

PEER-BASED OUTREACH WORKERS  
AS AGENTS OF SOCIAL COLLECTIVE CHANGE

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By

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## ABSTRACT

Place is not a static backdrop for social relationships; rather, it is a dynamic product of the interactions among the people, practices, objects, and representations contained within it. Often, street-involved people who use drugs are excluded from interactions that would otherwise allow them to participate in community dynamics. In Vancouver, British Columbia, peer-based outreach groups redress these barriers by providing low-threshold positions to individuals living with active or past addiction. The overall question of this thesis is: what is the role of place in the health of an individual and of a community? Objectives include: (1) applying existing models of social exclusion to outline barriers preventing Peer Members from engaging in placemaking; (2) mapping the ideological positionality of the Peer Members and the rest of the community with regard to citizenship; and (3) exploring how Peer Members utilize their biosocial role as outreach workers to establish social capital and situate themselves as participants in a healthy community. By providing a platform where various social identities can interact with one another, ties of familiarity are established between these groups, thus enabling the transfer of resources, knowledge, and shared norms of respect. The first half of the discussion focuses on how social and geographic displacement legitimizes the process of social abandonment. Consequently, this relegated the Peer Members and their peers into the role of anti-citizen, rationalized their marginalization, and reinforced the wider community's stigma toward people who use drugs. The latter half of the discussion illustrates how the Peer Members utilize their biosocial role of outreach and support workers to navigate boundaries and establish social connections to circulate knowledge and information within and among different social fields. This enabled the expression of mutual reciprocity, thereby negotiating the place of people who use drugs and harm reduction among the wider community. Place is therefore a concept that shapes, and is shaped by, the social networks that determine social legitimacy or illegitimacy. Although marginality and oppression cannot be transformed immediately, creating a social environment where Peer Members can be supported and support one another helps mitigate the marginalization that characterizes their lives.

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## LIST OF ABBREVIATIONS

AIDS Acquired immunodeficiency syndrome  
HCV Hepatitis C virus  
HIV Human immunodeficiency virus  
P2P Peer 2 Peer  
VANDU Vancouver Area Network of Drug Users  
VCH Vancouver Coastal Health

## CHAPTER 1 INTRODUCTION

Among people who use drugs, how do the displaced create place within the larger society? This process of establishing place – a cultural construct formed by a dense network of relationships – is known as “placemaking” (Sutton and Kemp 2010). Given that the health of a community is contingent on the presence of these dense social networks (Duhl 1986; Minkler 1989), this thesis attempts to answer the following question: how do socially excluded and geographically displaced drug users engage in placemaking? To answer this, I spent several months with a peer-based harm reduction outreach and support group located in Vancouver’s Grandview-Woodland community. In addition to observing how placemaking could manifest, it soon became clear that social networks play a dominant part in creating a role, and hence sense of place, for an individual within the larger community. Social networks allow for the transfer and exchange of goods, and enables community members to be responsive to one another’s needs. Ultimately, this creates a sense of social order among members of a community. Listed alongside other factors fundamental to health – including food security, proper sanitation, clean water, and clean air – (Fullilove 2006:176) one of the key characteristics of social order is that it promotes a collaborative form of problem solving. Essentially, social order is the interdependent set of relationships among people of different abilities, needs, and social identities. Social disorder, which affects and involves the entire community, fragments residents and overwhelms service providers within the community. Inevitably, such fragmentation develops new, or exacerbates existing social and health problems. Therefore, the central argument of this thesis is that peer-based outreach and support groups create a social role for people who use drugs, thereby enabling placemaking. This, in turn, creates a social order that extends throughout the community.

Globally, illicit drug use – which refers to certain substances listed under the Controlled Drugs and Substances Act (Department of Justice Canada 2012), including heroin, cocaine, cannabis, and synthetic substances – has long been a source and symptom of social disorder. In Canada, past research has shown that criminal activities serve as a main source of revenue for people who use drugs (Manzoni et al. 2007). Costs attributed to illegal drugs are approximately 8.2 billion dollars, representing 20.7 percent of the total costs of substance abuse. Breaking down the total cost, 4.7 billion dollars account for lost productivity due to illness and premature

death, 2.3 billion dollars for law enforcement costs and over 1.1 billion dollars in direct health care costs (Rehm et al. 2006). In 2002, 1695 Canadians died of illicit drug use, with the leading causes of death being overdose (958), suicide (295), hepatitis C (HCV) infection (165), and human immunodeficiency virus (HIV) infection (87) (Rehm et al. 2006).

Since 1997, Vancouver has been dubbed “the epicenter of one of North America’s most dire and longstanding illicit drug use epidemics” (Urban Health Research Initiative 2009:10). A staggering number of overdose deaths occurred on a near-daily basis and transmission rates of HIV and HCV among people who use drugs continued to rise. This created a state of panic among public health officials, compelling Robert Remis et al. (Urban Health Research Initiative 2009) to declare illicit drug use and its related harms “an urgent and growing threat to community and public health.” Despite this, the Canadian federal government’s management of this crisis left much to be desired in terms of creating an evidence-based response to the drug situation. In 2007, a new National Anti-Drug Strategy was released, in which the majority of resources intended to address illicit drug use were allocated to interventions that excluded harm reduction and prioritized increased law enforcement (Government of Canada 2007, accessed November 18, 2010). The focus on increased incarceration was questionable as there is currently little evidence of benefit and has been scientifically proven to result in net community harm as well as harm to public health (Canadian HIV/AIDS Legal Network 2007; DeBeck et al. 2006; Global Commission on Drug Policy 2012; International Centre for Science in Drug Policy 2010; Urban Health Research initiative 2009). Furthermore, in excluding evidence-based harm reduction programs from funding and support, this Strategy exacerbated the already-widening gap between overburdened service providers and the people accessing these services. In a community survey released in 2006, a number of service providers in the Grandview-Woodland community of Vancouver – the site where the research for this thesis was conducted – expressed concern over the lack of cooperation and reorganization among groups competing for funding. With the growing pressure of managing their caseloads, little to no time was available for networking (Strathcona Research Group 2006:41). Without the opportunity to collaborate, service providers remained unaware of other providers they could refer their clients to. “There’s a huge wait list,” said a worker. “Not many people even know we’re here, but if we advertised, it would be even worse... you can’t advertise what you can’t deliver” (Strathcona Research Group 2006:41). Consequently, the lack of organization and responsiveness among service

providers worsened an already disordered response to poverty and ill health among the homeless in Grandview-Woodland.

In response to the gap in services offered to people who use drugs, Vancouver has, over the past decade, witnessed a proliferation in the number of peer-based outreach and support groups, where people formerly or currently living with addiction organized services to support their street-involved “peers” – that is, other people who use drugs. Consequently, the solidarity, political activism, and advocacy of grassroots groups such as the Vancouver Area Network of Drug Users (VANDU) has been instrumental in raising awareness among health organizations about the expertise and potential role people who use drugs do and can play in minimizing the limitations of provider-client programs, HIV risk behaviours, as well as rates of overdose deaths and blood-borne diseases (Hayashi et al. 2010; Kerr et al. 2006). There continues to be a growing need for peer-based initiatives in order to create an effective response to the drug-use epidemic, not only in Vancouver, but also across the country and internationally. Over the last five years, the use of crack cocaine and methamphetamine among people who use drugs has increased in Western Canada (Urban Health Research Initiative 2009:134-136), placing these individuals at even greater risk of contracting blood-borne infections (see DeBeck et al. 2009; Fischer et al. 2008; McCoy et al. 2004; Porter et al. 1997; Ward et al. 2000; Wong 2001). Therefore, a more concerted and inclusive effort in addressing illicit drug use from a local to a global level is needed, where “the response to illness is not limited to one profession or sector: it must be societal” (Meili 2012:24).

### **Home, Health, Hope, Everything**

Studies have consistently shown that legal prohibitions on the cultivation, production, transport, distribution, and possession of drugs have not produced any of the intended benefits such as decreasing drug use, crime, or increasing access to addiction treatment facilities (Elliot et al. 2005; Global Commission on Drug Policy 2012; International Centre for Science in Drug Policy 2010; Weatherburn and Lind 1997; Wood et al. 2004). In fact, these law enforcement efforts have driven people who use drugs into less safe environments and often away from HIV prevention services and other health services, thus fueling high-risk injection and drug storage practices (Dixon and Coffin 1999; Elliot et al. 2005; International Centre for Science in Drug Policy 2010; Maher and Dixon 1999). Therefore, given the current findings on drug prohibition,

it is likely that the increased law enforcement efforts proposed in Canada's National Anti-Drug Strategy will create more, rather than reduce, social disorder.

Underlining the significance of having social order in communities, Fullilove (2006:176) states, "It is this collective effort to solve problems and improve the human condition that ultimately creates health." According to Meredith Minkler's (1989:26) concept of a healthy city, an intimate interdependence exists among all individuals and the larger systems of which each individual is a part. I argue that the ability to participate in this interdependence forms the social connections that create an inclusive space for displaced individuals. The Public Health Agency of Canada (2003, accessed March 2, 2010) lists "social environments" as one of the key factors influencing population health, stating that comprehensive approaches addressing health as a shared issue can "add resources to an individual's repertoire of strategies to cope with changes and foster health." The significance of such social environments is described in the following passage:

The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province or country. It is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others. The array of values and norms of a society influence in varying ways the health and well being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. A healthy lifestyle can be thought of as a broad description of people's behaviour in three interrelated dimensions: individuals; individuals within their social environments (e.g. family, peers, community, workplace); the relation between individuals and their social environment.

Therefore, as illustrated by the above passage, to be a part of this interdependence is to have a place in society, and as stated by Susan Sutton and Sharon Kemp (2011:1), "Place matters to the quality of human existence." Being excluded from this interdependence denies individuals a sense of place, thus limiting marginalized populations from accessing social, cultural, and economic resources. In Juha Mikkonen and Dennis Raphael's (2010:32) report on Social Determinants of Health in Canada, social exclusion is listed as one of the social determinants, defined as denying specific groups the opportunity to participate in "Canadian life":

Many aspects of Canadian society marginalize people and limit their access to social, cultural, and economic resources. Socially excluded Canadians are

more likely to be unemployed and earn lower wages. They have less access to health and social services, and means of furthering their education. These groups are increasingly being segregated into specific neighborhoods. Excluded groups have little influence upon decisions made by governments and other institutions. They lack power.

Illicit drug use and its treatment are reflective of those exclusionary societal and political practices that further deter people who use drugs from engaging effectively with their communities. Having a social support network – another key determinant of health defined as “support from families, friends and communities” (Public Health Agency of Canada 2003, accessed March 2, 2012) - is beneficial for both the individual as well as the community. Peer-based initiatives – in providing low-threshold employment opportunities – provide a social and economic means in which people who use drugs can engage with the community. Supporting the Public Health Agency of Canada’s (2003, accessed March 2, 2012) claim that “such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances,” studies have shown that involvement in these activities reduces drug-related street disorder and associated harms (DeBeck et al. 2011). However, the social, organizational, and individual impacts of these initiatives amongst people who use drugs have yet to be thoroughly explored. Using the concept of placemaking to outline these impacts, this research contributes to the understanding of the link between participation and the adoption of protective behaviours not only among people who use drugs but among the wider community as well. It helps identify the additional health and psychosocial benefits that people may enjoy as a result of their participation in society through a civic role (Jürgens 2005:33).

Thomas Kerr et al. (2006) have urged that more research be undertaken to examine the effect of participation in peer-based intervention groups on peer outreach workers themselves. However, because the health of a community depends on the cooperation and participation of various levels of community stakeholders, the level of participation and socio-structural transformation by peer outreach is greatly influenced by a community’s principles of interaction. Hence, the effect of participation on an individual cannot be examined without considering the contextual influences of the community and its constituent networks with which the individual is interacting.

Returning to the question stated in the opening sentence, how do low-income and socially marginalized populations of people who use drugs utilize peer-based programs to create a place for themselves in society? Furthermore, to what extent does this participation in peer-based programs affect the health of the community? Because this thesis argues that placemaking – by creating a social role in the community for the excluded – creates social order, the purpose of this study is to examine the processes through which peer outreach workers utilize a structural intervention to create and negotiate a place within their existing environment. Such processes include perceived reciprocity, trust, and social participation at the community level – all of which are crucial components to building and maintaining a healthy community (Minkler 1989). Specifically, the objectives to examining how peer service providers engage in placemaking are:

- 1) To apply existing models of social exclusion to outline how barriers preventing peer service providers from engaging in placemaking can lead to the development of the self-excluding anti-citizen;
- 2) To define place through concepts such as “citizenship” and “community” as interpreted by peer service providers and by other community members; and
- 3) To explore how peer service providers rely on and mobilize their social capital to situate themselves as participants in forming a healthy community.

### **Reviewing the Position of Peers**

No society can claim to be based on justice and equality as long as people who use drugs are not participating fully and meaningfully in shaping policy and delivering the services that affect their lives. [Jürgens 2005:vi]

To address drug use as a public health and human rights issue rather than a criminal issue, it is necessary that dominant cultural attitudes of stigma and discrimination be confronted and transformed. Peer-led initiatives play a significant role in challenging and transforming these attitudes. These initiatives are based on the belief that people who use, or have used, drugs do indeed have much to offer governing structures, services, and the community. By including and training people who use drugs as public health advocates who access and support peers who are unable to access services, or for whom services are unavailable (Needle et al. 2005:S50), peer support provides peer service providers and their peers the opportunity for individual and community self-development (Roe 2001). The current literature regarding the organizational, biomedical, social, and psychosocial effectiveness of peer-based interventions and their impact

on peers illustrates this. However, the latter two concepts have only recently emerged during the past several years. Current discourse is still predominantly focused on the impact of peer-based programs in the context of contagion, thus restricting the study of the impact of peer-based programs to people who use drugs and their drug-related behaviours.

### **Restructuring the Organizational Landscape**

Demanding to be involved in the development of policies and the delivery of services, self-identifying communities of people living with HIV/AIDS are credited with shaping much of the social and organizational response to the HIV/AIDS epidemic. At the 1994 Paris AIDS Summit, 42 national governments – Canada included – formally recognized the principle of the “Greater Involvement of People Living with HIV/AIDS” (GIPA) (Jürgens 2005:13). Similarly, in countries such as Canada where people who use or have used illegal drugs represent a significant proportion of people living with HIV/AIDS, this epidemic has prompted the development of grassroots organizations made up of self-identified peers demanding more meaningful involvement in HIV/AIDS policy, programs, and services. Importantly, the unique needs and experiences brought on by peers have changed the design and delivery of organizational services pertaining to drug use. Ralf Jürgens (2005:ii) points out that, historically, people who use drugs seldom have been included in discussions of issues that affect their lives. Part of the reason, he argues, is due to issues stemming from their drug use and other factors such as homelessness, mental health needs, or social exclusion. As Nick Crofts and David Herkt note (Jürgens 2005), “that IDUs [injection drug users] were one of the last groups to respond to the community development model was perhaps a reflection of the degree to which they had been disenfranchised by the prevailing ethos of demonizing of drug use.”

As people who use drugs became increasingly involved in the delivery of health services, it soon became apparent that perhaps the aforementioned barriers to participation also included the inaccessibility of current services. According to The Global HIV Prevention Working Group (2007), only 8 percent of people who use drugs worldwide have access to HIV prevention initiatives. Kerr et al. (2006) attributes this lack of accessibility to the services operating under a hierarchical “provider-client” model, where non-peer service providers are relied on to meet the needs of people who use drugs. Part of what made the “provider-client” model unsuccessful in terms of being both effective and accessible included issues such as clients feeling disrespected by staff and the fixed sites being geographically inaccessible. Communication between

providers and clients was reported to be difficult and strained. Furthermore, many of these services took place at fixed sites that operated from a 9 to 5 basis and were therefore difficult to access. There was also general fear among people who use drugs that if they accessed these services, police may be alerted of their activities (Broadhead et al. 1998; Grund et al. 1992; Rich and Larkin 1999). Despite having a space where services were supposedly catered toward people who use drugs, these people still felt alienated from these services. A place for people who use drugs had yet to be developed within the provider-client model. Clearly, by not acknowledging place-based barriers that people who use drugs faced, the existing services failed to reach people “where they were at.”

Much of the literature suggests that peer-led initiatives play an important role in extending the reach of conventional public health programs (Broadhead et al. 1995; Broadhead et al. 1998; Dickson-Gomez et al. 2006; Grund et al. 1992; Hayashi et al. 2010; Latkin 1998; Needle et al. 2005). This success stems from the accessibility of the peer outreach workers in terms of their ability to recognize place-based inequities relating to the accessibility of services. First, they are perceived by their peers as being more credible and influential sources of information because people tend to identify with peer outreach workers who are more culturally and ethnically similar to the target population (Broadhead et al. 1995; Dickson-Gomez et al. 2006; Latkin 1998; Weeks et al. 2006). Peer outreach workers who have status of being a veteran drug user are recognized as leaders among peers in their community (Weeks et al. 2006:554). Secondly, peer outreach workers utilize their already established networks for distributing information, materials, and advice (Broadhead et al. 1995; Dickson-Gomez et al. 2006; Weeks et al. 2006). Thirdly, because peer outreach workers are more likely to have up-to-date information regarding current locations of drug use sites (Dickson-Gomez et al. 2006), they are able to reach their peers in sites where, and at times when, high risk behaviours are likely to occur (Broadhead et al. 1995; Dickson-Gomez et al. 2006; Latkin 1998; Weeks et al. 2006). Peer outreach workers’ relations with their peers enable them to conduct outreach in locations other than the street, including abandoned buildings, participants’ own homes, or in someone else’s home (Weeks et al. 2006). Also, because of peers’ ability to relate with the peer outreach workers, it was reported by Julia Dickson-Gomez et al. (2006:683) that people who use drugs sought out their local peer outreach worker for prevention materials late at night or in drug-buying localities. In being able to set themselves apart from the traditional service providers by

being more accessible to people who use drugs and by being able to recognize place-based inequities, people who use drugs were beginning to create a place for themselves among harm reductionists.

Not only have peer-led initiatives changed how services are offered to people who use drugs, but the structure of peer-led initiatives in itself has evolved from being behaviour-oriented to community-focused. Before HIV/AIDS had become a public health threat, peer-based outreach models – in the context of illicit drug use – were already being applied in the United States and in Western Europe (Needle et al. 2005). In the 1970's, a community experiment in heroin addiction control (Hughes 1977) recruited former heroin users to provide targeted outreach to people who injected drugs in the Chicago drug market areas to encourage enrolment into methadone maintenance treatment programs. Emerging around the same time as the Chicago study, the self-help model of Western Europe – which had evolved from previous outreach prevention efforts targeting youth with drug-related problems – also relied on people who used drugs to access their peers (Needle et al 2005). Because harm reduction had yet to be established as one of the models for best practice, many of these interventions concentrated on individual behavioural change.

The model for peer-led outreach programming has continually evolved in response to: (1) changing perspectives regarding the dynamics of drug use, HIV and other blood borne infections; (2) the availability of a greater range of services; and (3) the increasing knowledge base regarding best outreach practices. Over the past several decades of peer-based outreach, the potentials for, and limitations of prevention efforts and the reduction in HIV and other drug-related risks have been realized (Weeks et al. 2006:541). These efforts have included targeting the social networks of people who use drugs with prevention efforts (Broadhead et al. 1998; Dickson-Gomez et al. 2006; Latkin 1998; Neaigus 1998; Trautmann 1995; Valente et al. 1998; Weeks et al. 2006), as well as potentially enabling people who use drugs to organize themselves politically and socially to address health and other community issues (Crofts and Herkt 1995; Friedman et al. 2004; Moore and Wenger 1995; Roe 2001). Over the past several years, the services offered by peer-led initiatives in North America have expanded from individual education and counseling (Broadhead et al. 1998; Latkin 1998; Latkin et al. 2003; Neaigus 1998); to the provision of sterile injecting equipment, crack kits and condoms, as well as the collection of used injecting equipment (Hayashi et al. 2010). More recently, these services have

expanded to targeting not only the behaviours but also place-based inequities by addressing community attitudes toward drug use and people who use drugs. Recent initiatives have included educating the public about the drug-using community as well as ensuring that people who use drugs are more involved in the decisions that affect them (Kerr et al. 2006; Osborn and Small 2006).

As an indicator of how peer-led initiatives are gaining legitimacy as a health service among existing harm reduction interventions, many of these initiatives are forming partnerships with regional health authorities, community-based researchers, and are receiving funding to develop and expand their initiatives. As of 2005, it has been reported that in the Downtown Eastside, several hundred people who use drugs were employed through health and harm reduction programs (Osborn and Small 2006). VANDU has also had success in securing funding through partnerships with health organizations and researchers. In 1998, then-Doctoral candidate Gordon Roe and Len Cler-Cunningham, Director of the Prostitution Alternatives Counseling and Education (PACE) Society, collaborated with VANDU to apply for funding that would assist in developing a sustainable program or program template. After receiving support from the VANDU board, Roe and Cler-Cunningham worked with VANDU on research design and mutual education, formed an ad hoc “Research Advisory Committee,” and distributed articles from peer-reviewed publications (Roe 2001). Importantly, Roe was able to obtain funding financially independent of the stakeholder-dominated funding services in the Downtown Eastside. He was successful in being granted the Soros Harm Reduction Fellowship from the Lindesmith Foundation in San Francisco. He then proceeded to divide the fellowship funds by placing half in one account for himself over the 12 months of the fellowship, and the other half in another account to finance the project’s activities for 6 to 8 months (Roe 2001). VANDU and its ad hoc committee, VANDU Health Network volunteers, determined the overall budget and spending priorities for the project funds and detailed bookkeeping was presented on a regular basis to account for the money being properly spent. In February 1998, the local health authority – Vancouver-Richmond Health Board – eventually committed to funding VANDU as a part of the Vancouver Action Plan (VAP) to address the “health emergency” of HIV (Strathdee et al. 1997:F59). They became the first health board in North America to ever fund an organization led by people who use drugs (Osborn and Small 2006; Roe 2001). This funding was given so

that VANDU could serve as an advisory body to provide a “consumer’s” voice in the implementation of the VAP’s additional services (Roe 2001).

Another example of peer-led initiatives having a place in creating an effective public health response to the HIV/AIDS epidemic can be found in the British Columbia Community Guide for Harm Reduction. “Working with people who use” was recommended under its guidelines listed in the development of a municipal harm reduction response, stating that the “key aim of any harm reduction strategy is to engage the co-operation and collaboration of people who are at personal risk of substance-related harm” (British Columbia Ministry of Health 2005:21). On the level of provincial governmental, peer-led initiatives finally found a place in policies and best practices.

Therefore, it is important for organizations to continue to recognize that people who use drugs are “especially well placed to be health activists among other IDUs because they have insider knowledge and are often physically present when advice or assistance can usefully be provided” (Friedman et al. 2004:259). This thesis further elaborates on how this unique positioning of peer outreach workers, in terms of their specialized knowledge and their physical presence, affects not only people who use drugs, but also the community as a whole. It is known that people who use drugs have first-hand knowledge about drug use and addiction. However, how does occupying this specialized space affect the social landscape in which people who use drugs find themselves?

### **Redressing the Biological Landscape**

People who use drugs do more than serve as passive representations of social and medical problems. As previously demonstrated, these people have been active in organizing and being involved in community-based programs surrounding drug use, and have actively urged their peers to be active in helping reduce the risk of getting infected by, or transmitting, blood-borne or sexually transmissible infections.

Globally, studies evaluating the outcomes of peer-led interventions have shown that peer-led outreach is an effective strategy for instructing and enabling people who use drugs to reduce their HIV risk behaviours (Medley et al. 2009; Needle et al. 2005). These behaviours include reducing equipment sharing, such as syringes, filters, cookers, and water for rinsing syringes (Broadhead et al. 1998; Hayashi et al. 2010; Latkin et al. 2003; Medley et al. 2009; Needle et al. 2005); reduction in crack-cocaine use (Needle et al. 2005); decreased frequency of injection

(Broadhead et al. 1998; Cottler et al. 1998; Latkin et al. 2003); cessation of injection drug use (Needle et al. 2005) and increased condom use (Broadhead et al. 1998; Latkin et al. 2003; Latkin 1998; Medley et al. 2009; Needle et al. 2005).

Due to the limited number of empirical studies available, it is difficult to assess whether these behavioural changes have a significant impact on the number of new infections (Medley et al. 2009; Needle et al. 2005). One major study conducted by Wayne Wiebel et al. (1996) indicated that reductions in the sharing and reuse of syringes among peers reached by outreach workers were followed by reductions in seroincidence. However, as illustrated in the following two sections, the successes of peer organizations are not limited to individual change nor are these successes restricted to biological outcomes. Sustainable change is not created by treating individual symptoms, but rather, by addressing the root cause of those symptoms. What makes most peer programs unique is that by involving people who often fall victim to structural inequities, these programs provide a way for those who use drugs to redress the structural and immediate social landscape.

### **Redefining the Social Landscape**

To better understand and create effective responses to public health concerns, social scientists, health providers, and advocates are becoming increasingly interested in the significance of social context and the dynamics of social processes (Weeks et al. 2009). Recognizing that individual behaviours are shaped by social relationships that occur within a broader social and political environment (Bourgois 2003; Bourgois et al. 1997; Fairbairn et al. 2010; Kirst 2009; Rhodes et al. 2005; Weeks et al. 2009), concepts involving the community in these initiatives – such as social structural transformation (Blankenship et al. 2006), community empowerment and participation (Minkler 1989), social network and peer influences (Broadhead et al. 1998; Friedman et al. 2004; Latkin 1998), and advocacy – become important in “creating responses beyond individual behavioural modification to affect the broader social context” (Weeks et al. 2009:330).

Although peer-based interventions are premised on the assumption that “social norms, group processes, and peer pressure are key factors in individual behavioral decision making and practices” (Dickson-Gomez 2011:370), there are numerous variations in how these assumptions are conceptualized and applied. For instance, there are different models that exist regarding the

definition and recruitment of peers, the intensity of their training, types of intervention offered, and breadth of outreach.

Much work remains to be done regarding creating a multi-sectorial and policy environment that is conducive to peer initiatives. Suggesting that drug policies may be contributing to the exacerbation of current drug use patterns, Samuel Friedman et al. (1992:400) recommend that creating effective policies will require inquiry into what social structural changes “are appropriate to reduce HIV transmission through drug injection. Furthermore, he recommended that “they take adequate account of the social forces that produced the policies targeted for change, those that create social support for the policies, and those that might interact with proposed reforms to produce undesired consequences” (Friedman et al. 1992:400). Relative to paraprofessional outreach programs, peer-led outreach programs do face unique challenges. For instance, in fear of provoking unwanted attention from the police, peer outreach workers and peers were reluctant to give or receive syringe-cleaning demonstrations (Dickson-Gomez et al. 2006). In addition, the sustainability of the program itself was at times threatened by burnout or the triggering experienced by the peer outreach workers (Needle et al. 2005; Roe 2001). Unlike paraprofessional outreach workers, many peer outreach workers were at risk of being arrested by police for drug-related or other charges, such as theft, trespassing, or loitering (Weeks et al. 2006). Robert Broadhead et al. (1995) noted that “street-based” peer outreach workers faced programmatic challenges related to supervision, political conflicts, conflicts between prevailing local cultures and the goals of outreach, and the risks of outreach. From these examples, it can be seen that the structural and organizational environment – both within and outside of peer initiatives – require reworking.

In terms of creating a social environment that includes people who use drugs, current findings indicate an optimistic future for the place of peer initiatives in communities. In Canada, findings from a questionnaire conducted by Allman et al. (2005) suggest that, based on the responses on peer networking from people who use drugs, community agencies, research institutions, and government officials across Canada, some harm-minimizing sub-cultural change had begun to occur as a result of existing peer networking activities. Some respondents believed that peer-based approaches to harm reduction would promote a socially inclusive community-based response to a growing public health issue. Yet how these sub-cultural changes occur and impact community inclusivity remains unanswered. Importantly, there is a lack of data available

regarding how peer-based initiatives socially impact the peer providers themselves. In terms of placemaking, what does the role of peer provider do for the peer providers themselves?

### **Reshaping the Personal Landscape**

In recent studies, qualitative ethnographic methods have been applied to collecting information on peer outreach workers' personal experiences of being involved in peer initiatives. Most recently, Dickson-Gomez et al. (2011) have focused on the social psychological dynamics among peer outreach workers as a model for explaining the significant HIV risk-reduction behaviour change among peer outreach workers in Weeks et al.'s (2009) study of the Risk Avoidance Partnership peer outreach group from Hartford, Connecticut. In this model, it was found that three mutually reinforcing social psychological processes influenced the peer outreach workers' motivation and efficacy to conduct outreach as well as reduce their own risk behaviours: the development of a pro-social identity, gaining positive social reinforcement from drug users and community members, and experiencing cognitive dissonance between their own continued risk behaviour while simultaneously engaging in health advocacy to their peers. In other words, these studies found that involvement in peer-based programs helped peer outreach workers form a sense of self through their work and their relationships formed through those programs. In addition to reporting that engaging in peer outreach work strengthened the peer outreach workers' determination to make positive personal changes (Dickson-Gomez et al. 2011; Weeks et al. 2009). The peer outreach workers also attested to feeling increased self-confidence, resulting in increased comfort in interacting with others (Guarino et al. 2010). Because involvement in these activities made them feel that they could contribute positively to society (Dickson-Gomez et al. 2011; Guarino et al. 2010), some peer outreach workers had increased motivation to pursue vocational activities (Guarino et al. 2010). These results are consistent with DeBeck et al.'s (2011) findings that low-threshold employment for people who use drugs offer important opportunities to reduce drug-related street disorder and associated harms. This is especially important for individuals living with multiple dimensions of marginalization, such as sustaining the negative psychiatric effects of high intensity cocaine use, which has been demonstrated by Cross et al. (2001) and Richardson et al. (2010) as barriers preventing them from attaining formal employment (DeBeck et al. 2011). Thus, community health involves more than the eradication of disease, but also requires the meaningful involvement of all of its members. To do so requires that multiple levels of marginalization and the barriers it presents be

acknowledged and confronted. In this context, peer outreach is a form of low-threshold employment that addresses the important structural role employment plays in shaping risk behaviour (Blankenship et al. 2006; Des Jarlais 2000; Heimer et al. 2002).

Therefore, current literature on the efficacy of peer-based programs ranges from studying structural to individual changes. However a place-based analysis is needed to connect the effects of these individual and structural changes on and by the peer service providers, particularly beyond the context of disease and contagion. In current literature, there is still a disconnect between the role of people who use drugs in peer-based programs and the dynamics of the rest of the community. To use the concepts of social capital and placemaking to situate the peer-based provider within the community, we can better understand how disenfranchised members of a community can voluntarily reintegrate back into society. There needs to be more information on whether peer-based initiatives affect the positionality of people who use drugs within a community. Change is transferred through social networks, and the aim of this thesis is to illustrate the processes that manifest such change.

### **Central Theoretical Concepts**

Throughout this study, three central concepts emerged as being particularly useful in understanding how peer service providers negotiate a sense of place in their local communities: (1) social exclusion, (2) social capital, and (3) placemaking. In this section, existing literature surrounding these concepts will be explored, with specific focus on how this framework will aid in explaining how inclusiveness and interdependence are established as a form of resistance against marginalization.

#### **Social Exclusion**

Before it is even possible to describe the interaction between the individual and his or her place, it is necessary to establish a mechanism that first identifies which boundaries are being transgressed by peer service providers as they accrue social capital to form the interconnections necessary to create a sense of place. The “Risk Environment Framework” presented by Rhodes et al. (2005) is useful in its emphasis of the importance of considering factors exogenous to the individual when examining drug-related harm. Critiquing public health approaches that over-emphasize “individual agency which is constrained by social structural forces related to poverty and social inequality” (Rhodes et al. 2005:1033), the authors define risk as not only a product of individual behaviour, but something that is also shaped and structured by laws, policies, services,

and social relations that surround individuals. This form of systemic oppression, normalized by those aforementioned factors, commonly referred to as structural violence. This concept dates back to at least 1969, to Johan Galtung and Latin American liberation theologians and is commonly used to stratify suffering by social order and perpetuate socioeconomic inequity (Farmer 2010).

Having a social exclusion framework is useful in identifying actual and symbolic barriers (Grenier and Guberman 2009) that are present in policies, organizational, and everyday practices that deprive people the capacity to exercise their rights, participate in the activities of citizens in a given society, and hence from achieving personal and social fulfillment (Burchardt et al. 1999). In addition, this concept is an important dimension of health to consider because studies have shown that feelings of hopelessness lead to actions demonstrating a lack of control, which has been shown to directly affect health (Marmot 2006). Fran Baum et al. (2010) likens this to a negative feedback loop contributing to a vicious cycle of exclusion, disempowerment, losing control, and poor health.

The social exclusion framework used for this thesis is borrowed from Amanda Grenier and Nancy Guberman (2009), in which seven intersecting forms of exclusion have been outlined: (1) symbolic exclusion, (2) identity exclusion, (3) socio-political exclusion, (4) institutional exclusion, (5) exclusion from meaningful relations, (6) economic exclusion, and (7) territorial exclusion. For the purpose of this thesis, this framework will be applied to investigating ways in which peer service providers, within and outside of the peer organization, experience and address these multiple levels of social exclusion in order to create and maintain their relationship to the rest of their community.

Symbolic exclusion is defined as “negative representations afforded particular groups as well as the invisibility of such groups within society” (Grenier and Guberman 2009:118). Philippe Bourgois et al. (2004) report that people living in cultures of stigmatization, discrimination, and other forms of social and physical violence may eventually come to internalize these acts as “everyday features of lived experience” (Rhodes et al. 2005:1033). Paul Farmer et al. (1996), Duncan Pederson (2002), and Merrill Singer (2001) all argue – through their independent findings – that at the individual level, these experiences may be expressed “in terms of psychological or emotional harms, such as fatalism, self-hatred or powerlessness” (Rhodes et al. 2005:1033).

Identity exclusion is the “dismissal or diminishment of the distinctive and multiple identities of the person or group through reduction to one identity such as age” (Grenier and Guberman 2009:118). Dennis Altman (1991) cautions against essentializing people who use drugs in a single “community,” given the ethnocultural and geographic diversity among the population of Canadian, and in particular, among people who use drugs. Participants in Broadhead et al.’s (2005) peer-driven intervention expressed frustration at being expected to relate to the peers despite differences in age, ethnicity, gender, and other characteristics.

Socio-political exclusion is represented as “barriers to civic and political participation resulting from a lack of involvement in decision-making, collective power, limited political clout or agency” (Grenier and Guberman 2009:118). In 1997, the National Task Force on HIV released a report that identified the marginalization of people who use drugs – from wider society and from political settings – as an obstacle to the fight against HIV/AIDS.

Institutional exclusion is defined as “exclusion from social and political institutions resulting from decreased services that negatively affect their health and well-being and/or no consultation with the individual or their caregivers regarding their care” (Grenier and Guberman 2009:118). For instance, in a study by Nadia Fairbairn et al. (2010), a number of participants whom are unable to administer their own injection described that the rule in Vancouver’s safe injection site prohibiting assisted injection compelled them to leave the facility and into nearby alleys to find another person who used injection drugs to assist with their injection. At the safe injection site, staff members are only permitted to give verbal direction and offer limited manual assistance that does not include the act of injecting. In other cases, hostility from hospital staff often deterred people who use drugs from accessing medically necessary services (Bourgois and Schonberg 2009). As was illustrated in the literature review, the limited hours of operation staff-run needle exchange sites deterred people who use drugs from accessing these services (Needle et al. 2005).

Economic exclusion is simply the “lack of access to income or material resources required to meet basic needs” (Grenier and Guberman 2009:118). Although employment has been shown to reduce injection drug use and reduce involvement in crime (Faupel 1988; March et al. 2006; McLellan et al.1981), people who use illicit drugs – particularly those who are addicted – are often unsuccessful in acquiring and sustaining formal employment (DeBeck et al. 2011). Previous research found that frequent crack cocaine smoking is negatively associated

with labour market outcomes among people who inject drugs (Richardson et al. 2010). Findings by John Cross et al. (2001) support this, suggesting that the negative psychiatric effects resulting from high-intensity cocaine use prevents those individuals from engaging in formal employment. However, this form of exclusion is not limited to the physiological and psychological effects of drug use – other studies list factors including criminalization, stigma, employer prejudice, and policy discrimination (Dillon 2004; Gold 2004). Other factors suggesting significant barriers to employment found by Lindsey Richardson et al. (2010:298) fell along “lines of intrinsic socio-demographic characteristics” of:

Age, gender and Aboriginal ethnicity; acquired factors of HIV-positivity and HCV-positivity; behavioural factors, including daily heroin use, daily crack use, public injecting and sex trade involvement; and circumstantial factors relating to housing status, housing location and recent incarceration.

However, the high costs associated with obtaining illicit drugs or resources to meet basic needs may drive individuals to find alternate means of generating income – such as street-based sex work, drug dealing, panhandling, and recycling/salvaging/vending – which puts them at further risk for multiple negative health and social outcomes (DeBeck et al. 2011). According to Kora DeBeck et al. (2011), 47 percent of their participants reported that if they were offered other opportunities for low-threshold employment, they would be willing to stop engaging in the aforementioned alternatives to generating income.

The final two forms – exclusion from meaningful relations and territorial exclusion – are both affected by the geographical allocation and by policies that focus on the criminalization of drug use. Exclusion from meaningful relations is represented through the “exclusion from the development and maintenance of meaningful social relationships through the absence of networks, lack of access to them, or rejection from them” (Grenier and Guberman 2009:118). Territorial exclusion is defined as the “regulation to spaces with limited opportunity for social involvement, lack of geographical mobility or control over one’s environment” (Grenier and Guberman 2009:118). Bourgois (2003:34) traces Canada’s urban injection cocaine epidemic to “the particularly disruptive pattern of rural-urban migration – spearheaded by Native Americans in Vancouver and Francophones in Quebec exacerbated by over-centralized, ethnocentric social welfare services.” Other studies (Ley and Dobson 2008) shared similar opinions to Bourgois (2003:34) in that people who use drugs in the Downtown Eastside were segregated due to needle exchange, housing, and health services being concentrated into “one-stop, multi-service centers

located in inner city neighbourhoods with cheap rents and inferior housing that are isolated by surrounding gentrification real estate patterns.”

Therefore, Grenier and Guberman’s (2009) framework will be applied to categorize different manifestations of social exclusion. To spatialize the social inequities faced by street-involved drug users relative to the rest of the community, the concept of structural violence will serve to stratify these experiences of social suffering. As structural violence is the “natural expression of political and economic order” (Farmer 2010:373), to study the mechanism behind these expressions of social order, I have borrowed the concepts of “the politics of life” and “social abandonment” from Didier Fassin (2010) and João Biehl (2001), respectively. Through these concepts, interpersonal relations, moral and market economies, and identity-making processes casts the individual as a subject of “both a strategy of existence and a material and means of sociality and governance” (Biehl 2001:217). Biehl (2001:217) argues that consumer culture increasingly articulates citizenship, which reinforces “totalizing assumptions of the workings of collectivities and institutions.” In understanding how citizenship is defined and hence how structural violence is rationalized, Fassin’s “politics of life” describes how lives are saved and risked (2007:453). He defines “politics of life” as “politics that give specific value and meaning to human life. They differ analytically from Foucauldian biopolitics, defined as “the regulation of population,” in that they relate not to the technologies of power and the way populations are governed but to the evaluation of human beings and the meaning of their existence.” Importantly, Fassin argues that a politics of life produces public representations of those to be excluded and defended to rationalize such decisions.

### **Social Capital**

Why bother with social capital in these circumstances? Because without attention to the quality of the relationships between those with differential access to power and without paying attention to the need to build extensive transitive networks of respect and trust in such frequently met circumstances, efforts at poverty alleviation, economic development, and service provision to the poor are unlikely to succeed. In the field of health services, in both the developing and developed societies alike, this is particularly relevant for the effective implementation of measures to assist the ill, poor, and the “socially excluded.” [Szreter and Woolcock 2004:656]

Within harm reduction programs, there has been a paradigm shift from individual behaviours being the focus of interventions to understanding the significance of social context

and the dynamics of social processes. Programs and policies have expanded their focus on developing people's capacities and skills rather than on providing advice that subsequently victimizes the person receiving services (Bourgois and Schonberg 2009). Part of the process of creating sustainable change in the community involves allowing people to apply their unique expertise in terms of their social and cultural framework, including their patterns of social interaction. Thus, peer service providers are ultimately creating a place in society that integrates, rather than conforms, them. It is here that social capital acts as a marker of place and becomes useful in studying the processes through which this occurs.

Social capital may be defined as “features of social life such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit” (Putnam 1995:67). By integrating concepts such as social support, social integration, social control, social networks, and social cohesion, this is a useful conceptual framework that combines how structure and agency interact to shape risk. Ichiro Kawachi and Bruce Kennedy (1997) found that socio-economic inequalities that exist in industrialized countries reduce social cohesion and integration, and instead increase social isolation. These areas tend to have poorer access to social capital and provision of health services, resulting in the poorest populations living in inner-city areas lacking social resources and characterized by social disintegration (Hefferman 2002).

Although there are many rival views on how social capital should be conceptualized, there is at least consensus in the area of public health that “social capital ‘matters’ in some basic sense” (Szreter and Woolcock 2004:651). However, there remains ongoing methodological disputes over what exactly social capital is demonstrating, particularly in the areas of relationships between health measures and both inequality and trust (Rhodes et al. 2005; Szreter and Woolcock 2004). For the purpose of this thesis, social capital will be applied to study the quality of bonds established through outreach, and to elaborate upon how outreach establishes the social bonds necessary to form a sense of place for peer service providers. The framework used for this thesis will combine concepts presented by Robert Putnam (1995) and Simon Szreter and Michael Woolcock (2004).

Putnam's conceptualization of social capital focuses on “the nature and extent of networks and associated norms of reciprocity,” thus being a relational property of individuals that is expressed through their membership in a group (Szreter and Woolcock 2004:654). While

network scholars argue that social capital refers to the resources that are transferred through networks, Putnam uses social capital to refer to the structure of the network itself. Szreter and Woolcock (2004) also view social capital as a group property, arguing that social capital is a property of individuals' relations with one another, and that one of its outcomes is that it enables individuals to perform actions they would otherwise be impermissible. As a property already demonstrated by peer groups (see Dickson-Gomez et al. 2011; Kerr et al. 2006; Osborn and Small 2006; Roe 2001), social capital, in the form of trusting relationships, can become a resource that individuals can draw upon in certain circumstances (Szreter and Woolcock 2004). Putnam's concept of social capital is also embedded in "networks and norms" (Putnam 2005), where its participants have shared norms of reciprocity as a group property. Szreter and Woolcock (2004) extend this statement by adding that these shared norms can exist as a form of trust established by repeated interactions. Much more important, however, is the minimum degree of understanding among the participants of the network, which is expressed through shared goals and purposes and their working together towards "mutually compatible goals" (Szreter and Woolcock 2004:656). Therefore, these relations are not created spontaneously, but are instead "the product of a prior history of political, constitutional, and ideological work to construct the conditions for such a shared sense of fairness to be perceived by those choosing to participate in the network in question" (Szreter and Woolcock 2004:656). As will be elaborated upon in the description of the Grandview-Woodland, it becomes apparent that the history of that community played an important role in the success of the peer program situated there.

In the late 1990s, qualities of social capital were made distinct in the forms of "bonding" and "bridging" social capital (Gitell and Vidal 1998). Later, "linking" social capital was introduced (Szreter 2001; Woolcock 2001; World Bank 2000). Bonding social capital refers to relations of trust and cooperation between members of a network who perceive one another as sharing a social identity, such as between friends, family, and neighbours. Bridging social capital, on the other hand, occurs between people who realize that they are unlike one another in some socio-demographic sense, and the boundaries distinguishing these people is highly context-specific. However, like bonding social capital, bridging social capital is still "horizontal" in the sense that those relationships "bridge" individuals who are more or less equal in terms of status and power. Linking social capital is defined by "vertical" power differentials, and is defined as "norms of respect and networks of trusting relationships between people who are interacting

across explicit, formal or institutionalized power or authority gradients in society” (Szreter and Woolcock 2004:655).

### **Placemaking**

By integrating concepts such as social structural transformation (Blankenship et al. 2006), community empowerment and participation (Minkler 1989), social network and peer influences (Friedman et al. 1992; Latkin 1998), and advocacy (Sutton and Kemp 2011), placemaking provides a useful framework for analyzing how peer service providers collaboratively shape existing norms and values of citizenship and of a healthy community.

First, what is “place”? Whereas space is a geographic location or a backdrop to activity (Rodman 1992; Sutton and Kemp 2011), place is the dynamic product of the interplay among the “people, practices, objects, and representations that fill it” (Sutton and Kemp 2011:1). Therefore, place is shaped by the tensions among interrelationships and plays a role in influencing and sustaining social structures and norms. Place is a narrative that is embodied in the dialectical tension between humans and their social and physical environment (Berdoulay 1989). Being dynamic, communities also shape individual and collective identities by producing, negotiating, and resisting those social structures and norms (Sutton and Kemp 2011:1). Place thus becomes a site of collective action, where it is possible for people who use drugs to achieve social and environmental justice by being involved in redressing place-based inequities on their own terms (Sutton and Kemp 2011:2). Similar to Sutton and Kemp’s conceptualization of place, Roberta Feldman and Susan Stall (2004) use the term “homeplace” to refer to “sites of both resistance to marginality and oppression and of expression and developing power over the places that support their everyday lives” (Feldman 2011:158).

In her paper, “Empower Place: Multilocality and Multivocality,” Margaret Rodman (1992) argues that place is a complex anthropological construct. From an ethnographic standpoint, she calls upon anthropologists to be reflexive in recognizing that places are neither “inert containers” nor are they “a passive target for primordial sentiments of attachment” (Rodman 1992:641). Rather, these are “lived spaces,” referring to the living space, social space, and the values attached to both” (Berdoulay 1989:130). In promoting the concept that “places produce meaning and that meaning can be grounded in place” Rodman (1992:643) emphasizes the cultural and social construction of place by presenting its three forms: “location,” being “the spatial distribution of socioeconomic activity such as trade networks”; “sense of place,” also

known as one's attachment to place; and "locale," the "setting in which a particular social activity occurs."

Therefore, the lines between place as an analytical concept and as a locality in the "real world" (Rodman 1992:194) are blurred. As reflected in David Ley and Cory Dobson's (2008) article on gentrification in Vancouver's Downtown Eastside and Grandview-Woodland, shifting demographics in these neighbourhoods will ultimately change the dominant values held in the community; therefore, despite having a long history of, as well as retaining the reputation of, being a community with socially progressive values, a locale that was once a place for a marginalized person living in addiction may not remain that way. Hence, place is not fixed, nor is a purely geographic concept (i.e. space). Although physical space does play a role in defining place, for transient populations who are constantly displaced by structural violence, place becomes more importantly defined as a portable entity grounded by social networks. Place therefore becomes the representation of having a social role and purpose in the community. Placemaking is the act of establishing place by consistently reinforcing that role, hence the public identity of that individual, to others within the community.

Biosociality, in the context of disease and contagion, serves as a form of placemaking. Miriam Ticktin (2010:247) uses the term "biosocial space" to describe a social community created by shared illness, where biology becomes a "flexible social space." In communities where illicit drug use and addiction is a publicly visible problem, biosociality becomes stratified. For instance, through social exclusion, people who use drugs would congregate through a shared sense of suffering or addiction and support one another's drug use. Meanwhile, harm reductionists would occupy another biosocial space through the shared goal of addressing addiction and contagion among people who use drugs in an accessible manner. Furthermore, other members of the public such as business owners would occupy another biosocial space by working together to bar people who use drugs from being near their premises. Therefore, placemaking, despite creating a place for individuals through social networks of shared experiences, is not necessarily a health-promoting process. It establishes a social order that can include or exclude certain social identities.

However, placemaking does more than establish a social identity and role in a civic space; it is also a process of transforming a social and structural environment to be more conducive to an individual or population. It is a process where "marginalized communities can

redress social and environmental inequity via spatial interventions” (Sutton and Kemp 2011:113). Lynda Schneekloth and Robert Shibley (2005, accessed April 2, 2012) define it as:

The ongoing work of transforming the places we find ourselves into places in which we can truly dwell as individuals and communities of people. The practice of making our places changes and maintains the physical world and our ideas about it, while it also creates communities of people who share concerns, interests, and fears.

Placemaking is a highly localized concept; however, because structural violence extends beyond inner cities, placemaking strategies encompass multiple levels: social and spatial, personal and political, local and global (Sutton and Kemp 2011:114). Placemaking comprises components of citizenship and community building, which include local activism, cooperative effort, and the struggle for place. This concept of placemaking ties in with place by using social capital to establish a role, and hence place, for the displaced individual in the greater community.

Health promotion is a form of placemaking. Peer-led interventions represent an effective form of structural intervention for health promotion. Structural interventions are defined as “interventions that work by altering the context within which health is produced and reproduced,” by locating the source of public health problems according to social, economic, and political factors “that shape and constrain individual, community, and societal health outcomes” (Blankenship et al. 2000:11). However, it is also necessary that there is an ongoing responsive interaction occurring between the city and each of its members. Emphasizing the need for education, community, and reciprocity between individuals and their social environment, both Leonard Duhl (1986) and Minkler (1989) describe a healthy city as one that is responsive to its developmental needs and its organizations and its people. Reflecting the values of the “Nothing About Us Without Us” mantra of peer-led grassroots organizations (Jürgens 2005), for a healthy city to function, it is necessary to have “respect for the rights and dignity of the individual, broad means of ensuring communication and participation in decision making and opportunities for employment, education, and other key components of a full and healthy life” (Minkler 1989:26).

Placemaking is a social and portable concept that, like social exclusion, plays a critical role in shaping the social geography of bodies. A concept that lends itself well to representing the multiple degrees through which exclusion or placemaking can occur is Margaret Lock and Nancy Scheper-Hughes (1996) “tripartite body,” which is comprised of the individual body, social body, and body politic. First, the individual body is the lived experience of the body-self:

the “mind, matter, psyche, soul, self” (Lock and Scheper-Hughes 1996:45). The social body is a symbolic representation of the body where there is a dialectical exchange of meanings between the “natural and social worlds” (Lock and Scheper-Hughes 1996:45). Finally, the body politic refers to the “regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality, work, leisure, and sickness” (Lock and Scheper-Hughes 1996:45). For instance, the National Anti-Drug Strategy relies on portraying those who use drugs as societal deviants while casting the rest of the public as being “the most vulnerable” (Government of Canada 2007, accessed November 18, 2010). In doing so, the Government becomes able to legitimize policies that criminalize people who use drugs, thus regulating the body politic of those who use drugs to the periphery of society. At the same time, designating the non-using population as “the most vulnerable” negotiates and influences how suffering is recognized. Consequently, how suffering is experienced on an individual basis also becomes altered. Just as there are many different forms through which placemaking and social exclusion are represented, there are also different degrees through which placemaking and social exclusion experienced. Applying the concept of the tripartite body will allow insight into the extensive effects of placemaking and social exclusion.

As an overview of the following chapters, Chapter 2 investigates the definition of harm reduction and provides a brief outline of Vancouver’s organizational approach towards harm reduction and the role of the peer organization in delivering harm reduction services to the community. Chapter 3 describes the methodology used to design and carry out the research. This chapter also describes the participants and the community in which the study took place. Chapter 4, titled “Defining Boundaries,” prefaces the exploration of placemaking by first identifying the multiple barriers to placemaking that peer service providers face, and by illustrating how peer service providers’ conceptualization of citizenry and community identifies with the shared norms and values held by the rest of the community. Chapter 5, “Transforming Boundaries,” investigates how people living with or recovering from addiction use collective reflection and action to realize their own roles and potential power in the process of reconstructing exclusionary policies and practices that affect their sense of place within their community.

CHAPTER 2  
‘NOTHING ABOUT US WITHOUT US’: ORGANIZING AND DELIVERING HARM  
REDUCTION IN VANCOUVER  
**Interpreting “Harm Reduction”**

As a paradigm of drug policy, the concept and application of harm reduction has had a long-standing history outside of North America, particularly in countries such as the United Kingdom, the Netherlands, Switzerland, and Australia (Government of Alberta 2007:4). Some authors have commonly referred to the UK Rolleston Committee from the 1920s as the “original reference to harm reduction.” In addition, methadone maintenance has been available in several countries since the 1950s (Ritter and Cameron 2006:611). Nonetheless, in comparison to other paradigms in drug policy such as prevention, treatment, and law enforcement, harm reduction is a relatively new – and is the most politicized – approach to drug policy. Due to the controversy surrounding the fact that harm reduction primarily focuses on the reduction of harm and not necessarily the reduction of drug use (Lenton and Single 1998), advocates often feel pressed to justify that harm reduction is more than a dogma. Consequently, attempts have been made to create standardized criteria that determine whether or not certain policies or programs encompass harm reduction (Lenton and Single 1998). These criteria often measure effectiveness in reducing either the biological or social harms to those who use drugs and to the rest of the community.

Although both alcohol and drug literature have alluded to ideas related to harm reduction since the mid-1970s (Erickson 1995), harm reduction has only emerged “as a significant paradigm” in the early 1980’s, and during this time, began to focus largely on illicit drug use (Riley and O’Hare 2000). As a relatively new approach to drug policy, there are many variations on how harm reduction is conceptualized and applied in policies and programs, ranging from targeting direct biological harms such as the spread of biocommunicable diseases, to social harms regarding community wellbeing, to drug policy reform. Included are examples taken from the BC Harm Reduction Strategies and Services’ Harm Reduction Training Manual (2011: Appendix 1A):

1. The International Harm Reduction Association (2002): “Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use.

2. The Harm Reduction Coalition (2008): “A set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence. Harm reduction strategies meet people who use drugs ‘where they’re at’, addressing conditions of use along with the use itself.”
3. The Drug Policy Alliance (2008): A “public philosophy that seeks to lessen the dangers that drug abuse and our drug policies cause to society. A harm reduction strategy is a comprehensive approach to drug abuse and drug policy.”
4. The Vancouver Area Network of Drug Users (VANDU) (2008): “Committed to increasing the capacity of people who use drugs to live healthy productive lives. We do this by affirming and strengthening people who use drugs to reduce harms to themselves and their communities.”

Different groups have varying levels of involvement with people who use drugs. Because not all movements or organizations by or involving people who use drugs have identical agendas, what often results are differing interpretations of what encompasses harm as well as differing opinions over appropriate responses to harm. A common feature found in the many variations on harm reduction is the importance of working with the individual. Importantly, this approach emphasizes working at the level of the individual in order to reduce the harms associated with illicit drug use, thus making this a very inclusive and accessible paradigm. However, what constitutes as the “harm” as well as how its reduction can be measured, can range from being very narrow in focus to being very comprehensive, with each end of the spectrum having its own advantages and disadvantages (see Erickson 1995; Lenton and Single 1998).

Harm reduction is an important drug policy approach that leads to the development of “policies and programs, which attempt to primarily reduce the adverse health, social, and economic consequences of mood altering substances to individual drug users, their families and their communities” (Elliott et al. 2005:106). Because of this, it is important to be able to articulate and communicate its principles and merits to improve public understanding of this concept. To do so, distinguishing harm reduction as a movement grounded in public health becomes necessary (Hunt 2001:35).

By better articulating what harm reduction is and is not, it becomes easier for advocates of harm reduction to communicate where their interests overlap and how collaborative action can be accomplished. Also, establishing criteria for harm reduction prevents this concept from being misconstrued by policies and programs that focus on reducing drugs and drug use rather than drug-related harm in the broader context. For the purpose of this thesis, harm reduction is an important concept because of its capacity to recognize the contributions and abilities of people as well as identify the issues underlying drug use. Therefore, harm reduction will be conceptualized as an amalgamation of the concepts provided by Simon Lenton and Eric Single (1998) and Friedman et al. (2001). Lenton and Single (1998:219), in their socio-empirical definition of harm reduction, state that:

A policy, programme or intervention should be called harm reduction if, and only if: (1) the primary goal is the reduction of drug-related harm rather than drug use *per se*; (2) where abstinence-oriented strategies are included, strategies are also included to reduce the harm for those who continue to use drugs; and (3) strategies are included which aim to demonstrate that, on the balance of probabilities, it is likely to result in a net reduction in drug-related harm.

To expand this definition, Friedman et al. (2001:9) emphasize the use of harm reduction to acknowledge the connections between poverty, social exclusion, and drug-related harm. Importantly, Friedman et al. include the following phase of harm reduction to the shared definition: “redemption through social struggle,” which is understood as drug users becoming activists, leading them to engage in less risk. Therefore, if research is able to meet the third criterion of Lenton and Single’s conceptualization of harm reduction, creating an inclusive space for people who use drugs follows the definition of harm reduction. Through this, drug use could be presented as a positive thing and drug culture could potentially be seen as a “force for mutual support and collective action” (Southwell et al. 1999). Recognizing that the interpretation of harm reduction will change over time as a “healthy process that is essential in the full articulation of an ‘emerging public health perspective’” (Erickson 1995:283), it is important to establish a shared definition among researchers to establish criteria to evaluate the efficacy of a harm reduction program.

Essentially, how harm reduction is conceptualized will have implications for programs and policies related to illicit drug use. As will be further discussed in the later chapters, community-based programs may operate under and be evaluated by different aspects of harm

reduction. For example, a program may operate under the values of reducing the biological and social harms associated with drug use, while stakeholders evaluate the efficacy of the program exclusively in terms of whether or not biological harm was reduced. Therefore, for future directions beyond the scope of this thesis, developing standardized and unified harm reduction criteria for evaluative and practical purposes would be beneficial to those involved with developing policies and programming related to illicit drug use, researchers evaluating the efficacy of these programs and policies, stakeholders, and importantly, people who use illicit drugs. Developing a commonly understood definition will help justify the existence of community-based programs, and having a standardized set of criteria for harm reduction to be used to evaluate these programs will in turn help validate the harm reduction paradigm and its values.

### **The Harm: Drug Use and Consequences in Canada and Vancouver, British Columbia**

Being that people who engage in illicit drug use are among the most highly marginalized and hidden populations, it is difficult to obtain an accurate and comprehensive representation of this population. However, the 2004 Canadian Addiction Survey (Health Canada 224:11) states that from 1994 to 2004, the number of Canadians that had used an injectable drug at least once during their lifetime had increased from 1.7 million to a little over 4.1 million. Of that 4.1 million, 269,000 individuals reported having administered an illicit drug via injection that year.

In 1997, Vancouver experienced a public health emergency, where 25 percent and 85 percent of Vancouver's estimated 15,000 injection drug users – through the shared usage of drug equipment – became HIV- and HCV-infected, respectively (Strathdee et al. 1997). Furthermore, according to the British Columbia Coroners Service (2004), deaths due to drug overdoses began to occur at the rate of one death per day (Urban Health Research Initiative 2009). As of late, rates in crack cocaine smoking have increased among people who inject drugs (Urban Health Research Initiative 2009:134-36), placing these individuals at even higher risks of contracting blood-borne infections (see DeBeck et al. 2009; Fischer et al. 2008; McCoy et al. 2004; Porter et al. 1997; Ward et al. 2000; Wong 2001).

Among the successes associated with the expansion of harm reduction programs are: the increased role people who use drugs play in the design and implementation of policy and programs as well as in addressing marginalization and stereotypes associated with drug use (Osborn and Small 2006), a steady decrease in the reported level of used syringe sharing

(Hayashi et al. 2010; Needle et al. 2005:S52; Weeks et al. 2009; Wood et al. 2003), and a consistent decline in the number of new HIV and hepatitis C infections among people injecting drugs (Urban Health Research Initiative 2009:8). Despite this, however, the number of new HIV infections remain high (Urban Health Research Initiative 2009:8) and policies such as the National Anti-Drug Strategy created by the Government of Canada that call for increased law enforcement while neglecting harm reduction further marginalize people who use drugs. Furthermore, extensive ethnographic and qualitative studies have demonstrated that the aforementioned environmental and structural factors are inseparable (Singer 1997; Bourgois et al. 1997) and that the synergistic interplay between these factors often have unintended consequences on shaping drug use patterns.

As an increasingly pressing issue that threatens community and public health, it is critical to investigate both the potential and existing roles communities and its members play in influencing and attenuating the effects of illicit drug use. Effective HIV prevention involves more than individually oriented interventions; it also involves interventions directed toward creating what Tim Rhodes et al. (2005:1027) call an “enabling environment.” This entails creating local environments that are “conducive to, and supportive of, individual and community-level behaviour change” (Rhodes et al. 2005:1027). Therefore, in order to understand how these factors associated with drug use should be addressed, it is important to create an inclusive and accessible environment that enables people who use drug to participate and identify which measures need to and can be taken in developing a healthy community to which they can belong.

### **Reducing: The Intersection of Top-Down and Bottom-Up Organizational Efforts**

Despite the aforementioned achievements in reducing high-risk behaviour as well as reducing the number of new HIV and hepatitis C infections, and that international public health organizations such as the World Health Organization support harm reduction, harm reduction programming remains a heavily politicized issue in Vancouver and throughout Canada (Urban Health Research Initiative 2009:8). The Government of Canada’s individual-oriented National Anti-Drug Strategy, as outlined in the introduction, is an excellent example of this and stands in stark contrast to Vancouver’s community-oriented Four Pillars Drug Strategy. Nonetheless, health organizations such as Vancouver Coastal Health (VCH) are working in joint action with grassroots initiatives such as the Peer 2 Peer (P2P) program of Grandview-Woodland

Community. Under the guiding principles outlined in British Columbia's Community Guide to Harm Reduction (2005:5), "Drug user involvement" is featured as one of the guiding principles, stating:

Harm reduction acknowledges that people who use drugs are the best source for information about their own drug use, and need to be empowered to join the service providers to determine the best interventions to reduce harms from drug use. Harm reduction recognizes the competency of drug users to make choices and change their lives. The active participation of drug users is at the heart of harm reduction.

To avoid confusion, I distinguish several terms, starting with the terms "peer" versus "Peer Member." Because people who use drugs employ the term "peer" to refer to other people who use drugs as well as to others who are more or less living in the same socioeconomic conditions as they are, the term "Peer Member" will refer to peer outreach and support members of P2P, which is the peer-based outreach and support group I was affiliated within Grandview-Woodland. Therefore, the research participants for this study were all "Peer Members" (i.e. peer service providers) because they provided peer outreach and attended the support meetings at P2P. Other people who use drugs – those who are outside of P2P – will simply be referred to as "peers." Another term used frequently throughout this thesis is "street-involved," which is used to refer to people who are homeless, precariously housed, accessing services such as those listed in "P2P Referrals to Services and Programs in Grandview-Woodland Community" (Appendix D), spending the majority of their time on the streets, and/or identifying with and forming support networks with others that fall into this criteria. Also, except when citing from other documents using the following terms, in continuation of the terminology used in a report released by the Canadian HIV/AIDS Legal Network (Jürgens 2005), the term "people who use drugs" will be used instead of "drug user" or "injection drug user" (IDU). To use the term "drug user" or similar terms is counterintuitive to the fact that one of the goals behind peer movements is to challenge the general public's image of them. There are two main reasons behind this decision. First, as reflected in the participant interviews as well as in other reports (see Jürgens 2005), the use of terms such as "drug user" is disempowering in that it carries a substantial amount of stigma and reduces such individuals to their drug use activities. Drug use is one aspect of a person's life. Secondly, injection drug use is not the only way through which communicable diseases can be transferred through drug use. The shared use of crack-pipes also

carries a risk for contracting blood-borne diseases such as HIV or HCV (see DeBeck et al. 2009; Fischer et al. 2008; McCoy et al. 2004; Porter et al. 1997; Ward et al. 2000; Wong 2001).

### **BC Harm Reduction Strategies and Services**

The policy statement of the BC Centre for Disease Control (BC Harm Reduction Strategies and Services 2011) recognizes the diversity and marginalization of populations served by harm reduction. Much emphasis in the policy is placed on reducing stigma and discrimination as it “inhibits the distribution and recovery of harm reduction supplies,” (2011:1) and criticism is directed towards the criminalization of illicit drugs and the criminalization of the people who use drugs. Also, it recommends that each regional Health Authority and its community members work together to provide a comprehensive range of harm reduction services “that promote safer sex and safer psychoactive substance use, including legal drugs such as alcohol” (2011:1).

In the province of British Columbia, the BC Harm Reduction Strategies and Services Committee is comprised of representatives from: the Regional Health Authority, BC Centre for Disease Control and Provincial Health Services Authority, the BC Ministry of Healthy Living and Sport, and First Nations and Inuit Health. VCH is one of the 5 geographically distinct Regional Health Authority representatives in British Columbia, and is comprised of three health service delivery areas (HSDA), including: North Shore/Coast Garibaldi, Richmond, and Vancouver. The Vancouver HSDA is divided into six local health areas and the North Shore/Coast Garibaldi HSDA is further divided into seven local health areas, with two local health areas in Coastal Urban and five in Coastal Rural. It is estimated that the VCH population is 1.1 million, which is approximately 25 percent of British Columbia’s population (Vancouver Coastal Health 2011, accessed February 1, 2012).

### **Grassroots Organizations**

The grassroots efforts of drug user organizations such as VANDU have played a key role in shaping harm reduction in Vancouver. VANDU has been influential in raising public awareness of the systemic factors shaping drug use as well as informing services about barriers people who use drugs face when trying to access services. Therefore, both the harm reduction approach and involvement of individuals directly experiencing addiction and drug use played large roles in informing policies and programs for practices in prevention, treatment,

enforcement, and in reducing harm. For a list of peer-based services offered in Vancouver, refer to the Appendix C.

It was almost a spiritual thing that we had talked about, that the cry of suffering users themselves, if that could be heard publicly, that was the most powerful weapon of all...what is most denied and repressed in society is the collective expression of pain. There are so many institutions that privatize pain and keep it hidden, whether it is the psychiatrist's office, the mental health system, or bars. Facilitating the public expression of pain was the most subversive thing we could do. (Founder of VANDU) [Kerr et al. 2006:63]

Formed in 1998 with the purpose of bringing together groups of people who use drugs (Kerr et al. 2006:62), VANDU is the largest Canadian organization of its kind. Early in their work as advocates, this organization was dedicated to political activism and advocacy so that the “voice of users” (Kerr et al. 2006:63) could be brought into mainstream political discourse and de-marginalize people who use drugs from society. By inviting media, academics, and the public to observe their work, VANDU has been successful in engaging in multiple spheres of discourse. A service provider in fact described VANDU as being “key to public education” (Kerr et al. 2006:64). Now – at the municipal, provincial, and federal levels – representatives of VANDU are invited to be participants at policy planning meetings.

Alongside encouraging people who use drugs to engage in discussions around harm reduction interventions, VANDU plays a role in challenging the hegemonic structures of traditional client/service provider relationship. This helped reinforce the agency of the person who uses drugs not only to people who use drugs but also to the rest of the public. Important to this thesis is the way in which VANDU interprets harm reduction. Nowhere in VANDU's literature is there any mention of the reduction of rates in biocommunicable disease (VANDU 2010). Rather than the impetus for the greater involvement of people who use drugs be based on targeting the spread of disease, VANDU's mandate is to affirm and strengthen people who use drugs to “act as citizens and exercise real decision making power” (VANDU 2010:1). Therefore, their interpretation of harm reduction is focused more on social communicability than to biological communicability. Often, the latter is more prominently featured in the harm reduction objectives outlined by most health organizations.

P2P is a peer-based outreach program initiated by members of VANDU as a response to the service gap that communities outside of the Downtown Eastside faced with regard to the

accessibility of services related to safer drug use. Initially, the members would hold meetings in one of the parks in the Grandview-Woodland community. In 2004, P2P became a program operating within VCH's North Community Health Centre (Reichert and Associates 2009:3).

I had come across P2P because I was interested in studying how the presence of a peer organization affected the dynamics of a community as well as the Peer Members themselves. Across Canada, non-governmental organizations from other provinces are attempting to encourage the presence of peer-based programs to enable people who use drugs to be more involved with the organization and delivery of harm reduction services. However, there is still resistance from many provincial health ministries to fund these initiatives. Much of these attitudes, I suspect, stemmed from a mistrust of people who use drugs and skepticism over their ability to organize and their capacity to work. I wanted to find a model to show that peer outreach programs are operational. However, it wasn't until I started working with P2P that I witnessed the vast social impact it had in creating a more inclusive community.

The operational structure of P2P has remained more or less consistent (Reichert Associate 2009:4). There is an active membership of up to 15 Peer Members. There is one fulltime coordinator, and one casual Harm Reduction Worker. The P2P Coordinator is directly supported by the Peer Programs Coordinator of VCH and is indirectly supported by the Harm Reduction Coordinator, to whom the P2P Coordinator reports.

With regard to roles and responsibilities, the Peer Members are involved in this program through one or more of the following ways: (1) participation in the weekly peer support meeting, (2) active as a supervisor during the outreach patrol, (3) acting as outreach patrol members, and (4) serving as a kiosk volunteer. When community meetings are taking place or when special short-term projects of the P2P program become available, Peer Members are encouraged to participate. The P2P Coordinator's role is to directly supervise all Peer Members, the scheduling of outreach shifts, the facilitation of meetings and workshops, and community involvement. Finally, the responsibilities of the Peer Programs Coordinator include projection direction, honoraria, and program planning, which is to be done with the input of and in collaboration with the Peer Members, the P2P Coordinator, and community stakeholders (Peer 2 Peer 2011).

Weekly support meetings are held on Monday evenings from 6:00 PM to 8:00 PM. At each meeting, a Peer Member is chosen by the rest of the Peer Members to be the co-facilitator

for the following meeting. This role is rotated on a weekly basis. Being a co-facilitator involves helping pick up and bring supplies to the meeting room; preparing the meeting room and making coffee; greeting Peer Members as they arrive as well as introducing new Peer Members to the rest of the group; reading out the guidelines and the meeting agenda; assisting with activities or workshops; helping maintain focus during the meeting; assigning outreach shifts; cleaning up after the meeting; and assisting with payout.

At these meetings, Peer Members are given a meal and have the opportunity to share personal issues and concerns in a confidential environment. These meetings provide an environment where Peer Members can gain and provide support from and to other members. Occasionally, guest speakers are invited, workshops are conducted, and low-threshold volunteer opportunities are brought to the attention of the Peer Members. At the end of each meeting, members sign up for outreach patrol shifts.

There are six outreach patrol shifts per week, with each shift being three hours in length. During the majority of the year, the shifts take place on Tuesdays to Sundays during the afternoon from 2:30 PM to 5:30 PM, involving a team of two Peer Members – with one of the Peer Members acting as Peer Supervisor. Before a Peer Member can work a shift, he or she is required to attend a 3-hour harm reduction and needle recovery-training workshop offered through VCH. This workshop is co-facilitated by the Harm Reduction Program Coordinator and a Peer Member. The structure of the patrol shifts, and of the program itself, is very flexible. Peer Members are not required to attend all support meetings, and when a Peer Member is unable to make a shift, it is generally understood that circumstances make it difficult for most Peer Members to have structured lives.

To participate in the outreach shifts, Peer Members must have demonstrated reliability in attendance at weekly meetings as well as have personal knowledge and interest of the outreach target group. At the completion of each outreach shift, the Peer Members are given an honorarium of 25 dollars. To apply for the position of Peer Supervisor, the Peer Member must fulfill the same qualifications outlined for being an outreach worker. In addition, the Peer Member must have completed a first aid, CPR, or overdose response training. Peer Supervisors have additional access to training opportunities and are granted a stipend of 30 dollars per shift.

Prior to each outreach shift, the Peer Members are provided with a snack, one bus ticket, and a meal voucher to be used during the middle of the outreach shift. During the three-hour

shift, the Peer Members patrol a segment of the Grandview-Woodland community and identify as well as engage with people who use drugs. Engagement includes the distribution of harm reduction supplies such as sterile injection equipment, condoms, and safer smoking equipment; also, if requested, information about harm reduction as well as referrals to appropriate services can be given. “Sweeps” – retrieval of condoms and drug paraphernalia – are also conducted.

Other ways in which Peer Members are able to engage with the community are through meetings, training sessions, and workshops. Meetings and events that occur regularly include: sweeps meetings, harm reduction service providers meetings, Grandview-Woodland Outreach meetings, Under One Umbrella meetings, the Homeless Connect Event, and Harm Reduction/Needle sweeps training. The sweeps meeting occurs on a monthly basis and involves all programs in Vancouver that conduct needle sweeps. Peer Supervisors attend this meeting and are invited to describe the trends they are seeing. The harm reduction service providers meeting focuses on meta issues arising in harm reduction and takes place on a bi-monthly basis; this meeting is attended by Peer Members volunteering in the harm reduction kiosk. As an ad-hoc group that meets irregularly, the Grandview-Woodland Outreach meeting is made up of all outreach service providers from within the community. To attend these meetings, Peer Members enter their names in a draw. The Under One Umbrella meeting occurs on a monthly basis. Under One Umbrella is a collective of people who live or work in the Grandview-Woodland community. To attend this meeting, names are only drawn when the current Peer Member attending the meeting steps down from their representative role. The Homeless Connect Event takes place twice a year and is open to all Peer Members; participation may include setting up the event, providing information at the P2P table or helping out in food services. The Harm Reduction/Needle Sweeps training occurs on a monthly basis and is mandatory for all Peer Members conducting outreach shifts. Peer Members are selected on the basis of consistent attendance, and names are drawn if more than two Peer Members want to be trained. Aside from the aforementioned, Peer Members are told about coming events, trainings, and workshops at weekly P2P meetings. Peer Members are paid 10 dollars per meeting and 20 dollars per training session or workshop attended.

To conclude, organizations such as P2P serve as a useful example of programs that are produced as a result of institutional and grassroots collaboration. P2P is also a valuable example of the role locality plays in shaping the success of this program. Street-involved people, through

these programs, are given a venue where they can be involved in the shaping and delivery of health services to their peers. As illustrated in the literature review, a number of studies have shown the biological impacts of such groups, and some are beginning to investigate the personal psychosocial impacts on the peers involved in an outreach capacity (i.e. the Peer Members). However, few studies are available regarding the effects of these programs on the social fabric of the community, extending beyond the personal effects on the Peer Members themselves. The following chapter on methodology will outline how this type of research was approached.

## CHAPTER 3 METHODOLOGY

### Study Design

#### Empowerment as a Participatory Process

As a strategy for enhancing community health, social empowerment models of community transformation emphasize change through empowering individuals and communities as well as addressing the social and political context of the factors of the community (Brown 1991; Minkler 1989). On the individual and the community level, empowerment refers to “people having power to take action to control and enhance their own lives, and the processes of enabling them to do so” (Grace 1991:330). Critics of empowerment as a participatory process have indicated that historically, empowerment has been treated as a provider-client concept, where support and assistance was provided to individual cases, as opposed to being collaborated upon (Kirby and McKenna 1989; McCarty et al. 1996). Now, empowerment instead refers to the collective efforts to transform conditions that have negative impact for these community members as individuals and as a group (Mosher 1999; Treno and Holder 1997). As stated by Lather (1991:4):

I use empowerment to mean analyzing ideas about the causes of powerlessness, recognizing systemic oppressive forces, and acting both individually and collectively to change the conditions of our lives... Empowerment is a process one undertakes for oneself; it is not done ‘to’ or ‘for’ someone.

In attempting to apply the concept of empowerment to explain its role in mediating social inclusion and community capital among the Peer Members, their peers, and the greater community, the complexity and multiplicity of empowerment became evident. As will be further discussed in the following chapters, many of the Peer Members – despite having great pride in the work they did – disagreed with, or avoided using the term “empowering” to describe their experience with outreach work. However, in many of the Peer Members’ recollections of gradually overcoming personal barriers, developing a pro-social identity, finding a safe space, being involved in advocacy, and in observing the response of the greater community to the program, empowerment as a process – not as an end – was evident on multiple levels. From their stories, one could find empowerment at an individual, interpersonal, professional, organizational, and societal level (Ristock and Pennell 1996). From this, it is important to

recognize that rather than being an explicit gain or achievement; empowerment can also be a gradual implicit process that strengthens community interconnections.

### **Community-Based Participatory Research**

The lower classes of the populace, forced to live on the margins of society and oppressed since time immemorial, are beginning to speak for themselves more and more rather than relying on intermediaries... They are less and less willing to be the passive objects of demagogic manipulation and social or charitable welfare in varied disguises. They want to be the active subjects of their own history and to forge a radically different society. [Gustavo Gutiérrez, cited in Osborn and Small 2006:70]

Collective struggle and action – namely, the collective struggle to create an inclusive space that challenges the stigma faced by people who use drugs – is the prerequisite for social change (Sutton and Kemp 2011:262). Because placemaking is a social act of resistance that exposes “persistent structural inequities experienced in low-income ethnic minority communities” (Sutton and Kemp 2011:1), it is necessary to involve those socially and economically marginalized communities in redressing place-based inequities on their own terms (Sutton and Kemp 2011:3).

For work grounded in social action such as community-based research, one of the ways in which researchers can enable “place-making” is by adopting a more inclusive and collaborative approach that is driven towards gaining knowledge and creating change. In both research and practice in disciplines such as anthropology, public health, nursing, community development, and agricultural development, participatory methods have a well-established history (Hall 1992; Minkler and Wallerstein 2008; Wallerstein and Duran 2010). Methodologically, this study aligns with community-based participatory research, defined as “a form of action research in which professional social researchers operate as full collaborators with members of organizations in studying and transforming those organizations” and emphasizes “co-learning, participation, and organizational transformation” (Greenwood et al. 1993:177). The participation, influences, and control by non-academic researchers are believed to have positive implications for the validity of the research findings as well as assist in ensuring that those findings can be used to inform and foster social change at the local level (Roche et al. 2010).

As described by Roche et al. (2010:4) in their examination of community-based research projects that adopted a peer research approach, the definition of peer research and the role of

peer researchers vary “according to context, community, the nature of the project, the understanding of community-based research, and over time.” Although the aim is to engage and enable community members as “partners” or “collaborators” in the research process, there remains considerable variation as to how these projects are implemented or designed (Roche et al. 2010). However, drawing from the works of Israel et al. (1998, 2005) as well as Minkler and Wallerstein (2008), Roth et al. have established the following as key principles of community-based participatory research (CBPR):

1. CBPR recognizes community as a unit of identity.
2. CBPR begins with and build on strengths and resources within the community.
3. CBPR facilitates collaborative, equitable partnership in all phases of the research, involving an empowering and power sharing process.
4. CBPR promotes co-learning and capacity building among all partners involved.
5. CBPR integrates and creates a balance between knowledge generation and action for mutual benefit of all partners.
6. CBPR emphasizes the local relevance of public health and social problems and ecological approaches that address the multiple determinants of disease and wellbeing.
7. CBPR involves systems development through a cyclical and interactive process.
8. CBPR disseminates findings to all partners and involves all partners in the dissemination process.
9. CBPR involves a long-term process and commitments.

Often distanced from mainstream services and structures, people who use drugs have seldom been included in discussions of issues that affect their lives (Canadian HIV/AIDS Legal Network 2007). For over a decade, organizations by people who use drugs, such as VANDU, have demanded to have a more active role in determining what they need – be it in the healthcare system, the political arena, or in wider society (Osborn and Small 2006). As previously discussed, people who use drugs are best able to identify the needs of their community as well as raise awareness of gaps in services and policies. Effective responses have been created and people who use drugs have demonstrated that they can organize themselves and contribute to the community. Examples include: expanding the reach and effectiveness of HIV prevention and harm reduction services by making contact with those at greatest risk, providing much-needed care and support for people who use drugs, and advocating for their rights and for the recognition

of their dignity (Canadian HIV/AIDS Legal Network 2007). Therefore, greater involvement of people who use drugs in initiatives including community-based research is an effective process in gaining knowledge and creating change.

As outlined by Roche et al. (2010), greater community involvement in research is important for the following reasons: improved access to and greater representation of marginalized groups in research, having data that are richer in quality and more authentic in their representation, and creating opportunities for local capacity building and empowerment (Minkler and Wallerstein 2008; Israel et al. 1998, 2005). Aside from including people who use drugs on an informative basis, there are both practical and ethical imperatives for including people who use drugs. First, in Canada and many other countries, people living with HIV/AIDS are significantly represented by people who use drugs (Canadian HIV/AIDS Legal Network 2007). Secondly, as an ethical and fundamental principle to meaningful involvement, all people should have the right to be involved in decisions affecting their lives. The United Nations “International Guidelines on HIV/AIDS and Human Rights” urges states to involve representatives of vulnerable groups, such as people who use drugs, in consultations and in the planning and delivery of services.

In addition to adopting a community-based participatory approach, an ethnographically informed process evaluation in interventions is particularly useful for understanding how local contexts and specific populations influence the implementation and impact of interventions. The flexibility of ethnography to account for changing conditions enables the documentation of unanticipated findings, participants’ lived experiences, and their evaluations of these experiences.

As was previously mentioned, there are few explicit models of peer research available. However, of the three broad models of peer outreach described by Roche et al. (2010), the study design was most similar to the advisory model, where peers play an advisory role. Although the peers were largely removed from the operational tasks of the project, they were involved with providing guidance on the design and research methods, as well as with the translation and dissemination of the knowledge.

Facilitated by the Health Systems Planning Advisor of VCH, during October of 2010, the researcher, the Coordinator of Harm Reduction Programs, and I exchanged ideas for identifying research questions. The ideas were forwarded to the Peer Programs Coordinator of VCH.

Following up on these consultations with the Coordinator of the P2P Program, the Coordinator of Harm Reduction Programs and I then discussed the ethics review processes at VCH and at the University of Saskatchewan. The need to involve the Peer Members fully in developing the research questions and ensuring their participation throughout the research process was also discussed.

During January of 2011, the initial draft of the research proposal was sent to the Coordinator of Harm Reduction Programs. Over the phone, the Coordinator and I discussed changes to be made to the proposal, as well as reworking the research proposal into a document that could be presented to the Peer Members for their approval. We also discussed how the results from the data could be used. In February, the P2P Program Coordinator shared the revised proposal with the Peer Members during one of their weekly meetings, during which they voted on whether or not they would be interested in collaborating in this project. The Peer Members expressed interest in a collaborative project, stressing, however, that they wanted a project that focused on their accomplishments within the community as a group.

After ethics approval was obtained through the University of Saskatchewan, I flew to Vancouver and attended one of their meetings to meet the Peer Members directly, presented the research proposal and answered questions. Upon exiting the room, the Peer Members voted and I was informed the following day of their decision. During the rest of June and the early part of July, the proposal, research questions, and interview guide were refined with the input of the Peer Members. As a group, we also discussed how the results would be disseminated in a way that would directly benefit the Peer Members and the program. The Peer Members and I agreed that aside from the thesis, the data would be used to create a peer advocacy piece for P2P as well as a presentation for the Peer Members to take to conferences and other events.

### **Setting and Population**

#### **The Land**

Adjacent to the Port of Vancouver and separated by a barrier of industrial land, the Grandview-Woodland district sits to the east of the Downtown Eastside neighbourhood. Described as a working class area consisting of mainly single-family dwellings and apartment units, the eastern half of the area is filled with old wood-frame houses with towering trees lining the streets while three-story apartments crowd the western half (Ley and Dobson 2008). Throughout the neighbourhood, particularly in the residential areas and the parks, are bushes and

trees with various kinds of wild berries. Recently, many of the parks, particularly the skateboarding park, have had many benches removed as a way to discourage loitering and public drug use. Creative uses of space also reflect the transient and homeless population of Grandview-Woodland. Although frequently searched by security, the tunnel underneath the train bridge, hidden away by thick foliage, is a popular area for shelter. It can be accessed either by climbing over the bridge and one of its ends and carefully walking down the steep tangle of bushes and trees to the tunnel; or climbing over the side of the bridge and leaping onto the net-like mesh fence that hangs across the bridge. Often, notebooks, shoes, pens, articles of clothing, or even bags are left on the mesh fence during the day. In the business district, the diversity of the local shops, organic grocery markets, independent coffee shops, and ethnic restaurants that punctuate Commercial Drive – the main retail street running north to south through the community – aptly reflects the counter-cultural style and the ethnic diversity of its residents.

### **The People**

The Grandview-Woodland community has had a long history of multiculturalism. After the First World War, Italian, Chinese and East European immigrants arrived in the area, followed by a second wave of Italian immigrants moving in after World War II. During the 1950s and 1960s, as some of the earlier Italian and East European residents moved into other neighbourhoods, the number of Chinese residents increased. Later during the 1960s, East Indian residents began to make the community their home (Dobson 2007).

Throughout the year, due to Vancouver's temperate climate and this particular neighbourhood's counter-cultural vibe, Grandview-Woodland is a popular destination for young backpackers from across Canada. These youth are commonly dressed in the distinct "crust punk" style of chains, studded collars, dark baggy clothing, and heavy make-up. Despite the Grandview-Woodland community's reputation for social tolerance, there is – as described by a local retailer – (Ley and Dobson 2008) an intolerance for "corporations and stuff like that." During its first few months of business, Starbucks had its windows smashed on a regular basis (Dobson 2007). Nowhere to be seen in Commercial Drive, chain stores such as McDonald's, A & W, Starbucks, Blenz Coffee, and Booster Juice are more or less concentrated within the same block near the Broadway-Commercial SkyTrain Station.

With its "well-established counter-cultural lesbian and leftist presence" (Ley and Dobson 2008:2487), neighbourhood ambience, cheaper rents, and old industrial spaces, many artists are

attracted to the Grandview-Woodland Community. However, despite decades of predictions that this area would become a trendy inner-city neighbourhood (Berson 2005; Bulhozer 1979; Hanson and Daniels 1974; Jackson 1984; Smith 1976; Stainsby 1989), this neighbourhood seems to have undergone decades of stalled gentrification (Ley and Dobson 2008). Although many young, White professionals with few or no children (Bohn 1981) did move into this area, few stayed. This was often due to the noise coming from the truck traffic down the main streets brought working industrial waterfront; the stench of the meat- and fish-stripping plant, West Coast Reduction; and the perception of danger, with the district ranking third after Downtown and the Downtown Eastside among Vancouver's 24 local areas in terms of criminal assaults (Sinoski and Bohn 2008). The local SkyTrain station is perceived by Grandview-Woodland locals as the source for bringing in "undesirable outsiders" (Ley and Dobson 2008:2488; Mosca and Spicer 2008) that congregate to engage in drug trafficking.

The residents of Grandview-Woodland are quite family-oriented and engage in a number of self-policing activities that could be described as collective socialization. There is the Grandview-Woodland Community Policing Centre (CPC) that is volunteer-run and works in partnership with the Vancouver Police Department. Also, according to one of the Peer Members, several years ago, families and many of the older residents of this community organized a "Shame the John" campaign. Community members would carry around cameras and take pictures of patrons to discourage the patronage of prostitution in the neighbourhood. Because many of the clients were being driven to other neighbourhoods of Vancouver, many sex workers eventually relocated to offer their business elsewhere.

Although this community tends to attract younger people with similar political views as the residents whom have lived in the area for several years, there is still a conflict of expectations of appropriate public behaviour between the two groups. As noted by Ley and Dobson (2008:2492), this tension stems from "the evolution of the local balance of power between recent gentrifiers and the older, more tolerant, public culture of Grandview-Woodland."

According to the Commercial Drive Community Surveys from 1997-2007 (Mosca and Spicer 2008:5) there is a high level of appreciation for the "social awareness, diversity, artistic ambiance, tolerance, and vibrant street life" of the neighbourhood while also expressing a level of tolerance for activities and situations such as passive panhandling, street vending, and public recreational drumming on the streets that might be viewed problematic elsewhere. However, an

increased number of residents perceived the following activities as “completely unacceptable”: aggressive panhandling, discarding syringes, disposing of condoms publicly, and sex trade involvement in residential areas and near schools.

However, as property prices inflate, street people are becoming more visible. The neighbourhood went through many changes when Vancouver hosted the 2010 Winter Olympics. The Britannia Community Centre – the community/municipal center for Grandview-Woodland – was used as a training centre for the men and women’s hockey teams. With the expectation that this neighbourhood, especially near the Commercial Drive strip, would attract many tourists, police enforcement intensified, public benches were removed from parks, surveillance cameras were installed outside of business buildings to discourage loitering, and many local businesses hired people to provide security and do needle pick-up. Many of the Peer Members had attributed this event to the lack of outreach opportunities since, and were informed that many of the peers to whom they provided outreach to had either stayed mostly in their housing complexes or were driven to the Downtown Eastside. Nonetheless, much displacement had resulted, affecting peer services such as P2P.

### **The Services**

The services available in Grandview-Woodland for people who use drugs appear to encourage the involvement of people who use drug in community events while also providing subsistence interventions, thus enabling these people to survive in the community. In this community, the Grandview-Woodland Policing Center circulates newsletters to inform the community of the latest events, incidents, and developments. Other newsletters such as Community Lines or those by Under One Umbrella are targeted toward informing low-income people who use drugs of community events and resources. Reflective of the resourcefulness of the Peer Members, a list of resources within the Grandview-Woodland Community was compiled by the Peer Members of P2P (Appendix A). This list was regularly updated and was used as a resource guide to be shared among Peer Members and as an outreach guide.

In terms of social housing properties, Grandview-Woodland has a large number of these projects. There are roughly 70 projects with over 2100 subsidised units, which is roughly 15 percent of the neighbourhood’s housing stock. Among this number, 22 buildings are for urban natives (Dobson 2007).

Because residents with mental health challenges are among a large number of residents living in social housing, subsidised rental units, and housing cooperatives, Grandview-Woodland is also home to the Kettle Friendship Society. The Kettle Friendship Society is a non-profit organization that offers 26 services, a mental health drop-in centre, transition housing for women, and over 200 units of supported housing. Immigrant and refugee communities have traditionally represented large number of Grandview-Woodland's residents. For immigrants and refugees residing in Grandview-Woodland, the multilingual non-profit organization MOSAIC provides multilingual services that focus on advocacy, public education, and community development.

In 2009, the city council included Grandview-Woodland in the Vancouver Agreement. The purpose was to create population diversity, which was perceived as a key component of sustainability. According to the Vancouver Agreement, the creation of a sustainable community required that "all organizations from informal groups to governments" work "effectively together to improve the quality of everyone's life" both "now and in the future" (Murray 2011:33). Hints of regulated gentrification and economic development can be found in the following statement from the Agreement (2009):

The community continues to include and support lower-income individuals and families, and people who require specialized services for mental illnesses and addiction. It should also be open to new people, lifestyles and businesses.

Although the motto of this Agreement was to revitalize while avoiding displacement (Murray 2011:33), findings by Dobson (2007) as well as recent events such as the 2010 Winter Olympics seem to suggest otherwise. Although gentrification may seem stalled, enough transformations have been made in the community, representing an "intra-neighbourhood pattern of simultaneous upgrading and downgrading" (Dobson 2007:127).

### **Study Participant Characteristics**

For a brief description of each participant, refer to Appendix A. Reflective of the transient and mobile nature of residents within the Grandview-Woodland community, the membership of P2P varies. A comparison of the study participant characteristics from this study to the one conducted for a program evaluation by Reichert and Associates (2009) supports this. Participants of this program often drop in on an ad hoc basis (Reichert and Associates 2009).

The program does not collect baseline data from participants, hence there currently lacks a mechanism to capture demographic information. Therefore, the descriptions presented here apply only to the participants in this research. In terms of involvement, all the participants from this study indicated that they had heard about this program via word-of-mouth from a peer, service provider, family member, partner and/or Peer Member. In total, the length of connection to the P2P program ranged from two weeks to five years, with the average being one year. One Peer Member noted, “We’re going through a stormy period,” indicating that in the past, membership was more stable.

Over the duration of the summer I was with P2P, there were in total 15 Peer Members involved with P2P, which is the average number of members involved with P2P at a time. Of those 15 Peer Members whom I had met at the Peer Support Meeting, 13 were interviewed, including three Peer Supervisors. All of the Peer Members interviewed had been, or are currently, involved in peer outreach work. Six identified as female, and seven identified as male. Ages ranged from 23 years to 66 years, with the average age of participants being 32. Four of the participants had lived, at one point, in the Grandview-Woodland Community, one currently lives in the Community, and the rest live in other neighbourhoods and have to travel either by foot or public transportation to attend peer support meetings and conduct outreach shifts. Two of the participants reported being of Aboriginal heritage. In terms of education, most indicated that they had completed high school, and six of the participants had at least some post-secondary education; additionally, one of the Peer Members is currently pursuing post-graduate education and another Peer Member had completed Post Graduate and Professional Degrees.

### **Operational and Ethics Approvals**

Approval to conduct this research was granted by the University of Saskatchewan, VCH, and the University of British Columbia. All three agencies reviewed the proposal application, the oral consent form, and the transcript release form.

### **Data Collection and Analysis**

#### **Participant-Observation**

Prior to participating in the peer outreach shifts, I took part in the harm reduction training that was mandatory for all Peer Members involved in picking up needles. This workshop was co-facilitated by Harm Reduction Coordinator and a former Peer Member who was one of the founders of P2P. Those attending this workshop included frontline workers from professions

such as social work and nursing. Peer Members were also required to attend this workshop but during the time I was there, all the Peer Members had already completed their training. Participating in this workshop was useful to understand the organization and delivery of harm reduction in Vancouver. Also, taking up this workshop enabled me to participate in the outreach shifts and help the Peer Members pick up needles, as opposed to being limited to observing them. I participated in at least two outreach shifts per peer supervisor and was able to observe the outreach activities being conducted in various parts of the Grandview-Woodland neighbourhood. While assisting in the picking up of needles, including keeping record of the number of items picked up as well as the number and location of outreach opportunities, field notes were taken. The field notes focused on the receptivity of peers, local business owners and other neighbourhood residents to the outreach services, the types of locations visited, how the Peer Members engaged the public, and how the Peer Members interacted with one another. Also, because participation in these shifts occurred prior to interviews, engaging in the shifts helped inform the interview guide. Initially, I had carried around a voice-recording device during these shifts to supplement the field notes although I was not planning to quote any of the Peer Members outside of the interviews. However, although the Peer Members would instruct me to record certain aspects during the shifts or wanted me to quote them during the shifts, the Program Coordinator, to protect and serve the best interests of the Peer Members, saw this as a breach in privacy and requested that I not use my recorder.

### **Interviews**

Participants were consulted regarding the nature of the questions presented in the interview guide (Appendix E). These questions were presented to the Peer Members during one of their support meetings. They divided into groups to critique the questions and their feedback was returned to me over the next several days. This was particularly useful for someone who had not previously encountered a peer organization. Furthermore, each peer organization is unique so from the feedback of the Peer Members, I could refine my questions. I also received feedback from the Peer Members while conducting outreach alongside them. They had suggestions on how to make the questions more accessible, as well as which questions did not pertain to their group.

For the first several interviews, the Program Coordinator had organized a sign up sheet that would be distributed among the group during the support meetings. At first, only the Peer

Supervisors signed up to be interviewed. However, through word of mouth and by developing trust with other Peer Members during outreach shifts, more Peer Members signed up. The fact that I was from Saskatoon got many of the Peer Members interested in teaching me about P2P, hoping that their model could be expanded to different provinces. Knowing that someone from another province had heard of their group made the Peer Members proud of the success of P2P and more eager to share this success. Eventually, I was able to interview 13 out of the 15 Peer Members involved with P2P at the time. This allowed the study to give a representational portrayal of the Peer Members' experiences being in P2P.

Semi-structured open-ended interviews with each of the 13 participants were undertaken, recorded, and transcribed verbatim. The voice recorder was placed on a table between the participant and me. The length of the interviews ranged from being 20 minutes to two hours. The Peer Members generally chose where they would like to have the interview take place, with the Peer Room being the default, although least popular, option. Popular choices included parks and the occasional coffee shop. However, after two interviews, the owner of a coffee shop at the SkyTrain station began arranging the chairs so that only single seating was available.

The interview questions focused on the Peer Members' experiences with the program. Topics covered included: the length of time the Peer Member had been involved as a peer member; how he or she had discovered the program and why she or he had become involved; what kept him or her in the program; roles and responsibilities of Peer Members; what being a peer personally meant; whether or not peer initiatives were important; whether or not the program encouraged leadership; whether the program affected how the Peer Member engaged with his or her communities; what the Peer Member did outside of the program; and reactions of family, neighbourhood residents, peers, and friends to their involvement. During the interviews and during fieldwork, the participants for the most part were very eager to share their knowledge and experiences, particularly focusing on their progress in stabilizing their lives. Also, the fact that I was from Saskatchewan and had no previous experience working with peer programs affected the dynamics in our relationships as they were the experts on the topic of harm reduction, peer programs, and its associated factors.

### **Analysis**

All in-depth interviews were entered into MAXQDA 10 Plus for analysis for coding. Codes were generated deductively, from the theoretical framework, and inductively, from themes

identified in patterns of responses and observations from the data. The inductive codes were then used to inform and modify the original framework. Deductively derived codes, as previously mentioned, included the meaning of peer work for participants, others' reactions to their outreach work, and motivations and barriers to participating, whether the program affected their lives outside of P2P and their interactions with the community. Inductive analysis using these codes revealed additional themes, including: forming an inclusive space; the multiple levels of community; navigating barriers; structuring identity; exclusion and displacement; and the negotiation of power. In total, 50 codes were derived (see Appendix F).

The next step in the qualitative analytical process was to examine the codes and the processes that related them. I then used these derived codes and fieldwork observations to revise the theoretical model. For instance, although the theoretical framework was still oriented towards the individual Peer Member and how they related to their environment, more emphasis was placed on social exclusion and the processes of placemaking within the multiple levels and spheres of community, rather than on social capital and the processes of diffusion of harm reduction information.

## CHAPTER 4 DEFINING BOUNDARIES

How was a group of individuals transformed from being displaced and stigmatized outcasts to being authoritative and humanized members of a community? For many socioeconomically marginalized members of a community, exclusionary policies and practices often prevent – if not discourage – meaningful participation in one’s own community (Burchardt et al. 1999). However, this inability to engage was commonly interpreted by the general public as a deliberate unwillingness to contribute. Consequently, the image of the excluded individual as the “anti-citizen” became reinforced in the Peer Members’ interpretation of themselves and their place in the community. Therefore, before the process of placemaking could be explored, it was necessary: (1) to identify the multiple barriers, identified by the Peer Members, that resist placemaking; and (2) to examine the criteria, as perceived by the Peer Members, that determine membership within a community. The purpose of this chapter is to outline how social displacement forms the anti-citizen. Both parts illustrate that displacement and citizenry are important determinants of place that shape interconnections within a given space.

### **Casting and Conforming the Anti-Citizen**

One of the themes prevalent throughout the research was the lack of place among the Peers Members, which was reinforced by their daily exposure to social exclusion. To them, exclusion took shape in multiple forms and presented itself both explicitly and implicitly through varying modes and frequencies. Many of the policies and practices that reinforced marginalization among people who use drugs were based on a general lack of understanding among the greater community of the broader structural issues that contributed to illegal drug use. In terms of community connections, it soon became evident that a dynamic interplay existed among structure, societal seclusion, and stigma. Applying Grenier and Guberman’s (2009) framework of social exclusion, this section illustrates how different forms of social exclusion fed into an interplay that cast people who use drugs as being without agency and displaced all structural associations that shaped drug use from the rest of the public. By disrupting community interconnections, social capital cannot be established. This in turn denied the Peer Members and their peers opportunities to participate in civic affairs or in economic and social production, which ultimately eroded their wellbeing and health-seeking behaviour.

## **Geographic Exclusion**

Without place, social capital cannot be formed. The lack of social, political, and geographical place available for people who use drugs makes it difficult for them to establish or maintain the interconnections necessary for participating in community dynamics. The combination of unstable housing, incarceration by law enforcement officers, city bylaws limiting the occupation of public space, play a large role in contributing to the transiency and displacement of people who use drugs. Because regulation of these environmental and structural factors is beyond the control of people who use drugs, these people are often compelled to relocate quite frequently, thus limiting opportunities to form and sustain social networks.

A most recent example of geographic displacement in Grandview-Woodland was when Vancouver hosted the 2010 Winter Olympic Games. In preparation for the Games, the city applied some form of James Q. Wilson's broken windows theory to regulate the revitalization and redevelopment of the city. Wilson posits that because the appearance of a local physical environment influences the behaviour of its locals, maintaining and monitoring the order of urban environments may prevent vandalism from escalating to more serious forms of social disorder (Coutts and Kawachi 2006). Then-Mayor Sam Sullivan had released an urban revitalization strategy titled, "Project Civil City," which outlined policies intended to enable "citizens" to reclaim their sense of place by "[choosing] to live in high-quality, ecodense neighbourhoods [which] requires a commitment to minimize public nuisances and improve public order and community safety" (City of Vancouver 2006:3). Recommendations included the removal of "public nuisances" such as aggressive panhandling as well as increasing the number of surveillance cameras to be installed. Incorporating Jane Jacob's concept of "eyes on the street" as a form of natural surveillance, Sullivan expanded funding to the Downtown Vancouver Business Improvement Association's (DVBIA) Downtown Ambassador Program (City of Vancouver 2006:9). In addition to assisting the public with directions and checking in with local businesses, these Ambassadors were responsible for decreasing graffiti, litter, aggressive panhandling, visible drug dealing, and passed on information they collected to the police. However, these initiatives did little to benefit those who could not "choose to live" in such high-quality, ecodense neighbourhoods. In 2008, Pivot Legal Society, United Native Nations, and VANDU filed a complaint to the B.C. Human Rights Tribunal. According to the

complaint, the Downtown Ambassadors Program had exhibited “systemic discrimination” towards “Vancouver’s street homeless population” (Lupick 2008). Allegedly, people sitting or sleeping on the sidewalk were ordered to “move along” and were told that they were not allowed on a number of publicly open premises. Through this mission of restoring public order, the homeless were displaced from the public spaces they once transiently occupied.

Historically, Grandview-Woodland has been known throughout Vancouver for its tolerance towards the impoverished populations that frequented the neighbourhood’s streets (Ley and Dobson 2008). However, the increase in surveillance and the added restrictions to the use of public space suggested otherwise. More business owners and building managers hired security guards and installed outdoor security cameras. A number of park benches were removed to reduce loitering and crime. Peer Members involved with P2P began to witness a significant decline in the number of people who would normally access their services. Tegan, a soft-spoken young woman who had been a Peer Member for approximately two and a half years, recounted:

When that [the Olympics] came, that was huge for our group. A lot of areas where people were using drugs were cornered off and shut down or fenced off... So that the community wouldn’t see the homeless people there, right? And they’re kind of pushed out of the community... So they had huge guards and everything. And also, just some smaller areas where we would pick up some needles and stuff, they had fenced them off or boarded them up, so people couldn’t use there. Just so people coming into Vancouver from outside of Vancouver would get a good view of what Vancouver’s like. You know? Like clean and stuff, and they wouldn’t see drug use and have a good opinion to take away. It was mostly for the tourists. Cameras everywhere.

In order to hide evidence of drug use and social disorder, heavy surveillance was applied to displace the physical bodies of the homeless from public awareness. One year after the Winter Games, the number of outreach opportunities remained substantially reduced. When asked about what had happened to their peers, the Peer Members replied that many chose to stay indoors to avoid public scrutiny and encounters with the police. Others moved to surrounding neighbourhoods such as the Downtown Eastside, where public drug use was more prevalent. It was not uncommon to hear Peer Members use words such as “swept away” (Maggie) and “pushed out” (Tegan) to describe the routine territorial displacement that took place. Through these words, one can imagine the dehumanizing effects of geographic exclusion that is found in the allocation of services and law enforcement. This language reflected the shared perception among the Peer Members that people who use drugs were often relegated to the margins of the

community in order to maintain the healthy image of a city. Frustrated that many of the services for homeless and addicted people were concentrated in the Downtown Eastside, and that people from surrounding communities were being directed to the Downtown Eastside in order to access those necessary services, Peer Member Maggie referred to service providers as “the herding class.” This alluded to the lack of agency among people who use drugs, which explained why the Peer Members often felt that the dominant class – which included service providers from professional sectors, politicians, and gentrifiers – was to blame for how people who use drugs were being regulated to specific spaces. There was also the shared use of the phrase “conducting sweeps” among the Peer Members. In its original sense, this referred to the task of collecting discarded drug paraphernalia and condoms off the streets during outreach shifts. However, “conducting sweeps” also referred to the periodic patrol rounds law enforcement officers conducted throughout the day to drive away people who use drugs. Not surprisingly, none of the Peer Members saw this as effective in dealing with the issues underlying drug use. According to Craig, another Peer Member, because city officials did not want tourists to be exposed to the deplorable conditions of the Downtown Eastside during the Winter Games, many homeless addicted individuals were apprehended and kept in jail during that event:

And it [the issue of drugs and homelessness] was just swept – swept away, swept under the carpet, right? Not to speak of, done discretely. And that’s how they [the police] wanted it. Just sweep people away and the problem doesn’t exist, you know. Hastings is fine – for three weeks.

For other Peer Members, attempts at being responsible citizens while preserving what remained of their social environment further exacerbated their marginalization. Throughout the duration of this research, Raina and Pete worked towards regaining custody of their child. Their efforts to fulfill the Ministry’s requirements while working several jobs, however, placed them in a paradoxical dilemma:

We’re so busy with like – we have parenting groups, and then drug and alcohol groups and then our visits, and we work and – I also work at Insite, in the chill room. And yeah, so that’s another – It’s like a big drop-in centre for people that are high, right? And I mean, you know, that’s the other... but that’s my other source of income as well, so...

I became homeless when I moved back out here from the Kootenays. And so I lost my child to the Ministry, and he’s been in care for eight months. And I still can’t find a two-bedroom suite. I have to find at least a two-bedroom suite before he can come home, so... I see him twice a week and, you know, I

bring presents and stuff like that, but it's really tough. He asked to come home at the end of every visit, you know, he's like, "But I want to go with you!" And I'm like, "I know, baby, I know! I love you so much but we can't bring you home right now," so it's tough. Yeah, it's tough. But we're working on it. Like, I mean, I'm on as high up as I'm going to get on the wait list for BC housing but we only have up to eight hundred dollars a month, including utilities and everything, so. It limits our ability to find a place, right? And I don't know any other city. We're looking for places out as far as Surrey, but... Yeah, because I mean, that's where the cheaper places are, but we would just – we would be so lost if we went out there! Yeah, so... Yeah, I really, really want to stay living in the Strathcona area in Vancouver somewhere, so... We're trying. We're trying to find a place. [Raina]

As inferred by the passage above, place is more than geographical. Place is formed from the multiple relationships between the individual and their places of employment, the services they access, their family, peers, and friends. When Raina stated that she and Pete "would be so lost" if they moved to Surrey, she was not referring to navigating the physical structure of the city itself. Rather, the possibility of having to move to an unfamiliar city where rent was cheaper meant that Raina would have to seek employment elsewhere. Given that she was already at the margins of the labour market and relied on low-threshold employment opportunities to support the family, this would have created more of a financial barrier to her efforts in regaining custody of her son. Furthermore, moving would have separated both her and Pete from familiar health and social services, as well as from the supportive environment they currently shared with other Peer Members. Being dislocated from a place and "becoming lost" therefore meant losing the social structures that otherwise would have provided a network of support in both social and material forms.

Meanwhile, in a separate interview, Pete emphasized that every step he took in life was carefully oriented toward one goal: being able to raise his and Raina's child. Having suffered a neck injury two years prior, Pete no longer had the capacity to do the intensive physical labour required for working in the oil fields. Forgoing a scheduled surgery in order to secure, or work towards securing, a stable source of income, he instead decided to complete a Certificate in Community Capacity Building at Simon Fraser University. From Raina and Pete's experiences, it became evident that in trying to fulfill the requirements to prove themselves to the Ministry as being adept parents, both individuals risked compromising their ability to survive. For Raina, moving meant losing her income and network of social support; in Pete's case, delaying a

medically necessary procedure in order to provide for his family compromised his physical wellbeing. Like the homeless individuals who were displaced during the Winter Games, Pete and Raina risked losing the social capital they currently shared with their peers, Peer Members, and the services they accessed. In order to derive support and resources through social capital, developing and maintaining a sense of place by forming a proximal community or network with others is crucial.

### **Institutional Exclusion**

Like Pete and Raina, in order to access various healthcare and social services, attend classes, and work multiple jobs – which were often located in different communities – many of the Peer Members relied on public transit. Despite challenges associated with coordinating schedules and with traveling to multiple locations, a number of Peer Members took great lengths to access these services. Mark, one of the Peer Supervisors, made regular trips to the food banks in Richmond. Transportation, location, and timing – although challenging – were, however, not among the factors identified by the Peer Members as being the primary barriers to accessing services or employment; rather, it was the denial of services and the lack of employment opportunities that acted as barriers. Empirical data from a population consisting mainly of people who use injection drugs from Vancouver’s Downtown Eastside indicates that approximately 30 percent of people who use injection drugs participate in the labour market at any given time (Richardson et al. 2010). Meanwhile, there is still 70 percent of that population that remains unaccounted for. Unfortunately, for those who are heavily addicted, drug use leaves both physical, psychological and social scars that exclude these people from the labor force, housing, and from services (Cross et al. 2001; Pager 2003):

There’s a lot of jobs out there for people that... Like people that don’t have addictions and stuff and there aren’t a lot for people that do have addictions. And a lot of jobs just discriminate and stuff. [Miranda]

‘Cause you’re treated different, right? You can’t get housing, or like, you know what I mean? It’s like you can’t get housing, you can’t get proper health care. I’ve seen people – they have cancer and they have huge sores on their leg and stuff and they can’t get Tylenol 3’s from the hospital for pain because they’re labeled an opiate user, so they have to suffer and they’re forced to use more street drugs, right? Like, instead of getting help from medical people and getting the proper medication that they need, right?... I mean, the stigma still carries on. Once you’re labeled as a drug addict in the medical system and stuff like that – Even if you’ve been clean and whatever,

you still go to St. Paul's Hospital and it's on your file that you used to use drugs, they totally are very harsh to you. They won't serve you. They won't treat you. [Raina]

Raina and Miranda made it clear that societal relations played a large role in restricting the ability of their peers to access resources pertinent to their health. Worse yet, such barriers drove those peers to remain dependent on street drugs to regulate their pain. Being unemployed and unable to access care, the Peer Members and their peers were often thrown into a paradoxical form of abandonment where, despite their efforts, they were blamed for being sick and poor and were, as noted by Craig, treated as a burden to the rest of the community. In his criticism of Canada's "bi-polar drug policy," Philippe Bourgois (2003:35) argues that while the Canadian social welfare support system "softens the pharmacological destructiveness of injection cocaine," there remains to be desired substantial- or coherent-enough policies and practices "to offer marginal, urbanized substance abusers a viable alternative and to integrate them in a dignified manner into the labor market." Many of the Peer Members expressed interest in being employed, but because they had – in some way, shape, or form – been marked by their addiction, had great difficulty being employed. The following excerpt demonstrates how physical scars left by drug use can be used by employers to demarcate who can and cannot reenter the workforce:

It's not their [people who use drugs] motives or their affective level, you know, of engagement, it's really how all this stuff is set up –that people are excluded from being considered part of, just... everyone in society, and it's really, really difficult for people to reenter. Especially when a lot of them... Like, some of the drugs have given them... It's affected their appearance. Like the different kinds of speed, you know. Like ones with problems with their teeth and gums breaking down, and the tissue and stuff like that, and their faces. And it's going to show forever and it's very hard for them to get jobs again and even if they have an education, because they're marked by that. [Maggie]

Maggie's words illustrate how physical manifestations of heavy addiction come to symbolize a lack of motivation to engage in market dynamics. In accordance with other ethnographies on the socially excluded (Biehl 2010, 2001; Bourgois and Schonberg 2009), the policies and public attitudes encountered by the Peer Members were structured around the sentiment that the worth of an individual is dependent on his or her value to society. True to Biehl's (2001) ethnography of a society operating through market dynamics, whether an

individual belongs to that society is dependent on his or her ability to contribute to the labour market. In this sense, the individual's sense of worth, now a measurable economic commodity, becomes abstracted from his or her body. Raina had stated that society's perception of drug addicts as unsanitary and unemployable citizens revolved around the collective belief that "You're an addict, you're a failure, you're useless... you're a drain on society, you can't do anything, you're not competent." This brings to mind George Lamming's (1960) assertion that the abandoned is often left to feel a sense of exile by his or her inadequacy and irrelevance of function.

### **Symbolic Exclusion**

A study conducted in Vancouver on drug use and employment (see DeBeck et al. 2011) suggests that the reason why individuals such as Miranda, despite having a college education, have difficulty finding employment is partially due to the implicit assumptions employers make regarding the capacity, interest, and motivation people who use drugs have to engage with the labour market. Although it cannot be assumed that all employers think this way, and although there is no evidence that employers in Grandview-Woodland share this view, it is important to note that the majority of the Peer Members did not reside in Grandview-Woodland and sought employment throughout Vancouver. Nonetheless, discrimination amongst employers does exist; for instance, having a criminal record is shown to severely limit licit employment opportunities among people who use drugs (Pager 2003).

Without formal employment as a means to generate income, several of the Peer Members and their peers had no other option but to resort to other available income generation opportunities that were often illegal and were associated with street disorder. These activities – including street-based sex work, drug dealing, squeegee activity, panhandling, and recycling/salvaging/vending – were generally considered by the community as a whole as unacceptable activities (DeBeck et al. 2007; Mosca and Spicer 2008). These disorderly activities consequently fed into the public's perception that all people who use drugs were disruptive to the social norms of the dominant class. Eventually, what ensued was an "us" versus "them" mentality between home and business owners and the homeless people with addictions. The following comment, which illustrates this dichotomy, is from a community survey conducted in 2007 on the Commercial Drive strip of Grandview-Woodland (Mosca and Spicer 2007, "Comment #961"):

The people that actually live and own/rent homes in the area are fantastic and have a wonderful sense of community. However, the level of drug use and the crime, property damage, needle disposal etc. is completely out of control and unacceptable. It drives families away in droves.

In the comment above, the outlined unacceptable behaviours and activities are juxtaposed against the backdrop of the idyllic family setting. It is interesting to note how the commenter remarked that only the people who owned or rented homes had a sense of community, ruling out people who were homeless or lived in social housing developments. The people engaged in those conventionally undesirable behaviours were portrayed as a threat to families, and hence, to the shared sense of community. In doing so, people who use drugs, whose image is defined as undesirable, were depicted as out of place, and even destructive, to the wellbeing of the neighbourhood.

What further fueled this stigma was the presence of discarded drug paraphernalia and condoms, which served as a reminder of the public disorder that existed within this family-oriented community. Because such activities were attributed to people who use drugs, these discarded artifacts reinforced people who use drugs as symbols of social deviance and disorder. The Peer Members were well aware that, in the Grandview-Woodland community, there was a general dislike of the visibility of illicit drug use and prostitution: “It’s [sex work and illicit drug use] illegal and they don’t like to see that kind of stuff,” Raina explained. From the ICURS survey (Mosca and Spicer 2007), the most common response regarding the acceptability of condoms and needles on the ground was “gross” (Comments #132, 761, 1002), with another respondent replying to the question with the comment, “uncivilized people” (Comment #285). Observed in the following statement provided by Jenna, the presence of needles evoked negative feelings among the rest of the public towards people who use drugs: “Demonized image, that’s what I meant. You know, because people see needles and they’re like, ‘Fucking junkies!’ or whatever.”

Although the Peer Members disapproved of the public presence of discarded condoms and needles, citing their concern for the safety of the children, their responses were quite different in comparison to the general response of the public. Compared to the negative and “judgmental” responses they had experienced from some members of the general public, the Peer Members’ responses were more empathetic. “You’re dealing with everybody – all races, all mixes, all... Young. Old. You’ve really got to be open-minded... And you’ve got to be totally

supportive,” stated Guy in reference to the people they provided outreach to. Having been well acquainted with addiction, its social causes, and its physiological effects, the Peer Members – rather than accuse all people who use drugs of consciously undermining the wellbeing of the community – attributed these actions to what Craig called “the insanity of addiction.”

However, in an individualistically driven society that places so much value on individual agency and self-sufficiency, many of the broader issues constraining the behaviour and options available for people who use drugs remained unacknowledged. Equally important was the lack of appreciation of the agency involved in confronting addiction. Many of the Peer Members’ responses indicated that this lack of awareness of the social and structural constraints of addiction was another factor that contributed to the stigma towards people who use drugs:

We just don’t see it here because we have such large spaces and we have it so well. How do you know [there’s] a problem when you’re surrounded with pastry? Try to sit in a bakery and think about bad stuff. And nobody cares about the spat-upon minorities. HIV doesn’t really affect the general populous so much as people that are either in the sex trade, the drug trade, or, you know, people who are in a lower status. [Pete]

As was reflected in some of the comments from the ICURS study, the encounters the Peer Members had with the general public suggested that people who use drugs were still being perceived as parasitic, useless, and unclean:

We’re trying to make a positive outlook. Especially for our community, because our community sees us as evil, drug dealers, thieves, whatever, mooches... There are some people here who would like to see us all locked away in jails. [Dana]

That’s what people always say about druggies, right? They don’t care about anything but drugs. [Jenna]

Because the whole idea of “you’re a drug addict, you’re a failure, you’re useless,” you know? “You’re a drain on society, you can’t do anything, you’re not competent.” [Raina]

As for the Peer Members’ responses to drug use and its visibility to the public, because they had all experienced drug dependency of some form, their reactions were more empathetic. For instance, there was Maggie, a Peer Member who saw her personal experience with drug dependency as being unique from the other Peer Members. When Maggie was 13 years old, she was hospitalized so that the psychiatric drugs she was taking, which she referred to as “clinical

speed,” could be detoxified from her body. The memories of the extreme withdrawal she experienced while in the hospital combined with her belief that the experience had affected the functioning of her nervous system made her sensitive to understanding the experiences of the other Peer Members. She therefore often referred to her fellow Peer Members using an outsider’s point of view. Although she did not personally identify as “an illegal drug user,” she was compelled to join the group because she felt that her experience in the hospital enabled her to relate to the rest of the Peer Members: “My particular background is a bit weird. This group of people is one of the only ones that can actually converge with my background.”

And... I see that they’re [the Peer Members] completely the opposite of what people stereotype them as. Like, as selfish, and juvenile and stuff like... They’re so caring about everybody else. [Maggie]

These examples made it apparent that while the structural constraints driving drug use remained invisible, the people who use drugs, however, were very much visible as symbols of deviancy and social disorder. Consequently, they became representations of objects rather than individual beings:

Like you’re a piece of garbage... It just kills your self-esteem and you feel like this is where you belong and nothing’s going to change... It’s really sad, but it happens way too much, right? And because people just really don’t see them as people, too, right? And they are people, you know. They are vulnerable people trying to get by and deal with their stuff that they got going on and it’s kind of sad, right? I mean it’s like most drug addicts are drug addicts because there’s underlying stuff that, you know, made their life so hard to deal with that they had no other way to cope, so they use drugs to deal with whatever the underlying stuff was. Whether it was like physical trauma, or emotional, or you know, some other kind of trauma, right? [Raina]

By portraying such individuals as being unwilling to change their lifestyle or take control of their wellbeing, the barriers created by the social structures they inhabit remained unchallenged. In turn, the agency of people who use drugs became constrained and was ultimately denied. This reliance on a simplified faceless representation of intrusion and contamination displaced the Peer Members from all apparent structural association, and in doing so, the public became unable to find anything to empathize with. From Raina’s previous statement, there was a contrast in how the Peer Members interpreted drug use versus how they observed non-peers interpret drug use. The Peer Members saw drug use as a form of coping with trauma – as a symptom of reduced agency rather than as an individual choice.

Unfortunately, the assumption that drug use is a matter of individual choice did more than reinforce and rationalize the public's perception and treatment of people who use drugs as the anti-citizens of society. The negative psychosocial effects of these stereotypes eventually led the Peer Members and their peers to believe that they were the anti-citizens of society.

So there's a lot of issues that keep people down and there's also an attitude that, you know, a good junkie's a dead junkie. And with that, I mean, it's just – it's really judgmental and harsh... And what I mean by that is... you know that the less fortunate are... they're disposable. They don't really have, you know, a good position in society. They're sort of beat down. [Mark]

These people are expendable, right? They don't have families. There's nobody looking for them. And nobody notices that they're even gone. A lot of the time people would just disappear. Or when they die, you just forget their name. You forget about them and it's like they never existed, right? It's really sad, but it happens way too much, right? And because people just really don't see them as people, too, right? [Raina]

They seem to be, you know, pushed further into different other areas where they're not going to be noticed by people... And who's even noticing if they're not around, if they've gone missing? [Maggie]

Here, exclusionary social processes acted as a structured risk that led to poor health among marginalized individuals. Particularly from Raina's reflection on her past and from the narratives of the other Peer Members, people excluded by, and living at the margins of society came to embody these symbols and negative affects. Isolated and transient, these people were treated as faceless disposable entities. Social connectivity, being reflective of the extent of one's social capital, played an important role in shaping an individual's position and identity within society. Without community support, many of the Peer Members began to believe that they ought to be disconnected from the community and thus sought ways outside of community services to cope with their pain. Lacking an identity, and importantly, any aspect of their social identity with which other community members could relate to, social connectivity was lost. Symbolic exclusion, therefore, is a structural risk factor that disconnects an individual not only from the rest of society, but also violently disconnects an individual's sense of worth from his or her body. When an individual's self-worth becomes abstracted from the body and translated into an economic commodity, the rest of the body – political, social, and individual – becomes easily neglected.

### **Exclusion from Meaningful Relations**

The above forms of exclusion prevented the Peer Members from developing and maintaining meaningful social relationships, whether through the absence of networks, lack of access to them, or rejection from them. Alongside this was an eroding sense of identity that formed a negative feedback between exclusion and self-harming behaviour. As illustrated in the following excerpt by Raina, succumbing and conforming to the public perception of people who use drugs would result:

‘Cause like, I mean, a lot of drug addicts and stuff, they lose hope, right? Because the whole idea of “you’re a drug addict, you’re a failure, you’re useless,” you know, “You’re a drain on society, you can’t do anything, you’re not competent.” All that’s just – you know, it’s a lie. You choose to – you know, it’s like a self-fulfilled prophecy. You hear that stuff enough and you begin to believe it, right? So you don’t try and you have low self-esteem and you just stay in the same kind of rut all the time, but...

Many of the Peer Members had used drugs as a form of escape to cope with their trauma, whether it was from past childhood experiences or with current struggles of survival. Lacking appropriate networks of support, Peer Members such as Pete and Raina were driven to harmful coping mechanisms as well as illegal forms of income generation to support those mechanisms. Pete viewed drug use as a way of making do with whatever remaining resources he had. Being rejected from institutional services and with the absence of available networks, no other opportunities were available to help the Peer Members alleviate, cope with, or confront their trauma. The following statement by Pete reflects the issue of agency in drug use: whether it was because he was “hooked on them” or chose to use drugs, the issue of there being a lack of available support networks and resources to deal with internal and environmental stressors remained.

Obviously I know doing drugs is not smart. I’m hooked on them. Or I’m doing them because I want them. I’m filling some hole in me. And if you can’t tell me how to fill that hole in another way, then I don’t wanna here about how my way doesn’t work for you.

Eventually, the reliance on drugs as a coping mechanism created a cycle of dependence that required money. In Raina’s case, street sex work became a form of income to support her addiction. Although it is unclear which incident preceded the other, what is clear is that a vicious cycle of dependency among sex work, drug use, and low self-worth was at work:

I mean, most of it comes from trauma as a child, right? And then not having the proper stuff in place and the support to help deal with that trauma, right?

And so you get a really low self-image of yourself and that you deserve that or that's, you know, a way of life thing. Once you've had your dignity and stuff like that taken from you in that way, you kind of come to a place, "At least I'm getting money for it. At least, you know, I'm in charge of this situation." Or you don't have that self-worth or anything anymore to say that you matter or you deserve better, right? A lot of people, they do it for the money, right? Because I mean it can be good money and it's like once you get money quick like that, it's fast and easy money, right? It's hard to switch to do something else, right? You just kind of get used to it. And then, yeah. Once you're entrenched in that life, it's another vicious cycle. It's hard to get out of, right? 'Cause you know, you keep going back to the drugs to kill the pain and then you've got to make money to get the drugs, right? So it kind of goes around and around.

Like Pete, Raina's words reflected the desire among the Peer Members to preserve their agency. In her case, earning money to sustain her drug use was a way of maintaining control over her method of coping. Just as Pete had said that drug use was a way to "fill a hole," Raina had become reconciled with her entrenchment in addiction and sex work as soon as she felt she had lost her dignity. In order to self-medicate and generate income, Raina became trapped in a cycle of low self-worth, addiction, and trauma.

This entrenchment in drug use played a role in the formation of the "anti-citizen," where drug-using individuals actively excluded themselves from the rest of the community – either by keeping to themselves or by limiting their interaction to other people who use drugs. From the interviews, there were three main pathways that influenced how one became an anti-citizen. These were not mutually exclusive: (1) as a defense mechanism against social rejection (2) avoidance of social; and (3) as a result of apathy. Some Peer Members discussed that they became anti-social as a defense mechanism against the discriminatory attitudes they received from the greater community.

Just in my day-to-day life, I would ignore them [the general public] if they spoke to me. Pretend to be listening to my imaginary headphones or whatever and just keep going. [Matt]

It's kind of like a snowball effect, right? It affects people's self-esteem, and so then they kind of put up their defenses and close off from other people and they don't – You know what I mean? And so it perpetuates the image of an anti-social negative person... Well, it's like, a lot of the time, you know, especially smaller isolated groups of people like drug addicts or street people and stuff like that. You know, it is an 'us' or 'them' kind of thing. [Raina]

In another example of self-preservation, Pete went as far as to detach himself on an affective level from community dynamics. Pete's struggle with maintaining the appearance of being emotionally detached from the community was a reaction against the rejection he had experienced during his years of addiction. Initially during the interview, he described his motivation to contribute to community as a form of repaying a debt, rather than as an act of caring:

I've a real issue with caring about stuff. I don't really give a shit about anything. Caring is just an emotion. Emotions are just chemicals in your brain. And once those chemical reserves are depleted, they're gone so they don't really mean anything.

Emotional detachment from community dynamics was a way for Pete to disengage and become independent from the community that once rejected him. However, as the interview progressed, he admitted, "It's just... It's not just a debt feeling anymore. It's a feeling of like, you now, it doesn't matter, you know? I'm starting to get to a little bit of a bigger realization that I don't want to realize yet."

Fearful of experiencing further social rejection, other Peer Members became socially detached in order to hide their addiction from people who would disapprove of drug use. Because of the stigma associated with illicit drug use, Jenna, a single parent with a grown daughter, hid her addiction from her daughter and her mother.

[Y]ou don't want to get too involved with people because you don't want them to know, because it's so frowned upon and stuff... I can't admit to my family that I've been doing drugs, you know? And that all comes from it being illegal. You know, the stigma attached to it, right?

The fear of being incarcerated by law enforcement officers was another commonly cited reason to be less visible.

You're not going to wander around too much with your drugs, 'cause of the danger of arrests, so you tend to be pretty home-bound or home-based bound.  
[Jenna]

Other Peer Members who experienced heavy addiction in the past recalled being so drug-dependent that they were simply disinterested in engaging with the community. Prioritizing their need to feed their addiction, these Peer Members recalled forming a tunnel-vision state of mind. Leon referred to this as having one's "blinders" on – a state characterized by one's dogged obsession over securing his or her next fix.

It – it’s just really a mental health issue, because it really destroys your brain, you don’t think right, you become aggressive, and you will do anything to get more. [Matt]

As a drug addict, your blinders are, “Screw everything else, I need to, you know, get my next fix, right? I find this in my own life. Things drop by the wayside – friends. Because it takes so much time just to get your fix, right? [Leon]

When you’re in addiction, your whole day’s wrapped around drugs. If you’re not doing them as soon as you’re done doing them, you have to start finding a way to get more. Because it doesn’t end, right? You’re not gonna be high in a few hours so you – and you’ll gonna want to be high in a few hours ‘cause or else you gonna start hurting with certain drugs, right? So like, it’s not even – You don’t even get to enjoy your high anymore, right? It’s twenty-four hour day, seven-day-a-week habit. [Pete]

The insanity of addiction, right? And I would have been more into taking than giving back. I wouldn’t – you wouldn’t have seen me at these meetings or sitting here with you, or certainly doing the outreach and the sweeps. You know, I would have taken their supplies when they cam by, because I’ve done that before. Or whatever they had to offer. But it just wouldn’t have been me. So I would have been very closed and narrow-minded in that aspect. [Craig]

Addiction, stigma, and fear constrained the engagement of the Peer Members. This lack of engagement reinforced the rest of the community’s notion of people who use drugs as anti-citizens who are unwilling to participate, which then rationalized the perpetuation of discriminatory attitudes towards these people. In response to this social rejection, these people who, in trying to retain their dignity and autonomy, no longer felt obligated to contribute to the wellbeing of the community. This apathetic response towards the so-called shared sense of community was consequently used to justify not only stigma in daily public interactions, but also structural constraints such as policies and programs that discouraged or prohibited people who use drugs from participating.

The study of these structural constraints in a localized context remains important. The more people who use drugs are dehumanized and vilified, the more difficult it becomes to include these people, and hence, develop and deliver the kind of interventions necessary to help them. Simply put, stigma impedes progress, thereby making risk the product of the interaction between human agency and the forces that constrain it. Rhodes et al.’s (2005) ”Risk

Environment Framework” emphasizes the important roles social, structural, and environmental level factors play in shaping individual behaviour and decision-making. Stigma and oppressive structure – through policy and daily interactions – create an inflexible dilemma, where throughout the different forms of social exclusion previously discussed, it can be seen that the Peer Members as well as other people who use drugs are condemned for not participating in society but at the same time are denied access from participating in the community. In their attempt to transition from being an anti-citizen to citizen, people who use drugs are trapped in this marginal paradox that sets them up to be punished, publicly ostracized, and eventually detached from community and life. This position and consequent lack of social capital among the greater community therefore makes it difficult for people who use drugs to engage in civic activities, despite possessing expertise in identifying the needs of their peers. Sadly, this current situation brings to mind a quote from *Utopia* by Thomas More (1992:14):

If you do not find a cure for these evils, it is futile to boast of your severity in punishing theft. Your policy may look superficially like justice, but in reality it is neither just nor practical. If you allow young folk to be abominably brought up and their characters corrupted, little by little, from childhood; and if you punish them as grownups for committing crime to which their early training has inclined them, what else is this, I ask, but first making them thieves and then punishing them for it?

The harm that results from excluding and displacing people who use drugs extends to other non-using members of the community. Policy responses to illicit drug use, particularly street disorder resulting from the income-generating activities of people who use drugs, often rely on law enforcement to regulate socially unacceptable behaviours and practices (DeBeck et al. 2006, 2011). However, these initiatives do little more than displace the aforementioned activities to surrounding neighbourhoods (Maher and Dixon 1999; Wood et al. 2004). With the case of the 2010 Winter Games, many Peer Members reported that peers who would normally access their services were driven to the Downtown Eastside. Other studies have shown that social exclusion not only separates people who use drugs from familiar social and health services but also negatively impacts communities through increased perceptions of heightened risk of assault, and increased hospitalization rates and associated costs (Aitken et al. 2002; Cooper et al. 2005; Maher and Dixon 1999; Mosca and Spicer 2008; Strathcona Research Group 2006; Wood et al. 2004).

Another effect on community dynamics is a growing sense of “community disempowerment” (Strathcona Research Group 2006). Eighteen percent of survey respondents cited this as one of their top three concerns related to drug and alcohol problems in Grandview-Woodland. One participant in the survey said that she found living around drug problems “sad and depressing... non life-affirming,” while another participant said, “people want to ignore it [because] they don’t know what to do.” The residents of Grandview-Woodland were known to organize campaigns to counter the presence of undesirable activities. Dana, one of the Peer Supervisors, was a longtime resident of Grandview-Woodland who used to volunteer for the Grandview-Woodland Community Policing Centre. During that time, she witnessed the “Shame the Johns” campaign. To protest the presence of street sex work near school grounds, community members would patrol these areas with fake cameras, pretending to photograph the johns. The campaign was successful in removing street sex work near schools and family residential areas. However, there was evidence of burnout from the residents. A respondent admitted that their campaigns were limited to addressing the symptoms of the problem by moving it into another neighbourhood. However, even this helped make “people feel they have some power over the issues” (Strathcona Research Group 2006:41-42). Similar to the Peer Members, those community members struggled to maintain their physical and social sense of place in order to preserve their social connections, and hence, wellbeing. Having a sense of place clearly played a critical role in defining an individual’s and a community’s sense of self and health.

As such, the effects of social exclusion are not socially discrete nor are they exclusively geographic. Connections between groups of different social identities become disjointed and polarized; as for the individual, his or her sense of worth becomes separated from the body. Social exclusion establishes a process of social death where society becomes complicit in the displacement of the body politic, social body, and individual body from the familiar. By displacing the suffering of an addicted body from its social life and political life – essentially away from public awareness and empathy – this consequently leaves little impetus from the public to intervene and reduce such suffering. Therefore, through flawed structural policies and social disconnect, the process of letting die becomes possible. The initiation into, the entrenchment in, and the exacerbation of, drug use have more to do with there being a lack of social supports or support services than individual agency. Particularly in an environment where

public attitudes towards people who use drugs as well as structural policies inhibit and discourage the presence and participation of people who use drugs.

### **Conceptualizing the Citizen**

If social exclusion is a response towards those who seem non-compliant to the values and norms of a dominant culture, what are those particular values and norms? In the previous section, Grenier and Guberman's (2009) paradigm of social exclusion was applied to define the geographic and interpretive positionality of the Peer Members. To identify the ideological positionality of the Peer Members, this section outlines the Peer Members' interpretation of citizenship relative to that of the non-using community. To capture the rest of the community's perception of an ideal citizen and community, I have used answers drawn from community surveys provided by the Strathcona Research Group (2006) and ICURS (Mosca and Spicer 2008) and have referred to the federal government's National Anti-Drug Strategy (Government of Canada 2007). In comparing the ideological positionality of the two groups, it becomes evident that a shared ideological positionality does not necessarily guarantee a sense of place.

#### **What is Citizenship?**

As a cultural, civil, and political concept (Marshall 1977), citizenship is a socially negotiated construct that is collectively regulated to govern the body politic and allocate limited amounts of space. The sociocultural construction of citizenship often determines, through policy and interpersonal interactions, how place is allocated and negotiated among people who share a defined space. What often results is a not only a contested occupation of a given space but also a contest for place among competing values. As stated by Kivisto and Faist (2007), citizenship mediates the relationship between exclusion and inclusion by maintaining the dialectical process between "those deemed eligible for citizenship and those who are denied the right to become members" (Fleischmann et al. 2011: xviii). Therefore, there is more to citizenship than formal membership through geography and passports; citizenship includes how citizens are expected to behave as well as what members should expect to obtain in a specific socio-political circumstance (Chen 2011; Fleischmann et al. 2011; Sutton and Kemp 2011).

Citizenship is a marker of social inclusion, because to be a citizen is to be a part of an interdependent system necessary for healthy and responsive communities. In "an urban society that is increasingly socially and spatially disconnected, fragmented, and polarized" (Marcuse and van Kempen 2000:7), citizenship provides a way to maintain interconnections between both

similar and dissimilar individuals. By granting access to certain material, social, and human resources, citizenship provides a supportive way for individuals to navigate and survive in a community with limited space and resources (Sutton and Kemp 2011:2). At the community level, harm reduction is an issue of citizenship that is based upon viewing people who use drugs as active citizens (Chen 2006:184). But how is citizenship, as the key to finding place, expressed and established?

Given the emphasis placed on mutual reciprocity, particularly on a market level, citizenship is embedded within “spheres of politics and economics” that extend past the immediate or individual body (Petryna 2010:204). As demonstrated by the Peers Members’ interactions with, and observations of social exclusion in the community, whether the greater community considered an individual to be a citizen was influenced by the capacity possessed by that individual to contribute to the functioning and wellbeing of society – namely through the market economy. By associating a social and political value to an individual, a political dimension of human life becomes entangled with biological life, or “bare life” (Ticktin 2010:247). In doing so, this definition of citizenship becomes a definition of the “threshold of humanity and of life itself” (Ticktin 2010:247).

### **Projecting the Profitable Citizen**

One of the community dynamics that Grandview-Woodland operated under was the moral economy of exchange or “reciprocal maintenance” (Duhl 1986). Under this concept, individuals and social units that take from the broader system are obligated to put back into that system. Among the home- and business- owners surveyed in Grandview-Woodland (Strathcona Research Group 2006), “putting back” was generally perceived as the capacity to contribute directly to the market. In one of the focus groups led by the Strathcona Research Group (2006:21), a businessperson complained that homeless people and others implicated in street disorder were “not participating in the economy.” The same report cited a 2004 community survey of homeless people, which found that 48 percent of its respondents had not used income assistance in that last two years and 85 percent did not have steady employment. However, although those respondents did not participate in the licit market economy, most respondents did earn their living by engaging in activities such as binning (79 percent) and panhandling (49 percent). Other activities included selling drugs (38 percent), and 26 percent of respondents had stolen at some point in the last two years, although five percent reported having stolen often. Of

course, these activities violated the community value of reciprocal maintenance, with community members viewing these activities as “significant irritants” to community life (Mosca and Spicer 2008; Strathcona Research Group 2006). In fact, some individuals felt that this non-compliance justified the removal of these people from public space. In the early 1990’s, the head of the Commercial Drive Merchants Association, Gina Marshall, initiated a campaign to remove the “bums and panhandlers” as well as the “moochers and alcoholics” from the neighbourhood (Shore 1992). The frustration from community members was also reflected in the verbal abuse endured by the Peer Members. Examples included: “drain on society,” “useless,” “not competent,” “mooches,” “thieves,” “selfish,” and “entitled” (Dana, Raina, Craig, Pete). Being unable to contribute to the dynamics of the community, the Peer Members were seen a burden by the rest of the community and were treated as such. Living under the mutual dynamics of the market economy, the options were either to participate and reciprocate or otherwise accept social exclusion.

This expectation of reciprocal maintenance extended beyond the community of Grandview-Woodland and into the federal government. For instance, one can find these expectations implicitly expressed in the Prevention, Treatment, and Enforcement Action Plans of the federal government’s National Anti-Drug Strategy. These three Plans, aimed towards benefitting youth, include health promotion and prevention projects, treatment and rehabilitation in the justice system, and prevention and early intervention. In the three Action Plans, resources are provided to support the social groups deemed by the federal government to be “most affected by drug use.” This includes: “parents, young people, educators, law enforcement authorities, and communities” (Government of Canada 2007). The parents and educators of the youth, as well as the law enforcement officers, function in the Strategy to inform and support youth (Prevention Action Plan), prevent youth from engaging in illicit drug use (Prevention Action Plan), and create an environment where youth will not have access to, or encounter sources of illicit drugs (Treatment Action Plan and Enforcement Action Plan) (Government of Canada 2007). Meanwhile, adult persons using drugs – especially those not intending to seek treatment or rehabilitation – are not included under the “most affected by drug use” designation and are thus excluded from the Strategy. The only exception is under the Enforcement Action Plan, which proposes increased law enforcement as a way to curb illicit drug production, distribution, and use.

In these policies, for adults who use drugs, there is an emphasis on the rehabilitation of the individual into a licit body that can contribute to the market economy. However, little, if anything, is said about the need to reform the structural risk factors that contribute to drug use. In his criticism of Canadian drug policies, Bourgois (2003:35) compares the Canadian drug service model to “abusive parents who alternately whip and pamper their children” in that on the one hand, there are policies representing “neo-liberal repression,” while on the other hand there exists “biomedicalized, patronizing welfare services.” In the exclusion of addicted adults – in particular the unemployable ones – from the entire Strategy, this demographic is denied both medical citizenship and the hope for reintegration into society to form a social identity and role. Once again, structural policies such as this Strategy enable the process of selective citizenship that sifts through and determines which lives are worthy of protection. Through this form of dissociation of political life, the governing body is no longer held accountable for this population’s bare life. Hence, those excluded from social and political citizenship become the object of a logic and sociality where they are no longer, in the words of Biehl, “worthy of affection and accountability” (2010:214). In his ethnography, Biehl (2001:135) is told by the founder of Vita – a site of “social exile” for those perceived by family members or the rest of the community as a burden – that, “Society lets them rot because they don’t give anything in return anymore.”

### **Being a Sanitary Citizen**

The concept of the sanitary citizen is particularly applicable here. Extensive literature has been written on this concept, which has roots in colonization and oppression. Acknowledging this, the concept of the sanitary citizen will be applied to how bodies become regulated and excluded into certain social orders such as that of the anti-citizen. Because discarded needles potentially contained communicable diseases such as HIV and hepatitis C – despite the risk of transmission to HIV-infected, and HCV-infected, blood is about 0.3 percent and 10 percent respectively (Canadian Centre for Occupational Health and Safety 2005) – the community employed the precautionary principle of risk to prevent “the occurrence of incalculable severity” with the mindset that, as declared by Purdy (2003), “thinking the unthinkable has become mandatory” (Leslie 2006:372). Pollution risk logic, on the other hand claims that disease is an unavoidable part of life and the most that can be done about it is to contain its more virulent forms (Leslie 2006:372). Its primary goal is to create a sense of

community through containment, where the threat of pollution compels a group to respond by emphasizing its margins regarding who is, or is not, a member (Leslie 2006:372). To defy community hygienic values was to demonstrate a lack of competence as a sanitary citizen. This depiction of irresponsibility further legitimized the greater community's antagonistic representation within, and exclusion of drug addicts from the community. This attitude was reflected in a community survey, where a respondent associated condoms and needles on the ground with "uncivilized people" (Mosca and Spicer 2008:40). In the survey, 92 percent of Grandview-Woodland community members responded that condoms on the ground were unacceptable, and 97 percent of respondents found needles on the ground as unacceptable. The finding that needles on the ground "are the most unacceptable form of public disorder on the Drive" reflected Mary Douglas's (1992) statement that only those who do not care for the community would dare to disobey with rituals of group cleanliness and solidarity (Leslie 2006:374).

Because Vancouver had long accepted that the spread of contagion through illicit drug practices was a problem, distinguishing pollutionary from precautionary risk logic was difficult. Precautionary risk logic, however, stood out as being particularly applicable to children. From observing the following remarks of the Peer Members as well as the Prevention Action Plan of the National Anti-Drug Strategy, it seemed that having a child be exposed to illicit drug use would be an "incalculable severity" (Leslie 2006:372).

There's places to me that seem like a priority, like schoolyards and playgrounds, because there's places kids go that parents don't go and some of those are similar to places where people throw old rigs, like where it's dark – Like into the tunnels or under the slide, or something. 'Cause you know, if you don't know how kids operate, you might think no one ever goes under the slide, but they do! Or into bushes. You think maybe no one ever goes into the bushes, but kids do. [Jenna]

I don't want him [Pete's son] to come running up, "Ma! Daddy! Mommy, mommy, mommy, I hurt myself!" with some needle sticking in his arm or carrying some old used condom or something, "What's this? It's a balloon! Look!" Yeah, so like, to do your part, right? [Pete]

We do find stuff, we do find stuff. And that's important, too. 'Cause the Grandview-Woodland area is very... family-community oriented. So to have this stuff lying around where people are bringing their kids is... it's not good. It's... no. Even if they don't touch it, maybe they'll start asking questions about it. "What is that? What is that? What is that?" I wouldn't want to be the

parent having to explain what it is. [Matt]

These displays of pollutionary and precautionary risk logic were also extended to their peers. Pollution risk logic, in the form of preventing an individual from contracting a communicable disease through shared drug use, was incorporated with their harm reductionist approach to drug use:

And so we understand that, you know, “Hey man, you don’t have to want to quit drugs. It doesn’t mean that you deserve to get HIV or hepatitis. [Pete]

My job is to, “You know what? Things have improved, guy. We can all get you clean stuff.” If you stay healthy, you know, less chance of getting hep [HCV] and all the bad diseases that we’ve had. [Dana]

Peer Members also expressed pollutionary risk logic in an affective rather than virulent sense. From the following passage, Mark situated the peers not as individuals in a social vacuum where the disease could be quarantined, but as a part of a social web where the impact of disease had socially dispersive effects. Here, citizenship – or having a sense of place – was defined more by social bonds than one’s sanitary or economic contributions to the community.

When that person dies, it affects their family, it affects their friends... It has these huge consequences in other people’s lives. [Mark]

### **Embodying the Responsible, Self-Reliant Citizen**

For many of the Peer Members, being a citizen meant having a personal stake in the community. Seeing the community as a web of mutual obligations, sharing occurred on many levels of the community, whether it was among the Peer Members, with their peers, or with the community at large. This enabled not only personal survival and expressions of individual generosity, but also built community connections through reciprocity, mutual trust, and civic engagement.

When asked what being a Peer Member meant, the Peer Members compared their role to that of an everyday citizen: to contribute to the dynamics of the community. Pete described the community as a team, stating “That’s what society is about, is the fact that everybody takes one for the team once in a while because whether you dish it out, someone else will take it for you.” Pete viewed the community as being made up of interconnecting links among people, with each individual action causing a ripple effect throughout the entire community.

The work at P2P provided a medium for the Peer Members to express such expectations. As to what it meant to have a “stake in the community” – whether or not P2P had a role in influencing their engagement with the community – the majority of Peer Members agreed that this meant being involved in supporting the community as a whole. Peer Members such as Raina, Maggie and Pete saw having a stake as being a “useful member of society.”

Life should be that everybody put their part in. And I’m one of those people that is very outspoken about that and if I want to be like that – If I want to deserve to be – earn to be like that without having to owe again later on in life, then I have to live that. [Pete]

And we do the jobs that no one else wants to do. I mean, really, garbage disposal people, street cleaner people – They don’t want to deal with dirty needles and condoms and stuff like that. And it’s like – It doesn’t bother us... It doesn’t bother me. We’ve all had our training and we know how to do safely and stuff like that. [Raina]

For other Peer Members, citizenship meant more than having a functional role in the community; being a part of the community meant being motivated and engaged at an affective level. This included sharing concerns and values with the rest of the community, which enabled them to be responsive to its needs:

Caring more, I would say. And seeking out different opportunities to benefit the community, right? [Mark]

It’s a problem that’s to our heart, right? It means something to us. So it’s like, we’re willing to work with people and see objective views in places where we wouldn’t be with other people. [Pete]

For others, citizenship meant knowing someone on a personal level in the community and wanting to create a safe environment. Knowing someone in the community, or wanting to be a part of the community, played a large role in driving the Peer Members’ motivation to play the role of the citizen. The impetus driving this was to create a safe environment for those whom they cared about. Those social relationships were crucial in embedding an individual into the dynamics of a community. For example, Pete credited his son for his drive to help make a safer community to live in. Being socially connected became a way for many of these individuals to realize the mutual effects of interactions and actions within a given society:

That harm reduction – harm prevention through harm reduction, right. They say HIV and all this stuff is spreading so hugely. Well, you know, if giving needles out – whether you like the fact that people use them for drugs or not –

if that means reducing the amount of people that catch that and can give it to my children, then I'm all for it. Who the hell is gonna, you know – putting it that way, who's gonna say they're not for it, really. Yeah, everybody's got a loved one... Now I have a stake in the community at large, right? My son is going to be raised here. I want him to be raised in a decent community that's good for a child. Like he's four years old. He doesn't need to be around needles or anything. [Pete]

Among those interviewed, citizenship was expressed through the establishment of mutual trust and civic engagement as well as through reciprocity in the use and transfer of material and social goods. As outlined by Duhl (Minkler 1989:26), one of the components of a healthy city is reciprocity between the individual and the broader unit. Szreter and Woolcock (2004:662) argue that improving human health requires both “the entitlement to appropriate ‘material’ needs and the capability to benefit from it, which is so often mediated through social relationships.” With the general feeling that their addiction had in some form cost the community, many of the Peer Members' answers reflected a need to balance this cost:

And eventually, you know, the time came where age eventually just got me to the point where I realized, I owe here. I owe here, I owe people in general, you know? They – there are people in general out there – There are a lot of people in general that I don't even know have helped me out, now. I've seen the direct – Directly seen them help me. You know, the results of that help have been quite astounding in my life. So, like, if they wouldn't have done that for me, then I wouldn't be in a position where I am now. So maybe I can do that for someone else. Because, I mean, they didn't do that because they liked me. They did that because everybody should – has to do their part. And I didn't do my part for a long time, so maybe I need to do a little bit of extra. You have to somehow physically or mentally contribute directly to other people's wellbeing if you demand from them that they will contribute to your wellbeing. [Pete]

For all the taking that I've done in my addiction and I'm nine months – over nine months, now – I feel I should give back a little bit, right? And it's rewarding. That's a good way – rewarding, yes. Not that I feel I should get rewarded for it, but. You know what I mean. [Craig]

And I think some of us realize that. We're peers in the sense that we're trying to give back to our community. We're peers who say, “We've taken, now it's our time to give back.” That and to share with our fellow peers... We're a part of that community. We're just trying to give back to our own community and to the greater community... So the role of a peer is to give back within my community of peers, my fellow group. [Dana]

As a right and as a responsibility, participation in the public discursive space was at the core of how citizenship was expressed (Modood 2002:198). Riva Kastoryano (2002: 219-220) argues that citizenship is expressed by “the engagement of individuals in politics, and their direct or indirect contribution to the public good.” Yet for people facing multiple levels of marginalization while simultaneously being socially excluded, the expression of their citizenship through engagement was difficult. Sharing the same community values does not necessarily guarantee citizenship, or even entry into the market economy, for that matter. There is still the gap between the experience of suffering and the awareness of public that needs to be addressed. The qualifications and dynamics for attaining citizenship gives way to what Fassin (2010) classifies as the “politics of life,” where human beings and their existence are given specific value and meaning. Through this, despite being physically visible, the social issues surrounding people who use drugs are rendered invisible due to their inability to contribute. Thus, through “a blend of learned indifference, sense of intolerability, and failed witnessing” (Biehl 2001:134), the general public becomes engaged in a socially authorized process of “letting die.” This restricted level of expression is thus useful in measuring the levels of social inclusion and exclusion. As stated by Robertson (2006:301), “it is the public silences, the apparently unoccupied positions in national arenas, that provide a gauge on citizenship.”

Having lived through social exclusion and being grounded in the tenets of harm reduction, the Peer Members were more flexible and sympathetic to peers who were at the time unable to adhere to the rules of sanitary or reciprocal citizenship. Contrary to the federal goal of rehabilitating the body, the Peer Members instead focused on protecting the body. Matt was careful not to impose his ideals of harm reduction on his peers, explaining, “I mean, we’re helping them [the peers]. There’s definite a definite thing that we’re helping them, but whether they want it or not, I guess...” Echoing this, Dana stated:

A lot of people avoid that, and they stay clean until they are ready to realize that it’s not good for them or it’s not their thing and they want to go on with their lives and have a family or do whatever. Because they can’t do family and that. Obviously, they have to come to that realization. How long it takes, I don’t know. But it’s not my thing to judge... I mean... we’re just trying to keep them safe so that maybe they can stay alive to maybe reconsider their – their habits and try to work on their addiction. And our whole thing is to keep people alive so maybe they can make changes down the road for better care.  
[Mark]

To conclude this section, all of the previous statements made by the Peer Members demonstrated the criteria necessary for becoming a citizen as well as how one could express the role of a citizen. Yet aside from overcoming socially exclusionary barriers that impede survival, what compelled these individuals to contribute to a community that shunned them? Perhaps this goes back to the need to express one's inherent worth or justify an individual's occupation of a shared space – something that is highly contested within a community (Dobson 2007). Of all the Peer Members interviewed, Dana, a well-known fixture of the Grandview-Woodland community, was the only one who felt that she truly belonged in the community, despite her socioeconomic position. Prior to joining P2P, Dana was a fixture at various community events throughout Grandview-Woodland as a volunteer, and was a recognizable and mostly respected face in the community. Many peers and Peer Members referred to Dana as a walking directory because she could list off any services that offered free meals and support. When asked if P2P made any difference in how she related to her community, Dana replied:

I think I've been part of this community such a long time that this has been my neighbourhood. I feel that I'm a part of it, sometimes. The best part of it, the worst part of it. But this is my neighbourhood. I've been here and I ride my bike, walk the trails. I'm on the sidewalk. I drive a car on the odd occasion. Don't like the traffic sometimes, you know, but what can you do. My complaints are the community's complaints. I tend to have the same complaints that everybody else has. It's too loud, too much traffic, or too much crime or such. This has really been my community for such a long time that I don't think it's... Peer 2 Peer hasn't changed me that much. [Dana]

Dana, in her words, embodied the best and worst aspects of her neighbourhood. Sharing the same values and concerns made her feel connected to the neighbourhood. But another component of being a citizen that she possessed, and that many other Peer Members lacked, was the ability to navigate comfortably about her community. Belonging to P2P therefore became a means of publicly expressing that although the Peer Members formerly used or continued to use drugs, by contributing to the community, should be accepted by the rest of the public.

## CHAPTER 5 TRANSFORMING BOUNDARIES

Certain spatial policies and practices, as illustrated in the previous chapter, normalize values and lifestyles that ultimately benefit dominant groups while rationalizing and perpetuating social inequities among marginalized groups. What defines a community extends beyond its physical spaces and geographical boundaries. For the Peer Members, it was not the physical structures, but the beliefs, policies, and practices of a dominant culture that rendered a space inhabitable or uninhabitable. Now that we know how the anti-citizen is created, how can the anti-citizen be recast back into society? This chapter investigates how people living with or recovering from addiction used collective reflection and action to create networks of social capital that established an inclusive and multilocal (Rodman 1992) space. In realizing their role in reconstructing exclusionary policies and practices that affect their place within their community, these Peer Members helped re-appropriate place and its meaning among the marginalized.

Being involved in decision-making engaged the Peer Members in the dynamics of their community. By articulating how they felt the world ought to be, and by developing a sense of interdependence among multiple sectors of the community through their work, the Peer Members exercised their rights as citizens. Through their cooperative efforts at local activism, they were directly and visibly involved in community building. Arguing that social capital gives rise to multilocality, an integral component of creating an inclusive and polysemic place for the marginalized, this chapter demonstrates placemaking as a form of liberation and re-appropriation of space. In “Crafting a Counter-Public Space Within Homeplace,” placemaking is utilized to resist oppression. In particular, the weekly support meetings where Peer Members shared their experiences, concerns, and interests, provided a place for them to exist as individuals and as a unique community of people. Through this weekly appropriation of space, Peer Members bonded through a shared social identity and collectively applied their diverse experiences to redress place-based inequities. “Creating a Biosocial Space to Expand Place” illustrates placemaking as an individually and collectively transformative process. Peer Members validated their place as citizens by applying their experience with drug use to their role as outreach workers. This created a mediatory role for the Peer Members where they facilitated relations and

broke down barriers of misunderstanding between the street-involved members and the home- and business owners in the community.

### **Crafting a Counter-Public Space within Homeplace**

“Homeplace” refers to specific “sites of both resistance to marginality and oppression and of expression and developing power over the places that support their everyday lives” (Feldman 2011:158). Whereas place involves multiple social identities, homeplace represents a singular shared social identity. In providing a locality where social connectedness could be established based on shared social identity, the weekly support meetings acted as a homeplace for the Peer Members. This meant having an environment that forged networks of social bonding capital among the Peer Members, which compelled the Peer Members to re-conceptualize meanings of place and identity within their community. This shift in meaning was made possible by the following three processes. First, having a new social environment enabled the Peer Members to re-appropriate their identity and their place in the greater community. Secondly, being a part of a positive social environment instilled a sense of social legitimacy among the group. Finally, through collaboration, the Peer Members were able to exercise their rights to navigate and access services from the community.

The peer support meetings were one of the few settings where Peer Members could address and share their struggles. Prior to joining P2P, many of the Peer Members lived in social isolation or in social environments that fuelled their drug use. Socioeconomic marginalization tends to produce a “shared sense of social suffering” among people who use drugs. Because this reinforces social bonds within networks that “act as the conveyor belts of drug injection technical knowledge and encouragement” (Rhodes et al. 2005:1032; Singer 2001:205; Bourgois 1998), these networks possessed both potential beneficial and deleterious effects on individual health.

Although the support meetings also reinforced social bonds on the basis of shared experience among people who use drugs, these meetings provided an alternative and importantly, a more stable, social environment for Peer Members. Tegan described the meetings as a place where Peer Members could meet on a weekly basis to “touch base with other people who they know... Some people outside of the group don’t have many friends at all.” This was the case for Jenna. Jenna suffered from a number of psychiatric disorders, which included depression, panic attacks, agoraphobia, and social anxiety disorder. Any situation that required social interaction – particularly with strangers – would give rise to a panic attack. “People don’t get

how much energy it takes for me to hang out on a social level,” she argued. A pragmatic and intelligent woman, Jenna was once the editor of a student-run campus newsletter and was interested in clinical research. During the senior year of her honours program, however, she was overcome with depression. Due to complications associated with her anti-depressant medication, she was shortly forced to withdraw from her program. Being away from a social setting reduced her anxiety of having to “live with the stupid things I say, or try to think of things to say that wouldn’t be as stupid... You know, the energy and time that goes into recriminations afterwards.” Consequently, this isolation exacerbated her addiction. Therefore, for Jenna, attending the peer support meetings was an exercise in helping her become accustomed to “getting involved with people socially and engaging socially.”

For many of the Peer Members, having an inclusionary yet alternative and stable social environment where they could express their struggles was a critical part of overcoming their addiction. Tegan expressed that the meetings were a place to share her personal issues “and have somebody to share that with, other than other users that are still using.” For those who wanted to stop using drugs, it was often a choice between recovering in isolation or being included among their peers at the risk of having their addiction triggered. “I don’t have any people who are close to me that I can hang out with and stuff,” Raina admitted. Many of the Peer Members agreed that having a drug-free environment to express their struggles was critical for recovery – as addicts and as socially excluded individuals. Matt, who had been using crystal meth since he was 12 years old, attributed much of his addiction to his former group of friends from his previous hometown:

In [hometown], everybody I knew was in addiction, and like, there would always be so much. You didn’t even have to pay for it if you were friends with people. It just goes around. You just go hang out somewhere and you’re high... Because there’s so much of it. Everybody’s sharing... And I didn’t want that, I left. I left and I came out here and I realized how shitty it is out here.

Like Matt, Craig lived in a district municipality outside of Metro Vancouver. He, however, had been so entrenched in his social environment, that prior to joining P2P at the request of his ex-girlfriend, he had not realized the extent of his addiction. Although he continued to live in the same trailer park, he spent the majority of his time outside of his district municipality trying to organize social events with other Peer Members in Metro Vancouver:

It opened my eyes to what I've forgotten. I thought I was doing good, but I could've been doing a lot better. I realized that there's a better life out there. A year ago at this time, I had a thirty-five foot Winnebago motor home on a half-acre lot in [district municipality]. And all it was... just a party shack. People coming and going at all times of the day, and you'd think the roof was going to come off of it because it was that much of a party spot.

This form of social capital – in this case, bonding social capital – did not necessarily guarantee positive health outcomes. Like social exclusion, it further entrenched these individuals into addiction. Craig bonded with his peers in his district municipality because of their shared living conditions. Having no other people to interact with outside of this immediate community, particularly those with whom he could relate, Craig failed to notice his addiction and that this lifestyle was overtaking his life:

And fuck, I thought that life was good. I thought I was doing good, 'cause I was making money and I was holding it together and that. But I was barely holding it together. And I could've been doing a lot better.

Certain factors in a social environment, including the absence and presence of a social environment, play a significant role in determining drug use (Needle et al. 2005; Rhodes et al. 2005). Removing an individual from drug use can also lead to the removal of his or her community of peers. Whereas being in an environment where drug use is normalized makes it difficult for someone to abstain from drugs, isolation – as seen in the previous chapter – can also perpetuate drug use. Having a new support network provided an environment where the Peer Members could be away from drugs while being around people whom they identified with. “The support circles and all that kind of stuff – takes two hours out of the day... And it starts separating you from those kinds of people that live that kind of lifestyle,” Pete pointed out. “It's a good way to break out of a certain lifestyle and move to another. In this case, to move out of the – away – try to move away from the addictive lifestyle. It gives you an excuse – ‘I don't want to get high right now – gotta go to work.’”

The support meetings also provided a space for self-healing. Jenna stated that being surrounded by other Peer Members during these meetings helped her realize that, “Okay, it's possible to quit drugs. You know, it can be done. So whatever you're at, there's some – you can kind of see people around you who have gone to the next step towards being what you might want to be, right?” This notion of a support network being a part of recovery – from isolation and from addiction – was prominent throughout the interviews:

I had been struggling with addiction as well, and... And so it was a good opportunity to network and join other users... And have a fellowship of sorts... [Mark]

I was looking for different alternative ways of healing myself other than just regular counseling in the area, because I was living in the area at the time. I've met a lot of people in the group who are more recovered than recovering addicts. They don't use anymore, so they've really inspired me to get clean, and given me other people to hang out with other than, like, users... So it's a support network for them [other Peer Members] to be able to see, I guess, how they're doing, too. Because when they share with other people, what's going on in their life, they can recognize, "Oh, I need to get back on track," or like, "Oh, I'm doing really well." I guess, that was a personal thing for me, me going there every week kind of shows me how I'm doing. Because sometimes I forget to check in with myself, so... But yeah, for other members, that's one way for them to get help. [Tegan]

Contrary to Craig's experience with his district municipality, bonding social capital in Tegan's case was a positive factor that shaped her health. By participating in the support meetings, Tegan could assess her recovery in relation to others. In bringing together individuals who shared experiences of addiction and had the common goal of bettering the community as a group property, this support group established relationships between the Peer Members within a given place. Putnam (Szreter and Woolcock 2004:655) classifies this group property as shared "networks and norms." Pete stated that his reason for staying with P2P was for the support meetings, and referred to the other Peer Members as his friends because "these are people I can associate with that are, you know, getting to the point or at the point that I am in life, right?"

In addition to creating an environment where people bonded over a shared sense of suffering as well as a shared desire to help the wider community, another draw to this group was the sense of care the Peer Members held for each other's wellbeing. This helped instill a sense of social legitimacy among the Peer Members in the group. In establishing meaningful relations, Raina felt as if she was a "part of something positive":

Those people [Peer Members] care about what's going on in my life and I don't really have a lot of friends. And so, yeah, it's nice to have a safe place to just be able to talk about what's going on for me and, you know, have people that genuinely care about what's going on, right?

This resonated with other Peer Members. The concept of care arose whenever Peer Members noted how empathy and the agreement of confidentiality within the support meetings gave them a “safe place to talk freely and openly” (Mark):

What I found was... sort of a judgmental – There is, there is... but there’s also the stigma of, that if you’re a user, you have to hide and you can’t be so out there. So I found that a lot of people were still really private with their lives. And that it took a great amount of trust... um, which takes time and nurturing and compassion.

It was these regular interactions on a micro-level that formed the trust necessary for this network of bonding social capital to exist among the Peer Members.

Oh what keeps me going? Yeah, the people. So there is – not as many members that are the same people, but the feeling that you have when you come to group. Everything that is said there stays there. Confidentiality and the feeling of support that you get. That’s what keeps me coming back. [Tegan]

In establishing trust, Peer Members were comfortable with expressing whether or not they still used drugs. This freedom of personal expression helped Peer Members such as Jenna feel less stigmatized. She explained:

No one’s asked me anything about drugs, or really, or told me anything about drugs. It’s just there – accepted... And then, also I like it not being secret that I’ve used drugs and stuff like that. I like not – you know, nobody knows about what I do except for... I like that it’s open, that we’re removing the secretiveness of it. ‘Cause everything that’s secret always feels like it’s probably bad if you’re keeping it secret, you know? Even if it isn’t necessarily bad. It’s just like, well, if you’re keeping it a secret, you feel like it’s something bad that you’re doing even if you might argue that... You might have great arguments why it isn’t morally wrong what you’re doing, it still feels like you’re doing something morally wrong... You know what it does besides social marginalization is it gives you a group of people where you don’t have a stigma, which is an amazing feeling. You know, where you don’t have to be really careful not to show your arms or whatever, right? So... Or to let something slip about what you did last week, or you know. So a group of people where you can be – Maybe not candid, but considerably more candid than you are used to being. And not be stigmatized as a druggie or whatever, so.

This implicit acceptance of drug use was a way to legitimize their suffering. The fear and consequences of being socially identified as an addict was what often compelled the Peer Members to conceal proof of their drug use or conceal themselves from public visibility. Being

socially identified as an addict is what excludes them from the mainstream community, compelling the Peer Members to either conceal proof of their drug use or conceal themselves from public visibility. However, the denial of the existence of their experience with drug use was also to rob them of their narrative and hence neglect the social and structural factors shaping this narrative. For the Peer Members, the opportunity to establish a new social environment fostered a sense of optimism that this inclusion in the support meetings would eventually extend to the wider community. In describing the meetings and social events such as barbeques organized for the Peer Members, Mark stated, “It just builds friendships, it builds support networks, and it encourages people to see past the doom and gloom and to reconnect and to have a sense of hope.” In the environment provided by the support meetings, where illicit drug use is neither concealed nor emphasized, Peer Members began to feel comfortable being visible with this shared social identity.

You’re always welcome to come back. Doesn’t matter what you did, what happened, or whatever. You’re still seen as an equal and you’re still welcome back to be a part of, right? And I mean people need that – they need that sense of belonging and that they’re worthwhile. And have value, right?  
[Raina]

And we also see, it’s actually possible to be engaged in your community, even while you’re using drugs, you know? And the people we do outreach with get to see that too. Yeah, you know, you don’t have to be like perfect to make a contribution. So that’s a really good example to get out there, I think. And peer initiatives are the only way to do that, I think... It’s actual people who have been in the position you’re in and now are either are or no longer in that exact position, but they’re still contributing on some level. They’re still keeping themselves healthy on some level. [Jenna]

Therefore, these meetings provided a place where Peer Members’ identities and personal narratives were accepted rather than rejected and conformed to meet what they perceived to be dominant cultural values of the neighbourhood. Within this given space and social setting, they were able to re-appropriate their identities. In addition to creating a space where Peer Members could share experiences and identify with other Peer Members, either as a form of social belonging, or as a form of recovery, support meetings provided a collaborative environment.

Finally, these meetings allowed Peer Members to exercise their rights to navigate and access services from the community. Here, Peer Members exchanged knowledge of community events, services, and related resources. In collaborating knowledge and expertise to resist and

challenge situations in their community – for instance, hunger, transportation, shelter, health services, civic rights – Peer Members found a mode through which they could resist and challenge situations, policies, and practices that would create further social exclusion for themselves and their peers. Tegan, after saying that the support meetings helped Peer Members connect with themselves, added that the meetings also connected “other people. And also get help if they need it, because all the resources and experience from the peers [Peer Members] are in the group.” Here, if any of the Peer Members were dealing with any problems, they had a supportive environment that helped them work towards a solution. For Peer Members such as Pete, they were able to receive input or other forms of assistance from fellow Peer Members to make changes in their lives:

So far, any type of problem I’ve really come across that I’ve raised by the group, stuff has been done about it. And like, you know, if someone told me they were going to do something for me, they’ve done it. It might not happen right away, but it happens. And it’s good to see that. It’s good to have that kind of support. It’s an excellent support circle. It’s excellent support in the community.

If... when someone... One of our members was having problems with housing. And he came to the group, and was like, “Okay, well, I’m having problems with housing,” and everyone who had that problem before was like, “Okay, well you’ve got to see this person, get this done,” and like, because we’ve all experienced different things, it helps us put it all in one group and one circle. If anybody’s having any problems with housing or welfare, at least one person in the group has experienced that before and can give some sort of insight to the situation here. Or might know somebody they can go talk to help resolve their issues. [Matt]

The interactions that took place within these meetings also functioned to reinstate a sense of agency among the Peer Members. Similar to the philosophy of harm reduction, Peer Members did not impose their input – instead, they first asked for permission before giving out suggestions. This was done to acknowledge the agency of each individual when it came to determining how he or she would handle his or her dilemma. In doing so, this reinforced the message that the Peer Members had every right to resist anything that was imposed upon them:

Like you just put your hand up and say, “Do you want feedback?” And then they say something like whether it’s like, “Did you know there’s also this to do with what you’re saying?” and stuff. “Did you know you could get this if you were doing that?” [Miranda]

By being able to apply their expertise to support and make change for their fellow Peer Members, this once again validated the fact that Peer Members could make an effective contribution with their experience. Informing one another about how to use and where to find resources to manage their lives were a way of re-appropriating a space they occupied yet were excluded from. At one meeting, the Peer Members had made a map marking where one could find food, housing, and social – and health – services (refer to Appendix D).

That's what we did. Everybody was like, we sat down in a group, and we're like, "Okay, where are all the resources?" And this is what the [Peer Members] came up with, boom, boom, boom, boom, boom, stickers everywhere... It's a combination of just everybody. Everybody had their own things that we all knew where these places were. Especially the food. Everybody knew where the free food was! [Matt]

Another way Peer Members were able to re-appropriate their place within the community was to stay informed of community dynamics. At each meeting, the Peer Members shared knowledge of community events, issues, and opportunities to participate in conferences. As Dana remarked, "In that, I see we're doing good. That's changing. That's where the change is."

We all come in and announce to each other different things that are happening in the community and what's going on at group and have announcements that way. [Tegan]

We're informing... When we see something wrong with each other, we support each other, we're always passing on new information to each other and I'd say I'm passing on what I've learned from previous supervisors, peers. [Dana]

Sharing and collaborating also functioned to highlight the heterogeneity among the Peer Members. Each Peer Member seemed to have a specialized area of expertise. Matt had boasted, "Our group is like the jack-of-all-trades. If I can't deal with it, maybe one of my peers can, and so on and so forth." These meetings also demonstrated that despite the diversity of experiences present, no individual experience carried more value over the others. Rather, it was the combined use of these experiences that was most valuable.

And it's not like hierarchical in any way. So nobody's worth is more valuable or experience is more valuable than any other person. And together, we can use our experience to help peers who aren't necessarily involved with our project but who are on the street and are drug-involved. [Tegan]

That's just it – we're a group of individuals. That's why we are strong. Because we're not a group of people who are just a group of people with a common goal. We are a group of individuals hitting the same problem from every different aspect of, you know, that we can get together. It's a problem that's to our heart, right? It means something to us. So it's like, we're willing to work with people and see objective views in places where we wouldn't be with other people. [Pete]

To conclude, these support meetings acted as a homeplace that provided the foundation necessary for the Peer Members to belong to, and foster, a positive form of community. These support meetings created an environment where the Peer Members established a sense of place through one another. This shared sense of belonging was not only a collective act of self-sufficiency to survive the neighbourhood, but was also a way to express one's right to challenge, navigate, and utilize the neighbourhood space.

### **Creating a Biosocial Space to Expand Place**

As outreach providers, the Peer Members – acting both as activists and as biomedical citizens – extended their addiction narratives beyond the homeplace of support meetings. The role of outreach provider granted the Peer Members access into the plural and permeable boundaries of Grandview-Woodland. To expand their place to be among the biomedical, civic, and disenfranchised populations of Grandview-Woodland, the Peer Members used, as social resources their experiences with drug use, addiction, and harm reduction training. In forming linking, bridging, and bonding social capital among these populations, these plural boundaries that defined community delineations within Grandview-Woodland became permeable. In effect, a biosocial space – a social community created by shared illness – was created.

### **Linking the Gap in Services**

As illustrated in Chapter 4, social exclusion delegitimized the social suffering of people who use drugs by restricting their ability to share their knowledge and experiences in a discursive public space. In turn, this limited discourse brought about a hegemonic process that enabled dominant groups to maintain, reinforce, re-construct, and obscure the social structural context of illicit drug use and addiction. With the biomedical and political sphere largely occupying the discursive space of harm reduction and addiction, the use of cultural reasoning by institutional authorities legitimized the rhetoric of culture (Briggs 2001:687), leading to designating addicted drug users to an essentialized mode of existence. Having a public fixed

imaginary of addicted drug users grant institutional authorities the opportunity to legitimize and expand upon regimes of surveillance and control (Briggs 2001:687). Therefore, in creating an essentialized account of a group that is associated with risk, risk became capable of, as stated by Leslie (2006:370), “accomplish[ing] much heavier social work than simply predicting infection patterns and chains of transmission.”

However, through P2P, the Peer Members became involved in the discursive space of communicative authority and competence, thereby being able to express their agency through their experiential authority on harm reduction and addiction. Rather than being perceived as passive victims or perpetrators of community health “lacking knowledge, resources, and initiative” (Briggs 2005:270), they were treated as leaders asserting their own agency in investigating, taking precautions, and providing information. Participation in this discursive space, albeit in a limited capacity, addressed power relations that, in a hegemonic way, “further constrain socially vulnerable populations and that shape subjectivities” (Bourgois and Schonberg 2009:107). Being a part of this communicability decentralized biomedical and political authority.

To establish linking social capital, the Peer Members applied their specialized knowledge to working with those in the biomedical, social services, and political sectors – including policy-makers, healthcare workers, and other service providers associated with illicit drug use. These services and groups were not limited to within Grandview-Woodland, often extending throughout the city of Vancouver. By sharing their firsthand experience of the needs of peers, of addiction, and of constraining socioeconomic factors, the Peer Members were recognized by those in the biomedical and political field as producers and circulators of knowledge involving addiction. Collaboration with other experts from various fields through this network of linking social capital bridged the knowledge gap in terms of addressing needs:

They may not understand the needs that peers have to be able to outreach to other peers. Even the peers who come to the meetings and do the outreach, they also have harm reduction needs. So, say for example, we would need the bags accessible during the Monday meetings and things like that. Those little details are really important and I think some rules could be made up that wouldn't allow that stuff or wouldn't be thought of if it... was controlled by somebody who wasn't a peer... Just that they won't think about it in that way [Tegan]

The Peer Members saw their role as filling a gap in services. As Jenna explained, the Peer Members had all “been there” in that they “have had problems with drugs or still do.” Hence, in addition to knowing how to approach people, they knew “what to look for” and “where to look for it.” They saw, as suggested by Dana, their role as complementing, rather than replacing, existing roles:

So it’s very important that you go right to the source. You go to the source of that information and you partner up with them. And you’re also empowering that person, because you’re like... you’re validating their knowledge and their experience. [Mark]

And we got to sit with like one of the local politicians or something and you know, we were guest speakers and stuff and we ran a forum or an education thing. People chose to come and listen to us speak about our beliefs and our harm reduction tactics or techniques and stuff... We had lots of government officials and policy-makers and professionals and stuff like that coming to listen to what we had to say and it was pretty cool. Yeah, ‘cause we were considered experts in our field, right? [Raina]

Being considered as experts in their field as well as being given the opportunity to travel to conferences as guest speakers validated the role of the Peer Members as contributors to a healthy community. Raina was once flown to Ottawa to speak at a conference aimed at addressing drug use. In October, the three Peer Supervisors – Craig, Dana, and Mark – were invited to lead workshops and panel discussions on their work as Peer Members to local politicians and healthcare professionals. Other community groups would approach P2P as a whole or individual Peer Members to collaborate on events and projects: “And some other groups have come to us, and said, “Hey, can you help out with our project? It would be really great for the community, it would really help out your team.” So we’ve gone out and we’ve done, like... we’ll set up booths for, you know, a health care convention or other harm reduction teams out there” (Mark). Craig had been asked by an acquaintance from his community’s treatment centre to introduce a similar peer-based initiative. In doing so, the Peer Members’ pre-existing boundaries between their past drug use and sense of self worth began to transform:

It’s given me an environment where I can use my experience to deal with the street and drug use, for good, to be able to help other people. [Tegan]

It was really exciting. And it was like – it made me feel really important and stuff. I mean, that was the first time in my life – I started doing Crystal Clear when I was nineteen. And that was like the first time anybody had trusted me

and given me a position of power and be responsible for things... But they still, you know, stuck with me anyway and it made me really passionate about the whole idea that you can change and, you know, just because you're on drugs or you're on the street, whatever, doesn't mean you're worthless. And, you know, that you can be – do anything with yourself. They gave me a chance for me to see that I actually can accomplish things and be useful and make things happen! And that was really amazing. [Raina]

Therefore, developing “norms of respect and networks of trusting relationships between people interacting across explicit, formal or institutionalized power or authority gradients in society” (Szreter and Woolcock 2005:655) was made possible by the Peer Members utilizing their experiences with addiction as a social resource. This vertical interaction between the Peer Members and institutions of power allowed Peer Members to feel as if they could help address arising issues related to poverty and addiction, be a part of society, and helped secure health-promotion resources for themselves and their peers. Through linking social capital, the Peer Members challenged their essentialized mode of existence as passive and agentless recipients of care.

### **Bridging Communities**

The type of placemaking that maintained bridging social capital among members of Grandview-Woodland is best described by what Jane Jacobs (1993) calls the “sidewalk ballet.” As the name suggests, the sidewalk ballet is a fine pattern of daily interconnections that form the central enabling feature of neighbourhood life: multilocality (Fullilove 2006; Rodman 1992:647). In this sense, a single physical space is polysemic. Within a given physical space, people of different geographical, cultural, and historical contexts will have different meanings and experiences of that space. Often, these differences are seldom appreciated, which subsequently leads to the issue of a finite space being highly contested among different groups. Outreach, however, in creating a biosocial space for the Peer Members with the goal of achieving social order, established interdependency among the members of Grandview-Woodland. Through demonstrating their role in the moral economy of exchange, the Peer Members validated their place in the community. Eventually, trust, or understanding at least, began to bridge the gap between the greater community and the peers. Therefore, these repeated ritual displays of interdependence helped transform a space into an inclusive and socially cohesive place where the Other is present rather than “represented,” which is predicated on the absence of the Other (Fabian 1990).

Outreach was an opportunity to convey the heterogeneity of the “street-involved” population to other locals of the community and to counteract the stereotypes others held regarding people who use drugs and other street-involved individuals. As was reflected in the experiences of the Peer Members in Chapter 4, negative terms such as “drug user,” “junkie,” and “addict” removed people who use drugs of their right to participate in civic society. Functioning as a form of symbolic exclusion, these terms reduced those individuals to caricatures of disorder by eclipsing all other life experiences and contexts that otherwise would have rendered them relatable. Outreach challenged doubts regarding the capacity and willingness of people who use drugs to contribute to the community. Jenna, having spent much her childhood as a “pseudo-mom” caring for her younger siblings, and later on, her adulthood as a mother and grandmother, was always vigilant about conducting sweeps near parks and school-grounds. “I’ve spent a lot of time thinking about kids and what’s best for them... It might be the only thing I’m good at, if I’m actually any good at it, I hope.” For many others such as Jenna, outreach was a way to contribute to the community as a whole, rather than as someone with prior experience to using drugs only looking after other people who use drugs.

Conducting outreach became a form of expressing to the non-peers of Grandview-Woodland that they, the Peer Members, shared the same goals and purposes as the rest of the community in terms of contributing to the wellbeing of the community. A way to express these goals and purposes was to wear bright green shirts labeled “P2P” on the back, making themselves and their role highly visible to the rest of the public.

Yeah, people know who we are and they know we’re picking up needles and drug stuff... You know where to look because we’re carrying a needle box – a sharps container, I mean. And we’re wearing outfits and we have tongs and stuff. It’s easy to see. [Dana]

Well, they’ll eventually see us do some good, they’ll be able to question that [stigma]. So all we have to do is keep doing our job and those opinions will be changed. You can show that you do care about something other than just drugs, because that’s what people always say about druggies, right? They don’t care about anything but drugs. Well, then why are all these people here? ... It’s obvious there’s more things that people care about. [Jenna]

Like, helping others shows the world that helping others works. And it comes from people that you don’t expect. And that opens some people’s eyes. [Pete]

To foster a sense of interdependence among community members, the Peer Members' work in outreach also engaged non-peers such as local business owners, parents taking their children to parks, and other residents in their harm reduction work. The response from the non-peer community, as indicated in the Peer Members' interviews as well as observed during the shifts, seemed generally favorable. Grinning as he waited outside his garage, an auto-mechanic would bawdily greet the Peer Members on shift, leading them to the back, where at least a dozen condoms would be scattered about. These exchanges occurred on a regular basis:

When we go by businesses and stuff like that, they'll tell us if there's something somewhere, or whatever. [Raina]

I mean, I've been out on shift and a guy came out from where he was working and he's like, "Oh hey, what are you guys doing?" Right? He didn't – he wasn't saying it like we were doing something wrong. He just asked what we were doing, I explained it, and he had all sorts of questions, and he's like, "Hey, right on for you guys, man!" He's like, "I'm glad somebody's doing this out here." 'Cause where he is, where their shop is, he said that there used to be lots of garbage in their alley, and they had to – all the people who worked there had to get training to pick up needles because they would move stacks of pallets and stuff and there would be needles in there. So he said that they have a little box and stuff. And so I told him, "You know, if you ever need it changed and you see us, we'll go get a box for you and we'll switch it out." [Matt]

Me and Dana – a month or two ago – were out on the Drive... And we were behind a building. Well the owner pulled up and he was a Hungarian guy. Pulled up and he recognized us right away from the shirts that we wear and we identified ourselves first, and asked if there was problems or whatever. And he said, "There used to be, but since you guys have been coming around, it's really made a difference." He's had this security guard that he's had to hire and he doesn't have him on as much as what he used to, right? And... So that was a really good feeling. After that – knowing that we made that much of a dent that he's noticed that. [Craig]

I sometimes ask, like, if they've seen any needles around that need to be picked up or if they know where we should be looking or whatever, because I think that makes them feel that they're helping a bit and that makes us a little less intimidating. So there's definitely ways that we can choose to engage the wider community at least, you know? Or if we're at a park and there are little kids, I ask the little kids, "Have you guys seen any dangerous garbage around that we can get?" [Jenna]

By engaging the public in their work, Peer Members could display the importance of their role. These acts not only benefitted their peers; by contributing to the overall health and safety of the community, the rest of the community benefitted as well. Most of the Peer Members were eager to explain, when asked, their roles to others, and to educate non-peers in terms of letting them be aware of other services in the community that would help pick up needles, and why harm reduction was a necessary approach in working with their peers.

And just – you know, we give them a pamphlet on safe needle recovery if they happen to find something. And the number of the needle van, or just to call for us to come and pick it up, right? ... We encourage education and, you know, stuff for the general public, too. [Raina]

And I always, if people are watching us and wondering what we're doing that day and the shift I went on after that, I always try to tell them what we're doing. [Jenna]

When they ask us general questions, we can give them real answers, right? So if they're generally concerned with, well, is this really helping or hurting our community, you can tell them all the benefits of it, right, and I'm sure their minds would be changed by us talking to them directly. [Matt]

Hence, change in community health and in the public's perception of the Peer Members and their peers came with using their biosociality to establish bridging social capital with community members. However, bridging social capital did not form spontaneously. Rather, it required relationships of trust to be established between members of a network who differed not only in terms of social identity, but also in terms of their existing possession of material and social capital. Therefore, by participating in a role that required interaction on a daily basis with community members, Peer Members were able to establish trust by instilling a shared sense of fairness and mutual respect through their demonstrations of mutual reciprocity.

These efforts of engagement, repeated expressions of mutual reciprocity and community education, built a dense network between Peer Members and other community members who eventually came to be familiar with the sight of Peer Members conducting outreach. "They're [non-peers] not threatened because they know that we've been around for a while," said Tegan. Soon, the public presence of people who use drugs no longer seemed as threatening or misplaced. Interactions between community members and the Peer Members soon followed, thereby validating the presence and place of the Peer Members in the community:

I'm usually in the alleys cleaning up stuff. When I come out of an alley and someone's like, "Hey, you guys are those guys that pick up the needles!" I'm like, "Yeah, yeah, that's us." They're like, "Right on, man!" [Matt]

Yeah, they know who we are now. They definitely know who we are now. They know we're not bad and so... They let us do our thing when they see us. I don't know how many of them recognize us or anything. We don't really walk up the Drive itself too much. But when we do, it's when we see people that are like, "Hey, how's it going?" [Matt]

I've had quite a few people come, "Hey, how's it going, guys?" [Pete]

But surprisingly we get a lot of people who come out and say, "Hey, way to go, good job." I've got people around here who see us and they come out and they say, "Hey," I've been out with Chris and he'll tell you that we've had people come up and say, "Hey, thanks for doing this – thanks for keeping people aware, picking up the trash, talking to us... We've had people just around here over around Woodlands come out of their houses and tell us that. [Dana]

Many of the Peer Members saw themselves as representing their peers, and perceived their outreach role as a way to refute "some of the claims about drug users or the biases about drug users that people have" (Jenna). For Jenna, conducting sweeps so that "people aren't tripping over needles and stuff like that and thinking more bad things about junkies," was a way of contributing to a better public image of people who use drugs:

So to try and bring – close the gap between the two kinds of communities, right? Because they both live in the same neighbourhood – it's just that one's outside and you know, the other one's in their condos or whatever. And try and bring them both together to realize that they're not – they don't need to be enemies, right? You know, that we both kind of have our place and you know, that we can coexist and it doesn't have to be this war or whatever, right? But I mean there's always going to be the few that screw it up for everybody else, you know? The couple of people that just don't care that are going to leave a mess anyway or break into cars and stuff in the parkade that everybody's sleeping in and so things get locked up and locked down poor people get shunned. And then the poor people are like, "Argh!" to the rich people because they feel judged, and... Yeah, so you know, I mean, it's just kind of how it goes. But I mean to still try and get people to not give up and to keep still being the best person they can be. Anyway, 'cause I mean change does happen with one person, it can be like that, right? [Raina]

It might reduce the sort of anger that neighbourhood residents might feel towards drug users and stuff like that. So making it clear that... Like

contribute to a better image for drug users or at least less of a demonized image. [Jenna]

We're picking up the needles and stuff and they feel like the community is safer and they can understand that the drug users – they're better, so it's not so negative between drug users and people that live there. [Tegan]

Guy and Pete were quick to point out that their role allowed the non-drug-using community to realize that people who use drugs could contribute to the community. With this, the static stock-image of a person who uses drugs became less stereotypical, and hopefully, more humanized:

Okay, but regarding community, it's opening their eyes that drugs are part of the community. And there are functioning drug addicts all over the place. [Guy]

Because they show the community that other people in their community care about that community. And that awakens – That opens up people's eyes to the fact that, you know, just because somebody has been – Because everybody knows that most people involved in anything to do with harm reduction were at one point harm contributors, right? Anybody that picks up rigs must be at one point in time at least be a junkie and they're paying back. Well it's good for people to see that people do care. And it's good for us to show them that not everybody that's a fuck-up once sometime in their life is always gonna be a fuck-up, right? I mean it gives them – it's more likely that the next time they run into somebody doing that they can see that hey, maybe that guy might be the guy in five years picking them up. [Pete]

Whereas now they can see that, you know, they see that there's more to an addict than just a lifelong addict. Addiction isn't for life. Just 'cause someone's a drug addict or a drinker or whatever they are, or a smoker, or a food addict, or a sex addict – whatever they're addicted to, addictions aren't for life. It's not a lifetime stigma. It's something you can overcome if you wanted. [Pete]

With the establishment of these bridging community ties, individual and collective transformation resulted. A more cohesive and inclusive society was achieved by bridging the cultural gap between peers and non-peers members of the community. “We're the people to fill the gaps in between the ‘us’ and ‘them.’ Try and close the bridge and make it – Close the gap between the rest of the world and then, you know, the drug-using community,” Raina emphasized, when asked why peer initiatives were unique. By bridging the gap between socioeconomically disparate groups, a more cohesive society was formed. The connections

responsible for such cohesion were largely predicated on the formation of trust between these two groups of contrasting social identities. Szreter and Woolcock (2004:656) argue that for the formation of trusting social norms, “there needs to be a minimum degree of understanding among the participants in the network in their mutual dealings with one another that they share each other’s goals and purposes and are working towards mutually compatible ends.”

Participation in a network required trust. The development of trust required that the Peer Members could prove that they shared the same ideological values and norms as with the rest of that community. Chapter 4 demonstrated that these mutually compatible ends were that of a community based on reciprocal maintenance, focusing on the concepts of sanitation and the market economy. However, socially exclusionary barriers prevented the Peer Members from participating – despite their indicated desire to – in these community norms and dynamics, hence validating public stigma against people who use drugs. The role of peer outreach worker allowed the embodiment of “citizen” within the Peer Members to be publicly visible, which was achieved through repeated displays of community contributions as well as meaningful interaction with non-peers.

### **Bonding the Excluded to Place**

Meaningful interaction and relationships with the peers extended this sense of place to the peers themselves. This also required the establishment of trust. Whether it was the shared experience of being socially disenfranchised, living with an addiction, or living in poverty, these shared experiences created bonds of mutual trust between the Peer Members and their peers. This enabled the successful exchange of materials, and knowledge, and eventually in some cases, power between these groups. Hence, once trust was established, the moral economy of exchange came into play. For the peers, the Peer Members offered referrals to services if requested, invitations to their support meetings, and harm reduction materials. From the peers, the Peer Members received information about issues surrounding the neighbourhood. These exchanges of shared experiences, mutual trust, and information between the Peer Members and their peers reflected the strength of their network of bonding social capital. Raina and Dana equated having lived the experience of addiction with being a part of an ethnic group or a different culture:

I see being a peer as a – it’s like being a... Well, it’s like being a part of an ethnic group. And we’re just a different part of it. So we understand some of the pain and suffering that they have, and the craving and we’ve survived it,

we're trying to get off it, or we are off it and we're trying to share that.  
[Dana]

The degree of bonding social capital between the Peer Members and the peers suggested that their shared lived experiences created a culture among them. Despite their transiency, these shared experiences of poverty, addiction, and marginalization transcended geographic barriers. Most of the Peer Members lived in communities other than Grandview-Woodland and travelled to Grandview-Woodland for meetings and shifts. Raina worked for peer groups based in the Downtown-Eastside, the West End, and Grandview-Woodland. Each of these communities possessed distinct characteristics in terms of the mean income of its residents, the overall style of the community, as well as the mean age of people who use drugs. Apart from the prevalence of drug use differing according to each neighbourhood and the difference in age groups, the Peer Members spoke of their peers as if they were from one large community in Vancouver. In this context, place was a cultural construct that was defined more so by social relations and values than by geography. From the Peer Members, it was clear that it was the shared experiences that allowed them to relate to their peers across different geographical boundaries within the city, and perhaps beyond. All of the Peer Members believed that what made peer programs successful was the trust between the peers and the Peer Members was established through shared experiences.

While the plural role of the Peer Members allowed them to transgress barriers that once seemed impermeable to people who use drugs, the Peer Members also benefitted from being able to acknowledge other boundaries; specifically, the boundaries of their peers. Sharing these experiences was what differentiated the exchange of knowledge from the imposition of knowledge. What made the traditional provider-client model of some harm reduction services disempowering to peers was that although service providers recognized the power of people who use drugs, they neglected to acknowledge the powerlessness of these people. By acknowledging that adopting and adhering to safer practices was not accessible to all peers, the Peer Members recognized the boundaries of their role in addressing addiction and harm reduction. Dana explicitly stated that she did not and would not counsel other peers to cease their drug use and seek treatment. For her, it wasn't until three of her friends had died of drug-related causes that she finally took notice of her own deteriorating health. She then decided to go "cold turkey." However, many Peer Members pointed out that this was not possible without the proper social

environment and treatment facilities. Matt had to relocate to a district municipality where drug use was less prevalent. Craig arranged to have a friend drop him off at a treatment centre. Although his friends were supportive, they were skeptical over whether could quit using drugs. Maggie was hospitalized as a child so that her body could detoxify safely. “Having to withdraw and that, they should not and cannot do it by themselves, instantly. They really should be under really good supervision – medical supervision,” she emphasized. In Dana’s case, she was lucky in that she had a familiar circle of support, although her medical supervision was quite different from Maggie’s ideal biomedical model. Being of Aboriginal descent, Dana’s family took her to a sweat lodge, where they accompanied her as she recovered. Chuckling, she recalled, “I was all scarred up. It was so ugly... I think I’ve learned, and it takes a little realization. You have to reach that point. Sometimes it’s very hard. I’ll never get back what I lost, I... I’ve still got my teeth! Some of them!” The second time we met, she eagerly showed off her new teeth, which her brother – a dentist – had given her. Instead of pressuring their peers to seek treatment, the Peer Members were more focused on inclusion by ensuring that their peers were still being cared after:

We’re just trying to keep them safe so that maybe they can stay alive to maybe reconsider their – their habits and try to work on their addiction. And our whole thing is to keep people alive so maybe they can make changes down the road for better care. [Matt]

It was through the shared sense of wanting to survive with dignity that the Peer Members conceptualized their role as Peer Members. Although resourceful in terms of being able to offer harm reduction materials and referrals to services, the Peer Members were adamant about not counseling their peers into ceasing drug use or seeking treatment. Having survived addiction, or in trying to survive, many of the Peer Members simply wanted to ensure the survival of their peers by reducing the social and biological risks associated with addiction. Rather than impose their services, Peer Members such as Tegan would greet them in a casual member, just as how neighbours would acknowledge one another. Her rationale for doing so was, “They know who we are, so if they see us walking and they want our services, they’ll come to us.”

While the Peer Members believed that other peers regarded them as “equals,” by using their experience to help “peers who aren’t necessarily involved with [P2P] but who are on the street and are drug-involved” (Tegan), the Peer Members also saw themselves, and were

regarded by others, as role models. Dana, for instance, was celebrated for surviving heroin addiction and for being resourceful:

People – I’m told this. Craig – you’ll talk to him – he says sometimes, he calls me a role model. I go, “I’m not a role model!” He says, “Yeah! You survived, you’re here, and – you’re leading the way!” So people tell me that. I’m kind of shocked when people tell me that. I never consider myself a role model. I’m lost half the time, as far as I’m concerned! ... These people still have hope. They’re not totally sick yet, and we’re trying to keep them from being sick. We’re trying to say, you know, “Look, we’re survivors, too. Let us be your role model,” in a sense. [Dana]

Raina was seen as a role model through her involvement in providing outreach, which she used to challenge the general public’s perception of people who use drugs. As well, she used her role as outreach worker to model responsible practices to her peers:

And they [the peers] really wanted to get involved and stuff, because, you know, they saw how we were proud of what we were doing, right? That we were like bringing dignity and self-respect to the drug addict homeless person, which is like usually kind of in short supply. And showing people that if you want the general public’s opinion to change about you, you have to change how you behave, right? Clean up yourself, pick up your rigs, you know. Don’t leave a mess where you sleep and don’t do crime in your backyard and stuff like that. Trying to teach them to be a good neighbour, you know? [Raina]

Therefore, the Peer Members were seen as bringing dignity as a shared commodity to their marginalized peers – both by how they themselves treated the peers and also through how the public regarded the work of the Peers. Through shared experience, Peer Members encouraged bridging social capital among the peers by addressing their immediate needs, and in doing so, establishing trust and introducing new social norms, as Raina had done.

Establishing bonding social capital became a way of including the disenfranchised into the daily dynamics of the community. Social exclusion could drive an individual into becoming an anti-citizen, but outreach mitigated this effect. Maggie saw her role as being a “liaison” that helped displaced communities of people who use drugs into the wider community.

Being a liaison to make sure that other people know that – That they’re a part of society, too, though. That they’re... It’s like interconnections, to make sure that people still feel connected, not completely tossed out. Whether they’re fixing in the alley or not, that they’re not just being relegated there forever... In a sense, we’re keeping them safe in that sense because people are – it just means that there’s still some people paying attention in the area. [Maggie]

Inclusion was represented in many ways. Offering services to peers was a way of engaging and addressing their needs:

And we do outreach there, in which we offer them supplies. We ask them if they need any help, how they're feeling, etcetera and just engaging them so that... I think that keeps people within the stream of, like the fuller... continuity of society, that they're not completely estranged. [Maggie]

Yeah, no, I think peer programs are a really invaluable part of harm reduction and being able to access the hard to reach populations like the people that aren't already hooked in with health services or addiction services and stuff like that, you know? 'Cause those people who aren't accessing those services, could be because of the stigma and or because they've been barred or whatever for whatever. They still need to be able to access these harm reduction things, right? [Raina]

Both Peer Members and peers benefitted from exchanging information about community dynamics. Transmitting news of community events involved peers in volunteer opportunities and included them in community events:

For people who use drugs, I think we handed out a lot of flyers for events that include everybody in the community. Including homeless people, drug users, as well as homeless– or drug user- specific events. So things like that, we let people on the street know about and give them the pamphlets so that they can participate, otherwise they wouldn't normally know about it. And for community members, the same thing. [Tegan]

As illustrated in the following exchange, Tegan elaborates upon how establishing communication with peers helps gather information to inform the needs of marginalized community members. This information would normally not be available to other community stakeholders involved in identifying community needs and gaps in services:

Tegan: Yeah, like I said, when we're out doing outreach, with the flyers that we hand out for special events, but also, I guess just talking to them and seeing how they're feeling about things in the community. If there are any changes or trends that are going on, or things that are happening. For example, the Olympics. When that came, that was huge for our group. A lot of areas where people were using drugs were cornered off and shut down or fenced off.

Interviewer: In Grandview-Woodlands?

Tegan: Yes! So that the community wouldn't see the homeless people here, right? And they're kind of pushed out of the community so talking to people

about things like that, it really gives them the sense that their voices are going to be heard more. Even if it's just us.

Daily interaction with street-involved peers also created a perpetuating chain of empowerment, where some peers were inspired to be a part of P2P. As stated by Mark, "You're empowering them to help themselves, and then to help others." In fact, many of the Peer Members had become a part of P2P through their partners or other outreach workers. Peer Members acted as representatives of the idea that "people do see you different once you've shown that you are changing and you're doing better for yourself," as expressed by Raina.

Raina: And just to let them know that we're there and if you want to be a part of, you're more than welcome. Anytime, right? And it's just – I think it's important to always have that door open so that when the time comes in their life that they decide that they want to make a change and they want something more, that that option is available and they can do that.

Interviewer: The people you're reaching out to, does it help include them into society?

Raina: I think so, yeah. At least it gives them an opportunity to, if they want to. I mean, the door's there. It's up to them to come through it, right? And just to let them know that we're there and if you want to be a part of, you're more than welcome. Anytime, right? And it's just – I think it's important to always have that door open so that when the time comes in their life that they decide that they want to make a change and they want something more, that that option is available and they can do that.

Jenna noted that, "Beyond the community engagement being a good way to get people into treatment," and was "a good way also to get people out of isolation and more broadly involved." Her former partner, Leon, also a Peer Member, was introduced to P2P through a friend. His friend had felt uncomfortable attending the support meetings alone, and had urged Leon to accompany him. Later, Leon encouraged Jenna to attend the meetings and was instrumental in ensuring that Jenna would, indeed, show up at those meetings. In Raina's case, when she was involved with Crystal Clear, a peer outreach program directed to youth addicted to crystal meth in Vancouver's West End neighbourhood, she and other outreach workers would inspire those youth:

In the West End, in the Crystal Clear thing, everybody really looked up to us. They were like, "Wow, that's so cool!" And they really wanted to get involved and stuff, because, you know, they saw how we were proud of what we were

doing, right? That we were like bringing dignity and self-respect to the drug addict homeless person, which is like usually kind of in short supply. [Raina]

Leon surmised that it was the familiarity established by daily outreach that would pique the interest and curiosity of some peers:

I haven't personally seen it, but I can imagine just that familiarity and some client wanting to know how we do this and come into Peer 2 Peer and then that whole process gets started, right? I think, yeah, Billy's known Sam for years and he just started with Peer 2 Peer. So, it's kind of hard to say. That's a case where somebody on the street, a client, coming into Peer 2 Peer, and become more engaged with the community. [Leon]

Many Peer Members often encouraged interested peers to join P2P:

I try to encourage people, whatever to come and be a part of it. But yeah, it's mostly a word of mouth thing. It's how people find out about it. And that's how people get involved and stuff. [Raina]

A couple people we got from the streets have come out and joined us. Now they haven't lasted very long; they've gone back to the streets, but, you know, at least they've experienced it. [Dana]

Everybody wanted to be involved and be a part of. They knew us and were cheering us on. It's like, got lots of feedback from people saying, "Wow, we're so proud of you. We want to be like you." It's like we were really positive influence and stuff on that community and stuff. It's cool. It was really cool. It was good to get that kind of feedback from people, too. That we were actually giving them hope and making a good impact in their life. [Raina]

Yeah, absolutely. I... I myself have seen... I can give eight... maybe eight to ten people that came in to see what we were all about, and that we reached them to a point where they wanted to do the same and give back. And so, I've seen a few cases where, you know, I was on the street... I met them on the street, told them about our meetings, they came. [Mark]

In many ways, by becoming outreach workers, Peer Members were able to contribute to the community under their own terms of citizenship; this, of course, included respecting the community norms of reciprocal maintenance. The program was flexible in that although Peer Members acted as sanitary and biomedical citizens as outreach workers, they were not required to abstain from drugs. For Peer Members working several jobs or attending classes, outreach shifts were also flexible in terms of scheduling shifts because Peer Members were able to choose which days worked best for them. This provided a stable platform for both economic

opportunities and social security. For Raina, having a low-threshold form of employment provided the income and flexibility that aided her attempts to regain control over her life:

I don't have to worry about it if I don't make it for a week or two, or whatever, right? But it's like I'm always welcome back just the same as if I've been there every week, so it works really good with my schedule. 'Cause yeah, we have a lot going on. We're trying to get our son back and dealing with the Ministry and all their expectations of us and trying to make a living and get by and – looking for housing and all this other craziness... Even though I'd be asleep through half the training sometimes because my medication, you know, whatever, right? But they still, you know, stuck with me anyway and it made me really passionate about the whole idea that you can change and, you know, just because you're on drugs or you're on the street, whatever, doesn't mean you're worthless. And, you know, that you can be – do anything with yourself. They gave me a chance for me to see that I actually can accomplish things and be useful and make things happen! And that was really amazing. [Raina]

Participating in these shifts also helped build more structure into the lives of the Peer Members as they transitioned from unemployment to low-threshold employment. This involved the gradual catabolism of the Peer Members' previous deleterious social networks that promoted drug use:

It's a good way to start getting back into a different life. It's a good way to break out of a certain lifestyle and move to another. In this case, to move out of the – away – try to move away from the addictive lifestyle. Because I mean, that's part of it. Like, when you're in addiction, your whole day's wrapped around drugs. If you're not doing them as soon as you're done doing them, you have to start finding a way to get more. Because it doesn't end, right? You're not gonna be high in a few hours so you – and you'll gonna want to be high in a few hours 'cause or else you gonna start hurting with certain drugs, right? So like, it's not even – You don't even get to enjoy your high anymore, right? It's twenty-four hour day, seven-day-a-week habit. Right, and then trying to start doing stuff like this – the support circles and all that kind of stuff – takes two hours out of the day. Two or three hours, and then another three and a half hours out of the day another time. And it starts separating you from those kind of people... that live that kind of lifestyle. It's like a good way – a good foot out of the door, right? It gives you an excuse – “I don't want to get high right now – gotta go to work.” [Pete]

As Pete had stated, in addition to providing Peer Members a more structured lifestyle that made it easier for them to transition into employment, being involved in P2P also provided an alternative focus for the Peer Members that kept them away from the drugs. Another part of

providing an alternative focus included the Peer Members having a “sense of purpose,” which helped rebuild their self-esteem.

I guess in a way, to be honest, it’s given me a sense of purpose. ‘Cause I look forward to the meetings, I look forward to my shifts. I shared earlier that I would like to be doing this more. I’m comfortable with the group and with the people in the meeting and that. And it leaves you with a rewarding feeling of feeling good. [Craig]

It gave me the hope and purpose in my life – That I can do something better, that I am worthwhile. You know, that I am important and I deserve a better life. And I deserve to be happy and safe... It changed my life so much for the better. It gave me something positive in my life, so like drugs wasn’t the main focus of my life and that’s kind of where I started to slow down off drugs... [Raina]

Besides extending their personal experiences into their role as outreach workers, the constant interaction with community members during their work eased the Peer Members more comfortably into the community. However, the initiation of social interaction and establishment of meaningful relations required trust. Having been excluded from meaningful relations with the greater community, many of the Peer Members had initial reservations about approaching people outside of their peer group. Mark, a longtime member of P2P, remembered his initial encounter as fearful, explaining that it required him to be outside of his comfort zone. Being an outreach worker helped, on a personal level, establish a communicative bridge where Peer Members now had the means to interact with people beyond their peer group. Peer Members such as Jenna and Matt regained confidence to be among and interact with people outside of their peer group. Matt admitted that prior to joining P2P, he would ignore people by pretending to listen to his headphones. However, outreach required that he and others with similar reservations “get out of their shell a little more.” Referring to his own experience and other Peer Members with similar experiences, he explained:

Like, so once they get out there – if they have to talk to the community, then they start to open up and they don’t feel so closed. So it helps them become part, of like, any community, not just our community, but any community. Because now when they’re somewhere else, if somebody talks to them, instead of just rushing off, maybe they’ll actually stop and talk to that person who’s talking to them.

In Jenna’s case, regular interaction with strangers helped attenuate her fear of social interaction. She was particularly fearful of being negatively judged – especially for using drugs –

and, hence, was always “waiting for something terrible to happen.” Engaging with more people, however, helped her realize that “nothing terrible was happening.” In forming a more trusting relationship with the community at large, Jenna became more at ease with being in public settings:

It makes it easier for me to try new things, I guess. Like, I went swimming with my grandson yesterday, and my mom – his great-grandma – and my niece. And it was a lot less difficult than I expected it to be. And probably part of the reason why it was less difficult... Well, it was less emotionally difficult. Like, actually going to the pool. It was crowded! There were so much people to be scared of! And it was probably a lot less difficult because of my experience here doing shifts and stuff like that, and getting a little more comfortable with that.

From the above passages, a true sense of belonging was created when Peer Members were not forced to repress and conceal their experiences with drug use. Rather, acknowledging this experience and being able to express the value of one’s knowledge facilitated a sense of belonging.

To conclude, it was expected that as outreach workers, the Peer Members would eventually be recognized, by creating a biosocial space, as producers and circulators of biomedical knowledge. However, another effect of this role was that the Peer Members had a place to challenge the homogeneous cast of the “drug addict”; they were now in a position where they could express shared identities with the community at large. Biosociality enabled the Peer Members to escape the ossified image of the agentless and pollutionary addict in favour of a more proactive political and cultural identity. Furthermore, they were able to participate meaningfully in dominating public discourse surrounding poverty, illicit drug use, risk, and health. This role reconciled the notion of responsible citizen with person who uses drugs, and that the two concepts are reconcilable: people who use drugs can be responsible citizens. As a result, the Peer Members were able to express their citizenship by being engaged in politics while directly or indirectly contributing to the public good (Kastoryano 2002: 219-220). However, this required the development of mutual trust as well as the presence of supportive structures and circumstances. This trust was established on the basis of a shared sense of fairness, norms, and mutual respect. As soon as the Peer Members developed this trust with their peers as well as with the rest of the community, this sense of trust subsequently extended to bridge the gap of mistrust between the greater community and the peer community.

Transformation of a community place through placemaking occurred by having the Peer Members connect dissimilar groups of people who share concerns, interests, and fears (Sutton and Kemp 2011:113). Therefore, change within and beyond the community occurred due to the ability of the Peer Members to establish relationships within the community and use those linkages to affect normative beliefs and practices to establish social transformation. By collectively creating a space where they could contribute to the needs of the community, and in doing so, extend a sense of place to their peers; by bridging the cultural gap between peers and non-peers; and by creating links with other organizations and levels of power within and beyond the community, the Peer Members were able to transform the places in which they found themselves on an individual- and community- level.

And I guess that is my message – is to share this information. You know, from a drug... from a drug using community, I think it's time to come out of the shadows and to stand up for our rights and to be seen and heard. [Mark]

It should come to no surprise that, in strengthening community ties among members of different social identities, this daily interaction helped Peer Members foster for themselves a sense of community in Grandview-Woodland, and this sense of belonging also extended to their peers. It is important to note, however, that for a socioeconomically marginalized and stigmatized group, this form of interaction and integration is healthy not only for the community by creating interdependent ties, but also functions as a form of healing for Peer Members and their peers. Outreach provided Peer Members with a role that helped them feel comfortable to be visible in public and in interacting with other members of the community, while the support meetings offered an alternate social environment that addressed their own needs necessary for their survival and recovery from addiction. Therefore, in establishing the ties that enable the exchange of social values, material goods, and knowledge among Peer Members, their peers, non-peer community members, and political and health organizations, a healthy and inclusive community becomes possible.

## CONCLUSION

To return to the question stated in the introduction, can one be transient yet still have place within the larger society? For the Peer Members, the answer is yes. In their homeplace, the support meetings, they found place amongst one another through shared experiences. Through outreach, they created for themselves a sense of place within the greater community through public displays of mutual reciprocity. For their peers on the street, they extended this sense of place by offering them support and services. Simply put, a healthy society is an inclusive locality where individuals, families, and communities have a place to engage and be engaged. The goal of this thesis was not only to illustrate the barriers and mechanisms that keep people who use drugs in the role of anti-citizen, but more so on how people who use drugs, as citizens, could positively transform space and the communities that inhabit that space. Place is critical for determining the health of an individual: whereas the first half of the discussion acknowledged the power of place-based marginalization, the final half of the discussion focused on how these marginalized people working in solidarity and in collaboration with institutions asserted their rights to inclusion. Place is the product of the interplay between individual agency and the external structures that constrain it. Mediating this dynamic interplay is social capital – the networks available for individuals to accrue support and resources. Despite structural constraints, the Peer Members were able to engage in placemaking by using moral reciprocity and biosociality to establish and utilize social capital to negotiate a place for themselves within an existing system.

In summary, Chapter 4 focused on the themes of disconnect and structural barriers that regulated bodies and the allocation of resources, whereas Chapter 5 focused on connections and social boundaries. On the topic of social exclusion, Chapter 4 illustrated how various forms of displacement – through structural violence, societal seclusion, and stigma – disrupted the formation of social capital. Social displacement disrupts any opportunity for meaningful interaction between the mainstream and marginalized populations of a community. Without direct meaningful interaction with the subject, other representations, such as through media and other forms of popular discourse, are relied on to understand the subject. With this, there is the risk of reinforcing the imaginary representation of that subject. Applying Lock and Scheper-Hughes' (1996) concept of the tripartite body, the bodies of those who use drugs become removed of self-worth, the social bodies became a regulatory symbol of deviancy, and the

political bodies become marginalized and stripped of its social connections. What remains is the bare biological life, which without any humanizing associations to protect it, becomes deemed as being unworthy of protection. By not participating in the moral economy of exchange and by not adhering to the rules of being a sanitary citizen, the body becomes apolitical and asocial, and is consequently abandoned. Therefore, by determining which bodies are worthy or unworthy of protection, social exclusion establishes a process of social death where the community becomes complicit in the procedure of “letting die” (Biehl 2001:217).

This politics of life, in enabling social exclusion, regulates citizenship. Citizenship is a marker for social inclusion and is measured through one’s ability to participate in the public discursive space, be it through the engagement of individuals in their given space or their direct or indirect contribution to the public good. Through the moral economy of exchange, both public health and the market economy shape citizenship by controlling and rationalizing the allocation of space and resources. Yet despite sharing an ideological positionality such as the moral economy of exchange, community boundaries and structural barriers are in place to prevent the formation of social capital. Without social capital to communicate the mutuality of these norms and values between the two social groups, these two communities remain bounded, and hence separated from one another. Consequently, the geographic and social positionalities of those who use drugs remain displaced. Therefore, although the moral economy of exchange is expressed within discrete communities and the market economy is in place, without social capital bridging or linking these values across communities, there remains a gap in understanding and communication.

Yet, we need more than a zone of abandonment that collects “a society of bodies” (Biehl 2001). There needs to be more than a place to share silent suffering. Having a biosocial role makes community boundaries more permeable by helping establish connections across different communities through bonding, bridging, and linking social capital. Merely having a physical space to dwell in – for instance, shelter – is important yet alone is insufficient for addressing social exclusion or improving quality of life. In Philippe Bourgois and Jeff Schonberg’s (2009) ethnography of the Edgewater homeless, many of the participants, after obtaining housing and treatment services, became isolated and bored, and returned to using drugs. Thus, in addition to having a space to engage with peers and other community members, having a sense of purpose is also a crucial component of individual and community wellbeing.

Another critical aspect of place is having an environment where one can, to some degree, express oneself comfortably. The first part of Chapter 5 discussed how specific spaces help excluded groups, while being integrated into community dynamics, re-appropriate their identity, attain a sense of social legitimacy, and work among themselves to exercise their rights to navigate and access services from the community. What is most important about having a homeplace in addition to having place among the wider community is that a homeplace creates a place for not only the individual as a body but for his or her experiences and imperfections. Having a homeplace allowed the Peer Members to address their drug use openly without risking moralizing judgment. Furthermore, within a homeplace, the Peer Members could rebuild a sense of trust within a supportive environment of peers.

This creation of a safe environment that enabled the expression of self and established a sense of mutual trust eventually extended to members of the wider community. This bridged the gap between dominant and excluded cultures. In creating a biosocial role, the Peer Members became producers of biomedical knowledge and had the authority to publicly circulate knowledge through their establishment of bonding, bridging, and linking social capital. This biosocial form of placemaking challenged existing structures of violence and created a place in the community where they could begin to participate in its structure of interdependency. Without place, there would have been no basis upon which interactions such as the moral economy of exchange could have occurred.

P2P, as a peer outreach and support program, appears to occupy a space in society that mediates between bare life and the social and political life, between the grassroots and the institutional. Thus, do peer outreach and support programs similar to P2P have the capacity to create place, regenerate citizenship, and become a structural possibility? To return to the importance of considering place as a dynamic multivocal concept, when evaluating the success of such programs, these factors must be taken into consideration: the commitment of the Peer Members, the structure of the program and other governing structures, the community in which the program is based, and the interactions that occur among these components. In a society that values self-governance, self-governance on its own is not enough to ensure the survival of people who use drugs. Throughout this research, it was clear that the Peer Members were resilient and resourceful. They were not passive victims of structural violence; they were active, yet powerless, agents. They could only survive to a certain extent – self-sufficiency and the

presence of subsistence provisions can only do so much to enable survival. There were still the socially exclusionary barriers in place that prevented them from creating place, regenerating citizenship, and challenging structures. What makes P2P most successful is that it appears to be premised on the concept that everyone has a need to belong and have purpose. Hence, programs that wish to address addiction in the long term and rehabilitate Peer Members into the wider society must consider creating a place that fosters not only a sense of belonging but a sense of purpose as well. The Peer Members were able to develop some sort of place within the existing structure and shape communicability around drug use and public opinion of people who use drugs. Peer outreach and support groups such as VANDU and P2P are changing the structure of how biomedical knowledge is produced and in how services are delivered. For instance, the British Columbia Ministry of Health's (2005) guide on harm reduction features peer programming as a way to address addiction.

On a theoretical level, placemaking is mediated by the relationships governed by the moral economy of exchange, the tripartite body, and social capital. The moral economy of exchange regulates social exclusion using the mechanisms of the sanitary citizen and the market economy. The tripartite body, which risks being essentialized by the aforementioned governing structures, consists of the individual, social, and political body. Lastly, social capital, which connects these bodies and in doing so regulates exclusion and inclusion, consists of bonding, bridging, and linking social capital. These three overarching components of placemaking thus make P2P a potential vehicle of structural intervention. P2P, for the Peer Members, had a marked impact on creating community-level change. In being able to regenerate their citizenship using biosociality, they were no longer excluded from the body politic. Narratives of their suffering, resilience, and capacity to create community change circulated alongside their knowledge of harm reduction and addiction within the public sphere. This challenged the normalization of their suffering. Extending services and inclusive opportunities to transient people who use drugs and by having a specialized role in being a sanitary citizen bridged relations of trust between the wider community and people who use drugs.

In forming these bridges of trust, the Peer Members' biosocial role to some extent transformed the social body of people who use drugs. Often, the excluded body is the one that becomes the easiest to essentialize and hence, regulate. By challenging programs and stigma that constrained the agency of people who use drugs to navigate place, this prevented their being

relegated into essentialized modes of existence. In the struggle to redefine their social body, the Peer Members helped challenge the imaginary categories that regulated addicted bodies through predominantly criminalizing, pathologizing, and racializing forms of discourse. In transforming the image of the social body, the presence of the addicted body in public spaces became more meaningful in relation to the rest of the community.

One of the initial questions that drove me to work with peer groups was, “What about the people working in these groups?” The majority of research on peer programs comes from the biomedical domain and focuses on the impact of peer outreach programs in terms of disease rates and high-risk behaviours. Yet little attention is paid to the cultural impact of these programs on the providers themselves. Being in a program with a flexible structure acknowledged and accommodated to the unpredictable and challenging schedules of the Peer Members as they adjusted to the scheduled lifestyle of participating in the labour market. Conducting outreach shifts for P2P was not the only income-generating activity for the Peer Members; several worked at other low-threshold legal income generating programs and collected cans to be recycled. For instance, Guy was a peer outreach worker for the Portland Hotel Society, which was situated in the Downtown Eastside, and Raina worked at a drop-in centre by VANDU in the Downtown Eastside. The Peer Members made it clear that, although it was an initial incentive to be a part of P2P, money was not the main objective for being a Peer Member. It was a way to better the image of themselves and their peers, and was one of the few ways available for them to demonstrate to the wider community that they wanted to, and could contribute to society. Most importantly, in developing pro-social roles, Peer Members such as Matt, Raina, Craig, and Pete gained confidence in their ability to be employed, challenging their pre-conceived boundaries of their capabilities.

Is P2P an effective structural intervention in public health? To revisit the definition, structural interventions “refer to interventions that work by altering the context within which health is produced or reproduced” and “locate the source of public-health problems in factors in the social, economic and political environments that shape and constrain individual, community, and societal health outcomes (Blankenship et al. 2000:S11). Using Blankenship et al.’s (2000) dimensions for structural interventions, P2P did identify and address the contextual factors that determine health: availability, acceptability, and accessibility. P2P, according to the definitions provided by Blankenship et al. (2000:S13), functioned primarily as a structural intervention that

emphasized accessibility, in that it acknowledged that “health is a function of social, economic and political power and resources, and, as such, manipulate power and resources to promote public health.” Being that P2P began as a grassroots organization formed by former members of VANDU, this focus is not surprising. In increasing access to the tools, mechanisms, environments, and behaviours (Blankenship et al. 2000) for addressing health problems, the social, economic, and political power of the marginalized enables improved health and wellbeing. However, indirectly, particularly after being adopted by VCH, P2P as a structural intervention also focused on ‘availability’ and ‘acceptability’ as contextual factors. In providing Peer Members with a low-threshold form of employment to generate income, and by providing their peers with harm reduction materials and referrals to services, P2P made accessible the means to reduce risk. Also, as a structural intervention, P2P focused on the contextual factor of “acceptability,” which recognizes that a healthy society is in part determined by its values, culture, and beliefs, and promotes public health by influencing cultural norms and values. In recognizing the shared values of mutual reciprocity and sanitation among the subgroups of the community, P2P helped challenge the popular perception of people who use drugs as being “deviant” members of society. Therefore, P2P was successful as a structural intervention that challenged the structures and processes that perpetuate inequalities within the social, economic, or political sphere, all social groups benefit.

Within the biomedical sector, peer involvement is gaining more recognition, as evidenced by the increase in funding opportunities (see Roe 2001). Within the political sphere that controls addictions discourse, however, the structure remains more or less the same. Harm reduction, in its most basic form, is vital in enabling the survival of bare life (Ticktin 2010). Expanding the scope of harm reduction, P2P as a peer outreach and support group enabled cultural and economic survival. However, health advocacy needs to go beyond harm reduction. Structural violence cannot be ignored and must be addressed. Having a mechanism for “keeping alive” does not excuse the continual presence of mechanisms that allow for “letting die.” At the federal level, there are more policies framed around criminal justice laws that promote drug prohibition rather than human rights laws advocating for harm reduction. Given recent events such as attempts by the Conservative federal government to oppose the operation of Insite, a safe injection site, and seeing how the government had dropped harm reduction from the National Anti-Drug strategy as soon as they had come into power (CBC 2011), there is little support at the

federal level for addicted bodies. Health Minister Leona Aglukkaq, in response to the ruling of the Supreme Court to allow Insite to operate, stated that, “We believe that the system should be focused on preventing people from becoming drug addicts” (CBC 2011). In advocating for policy reform, the Vienna Declaration has been pushing towards incorporating a more evidence-based approach in drug policy with the purpose of replacing drug prohibition policies that engender practices inhibiting drug users’ access to care, treatment, and support for HIV infection, addiction, overdose, and other health concerns (Elliott et al. 2005:105). Yet despite overwhelming evidence that drug law enforcement fails to achieve its stated objectives and has harmful consequences toward those experiencing drug dependency (Lurie and Drucker 1997; Rhodes et al. 2005), the Government of Canada persists in increasing law enforcement efforts in investigating and prosecuting drug crimes (see Government of Canada 2007). With policies that overlook contexts such as poverty, suffering, and social inequity faced by socioeconomically marginalized populations, it becomes necessary to question how the governing body is able to – without public dissent – legitimize “ideological bullying” that allows for the continuation of structural violence such as the unequal class-based distribution of health services for addiction.

In terms of protecting the health of the vulnerable regarding those who are displaced and marginalized to the outskirts of the body politic, the National Anti-Drug Strategy fails in providing protection to the health, safety, and sense of membership. This Strategy causes further harm to the socioeconomically vulnerable drug addicts by: first, displacing and exploiting them by casting them in a fixed, homogenous, and faceless imaginary role in order to maintain the cohesiveness of the body politic; and secondly, by further disconnecting the subjects who are suffering, from the awareness of the general public. Therefore, this Strategy perpetuates social inequity in how the addicted body is treated, and also in how its individualistic approach removes the underlying issues surrounding illicit drug use. Thus, despite programs such as P2P, citizenship remains a matter of biopolitics and the Peer Members gained citizenship by adopting a biosocial role. That structure remained unchanged. And for those unable to adopt a biosocial role, there seems to be no other way to express citizenship in order to access the benefits of becoming a citizen. Yet with the presence of peer programs such as P2P, although the structural inequalities have yet to be immediately changed, at least by acknowledging the existence of structural inequalities, part of the suffering is mitigated.

Another pressing question remains: is this type of peer-based initiative successful or effective as a harm reduction program? With the lack of consensus regarding what constitutes harm reduction, it is difficult to provide a definitive answer. In Chapter 2, under “Organization and Delivery of Harm Reduction Services in Vancouver, British Columbia,” I outlined existing definitions of harm reduction and expressed the need for a standardized definition that acknowledges the social determinants of health. This is particularly important when the efficacy of harm reduction programs is evaluated according to how much harm is reduced. Being that harm reduction is recognized a key pillar in Vancouver’s four-pillar approach (British Columbia Ministry of Health 2005), it would be assumed that Peer Members should not have to be concerned about retaining funding for their program. However, gauging the success of this program on (1) the number of needles collected during sweeps as well as (2) the number of peers accessed for outreach is problematic. First, in Grandview-Woodland, finding fewer used needles on the street does not necessarily indicate that there is a decreased demand for outreach services. Reports indicate that crack smoking is on the rise (Urban Health Research Initiative 2009:134-136); because crack pipes are reused, there is less – if any – discarded evidence to collect. Furthermore, attributing success to the number of needles collected disregards the effect these programs have on the individuals and the community involved. This program fulfills Friedman et al.’s (2001:9) criteria for harm reduction, which includes the “redemption through social struggle.” However, admittedly, it is easier to measure the net reduction in drug-related harm reduction through the number of needles collected versus finding – or creating – a consistent measure of the psychosocial effects on those impacted by the program.

Obvious limitations to this study include the limited amount of time spent working with and observing the Peer Members. Had this been a longitudinal study, more observations could be made on the effects of P2P on the lives of the Peer Members. Furthermore, the time constraints involved with writing a Masters thesis made it difficult to collaborate effectively and exchange ideas with the Peer Members. Because both sides had different schedules and projects to manage, being able to coordinate schedules or set deadlines was challenging. However, both the Harm Reduction Programs coordinator and the P2P Program Coordinator have been very gracious about presenting the findings to the Peer Members during the support meetings for their feedback.

To conclude, because drug use and addiction affect the community as a whole (Urban Health Research Initiative 2009:10), and not just the individuals involved, peer networking is critical for reducing drug-related harm. Because Peer Members are effective change agents (Allman et al. 2005; Dickson-Gomez 2010; Hayashi et al. 2010; Kerr et al. 2006), peer networking needs to be recognized as a part of community development (Altman et al. 1991:403). A healthy community is not made of homogenous individuals, but is a system consisting of diverse communities with its own unique individuals. As described by Hughes (1977:28):

Wherever some group of people have a bit of common life with a modicum of isolation from other people, a common corner in society, common problems and perhaps a couple of common enemies, there culture grows. It may be the fantastic culture of the unfortunates who, having become addicted to the use of heroin, share a forbidden pleasure, a tragedy and a battle against the conventional world.

Therefore, in connecting isolated individuals to the community and space in which they find themselves, a peer culture “where the interplays of harm reduction and safety can act to create social foundations for risk reduction” is created (Allman et al. 2005:402). To quote Biehl (2007:6), “What do these struggles over...survival say about the state of human rights, politics, and equity on the ground and globally? Which forms of health are sufficient to liberate life, wherever it is confined?” Community-based research and anthropology are particularly pertinent to informing the development of collective, conscientious, localized, and inclusionary practices and policies that engage the marginalized into society. Like grassroots initiatives, anthropology can be applied to social action, an approach “that seeks to alter institutional policies and to make changes in the distribution of power” (Brager et al. 1987:54). This discipline is essential for understanding the tensions that arise from sharing space, how information is circulated among structures, and how place is facilitated within such spaces and structure. Place matters for the transient.

As a structural intervention, P2P provided not only a small form of income-generation that helped stabilize the lives of the Peer Members, but also was instrumental in stabilizing the place of these Peer Members and their peers as active agents in the community, thus creating an inclusive and place-conscious community. It created an environment where the Peer Members’ identities were negotiated, produced, and sustained. In order to foster involvement in community

life, it is necessary to first foster a feeling of belonging within a community. For a socially excluded individual, it is the occupation of a space where one can experience belonging to a social network that allows for transformation. Whether it is the transformation of one's identity, how one relates to a place and its occupants, or the social structures of a place, the support meetings and outreach reconfigured the knowledge and experiences of the Peer Members into something positive. Although marginality and oppression cannot be transformed immediately, creating a social environment where Peer Members could be supported and support one another both within and outside of the meetings helped mitigate the marginalization that characterized their lives.

## APPENDIX A DESCRIPTION OF PARTICIPANTS

### **Tegan**

Tegan is a young, soft-spoken woman in her early twenties. Tegan first heard of P2P while searching online for alternative ways of recovering from addiction and has been involved for nearly three years. She is actively involved in peer and community forums across the city where she works on bridging the gap in understanding between service providers, the rest of the community, and the homeless. During outreach, many of her peers – particularly women who would normally avoid other Peer Members – trust her and access her for materials. She is very attuned to the sensitivities of her peers and Peer Members and is quick to provide emotional support.

### **Craig**

Craig is in his late thirties and has been with P2P for over five months. His former partner had introduced him to this program. As this study was nearing its end, Craig was promoted to being a Peer Supervisor and was about to celebrate his yearlong anniversary of sobriety. Craig lives in a District Municipality northeast to Metro Vancouver, and travels by the SkyTrain to attend all the P2P meetings and shifts. Craig has ADHD and is very active and social. He also possesses a sharp sense of humour. He tries frequently to arrange social events with other Peer Members. Because of him, Craig's sibling is now a part of P2P, which has brought them closer to one another. He plans to volunteer as a peer support worker at the addictions and treatment centre that he used to attend from his municipality and has been asked to extend the P2P program to his District Municipality.

### **Dana**

A longtime resident of Grandview-Woodland, Dana is a transgendered female in her early sixties. She is of Aboriginal ancestry and was at an early age removed from her community, sent to residential school, and was brought up in a Judeo-Christian household. She has since reconnected with her biological family, and is very close to her parents as they had played a large role in her recovery from addiction by taking her to a sweat lodge. Coming from a

family of volunteers, she is actively involved in the community and volunteers for many local events and associations, including the Grandview Woodland Community Policing Centre, as evidenced by the many volunteer T-shirts she possesses. She is one of the three Peer Supervisors, and although she has been a part of P2P for only eight months, she has long been involved with peer outreach groups in the Downtown Eastside. However, she had decided to quit doing peer outreach in the Downtown Eastside, citing burnout as the main cause. She is currently taking a course on clown performance and applying for a job at the hospital to aid Aboriginal patients living with HIV/AIDS. Always resourceful and knowledgeable of the services available in Grandview-Woodland, Dana would guide me to addictions and advocacy services, recite the history of certain services, buildings, and parks, and ensured that I knew which parts of the neighbourhood had the best berry bushes. She is very friendly and talkative and is well respected and liked by Peer Members and community residents.

### **Maggie**

Maggie is an artist and writer in her fifties and learned of P2P through her daughter, who is also a Peer Member. Relative to her fellow Peer Members, her experience with addiction is quite unconventional in that she is not addicted to illicit drugs; because of this, she is very protective of her peers and often positions herself as having an outsider's perspective of the group dynamics and experiences. When she was 13 years old, she was placed in the hospital to detox from the psychiatric drugs she was prescribed. Believing that her prescribed drugs have permanently affected her nervous system, particularly the way in which her brain processes information, being involved in P2P helps her in relating these experiences of the difficulty of withdrawal. Working in the best interests of homeless, the addicted, and the impoverished, she is often critical of the motivations of political leaders and service providers who work with that demographic.

### **Billy**

Billy grew up in one of the prairie provinces, is of Métis heritage, and currently lives in one of Grandview-Woodland's mental housing facilities. He became involved with P2P through the P2P Program Coordinator and has been involved for 1-and-a-half months. Billy uses illicit

substances, but since joining P2P, he has adopted safer practices and is gradually decreasing his use of drugs.

### **Leon**

Leon lives in the Downtown Eastside, is in his early forties, and had heard of P2P from a friend who formerly attended P2P. His friend's partner had been feeling ill that particular week, and not wanting to attend the meetings alone, he persuaded Leon to join him. Since then, Leon has been a part of P2P for over eight months and is now a Peer Supervisor. Recently, he has convinced his former partner and close friend Jenna to join P2P. Leon is very responsible, as evidenced through his interactions with Jenna. Because Jenna suffers from disorders such as agoraphobia and social anxiety disorder that prevent her from engaging comfortably with the public or being in public spaces, Leon constantly phones to remind her of meetings and personally escorts her to the meetings. Leon grew up in Vancouver, where he obtained his undergraduate and graduate degree. He then proceeded to a professional college overseas where he practiced for several years and met his wife. Eventually, because of his addiction going out of control, he lost his job and home, divorced from his wife, and moved back to Vancouver.

### **Jenna**

The newest member of the group, Jenna is in her forties and had become involved with P2P for two weeks. She had heard of this program through Leon. Although she feels extremely uncomfortable and self-conscious in public, open spaces, Jenna feels that being involved with P2P will help her overcome her social anxiety disorder and agoraphobia. During her early twenties, while completing the fourth year of her honours degree at the University of British Columbia, her depression had become so severe that she had to drop out. In close familiar groups and among people whom she trusts, Jenna is talkative and speaks in a very analytical manner that reflects her undergraduate training. Being a mother and a grandmother, she is very protective of others, particularly children, and has an easier time interacting with parents during outreach shifts than with other Peer Members. She openly expresses concern for others' comfort and safety. In the middle of our interview, the fire alarm had gone off and we had to wait outside for a while in the cold weather. Concerned that I may be cold, she takes off her shawl and puts it over my shoulders. Afterwards, she offers a cigarette to Leon and hands me a granola bar as we

waited. During shifts, she is often concerned about children coming across drug paraphernalia and thus always ensures that public parks and school grounds are searched.

### **Matt**

Matt is 29 years old and has been with P2P for a little over a year, having learned of the program through a former partner. Like Craig, Matt travels by SkyTrain to attend P2P support meetings and to work outreach shifts. He recently moved from one District Municipality into another to escape the social environment that fuelled his drug use. Since moving, he has stopped using drugs. Being involved with P2P has made him want to see similar programs be offered in his former District Municipality. Through being involved with P2P, he hopes to one day become an addictions counselor and continue working for VCH.

### **Raina**

An engaging woman her mid-twenties, Raina has had extensive experience with being involved with peer outreach groups. Prior to P2P, which she has been involved for seven months with, Raina was part of the pilot group for Crystal Clear – a peer outreach group in West Vancouver for street youth addicted to crystal meth – and had been a part of the program for three years. Just as funding for Crystal Clear was ending, Raina was raising her newborn son with Pete. After a year or so, Raina wanted to rejoin Crystal Clear but later found out that the program had closed down; however, the director for that program was now the peer programs coordinator for VCH and referred her to P2P. Always advocating for the rights of her peers, Raina sees being involved with P2P as a way to inspire peers to be involved in the community. She hopes to work for Insite, an organization she also currently volunteers for. Both she and Pete are working to meet the requirements of the Ministry to regain custody of their child.

### **Pete**

Pete is Raina's partner and has been a part of P2P for seven months, joining at the same time as Raina. An avid fan of heavy metal music, Pete is originally from Europe but spent his child growing up in the East Coast. He later attended university at Queens, where he completed a degree in computer sciences. Like Raina, he also works in the Downtown Eastside, where they both currently reside. Pete used to work in the oilrigs, but due to a recent neck injury, was forced

to quit. Applying his experiences as a peer outreach worker, he is now completing a certificate program in community development through Simon Fraser University.

### **Miranda**

Miranda is the youngest member of P2P and has been a part of this group for five months. Having once lived in the Grandview Woodlands, Miranda learned of this program through a youth services group she had been accessing. Because she is the youngest and is far into her recovery from addiction, she at times struggles to relate to other Peer Members. She is extremely reserved and cautious. Currently, she is attending a college in Metro Vancouver.

### **Guy**

Guy is the oldest member in the group, and has been a part of P2P for three years. He lives in the Downtown Eastside, where he also works as a peer outreach worker. Formerly, he worked as a baker for several popular chains in the city, but lost his job due to alcoholism. He has tried on several occasions to find work as a baker; however, with the hours and wages he was offered, he felt that his need to find employment was being exploited. Now, his income is derived from collecting welfare, working multiple low-threshold jobs, and binning (collecting bottles and cans for recycling).

### **Mark**

Mark first joined P2P over three-and-a-half years ago. No longer working outreach shifts, Mark can often be found working at P2P's harm reduction kiosk. Deeply philosophical and self-aware when speaking, Mark's answers often reflect his deep emotional connection with the street-involved population of Vancouver, referring to them as "brothers and sisters." He lives in the Downtown Eastside and spends much of his time engaging in environmental and social advocacy work. He keeps up to date with harm reduction initiatives on an international level.

APPENDIX B  
RATE TABLES OF INCOME ASSISTANCE

Ministry of Social Development

BC Employment and Assistance Rate Tables: Income Assistance

(Effective June 1, 2007)

Accessed May 20, 2012

<http://www.eia.gov.bc.ca/mhr/ia.htm>

<b>Support Rate</b>									
<b>Unit Size</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>G</b>	<b>H</b>	<b>Shelter Maximum</b>
1	\$235.00	\$282.92	N/A	\$531.42	N/A	N/A	N/A	N/A	\$375.00
2	\$307.22	\$452.06	\$375.58	\$700.56	\$949.06	\$672.08	\$423.58	\$396.22	\$570.00
3	\$401.06	\$546.06	\$375.58	\$794.56	\$1043.06	\$672.08	\$423.58	\$490.06	\$660.00
4	\$401.06	\$546.06	\$375.58	\$794.56	\$1043.06	\$672.08	\$423.58	\$490.06	\$700.00
5	\$401.06	\$546.06	\$375.58	\$794.56	\$1043.06	\$672.08	\$423.58	\$490.06	\$750.00
6	\$401.06	\$546.06	\$375.58	\$794.56	\$1043.06	\$672.08	\$423.58	\$490.06	\$785.00
7	\$401.06	\$546.06	\$375.58	\$794.56	\$1043.06	\$672.08	\$423.58	\$490.06	\$820.00

<b>Key</b>	<b>Effective April 1, 2007, rates for:</b>
<b>A</b>	Employable singles, couples, and two-parent families where all adults are under 65 years of age.
<b>B</b>	Singles, couples, and two-parent families where all adults meet the Persons with Persistent Multiple Barriers (PPMB) criteria and all are under 65.
<b>C</b>	Employable one-parent families where the parent is under 65.
<b>D</b>	Singles, couples, and two-parent families where one adult is aged 65 years or older.
<b>E</b>	Couples and two-parent families where both adults are aged 65 years or older.
<b>F</b>	One-parent families where the parent is aged 65 or older.
<b>G</b>	One-parent families where the parent meets the Persons with Persistent Multiple Barriers (PPMB) criteria and is under 65.
<b>H</b>	Couples and two-parent families where one adult meets the PPMB criteria and all are under 65.

APPENDIX C  
LIST OF ORGANIZATIONS OF PEOPLE WHO USE DRUGS IN VANCOUVER

Compiled from:

Jürgens, Ralf  
2005

“Nothing About Us Without Us”: Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative. Technical Report, 56. Toronto: Canadian HIV/AIDS Legal Network.

Harm Reduction Service Providers List, February 2010 (email to author, October 5, 2011)

<b>Group</b>	<b>Services Provided</b>	<b>Clients</b>
BC Persons with AIDS Society	Outreach, support, treatment information, advocacy, education, and safer sex supplies	Persons living with HIV/AIDS
DAMS Women’s Inner City Initiative	Harm reduction supplies, safer injecting, safer smoking, mobile access services (including accompaniments), case management, women’s group, meal program	Self-identified women who are HIV-positive, or are at risk
DTES (Downtown Eastside) HIV/IDU Consumer Board	Harm reduction supplies, needle exchange, safer sex supplies, referrals and advocacy around HIV	DTES community members
Hustle: Men on the Move	Outreach, harm reduction supplies, referrals and support	Male/trans sex workers
Insite	Health and addictions support, supervised injection, detox facility on-site, harm reduction supplies, needle exchange and safer sex supplies	People who inject drugs
Kettle Friendship Society	Safer sex supplies, mental health drop-in, advocacy, health clinic, employment program, housing assistance, volunteer opportunities	Community members with mental illness
MAP (Mobile Access	Mobile outreach service providing	Self-identified

Project)	support, referrals, harm reduction supplies, coffee, juice	women involved in the survival sex trade
PACE (Prostitution Alternatives Counseling and Education) Society	Harm reduction supplies, needle distribution and safer sex supplies, advocacy and support	Sex workers – trans/male/female
PEERS Vancouver	Employability program for people who want to exist the trade. Resumes and cover letters by appointment only	Anyone with experience with sex work
VANDU (Vancouver Area Network of Drug Users)	Needle Exchange, harm reduction supplies, outreach, education, support	People who use drugs
Washington Needle Depot	Needle exchange, harm reduction supplies, outreach	People who need access to harm reduction supplies
YouthCO AIDS Society	Drop-in space, food, housing support, advocacy and education	Youth ages 15-30 affected by HIV and HCV
Peer 2 Peer	Harm reduction and needle recovery. Support group for peers in Grandview Woodlands	Grandview-Woodlands community members
Western Aboriginal Harm Reduction Society (WAHRS)	Harm reduction supplies, alcohol maintenance program, footwear donations	Aboriginal community members who use drugs
WISH Drop-In Centre Society	Drop-in centre for women providing meals, support, referrals, makeup, clothing and harm reduction supplies	Self-identified women involved in the survival sex trade

APPENDIX D  
P2P REFERRALS TO SERVICES AND PROGRAMS IN GRANDVIEW-WOODLAND

Compiled from:

Pagnucco, Joyce

2008 Peer 2 Peer Outreach Manual. Unpublished, May.

Resources and Services	Name
Low-Cost Meals	Quest Outreach Society
	Greater Vancouver Food Bank
	Low-Cost Services to the Public
Free Meals	10 <sup>th</sup> Avenue Alliance Church
	Grandview Calvary Baptist Church
	Chili Wagon
	Community of Hope
	Salvation Army Family Services
	Gold Buddha Monastery
	La Boussole
	New Beginnings Baptist Church
	Collingwood Neighbourhood House
	The Gathering Place
	Maja Lakshmi Hindi Temple
	Evelyne Saller Centre
	Harbour Light Meal Service
	Meals on Wheels
	Emergency Food and Shelter Lines
Wilson Heights United Church	
Youth Services	Covenant House Vancouver
	Downtown Eastside Youth Activities Society (DEYAS) Youth Detox
	Sexual Assault Recovery Anonymous (SARA) Teen Peer Support
	Broadway Youth Clinic

	BC Centre for Disease Control Society
	Boys R Us
	Peak House Recovery House
	Dusk to Dawn
	Urban Native Youth Association (UNYA) Young Bears Lodge
	Watari
	Early Psychosis Intervention
	Pacific Legal Education Association (PLEA) Daughters and Sisters Program
	Kidstart Mentoring Program
Crisis Help Lines	Vancouver Crisis Line
	Youth Against Violence
	Alcoholics Anonymous
	Crystal Meth Anonymous
	Narcotics Anonymous
	Sexual Assault and Family Crisis
	Squamish Nation Crisis Line
	Alateen
	Gambling Anonymous
Lesbian, Gay, Bisexual, Transgender	Parents, Families, and Friends of Lesbians and Gays (PFLAG) Vancouver
	Trans Alcohol/Drug Group
	Out from Under
	WTF? Queer Men's Early Recovery Group
	Taking it Deep Queer Men's Later Recovery Group
	Gab Youth Services
	Gayway
	Crystal Meth Matrix Program
	Prism

	Mixed Lesbian, Gay, Bisexual, Transgender (LGBT) Group Daytox
Legal Services	Brydes Line
	Pivot Legal Society
	Downtown Eastside Residents' Association (DERA)
	Drug Treatment Court of Vancouver (DTCV)
	Circle of Eagles Lodge
	Human Rights Clinic
	Prison Services
	Pro-Bono Law Clinics
Temporary Labour Centres	Labour Ready
	Labour Unlimited
	Labour Link
	Workforce Temporary Services Ltd.
Women's Services	Battered Women's Services
	1424 Commercial Drive
	Peers Vancouver
	Downtown Eastside Women's Centre
	New Start Employment Program
	Kettle Health Clinic
	Vancouver Rape Relief
	Bridge Emergency Women's Shelter
Aboriginal Services	Hey-Way-Noqu' Healing Circle for Addictions Society
	Vancouver Native Health Society HIV/AIDS Outreach Program
	Aboriginal Wellness Program
	Vancouver Native Health Society (VNHS) Walk-In Clinic
	Aboriginal Mother Centre Society (AMCS)
	Urban Native Youth Association (UNYA)
Women's Shelters	Powell Place

	St. Elizabeth Home
	Bridge Shelter for Women
	Anderson Lodge
	Kate Booth House
Men/Women/Families Shelters	Belkin House Salvation Army New Beginnings
	VI Fine Day Family Shelter Society
	Yukon Shelter
	Out of the Cold Grandview Calvary Church
	10 <sup>th</sup> Avenue Alliance Church
	Catholic Charities
	The Haven
	Stevenson House for Men
	Salvation Army Family Services
	Emergency Shelter for Men

APPENDIX E  
INTERVIEW GUIDE

1. What is your role as a peer?
2. Can you describe what you usually do during shifts/meetings?
3. How long have you been involved with Peer 2 Peer?
4. How did you find out about Peer 2 Peer?
5. What made you want to join Peer 2 Peer?
6. What has kept you in Peer 2 Peer?
  
7. What does empowerment mean to you?
8. Do you feel you are a role model among your peers? How so? How does that make you feel?
9. Does being a part of Peer 2 Peer affect how you see yourself in terms of being a leader and how you relate to your community?
10. How do others (peers within and outside of the program, family, health care professionals, police) react to your role?
  
11. In what ways do you contribute to the community (as a peer, as a harm reduction worker)?
12. Is a peer approach valuable? I'm noticing that harm reduction programs are increasingly adapting a peer-based approach – why do you think that is?
13. Have you accessed services from a peer-based organization? If so, what were the challenges you faced? Are there times its better to access from someone outside P2P?
14. Has being involved with P2P changed your views on harm reduction?
  
15. How do other peers receive the information you give them during your outreach shifts? Does this information reflect and fit with the reality of people's lives on Commercial Drive and Grandview-Woodlands?

16. How does involvement in the group translate to life outside the group? Are any of the peer members your friends? Do you hang out with your peer members outside of the program?
17. Can you tell me how you work together as peer members? How do you support one another?
18. How has this program impacted your life (outside of P2P, social life, work)?

## APPENDIX F INTERVIEW CODES

### Coding Set 1: Inclusive Space

- Community via engagement
- Community via shared experience
- Community via contributions
- Peer support via safe space
- Peer support via self-healing
- Peer support via collaboration
- Client support
- Greater community support
- Providing hope
- Employment
- Fulfillment

### Coding Set 2: Navigating Barriers

- Overcoming/Dealing with personal barriers
- Demonstrating via action
- Communication via bridging gap
- Communication via exposure

### Coding Set 3: Forming Identity

- More structure
- Advocate
- Embodying harm reduction
- Providing alternative focus
- Agency
- Diversity of experience
- Worth
- Credibility/Using existing skills/knowledge

#### Coding Set 4: Loss of Identity

- Removal of humanity and dignity
- Expendable/Worthless/Useless

#### Coding Set 5: Exclusion/Displacement

- Vulnerability to acts of discrimination
- Entrenchment/Coping mechanism
- Anti-community
- Exclusion via invisibility and being voiceless

#### Coding Set 6: Barriers

- Personal (triggering, social environment)
- Does not relate to some peers
- Funding (specific to P2P)
- Displaced population/lack of outreach
- Personal (lifestyle)
- Transient/Mobile community
- Organizational (specific to P2P)
- Structural
- Stigma
- Blindness (community)
- Blindness (Peers)

#### Coding Set 7: Various Levels of Power

- Non-Judgmental
- Equality/Accessibility
- Cannot relate (sympathy versus empathy)
- Hierarchy/Lack of accreditation as barrier

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