared experiences accessing prescription drugs for a variety of purposes, such as HIV treatment and opioid replacement treatment. Experiences navigating this system were shared by several participants. Day Late struggled with Pharmacare coverage for his antiretroviral treatment for HIV. The annual deductible (which can be as high as \$1000) must be paid for coverage to continue, which would result in treatment interruptions for him.

The only thing that ever happened to me was the deductible. I keep getting screwed up on my deductible. My HIV has become full blown AIDS about three times because I had to wait so long to get the funding and figure out how I was paying for my 20, 000 dollars' worth of pills a year. (Male, Caucasian, 50s)

Sam was able to negotiate maintenance opioid treatment with a doctor, which allowed him to return to work and not have to engage in illegal income generating practices to maintain his addiction.

I went back to work. I provided a doctor's note. I told the doctor, "If you tell them it's from IV drugs I'll lose my job." So he creatively filled out my private insurance

application saying it [my abscess] was an infection of unknown cause. He was willing to do that for me. So my doctor, bless his heart, believes that if he can give me a prescription and that'll stop me from doing crime, then by all means. (Male, Caucasian, 40s)

Accessing non-beverage alcohol through the health care system was mentioned by a few participants. Mojo (a First Nations man in his 30s) recalls being kicked out of the hospital where he received his care because he was caught taking hand sanitizer.

They don't let me go in there [Health Sciences Centre] because they know I'm making a mix out of the hanitizer [hand sanitizer]. I take it, squeeze it in my cup, mix it up, and I put it back there. They told me "You're going to Seven Oaks [hospital]. I said "Why?" "Because you're drinking." "Do I smell like hand sanitizer?" "Yeah, you do" "Okay."

Mistrust and differential treatment from health care providers. Several participants shared negative experiences with health care providers, particularly where they felt judged or differentially and poorly treated because of their history of drug use. C is a First Nations man in his 30s, diagnosed with terminal cancer. He reported daily use of morphine by injection to manage his pain, and crystal meth if he couldn't find morphine. *"No. I've tried to go to my doctors and ask for help. They look at my records and they know I'm diagnosed with cancer and they still don't give me shit [for pain]."*

Linda lives in chronic pain due to a history of injuries. She shared her experience with her family doctor who would not give her a prescription for painkillers because she has a history of addiction.

She [my doctor] seems to think I just want [drugs] because of my addiction. She doesn't believe me. I gave her shit and told her, "You don't understand about addictions. You don't even know what it's like to be addicted to anything. Have you ever been addicted?" I was so pissed off I just kind of stormed out of her office and wanted to fire her but my support worker convinced me to keep her [laughs]. (Female, First Nations, 40s)

Hank, a Métis man in his 40s, shared his concern that physicians in Winnipeg would not want to take him on as a client because of his stigmatized health conditions and social practices.

It's sad because the physicians at different clinics throughout the city, they're going to say, "Oh you're HIV and have hep C and an intravenous drug user." Most practitioners and/or physicians will try and divert you to someone else. They'll say, "No I don't want to deal with this."

Sam shared an experience that occurred about 20 years ago when he sought care at a hospital in Winnipeg and was denied adequate service because his injury was due to injection drug use.

My right arm could not straighten, that's how bad it was. I went to the Health Sciences Centre, waited four hours to see a doctor who absolutely lost it on me. "That's what you get for using IV drugs. There's nothing I can do. Get out of my room." That's how I was treated at Health Sciences Centre. (Male, Caucasian, 40s)

Although racism was not specifically mentioned by participants as a reason for differential treatment, Hank made note of a perceived social class division between him and his provider, made evident by the expensive looking jewelry his provider wore.

I had shown up and I sat there in front of this woman who had nothing but gold rings on every finger. I sat there and I thought, “What did you really do to earn that money? And you’re sitting there judging me.” (Male, Métis, 40s)

Difficult access to addiction services and tensions with addictions treatment ideology.

Several participants discussed difficulty accessing addictions treatment, including opioid replacement therapy. Patrick discussed tensions or disagreement with the way addictions are framed within drug treatment modalities.

BHF [Behavioural Health Foundation] is different from AFM [Addictions Foundation of Manitoba]. At AFM, like, it's a disease where at BHF is more it's a lifestyle choice with inappropriate behaviours. It's trying to rebuild you from all this stuff that you ended up picking up while you're in the drug scene. It's [about] inappropriate behaviour, how you may treat people and being empathetic. I think if BHF and AFM got together and combined everything that would be really good. Myself personally, I don't think it's a disease where I need to go to these meetings after, like an insulin shot. They compare it to insulin, and it's not that way. It's not like I'm different from everybody. (Male, Caucasian, 30s)

Similarly, Sam experienced drug treatment ideologies that were incongruent with his own experience and analysis about his use of drugs.

One time in jail it was suggested that I take this course called “The Inner Child.” What they were going to do through [a] six-week course was determine what may have damaged me as a child to make me a criminal slash addict later in life. In about the second week of this course they were steering all of us into blaming our parents. I handed

in my duo-tang and I said, “Sir, if you think I am going to sit here and blame my parents because I shoot morphine, then you're dead wrong and I don't want anything to do with this course. My parents gave me the world.” (Male, Caucasian, 40s)

Harm reduction resources and services. When participants were asked if harm reduction programs could do things differently, participants generally suggested different types of material supplies, such as cookers (spoon-like containers for preparing drugs), or filters for removing fillers from prepared pills prior to injection. Most participants stated they were able to access injection supplies when they needed them, either from a health care service or from a friend. Participants generally reported good access to harm reduction/injection drug use equipment compared to in the past.

Sam recalls the challenges he had accessing sterile injection supplies in the 1980s.

[In the past] even at pharmacies you had to show that you were a diabetic to be able to buy syringes. It was extremely difficult to buy syringes back then, but it was easy to steal 3ccs from doctors' offices because they'd have them on the shelves. If you had a few minutes you could grab a handful and put them in your pocket. (Male, Caucasian, 40s)

Naloxone, the drug that reverses opioid overdose, was not available for free anywhere in Manitoba at the time the interviews took place. Poor access to naloxone, the drug that reverses opioid overdose, was mentioned by Eli. *“I tell you friends of mine are dead now because there was no [naloxone]. If there were Narcan [naloxone] packs, we could have kept them going”* (Male, Caucasian, 60s).

Another harm reduction service deficit that arose in conversation was managed alcohol. Harm reduction services often involve the formalization or institutionalization of services or

resources that already exist among people who use drugs, with the purpose of reducing drug-related harm. The nature of existing community-based managed alcohol arose in conversation with Celina.

Nobody likes to have the shakes. I've had bad shakes where I need a drink, I feel sick. I try to have a cigarette or try to have a drink [of water] and I puke it out. It doesn't settle. You need to have pure alcohol that way, then have something to eat. Tizer [hand sanitizer] is okay, not to the extent where I get hammered on it, but just to fix and take the edge off. Then it's fixed and I'm not shaking any more, I can go back to beer. (Female, First Nations, 30s)

Throughout Celina's interview she shared how she commonly checked in on her street family in the morning, particularly those who slept outside, helping those experiencing alcohol withdrawal symptoms, bringing water and food.

Harm reduction services, such as Street Connections, were generally described as places where material supplies could be accessed for free without judgement. These services were not described as ally organizations that would champion new policies or programs for people who use drugs, or as organizations that intervene in social conditions that shape drug harms. This perception of harm reduction services from participants is markedly downstream from the description of harm reduction detailed in the WRHA (2016) *Position Statement on Harm Reduction*, where harm reduction is largely understood in terms of policies, advocacy, and political engagement.

Positive experiences with health care programs. Positive experiences within the health care system were shared by a few participants regarding Assertive Community Treatment

(ACT), a Housing First social support service, and Nine Circles Community Health Centre that provides volunteer opportunities for clients. Regarding ACT, Brian commented: *“Yeah, I guess instead of being out of jail to homeless, it was more like I was homeless, had a place, homeless, had a place, homeless, had a place”* (Male, First Nations, 30s).

Kim found the volunteer opportunities that her clinic made available engaging and helpful.

A typical day in my life nowadays is a little volunteer work at Nine Circles and being kind of a home body. I stay home and am kind of settling down. They [Nine Circles] have lots of different programs going on. It’s good for me. (Female, Caucasian, 40s)

Generally, structural disadvantage positioned participants to be dependent on institutions, agencies, and services for basic resources, and relations with these institutions shaped their everyday lives in several ways. The rules, regulations, and practices of institutions were well known by participants, and navigating these hurdles was part of everyday practice. The individual attitudes and actions of institutional service providers varied widely and shaped participant experiences and impressions of institutions, which similarly shaped the actual and perceived accessibility of resources for daily living. External to the operations of the institutions, the conditions created by others who receive service at community agencies tended to shape participants’ experiences, particularly concerning participants’ sense of “fitting in” in an organizational setting.

There were various levels of stigma that participants experienced and navigated in everyday life related to institutional encounters. Stigma related to practices of drug use, and health conditions such as blood borne infections, complicated access to services. Participants

were mindful of the stigmas attached to their own practices and conditions, and navigated disclosure to service providers carefully. Further, services tended to carry stigma if they served people who were stigmatized due to social location or social practices. Some participants avoided accessing services, such as needle distribution, because of the stigma associated with approaching the service.

Instances of institutional racism were not explicitly voiced in participant interviews. However, there were subtle and often symbolic forms of exclusion and oppression apparent in institutional encounters arising from the prohibition of everyday ways of being amongst participants. In service institutions such as shelters, street skills and conflict resolution techniques that were necessary to everyday functioning and a norm amongst participants within a habitus sharing group were prohibited and punishable. Drug prohibition operated in most institutions as a form of socially sanctioned stigma against people who use drugs. Everyday devices for safer drug consumption were banned in most places, reinforcing the idea of drug consumption as fallacious. Drug and alcohol use was the most common reason for interference by child protection and criminal justice systems, contributing to major losses in participants' everyday lives and opportunities. Family separation arose as a profound form of socially produced pain shared by many participants and is discussed in greater detail in Chapter 7. In encounters with health care providers, participants often felt treated like a burden to the health care system and unworthy of care. These institutional policies and practices resulted in a pervasive denigration of participants' ways of being and reproduced participants' outsider and subordinate status.

Drug Market Characteristics

Participants shared experiences and observations about Winnipeg's drug market, how it impacts Winnipeg's inner-city injection drug use scene, and how it impacts the use of Ts and Rs. Winnipeg's drug market is shaped by the fact that it is a land-locked city several hours' drive from another major urban centre, thus limiting access to some drugs that tend to enter the market through shipping ports, such as heroin (UNODC, 2016). Geographical factors shape drug markets in complex ways, and individuals enter different parts of the drug market through social relations. For instance, Eli shared how geography and the relations he has in different locations shapes his drug options and practices.

I drove to Vancouver and what I do in certain cities determines what kind of drugs I'm going to use. If I go home to Niagara Falls I'll shoot speed, and some heroin but more in Vancouver than anywhere else because it's hard to get right? It'd be nice if it was like it is in the States where you can get a flap [of heroin] for 10 bucks, but you can't get it here. The times I've tried to get it it's been garbage.... Even today it's a question of what you can get on the street. There is no heroin in the city. The main guys that used to sell morphine died. It's hard to get what you want. (Male, Caucasian, 60s)

Most participants reported the use of pharmaceutical products as their main substance. Although participants informed that crystal methamphetamine use has grown significantly in Winnipeg, the eligibility criteria for this study favoured participants who used Ts and Rs.

Participants who accessed Ts and Rs did not report diverted prescriptions as the source. The drugs were mainly sold in sets (typically, two Talwin 50 mg pills, one Ritalin 20 mg pill) and accessible from a few local dealers associated with particular venues, indicating the market

source was likely large quantity, diverted pharmaceutical products or illegal manufacturing, rather than post market/prescription procurement. Participants who used Ritalin alone generally reported accessing diverted prescriptions or their own prescriptions for Ritalin. There were several insights provided by participants about the nature and supply of the local Ts and Rs market; however, this was not the focus of the study. Further, sharing supply chain information could potentially cause harm to participants, those involved in trafficking, and the researcher, thus this information was removed from transcripts.

Notably, bootleg fentanyl emerged on the Winnipeg drug market in 2015-2016 and resulted in a significant amount of media coverage and a doubling of non-fatal overdose/naloxone administration rates by Winnipeg Fire and Paramedic responders in Winnipeg (MHSAL, 2017). However, fentanyl and opioid overdose did not emerge as a significant topic in conversations with the participants. Participants spoke primarily of Ts and Rs, crystal methamphetamine, crack cocaine, and morphine as the most prevalent drugs in their circuits, and to some degree alcohol, including alcohol containing substances not marketed for consumption (e.g. hand sanitizer).

Participants in this study were considered experiential experts and keepers of situated knowledge about inner-city drug use, and many had been using injection drugs since the 1980s. In addition to insights about Ts and Rs, participants shared insights and experiences with the Winnipeg drug market over past decades, particularly large shifts in the drug market that would influence the availability of drugs used for injection. The most robust themes in this category were: the declining supply and demand of Ts and Rs; changes in the cocaine market; growing prevalence of crystal methamphetamine; and the pharmaceutical drug market.

Declining supply and demand of Ts and Rs. Many participants discussed their experiences navigating an irregular or unstable supply of Ts and Rs. This finding also captured instances where the demand for Ts and Rs was perceived to be diminishing.

Crystal is a First Nations woman in her 30s with great knowledge of Ts and Rs as she has used them for over a decade and has many friends and family that do so as well. She shared her insights on the supply and demand dynamics of Ts and Rs in Winnipeg.

They [people I know] still use Ts and Rs, it's just that it's getting harder to find them so people choose another drug. I noticed one dealer goes out of town to get them, like a different city, I think it's Toronto. It's just the same people I know that use it [Ts and Rs], but they're slowing down and they're getting into other drugs.

Brian Two uses Ts and Rs occasionally and shared a similar observation about the irregular supply of Ts and Rs and the new options on the market.

We call it [Ts and Rs supply] the quantity and it's hard to find, or you always have to wait until people have it. Yeah, I think it's slowly going to die out, because they have these different kind of drugs coming out now. What's that one called, fentanyl? And what's going to be after that? (Male, First Nations, 30s)

Bill has been involved with Ts and Rs for decades. He made similar observations about the supply and demand of Ts and Rs.

I found most everybody that I've known who were doing Ts and Rs steady have switched to morphine. If they switch to another drug it's most likely morphine. They [Ts and Rs] are still around, but the odd time they are hard to get. (Male, Caucasian, 60s)

Notably, none of the participants suggested that a declining supply of Ts and Rs would result in people not using drugs, but rather that people would migrate to other sources.

Changes in cocaine market. The available literature suggests that there is a relationship between the cocaine and Ts and Rs market; specifically, when cocaine becomes difficult to access or afford, Ts and Rs will dominate, and vice versa (Gold, 1990). Most of the participants who talked about cocaine generally stated that the quality has declined over the decades. The participants who made these observations were all over 45 years of age and had reported using cocaine in the 1980s and 1990s. For many, the undesirable change in powdered cocaine quality and availability influenced drug choices.

Carl found not only the availability of cocaine in decline, but the quality became less trustworthy.

I don't do that anymore. I don't snort [cocaine] because I don't know what's inside it.

That's why I don't do it. At least you know what it [Ts and Rs] is, not like the cocaine.

What's inside it, what's mixed into it? You never know. (First Nations, Male, 40s)

Day Late perceived the decline in cocaine availability to be the result of people injecting Ts and Rs in Winnipeg.

The reason you can't find good powder in Winnipeg is because of the Ts and Rs. That's the reason you can't find good cocaine powder in Winnipeg.... Nobody will bring in good cocaine powder in Winnipeg because people will start shooting it and spreading HIV, and that all stemmed from the Ts and Rs back in the 80s and 90s. Thank you very much, so now there's no good coke in Winnipeg because of shooting and Ts and Rs. (Caucasian Male, 50s)

Cinnamon is a First Nations and African woman in her 40s. With the decline in powdered cocaine she shifted toward the use of crack cocaine and crystal meth and found herself immersed in a scene of people that she didn't trust.

When powder went out everybody was going to the crack. So I picked up the pipe ... and then I did dabble in the [crystal] meth. This was after [my partner] died. And how I see these people are greasy. They knew how vulnerable I was at the time.

In general, a decline in the availability and quality of powdered cocaine since the 1980s and 90s was seen to promote a shift toward the use of Ts and Rs and/or crack cocaine use.

Growing prevalence of crystal methamphetamine. The majority of participants mentioned crystal methamphetamine (“crystal meth,” “meth,” or “jib”) as a drug that currently pervades the inner-city drug use scene and market. Although crystal methamphetamine has been a part of Winnipeg’s inner-city drug market for over a decade, participants reported a growing prevalence of crystal meth use, people switching from other drugs to crystal meth, and reports of harms related to crystal meth.

Patrick noticed the prevalence of inner-city crystal meth use when he attended a treatment centre (Anchorage) on Main Street.

It was just sad because I knew about meth before I got to Anchorage, but as soon as I got into Anchorage, meth was an epidemic. Everybody shot meth. I didn't realize so many people do meth, never mind shooting it. (Caucasian, Male, 30s)

Hezus and Linda shared observations about the harms of crystal meth use.

It's [crystal meth] more prevalent. I see a lot of people that years ago were normal as can be. Now they're twitching and everything and all they do is jib. (Hezus: Male, First Nations, 40s)

I tried it [crystal meth] but I don't like it because, well, it kind of scares me. I've seen people get really weird on it. My niece has kind of lost it now. She talks to herself, she hears voices all the time. And I see another girl talk to herself. (Linda: Female, First Nations, 40s)

Not surprisingly, Day Late and Bob, who identified crystal meth as their drug of choice, reported more beneficial or neutral experiences with the drug.

Like cost-wise it's cheaper, because I can do like a couple shots and a point and I'm good like all day. (Day Late: Male, 50s, Caucasian)

Ts and Rs came before meth. I did it last October. One of the reasons I got into meth was because I was curious about it. Ts and Rs are still out there from what I understand.

(Bob: Male, First Nations, 40s)

Pharmaceutical drug market. Most participants reported a pharmaceutical product as their main substance. As prescription drugs were often mentioned as a necessary source of income for basic needs, this theme is explored under the category “habitus and everyday life” as an income generating practice. Ts and Rs were not discussed in terms of diverted pharmaceuticals, but Ritalin alone, codeine, morphine, benzodiazepines, and a range of other diverted prescription products were seen to be widely available in Winnipeg’s inner-city.

Bill shared his observations about the prescription drug market.

There's a lot of Ritalin around. I run into people that have lots of it at home, they took their kids off them, or whatever, but I don't know a single person that has a prescription for Talwin. They wonder why everybody is selling their pills. Well, that's the only way they can get money. You've got your Tylenol, Restoril, Valium, and your Xanax, and all that. That's why people are going in and getting prescriptions. They're often selling them out on the street and doing some other drug. (Male, Caucasian, 60s)

Sam found he was able to easily access diverted prescription Ritalin.

I'd buy a prescription from this grandma that was in care of her grandson who was on Ritalin. She chose to sell it rather than have her grandson on this drug she thought was bad, so I had various avenues to get Ritalin. I've never had children but I have a lot of friends and associates with children. (Male, Caucasian, 40s)

In sum, international drug trade transportation routes and the diversion of prescription products through various mechanisms contribute to what drugs make their way into the Winnipeg drug market. The prescription drug market was seen as a permanent fixture of the Winnipeg drug market, and a source of street economy and trade that people living in poverty could access. Participants in this study were connected to a particular segment of the drug market that made Ts and Rs available, and a scene where the injection drug use was a common practice. The connection to Ts and Rs supply was facilitated by a shared habitus and social location, and geographical proximity to the trafficking mechanism of Ts and Rs.

Illegal drug markets, like other economies, are subject to laws of supply and demand. (Horyniak et al., 2014). Changes in drug market can lead to changes in consumption, product substitution, and transition to alternate routes of consumption (Horyniak et al., 2014). There was

a sense among participants that the Winnipeg illegal drug market was shifting. Participants had expert insider knowledge of the supply and demand dynamics of the Ts and Rs market. Ts and Rs was seen as an “old school” declining trend with few to no new recruits, and an increasingly unstable supply chain. The anticipated drop in supply was considered likely to divert people from Ts and Rs to other less trustworthy drugs, such as morphine or crystal meth. Regardless of high opioid overdose and fentanyl coverage in the media over 2015 and 2016, there were only few mentions of fentanyl by participants, suggesting this drug had not yet infiltrated the inner-city drug market at the time the fieldwork was undertaken. Observations and concerns about the growing prevalence of crystal meth were shared by most participants. Crystal meth was considered an unpredictable drug associated with a rise in injection drug use, and a change in neighbourhood dynamics.

Habitus and Everyday Life

Habitus is the embodiment of structural influences into a set of dispositions and ways of being (Bourdieu, 1990) that generally include actions, skills, habits, perceived possibilities, style of speech, manner of dress, drug consumption practices, and preferences (Harker et al., 1990). A group of people similarly affected by structures and shared geography can become a habitus-sharing group. Hence, the concept of habitus is highly relevant to localized drug use trends.

Much of what comprises this category arose from discussions with participants about the typical activities of daily life. Everyday life encompasses observations and practices shaped by the immediate built, physical, and social environment. Within this everyday environment are social players, institutions, and organizations that must be accessed, and rules and regulations that must be navigated. Institutional impacts and relations were separated into their own category

as the actors of these institutions are generally seen as outsiders to the social networks participants identify with. This category focused primarily on social practices of participants and their peers, and descriptions of the social environment. The most salient themes that emerged were: income generating and exchange of capital and resources; social and environmental management; pervasiveness of drugs and alcohol in everyday life; experiencing harm, violence or threat; and spaces of drug consumption.

Income generating and exchange of capital and resources. Participants in this study were largely excluded from gainful and legal income generating practices due to structurally mediated inequities in resources and opportunities. As previously stated, the majority of participants received income assistance as their primary income source. Participants mentioned the need for other sources of income beyond this basic allowance. As Max stated “*Welfare just doesn’t pay that much. I have to do something else to support my habit and I don’t really want to go down that road again [illegal income]*” (Male, Caucasian, 30s).

Sam did not see many options for himself beyond being on income assistance. “*I’m really not employable because of criminality and because of being a junkie essentially, so I’m on disability, EIA, and I’m fine with that...*” (Male, Caucasian, 40s).

Bill spoke of a place at an inner-city hotel where insiders could purchase stolen/boosted goods, including essentials like groceries, or diverted prescription drugs.

Well the [name omitted – hotel], everyone goes there to do their shopping. You got to eat, and the meat’s half-price, and you can just walk in there. People get prescriptions and sell them because they need that extra money, right? (Male, Caucasian, 60s)

Income generating was not necessarily in the pursuit of money for drugs, and at times drug use would enable income generating practices. Chris shared how his use of crack (cocaine) enhanced his ability to sell crack. *“Gang work is all about drugs. I used a lot of crack and that would help me sell more crack. I’d stay awake all night on the street so I could sell. At times I’d go days without sleeping”* (Male, First Nations, 40s). Income generating practices arose as an expression of independence for Cinnamon: *“I’m better off just going out there and shaking my ass [doing sex work]. That way I could say, ‘Screw you’ you know? ‘I’m paying for this.’ Right?”* (Female, First Nations and African, 40s).

Income generating activities that surrounded drug use were often considered more harmful than drugs themselves. This study took place in the policy context of harsh penalties and minimum mandatory sentences for a range of drug-related offences brought in during the Harper Conservative government era (Comack, et al., 2015; Marshall, 2015). Participants discussed the harms associated with income generating practices such as drug dealing and sex work. For Linda, the harms of these practices were greater than the harms of drugs. *“Yeah, definitely, because you’re risking your freedom [dealing] and working the streets you risk your life. Someone’s going to kill you or whatever, those thoughts always run through your head”* (Female, First Nations, 40s). Similarly, although Day Late was involved in some income generating practices that were criminalized, he was wary of the potential harms of dealing: *“I don’t want to deal drugs either, because you’ll go to jail for that”* (Male, Caucasian, 50s). Eli had a history of selling drugs but was not willing to at this point of his life: *“I’m too old for it now. It’s a young man’s game. And when they see somebody my age it’s so easy to get robbed, you know. I’ve had it happen”* (Male, Caucasian, 60s).

Income generating practices included work that was available to participants, they had the skills and knowledge to carry out, and are within the norms of their peers. There were gendered differences in the types of income generating practices participants engaged in. Women were more likely to report panhandling, boosting (selling stolen goods), and transactional sex than men. Male participants more often reported theft, drug dealing, odd jobs/casual labour, and scrap metal and can collecting. Linda made money making and selling art. Gino mentioned occasionally making money letting himself be kicked. *“People are drunk and they just kick me. They usually stop by and say, ‘Hey, we’ll give you ten bill and we’ll kick you in the nuts’”* (Male, First Nations, 30s).

Selling prescription drugs tended to arise from complex social situations. Prescription drugs were required for medical purposes; however, the ability to commodify pills for cash was a source of financial security and called upon in times of dire need. This was the case for Bill: *“Yeah, I know the pills I get, I get them once a week, and I call it my alms. I have somebody to take them [buy them] off me”* (Male, Caucasian, 60s).

For Eli, who experienced limited options for income and employment, his prescription pills were occasionally commodified to get him out of a bind, although he needed his medication for basic functioning and pain control.

You get a list of choices like this and it’s even worse when you’re on these street drugs. I’m really fortunate that my pills are worth 70 dollars each so if I want to sell a pill I got the money. Other than that I’m fucked. If I lost this, I’d probably die to tell you the truth – to go back to not being able to walk. With the morphine I can do things I couldn’t do.

Before, I was stuck in my room. I broke my back in a bad car accident. Now I don't have to steal, you know what I mean? (Male, Caucasian, 60s)

As discussed in the theoretical foundations chapter, Bourdieu's concept of capital includes any goods or resources in society worth being sought after and is central to relations of power. Forms of capital shape societal positions and define possibilities of actors in a given field, and some types of capital have the capacity to transform into other types (Jenkins, 1992). For instance, social capital in the form of connections with dealers can be transformed into economic capital by connecting buyers with dealers. Robin found a way to make money from connecting people up with dealers. “[For] the people that can't score, I know all the people in Winnipeg that have the stuff [drugs], so that's how I make my money” (Female, First Nations, 30s).

Day Late had a home where people would come to consume drugs, specifically women involved in transactional sex. He shared his observations on how some of these women made money through connecting people with dealers.

Lots work hooking up guys with drugs. Half the hookers I know just work hooking Johns up with drugs because the Johns don't want to keep any numbers or anything like that. They use the hookers to keep them in it, for getting drugs, and the girls never even have sex with these guys. These guys come back once a month or once every payday. (Male, Caucasian, 50s)

Space as capital. Access to or control of a space where other people could come to use drugs arose as a form of material and social capital, often exchanged for drugs or other material goods. Many people came to Bill's home to consume drugs. Bill stored sterile injection equipment at home and had significant experience with safe injection practices. In exchange for

the use of his space he generally received “second shot” which would account for about a quarter of the amount of drugs the person was using.

There can be five people sitting around my table, and if someone is using your place to do a shot, you get the second shot. So I can have four people sitting at my table, say you get four shots out of a half [set of Ts and Rs], well I get the second and the fourth. I got five people around me doing 10 shots, they're only doing two each. (Male, Caucasian, 60s)

Tina Two also had a place where people would come to consume drugs in exchange for getting her high. She found sharing her space a better source of income than sex work.

Just now and then [I work the streets]. I used to be really bad into crack and stuff. My boyfriend does Ts and Rs too. Him and some other people come here and do it [use drugs]. It's better than working out there. Nobody gets out of hand or nothing. They're very respectful. (Female, Métis, 30s)

Social and environmental management. Everyday life for participants involves managing and navigating characteristics of the physical, social, built, and natural environment. This aspect of habitus and everyday life captures elements arising from participant interviews about immediate social relations and material realities of everyday life as they relate to drug use.

Drug use is largely a social practice. Most of the participants discussed aspects of their drug use that were mediated by social relations. Participants recognized the influence of others, or of the “drug scene,” on their drug use practices and often attempted to manage these relations. For many participants, social management in everyday life involved maintaining social relations to “stay in the game” or distancing from social relations, places, and spaces to step out of it.

Themes related to social management included: taking a break; identification and othering; managing stigma related to drug use; taking care; reclamation; valuing toughness; and environmental management.

Taking a break. Several participants discussed past or current efforts to “get out of it” or take a break from drugs when their involvement became problematic. Some used formal addictions treatment programs and others used the natural resources available to them. Although participants tended to talk about breaks in terms of quitting drugs, they generally returned to some form of drug use. Thus, it may be more accurate to consider efforts to cut down, stop using, or take a break as a normal part of life for people who use drugs.

Social distancing efforts were used to take a break from drug involvement, including drug use and drug trafficking. This involved physical moves to new neighbourhoods, avoiding places and spaces, family, friends, and partners, and making new connections.

When Hank was taking a break from injecting drugs, he had to avoid his own partner on pay day, as well as avoid many people in his social network who had been supportive of him when times were tough.

I straightened out my life, but I noticed that in order to do that I had to sever all my ties with the street people that had shown me the ins and outs, like, which soup kitchens [to attend] or what we used to call slop lines. He [my boyfriend] asked me “How do you do it? How do you stay away from it?” I said, “Well, on cheque day I stay away from you.”

(Male, Métis, 40s)

In this way, taking a break from drugs caused Hank’s social support network to shrink.

Patrick had a range of people in his social network, some who injected drugs and some who did not. As such, Patrick had a range of different social opportunities when he was taking a drug break. *“Friday night, instead of going to a movie or something, versus Friday night you meet up with some buddies [and] you end up shooting up. Your activities are different with different people, and environment's a big thing.”* (Male, Caucasian, 30s)

For Sam, an ultimatum between drugs and his girlfriend provided the motivation to take a break.

My girlfriend was straight [didn't use drugs], and when she found out, she first saw the bruising on my hips and then later the marks on the arm – she gave me a "pick me or pick drugs" ultimatum. I chose her. I stopped using for about a year and a half. (Male, Caucasian, 40s)

The impact of major life events, such as a traumatic loss, pregnancy, or a serious health condition, was discussed by a few participants as the reason drug use was reduced or stopped. Pregnancy is often such a transitional time for women, as was the case for Robin. *“Maybe sometimes I just want to quit. I did quit for about six months last year when I was pregnant”* (Female, First Nations, 30s).

Lee was his grandmother's favourite of his seven brothers and sister. *“I remember she'd carry me in her arms and dance with me. She taught us not to steal and all that.”* For Lee, the death of his grandmother was a tremendous loss and painful transition that had him re-assess his involvement in drug dealing.

I quit dealing that stuff when I lost my granny. I threw about seven thousand dollars into the Red River. I just quit that day, and those bikers came to see me, “Lee, come back,”

and I said, “No, I quit selling,” and I smashed a big 60 pounder of whisky and I threw that money away. (Male, First Nations, 40s)

Identification and othering. Most participants identified with or differentiated from others based on drug use practices, income generating practices, or places where people hang out or receive services. This was generally expressed by participants in terms of “fitting in” or expressing personal limits or rules. Jupiter felt like she didn’t fit in at Salvation Army. *“I don’t like being alone. I try to talk to those people but they all know each other. I don’t feel like I fit in”* (Female, First Nations and Caucasian, 30s).

A number of participants struggled with their association with Main Street and its inhabitants. C didn’t identify with the people who hung around Main Street or their activities *“I don’t do what other people do around here, they boost and shit. I don’t like stealing. That’s not the way I was raised”* (Male, First Nations, 30s). For Dan, hanging around Main Street was out of sync with how he was perceived by others. *“People see me and they go, ‘What are you doing?’ ‘How come you’re doing that now?’ ‘You’re not that person, you’re better than that”* (Male, First Nations, 40s). Chris was in a period of unemployment without a stable residence and found himself hanging around Main Street and using community food services. However, this was incongruent with his image of himself.

Right now I occasionally go to the soup lines, but I don’t like it at all. I don’t think I’m better than anyone else, don’t get me wrong, but I don’t feel like I belong in a soup line. I don’t think of myself as one of them, and I like to be able to take care of myself. I don’t want to be known as a “Main Streeter,” but it’s the life I chose. It’s the path I chose to take. My family is not happy about it. (Male, Métis and First Nations, 40s)

Chris’s experience suggests that “Main Streeters” are perceived as not being able to take care of themselves. These participants provided insight into how this place and space has become stigmatized, and how Main Street stigma was reproduced by its own inhabitants.

Managing stigma. Some participants shared experiences specific to injection drug use related stigma. Tina mentioned track marks as one of the most significant harms related to drug use. *“I would say the same thing with Ts and Rs too because it leaves you track marks and everything”* (Female, First Nations, 30s). For Chris, stigma related to injection drug use prevented him from accessing sterile injection supplies.

I actually get other people to go get them [needles] for me because I’m too embarrassed to go get them. I had no problem going up to the van [Street Connections] before and getting pipes, but not rigs [needles], I was too embarrassed to do it. Friends of mine would go do it for me. (Male, Métis and First Nations, 40s)

Stigma related to injection drug use was also noted among everyday social relations. Hank experienced being brushed off by people after disclosing a history of injection drug use.

I’ve mentioned [to acquaintances], “Oh well, yeah, I’ve occasionally stuck a needle in my arm”, and they’ll look at you like you’re like a third-class citizen. Not a second, but a third class citizen. Then when you want to go by and say “Hi,” “Oh I’m washing my hair, oh I’m busy, I’m babysitting my nephew” or something. Then I finally get it. (Male, Métis, 40s)

Taking care. The most robust aspect of social management was “taking care” or acts of community where people watch out for each other and act in the interests of others. More than half of the participants shared stories about looking out for and taking care of people in their

community. *“Like family that look after one another, yeah”* (Alicia: Female, First Nations, 20s). Acts of taking care contributed to participants’ sense of belonging and purpose within their community and included a range of practices such as child-minding, managing others’ withdrawal symptoms, providing counselling, providing sterile injection equipment, and providing a place to sleep/crash.

Jupiter talked about a friend who helps and advocates for her with child protection services, particularly in negotiating visitation with her children and helping her access drug treatment. *“I have a friend that advocates for me. She’s an advocate and a really good friend, and she was there for three of my births. She wanted me to go to St. Raphael [treatment centre]”* (Female, First Nations and Caucasian, 30s).

Tina Two has natural counselling skills, experiential knowledge, and authentic concern that people in her life recognize and benefit from.

People say to me, “Why don't you become a counsellor? Because at least you don't do it by the books, you do it from your own heart.” I tell people they can't keep holding things in, they have to talk about it because they might take it out the wrong way, or they might hurt themselves. I tell them it's best to get it out and who cares what people think of you or what they say. At least it's not bottled up. (Female, Métis, 30s)

Reclamation. Several participants were engaged in practices of reclaiming some lost territory in their lives such as: traditional language, art, medicine, or spiritual practices; connections with family or home community; autonomy over income; or aspects of personal identity. Hezus, a First Nations man in his 30s, was learning to speak Ojibway, the language of his family.

I just started relearning my language because I wasn't taught it by my mom and dad. They spoke it but they figured that I wouldn't need that language. That's what they said to us. "We don't need that language anymore." [laughs] I'm older now and I could use it because I know a lot of my relatives that speak it. My cousins and everyone, they speak it well.

Chris was in the process of reclaiming his First Nations status. *"I'm Métis, but I'm also First Nations. I just found out I'm eligible for status. I applied to the band, from North West Territories"* (Male, Métis and First Nations, 30s).

Valuing toughness. Participants shared perspectives on the value of personal strength, resilience, "street smarts," life challenges, ability to take a beating, or deal with pain. These values were generally conflated with masculinity, and often instilled in earlier life. At one point Chris remarked: *"For me and her, I'm supposed to be the man of the house, and I don't want to break down in tears in front of her"* (Male, Métis and First Nations, 40s). C also commented, *"I don't know how to say it. I like pain. It makes me stronger, I guess you could say"* (C: Male, First Nations, 30s).

Gino was born small and diagnosed with scoliosis in his youth. He was picked on from a young age and with the help of his grandfather, he learned to fight.

My dad left when I was seven. I had nobody growing up. I had to teach myself. I even learned how to fight because I used to get picked on when I was a little kid. I just got tired of people picking on me and I learned how to fight. My grandpa was pretty hard. He usually got me and my cousins to fight each other. He was trying to make me hard

because I was getting picked on all the time and I'd never do anything about it. (Male, First Nations, 30s)

Environmental management. Participants spoke of the interplay between drug use practices and the physical and built environment. One common theme discussed was discarded needles and injection supplies in the environment, and participants' disdain for this practice, concern for children in the community, concern about potential crack down or community action against PWID, and actions to remove discarded needles in the community. Day Late shared his disdain for the practice of discarding needles unsafely in the community, but also shared how spaces that promote safer drug use can reduce the pressure on people who use drugs, which results in less drugs used.

I hate people who do that [discard needles unsafely]. If you're going to do drugs, then do them clean. To have clean places to do them, clean and safe places to take them, that's the best thing for it. Then you do it and it doesn't cost you as much, you enjoy it more, it's done safer, no one gets hurt, and you're not using as much either. It just makes your life so much more at ease, so you don't need to do as much, and you're not wasting as much as you know there's less pressure on you. And it's just, you don't do as much. (Male, Caucasian, 50s)

Several participants expressed disdain over discarded needles and shared experiences where they cleaned them up and disposed of them, including who Chris shared his concern for children who may get stuck by a discarded needle.

I really don't like that, kids play down there and stuff. I pick them up [needles] sometimes, I'll take gloves and a pop bottle and pick them up. I don't like needles being left out.

Usually, if I have my backpack with me, I'll actually clean them up, I clean up after people. I don't want to see a kid get poked by a dirty rig. I get checked for STIs all the time, and I don't share. (Male, Métis and First Nations, 40s)

Experiencing harm, violence, or threat. In addition to experiencing trauma, abuse, and loss in their biographical histories, several participants shared instances of experiencing or navigating violence, threat, and harm in everyday life. This should not be taken as a negative characterization of inner-city Winnipeg, but as an expression of everyday experiences from within the inner-city. Violent forms of masculinity were experienced by both women and marginal or less dominant men in this setting. *“It's bad. Don't care if you're man, woman, whatever. I watch these guys doing it [beating and robbing] to 70-year-old people in the bus stops for Christ sakes. You know, Downtown Main Street is rough”* (Eli: Male, Caucasian, 60s).

Brian Two usually worked in casual labour but was temporarily unable to work because of an injury to his leg from a neighbourhood assault.

I got jumped in the back in the Northern [Hotel]. I was waiting for somebody and I got accused of stealing some beer. I didn't even have any beer, and I was trying to run away but got assaulted by this guy and his girlfriend. (Male, First Nations, 30s)

Harm was also experienced as a result of rumours or word of mouth. Cinnamon had untrue malicious rumours spread about her from someone in her social network that resulted in old friends turning against her violently.

The person that started the rumour, everybody found out down here that she did it, she started it because of jealousy. I was defending myself with guys that were six foot [tall],

guys and chicks, you know. I was piled on. People that I'd known for years tried piling on me because of this label that I've got. (Female, First Nations and African, 40s)

Pervasiveness of drugs and alcohol in everyday life. The majority of participants described their everyday life setting as one in which drug and alcohol use and access are pervasive, especially around North Main Street. Although this finding is not about a social process, this observation from the perspective of participants was robust enough to include in this category (habitus and everyday life) as it significantly shapes the conditions for Talwin and Ritalin injection to exist, and individual drug use practices. *“Well since I'm off work this week I'm not doing much, hanging around Main Street, and I don't like that. It's really hard to get away from drugs”* (Chris: Male, Métis and First Nations, 40s).

Carl stated he is commonly asked if he wants to buy Ts and Rs as he walks through the neighbourhood. *“Always asking, they ask me on the street. “Hey you, you want a set [of Ts and Rs]?” If they know what [drug] you do, they'll come and ask you”* (Male, First Nations, 40s).

Cinnamon had recently moved back to Main Street around the time of her interview and found the neighbourhood could be a trigger for drug use, as well as income generating, such as transactional sex. *“The thing is, it's [drugs] right in your face. As soon as you walk out the door, boom. The one thing is I haven't worked. I haven't gone out on the corner”* (Female, First Nations and African, 40s).

Spaces of consumption. The nature of drug consumption spaces arose as a robust theme during phase I of the study, and was selectively expanded upon in phase II, where PWID and had unstable housing were recruited to explore a diversity of spatial drug use practices. Participants discussed the physical and social nature of spaces in which drugs were consumed. Perspectives were shared on the nature of spaces and how they shape drug use practices, as well as

perspectives on supervised consumption services. Themes related to spaces of consumption included: perspectives on outdoor and public spaces; the social aspects of consumption spaces; and perspectives on supervised consumption services.

A set of Ts and Rs includes two Talwin pills (often 50 mg) and one Ritalin pill (20 mg). All the pills require crushing, solubilizing with heat and water in a cooker or spoon, and filtering out particulate matter before drawing up for injection. This is a more involved preparation than other drugs used for injection, which becomes a consideration in the suitability of spaces of drug consumption.

Outdoor and public spaces. Outdoor drug use is shaped by the physical environment, seasonality, and public and community monitoring. The North End of Winnipeg is separated by the Canadian Pacific Railway yards, which provide a large industrial space that is largely unmonitored. The Red River runs parallel to Main Street, providing a relatively sheltered and unmonitored riverbank on which to avoid public notice. Approximately one-third of the participants shared experiences with outdoor injection drug use and described the best outdoor spaces as those that are out of the way of law enforcement or other expressions of drug prohibition, and reasonably sheltered from the elements.

Chris, who had spent several months living on the bank of the Red River in Winnipeg, had a good sense of outdoor spaces that were sheltered, private, and amenable to injection drug use.

I know some people that [use] just across the field at Main Street, across from the Mount Royal, they sit in the corner where the willows are, out of the wind. For me, it's just a cubby hole, or down by the river. There are so many spots. Do you know down by the

water tower? They have that walk path that goes around underneath it. There are these rocks you can sit on out of the wind, and there's a building that nobody comes by. (Male, Métis and First Nations, 40s)

Mojo and his friends would sometimes use drugs in the underground tunnels in Downtown Winnipeg, being mindful of where the cameras were, and the strolls of security guards.

We only do it where there's no camera in the hallway. We keep six [on the lookout] once in a while and say, "I'm going to keep six right here, okay, six, six, six." Then he [my friend] leans over and looks and when he [the security guard] is gone, "Okay it's your turn." Then I suck up [in the syringe]. I'm really fast because I know how to do it. "I'm going to do it right here" [laughs]. I shove it [barrel of syringe] and I throw it in the garbage so I don't let other people know. (Male, First Nations, 30s)

Jupiter stated that she doesn't use drugs outdoors specifically because of the potential for police involvement. *"Well, everywhere I do it [inject drugs], it's always in someone's apartment or something. I've never done it outside. I wouldn't want to get caught"* (Female, First Nations and Caucasian, 30s). Alicia was also deterred from injecting drugs outdoors due the risk of police interference. *"Outside, no. Say if cops come around and whatnot"* (Female, First Nations, 20s). Not all participants were concerned about police interruption during outdoor injection drug use. Robin had experience being interrupted by police while injecting outdoors that did not result in charges or arrest. *"No, I just do it quick and then that's it. I get stopped by the cops here and there, but they just tell us to clean our mess"* (Female, First Nations, 30s).

Bob shared concern over dirt, dust, and wind with outdoor use. This may have implications for the use of Ts and Rs as the preparation of these drugs is more involved than others.

On the other side of the tracks there's a space there. One time I did that [injected there], and I didn't want to because you can get the dust on the ground into the spoon and the needle. At this given point I wouldn't recommend people do it outside because of the wind. The wind can pick up dust. (Male, First Nations, 40s)

Kendra shared experiences using drugs in public restrooms. *“In the summer time we usually do, when I'm on a boosting trip I'll take a couple shots with me, do a shot before I go in the store or do it in the washroom at the store”* (Female, First Nations, 30s).

Desirable spaces for drug consumption generally included places that were clean and safe, with people you can trust, with access to safe/clean drug consumption supplies, and free from the harms of drug criminalization. *“You know, you get a few friends and, you know. Basically it's about being safe eh?”* (Eli: Male, Caucasian, 60s).

Social aspects of consumption spaces. Spaces of consumption were shaped by drug acquisition and capital exchange. Participants discussed using drugs in the spaces they were acquired and use of someone's space for consumption was normally compensated by sharing drugs or other forms of capital or resources.

Lee explained his process for using a friend's house for drug consumption.

You find a spot, like, you have a friend's [place] to go to. You phone them, “I'm on my way,” and they wait for you. When you get there you get them high too [laughs]. [If] they

don't want to get high usually I carry beer on me and give them that. (Male, First Nations, 40s)

Bill's place was used by others for drug consumption, which was a convenient location as people would also buy their drugs nearby. Use of Bill's place was contingent on regulations of exchange, conduct, and safer use.

The place I stay at, a lot of people come there to get drugs and to use drugs, and a lot are homeless. They are staying at Siloam, Salvation Army. I got a clean place, clean everything for people to come and do the drugs. If they're sitting at my place nothing gets reused. If you draw up a second shot, you go into the same spoon because there's still enough in there, but you're always using a clean rig, so it doesn't matter if you are all drawing from the same spoon. There's nothing but a clean rig going in there. (Male, Caucasian, 60s)

Day Late described some of the regulations of conduct in the use of his space. Jupiter, who was present during the interview, reacted non-verbally to some of what Day Late shared.

Some sort of girl will come by and bring a sort of drug, and I'll give them a clean, safe place to stay, eat, use, and be safe. [I] never use sex as a weapon against them, and they come and go as they please [Jupiter looks at Interviewer and rolls her eyes].

Sharing one's space was not always desirable to Day Late. "A good day is when nobody shows up with a drug [laughs]" (Male, Caucasian, 50s).

Similarly, Cinnamon eventually found it hard to manage others who used her home for drug consumption. Establishing, communicating, and enforcing the rules of conduct for her space was challenging. She called in some other friends to help clear people out.

I'd always get an end in it [drugs for sharing]. [There were] three months of people coming in and what I noticed about meth heads is they have to touch everything. Not even asking. I open my door to the people and they think that they can just walk out with stuff. I noticed after a while, little stuff at first, and then, "What's going on here?" They made it seem like I had moved it, or I was imagining it. Oh, so greasy. Finally, I had help from a couple of good friends of mine. They came in and, "Get the fuck out of this house." No, I think if they know me and care about me, then they'll understand. There's a few people that I've had to turn away and say, "This isn't going to happen in my place anymore."

(Female, First Nations and African, 40s)

Celina, Gino, and Lee avoided the implications of borrowing space, including being dependent on others, having to provide a cut of their drugs, or being watched or rushed:

I'd go to a secluded area, where nobody is really driving by or walking by. Then I'd find a little water bottle. I don't depend on them [people with spaces that can be used for drug consumption]. (Celina: Female, First Nations, 30s)

I usually do it all the time by myself because I'm paying for it. I'd rather do it all by myself. Actually, I don't really use it outside; I usually go to the bathrooms in the restaurants and lock myself in there. (Gino: Male, First Nations, 30s)

[I use] outside because I sit there and take my time. Most people are always in a rush. If you do it by yourself then you feel like you got your own space, but if you're with

someone else that you know is watching it's like, "Okay, come on, don't watch. I want to get high." (Lee: Male, First Nations, 40s)

Perspectives on supervised consumption services. Most participants discussed perspectives on supervised consumption services. This was not central to the study at its onset, so was not asked in phase I, but participants recruited in phase II were asked about perspectives on supervised consumption as the interview guide was changed to include this topic. There were more participants that stated they would not use a supervised consumption service than those that would. Some would tentatively check it out, and some were in support of the idea but would not use the service.

Both Barbie and Linda had homes where they could comfortably prepare and consume drugs, but both stated they would access supervised consumption services out of respect for their roommates or partners. As Linda commented, *"I probably would, yeah, just not having to bring it to my home. Respect for my roommate and stuff. My roommate doesn't drink, do drugs, or smoke cigarettes"* (Female, First Nations, 40s).

There were various reasons that participants would not use supervised consumption services. For Cinnamon, injection drug use was considered a private practice that she would not be comfortable doing in a public 'supervised' space. *"No, I'd prefer at home. I'm that type, you know. Not at all [would I use supervised consumption services], because it's nobody's business"* (Female, First Nations and African, 40s). For Max, the idea of using a drug and experiencing a high in a "supervised" setting was unappealing.

Like, I don't mind getting high with my brother or sitting at my brother's or sitting here, but other than that I don't think I'd be able to do a shoot-up site. It wouldn't be something for me, anyways. (Male, Caucasian, 30s)

Chris also felt that injection drug use was a private practice that he felt compelled to conceal. For Chris, a stable home would be more valuable than a supervised consumption service.

I'd rather hide it from people, and I don't want everyone knowing what I do. Yeah, I'd rather use at home because your home is supposed to be your safe dwelling. Yeah, home is number one. (Male, Métis and First Nations, 40s)

Other participants stated they would have used supervised consumption services at a different time in their lives, but it is less relevant if a person has a home. *"I just wouldn't because I've got my home here. If I didn't have somewhere and I was outside then I would use it, if I lived on the street"* (Kim: Female, Caucasian, 40s). For Sam, the idea of supervised consumption services was symbolic of acceptance and inclusion of people who use drugs, even if he wouldn't use the service himself.

I watch the news and I read the paper and I see Vancouver open up safe injection sites, and now I see Montreal wanting to do the same thing. That's what this city needs. This city needs acceptance. You have so many needle users running around sucking water out of toilet tanks in public bathrooms.... I don't need a safe injection site because I have a comfortable home. But 10 – or 20 years ago, yeah. (Male, Caucasian, 40s)

Similarly, Tina supported the idea in principle, although she said she wouldn't use the service. *"I don't know, I wouldn't do it, but it does sound like a great idea"* (Female, First Nations, 30s).

For others, there was already a system of drug consumption space that was working for them and was more desirable. Finally, a number of participants envisioned themselves not using drugs in the future, so speculating on whether or not they would use supervised consumption services was inconsistent with this identity.

In sum, habitus and everyday life for participants was shaped by lack of access to material resources and legal employment opportunities in a setting of high drug and alcohol use where safety had to be navigated regularly, everyday social practices concealed, and a strong community of social support had developed. Social capital, one of the most important types of capital being exchanged, accumulated in resources such as friends, reciprocal care, connections, belonging, street skills, toughness, cultural identity, sharing space for drug consumption, and caretaking. Although material resources and economic capital were present and flowed regularly, they were not significantly accumulated. Further, material resources and economic capital were often procured from institutions and services, and from illegal or stigmatized income generating practices rather than mainstream employment.

Drug and alcohol use in the setting was normalized, and participants generally discussed drugs and alcohol in terms of what substances people use, rather than whether people use substances. Spaces of drug consumption were social and material environments that shaped individual drug use practices, such as drug acquisition, preparation, consumption, exchange of resources, the types of drugs used, and the conditions for drug-related benefits and harms (Spaces of consumption are discussed more fully as a major theme in Chapter 7.) Unsafely

discarded needles in the community were seen to reinforce stereotypes of PWID as reckless and careless. The practice of discarding needles unsafely in the community was offensive to most participants and was thought to contribute to stigma against people who use drugs. Discarded needles emerged as a symbolic extension of irresponsible drug users who did not respect the community. Several participants mentioned picking up discarded needles in the community when they were discovered as an act of social and environmental management.

Moreover, Main Street and its inhabitants were stigmatized, and the stigma was often internalized amongst participants. Several participants who lived in the area did not identify as a resident of the neighbourhood, or with other Main Street inhabitants, in terms of practices of generating income, drug use, lifestyle, and service use. Some participants talked about people who live on Main Street as lacking autonomy and self-care capacity, rather than as people who have been disadvantaged by structures and symbolic systems that privilege other members of society. This finding may be a demonstration of participants' internalization of neoliberal ideologies about individuals as autonomous agents in an equal, competitive society, where failure to thrive is an indication of individual faults. To some, Main Street was seen as a space that collects the refuse of society. Others described the Main Street neighbourhood as a place where street family forms and cares for each other.

Individual Drug Use Practices

Participants shared drug use preferences and practices that arose from a combination of individual preferences in altered state, maximizing benefit and minimizing harm, cost and accessibility/availability, social norms, and identification. Ts and Rs were the main drug reportedly injected by 17 of the 36 participants. Of the 24 phase I participants, 21 had injected Ts

and Rs in the last six months, three had injected Ritalin only. Although phase II participants did not have the injection use of Ts and Rs as an eligibility criterion, most (seven of 12) had injected Ts and Rs in their lifetime; those who hadn't were familiar with Ts and Rs and people who used them. Hence, participants were all knowledgeable about the injection of Ts and Rs from various perspectives. Other common drugs of preference discussed included morphine, crystal meth, crack cocaine, and alcohol. Individual experiences with Ts and Rs-related benefits and harms were experienced differently and drugs were consumed for different purposes. However, there were commonalities among the benefits and harms that arose in conversation. In discussing benefits and harms of drug use, what was considered beneficial or harmful was defined by the participant, not the researcher.

Benefits. Participants discussed the benefits of Ts and Rs use more than harms. This is not surprising since people generally take drugs in the pursuit of benefits. Thus, whatever drug people use will likely be described in terms of benefits rather than harms. However, the nature of the benefits tended to be unique to the drug and the context of its use. The main themes arising in discussion of drug use benefits related to Ts and Rs included: accessibility and cost; functionality; moderation of craving and use; pleasure and relaxation; product reliability; and relief of pain, symptoms, boredom, and grief.

Accessibility and cost. Price and accessibility of drugs, including the dose and length of high, were discussed by half of the participants as an influence on their choice of drug, and a benefit of their drug of choice. Eli, Max, and Tina Two considered Ts and Rs favourable in terms of accessibility and price. Eli noted:

Well, it's always a matter of what you can get. You get the ether rush no doubt about it, right? They call it [Ts and Rs] "poor man's heroin." Everything is money, money, money. You know, it's [Ts and Rs] not the best of buzzes but it's cheaper. (Male, Caucasian, 60s)

Max also found Ts and Rs an affordable drug option.

I started doing different things, then Ts and Rs came around. When I was living in the North End a friend introduced it to me and I just kept going with that because it was a lot cheaper. (Male, Caucasian, 30s)

Although Ts and Rs was not Tina Two's choice of drug, she understood the draw.

In their minds they probably think they get more out of it [Ts and Rs]. See, with crack, nowadays you'd probably get one hoot or two hoots out of that [rock], and you can probably get, like, four or five shots out of it [Ts and Rs]. So it lasts longer. (Female, Métis, 30s)

Functionality. Most participants discussed their use of Ts and Rs as advantageous if they were able to maintain their ability to function in activities of daily living, or if the drug enhanced their abilities in daily living. Bill was one of the strongest proponents of the benefits of Ts and Rs. He was skeptical before the interview that the researcher would believe him or be open to hearing about the benefits of drugs. *"I was surprised how much it [Ts and Rs] did for me, I didn't know if you'd believe me."*

Yeah, 30 years of use and some people still have a regular job, regular life, no problem on Ts and Rs. I know people that have been doing them since 1985. I know a guy, he has kids, a wife that's a social worker. I mean, all walks of life doing the Ts and Rs. I don't

get a real rush from them, but I can do that first shot and then I'll have the energy to clean my place. And it can be an hour before I do my second shot. Whereas if I'm just doing the rock [crack], that's all I'm doing. I can smoke and smoke, I can't get enough.

(Bill: Male, Caucasian, 60s)

Max also found the milder high of Ts and Rs to be amenable to social functioning.

I've tried a variety of different things. I can say no – but I tried a lot of stuff and Ts and Rs is a mellow sort of feeling. I can still socialize and I'm not a different person when I'm on it. It's something I can handle. I don't want to have drugs where my heart's going [fast]. I don't want to get scared like that. (Male, Caucasian, 30s)

Moderation of craving and use. Ten participants described Ts and Rs as a favourable drug choice in that the drugs were not “chased” or used in a binge pattern. Generally, Ts and Rs were described as a drug used in moderation or for maintenance and in some cases it would moderate the urge to use other substances to excess. Kendra makes this point in her discussion of the moderating effect of Ts and Rs on her craving for crack cocaine.

The high lasts longer and I find it better than crack because you're not chasing it. You get two, three hoots out of a piece [crack]; out of a half [Ts and Rs] you get four or five shots. If I were smoking crack and doing a shot, I prefer to smoke crack and then do a shot because then I won't be chasing it. It stops me from chasing crack. That way I don't spend more money on crack. [If] I'm going to end up smoking crack I always end up making sure I have a shot [of Ts and Rs]. (Female, First Nations, 30s)

Bill experienced the most diverse range of moderating effects from Ts and Rs. For Bill, Ts and Rs did not inspire binge use and they moderated his craving for crack cocaine and alcohol. These moderating properties were beneficial economically and socially.

I chased the rock steady. I wanted another hoot, another hoot, until I started doing the Ts and Rs. After I started doing the Ts and Rs I could smoke a few rocks and it didn't matter to me if I smoked another one or not. Once I started on the Ts and Rs I was able to shut down my drinking completely. I can have four or five beers and I don't feel like having any more. I was a drunk. I'd get in trouble a lot of different ways, arguments, be rude one day, apologizing the next day for something I didn't even remember doing. Now I have no problem. Nobody's starting to do Ts and Rs, but I can't see any harm, unless you've never ever done any drugs. As far as I can see, for those that are doing them, and not doing anything else, if you quit the Ts and Rs and turn to drinking or [other] drugs, that can bring you a lot more trouble. (Male, Caucasian, 60s)

Pleasure and relaxation. Another benefit of Ts and Rs described by participants is the sensation of pleasure and relaxation characteristic of the high. Robin experienced combined moderating and pleasurable effects of Ts and Rs. “*Yeah, it gets me off a lot of things, mellows me out, and relaxes my body*” (Female, First Nations, 30s). Tina and Jim also commented on the relaxing and mellow properties of Ts and Rs. “*Well, the reason why I do it is because it makes me relaxed and I feel better. It's more mellow*” (Tina: Female, First Nations, 30s). “*It seems like it's more like a pain reliever. So when you come down it's like you relax and you feel nice and tired*” (Jim: Male, First Nations, 30s).

One of the pleasurable aspects of injecting Ts and Rs, shared by several participants, is a coolness or taste in the throat that occurs immediately after injecting. Jupiter describes this

feeling: “*You get that taste when you do your shot. You’ll feel a cool sensation in your throat, it will just feel cool for some reason. That’s how you know you’ve got it [the high]*” (Female, First Nations and Caucasian, 30s).

Product reliability. As Ts and Rs are pharmaceutically produced drugs, the reliability of the contents was considered a benefit. As Barbie shared: “*Compared to meth, Ts and Rs is a lot cleaner. You know what’s in there*” (Female, First Nations, 30s). Bill found the reliability of pharmaceutically regulated drugs a benefit: “*Yeah, and the thing with Ts is Rs is that they are a clinically produced drug. It’s not like meth out there, other drugs that are man-made without regulations on them*” (Male, Caucasian, 60s). Similarly, Carl has moved away from cocaine as he feared it may be adulterated with other substances. “*At least you know what it is. Not like the cocaine. You know what’s inside it, what’s mixed into it then. That’s why I don’t do that [cocaine] no more*” (Male, First Nations, 40s).

Relief of pain, symptoms, boredom, and grief. For many participants, drugs were used to relieve unpleasantness in the sober everyday state of life. Physical and emotional pain, grief, guilt, and socially produced pain were highly implicated in the individual drug use practices of participants. Some used drugs to self-medicate physical or mental health conditions. Some used drugs to relieve boredom, often related to lack of meaningful modes of engagement in everyday life.

For Mojo, Ts and Rs moved his mind away from the people he lost and missed. “*It slows you down and you don’t have to cry and think about the people that passed away and you just relax, you don’t think about nothing*” (Male, First Nations, 30s).

For Jupiter, the pain of losing custody of her children was acute. Drugs, and in particular Ts and Rs, helped her escape this grief. *“I’m trying to quit but look where I’m staying. It’s hard and I miss my children so much [crying], so I use drugs to cope, yeah”* (Female, First Nations and Caucasian, 30s).

Chris described his use of drugs as a way of hiding from the troubles of life, and from the pain of the loss of his brother and son.

It calms me down and lets me escape or hide. I’d say drugs help me to hide. Yeah, pain, trouble, stress, loss. And I think I really haven’t dealt with it yet, the loss of my brother and my son. Drugs are a lot about hiding from that for me. (Male, Métis and First Nations, 40s)

Patrick found drugs a relief from boredom, and his boredom a product of lack of opportunities for meaningful engagement.

Right now everything’s changing back at the hotel that I’m at, so I’ve got to fill up my day with appointments or got to get back into the gym and continue seeing my kids and that. I’ve just got to fill up my day. A lot of me using is out of boredom. Sometimes I’ll use just because, hey, it’s fun or whatever, but most of the time it was out of boredom. (Male, Caucasian, 30s)

Problematic use and harms. In addition to drug-related benefits, participants were asked about their perceptions of and experiences with drug-related harms. Harms related to social and institutional responses to drug use (e.g. drug-related arrest or incarceration, eviction, child apprehension) did not often arise in these conversations about the harms of drugs. The most robust findings arising on the topic of problematic use were: greater preparation requirements;

struggling with craving and access; drug expenditures; social disruption; cardiopulmonary issues; sleep disturbance; shared injection equipment; and cotton fever.

Greater preparation requirements. As discussed earlier, a set of Ts and Rs is comprised of three pills. Preparing a set for injection requires: pill crushing, water to dissolve the drug (preferably injection grade), a cooker or container in which to add the drug and water that would be heated to help dissolve the drugs, and a filter through which the dissolved drug solution would be drawn up into syringe. The filter acts to remove particulate matter prior to injection. Bill explained this process.

You put water in a spoon, throw the Talwin in there, and it dissolves. You crush up your Ritalin, but your water has to be warm. Then you put in your cotton in and you draw it up in a clean syringe. (Male, Caucasian, 60s)

This process is cumbersome compared to the preparation of drugs that can readily dissolve in water, such as crystal meth. Day Late describes the relative ease of preparing crystal meth compared to Ts and Rs.

Crystal meth, it's easy to come by and it's easier to use. You just need to get the one part and then put it in the needle and it's good to go. You don't have to mix it up with everything else, filter the crap, and everything else. Anything you have to filter like that, you take the chance of getting the filter [cotton] in there. Then you got to use the lighter, and you get gas from the lighter. You're mixing all that stuff and it's just a dirty, dirty thing. (Male, Caucasian, 50s)

Struggling with craving and access. Not all participants experienced the beneficial moderating effects of Ts and Rs. Struggling with craving and access to drugs was the most commonly discussed harm related to drug use in general.

Cinnamon experienced this effect with Ts and Rs specifically. “*The worst thing about Ts and Rs? I’d say once you’re finished your second shot, you’re already thinking, ‘Okay, how am I gonna get my next hit?’ ‘Where am I gonna get the money from?’*” (Female, First Nations and African, 40s).

Linda also experienced cravings and binge use of Ts and Rs. “*My addiction got stronger as the years went by. When I was living with the actual dealer [laughs], I had it all day, every day because either he would give it to me or I would steal it*” (Female, First Nations, 40s).

Charles shared experiences of both cravings and withdrawal from Ts and Rs, particularly in the morning. “*I feel kind of sick when I get up and I have a craving to go look for my shot. If you’ve been doing it for a long time, you start getting to have withdrawals*” (Male, First Nations, 40s).

Drug expenditures. Low income was an issue for all participants and often arose in discussion around challenges in meeting basic needs, such as food and everyday necessities. Some participants discussed the economic harms specific to drug use practices and expenses, particularly for those clients who would use Ts and Rs in binge patterns.

Carl shared his remorse over the amount of money he spent on Ts and Rs in the past.

I spent most [of] my money on Ts and Rs back then. Sometimes on a binge there can be 1,000 dollars put down. Thinking about it now, I shouldn't have done that. But back then I was young and, you know. (Male, First Nations, 40s)

Hank recalled the realization of his drug expenditures.

Well, cocaine, Ts and Rs, and finally I quickly realized I'm just wasting all this money away. I sat down one day and I thought, "Jeez, you know, I'm doing these odd jobs both under the table and paying my taxes and everything else." I thought to myself, "Holy crap, you know, I'm spending thousands of dollars." (Male, Métis, 40s)

Social disruption. Some participants shared that their drug use had caused disruption or tension in their personal relationships. Carl attributed the loss of his marriage to Ts and Rs. *"Right, [Ts and Rs] cost me my marriage too"* (Male, First Nations, 40s). Max experienced tension in his relationship over his use of Ts and Rs.

She [primary partner] does know I do it but she doesn't do it and she's totally against drugs. She thinks that maybe sooner or later I'll quit and, you know, we have our little argues about it. Yeah, I'm trying to cut down a lot more. (Male, Caucasian, 30s)

Cardiopulmonary issues. Several participants shared concerns, experiences, and observations about chest or respiratory health issues arising from injection drug use, including concerns and observations about the non-specific negative effects of talc and fillers from Ts and Rs on the cardiopulmonary system. These concerns included experiences of participants themselves or others that used Ts and Rs.

Crystal, a woman in her 30s, stated she had been experiencing respiratory issues from injecting Ts and Rs since her 20s. *"Yeah, I got asthma from doing Ts and Rs. Actually, it's been*

years, about 10, close to 15 years already because of all the chalk and stuff” (Female, First Nations, 30s).

Linda had witnessed women she knew experience cardio-respiratory issues because of talc and chalk build up. When she started experiencing chest pain, which she attributed to the use of Ts and Rs, she switched to morphine.

I was getting sort of scared because there were women that were dying because of the chalk build up. They ended up using oxygen tanks and whatnot. I didn't want to end up like that, and I was getting chest pains. I felt like I was going to have a heart attack. The chest pains were getting pretty bad. I was starting to have a hard time breathing so I just said, “Now enough is enough, I better quit before it gets any worse or before I start actually having to use puffers and whatever else.” (Female, First Nations, 40s)

Similarly, Eli raised concern about the amount of filler one would inject when using Ts and Rs. *“The only thing about them [Ts and Rs] is that you got to use a big needle and all the chalk. You've got to do all that chalk inside it. You're shooting all that chalk in your body” (Male, Caucasian, 60s).*

“Shakers” are a drug preparation practice in which the barrel of the syringe is removed, the drugs (in powder or rock form) are dropped inside the syringe with water, and dissolved by shaking (Rhodes et al., 2006). This practice avoids heating the drug, which may assist with dissolving the drug and potentially kill microorganisms, and filtering, which can remove particulate matter that can harm the venous walls or cause talc buildup in the small arterioles of the lungs (Marchiori et al., 2010). This practice was discussed in formal and informal interviews. Only Tina and Cinnamon discussed the practice of shakers with Ts and Rs.

Both the Talwin and Ritalin, you'd crush it up. Then put the powder in, shake it up. It would be pretty thick so you'd have to draw it back a few times. But they found that your lungs would crystallize a lot faster by doing shakers. (Female, First Nations and African, 40s)

For Bill, the harms of fillers in pills was not greater than the harms of other substances people use.

The amount of chalk in them, yeah, people say, "Oh you shouldn't be doing them," but drugs are drugs. Are any drugs any better for you? A lot of people smoke cigarettes, they smoke the rock, so that's not good for your lungs either. Whether or not you want to blame it on one or the other. (Male, Caucasian, 60s)

Sleep disturbance. Sleep deprivation is a well-documented problem among people who experience residential instability (Brooks-Olsen, 2015; Chang et al., 2015; Reynolds, 2014; Walsh, Lorenzetti, St-Denis, Murwisi, & Lewis, 2016). Securing a sleeping space, lack of security for self and one's belongings, unrestful conditions, frequent waking, and having to wake at early hours are among the challenges faced (Brooks-Olsen, 2015, Reynolds, 2014). The relationship between drugs and environment on sleep quality is complex.

Bob told about a time that he used crystal meth to stay up all night because he didn't have a place to sleep. *"I got it [meth] last week because I wanted to stay up because I have a rough time sleeping sometimes, at the project [Main Street Project]"* (Male, First Nations, 40s).

As Ritalin is a long-acting stimulant drug, and because so many participants experienced unstable housing, questions around sleep disturbance or deprivation were built into the interview guide. Most participants who used Ts and Rs regularly reported no sleep disturbance related to

the use of Ritalin or Ts and Rs. Talwin, as a narcotic analgesic, may counter the wakeful effects of Ritalin to some degree. Although not an issue of the majority, both Brian Two and Max specifically mentioned sleep disturbance from the wakeful effects of Ts and Rs. *“It’s like dreaming. I was having a hard time sleeping. It’s like it was draining me somehow and I couldn’t get tired”* (Brian Two: Male, First Nations, 30s). *“Yeah, sometimes I have a hard time sleeping. I’ll be up till four in the morning sometimes just watching TV”* (Max: Male, Caucasian, 30s).

In relative terms, a few participants noted that crystal meth was more likely to keep a person wakeful and stimulated than Ts and Rs. Celina had experience with both crystal meth and Ts and Rs and shared her comparison on the wakeful properties.

[Ts and Rs] mellows me out, like a relaxant for me. But the meth, when I did that I was up, I’ve got to keep going, I’ve got to go somewhere. It made me tweak and I didn’t like tweaking. It’s like paranoia sets in, so I didn’t like that paranoia feeling. So I made myself get off the meth and just stuck to Ts and Rs. (Female, First Nations, 30s)

Shared injection equipment. Some of the drug-related harms discussed by participants were related to practices of drug preparation and consumption, specifically consumption by injection. Most participants shared that they never share, lend, or borrow used injection equipment and always access or carry new needles with them. However, there were a few participants who discussed needle lending, borrowing, or sharing. In these situations, the practice was shaped by lack of access to sterile supplies, and an attempt to rinse or clean the equipment first. According to Gino: *“Every time I finish shooting up I just tell them to wipe alcohol on it [needle] because I usually carry a little jar of alcohol just to mix and clean the needles”* (Gino: Male, First Nations, 30s). Jupiter shared how poor access to injection equipment in the past led to needle sharing: *“My cousins have it [HIV], because like they all shared. They even used to*

boil their needles because you couldn't get any back then, so they would re-use them” (Jupiter: Female, First Nations and Caucasian, 30s).

Sharing rinsed syringes was not uncommon for Mojo and his friends, and decisions may be premised upon whether there was visible blood in the syringe.

When there's no blood on the system, you just rinse it out really good with hot water 10 times. Then you put an alcohol swab under hot water and so it cleans it out. Then you shake it out and then rinse it out another five times and then do the thing, okay. When they're sitting at that trailer they say, “Mojo come and join me, I need a new one.” “Just use mine.” Then I rinse it out five times and suck it up and okay, I'm done. “Have a shot before you go.” “Alright then see you later.” (Male, First Nations, 30s)

Public health messaging about shared injection equipment is focused on preventing HIV and hepatitis transmission. These messages are likely received differently by people who are already infected with these viruses as there may be less perceived benefit for themselves in safer injection use.

Catching a fibre/cotton fever. Cotton is used for filtering crushed pills by many PWID. The term “cotton fever” is often used to refer to a transient high fever, chills, muscle aches, racing heart rate, and flushing, and tends to resolve without treatment (Harrison & Walls, 1990; Torka & Gill, 2012). The exact mechanism that causes this reaction is unknown. Robin shared her experience of “catching a bad fibre” and managing the illness.

The thing is that with Ts and Rs, when you catch a bad fibre, that's the worst part. Your muscles [ache], you go weak. When I catch fibre, I take a Tylenol. It takes it away. You

have to keep yourself warm, take a Tylenol, and then after a while, you're going to feel better. (Female, First Nations, 30)

Overall, participants tended to explain individual drug use preferences, practices, benefits, and harms in terms of one drug versus another, rather than between drug use or no drug use. The experiences, perceptions, effects, harms, and benefits of drug use, and specifically Ts and Rs, were diverse in character and content among participants. Practices were shaped by a range of social conditions and honed from experimentation, shared experience, wisdom, and an acceptable balance of benefits and harms.

A wide range of benefits related to the injection of Ts and Rs were shared by participants, particularly in relation to other drugs on the market. Ts and Rs were valued for the relatively low drug expenditures associated with them, their capacity to enhance function, moderate craving and use of other substances, assisting with coping with life conditions, product reliability, and pleasure and relaxation enabled by their use. Most notably, the ability of Ts and Rs to moderate intense cravings and produce satiating experiences was widely experienced. However, these benefits were not universal among participants, and some experienced intense drug cravings and high drug expenditures with Ts and Rs.

The most salient conditions for drug related-harms and problematic drug use derived from socially produced pain and loss, including family separation and drug law enforcement. Yet the burden of drug-related harms related to Ts and Rs appears to be relatively low in terms of overdose, sleep deprivation, psychotic episodes, and variable quality issues. Other drug harms that concerned participants were related to the injection of pills in general, including talc and filler related harms, and “cotton fever.” Although sharing injection drug equipment was

generally unacceptable to participants, blood borne infections were not mentioned as a key concern related to injection drug use.

Summary of Analytic Findings

The social location and biographies of participants were significantly influenced by macro systems of power that have manifested in Canadian institutional systems and mainstream symbolic systems, as discussed in Chapter 5. Violations against the rights of Indigenous peoples at multiple layers within Canadian society are key power relations shaping the field. Historical and structural processes contributed to a shared habitus characterized by family separation, intergenerational trauma and loss, exclusion from mainstream economy and employment, and a trajectory that positioned early street-involvement and injection drug use as a common and normalized path for many participants. Participants' everyday lives were characterized by high institutional interactions and navigation, and significantly troubling relations with health, child protection, criminal justice, and housing/shelter systems and services. The prohibition and stigma attached to drugs shaped interactions and relations of power at the institutional level. Drug use was often the reason for institutional interference and harm, or the reason that service and support from the institution was denied or removed. Macro systems, institutional manifestations, and symbolic systems also shaped the local drug market and determined what drugs were accessible and affordable. Ts and Rs emerged in this research as a slowly declining drug trend, used by older, experienced individuals with situated knowledge about inner-city injection drug use.

The exploration of everyday life focused on the exchange of capital and resources. Habitus shaped how, where, why, and with whom drugs were consumed, as well as how drug-

related harms were experienced, mitigated, and avoided. Due to the extensive reach of drug prohibition power, access to a space in which to consume drugs was a form of capital necessary for daily functioning. Indoor, private consumption spaces were available to those with network membership and having a space that was shared with others built social capital. Use of someone's space for drug consumption was contingent on the exchange of resources, which was not always an acceptable transaction. Caretaking and everyday harm reduction practices that arise as a function of membership in a community emerged as a significant resource amongst participants that contributed to a sense of belonging and purpose. Drug use preferences evolved out of a favourable balance of benefits versus harms. Ts and Rs were often found to moderate intense craving states for more Ts and Rs as well as other substances, including alcohol, enabling moderate use of substances. In this way Ts and Rs themselves were a resource for harm reduction for many participants. Three key findings that emerged from the ethnographic field work and interviews are explored in greater depth in the following chapter.

Chapter 7: Interpretation of Key Findings and Discussion

This study is focused on the social and material conditions that shape drug use practices in order to draw connections between structure and agency and reveal opportunities for policies, programs, and practices aimed at social conditions of drug-related harms and benefits. The injection of Ts and Rs in Winnipeg has come into view through this research as an actively declining trend, rather than a stable and persistent trend as posited at the outset of the study. This mode of drug use is maintained by a relatively small group of experienced, middle-aged PWID with a limited and unstable Ts and Rs supply chain. New initiates to injection drug use were not seen to be taking up Ts and Rs, and many of those who had been stalwart users of these drugs had moved on to other drugs, out of the scene, or were deceased.

Participants' social location and habitus were structured from a range of historical, social, political, economic, and institutional processes. In addition to illuminating some of the features of social context that created conditions for drug-related benefits and harms, this research has made visible some of the formal and informal resources available in this setting and uses of these resources that facilitate the everyday work of navigating and mitigating harms.

While the analytic themes from the ethnographic fieldwork and interviews were detailed extensively in the Chapter 6, three key findings that emerged from interpretation of the field warrant further discussion and examination, empirically and theoretically: reproduction and impacts of family separation; place and spaces of drug consumption; and harm reduction as everyday practice. The theoretical underpinnings of their explanation draw from the concepts of enabling resources, symbolic power, symbolic capital, and symbolic violence, discussed in the Theoretical Background chapter.

Reproduction and Impacts of Family Separation

The story of how separating families creates the conditions for problematic drug use and harm remains largely untold. This research project set out to capture an understanding of the social context surrounding the injection of Ts and Rs in Winnipeg, and the findings point toward family separation as a central feature. These findings arise primarily from the experiences of non-custodial parents separated from their children through the combined impacts of the criminal justice and child protection systems; institutional concerns regarding drug use often facilitated these interactions. This area of findings is related more to the social location of people who use Ts and Rs, rather than the practice of injecting Ts and Rs. As such, this finding may apply to a wider population of people who use drugs and have been structurally positioned for family separation.

Family separation was a pervasive theme in this study as it spanned most thematic categories, including: social location, everyday institutional relations, habitus and everyday life, and drug use practices. There were 13 female participants in this study; 12 identified as Indigenous and 12 had children. All these women had their children in the custody of child protective services, except one who had her children in the care of family members without child protection involvement. Five of these women were wards of the child protection system in their youth. For those who were never wards of the state, most of these women were living without adult supervision outside of their family homes in their teenaged years, some as young as age 12. Four of these women reported spending time incarcerated. Most of the female participants discussed drugs and alcohol in the home as the reason for child protection involvement.

Half (12 of 23) of the male participants in this study had children – nine of whom identified as Indigenous. Seven of the 12 male participants with children were non-custodial

parents, six of 12 male participants with children had spent time incarcerated. Thus, the majority of the children of participants in this study had their family structures significantly impacted by the child protection and criminal justice systems. The synergistic work of these institutions is essential to consider in the arena of family separation, as well as other aspects of everyday life for participants in this research. It is imperative to position these findings in relation to the historic and policy context shaping family separation, and the state of the literature.

Policy environment. North American child welfare policies and practices are often culturally inappropriate due to the differing worldviews between Indigenous and non-Indigenous child rearing practices (Simard, 2009). Further, child protection policies tend to be premised on the “best interests of the child” doctrine, which has been interpreted largely to favour material conditions over environments that promote cultural continuity (Lynch, 2001; Star & Brilmayer, 2003). Although the last two decades have seen the creation of Indigenous child welfare agencies, these remain controlled and guided by the dominant protection paradigm (Simard, 2009), and the majority of child welfare workers in Canada are not Indigenous (Aboriginal Children in Care Working Group, 2015). Child protection policies tend to disproportionately impact women, primarily those who are racialized and living in poverty (Star & Brilmayer, 2003). For Indigenous communities, families, and parents, involuntary separation is often premised on discriminatory assumptions about Indigenous peoples, and particularly Indigenous women’s caretaking abilities (Star & Brilmayer, 2003; Simard, 2009). These mainstream systems of meaning can intersect with discriminatory assumptions about the abilities of people who use drugs and people who live in poverty, compounding the problem of family separation.

Supported by the Harper government (2006 through 2015), the RCMP Drug Endangered Children initiative involved various educational initiatives to raise concerns about the dangers of

illegal drug activity and their conflation with child abuse (Marshall, 2015). Their efforts resulted in the creation of a document entitled *Drug Endangered Children: Equating Child Abuse with Drug Activity* (RCMP, 2010). During this period, legislative amendments took place in provinces and territories across Canada that would enable wide discretion for child apprehension on the basis of illegal drug activity in the home. For instance, in 2006 in Manitoba, the following amendments were proposed to the *Child and Family Services Amendment Act (Drug Endangered Child)*:

17(b) the child has been or is being abused, or there is a substantial risk that the child will be abused, because the person who has the care, custody, control or charge of the child exposes the child to any other form of illegal drug activity. (Bill 215, 2006, para 2).

The drug-endangered child has become a powerful political discourse with several implicit assumptions, including that people who use drugs require regulation and surveillance, are unequipped to parent and are unable to recognize when their parenting skills are compromised, and that illegal drug use is inherently problematic. These assumptions play out in everyday lived experiences and material conditions for parents who use drugs and are under the scrutiny of child protection services.

Family separation literature. Across the world it tends to be the most disadvantaged children who are most likely to be taken into the custody of the state, with neglect driving the overrepresentation of these children's child welfare involvement (Aboriginal Children in Care Working Group, 2015; Milward, & Office of the Children's Advocate Manitoba, 2016; Sinha, Trocmé, Fallon, & MacLaurin, 2013). The high rate of apprehension of Indigenous children in Manitoba is primarily attributable to poor living conditions, such as poverty and lack of access to safe housing (Brownell et al., 2015; Milward, & Office of the Children's Advocate Manitoba,

2016). Children of parents who were taken into Indian residential schools have been found significantly more likely to be involved with child welfare system (Clarkson et al., 2015). In Canada, First Nations families are more highly overrepresented in child welfare than Métis or Inuit children (Blackstock, Prakash, Loxley, & Wien, 2005; Brownell et al., 2015; Sinha et al., 2013), and the rate of child welfare investigations among First Nations children is 2.6 times higher than for non-First Nations children (Sinha et al., 2013).

In a study by Trocmé, Knoke, and Blackstock (2004) that compared child welfare cases among Indigenous and non-Indigenous families, Indigenous family heads tended to be younger, more often single, more likely dependent on social assistance, and more likely living in unsafe housing. The authors also found Indigenous families involved with child welfare more likely to have child welfare cases opened for concerns about neglect. Alcohol abuse was cited in almost two-thirds of Indigenous child welfare cases, compared to 22% of non-Indigenous cases. Indigenous child welfare cases were also more likely than non-Indigenous cases to involve criminal activity, lack of social support, and drug use concerns. The authors conclude that the high rates of parents' own histories of childhood abuse, particularly in Indian residential schools, have undermined the capacity of the present generation of parents.

Sinha et al. (2013) found that First Nations child welfare investigations were more likely to arise from non-professional referrals than non-First Nations cases in Canada. The authors suggest that this is consistent with a situation in which First Nations family investigations are partially driven by limited access to family supports, creating greater reliance on and interaction with support services. Compared to non-First Nations child welfare investigations, a significantly higher proportion of First Nations cases involved caregiver concerns regarding alcohol and substance use, and lack of social supports (Sinha et al., 2013).

As neoliberal economic shifts have created the conditions for slower launch to independence, today's children from privileged homes live with their family units until approximately 25 years of age on average (Hulchanski, Campsie, Chau, Hwang, & Paradis, 2009). Youth aging out of child welfare services, who lack these familial supports, face particular challenges in housing and employment (Gaetz & Scott, 2012; McEwan-Morris and Schibler, 2006). Among Indigenous youth who use drugs, child welfare involvement has been found to be associated with increased odds of experiencing homelessness, sexual abuse, sex work, self-harm, mental illness, needle sharing, and overdose (Clarkson et al., 2015). Drug-related harms such as HIV infections and overdose have been found to be higher among Indigenous youth grappling with the intergenerational effects of family separation (Christian & Spittal, 2008). Further, a history of child protective service involvement in youth increases the likelihood of being under the surveillance of child protection services as an adult (Trocmé et al., 2004), suggesting a key mechanism for intergenerational child protection interference.

Taking children into “care” has not resulted in equitable health and social outcomes for children or mothers in Manitoba. Chartier et al. (2016) found that children taken in care into Manitoba are more likely to experience mental health disorders, including substance use disorder diagnoses. Manitoban children involved in the child protection system have poorer educational outcomes than children without child protection involvement, regardless of socioeconomic or disability status (Brownell et al., 2015). In the *Winnipeg Street Health Report* (Gessler, Maes, & Skelton, 2011), over 40% of respondents without stable housing reported a history of child welfare involvement.

Family separation experiences among parents who use substances. Many sources purport drugs and alcohol as the primary cause of child abuse and neglect (see for instance:

Barnard & McKeganey, 2004; National Center on Addiction and Substance Abuse, 1999; RCMP, 2010; Wells, 2009; Young, Gardner, & Dennis, 1998). Substance use has been found to be a central concern of child protection agencies in cases of childhood risk, neglect, and abuse (Kenny, Barrington, & Green, 2015). This discourse implicates the need to protect children from parents who use drugs. Similarly, there is an implied need for the regulation and surveillance of people who use drugs, as they are perceived to lack the capacity for caregiving. While there is a strong body of literature recognizing the problematic nature of family separation among racialized people living in poverty, only a handful of studies qualitatively explored the impact of child custody loss on parents who use drugs (Bennet, 2009; Kearney, Murphy & Rosenbaum, 1994; Kenny et al., 2015; Raskin, 1999; Wells, 2011). The complex interactions between drug use and parenthood have been found to be more fully apparent in ethnographic data than in surveys or quantitative, closed-answer research approaches (Kearney et al., 1994).

Kenny et al. (2015) identified trauma as a key impact of family separation/child-custody loss among women who use drugs in Toronto, Canada. Family separation was found to result in loss of identity as a parent, lost connections to and between children, and loss of cultural integrity borne in the family (Kenny et al., 2015). Child apprehension was found to derail women's power and agency and define them as socially illegitimate – not capable of anything. The suffering of non-custodial parents after child apprehension was perceived to be unacknowledged and legitimized in the eyes of child welfare, and suffering remained unresolved over long periods of time (Kenny et al., 2015). Women also perceived the child protection system as designed to isolate non-custodial parents, undermining opportunities for community and mutual support (Kenny et al., 2015). Finally, the aftermath of child custody loss is often compounded by socially destabilizing events, such as loss of home, income, intimate partner

violence, initiation of injection drug use, suicide attempts, transactional sex for income, and loss of caring for oneself emotionally and physically (Kenny et al., 2015; Star & Brilmayer, 2003).

Raskin (1992) explored maternal bereavement among substance using women in Chicago, U.S. who lost custody of their children. The author posited that women who lose child custody because of substance use experience the same bereavement mechanisms as women with other forms of perinatal loss (death, adoption). Kearney et al. (1994) interviewed mothers who used crack cocaine in the San Francisco Bay area, U.S. These participants highly valued motherhood, held firm standards for managing parenting and crack use, and often sought assistance from child protection when they found their maternal responsibilities unfulfilled. Strategies for mothering while using drugs included: separating children and drugs; budgeting; isolating; and giving up custody as a last resort (Kearney et al., 1994). In both the Raskin (1992) and Kearney et al. (1994) studies, after their children were apprehended, the mothers often increased drug use to cope with the impacts of child-custody loss.

Wells (2011) undertook a narrative analysis of maternal identity construction in the context of custody loss and regain. Maternal identity was found to be based on high cultural expectations of mothers as primary caregivers, placing children's needs first. These expectations prove very difficult to meet, resulting in feeling lost, exacerbated by the inability to master substance use. When custody is lost, this maternal identity is denied or suppressed to quell feelings of failure and worthlessness (Wells, 2011).

Bennett (2009) reports on the experiences of Indigenous women with the child welfare system in Manitoba, many of whom had children apprehended due to concerns about drug and alcohol use. Participants expressed fear of the child welfare system, which prevented access to

services desired, such as drug treatment. Specifically, accessing treatment was seen as risky as it may be used as an indicator of child neglect or abuse. Participants also expressed concerns about having their privacy and autonomy invaded through mandatory monitoring with drug and alcohol testing by child protection agencies (Bennett, 2009). Wall-Wieler et al. (2017) used administrative data from Manitoba to compare the health outcomes of mothers who had children taken into child protective custody with mothers who experienced the death of a child. In this study, mothers who lost custody of a child experienced significantly greater incidence of depression, anxiety, substance use, mental health visits to providers, and use of psychotropic medications than mothers who experienced the death of a child (Wall-Wieler et al., 2017).

Contributions from this research. There is a large body of literature on the socio-structural production of drug-related harms. Conditions for drug-related harms have been found to include: macro political or economic transition, unstable housing, cross-border trade and transport links, population movement and mixing, urban neighbourhood disadvantage, local drug use environments, the impact of peer groups, social capital, communities and neighbourhoods, racialized inequities, gender and sexuality, stigma and discrimination, laws and policing, and complex emergencies such as armed conflict and natural disasters (Briggs et al., 2009; Rhodes et al., 2003; Rhodes & Simic, 2005; Rhodes et al., 2005; Rhodes et al., 2006; Small, Rhodes, Wood, & Kerr, 2007). Significantly, family separation has not been widely recognized as a condition for drug-related harm in this body of literature. The nature of this condition is well articulated by Lynch (2001):

As the family disintegrates, so too the community – that 'meaningful space and touchstone for identity formation and personal network [which] depends on ... the lives and development of its youngest members' – disintegrates. The net effect, felt both by

those who are removed and those who remain, is a sense of instability, loss, confusion and abandonment. (p. 519)

Family separation emerged as a central theme and key finding in this research. Three aspects of family separation warrant further discussion: social location and the reproduction of family separation; family separation as a condition for drug-related harm; and everyday caretaking capacity.

Social location and the reproduction of family separation. There are a number of modalities through which family separation was reproduced intergenerationally among participants. Childhood experiences of family separation were structurally mediated by colonial practices. However, some participants, such as Tina Two, experienced and perceived separation as parental abandonment, resulting in resentment toward family: “*My mom now tries to get me to know her family now and I tell her ‘I don’t need to know them’ because where were they when I needed them?*” This affective/feeling state was observed to impact some participants’ willingness to re-connect with family, or parents they lost touch with as children, thus reproducing or solidifying family separation.

Many participants were wards of the child welfare system in their youth and the outcomes of this system, by way of poor educational attainment and lack of social support, predisposed them toward low income and employment opportunities. In everyday life, lack of access to income, housing, and other resources positioned participants for greater potential for neglectful environments, increased system dependency and visibility, and increased contact with sources of professional and non-professional referrals to child protection agencies. A history with the child protection system in childhood increased the likelihood of being under the surveillance of child protection in adulthood. Combined with early street involvement and illegal

drug use, this created the conditions for child protection and criminal justice system involvement – thereby reproducing conditions for family separation. Charles, Linda, Kendra, Tina Two, Jim, Chris, Mojo, B, and Crystal all shared their history of involvement with child protective services in their youth, and later their own children became involved in the child protection system. For participants like Charles, who was introduced to injection Ts and Rs by his foster family, the role of the child protection system was very evident in this reproduction.

Family separation as a condition for problematic drug use. For participants who had their children in the custody of child protection services, family separation was found to create affective and material conditions through which problematic drug use may evolve and drug harms may be experienced. For many participants who were non-custodial parents, drug use was expressed as a coping mechanism for pain, loss, anger, grief, shame, trauma, and feeling isolated and lost. As shared by Jupiter: *“I miss my children so much [crying]. So I use drugs to cope, yeah.”* Notably, many participants stated that their drug use became problematic or heavy immediately after apprehension, during a period where child protection surveillance is high in expectation that parents would stop using drugs. Participants shared initiation of injection drug use, problematic alcohol consumption, and engaging in more dangerous or illegal income generating practices in this post-apprehension period. Powerlessness in interactions with child protection services arose from initial investigations, custody loss, ongoing lack of visitation privileges, forms of regulation, unclear rules, and poor communication. Participants who were separated from their children due to criminal justice system involvement struggled with feelings of worthlessness and loss of identity, particularly for males, such as Chris, who felt an unmet masculinized responsibility to provide for their family. *“When my kids were young, the triplets, and I was in jail, I felt useless in there because I couldn’t support them.”*

Duff's (2010) concept of affective resources provides some theoretical space to view these impacts. The affective, or feeling states, produced by child-custody loss can limit the capacity or willingness to act toward one's own wellness. For instance, hope is considered an affective resource that has shown to motivate action toward personal wellness, as to be hopeful is to feel capable (Duff, 2010). Thus, the lack of affective resources (such as hope, trust, and belonging) may lead to a lack of will or capacity to act in positive self-interest. The affective and emotional demands of family separation, and the hegemonic conditions that mediate family separation for racialized women who use drugs, impedes the accumulation of affective resources and emotional capital. Where social and emotional capital is often drawn upon for coping with everyday conditions (Duff, 2010), a lack of social capital or social, material, and affective resources can leave non-custodial parents fewer coping resources outside of drug use.

Following loss of child custody, many participants found the unstructured days, boredom, loneliness, lack of routine, and lack of meaningful modes of engagement in everyday life amenable to problematic drug use. This was the experience for Patrick: *"I've got to fill up my day with appointments or got to get back into the gym and continue seeing my kids and that. I've just got to fill up my day. A lot of me using is out of boredom."* This experience was not limited to involuntarily separation. Others, such as Barbie, who voluntarily placed their children in the care of others found the immediate loss of child care created a susceptibility to problematic drug use due to unstructured days: *"Lonely ... and then it spiralled out of control."* Thus child loss creates not only painful affective conditions, but material conditions that potentiate problematic substance use.

Everyday caretaking capacity. Contrary to mainstream cultural representations of people who use drugs as chaotic agents of public disorder, participants demonstrated everyday acts of

caring for community and children. The caretaking capacity of participants arose from accounts of concealing and managing drug use while caregiving, recognizing the need for help, and nurturing community, family, and street family.

Regardless of child custody, participants shared how they attempted to separate drugs and children. Drug paraphernalia were generally concealed from children and substances were generally consumed in the absence of children; being around children, in turn, discouraged substance use. Parent participants who used drugs described strategies and capacity to care for children, and the capacity to recognize when caring was compromised by problematic drug use. For instance, Tina Two called upon child protection services to request support and showed them her track marks to convince them that she was injecting. *“I told him [CFS worker], and he didn’t believe us because we hid it so well. I had to show them my arms and stuff [track marks]. ‘Here, I’m a junkie.’ So then they were like ‘holy.’”* This challenges a mainstream cultural belief that people who use drugs require regulation and surveillance because they are unable to recognize when they require assistance to care for their children. Participants recounted intentionally seeking support from child welfare when they recognized the caretaking demands of children were beyond their means.

Everyday life for participants, particularly non-custodial parents, was characterized by acts of caring for community. Some participants intentionally spent time around extended family, including grandchildren, to avoid using substances. This was the case for Carl: *“If I stay home or I go see my grandkids then I don’t do nothing [drugs or alcohol].”* For some, picking up needles discarded by others was generally motivated by concern over children in the community, whose curiosity may lead to needle stick injury.

Although child custody was lost for most participants, many belonged to large extended families of siblings, aunts, uncles, and cousins with whom close connections were retained. Several participants reported seeing or speaking to their siblings every day. Alicia was able to avoid child protection services by putting her children in the care of her sister, enabling the retention of family connections. *“My daughters stay with her [my sister] so I’m able to see them now.... If I want I take them out for lunch.”* At least three sets of siblings were interviewed as participants, referred by each other to the researcher. Thus, where ties were broken between generations, there were strong connections found across this generation of participants. This may be a function of limited social mobility among participants to move out of the geography and social scene of Winnipeg’s inner-city. At the same time, family connections arose as an important form of social capital, enabling social and material supports between siblings and extended family.

Many participants were involved in volunteering or acts of caregiving in their communities. *“Ma Mawi [Ma Mami Wi Chi Itata Centre], I used to volunteer there, and with my grandkids' school, I volunteered there. Just standing outside and watching out for the kids.”* Some expressed value in taking care of others or being a member of and caretaker to “street family.” Connections to street family tended to arise from loss of family connections. Caretaking and network building was central to street family involvement, and contributed to positive self-identities. Thus, for many participants, social resources were being reconstructed as building blocks to social capital – which can be leveraged to redress low affective, material, and social resources. Everyday enabling resources are explored further in the final key finding, “harm reduction as everyday practice.”

Historically and institutionally orchestrated family separation may be understood as acts of structural violence, resulting in an emotional habitus of social suffering. Emotional habitus, as an extension of Bourdieu’s concept of habitus, makes way for explaining a shared emotional field at the everyday level, or the unconscious backdrop of social interactions, structured by social forces (Gould, 2009; Scheer, 2012). Framing this social suffering as emotional habitus suggests that there is a range of response and resistance possible within this ever-changing field. However, social conditions common to a habitus-sharing group produce predispositions toward particular perceived possibilities, emotional responses, and coping strategies (Gould, 2009; Scheer, 2012). Within this set of possibilities arise social suffering related to family separation that may repress action and deplete coping resources, and family re-construction practices that build and maintain social networks of extended family and “street family.”

The discourse that substance-using parents require regulation and surveillance arises from assumptions about the lack of caregiving capacity of people who use drugs, and that drug use and parenting cannot be done safely together. In this way, the drug-endangered child ideology acts as a form of symbolic violence, exercised by professional and non-professional actors on women who use drugs by way of referring to child protection, instigating investigations and removing children from their homes. These forms of discrimination against people who use drugs intersect with other axes of power such as race, social class, and gender to reproduce inequality in everyday life.

Place and Spaces of Drug Consumption

This study examined the nature of the social and material environment(s) in which drugs are used, and how drug acquisition, preparation, consumption, and outcomes of drug use are

shaped by place and space. Participant perceptions and experiences were elicited regarding everyday spaces of drug use, favourable and unfavourable spaces, and the prospect of supervised consumption services in Winnipeg's core area.

Participants varied in their access to housing and indoor spaces for drug consumption. Sixteen had their own apartment, five lived in single-room occupancy hotels, one lived in partially owned property, and 14 had no stable housing. Among those without stable housing, some slept in shelters, some slept outdoors, and some stayed with friends (couch surfed). Those with access to their own residence generally injected drugs at home, as well as in other spaces, including outdoors at times. Those who had no access to housing used a variety of spaces, but more commonly injected drugs in outdoor or public spaces. According to participants, the most favourable qualities of drug consumption spaces include: lack of interference from law enforcement or other forms of drug prohibition, cleanliness, safety, privacy, and autonomy. Most stated that home would be the best place to use drugs, "*Home is number one*" (Chris), which is consistent with these values. These findings are important to position in the policy and practice contexts of homelessness, Housing First, outdoor injecting, private consumption spaces, and supervised consumption.

Homelessness and Housing First. The growth of mass homelessness in Canada coincided with shifts toward neoliberal policy and governance dating back to the 1980s, including divestment in social supports and public housing during a time of change in the economic climate (Gaetz, DeJ, Richter, & Redman, 2016). The current homelessness crisis is considerable, with over 200,000 Canadians each year experiencing homelessness and an estimated annual cost of approximately seven billion dollars between the health, justice, and social service systems (Goering et al., 2014). While efforts such as the *National Housing*

Strategy (Government of Canada, 2018) demonstrate some political will to deal with homelessness, redressing this crisis would require significantly increased investment and partnership across all levels of government and the private sector (Gaetz et al., 2016).

There is a growing diversity in the populations that experience homelessness. Among the 1500 people experiencing homelessness who were surveyed on April 17, 2018 as part of the Winnipeg Street Census 33.3% identified as women, 18.6% identified as part of the lesbian, gay, transgender, two-spirited, queer (LGBTQ) community, 24% were youth, and 80.2% identified as Indigenous (Winnipeg Street Census, 2018). In Winnipeg, the 2011 *Street Health Report* (Gessler et al., 2011) found that among the 300 unstably housed participants surveyed, only 7% injected drugs. Thus, competition for stable housing is vast, people who experience homelessness are diverse, and only a minority inject drugs. This contributes to some of the housing challenges experienced by PWID, and consequently contributes to outdoor and public injection practices.

Traditional housing approaches typically require people who use drugs to access treatment and attain a period of abstinence before they are eligible for housing, which has proven to be costly and ineffective (Goering et al., 2014). Housing First is a strategy arising from the Pathways to Housing project in New York in 1992, evidenced to redress homelessness by providing immediate access to permanent housing with wrap-around community supports, without housing readiness conditions (Goering et al., 2014; Tsemberis, 2010). Grounded in the principles of recovery, self-determination, and consumer choice, the Housing First approach aims to provide stability in basic needs as a starting point, regardless of where the person is at in terms of their substance use or mental health (Goering et al., 2014; Tsemberis, 2010). A five-year, multi-city Canadian study implementing Housing First demonstrated that it is an effective

and affordable program for helping people who use drugs maintain stable housing (Goering et al., 2014). Although Housing First is being supported federally through the Homelessness Partnering Strategy, Housing First options have not significantly expanded in Manitoba. Further, the Housing First model has been criticized for being less attentive to the unique needs of homeless women (Drabble & McInnes, 2017). Particularly, less contact with the shelter system and shorter episodes of homelessness renders women less likely to access and be eligible for Housing First programs (Drabble & McInnes, 2017).

Outdoor drug injection, private consumption spaces, and supervised consumption.

Outdoor or public injection drug use is an outcome of the combined effects of homelessness and drug prohibition, and has been associated with a range of health, social, and drug-related harms. Among youth in Vancouver, outdoor injection was found associated with rushed preparation and consumption, unsafely discarded needles, and injecting into uncleaned sites (Marshall, Kerr, Qi, Montaner & Wood, 2010). Frost and Taeko (2017) found public injection in New York City to be associated with lack of stable housing, needle sharing, history of witnessing and experiencing overdose, emergency department admission in the last year, and not having a primary care provider. Fear of arrest and overdose have been found to be primary concerns among who inject drugs in public (Dovey, Fitzgerald, & Choi, 2001; Frost & Taeko 2017; Parkin & Coomber, 2009a). Further, violence shapes the spaces of inner-city drug scenes, including gendered forms of violence differentially experienced among street-involved people (McNeil, Shannon, Shaver, Kerr, & Small, 2014).

Parkin and Coomber (2009b) qualitatively explored public injecting sites in South West England, and categorized public drug injecting sites as “controlled” or “uncontrolled” environments. Controlled environments were defined as spaces used by the general public and

are partially or permanently staffed, such as public toilets, parks, stairwells, and car parks.

Uncontrolled environments were spaces that were less structured and maintained, and included derelict buildings, doorways, streets, and alleys. Uncontrolled sites were more amenable to drug-related harms due to characteristics such as lack of sanitation and running water, poor lighting, poor surfaces for drug preparation, and less public traffic for assistance in case of an overdose or assault (Parkin & Coomber, 2009a, 2009b).

McNeil and Small (2014), who undertook a qualitative synthesis of safer environment interventions for PWID, defined interventions intended to “produce social, structural or physical settings that enable risk reduction or otherwise produce positive health outcomes among injection drug-using populations” (p. 152). The authors examined needle/syringe distribution, supervised consumption facilities, and peer-based harm reduction interventions. Environmental interventions were found to: mitigate drug-related harms; enhance access to material resources; provide refuge from street-based drug scenes; reduce stigma and structural violence; enable safer injecting; and foster trust that enhanced access to health care and ancillary services. However, the authors found that environmental interventions are primarily constrained by drug prohibition and law enforcement activities in the larger environments in which these interventions are enacted.

While there is interest from the public health and harm reduction sectors to make spaces used for drug consumption amenable to safer use, there are equal or greater efforts by public and private sector actors engaged in making public spaces unsuitable for injection drug use. Such policies and practices were explored by Parkin and Coomber (2009a, 2009b) in South West England, and included acts such as removing physical screens/barriers that provided privacy, community monitoring, and the installation of ultraviolet lighting in public washrooms to make

veins difficult to locate for injection. Parkin and Coomber (2009a) posited these policies and practices as expressions of symbolic violence by exacerbating drug harms and attempting to displace and remove PWID from public spaces.

Ouellet, Jimenez, Johnson, and Weibel (1991) explored the nature of “shooting galleries” in Chicago. The authors created a typology of three types of shooting galleries: cash galleries, taste galleries, and free galleries. Cash galleries were organized for profit, charged a fee for admission, had the highest attendee volumes, and the most explicit rules of conduct. Services such as access to sterile injection supplies, injection support, and overdose response resources were generally available in cash galleries. Taste galleries were governed by friendship or membership in a social network and a “taste” of one’s drugs was the price of admission. Taste galleries had less clear rules and inconsistent access to safer drug use resources compared to cash galleries. Some taste galleries were considered patriarchal in their gendered relations. Women may be expected to pay larger cuts of drugs and/or sex for access to the space. Women who required assistance with injection were found to frequent these “patriarchal taste galleries.” Finally, free galleries had no clear person in charge, no rules for admission or conduct, and the least safety resources. Free galleries tended to be in unclaimed spaces such as abandoned buildings or outdoor spaces where people would congregate to use drugs. This study reveals some of the intricate social and economic practices operating in drug consumption spaces.

The spaces of drug consumption are a growing frontier in environmental harm reduction by way of supervised consumption services (also called supervised injection sites, safer consumption services, or drug consumption rooms). Growing homelessness, urban development, gentrification, and drug prohibition have left drug using populations few spaces they can legitimately occupy. Supervised drug consumption services are facilities where people who use

drugs can prepare and consume their drugs (most often by injection) in supervised and hygienic conditions, where drug possession laws are not enforced (Hedrick, Kerr, & Dubois-Arber, 2010). The supervision is often provided by a professional health care provider, but may also be a person with experiential expertise in injection drug use (British Columbia Centre for Substance Abuse, 2017). These services have been shown to prevent morbidity and mortality associated with injection drug use, particularly in opioid markets (Fischer, Turnbull, Poland, & Haydon, 2004; Hedrick et al., 2010; Kazatchkine, Elliott, & MacPherson, 2016). The first sites were set up in European countries in the 1980s, and Canada's first site was established in Vancouver's Downtown Eastside in 2003 (Hedrick et al., 2010). Supervised consumption services have primarily been established in dense urban drug use settings in response to public health concerns arising from outdoor and public injection drug use (Fischer et al., 2004; Kazatchkine, et al., 2016).

In order to legally operate a supervised drug consumption service, possession of drugs must be decriminalized on the premises. In Canada this requires an exemption to section 56 of the *Controlled Drugs and Substances Act* by the federal Minister of Health (Kazatchkine et al., 2016). This has been a highly contested issue over the last decade, with the former Conservative federal government (2006-2015) denying a renewed exemption for Vancouver's safe injection site, InSite, in 2011, in the face of robust evidence of its benefits (Marshall, 2015; Small, 2012). This denial led to a Supreme Court ruling that deemed the denied exemption unconstitutional (Small, 2012). Following this, the Conservative government passed the controversial *Respect for Communities Act* (2013), which sets out extensive criteria required by an applicant requesting an exemption for the purpose of establishing a supervised drug consumption facility (Kazatchkine et al., 2016). With the Liberal Trudeau government coming into federal power in 2015, the policy

context has been changed and the burden on the supervised consumption exemption applicant has been relaxed. The legal activity around this issue brought supervised consumption services to the attention of local and national media, and may have contributed to participants raising the topic of supervised consumption services in interviews.

Fischer et al. (2004) offer one of the few critical analyses of supervised consumption services located in the published literature. The authors examined supervised injection services as sites of exclusion rather than inclusion, mapping the emergence of these services in the interests of urban development and public order – to purify public spaces or urban undesirables. The authors illustrate the operations of these facilities as projects of surveillance and discipline, premised on understandings of the drug user as an agent of risk that needs to be monitored and shaped into a responsible citizen. For instance, access to the service requires registration, supervision, education, and compliance with rules that promote public order, such as prohibition of dealing, littering, or aggressive behaviour inside and around the vicinity of the site (Fischer et al., 2004).

McNeil, Small, Lampkin, Shannon, and Kerr (2014) explored how banning assisted injection in supervised consumption facilities caused structural barriers to service. The prohibition of assisted injection is a major limitation of the clinical supervised consumption model. Those who are unable to inject themselves cannot use these services, and generally must procure injection through some form of resource exchange (e.g. exchange for drugs, money, sex), leaving the individual who requires assistance vulnerable to theft, assault, and unsafe injection practices (McNeil, Small, et al., 2014). This ‘no-assist’ policy is considered discriminatory toward people who are unable to self-administer injections, who are more often found to be women and people with disabilities (McNeil, Small, et al., 2014).

Finally, community-led supervised injection services have been described as community-led projects with clinical support (Livingston, 2017), as opposed to clinical models of supervised consumption with peer support. In Canada, the latter, community-based sites have emerged in Vancouver (Livingston, 2017; McNeil, Small, et al., 2014), exemplified in the Overdose Prevention Sites operating out of Vancouver’s Downtown Eastside, including sites provided by the Vancouver Area Network of Drug Users (VANDU) and the Portland Hotel Society (Vancouver Coastal Health, 2017). Within these sites, the social and power dynamics of traditional clinical models are disrupted; for instance, by having people who use drugs work as the overdose attendants, honouring experiential expertise over professional expertise (Livingston, 2017). Spatial arrangements have also been structured differently; for instance, with tables where service recipients may sit facing each other, rather than the clinical model of rows facing a wall, mirrored as to be visible to the attending clinicians (VANDU, 2017). These sites have shown promise for unsettling some of the professional power relations that can imbue professional supervised consumption services, and these sites have been able to reach people who would not attend professionally delivered services (Livingston, 2017; VANDU, 2017). However, the federal exemption process required to operate a legal supervised consumption service has requirements that force a clinical and professional driven model (Kazatchkine et al., 2016).

Contributions from this research. The findings of this research support drug prohibition as the primary force shaping the selection of spaces for drug consumption. Two key themes emerged in the exploration of drug consumption spaces: symbolic power, symbolic violence, and drug use spaces; and private community-based versus professional supervised consumption.

Symbolic power, symbolic violence, and drug use spaces. Generally speaking, Ts and Rs, due to their fairly extensive preparation requirements, are less amenable to outdoor and public injection drug use than other drugs discussed by participants. According to Bill, “*As far as doing the Ts and Rs, outside it’s pretty hard to.*” Most who reported regular outdoor injecting used other drugs (morphine or crystal meth) as their primary drug of injection. Outdoor injection spaces included parks, back alleys, urban industrial spaces, riverbanks, underground tunnels/malls, restrooms of health centres and shopping malls, and alcoves of industrial/manufacturing buildings not inhabited in the evenings. Most of these spaces were derelict, unkempt, and littered, as drug use was marginalized to the peripheral spaces that have not been claimed by dominant interests of urban Winnipeg development.

Participants described outdoor and public sites that were less amenable to safe use as dusty environments that lacked sanitation resources: running water, clean and stable drug preparation surfaces, and safe needle disposal options. These spaces were also vulnerable to disruption by police, community patrolling services (e.g. Downtown Biz patrol, a police endorsed safety initiative that provides community patrolling), business owners, and other community members. Two commonly frequented outdoor sites in back alleys were discussed and observed in this study, which participants referred to as “shooting galleries.” Better resourced indoor sites in hotel rooms or apartments where people congregated for injection were not referred to by participants as “shooting galleries.”

Participants feared the consequences of drug prohibition (e.g. getting caught or arrested, evicted, judged, discriminated against, or kicked out) over most other drug-related harms; thus, drug preparation and consumption practices within public and semi-public settings tended to be rushed at the expense of safety. For instance, “shakers” (injection of non-filtered, non-heated

substrate) were more commonly reported in public spaces; however, this may have been due to the larger proportion of people involved in outdoor injection using crystal meth, which is easier to prepare as a “shaker.” Participants were also more likely to report discarding their needles unsafely (outside of rigid containers) when using in public or outdoor spaces. Many participants had no other viable alternative to injecting in public spaces, so these compromises were accepted.

Drug prohibition is a system of meaning that acts as a complex form of symbolic power, able to take action outside of its legitimate enforcement. Fear of drug law enforcement was raised by participants as a primary concern and, even though this power exists by police legitimately, it is not often enforced by police officers according to the experiences of participants. Although fear of police and arrest was considerable, fear of disruption or discrimination in public space extended to those with arbitrary power, such as business owners, site caretakers, security, and community patrolling (e.g. Downtown Biz patrol). In this way, drug prohibition is such an effective symbolic power that it can be reproduced by arbitrary actors with no legitimate power, and does not need to be exercised by those with legitimate power in order to coerce, dominate, and oppress. In many ways, participants enacted drug prohibition power upon themselves by rushing injection practices when no actors were present to enforce it. Rushed injection in public spaces can be considered an element of habitus, as it becomes the way things are done when injecting in public spaces – even for Robin, who was more concerned with dust and dirt outside than police interruption. She described outdoor injection as a rushed practice. *“I just do it quick and then that’s it.”*

Symbolic violence arising from drug prohibition was also evident in drug paraphernalia and intoxication prohibition policies of shelters. Some shelters where participants stayed had

clear prohibition rules on drug paraphernalia inside the shelter, which forced drug use outdoors and limited availability of sterile injection supplies as they have to be procured daily. This was the case for Jupiter, who lived at the Salvation Army. Importantly, the main shelter used by unstably-housed participants, Main Street Project, did not have a prohibition policy and actually became a distributor of harm reduction/injection drug use supplies shortly after this study concluded. However, shelters, including Main Street Project, generally searched clients' belongings on entry for security reasons. Even if sterile needles were not prohibited, some participants were deterred from carrying them with the knowledge they would be exposed. This was the case for Lee. *“At the Project [Main Street Project] they went through my bag. ‘Oh, your needles, are you going to do a shot in here?’ I said ‘No.’ ‘They have to be in the package.’ So I just get a friend to carry them.”*

Private community-based versus professional supervised consumption. Having a space that could be shared with others for drug consumption was an important material and social resource. Control over such a space generally involved receipt of drugs or material goods/resources in exchange for access to it, and facilitated social network development. However, those who operated shared spaces needed to conceal practices from landlords/caretakers, as evidence of drug use may lead to eviction. According to Brian Two, *“That’s why I always look out the window.”* Sharing one’s space with others was accompanied by the responsibilities of social management of people using the space, maintaining injection drug supplies and rules, and continually monitoring for enforcement threat by police or landlord/caretaker. These private consumption spaces enabled a network of people to access other material and social resources for health, including safer drug use supplies, information on safer use, and assisted injection by experiential experts. These private, community-based

consumption sites represent an assemblage of enabling resources that may facilitate relations, reciprocity, exchange, and network connections that build social capital and enable health.

Professionally facilitated supervised drug consumption services were not available in the setting; however, private, community-based consumption sites and services were used by most participants, where the injection expertise was experiential rather than professional. These sites, including apartments and hotel rooms in the neighbourhood, were governed by regulations of capital or material resource exchange. Participants shared general regulations within these spaces, including: exclusive use of sterile supplies, no re-use, the expectation of the site operator to stock injection supplies, rules of reasonable conduct, and rules of exchange (generally, that the person who shares his/her space receives “second shot” or some remuneration). Participants who oversaw such sites explained safe injection practices in detail. The practice of exchanging drugs or commodities for use of a space deterred Gino and Celina from using in private, community-based spaces. However, exchange of material resources was extremely valuable to the recipient, and operation of these sites enabled the accumulation of social resources as building blocks toward social capital.

Notably, the social networks that were facilitated and maintained through these informal private, community-led drug consumption spaces were not universally accessible to community members. A number of participants were not well connected to these social and material resources, or welcomed into these spaces, and thus may have greater need for formal environmental interventions such as professional supervised consumption. It is also important to note that private, community-led consumption spaces are not presented here as innately enabling of health and wellness. The harm reducing or health promoting impacts of these resources are dependent on how they are used. Most participants involved in these spaces described them as

beneficial by way of being out of the reach of law enforcement, having material resources (running water, sterile injection supplies) for safer use, and even reducing stress. According to Day Late.

To have clean places to do them, clean and safe places to take them, that's the best thing for it. Then you do it and it doesn't cost you as much, you enjoy it more, it's done safer, no one gets hurt, and you're not using as much, either. It just makes your life so much more at ease, so you don't need to do as much, and you're not wasting as much as you know there's less pressure on you.

However, not everyone experienced these spaces as positive, even for the hosts. Tina and Bill shared only positive experiences sharing their space with others for consumption. Day Late and Cinnamon had negative experiences sharing their spaces, where the social management of their homes became unruly. Private, community-based consumption sites are enabling places in that they avail social, material, and affective resources for the reduction of drug-related harms. How these resources are deployed will determine their impacts on health.

The term “shooting gallery” is the primary expression used by health and community actors, institutions, media, and academics to describe settings in which people come together to inject drugs. This term is generally disparaging, is widely conflated with “high-risk” drug use behaviours in the literature (for instance, see: Celantano et al., 1991; Kimber & Dolin, 2007; Tobin, Davey-Rothwell & Latkin, 2010), and acts as a form of distinction between professionalized and private spaces of consumption. Private, community-led indoor spaces of drug consumption were not described as “shooting galleries” by participants, and positive characterizations were shared. Participants used the term “shooting gallery” only for outdoor

sites that were less resourced and organized. The power and problematics of language become apparent in this context as there is no positive, common term for a community-based place where people congregate to inject drugs safely.

Where professionalized consumption services are referred to as “supervised consumption sites” and private, community-based consumption sites are referred to as “shooting galleries,” this terminology can be understood as an expression of symbolic power, wielded by those able to distinguish and disparage PWID and the spaces in which drugs are consumed. Professional expertise is conflated with safety, while experiential expertise is only safe if delivered in a professionally sanctioned environment.

As discussed in Chapter 6, there were more participants who stated they would not use supervised consumption services than those who stated they would. Injection drug use was considered a private, stigmatized, and often intimate act that would be difficult to conduct publically. As Tina stated: *“That's like the guy standing there and taking his thing out. Same thing as shooting up in public. It's rude for other people.”* However, most were in support of the idea of the service and thought it would be helpful for others. Supervised consumption emerged in discussions as a symbolic gesture of inclusion and acceptance of PWID. According to Sam, *“That's what this city needs, this city needs acceptance.”* As supervised consumption services are spaces where drug possession is decriminalized, they can be understood to symbolically disrupt the dominant discourse of drug prohibition. Although supervised consumption services were valued symbolically, these services were seen to lack the privacy and autonomy of home or private, community-based sites. Privacy and concealment of injection drug use, and fear of enforcement, were significant features of everyday life for participants, primarily shaped by prohibition and stigma. Participants did not generally respond positively to the prospect of being

“supervised” publically during their injection by a health provider. Stigma, largely derived from drug prohibition, influenced participant perceptions of supervised consumption services. These findings constitute a preliminary discussion about these services in this setting, and are not intended to be generalizable or comprehensive in terms of consultation.

In summary, spaces of drug consumption were imbued by various forms of symbolic power arising from drug prohibition that shaped the availability and choice of spaces, the nature of spaces, the way spaces were talked about, and the practices within spaces. Significant resources for safer drug use spaces exist among the community but remain challenged in the context of drug prohibition and enforcement, and structural exclusion from material and social resources.

Harm Reduction as Everyday Practice

Everyday life for participants involved practices that maximized drug-related benefits and mitigated harms, although participants rarely described these practices as “harm reduction.” These acts served to mitigate harms for participants themselves, social network members, and the community at large, and included such practices as: the provision of information/education about safer drug use; private, community-based, supervised consumption services; reclaiming cultural identity; advocating with institutional agents; connecting with and reconstructing family; providing shelter/ place to crash, secondary injection supply distribution; responding to overdose; wound care; assisted injection; child-minding; picking up discarded needles; and alcohol or drug withdrawal management. These acts produced social and health benefits, and mitigated harms at the individual, network, and community levels. None of the participants in this study identified being part of formal drug user or peer organization or advisory councils for

harm reduction programs, and no participants referred to these acts as “harm reduction.” This key finding is elaborated upon by examining professional and community-based harm reduction discourse in order to position how the everyday harm reducing practices of people who use drugs may be understood and supported.

Professional versus community-based harm reduction. Professional harm reduction has been criticized for becoming depoliticized and sanitized of its activist roots with the institutionalization into public health systems (Rhodes, 2009; Roe, 2005; White, 2000). Underpinning these arguments are concerns regarding the professional focus on: “safer drug use” practices over harmful drug prohibition policies and inequitable social conditions; cost-effectiveness of harm reduction over the social justice imperative of harm reduction; regulation and control of urban undesirables; and the subordination of the expertise derived from lived experiences of people who use drugs (Fischer et al., 2004; Roe, 2005; Rhodes, 2009; White, 2000). Further, Roe (2005) notes a lack of recognition among health professionals of the harms that arise from health profession ideological systems about drugs and drug use. Even at the level of harm reduction service provision, the limitations of provider-client model are becoming increasingly recognized (Kerr et al., 2006).

Harm reduction has also been criticized for expressing neoliberal goals of regulating drug users, and failing to acknowledge the material constraints on the agency of people who use drugs (Moore & Fraser, 2006). Professional harm reduction that is focused on providing tools and information for safer drug use practices is consistent with the neoliberal goals of creating autonomous risk-managing citizens (Moore, 2009). Methadone maintenance treatment has received similar scrutiny as a means to regulate and neutralize drug use practices that are considered a risk to community (Quirion, 2003). As the health service arm in support of urban

public order, harm reduction has been accused of playing the “good cop” in drug user regulation (Rhodes, 2009). Moore and Fraser (2006) note a dilemma in this criticism, as recognizing people who use drugs as rational, autonomous citizens can be empowering.

The expert knowledge of people with lived experience, particularly people who use drugs, is highly recognized as an essential component of harm reduction (Canadian HIV/AIDS Legal Network, 2005; Non-Prescription Needle Use Initiative, 2007; Ti, Tzemis, & Buxton, 2012). Various terms are used in the literature to describe the involvement of experiential experts in health program and policy, such as “user involvement” (Patterson et al., 2009); most commonly, the term “peer” is used to describe people who use drugs/experiential experts who are engaged in harm reduction or drug policy services, programs, or policies (Wye, 2006). Despite wide recognition of its importance, very few published examples of meaningful peer engagement have been found in the literature (Ti et al., 2012). This dearth of published examples may be due to the difficulty in evaluating such involvement, or because publication is not a priority or particular skill set of peers (Ti et al., 2012).

Inclusion of peers in various levels of harm reduction programming has demonstrated various benefits, including: improved contact to existing services; the ability to change knowledge and drug use practices among their communities of peers; the ability to reach populations that institutional harm reduction services cannot; the ability to organize and engage politically; and benefits to peers themselves in terms of meaningful social inclusion and health outcomes (Faulkner-Gurstein, 2017; Greer, et al., 2016; Jozaghi et al., 2016; Jozaghi & Reid, 2014; Serovich, Brucker, & Kimberly, 2000; Small et al., 2012; Weeks et al., 2009; Wood et al., 2003). The Vancouver Area Network of Drug Users (VANDU), an organization of people who use drugs with over 1,000 members (McNeil, Small, et al., 2014; VANDU, 2017), is an example

of peer self-mobilization. VANDU has been able to provide care and support programs in response to the immediate needs of their community in ways that public health systems often cannot, and has been recognized for making a positive impact on the local drug use culture and practices by fostering social responsibility and caring amongst community members (Kerr et al., 2006).

Marshall, Dechman, Minichiello, Alcock, and Harris, (2015) undertook a systematic review of published and grey literature on roles of PWID in harm reduction programming, including barriers and facilitators to engagement. Roles for peers/experiential experts in harm reduction programming have included: education/training; direct services including supply distribution, support, counselling, and referrals; research support and engagement; advisory committee participation; and self-mobilization (Marshall et al., 2015). These authors used a typology to categorize peer involvement, and posited that drug user-run organizations, as a form of self-mobilization, represented the highest level of ownership and engagement of people who use drugs in harm reduction programming.

Drug prohibition and enforcement has been found to be the most significant barrier to peer engagement in harm reduction and drug policy issues (Marshall et al., 2015; Patterson et al., 2009; Ti et al., 2012). Other significant barriers to peer involvement include: power imbalances between professionals and peers; stigma related to drug use; lack of stable and adequate funding for peer remuneration and support; lack of engagement capacity among service providers; discrepancies between understandings of purpose and roles; and negative perceptions of the capacity of peers (Marshall et al., 2015; Patterson et al., 2009; Ti et al., 2012).

Harm reduction that occurs as a matter of everyday practice, outside of formal or semi-formal peer engagement, does not hold a strong position in the literature. Drawing from the concepts of enabling resources, social resources, and social capital provides a frame for explaining these everyday acts that produce benefits and reduce harms.

Contributions from this research. Harm reduction in terms of discourse, research, programming, and practice is a terrain of problematic power relations. The everyday practices of harm reduction emerged as a key finding in this research with three elements that require further discussion: discrepancy in perceptions of harm reduction; paradox and power in everyday harm reduction; and everyday enabling resources and social capital.

Discrepancy in perceptions of harm reduction. Participants experienced and perceived harm reduction programs and services as venues in which drug use supplies (such as sterile injection equipment) could be accessed anonymously for free. When participants were asked what types of things harm reduction programs could do differently, participants tended to suggest different types of material supplies that could be provided. Although the provision of sterile injection drug use equipment and other supplies is a fundamental feature of harm reduction services, harm reduction also recognizes structural drivers of drug-related harms, harmful drug policies, and the impact of stigma and criminalization (WRHA, 2016). The upstream structurally and politically engaged features of harm reduction were not recognized by participants as part of the work of harm reduction organizations.

This study did not explore the types of activities in which harm reduction programs were engaged. These findings do not suggest that peer or policy engagement were not occurring with local harm reduction organizations; rather, there lacks a common understanding between harm reduction programs and the populations they seek to serve in terms of the very essence of what

harm reduction is or ought to be. This presents an important missed opportunity for engagement between the situated knowledge keepers of everyday social conditions for drug-related harms, and programs that seek to understand and take action to improve these conditions.

Paradox and power in everyday harm reduction. Participants in this study were found to engage in everyday activities that promote health and mitigate drug-related harms. Everyday harm reduction arising from this research included practices of taking care, community building, and reclamation that enhanced participants' sense of belonging and purpose. This brings to light a paradox in the concept of harm reduction. If everyday practices of drug use are often construed as harmful, how may we simultaneously recognize everyday acts and knowledge of people who use drugs as the genesis of harms and harm reduction? This contradiction tends to arise from a few problematic features of the concept of harm reduction.

One significant problem with the concept of harm reduction is the predominant focus on harms at the expense of exploring and acknowledging benefits of drug use. Most people who use drugs report doing so in the pursuit of benefits, such as pleasure, coping, and recreation (Duff, 2015; Valentine & Fraser, 2008). In fact, being attentive to drug-related benefits has shown to open new spaces for discovery in research (Keane, 2008; Valentine & Fraser, 2008). Similarly, participants in this study sought to maximize drug-related benefits and described many more benefits than harms associated with their use, and did not refer to their daily practice of mitigating harms as "harm reduction." The term "harm reduction" was used by participants in reference to community health services such as needle/syringe distribution, but not everyday practices of navigating and mitigating harms. Thus, the language of harm reduction was not found to resonate with the everyday lives and practices of people who use drugs in this study.

A second and more significant problem with harm reduction is the symbolic power inherent in defining what the harms of drugs are. This refers to the ability to prioritize certain harms over others, and to name things as “harm” or “harm reduction.” This power lies primarily with the socially legitimate and powerful positions of public health systems and actors, who can use their symbolic power to subjugate everyday experiential knowledge. Navigating and managing one’s vulnerability to drug-related harms is an everyday lived experience for people who use drugs, which sets this experiential knowledge apart from the knowledge of service providers, who do not navigate these same harms personally. Bourdieu (1977) viewed everyday knowledge as largely unconscious, collective, practiced, and situated in contexts that are imbued by power relations. Drawing further from Foucault (1976), subjugated knowledge is described as a set of practical, localized, particular types of knowledge that have been hidden, oppressed and disqualified. Foucault (1976) stated: “it is through the re-appearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work” (p. 82). The concept of subjugated knowledge offers a way to understand and honour knowledge derived from the lived experience. However, this everyday knowledge amongst participants is vulnerable to subjugation through symbolic power.

One important example of symbolic power that operates in harm reduction is the power to determine the primary harms of drug use. In Canada, PHAC *I-Track* is the largest project of research and surveillance of PWID, with national samples of over 3000 (PHAC 2014a; 2014b). Injection as the route of consumption is centred due to concerns over transmission of HIV and hepatitis C as the primary harms of drug use. Further, *I-Track* is a behavioural surveillance of injection drug use with survey questions focused on needle lending and borrowing, sexual practices, numbers of sexual partners, and condom use, with limited or no links to harms shaped

by social and material environments or institutional practices (PHAC, 2006; 2014a; 2014b). Some of the social conditions that contribute to drug-related harms that arose in this research include; lack of access to meaningful modes of production and engagement, intergenerational and socially produced pain, and family separation that diminish peoples sense of belonging and purpose. Shared injection equipment and subsequent blood borne infections were not significant concerns among most participants.

The Thunderbird Partnership Foundation (2015) developed an Indigenous knowledge-based *Native Wellness Assessment* instrument that focuses on hope, meaning, belonging, and purpose as resources for health among people who use drugs. However, *I-Track* findings will inevitably point toward behavioural interventions such as education, blood-borne infection testing, and, at best (beyond individual behaviours), enhancing access to sterile injection supplies, condoms, testing, and treatment. Further, the PHAC community-action fund, which is intended to support community-based and peer-led projects, is available only to organizations that focus on addressing HIV and hepatitis C (Government of Canada, 2017). This creates difficulty for shifting power in harm reduction programming and intervention and privileges existing models that are aligned with nationally determined priorities.

Another example of symbolic power operating in harm reduction is the power to determine which practices constitute harm reduction. In fact, the very same act may be construed as either harm or harm reduction depending on how it is represented and by whom. Community-based alcohol maintenance as described by Celina involved checking in on members of her social network in the morning in order to provide a shot of hand-sanitizer (generally containing 70% ethanol) if someone was experiencing alcohol withdrawal symptoms. Some participants shared experiences of procuring hand sanitizer for consumption from health services. For Mojo,

this act had him banned from his care provider. Procuring hand sanitizer can be constructed as a story of street-involved people stealing from health services and drinking this very potent and harmful alcohol formulation. Conversely, this can be told as a story of clients using the resources they had available to prevent alcohol withdrawal (a potentially fatal health condition) among friends, in the absence of formal alcohol maintenance services. In this way, calling something harm reduction is an act of power with the capacity to oppress everyday practices and reproduce structures of inequality by preventing access to necessary resources.

Everyday enabling resources and social capital. The majority of community-based acts that enabled health involved the use of social resources. It may be helpful to return here to Bourdieu's concept of social capital. Social capital is the aggregate of social resources linked to a social network of shared capital (Bourdieu, 1986). The amount of social capital possessed depends on the size of network connections the individual can access and mobilize, and the amount and types of capital (symbolic, economic, cultural) possessed by network members that could collectively be harnessed (Bourdieu, 1986; Carpiano, 2006).

Empirically, participants had considerable access to social resources (trust, reciprocity, belonging) and network connections that could act as building blocks to social capital. Affective resources were sufficient to generate the will to take care of community, and participants demonstrated situated knowledge of daily harm navigation and reduction, as well as creative problem solving. What was lacking to build social capital, conceptually, was adequate collective, accumulated capital among the network members. Following this logic, community-based harm reduction would benefit most from resourcing network members with all forms of capital (e.g. economic, cultural, social, symbolic). This calls for the redistribution of other forms of resources, including power and influence. Further, these harm mitigating and benefit maximizing acts

cannot be professionalized as they are essentially enabled by membership within the network. The common health service practice of professionalizing community-based harm reduction does not appear the most logical approach, unless professionalization is accomplished in ways that add resources to the existing network, rather than resourcing professionals to appropriate these practices.

People's selection of mind-altering substances and practices of consumption were found to be based on an acceptable balance of harm versus benefit. In this way, harm reduction is always at play from the perspective of the individual. The use of Ts and Rs had health promoting qualities for many people interviewed. Ts and Rs were not found to be associated with overdose, poisoning, sleep deprivation, considerable drug expenditures, or other common drug-related harms. More importantly, from the perspective of many participants who regularly used Ts and Rs, these drugs had a moderating effect on cravings and compulsive drug and alcohol use. Carl, Kendra, Bill, Max, Kim, Robin, Charles, Jeff, and Tina Two all shared positive experiences with Ts and Rs due to their moderating "no chasing" effects. Thus, Ts and Rs were a material resource that enabled moderation over problematic drug use.

A number of material, affective, and social resources were present and leveraged in the everyday lives of participants, and used to build various forms of capital. Social resources such as bonds, connections, trust, belonging, reciprocity, and various forms of cooperation are the building blocks of social capital. Drawing upon social capital often helps people cope with everyday conditions (Duff, 2010). Where drugs may otherwise be used to serve coping purposes, social capital can replace some of this need, enabling the reduction of problematic drug use.

Summary of Discussion

The three key findings covered here represent the most robust findings in the exploration of the injection of Ts and R in Winnipeg. Family separation was highly structured by the external social, historical, economic, and political environment, and resulted in the depletion of social, material, and affective resources for many participants. The conditions created by family separation were found to be highly amenable to problematic drugs use. Spaces of drug consumption were significantly influenced by drug prohibition and enforcement, and within these spaces the material and social resources available tended to shape drug use practices and the conditions for harms. Access to an indoor space for drug consumption was a resource that enabled the accumulation of material resources and social capital and these informal sites were regulated by intricate social and economic practices.

While evidence and theory support meaningful engagement of peers or experiential experts in harm reduction programming, the informal harm reduction that exists in everyday practices comprise essential enabling resources in communities of people who use drugs. There were missed opportunities for collective action between community and harm reduction programs that may be arising from a failure of harm reduction programs to clearly translate the goals of their programs to populations they seek to serve and build alliances. Everyday acts of community and taking care constituted an important set of resources for producing a range of benefits and mitigating harms, and contributed to participants' sense of belonging, purpose, and meaningful contribution to community. These natural resources tend to be overlooked in professional harm reduction strategies. There is a tension in suggesting that institutions or professional harm reduction has a role in harnessing and bolstering these social, material, and

affective resources among networks of people who use drugs as institutions have historically contributed to the depletion of these resources.

This analysis has shed some light on the often hidden operations of power that shape the lives, conditions, and possibilities for people who use drugs. In exploring these three key findings, it was productive to stay true to the goal of focusing on power relations and everyday practice inherent in the application of Bourdieu's concepts. Paying attention to power has provided insight into how structure, policy, and environment may shape the distribution of drug-related harms across different populations, and how these are navigated in everyday life. Symbolic power was evident in most aspects of the findings discussed in this chapter, and can have important implications for policy, programs, and practice. Implications for action and ways forward are discussed in the following chapter.

Chapter 8: Conclusions

This research set out to explore the social context that surrounds and shapes human practices; specifically, the injection of Ts and Rs in Winnipeg. Relations of power, privilege, and oppression are centred in this exploration by drawing from Bourdieu's concepts of field, habitus, and capital. The combination of focusing on social context and centring relations of power leads to questions such as: Who has power? What types of power are operating? How is power wielded? Who gains and who loses? How are these power relations resisted and reproduced? What are the results for people in Winnipeg who inject Ts and Rs? These questions make space for a broader understanding of the source of drug-related harms, thereby shaping ways forward in research, policy, programming, and practice discussed in this final chapter. Relations of power also imbue this research project and there are valuable lessons learned from the limitations of this approach.

Ts and Rs emerged in this research as a declining trend, the demise of which is likely to result in people shifting to substances associated with a greater burden of harms. However, participants in this research project have navigated structural and symbolic violence and drug-related harms for decades, and have access to enabling resources to promote health and wellness in their community. Patriarchy, capitalism, and settler colonialism manifested in the construction of Canadian society, its institutional operations, and mainstream symbolic systems of meaning that impact daily life for people who use drugs. Systemic racism, neoliberal governance, drug prohibition, and medicalization are among the systemic manifestations that shape institutional dynamics and systems of meaning in contemporary society, playing out in social and material conditions at the local level. Out of this focused ethnography arose three key issues – family separation, spaces of drug consumption, and everyday practices of harm reduction – each with

implications for action. This final chapter describes limitations of this research project, and implications for research, policy, programming, and practice.

Limitations of the Research Project

Several limitations to this research project are important to acknowledge. First, the research product should be considered a partial, temporally specific, and positional co-construction of the social context, as analysis and interpretation are always problematic. The social context map was constructed by the researcher from accounts of lived experience, and is influenced by circumstances and experiences of the researcher and theoretical concepts applied in analysis. Social location differences and problematic power relations between the researcher and participants impact what participants share with a researcher, what the researcher can understand from participant interviews, and how the knowledge is analyzed, interpreted, and re-constructed through a Western worldview. Further, conversations and interviews with participants, and informal interviews that informed elements of the social context, are likely to have been shaped by a social desirability bias to some degree and are limited in that accounts were provided by self-report.

Similarly, a field, as the unit of analysis, has no clear boundaries and the researcher has great autonomy in deciding what to include and omit. There are elements of the field that were not included that warrant explanation. For one, there are a number of peer-reviewed publications that discuss Ts and Rs injection in Winnipeg, primarily drawn from a survey dataset collected in 2004-2005. These publications produce a form of discourse about Ts and Rs that arguably can be constitutive of the field and how people who inject Ts and Rs are understood. However, this academic knowledge was not included as part of the social context since the data were over 10

years old, and the publications would be known primarily by academics who did not have significant enough impact on the everyday lives of participants to arise in interviews. The voices and perspectives of institutional agents, local institutional policies and policy discourses, and non-injection drug using people were not included in the construction of this field, which accounts for sites of silence likely to be constitutive of the field itself and the lived experiences within. These voices were beyond the scope of this research.

Another limitation of the study was the seasonality of data collection phase. The study setting is characterized by extreme warm and cold seasonal temperatures, with summers as hot as 30 C and winters as cold as minus 30 C. Phase I data collection lasted from late October to late December of 2015, and phase II data collection took place in April and May of 2016, thereby missing the coldest and hottest months of the year, which are likely to shape many aspects of drug use practices, spaces of consumption, income generating practices, and access to resources. If interviews had taken place during the coldest or hottest months of the year, it is possible that other elements of daily life would have arisen in conversation. Further to temporal issues, drug use trends are dynamic, and thus cannot be captured adequately by studying them at any single point in time. Although the injection of Ts and Rs in Winnipeg had been captured in previous research, methods were too dissimilar to compare results meaningfully.

The injection of Ts and Rs was used as an entry point to reach a rather small group of experiential experts on urban injection drug use in Winnipeg, and situated knowledge about the field of study. Using the injection of Ts and Rs as an eligibility criterion arguably centred the drugs over the context in which they are consumed, and over the people who use them. Further, this method of recruitment may be construed to define participants by their drug use practices. This recruitment/eligibility strategy may not have been necessary as some deep insights on Ts

and Rs were provided by participants who did not use Ts and Rs, but were familiar with them, particularly in phase II of the project in which eligibility was not dependent on the use of Ts and Rs.

Further to recruitment, phase I and phase II processes sought diversity in the housing situations of participants in order to explore drug consumption spaces of a wider variety. However, these methods did not yield great participant diversity in terms of ability, race, non-binary gender, sexual orientation, or other important axes of social power and inclusion. While the data arising from ethnographic interviews were viewed through an intersectional lens, intersections of race, class, and gender were not readily apparent in the conversations. Much of the intersectional findings arose from comparing themes arising from interviews among participants of different gender or race categories.

The transferability or generalizability of the findings of this study is limited, and they should not be considered generalizable to other populations or people who inject Ts and Rs or people who inject other drugs in inner-city Winnipeg. Although qualitative research products are not intended to be generalizable to other drug use contexts, they potentially have generalizable principles that shape the conditions for drug-related harms and benefits that apply to other settings. The degree to which the findings may apply to other contexts will be decided upon by the reader, thus thick description of the context and robust participant quotes were provided in the written product.

The impetus for this research project did not arise from the research participants. Ideally, a study that seeks to understand social context and inform structural interventions to improve the conditions in which lives are lived would be generated from the lives of those concerned.

However, social disadvantage can create barriers to the collective organization of people toward causes, and there is no formal organization of PWID in the Main Street/Higgins Avenue area of Winnipeg with whom to engage for the purpose of research. However, this research project can open paths to enhance engagement with people who use drugs.

Finally, drawing from the sociology of Pierre Bourdieu focused the exploration and analysis on relations of power within the field. This perspective will inevitably draw focus away from other aspects of social context that can be meaningful to people who inject Ts and Rs. For instance, it has been acknowledged that Bourdieu did not provide robust conceptual tools for exploring affective and emotional resources. Similarly, many Western world views have a blind spot for spirituality.

Implications for Research, Policy, Programs, and Practice

Despite the limitations of this research project, there were important lessons learned, specifically related to the key findings of family separation, spaces of drug consumption, and everyday practices of harm reduction. These lessons are discussed in terms of implications for research, policy, programs, and practice.

Implications for research. A number of important issues arose from this study that would benefit from further focused exploration. Crystal methamphetamine use in Winnipeg arose as a significant issue in terms of scope of use and harms. Further exploration into this trend is necessary to better understand the social context that surrounds crystal meth use, the harms and benefits of use, and what types of services or resources people who use crystal meth would value. Similarly, this research project involved a nascent exploration into the applicability of supervised consumption services in Winnipeg, and the potential shape of such services. A robust

study on the applicability, feasibility, and acceptability of supervised consumption services in this setting is recommended, and arguably an ethical imperative to undertake. Similarly, exploration into other spatial interventions, such as those focused on homes/private residences, public restrooms, single-room occupancy settings, or outdoor spaces of drug consumption amenable to safer drug use would inform ways forward for local harm reduction, while building on extant resources in the community.

The impacts of family separation on drug use and the conditions for drug-related harms was an emergent theme in this research project. A study designed specifically to explore this issue would be poised to render greater insight and inform locally tailored interventions. Such a project should consider the impacts of criminal justice and child protection systems, and the insights of others involved in child care, including extended family, non-custodial parents, and child protection agents. Indigenous leadership in such an exploration would be necessary in order to have an appropriate lens on all aspects of the research.

Exploring drug-related benefits was key to opening areas of conversation around drug use practices. Two distinct advantages arose from discussing drug-related benefits. First, as people take drugs to experience benefits, interventions to support the health of people who use drugs often aim to bring alternatives to drugs in the pursuit of these benefits, such as recreation. Such opportunities for learning are more likely to be overlooked if exploring only the harms of drug use. Second, what was considered beneficial was defined by the research participants, not the researcher. Thus, exploring drug-related benefits was a way of uncovering participant perceptions and values of social practices and outcomes.

The impact of stigma and symbolic violence against people who use drugs requires further exploration. This should include analysis of the production of oppressive systems of

meaning about drugs, how they become recognized as legitimate, and how they become ascribed at the local level. For instance, participants in this study described spaces where people congregate to inject drugs that could be defined as supervised consumption; however, all common terms for such spaces are derogatory (e.g. shooting gallery), unless they have been approved by health actors. Also of note from this study was the symbolic value of supervised consumption services for people who use drugs. The symbolic aspects of inclusion and acceptance inherent in harm reduction and supervised consumption services are largely unexplored, and may be implicated in shifts in public opinion about people who use drugs.

Duff (2004) suggests that there may be potential for harm reduction focusing on the benefits of moderation, such as the intensification or maintenance of pleasure from drug use. Prohibition laws benefit from a moral social consensus that drug use is deleterious, while this idea is increasingly disintegrating in modern society (Duff, 2004). In ancient Greek culture, moderation was viewed as beneficial in that it preserved the capacity to experience pleasure, whereas over-indulgence was seen to destroy the capacity for pleasure and lead to danger (Duff, 2004). Moderation arose as a value among participants in this study, as well as a result of the use of Ts and Rs for many. Further exploration into practices, environments, agents, or substances that facilitate moderate drug use may uncover situated knowledge of community-based harm reduction.

Constructing a map of the social context was a promising method for exploring a complex social system such as the injection of Ts and Rs in Winnipeg. This method could be used to incorporate a broad range of data into the social context map, including media coverage, policies and other institutional texts, and perspectives from a range of different stakeholders. It was helpful in this research project to locate the researcher and research project within the social

context map that was being constructed. This enhanced reflexivity helped to visualize the researcher's perspective, and acknowledged the potential impact of the research project on the field itself. This is consistent with modes of reflexivity promoted by Bourdieu (1990) that include: identifying the researcher's social location; identifying the researcher's location in the field of study; and analyzing the researcher's motivation to study the object (Bourdieu, 1990).

Finally, there are implications for research into the non-medical use of prescription drugs (NMUPD). Regardless of whether the research methods are quantitative or qualitative, it is important to define the terms being used, what is being measured, and how it is being measured. Various definitions, discourses, assumptions, and survey tools imbue the field of NMUPD research, making it difficult to pull useful conclusions from the literature. There is a need to work with people who use drugs to validate questions being used to scope NMUPD in order to produce better quality data. It is also important to broaden exploration into the social and material environments that shape NMUPD, such as gaps in health care services, self-treatment, and the practices of the pharmaceutical industry. Research that explores the scope, harms, benefits, and reasons people are involved in NMUPD provides a sound basis for understanding the types of interventions that may be helpful. Finally, in this research, focusing on power relations and situated knowledge of people who use drugs opened new spaces for discovery that can shape public health priorities.

Implications for policy. Psychoactive substance use is an enduring feature of human life. The vast majority of people who use psychoactive drugs do so without harming their health and experiencing social or functional difficulties (GCDP, 2016). Many use drugs to self-medicate physical or mental suffering, often derived from social processes (GCDP, 2016). While some psychoactive substances are legally recognized, others are criminalized, and people who use

illegal drugs have to rely on an unregulated market of products, and suffer the various symbolic and material harms of drug prohibition. Drug prohibition, in its many forms, is one of the most significant way that societies punish people who cause no harm to others (GCDP, 2014, 2016).

Decriminalizing drug possession for personal use is permitted under the international drug control system, and approximately 30 countries have done so (GCDP, 2016), although Canada has not. According to the UNODC (2008), the international drug control system has unintentionally resulted in the marginalization and moral stigmatization of users of illicit substances, record incarceration rates, and the subordination of public health to law enforcement approaches to problematic drug use. The greatest beneficiaries of the international drug control system are organized and unorganized drug traffickers who collect revenue from an illegal, lucrative, unregulated, and untaxed market (Nadelman, 1989). Despite powerful evidence developed over the last 30 years about health-focused interventions, policies around substance use are too often driven by stigma, morality, and bias against drugs and people who use drugs (International Network of People who use Drugs [INPUD], 2016; GCDP, 2016).

UNODC (2016) proposes a number of sustainable development goals to address global drug problems, which have applicability between and within nation states. A few of these goals are highlighted here for their relevance to the findings of this research project. First, in recognition that women affected by drug dependence and HIV are more stigmatized than men, and more likely to have suffered violence and abuse, it is important to achieve gender equality and empower all women and girls. A second relevant UNODC recommendation is to end poverty in all its forms and reduce inequality within and among countries. The brunt of drug-related harms is borne by people who are poor in relation to the societies in which they live, and most negative health consequences of drug use are considered preventable. Third, UNODC

(2016) recommends nation states promote peaceful and inclusive societies and provide access to justice for all. The TRCC (2015a) has specific calls to action across all Canadian institutions to redress the harms of Indian residential schools and advance reconciliation with Indigenous peoples in Canada, including honouring the rights set out in existing Treaties. Finally, UNODC calls on nation states to build effective, accountable, and inclusive institutions at all levels, including health, social services, criminal justice, child welfare, and education, as all are relevant to the reproduction of harms associated with drugs and the societal response to drugs.

Some societies have come to consider problematic drug use as a health issue, and have consequently moved away from criminalization and enforcement and re-invested in social integration, treatment, and harm reduction (GCDP, 2016). For instance, in 2001, Portugal decriminalized the possession of all drugs for personal use and redistributed resources that would have been expended in criminal justice on social programming, harm reduction, and addictions treatment (GCDP, 2016; Greenwald, 2009; Hughes & Stevens, 2007). The results have been extremely promising in terms of reducing the burden of drug-related harms, such as infectious disease transmission and drug-related deaths (Greenwald, 2009; Hughes & Stevens, 2007). While there remains debate in Portugal around the best means to deliver services and distribute resources under this model, there appears to be wide public support to maintain decriminalization (Greenwald, 2009).

Substance use is one of the most misunderstood topics within Canada today, and policy is only weakly informed by research (Constandriopoulos, Lemire, Denis, & Tremblay, 2010). Drug prohibition, as the key response to drug use in Canada, contributes to the discrimination and marginalization of drug users, creates generations of single parents and separated families, and promotes the idea of people who use drugs as undeserving of support. Moving toward a future of

fundamentally different drug policy could be supported through increased public dialogue about drugs, drug prohibition, and alternative models. New understandings can help citizens become effective, collaborative, and flexible leaders within their communities, better poised to work together to solve intractable problems such as those related to substance use.

Settler colonialism past and present creates social injustice, and therefore an inequitable burden of health and social harms among Indigenous peoples. Canada is far from realizing the rights of Indigenous peoples as defined in the UNDRIP (United Nations, 2008). Articles 23 and 24 of the UNDRIP declare the rights of Indigenous peoples to be actively involved in developing, determining, and delivering health, housing, and other economic or social programs that affect them, and the right to access traditional medicines and health practices. Health services in Winnipeg, Manitoba, are determined primarily by a non-Indigenous government and delivered by a settler-model health authority. While there is Indigenous representation and consultation in health care program development, the autonomy and control remains within the settler institutions in Winnipeg. Indigenous communities must have the jurisdiction, legal responsibility, and financial resources to determine their own health priorities, policies, programs, and services.

The TRCC *Calls to Action* (2015a) for justice have specific implications by way of redressing over-incarceration of Indigenous peoples in Canada, involving all sectors of the criminal justice system. Culturally relevant services for prisoners on violence, substance use, and coping with histories of abuse are called for by the TRCC (2015a), and mandatory education on Indigenous rights, histories, treaties, cultural competency, and anti-racism for all criminal justice system actors is imperative. Substance use and drug prohibition play insidious and largely unexplored roles in the harms of the criminal justice system against Indigenous peoples, and

ought to be kept in view when exploring the high rates of criminal sanctions on Indigenous peoples.

Investments in public housing and supportive programs such as Housing First create important opportunities for enhancing social inclusion, autonomy, and support for people who use drugs. Drug use that occurs in the privacy of a home is protected from the immediate harms of community monitoring, policing, and other harms of public or outdoor use. More importantly, homes provide an autonomous space for safety and the pursuit of human goals. Access to a home should be considered a human right and not contingent upon abstinence from drugs.

Problematic drug use is most common in teenaged years through the early 20s, and most people involved in problematic use “age out” of this without need or assistance of formal health or addictions services (Heymang, 2013; Szalavitz, 2015). Aging out resources work by creating opportunities for meaningful or gainful engagement in society, and the demands of these opportunities become inconsistent with heavy or problematic substance use (McKenna, 2016). Natural or societal aging out resources generally include opportunities such as meaningful work, purpose, belonging, such as education, employment, relationships, or taking care of others. Thus, equitable economic and employment inclusion, caretaking of children, recreation, and creative development must be available in healthy societies. This research project demonstrates, in some ways, the outcomes of a society that fails to offer equitable opportunities to age out.

There are also implications for policies at the institutional level that can serve to mitigate harms. Drug intoxication and paraphernalia prohibition in housing and shelter facilities were implicated in this study as drivers of concealment and stigma, outdoor use, and difficulty accessing sterile injection supplies. Spaces of drug consumption such as public washrooms and other spaces where efforts may be taken to dissuade drug use have policy implications for harm

reduction advocacy. Harm reduction programs' focus on public health outcomes can work across sectors to reveal the impacts of institutional policies on drug-related harms, and offer ways forward in acknowledging the needs of people who use drugs and aiming to support non-problematic and safer drug use rather than abolition of drug use.

Implications for programs and practice. Working within the existing drug policy structure in Canada, there are many opportunities to mitigate the harms of the current system through innovations in programming and practice. Harm reduction, although strong in some sectors of the health institution, remains largely unrecognized and misunderstood. Moreover, the high levels of trauma experienced by participants, largely shaped by colonialism, point to the importance of preparing organizations and service providers to be trauma-informed and culturally safe. A more robust harm reduction, trauma-informed, and culturally safe framework within health systems can be facilitated by leadership and support at provincial and regional levels, champions at the local level, and meaningful involvement of people affected by drug-related harms. Within the TRCC calls to action for the health sector, addressing the unique needs of Indigenous peoples living off-reserve is integral, and making Indigenous healing practices accessible.

It is well established that drug-related harms are not evenly distributed across all populations, but tend to centre on structural disadvantage shaped by axes of race, social class, and gender (Rhodes, 2002; 2009). Accordingly, a more equitable distribution of social and material resources and power in society facilitates health equity (Varcoe, Pauly, & Laliberté, 2011), including a more equitable distribution of drug-related harms where they cannot be eliminated (Rhodes, 2002, 2009). Thus, professional harm reduction must stay focused on and act on the social causes of drug-related harms and the pursuit of social justice. Advocacy of this

nature by the public health sector is facilitated and constrained by a number of internal and external factors (Cohen & Marshall, 2016), and is likely to benefit from coalition and community engagement.

At the level of leadership within health institutions, position statements supporting harm reduction and a public health approach to drugs can be a form of organizational advocacy. Developing a well-articulated and evidence-informed position statement helps crystalize thinking and enhance conversation among health actors around the complex issue of substance use. Mobilizing a position statement through various levels of organizational leadership opens space for conversation about these complex issues that are not the everyday work of health leadership. Finally, formalizing a position statement at the organizational level provides a pre-vetted statement for media engagement opportunities, thereby influencing public perspectives. These opportunities allow health institutions to weigh in on policy decisions and conversations that profoundly affect health, and frame drug-related issues as health issues rather than issues of public disorder or criminality.

Large reputable health organizations are often trusted by the public, and can sway or legitimize public opinion. Nurses have a significant role to play in changing the policy, program, and practice conditions to improve the lives of people who use drugs. Nurses are a powerful body as the largest group of health professionals, with a number of national and regional bodies active in promoting harm reduction and a public health approach to drugs (see for instance, Canadian Nurses Association, 2017; Canadian Nurses Association, Canadian Association of Nurses in HIV/AIDS Care, and Harm Reduction Nurses Association, 2018).

The importance of community engagement with experiential experts, including people who use drugs, is widely recognized. Various levels of engagement are possible, but self-

organization by way of drug user organizations are considered the highest form of engagement (Marshall et al., 2015). Drug user organizations draw from existing enabling resources for wellbeing within communities, and can deliver programs and services that cannot be professionalized. Health institutions should invest in community organization and programming to enhance access to a broad range of expertise, community connections, create opportunities for meaningful engagement, and disrupt existing power relations in health and social services. Organizations should foster cultures that support the leadership and meaningful participation of people who use drugs in harm reduction initiatives (Marshall et al., 2015). Formal organization among people who use drugs appears to bolster activism and engagement in policy decisions, challenge stereotypical representations of people who use drugs, and engage with media (Kerr et al., 2006). Resourcing existing networks may enable this type of social capital to form and may, in turn, support the potential to challenge the power dynamics that shape drug prohibition.

It is necessary to identify, acknowledge, and challenge systems of power that operate within the discourse and practice of harm reduction. As discussed in Chapter 7, harm reduction program funding and research are often derived from programs and bodies that have predetermined the primary drug-related harms that programs are to redress, thus shaping the priorities for interventions and practices. Important ways forward in conceptualizing harm reduction have been offered by Indigenous leaders, such as the Native Youth Sexual Health Network (2014) *Four Fire Model* of harm reduction based on cultural safety, reclamation, self-determination, and sovereignty. The Manitoba Harm Reduction Network (2018) produced a *TRC Reading Guide for Non-Indigenous Organizations* that serves to help organizations and practitioners acknowledge and begin to dismantle systems of privilege and oppression and decolonize existing harm reduction practices. The Canadian HIV/AIDS Legal Network (2005)

Nothing About Us Without Us: Greater Meaningful Involvement of People Who Use Illegal Drugs provides harm reduction organizational guidance for collaboratively exploring and determining drug-related harms, and shaping policies, programs, and practices in response to those harms.

The systems of power that shape drug use are racialized, classed, and gendered, and the impacts are differential and intersectional. Naturally, the response to the harms that arise from these systems must be culturally safe and appropriate, and gender sensitive. Poole, Urquhart, and Talbot (2010) offer a framework for women-centred harm reduction focused on determinants of women's health in issues of violence and trauma, pregnancy and mothering, criminalized women, sex work, housing, and HIV/AIDS. Family separation related to substance use concerns is a significant issue arising from this research. Position or policy statements on maintaining family unity, coupled with cultural safety and harm reduction training, should be an organizational imperative for programs involved in healthy parenting and early childhood development.

The TRCC (2015a) puts forward a number of calls to action that serve to redress the highly problematic situation of family separation among Indigenous communities, with implications for resources, training, standards, and transparency. Among these calls to action is the need for adequate resourcing of child-welfare organizations and Indigenous communities to keep families together, and where the safety of children requires placement, to do so in safe and culturally appropriate environments. There is significant Indigenous community-based leadership to address family separation in the research study setting. For instance, Fearless R2W (fearlessr2w.wordpress.com) is a volunteer group of community helpers and parents who want to provide opportunities for learning about child welfare in Manitoba. This initiative arose in the R2W postal code area, comprising a significant proportion of Winnipeg's North End where this

research took place. Providing resources to support such community-led efforts would be consistent with the TRCC recommendations.

Some developments in programs have incorporated child welfare, parenting, and substance use. A promising practice in Australia, described by Fowler, Rossiter, Sherwood, and Day (2015), is a mothering program that incorporates substance rehabilitation and parenting support to: enhance maternal capacity and competence; provide mother and child-centred care; and managing child behaviour. The program seeks to facilitate a more accepting and realistic view of participants as mothers, and develop appropriate skills and confidence. In Winnipeg, the Mothering Project (Manito Ikwe Kagiikwe) is a promising community-based program that provides service to mothers impacted by substance use who are at greater risk of having their children apprehended by child welfare authorities (Mount Carmel Clinic, n.d.). There is growing evidence of family unity being supported and improved when child welfare and substance use services are integrated (Marsh, Smith, & Bruni, 2011).

An example of a promising practice, described by the Aboriginal Children in Care Working Group (2015), is the Jackson Lake land-based treatment program in the Yukon, a four-week residential program that provides after care and recovery programming grounded in First Nations teachings. The program works with families as well as children aging out of child welfare. Completion rates are high and success following treatment is measured in well-being, improved and lasting quality of family relationships, and parenting from a traditional perspective. The program focuses on intergenerational family separation and historical trauma as root causes of problematic drug use and creates opportunities for community and cultural connection, moving away from understanding addiction as individual pathology.

Service providers, harm reduction advocates, and researchers must support existing injection environments to enhance safety and develop new safer consumption environments where they are lacking. Where supervised consumption services often seek to move people from existing consumption sites to clinically operated sites, equal attention should be given to resourcing existing community-based consumption sites to enable safer practices, including home-based interventions, safer public restrooms, and outdoor interventions. Improved access to housing, including Housing First and gender sensitive housing programs and supports, are important spatial interventions that provide a foundation for more meaningful modes of engagement in society. Further, as supervised consumption services expand across Canada in settings more like the one in which this research took place, valuable lessons will be learned for the applicability of supervised consumption in less dense injection drug environments, and where stimulant drugs are predominant. As there are current efforts to deter and displace drug use in public spaces, such as ultraviolet lighting to make veins difficult to see, a counter movement to create safer spaces for people who use drugs is imperative.

Stigma is a significant problem contributing to everyday stress and harm among people who use drugs. Harm reduction as a way of practicing and working with people who use drugs is flourishing in parts of the health system, but remains subordinated across the health system as a whole. Carter and Graham (2013) suggest creating and implementing overdose and anti-stigma training for medical professionals and emergency service workers such as police, firefighters, and ambulance services. Harm reduction training for all health professionals may provide opportunities to disrupt ideological systems about drug use that are not grounded in evidence.

There is a dearth of evidence on population-based programs that effectively prevent problematic drug use. Drug use emerged in this research project for many participants as

something to do that relieves boredom and provides recreation. Where recreation is often the purview of the privileged, there have been notable successful programs that have focused on providing recreation for people who use drugs. In Winnipeg, the Solvent Users' Recreation Program out of Sunshine House has been successful in enhancing participants' quality of life and expanding formal and informal social supports (Health in Common, 2013).

The Iceland approach is one of the most promising models of social intervention to redress the conditions for drug-related harms. Iceland had among the world's highest rates of problematic alcohol use among youth in the early 1990s; over 40% of 15 and 16 year olds in Iceland reported getting drunk in the previous month (Young, 2017). In response, a large national state-funded Project Self-Discovery was launched with the intent of offering natural alternatives to drugs and crime, including music, dance, martial arts, art, and sports. The program is voluntary and is coupled with life-skills focused on improving self-image, positive social interaction, and changing parental social norms (Young, 2017). By 2016, rates of problematic drinking were down to 5%, although not likely attributable to this program alone (Young, 2017). This program is grounded in the wisdom that people do not abuse drugs, they abuse coping mechanisms.

The conditions for drug related harms are social and social problems cannot be cured with clinical methods. Social change is slow and can take decades to unfold. The Iceland prevention approach is a good example of a long-term primary prevention model with long-term impacts. In Canada, the PHAC Community Action Fund and Health Canada's Substance Use and Addictions Program offer project funding for a maximum of five years and are evaluated with clinical outcome indicators (Government of Canada, 2017). Although these funding opportunities are highly valued for immediate actions they are not well designed to support long

term social intervention. These approaches require multi-level commitment to incorporate the principles of primary prevention and social equity into the day to day operations of institutions.

Summary of Research and Ways Forward

Ethnographic methods were used in this research project to help locate a hidden population of individuals with situated knowledge about urban injection drug use in Winnipeg. This project attempted to capture and translate the voice of people who may otherwise be understood as deviant, and provide a highly contextualized account of human action. In doing so, connections between history, structure, environment, institutional dynamics, and drug use practices have emerged. Drawing from the sociology of Pierre Bourdieu, the research focused on the operations of power in the field, which helped to determine what to include and omit in a construction of the social context. Drug markets and trends change rapidly but the salient systems of power, oppression, and privilege that comprise the social context surrounding the injection of Ts and Rs in Winnipeg have been in place for many decades, and continue today.

A number of important ways forward were revealed. At the everyday level, hope, belonging, pleasure, responsibility, and autonomy emerged as things that matter. However, institutional services were not generally found to contribute toward these resources, and often diminish the ability for people who use drugs to accumulate them. Indigenous-led, culturally appropriate, and gender-sensitive harm reduction and addictions programming is an imperative. Creating opportunities to talk about drugs and parenting in open and honest ways is necessary. Engaging with and redistributing resources to Indigenous organizations and leaders to determine priorities, develop, and offer programs can help disrupt existing power relations within the health and social service institutions. Family separation among Indigenous families is one of the most

profound problems facing Manitoba, and the intersecting impacts of multiple institutions (criminal justice, child welfare, income assistance, health) must be considered. Further, the role of drugs and the societal response to drugs, grounded in prohibition, appears to be a major driver of family separation and, in turn, family separation is a profound condition for problematic drug use.

Significant harms arise from the symbolic and structural aspects of drug prohibition, which is shaped by settler colonialism, neoliberal governance, gendered power relations, and medicalization. Drug prohibition results in criminalization and lost opportunities, family separation, and stigma and shame, and forces people to navigate unsafe illegal drug markets every day. Disrupting the harms of drug prohibition is key to redressing conditions for drug-related harms. Health organizations can play a lead role by: engaging in drug policy conversations; fostering a culture of community engagement; staying focused on the upstream drivers of drug-related harms; and developing responsive, locally tailored, and community-informed harm reduction interventions grounded in the everyday lived experiences of people who use drugs. Finally, it is clear that policies, programs, and services developed to address issues of drug use are not meaningfully informed by people who use drugs. Health systems should implement and evaluate interventions to address individual, organizational, and systemic barriers to the involvement of people who use drugs in harm reduction initiatives.

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Appendix A: Demographic Questionnaire

Interview Participants (phase I and II)

Participant’s code number _____

1) In this study, participants will be identified by a pseudonym (fake name) of their own choosing in order to protect their privacy. What would you prefer to be called in this study?

2) Please tell me your age in years. _____

3) What do you identify as your gender? (male, female, transgendered, two-spirited)

4) What is your relationship status?

_____ Living with your partner (married or common law)

_____ Have a partner but not living with them

_____ Single

_____ Other (please explain) _____

5) How long have you been in a relationship with your current partner? _____ (years)

6) Do you have any children? ___ Yes ___ No

If yes how many children do you have? _____ Ages _____

7) What is your highest level of education?

_____ no schooling

Elementary school

___ Incomplete (highest grade completed)

___ Complete

Junior High School

___ Incomplete (highest grade completed)

___ Complete

High School

___ Incomplete (highest grade completed)

___ Complete

Vocational/Technical College

___ Incomplete

___ Complete

University

___ Incomplete

- Diploma
- Bachelor’s Degree
- Master’s Degree
- Doctorate

8) Were you born in Canada?

- Yes
- No

If No – How many years have you lived in Canada?

_____ Years

9) Which of the following best describes your population group?

- Arab/West Asian (Armenian, Egyptian, Iranian, etc)
- Asian (Chinese, Filipino, Japanese etc)
- South Asian (East Indian, Pakistani, Sri Lankan etc)
- Black (African, Haitian, Jamaican etc)
- Aboriginal
 - First Nations
 - Inuit
 - Métis
- Latin American
- White (Caucasian)
- Other (please specify) _____

(Statistics Canada, 2014)

10) Please tell me your sources of income:

- Paid employment (full time, part time, contract, casual)
- Income Assistance
- Unemployment insurance
- Pension or other government funding
- Money from family/friends
- Sex work/ prostitution
- Other

Illegal or Informal Sources

- Dealing/doing drug runs
- Stealing or boosting (selling stolen goods)
- Panhandling

___ Other

11) a) Where do you usually stay/sleep now?

- ___ My own place
- ___ house ___ apartment ___ single-room in hotel/rooming house
- ___ Girlfriend/boyfriend's place
- ___ Family/relative's place
- ___ Friend's place
- ___ Different place every night
- ___ Shelter
- ___ Outside/public place (e.g. Park; under bridge)
- ___ Other _____

b) Where did you stay/sleep last night?

- ___ My own place
- ___ Girlfriend/boyfriend's place
- ___ Family/relative
- ___ Friend's place
- ___ Shelter
- ___ Outside/public place
- ___ In jail
- ___ In drunk tank
- ___ Other _____

Appendix B: Interview Guide Phase I

Macro (explain line of questioning - people have different chances in life to become involved with different kinds of drugs - I would like to understand more about the background of people who come to use Ts and Rs)

Can you tell me about yourself, where you grew up, what that was like for you?

Where you live now, how you come to be living here?

Prompts: What should I know about who you are? Do you have people (friends or family) you are close to now?

How would you describe people who use Ts and Rs (in terms of social community)? Are there ways they would be or act different from people who use crack, or alcohol, or other drugs?

Meso: (the next set of questions are about your everyday life - where you go, what you do, places you like and don't like)

Can you take me through a typical day in your life, for example, where you sleep, wake up, eat, get money, and so on?

Prompts: Why do you use Ts and Rs instead of something else - what factors into that choice?

Anything else you use regularly to get high? Why that rather than something else?

About how many people do you know who use Ts and Rs?

What kind of places would you go during the day and who would you interact with? Does this change in different seasons or types of weather? How so?

What kind of services do you use? Why do you go there? Anything you wish existed?

What would be valuable to you?

Have are you treated at these places? Are there rules you have to follow? Is it different for men and women? How so?

How do Ts and Rs and/or other substances make their way into your average day? Do you find it easy to get Ts and Rs? And how about the supplies to prepare and use drugs?

What strength of pills do you usually get? Does this change? What is the price like?

Where would you go to prepare and use Talwin and Ritalin? What is available to you in that space? Does that space get disturbed by people? - tell me what that is like. Would you move often or use the same space regularly? How does this change in different seasons or types of weather? Is this different for men and women? How so?

If you are looking for a space to use drugs in, what do you look for?

Micro: (I'd like to ask about some details of drug use - how you get drugs ready to be used, the good things and bad things that drugs do - things that programs could do to support people)

How are Ts and Rs prepared and used. How often? Is this usually alone- or with other people (patterns of use, frequency - binging - breaks)? Is this different for men and women? How so?

What good things come from using Ts and Rs? What kind of things do you like doing when you've used them?

What do you think some of the harms are of using Ts and Rs or other drugs? (for example: problems with sleep, the cost of drugs, police bugging you or arrest, getting kicked out, relationship troubles, needle sharing and infections, having kids taken away because of drug use)

Prompts: Are there differences for men and women? How so? Can you tell me about some of the things you and other people do to avoid these harms (do people look out for each other - in what ways)? Are harm reduction programs helpful in addressing these harms? What could harm reduction programs do differently? How about addictions treatment programs? Housing? Are there differences between what men and women might need? What drug or substance (like tobacco or alcohol) do you think is the most harmful? Can you tell me about that?

Are there any other issues relating to the use of Ts and Rs that we should talk about?

Thanks very much for sharing with me.

Appendix C: Interview Guide Phase II

Macro (explain line of questioning - people have different chances in life to become involved with different kinds of drugs - I would like to understand more about your background)

Can you tell me about yourself, where you grew up, what that was like for you?

Where you live now, how did you come to be living here?

Prompts: What should I know about who you are? Do you have people (friends or family) you are close to now? How did substances/drugs make their way into your life? Why do you use that/those drugs instead of something else - what factors into that choice? Anything else you use regularly to get high?

Meso: (the next set of questions are about your everyday life - where you go, what you do, places you like and don't like)

Can you take me through a typical day in your life, for example, where you sleep, wake up, eat, get money, and so on?

Prompts: What kind of places would you go during the day and who would you interact with? How does this change in different seasons or types of weather?

What kind of services do you use? Why do you go there? Anything you wish existed? What would be valuable to you?

Have you felt like you were being judged or treated differently at any of these places? Are there rules you have to follow that you don't like? Is it different for men and women? How so?

How do substances/drugs make their way into your average day? Do you find it easy to get what you need? And how about the supplies to prepare and use drugs? What is the price like?

Where would you go to prepare and use drugs? What is available to you in that space? Does that space get disturbed by people? - tell me what that is like. Would you move often or use the same space regularly? How does this change in different seasons or types of weather? Is this different for men and women? How so?

If you are looking for a space to use drugs in, what do you look for?

Micro: (I'd like to ask about some details of drug use - how you get drugs ready to be used, the good things and bad things that drugs do - things that programs could do to support people)

How are your drugs prepared and used. How often? Is this usually alone- or with other people (patterns of use, frequency - binging - breaks)? Is this different for men and women? How so?

What good things come from using drugs? What kind of things do you like doing when you've used them?

What do you think some of the harms are of using drugs? (for example: problems with sleep, the cost of drugs, police bugging you or arrest, getting kicked out, relationship troubles, needle sharing and infections, having kids taken away because of drug use)

Prompts: Are harm reduction programs helpful in addressing these harms? What could harm reduction programs do differently? How about addictions treatment programs? Housing? Are there differences between what men and women might need? What drug or substance (like tobacco or alcohol) do you think is the most harmful? Can you tell me about that? Can you tell me what you think about a safe/supervised injection site or service like they have in Vancouver? Would you go there? Why or why not?

Are there any other issues relating to the use of injection drugs and spaces that drugs are used in that we should talk about?

Appendix D: Script and Handbill to Inform Potential Participants

Phase I: Street Connections Program, Winnipeg Regional Health Authority

Research Project Title: A Micro to Macro Construction of Talwin and Ritalin Injection in Winnipeg

Script for approaching service providers at Street Connections:

The intravenous use of Ts and Rs is particularly prevalent in the Prairie Provinces of Canada yet little is known about it. This study will explore the nature of intravenous Talwin and Ritalin (Ts and Rs) use in Winnipeg and the lived experiences of people who use these drugs. Study findings will be used to support improvements to services used by people who inject Ts and Rs.

Your program has been selected as a site to recruit potential study participants because the program has regular contact and is trusted by people who inject drugs. This trust leads to open and honest communication about drug use during service provision enabling potential study participants to be identified.

This information is intended to assist you in providing information about the study to potential participants.

Inclusion criteria. The following criteria will be used in recruiting participants: people who report injecting with Talwin and Ritalin or Ritalin only in the last six months, over the age of 18 and able to provide informed consent.

Exclusion criteria. Exclusion criteria will include: if client is unable to provide informed consent. If temporarily unable, the interview will be rescheduled.

Script for use in approaching potential participants.

A nurse in the PhD program at the University of Manitoba is conducting a study to understand more about the use of Ritalin and Talwin/Ritalin by injection. This study is trying to find out why the use of Ritalin and Talwin/Ritalin by injection is particularly common in Western Canada, and if there are specific needs that people who use these drugs have that can be supported. The study involves an interview with the researcher that will be like a conversation, and the interview will be recorded. The interview will take 30-60 minutes, and participants will be provided at \$25 gift certificate for SuperStore/No Frills for their time.

If you think you may be interested I can provide you with the phone number for the researcher and you can contact her to find out more.

[OR]

If you think you may be interested, the researcher is here today and she can tell more about what is involved.

Your participation in this study is completely voluntary. You don't have to make a decision about participating in the study until you receive more information, and if you decide not to participate, your service will not be affected in any way.

The researcher, Shelley Marshall, will arrange to meet with you.

This study has been approved by the University of Manitoba Education/Nursing Research Ethics Board; any concerns can be directed to the Human Ethics Secretariat at _____ or

Thank you so much for assistance in recruiting participants for this study. Your efforts are greatly appreciated.

Handbill Phase I



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A nurse in a PhD program at the University of Manitoba is doing research on the experiences of people in Winnipeg who inject Talwin and Ritalin (Ts and Rs). The study involves a private interview of 45-75 minutes. A \$25 gift card will be given to thank participants.

If you have injected Ts and Rs or Ritalin alone in the last 6 months and over 18 years old, feel free to call or text Shelley

Marshall at _____ to find out more.

Phase II: Main Street Project

Research Project Title: A Micro to Macro Construction of Talwin and Ritalin Injection in Winnipeg

Script for explaining study to service providers at Main Street Project:

I am a nurse in a PhD program at the University of Manitoba doing research on inner city injection drug use, and the intravenous use of Talwin and Ritalin (Ts and Rs). I have interviewed quite a number of people so far, and the spaces in which drugs are consumed has arisen as a very important theme to explore further. These spaces include private residences, public spaces like washrooms and outdoor spaces, and perspectives on a supervised consumption site. Since most of the people I have interviewed so far have had housing – the missing voice of people who inject drugs and are unhoused is a significant hole in the data. For that reason, I will be trying to recruit about 5-12 unhoused people who inject drugs by posting handbills in Main Street Project, and recruiting people myself through direct outreach.

I would like staff to know about the study, but in order to avoid people who sleep at Main Street Project from feeling pressured to participate, I am not requesting that staff help recruit participants. However, if you are asked about the study there will be handbills throughout the facility and at the main desk

Inclusion criteria. People who report injecting any drugs in the last six months, have no permanent housing, are over the age of 18, and able to provide informed consent are eligible.

Exclusion criteria. People will be excluded if unable to provide informed consent. If temporarily unable (under the influence of intoxicating substances), the interview will be rescheduled.

The study involves a private interview of about an hour. An honorarium of \$25 cash will be given to thank participants. Participation in this study is completely voluntary and confidential.

This study has been approved by the University of Manitoba Education/Nursing Research Ethics Board; If you have any concerns or complaints about this project you may contact the Human Ethics Coordinator at _____, or by e-mail at _____.

Handbill Phase 2

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A nurse in a PhD program at the University of Manitoba is doing research on the experiences of people who inject drugs and have no fixed address. The study involves a private interview of 45-75 minutes. An honorarium of \$25 cash will be given to thank participants. Participation is voluntary, confidential, and kept private.

If you have no permanent address, have injected any drug in the last

6 months and are over 18 years old, feel free to call or text Shelley

Marshall at _____ to find out more or to participate.

Appendix E: Table 2. Self-Identified Participant Characteristics

Table 2

Self-Identified Participant Characteristics

Category	Phase I (n)	Phase II: (n)	Total (n)
<u>Gender</u>			
Female	10	3	13
Male	14	9	23
<u>Ethnicity</u>			
First Nations	12	11	23
Métis	2	-	2
Caucasian	8	-	8
First Nations and Caucasian	1	-	1
First Nations and African	1	-	1
First Nations and Métis		1	1
<u>Age Group</u>			
Age 20-29	1	1	2
Age 30-39	12	5	17
Age 40-49	8	5	14
Age 50-59	1	1	2
Age 60-69	2	-	2
<u>Housing Situation</u>			
Lives in in own apartment	16		16
Single-room occupancy hotel/rooming house	5		5
Stays at friend or family's	1	5	6
Stays in shelter	1	3	4

Sleeps outside		4	4
Owens home (in part)	1		1
<u>Education</u>			
Completed Grade 12	6	4	10
<u>Main Income Source</u>			
Income assistance	20	6	26
Pension	2		2
Unemployment insurance	1	1	2
Employed (casual or odd jobs)		3	3
No income	1	1	2
Only illegal income		1	1
<u>History of Incarceration</u>	8	7	15
<u>Main Drug Used</u>			
Ts and Rs	12	5	17
Morphine	4	2	6
Crystal meth	3	2	5
Crack cocaine	2	1	3
Other (Percocet, Dexedrine, solvent, alcohol)	3	2	5
Polysubstance use reported	17	9	26



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Appendix F: Consent Forms

College of Nursing

Helen Glass Centre for Nursing
Winnipeg, Manitoba
Canada R3T 2N2
Telephone: (204) 474-7452
Fax: (204) 474-7682

RESEARCH SUBJECT INFORMATION AND CONSENT FORM: PHASE I

Research Project Title: A Micro to Macro Construction of Talwin and Ritalin Injection in Winnipeg

Researcher/Principal Investigator: Shelley G. Marshall, RN, PhD(C), College of Nursing, University of Manitoba, 89 Curry Place, Winnipeg, MB, R3T 2N2
Phone: _____ Email: _____

PhD Advisor: Dr. Benita Cohen, Associate Professor, RN, PhD, College of Nursing, University of Manitoba, 89 Curry Place, Winnipeg, MB, R3T 2N2 Phone _____ Email: _____

Funding Agency: Manitoba Center for Nursing and Health Research — Graduate Student Research Grant.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information. Regardless of whether you accept or decline to participate in this study, confidentiality will be maintained.

Purpose of the Study:

This study is being conducted by a Shelley Marshall, a graduate student at the College of Nursing, University of Manitoba, as a dissertation project to meet the requirements of her doctoral program. The purpose of the study is to understand more about the experiences of people who use Ritalin, or Talwin and Ritalin (Ts and Rs) by injection in Winnipeg, and how the social setting that people live in may shape the way drugs are used. The information gathered will be used better understand some of the other challenges people face as they interact with different types of services and organizations, and to inform harm reduction, drug treatment, or other programs and services that may be valuable to people.

Who can participate in the study?

Eligibility criteria will include:

- Self-reported injection of Talwin and Ritalin or Ritalin alone in the last six months
- Over the age of 18
- Able to provide informed consent.

Exclusion criteria will include:

- Inability to consent as under the influence of intoxicating substances, or otherwise deemed unable to comprehend the potential risks and benefits of study participation (if temporarily unable to consent, interview can be rescheduled).

Participants will be recruited mainly through a needle exchange program, however there many people who meet the eligibility criteria who do not access needle exchange programs. For this reason, you may be asked by the researcher (Shelley Marshall) if you would be willing to provide a few handbills to people you know who meet this eligibility criteria. This is entirely optional and in no way impacts your care or participation in the study.

Procedures:

Your participation in this study is welcomed. You are being asked to participate in an interview (of approximately 45 to 75 minutes in duration). The interview consists of some general questions about who you are, what your daily life is like, and how your drug use is shaped by these everyday experiences. All interviews will be conducted by the researcher, Shelley Marshall.

Confidentiality:

With your permission, the interview will be audio recorded (otherwise notes will be taken). What is said will be held in strictest confidence. Only the researcher (Shelley Marshall) and the person who transcribes the interviews will have access to what you say. Both have signed a confidentiality agreement confirming that they will respect your confidentiality. There is *one exception* to confidentiality: if there is a disclosure of abuse involving a child then the researcher is legally obligated to report it to the authorities.

Confidentiality will also be maintained in the treatment of the documents of this study. The digital audio recordings will be stored on a password-protected computer in Room 212 Helen Glass Center for Nursing at the University of Manitoba (the Manitoba Centre for Nursing and Health Research). The audio-recordings will be transcribed (typed out word-by-word) by a trained transcriptionist. Any personal identifiers will be removed during the transcription process, and each interview will be assigned a number. Once transcribed, the digital audio recordings will be erased. Information containing personal identifiers and (eg. this consent form) and research data will be stored in a secured storage cabinet located in Room 398 Helen Glass Center for Nursing at the University of Manitoba and destroyed as soon as it is no longer necessary for scientific purposes **or** audit (7 years, or until December 2022). Your identity will not be revealed in any reports of this study. If any statement you make during the interview is used in a research report it will be attributed to an anonymous source.

In sum, the researcher commits to safeguarding the information entrusted to her during the course of this study (except for any disclosure of abuse involving a child), and to not misuse it or wrongfully disclose it.

Risks and Benefits:

While there are no overt risks to participating in this study, talking about your experiences may create some discomfort or unease. The researcher, Shelley Marshall, can help you connect with appropriate health and/or social services (such as counselling) if that would be of interest to you. In terms of benefits, there may be some benefit to you in terms of having an opportunity to tell a concerned listener about personal experiences. You may also benefit if the findings of this research help to promote the needs and priorities of people who use Ritalin or Talwin/Ritalin by injection.

Compensation:

To acknowledge your contribution to this project, you will be given an honourarium in the form of a \$25.00 gift card for Superstore at the start of the interview meeting. (You will be asked to sign a receipt indicating that you have received the gift card.) The honourarium will be paid regardless of whether you decide to participate, to not answer certain questions, or to stop the interview part-way through.

Voluntary Participation and Withdrawal:

Your participation in this study is completely voluntary and your decision about whether or not to participate will not affect the care you receive in any way. You have the right to not answer any of the questions you are asked during the interview. You also have the right to request that the interview be stopped at any time. Once the interview is completed you still have the right to withdrawal from the study by contacting the researcher (Shelley Marshall) by phone, email, or in person, and ask that your interview not be included in the study. If you withdrawal after the interview, your data will be destroyed (paper data shredded and electronic data permanently deleted). However, this request would need to be made by December 31st, 2015 because after this time your information will have already been included in the study results and so withdrawal would not be possible after this date.

Dissemination:

The findings from this study will be presented at a final dissertation defense meeting attended by all members of the PhD advisory committee. This meeting is open to University of Manitoba faculty, staff, students as well as the general public. Findings from the study will also be presented to health care providers who work in harm reduction and addictions. The results will be shared through publication in academic journals (magazines) and presentations at conferences and workshops.

Feedback:

A summary of results of the study will be made available to participants (approximately March 2016).

Please initial here if you would like to receive a copy of this summary _____

Also, please provide a land or email address where the summary can be sent:

Some participants may be contacted again in 2-3 months for a follow up interview. In this second interview, the researcher may discuss some of the early study findings with you to see how they sound from your point of view, and if there are important things that have been overlooked or not discussed in the previous interview.

Would you be open to being contacted for a second interview? Yes_____ No____

If yes, what would be the best way to reach you? _____

Statement of Consent:

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

Participant’s Signature: _____ Date_____

Printed name of the above:_____

Researcher Signature:_____

Date_____

Printed name of the above:_____

This research study has been approved by the Education/Nursing Ethics Review Board at the University of Manitoba (ENREB Protocol #E2015:049). If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Secretariat at _____, or Email:_____ A copy of this consent form will be

given to you for your records and reference. A copy of this consent form has been given to you to keep for your records and reference.



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College of Nursing

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Fax: (204) 474-7682

RESEARCH SUBJECT INFORMATION AND CONSENT FORM: PHASE II

Research Project Title: A Micro to Macro Construction of Talwin and Ritalin Injection in Winnipeg

Researcher/Principal Investigator: Shelley G. Marshall, RN, PhD(C), College of Nursing, University of Manitoba, 89 Curry Place, Winnipeg, MB, R3T 2N2

Phone: _____ Email: _____

PhD Advisor : Dr. Benita Cohen, Associate Professor, RN, PhD, College of Nursing, University of Manitoba, 89 Curry Place, Winnipeg, MB, R3T 2N2 Phone _____ Email: _____

Funding Agency: Manitoba Center for Nursing and Health Research — Graduate Student Research Grant.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information. Regardless of whether you accept or decline to participate in this study, confidentiality will be maintained.

Purpose of the Study:

This study is being conducted by a Shelley Marshall, a graduate student at the College of Nursing, University of Manitoba, as a dissertation project to meet the requirements of her doctoral program. The purpose of the study is to understand more about the experiences of people who use Ritalin, or Talwin and Ritalin (Ts and Rs), and other drugs by injection in Winnipeg, and how the spaces that people live in and use drugs in can shape the way drugs are used. The information gathered will be used better understand some of the other challenges people face as they interact with different types of services and organizations, and to inform harm reduction, drug treatment, or other programs and services that may be valuable to people.

Who can participate in the study?**Eligibility criteria will include:**

- Self reported injection of any drug in the last six months
- Over the age of 18
- No fixed address/permanent residence
- Able to provide informed consent.

Exclusion criteria will include:

- Inability to consent as under the influence of intoxicating substances, or otherwise deemed unable to comprehend the potential risks and benefits of study participation (if temporarily unable to consent, interview can be rescheduled).

Procedures:

Your participation in this study is welcomed. You are being asked to participate in an interview (of approximately 45 to 75 minutes in duration). The interview consists of some general questions about who you are, what your daily life is like, and how your drug use is shaped by these everyday experiences. All interviews will be conducted by the researcher, Shelley Marshall.

Confidentiality:

With your permission, the interview will be audio recorded (otherwise notes will be taken). What is said will be held in strictest confidence. Only the researcher (Shelley Marshall) and the person who transcribes the interviews will have access to what you say. Both have signed a confidentiality agreement confirming that they will respect your confidentiality. There is *one exception* to confidentiality: if there is a disclosure of abuse involving a child then the researcher is legally obligated to report it to the authorities.

Confidentiality will also be maintained in the treatment of the documents of this study. The digital audio recordings will be stored on a password-protected computer in Room 268 Helen Glass Center for Nursing at the University of Manitoba. The audio-recordings will be transcribed (typed out word-by-word) by a trained transcriptionist. Any personal identifiers will be removed during the transcription process, and each interview will be assigned a number. Once transcribed, the digital audio recordings will be erased. Information containing personal identifiers and (eg. this consent form) and research data will be stored in a locked filing cabinet in a secured research office located in Room 398 Helen Glass Center for Nursing at the University of Manitoba and destroyed as soon as it is no longer necessary for scientific purposes or audit (7 years, or until December 2022). Your identity will not be revealed in any reports of this study. If any statement

you make during the interview is used in a research report it will be attributed to an anonymous source.

In sum, the researcher commits to safeguarding the information entrusted to her during the course of this study (save for the exception noted above regarding disclosure of abuse involving a child), and to not misuse it or wrongfully disclose it.

Risks and Benefits:

While there are no overt risks to participating in this study, talking about your experiences may create some discomfort or unease. The researcher, Shelley Marshall, can help you connect with appropriate health and/or social services (such as counselling) if that would be of interest to you. In terms of benefits, there may be some benefit to you in terms of having an opportunity to tell a concerned listener about personal experiences. You may also benefit if the findings of this research help to promote the needs and priorities of people who use Ritalin or Talwin/Ritalin by injection.

Compensation:

To acknowledge your contribution to this project, you will be given an honourarium in the form of \$25.00 cash at the start of the interview meeting. (You will be asked to sign a receipt indicating that you have received the money) The honourarium will be paid regardless of whether you decide to participate, to not answer certain questions, or to stop the interview part-way through. You will also be offered up to two bus tickets if you need to travel by bus to get to or from an interview.

Voluntary Participation and Withdrawal:

Your participation in this study is completely voluntary and your decision about whether or not to participate will not affect the care you receive in any way. You have the right to not answer any of the questions you are asked during the interview. You also have the right to request that the interview be stopped at any time. Once the interview is completed you still have the right to withdraw from the study by contacting the researcher (Shelley Marshall) or the PhD Advisor (Benita Cohen) by phone, email, or in person, and ask that your interview not be included in the study. If you withdraw after the interview, your data will be destroyed (paper data shredded and electronic data permanently deleted). However, this request would need to be made by June 30st, 2016 because after this time your information will have already been included in the study results and so withdrawal would not be possible after this date.

Feedback:

A summary of results of the study will be made available to participants (approximately **September 2016**).

Please initial here if you would like to receive a copy of this summary _____

How would you like me to get the study results to you?

Dissemination:

The findings from this study will be presented at a final dissertation defense meeting attended by all members of the PhD advisory committee. This meeting is open to University of Manitoba faculty, staff, students as well as the general public. Findings from the study will also be presented to health care providers who work in harm reduction and addictions. The results will be shared through publication in academic journals (magazines) and presentations at conferences and workshops.

Statement of Consent:

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

Participant’s Signature: _____ Date _____

Printed name of the above: _____

Researcher Signature: _____

Date _____

Printed name of the above: _____

This research study has been approved by the Education/Nursing Ethics Review Board at the University of Manitoba (ENREB Protocol #E2015:049). If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Coordinator at _____, or by e-mail at _____

Appendix G: Table 3. Coding Density

Table 3

<i>Coding Density</i>			
Category	Code	# Participants Referencing	# References
Social Location and Biographies	Sixties Scoop and Indian residential schools	6	11
	Early independence or street involvement	14	25
	Family separation	29	69
	Bad breaks	4	7
	Low access to employment, income, educational attainment	11	21
	Abuse, trauma, and loss	11	16
	Antecedents to injection drug use and/or use of Ts and Rs	18	25
	Characterizations of people who use Ts and Rs	8	10
Everyday Institutional Relations	Housing and shelter	17	49
	Child protection	13	26
	Community-based food services	8	11
	Criminal justice	20	56
	Health care	36	86
Drug Market Characteristics	Changes in the cocaine market and quality	6	9
	Growing prevalence of crystal meth	16	23
	Pharmaceutical drug market	9	22
	Declining supply and demand of Ts and	20	37

	Rs		
Habitus and Everyday Life	Income generating and exchange of capital and resources	10	25
	Social and environmental management	32	71
	Pervasiveness of drugs and alcohol in everyday life	13	23
	Experiencing harm, violence, or threat	5	8
	Spaces of drug consumption	18	60
Individual Drug Use Practices	Benefits	36	95
	Problematic use and harms	36	83
