An investigation into the governmental rationalities of Vancouver Coastal Health's interventions in the Downtown Eastside

by

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Abstract

This study presents a qualitative analysis of some of the governmental rationalities that guide Vancouver Coastal Health's (VCH) service delivery in Vancouver's Downtown Eastside (DTES). High concentrations of urban poverty, illicit drug use, and protracted crises conditions in the area sustain a multitude of welfarist and medical interventions. How specific rationalities of care and variable power relations create conditions for the possibility of service operation in the area, ever-increasingly defined as a formalized space of population management, are investigated. Data employed in this analysis consists of interviews with 8 VCH directors and public domain policy documents. The topic is explored through the theoretical lens of biopolitical governmentality, whereby the affirmation of particular kinds of life-making strategies are understood as key elements in practices of governance, place-making and subject formation. Deficits in similar services in other locales throughout the city are identified to underserve communities outside the DTES. Contingent circumstance was shown to affect planned practices of governance. Bias in conceptualizations of harm reduction as public health measures to mitigate contagion risks have neglected mental health, undervalued housing as a therapeutic intervention, and underestimated the risks of a poisoned illicit drug supply. Further, essentialist or siloed thinking about practices of government and technologies of intervention are recognized to limit their efficacy.

Keywords: Downtown Eastside; Vancouver Coastal Health; Urban Governance; Biopolitics

Dedication

In memory of those we have lost and in recognition of all the unnecessary suffering because things are not otherwise.

This project was written on stolen and unceded land, under moderate levels of duress, in liminal and clamorous spaces. Substantial thanks are owed to my friends, family and colleagues. I offer my utmost gratitude to my wife Janet whose love, grace and resilience enabled me to complete this project. This document is dedicated to her.

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My gratitude to the eight respondents that took time from their busy schedule to meet with me and participate in my research.

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Preface

Two decades ago sociologist Nikolas Rose declared the “biologic and economic” to comprise “the two great underlying thematics that produce the modernity of space” [Rose 1999: 38]. Accordingly, around the same time, Vancouver’s Downtown Eastside was at the apex of a substantial inner-city rent gap and a growing public health crisis, expressed through the material-synecdoche of the abandoned Woodwards Building.

On October 24, 1997 the Vancouver/Richmond Health Board (VRHB), a precursor to the Vancouver Coastal Health Authority, released a communiqué that detailed the immanent re-allocation of three million dollars, and an additional $700,000 in new funding to address the emergency situation in Vancouver’s Downtown Eastside [VRHB, 1997: 2]. The report confirmed that “Vancouver has the highest known rate of HIV among injection drug users in the Western world. This is attributed to the intense geographical concentration of homeless people in the area as well as an increase in cocaine use as opposed to heroin use (cocaine users inject more frequently than do individuals using other drugs, increasing the risk of passing the virus through needle sharing).” [VRHB, 1997: 4] This modest sum of funds was to be used to enhance outreach teams, establish substance use treatment services, and to expand a community needle exchange program from one site to five. 45 new jobs were to be created, neighborhood amenities’ service hours were to be extended, and HIV testing and reporting in the Downtown Eastside was set to expand [ibid: 2].

The report directly linked HIV transmission to the area’s prevalent poverty. Longer-term strategies of sustained multilevel government engagement were listed to include demands for improved housing quality and availability, enhanced access to drug treatment programs and methadone maintenance therapy, engagement with the Vancouver Police Department, attention to food security and nutrition, and an improved transportation plan to connect the neighborhood’s residents to amenities and services elsewhere [ibid: 3].

The VRHB document presents an instance of a continued process of service development and provision in the Downtown Eastside in response to crises that had emerged out of depressed social conditions in the area that had augmented in the decade prior [Newnham, 2005: 3]. Reflecting back from today’s context, in 2021, these

investments might appear unexceptional. Yet, they worked to inaugurate a trajectory of transformed and heightened medicalized rationalities that were to become applied to the problematic conditions of life that had developed in Vancouver's eastern inner-city. Two key themes affirmed in the VRHB document that have endured to variably animate reasons and practices which presently govern the Downtown Eastside are 1) a complex interplay amongst epidemic logics of containment and mitigation - historically established through projects of colonialism and racial segregation [Sommers, 2001; Blomley, 2004; Wideman & Masuda, 2018], and 2) political demands for rights to life, security, autonomy, and habitation. The report concludes with a prescient "ongoing" action plan, that has yet to be realized twenty-four years later: "initiate major policy changes in the area of income security, *decriminalization of drugs,* civil rights and social justice" [italics and underline in the original, VRHB, 1997: 13]. The current document seeks to shed light on some of the asymmetries that have emerged a generation later by examining some of the contemporary reasons and values that work to sustain a medicalized focus toward the problematics of particular kinds of life in the DTES.

Chapter 1.

Research Question

This project is an inquiry into the social and political dimensions that pertain to a provincial health authority's service delivery and interventions in an inner-city neighborhood in Vancouver, British Columbia. Health care delivery in Canada is the principal responsibility of the provinces and territories.[1] In the late 1980's and early 1990's, in an attempt to streamline services and improve cost effectiveness, Canadian provinces began the process of decentralizing and regionalizing health services [Bolaria & Dickinson, 2001: 207]. Regional Health Authorities (RHA) were designed to focus on community-level service provision [Bolaria & Dickinson, 2001: 208]. In 2001, the government of British Columbia created six regional authorities wherein the Vancouver Coastal Health Authority (VCH) became tasked with service provision to several municipalities with diverse social geographies consisting of nine Communities of Care[2] [Vancouver Coastal Health, 2010: 2]. A metric that draws attention to the health authority's significance as an instrument for government that conditions and gives form to localized practices of life-making is its budget of 3.8 billion dollars - twice the budget of the City of Vancouver.[3] While this contrast might not be particularly surprising, it brings a key dimension of contemporary liberal government into focus – particular obligations within the social contract that affirm specific rights to health and the biological integrity and security of persons. As a geographic unit within VCH's administrative territory, Vancouver's Downtown Eastside constitutes a subordinate Health Service Delivery Area

[1] The Canada Health Act was created to off-set the high cost burden that results from a major function of government being delegated as the responsibility of the province [Madore 1996: 2]. It is based on a principle of distributive justice, insofar as it attempts to ensure that the economic burden of costs is fairly distributed amongst the provinces and territories [ibid]. However, universal healthcare remains a fraught issue across Canada, and there are broad regional disparities.

[2] "Richmond through Vancouver, the North Shore, Sunshine Coast, Sea to Sky corridor, Powell River, Bella Bella and Bella Coola, including Aboriginal Communities" [Vancouver Coastal Health 2010: 2].

[3] The 2021 budget for the City of Vancouver is listed at $1.5 billion in operating revenues, whereas the 2020 budget for VCH is listed as $3.8 billion. https://vancouver.ca/your-government/annual-budget.aspx and http://www.vch.ca/Documents/VCH-fact-sheet.pdf [Feb 2021]

(HSDA)[4] wherein a particular set of health services and rationalities have become established and intensified over the past two decades. The research presented in this thesis is an attempt to answer the following question:

> *How does Vancouver Coastal Health (VCH), the area's regional health authority, problematize Vancouver's Downtown Eastside (DTES)?*

This question is developed from a theoretical perspective that interrogates motives and rationalities of health care interventions in Vancouver's Downtown Eastside. It poses the DTES as a particularly problematized space that contains a target population that requires specific solutions in the capacity and form of uniquely tailored health care service delivery. It may be a truism to state that all neighborhoods are different from one another because of their different demographic and geographic constitution, and thus reasonable to infer that each neighborhood will have, to greater or lesser degree, its own unique needs and demands for health care. However, the DTES is particularly suited to this kind of questioning because of its historic demographic constitution and generations of problematizations through governmental strategies of intervention [Sommers, 2001]. The consequence has been the development of a sizably concentrated industry of regulatory and support services that consist of a variably integrated network of health care, criminal justice, social housing, and a number of other state and nongovernmental welfarist services within and around the neighborhood. Related questions in this line of inquiry are: How does VCH function as a governing apparatus in the DTES? And, what are the ends of VHC's governance in the DTES?

1.1. Significance of this research: health care as a mode of urban governance

This research was undertaken to both better understand and destabilize the obviousness of the function of a regional health authority as an instrument for government. I do this by examining its role in the political and social constitution, as well as the developmental dynamics, of a transforming inner-city neighborhood. This project examines the beliefs, rationalities, and forms of knowledge that guide and therefore

[4] https://www2.gov.bc.ca/gov/content/data/geographic-data-services/land-use/administrative-boundaries/health-boundaries [Nov. 2019]

make possible the implementation and allocation of health services in the area. I interrogate how problem-solution dynamics are conceived in order to make the current iteration of health service delivery in the neighborhood possible. Because of this, I set out to understand the manner in which a public institution integrates, contextualizes and operationalizes liberal logics of social contractualism and obligation, bodily autonomy and security, distributive justice, and choice and personal freedom – especially as they relate to extant conditions of pronounced social inequality that are expressed through stigmas that pertain to absolute poverty, mental illness, homelessness and illicit drug use which operate as defining qualities of the neighborhood. Moreover, this research aims to unsettle dominant narratives around the rationales of community health care delivery in order to provide a reflexive and critical lens on life-making policies and practices that operate at the neighbourhood scale. By doing this, I assert this project's significance in being a voice that articulates community-based health care service delivery as a politically relevant category of investigation.

1.2. Aim

This project explores the administrative and strategic rationalities of a key governmental actor operating within a space of prolonged crises. The DTES is rife with stark social asymmetries that intersect with the deployment of unique and controversial models of health care and social services. This project is an attempt to present a critical examination of the wider aspirations and socio-political contexts that inform the processes of neighborhood-level health planning. My aim is to highlight some of the contradictions, ambiguities, difficulties and complexities involved in the administration of care (a significant, slippery and non-neutral term that designates a spectrum of intentionalities and practises)[5] to a population that is increasingly subject to heightened levels of surveillance, intensive forms of behavioral modification (for instance, the prevalent use of involuntary intramuscular injection of antipsychotic medication under the

[5] This ambiguity of 'care' is the result of equivocation. Etymologically rooted to designate *matters of grief* and *to give serious attention to*, today it references variable technical and ethical practices and rationalities. First we can note the use of the term in a specialized, instrumental, clinical sense: a clinician provides *care* to a patient. But care also designates modes of ethical virtue: *care ethics* as a generalized practice of relating to the world and others; perhaps, established in the recognition of the inherent variability bodily and social capacities across the arc of lifetimes. The two uses are not antithetical, but nor do they always reference the same class of activities or scope of responsibility. While both uses of the term share a common referent, they also entail variable power relations.

Mental Health Act, or the juridical use of no-go zones in bail conditions) [Ng & Van Veen, 2015; Sylvestre, Blomley & Bellot, 2019; Boyd, Cunningham, Anderson & Kerr, 2016], and augmented forms of overall social exclusion - either through gentrification driven displacements from market housing, or economic dislocation as a result of the influx of new businesses that charge more for their services and products [CCAP 2016 & 2017].

1.3. Contribution

My research contributions are both exploratory and descriptive. I do this in two steps. First, I frame the institutional intentionality (aboutness) of the health authority within the broader socio-political context. Second, I then analyze how service delivery is made possible by approaching the governmental rationalities of the health authority as historically contingent phenomena which actualize circumstance in the present. This is a position which asserts that things - actions, states of affairs, physical qualities, ways of understanding, etc. - can always be otherwise, and that the given present need not be the case (for better or worse). My analysis proceeds through the lens of an urban-focused reading of a theoretical conceptualization called *biopolitical governmentality*. This is an orientation that focuses on rationalities and techniques that comprise the variable and contested drives to “make-live” as ends of government. I use this conceptualization of *life-making as a governmental practice and end* to pursue a reflexive and critical examination of expertise-driven instrumental rationalities of conduct-direction that are aimed at the biologic or vital capacities of a specific population. From a particular vantage point the ends, outcomes or goals of social medicine and public health initiatives can often be taken for granted or considered obvious in themselves – especially if one is a direct beneficiary as either consumer or provider. My analysis aims to trouble this obviousness.

I follow Bent Flyvbjerg’s acknowledgement that, “conflict and power are phenomena constitutive of social and political inquiry” [Flyvbjerg, 2001: 4]. The central focus of my inquiry is an attempt to understand how power dynamics operate at the neighborhood scale relative to a publicly funded institution. In his argument for the continued relevance of the social sciences in a world saturated with calculative instrumentalism, Flyvbjerg emphasizes the significance of the Aristotelian virtue of phronesis or practical wisdom, “because it is that activity by which instrumental rationality is balanced by value rationality” [Flyvbjerg: 4]. Likewise, I conceive my

endeavor to act as an intermediate and, therefore, contextual step between the technical instrumentalism of service delivery and the prescriptive activity of generating political norms and ethical judgements. That is, by examining how the DTES is problematized by VCH, I present a historically situated analysis of a particular, but complex, set of value rationalities that animate and structure service delivery in the neighborhood.

Vancouver is recognized globally as a tolerant and progressive city that is consistently ranked as one of the "most liveable" in the world[6] whose design and planning cast it as a global "exemplar" [Beasley, 2019: 37],[7] and hosts a publicly accessible health care system that is ranked among the best in the world.[8] So, in order to avoid the smugness or blindness that accompanies self-satisfaction, it is important to engage in critical analysis of reasons and actions that one might otherwise be partial towards. There are many detracting voices that criticize the "failed" policies of harm reduction, as if such an orientation alone is a panacea sufficient to address the complexities of phenomena such as inequality and poverty, or the intergenerational trauma of colonialism. In an era that is experiencing breakdowns and erosions of social solidarity (as evidenced in the global rise of authoritarian liberalism or illiberal populism),[9] and the continued increase of precarity and marginality as a result of a long generation

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[6] This is certainly boosterism. The perennial question remains: Livable for whom? https://www.vancouvereconomic.com/living-in-vancouver/#:~:text=Economic%20and%20political%20stability%2C%20universal,across%20all%20North%20American%20cities. [Dec. 2020]

[7] The planning and design strategy known as *Vancouverism* aims to link inclusivity, density, ecological sustainability, and urban diversity through regulated development in the actualization of the urban form [Beasley, 2019: 38-39]. Larry Beasley, one of the principal agents in the actualization of this strategy, refers to the DTES as the city's "black eye" noting, albeit briefly, the failure to address the "endemic poverty" and growing stratification, and laments: "We should have done better" [Beasley, 2019: 231-2].

[8] This claim is indeed contentious. However, in comparing the variability of provincial health performance globally, the Conference Board of Canada ranks the quality of British Columbia's health care as 3rd (below Switzerland and Sweden), whereas Newfoundland and Labrador, Manitoba and Saskatchewan fare the worst, on par with the United States. https://www.conferenceboard.ca/hcp/provincial/health.aspx [Mar. 2021]

[9] Pankaj Mishra details *resentment* to have emerged as a result of variously and unequally failed cultural imperatives directed toward the pursuit individual self-interest and accumulation. Today's disaffected and stifled individuals often operate from an alienated and cynical worldview characterized by negative solidarity "where it is easy to feel that there is no such thing as either society or state, and that there is only a war of all against all" [Mishra, 2017: 14]. This orientation complements Neil Smith's revanchist gentrifiers of the late 1990's – the vengeful enfranchised masses who prioritize their claims to urban space through exclusive private property rights [Smith, 1996: 43].

of neoliberal economic policy, purportedly humanitarian and progressively oriented policies and practices are in urgent need of internally reflexive critical appraisal.

1.4. Positionality

Since 2009 I have worked as a frontline service provider in supported social housing, shelters, outreach teams, and health care initiatives within the DTES as well as in adjacent and related communities. In my various roles I have participated in a complex, controversial, multifaceted, and multi-scalar process whose explicit goals are to reduce harm, extend life, promote health and well-being, as well as provide compassion and dignity to some of the most marginalized and vulnerable people in Canadian society. As a mid-level manager and frontline employee for the largest nongovernmental organization in the area (PHS Community Services Society), I was tasked with overseeing the operation of a low-barrier withdrawal management facility (Onsite) that is located above North America's first legal supervised injection facility.[10] Indeed, the very institution whose operational rationalities are the focus of this critical investigation both fund and directly partner in the operation of the facility where I worked. My job required that I involve myself in routine practices of applied rationalities of conduct that are directed at a target client population as well as a staff group. In my daily activities I bear witness[11] to, walk alongside with, plan and intervene – biologically, psychologically, socially and economically – in lives that have experienced

[10] Insite, located at 139 East Hastings St.. At the time of writing, I work at Onsite, at 137 East Hastings. The programs are related. Onsite is designed to provide Insite users and members of the surrounding community with rapid access to detox, stabilization and recovery services. Value rationalities that determine the existence of these services often operate through political affiliation and regional cultures. The conservative political sphere has, in spite of the overwhelming scientific evidence [UHRI, 2009], steadfastly rejected harm reduction as a reasonable approach to substance dependency or problematic substance use. In 2010 the Harper conservatives lost a legal battle in Canada's Supreme Court, and subsequently created the Respect for Communities Act, which made it extremely difficult for other organizations and communities to open similar facilities. [https://laws-lois.justice.gc.ca/eng/annualstatutes/2015_22/page-1.html Jan. 2020]

[11] Kelly Oliver distinguishes between acts of recognition and witnessing. While recognition (of capacity for suffering, for instance) is necessary for ethical action, it is not sufficient (recognition of capacity for suffering can serve as a basis for torture) [Oliver, 2015: 474]. Conversely, witnessing is an act that, due to both its juridical and religious contexts, moves beyond the bare factuality of acknowledging that something is, to situated accounts that detail the "why and how" of events with an emphasis of their intersubjective constitution [ibid: 483, 484].

vulnerabilities[12], traumas, sufferings, discriminations, exclusions, and oppression that I likely never will. In the spirit of what Donna Haraway has termed *non-innocence* [Haraway 1988: 583-4], it is important that I acknowledge my asymmetrical positioning as a nontrivially privileged and moderately empowered actor who sometimes decides who-gets-what, when, and how much. The DTES is a space and social reality that has been produced through generations of colonialism, racial segregation and social stratifications. It is a highly classed, gendered and racialized space where the effects of structural and systemic oppression and health inequities are immediately apparent to any observer. This state of affairs commands an ongoing reflexive appraisal of one's position as a minimum precondition for just activity and thought, as either a service provider or researcher. As a cis-gendered anglophone male of Western European heritage, it is imperative that I acknowledge my position as an agent whose perspectives and capacities are far from neutral, though explicitly aligned with decolonial and anti-oppressive projects. The view I aim to present in this document, therefore, is a partial and modest one from a place somewhere on the inside of the shifting and contested service continuum in the DTES looking upwards, wondering: how is the present situation made possible, and what are some of the significant trajectories of power that are engendered by its actualization?

My unequal and asymmetrical position as an actor who is paid a wage to serve the community and its members has given me the privilege to have had substantial life changing encounters with the varied intricacies and intimacies of life in the DTES. The DTES has been the object of considerable research[13] – especially research focused on the conditions, experiences and realties of the people that live and dwell there. This fact has worked to guide my interests away from certain research pursuits that set out to study the realties and experiences of people who are marginalized. Early on I decided that this project would not endeavor to tell that kind of story. Instead I observed that there appeared to be little research into the ways that key institutions, as instruments for government, conceptualize their activities and ends in the area, despite their centrality to the function of daily life and the various power relations engendered through their

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[12] Vulnerability is a key bioethical and biopolitical concept that delimits various thresholds of exposure to harm and forms of exclusion. It is a key concept that informs criteria that determine the degree or scope of life-making interventions someone might be entitled to.

[13] *Research 101: A Manifesto for Ethical Research in the Downtown Eastside* identified that there was at least 700 scholarly articles published about the DTES since 2017 [Boilevin et. al., 2019: 14].

operation. These two factors worked to direct my interests towards a project that sought to examine some of the larger-scale reasons and values that give form to social infrastructure, organize mechanisms of regulation, and make possible the allocation of certain resources and capacities for action while excluding others. The account presented in this project, therefore, is a partial one that is crafted from a reflexive consideration of position and power.

Chapter 2.

Methodology

2.1. Research Design

My research is a case study of some of the rationalities that direct a regional health authority's intervention in a specific neighborhood. The principal unit of analysis is a large social institution (Vancouver Coastal Health) operating within an inner-city neighborhood (Vancouver's Downtown Eastside). My research applies inductive qualitative methods of discourse analysis to semi-structured interviews and policy documents, with a principal focus on the historical period that relates to the conceptualization, planning and implementation of VCH's Second Generation Strategy for the DTES. This historical period spans from the late 2000's up to the summer of 2019. Because my project is idiographic in scope, I set out to gather information specific to the particular rationalities, strategies and techniques that make VCH service intervention in the DTES unique. My initial strategy was to collect as much data as possible which were then iteratively sorted, coded and analyzed.

2.2. Sources of Data

I derive my data from two sources: eight semi-structured interviews of a select cohort of respondents and policy documents available in the public domain. My research was developed from an initial analysis of the policy documents, begun late in the winter of 2018 and early 2019. This helped guide interviews that were conducted in the period ranging from February through to July 2019. Respondent data from the interviews are used to provide a greater degree of specificity and intimacy in the analysis of the subject matter. Data from the policy documents was then also later employed to further contextualize interview respondent data.

2.2.1. Documentation

The public domain policy documents that were used as primary sources of data in my research come from three sources: the British Columbia Ministry of Health, the City of Vancouver, and Vancouver Coastal Health.

1) British Columbia Ministry of Health:

- *Setting Priorities for the BC Health System*, February 2014
- *The British Columbia Patient-Centered Care Framework*, February 2015,
- *Delivering a Patient-Centered, High Performing and Sustainable Health System in BC: A call to build consensus and take action 2015*

2) City of Vancouver:

- *Downtown Eastside Local Area Plan*
- *Downtown Eastside Local Area Profile 2013*
- *False Creek Flats Area Plan*

3) Vancouver Coastal Health:

3.1) DTES Second Generation Strategy Documents:

- *Discussion Paper #1: Working with health agencies and partners in the Downtown Eastside*, October 2012
- *Discussion Paper #2: Staff perspectives on improving care and working with health agencies in the Downtown Eastside,* May 2013
- *Discussion Paper #3: Client perspectives on improving health care in the Downtown Eastside,* January 2014
- *Directions Paper #1: Health System Strategy Overview*, July 2013

- *Directions Paper #1: A Second Generation Health System Strategy for the Downtown Eastside,* July 2013

- *Directions Paper #1: Appendix – Workshop papers for the DTES Second Generation Health System Strategy*, July 2013

- *Theory Of Change*, 2015

- *Design Paper: Downtown Eastside Second Generation Health System Strategy*, February 2015

- *Women's Health and Safety in the Downtown Eastside: Companion Paper to the Second Generation Design Paper*, October 2016

- *Downtown Eastside Women's Health and Safety Strategy*, February 2019

3.2 – Other VCH Documents:

- *Regional Profile*, Vancouver Costal Health Authority and Ministry of Health Services, Sept. 2010

- *Response to the Overdose Crisis in Vancouver Coastal Health*, CMHO report, 2018

These above listed documents detail ways of knowing and doing that have relevance to the social, political and economic contexts that give form to the enactment of services in DTES. I determined the completeness of document collection by evaluating the relevance of the information provided and the capacity for it to be used in establishing a coherent and factually plausible account of my research question, relative to the information contained in the respondent data. While I was sensitive to the potentially indefinite and subjective nature of the endeavor, reasonable degrees of plausibility and coherence were established by limiting overall analysis to the themes and contents of the interview data.

2.2.2. Interviews

From February to July 2019, I conducted eight semi-structured interviews with select directors and policy makers from Vancouver Coastal Health who have been involved in the planning and direction of service delivery in the DTES. Candidates for interviews were chosen through a process of purposive sampling, and identified through contact information in the public domain, or pursued through snowball sampling. This number (n=8) of respondents allowed me to have a large enough sample size that ensured richness and diversity of data relative to the scope of the project undertaken. Each of the respondents provided a unique perspective about how they understand VCH's role in the DTES. Throughout the text respondents are referenced by the letter R followed by a number in parentheses. (R*n*) indicates a reference to data from an individual respondent. Though I have kept the exact roles of the respondents confidential, all had postgraduate degrees, three of them were physicians (R1 male, R2 male, R3 female), three were nurses with supplementary qualifications (R5 female, R6 female, R8 female) - all of whom had significant experience with addictions, mental health, and HIV care - the remaining two (R4 male, R7 female) were experts with equivalent positions and experience in public and community health management, delivery, and planning. Interviews were between 90 to 45 minutes in length and, in total, generated 129 single-spaced pages of transcribed data. The interviews were recorded and then individually transcribed by ear. The recorded interviews were destroyed after the transcription was finished, and the documents were then edited to ensure the anonymity and the confidentiality of the respondents. The result of this endeavor generated a multi-voiced and multi-perspectival set of narratives about the conceptualization of health care delivery in the DTES contemporary to 2019.

The decision to conduct interviews as a means to answer the research question was made because of the format's potential to yield nuanced and detailed information about the rationalities and direction of service delivery. In this respect, conducting semi-structured interviews had the advantage of potentially articulating tensions, power dynamics, and alternative narratives that further contextualize previously expressed rationalities, and disclose courses of action not otherwise specified in official documents or news media accounts. The use of interviews allowed me to elicit both contrasting rationales and problem formulations, as well as establish continuous and consistent themes, trends and patterns of thought. It is important to note, however, that all of the

primary data collected and used in this study pertains to the period in-time before the emergence of the COVID-19 global pandemic. The local implications of this species-level event are manifold and its long-term effects on biomedical rationalities and political economy are unknown. In British Columbia, the pandemic response has dramatically set-back recent (though still modest) gains from newer investments in harm reduction initiatives and significantly worsened the epidemic of 'overdose' death form tainted illicit drug supplies [BC Coroners Service, 2021]. It has intensified and further degraded the already fragile housing and economic circumstances of a growing section of Canadian society – forcing the Province and municipal governments to contend with the effects of generations of social security retrenchments (tent cities, vehicle encampments, and augmented street homelessness) and the pursuit of unbridled growth in real estate values. As an embedded first-person witness, I am able to attest that this event has shifted VCH's rationalities, resources and practices in the DTES, though the core problematics of poverty and marginalization remain.

2.3. Data analysis

2.3.1. Documents and interviews

Both datasets employed in this study are analyzed through the lens of Foucauldian Discourse Analysis (FDA) [Ussher and Perz, 2019: 884] using the constant comparative method [Babbie & Roberts, 2018: 338-339]. The research project and the interview themes were developed by an initial analysis of the "Guiding Documents" that pertain to the Second Generation Strategy that were publicly available on the VCH website between December 2018 and February 2019. Once interviews and transcription process had commenced, I employed a four-step iterative process to both sets of data. First, I initially organized both sets of data into appropriate general categories to be further broken down into more specific sets that relate to derivative concepts as they emerged and presented themselves. I began the process of data sorting during the collection phase of the study. Collected data was organized into basic pre-established categories that related to a given topic. Examples of such basic categories are 'historic VCH policy,' 'Ministry of Health documents,' 'public health documents,' and 'community health' etc. Second, after the all interviews were transcribed and anonymized, they were

segmented, categorized and placed into simple thematic groups. Examples of this are “housing,” “Second Generation,” “funding,” etc. From these thematic groups the interview data was coded and further arranged into basic conceptual blocks that formed the basis of the chapters within the present document. Third, after document and interview data was coded into conceptually meaningful categories and patterns, I used ‘memoing’ to elaborate and develop initial reflections, to flag difficult or significant passages, and to explore other possible trajectories of research on data subjects. The fourth step of data analysis consisted of an iterative application of FDA to both datasets. Here discourse analysis is understood as a method to analyze written and spoken language as specific *discursive formations* that perform and produce social realties and practices, power relations and subject-positions [Ussher and Perz, 2019: 882]. As indicated in the theory chapter, my discourse analysis is complemented by a conceptual orientation referred to as biopolitical governmentality. This approach toward social research is derived from a post-structuralist tradition within interpretive political theory that uses empirical investigation to critically examine how various institutions and social groups endeavor to govern, structure, regulate and direct the conduct of populations, individuals, and selves [Rose, O’Malley & Valverde, 2009: 24].

Because I am concerned with how well the collected data relates to a biopolitical governmentality conceptual framework my analysis has attempted to establish a high degree of content validity [Babbie & Roberts, 2018: 133]. Due to the textual nature of my data, the research presented in this document was produced through a series of iterative drafts. This involved constant revisions to simplify topics, clarify themes, and eliminate redundancies and digressions. As such it is consistent with other practices of discourse analysis which understand that “the process of analysis and writing are not separate, as analysis will be refined and clarified through-out the writing process” [Ussher and Perz, 2019: 886]. All of the primary data was sorted and coded prior to the emergence of COVID-19. Iterative data analysis and exposition was begun prior to the pandemic, but continued and was finalized under the shifting conditions of emergency health measures. The scope of the narrative presented in this document pertains to the historical period after the service growth initiated in the late 1990’s that extended into the mid-2000’s and before the emergence of COIVD-19, though the reality of the pandemic is mentioned occasionally where it is contextually appropriate and comparatively helpful.

2.3.2. Analysis justification

This project was not designed to test a hypothesis. Rather, I examined *how* a given set of rationalities informed and structured practices in operation within a specific space, across a particular historical period that ranges from the late 2000's until the summer of 2019. The interview data is contextualized by the fact that the respondents were deliberately chosen because of their historically situated subject-positions as specific kinds of knowers and actors. The respondent's technical expertise and strategic responsibilities as directors and planners of health services in the DTES were understood to yield a diverse range of informative data about historically specific asymmetries in modes of life-centric governance in the neighborhood. While I understand that the trustworthiness of my research was ensured both by my experiential relation to the topics at hand and by a belief that the respondents participated in good faith, a core tenet of FDA is that discursive activity both produces and exposes power relations [Ussher & Perz, 2019: 884]. As such, my concern was not principally with whether or not the respondents spoke truthfully, but what their responses indicated about how a non-arbitrary sample of specific actors internal to VCH rationalize strategies and values that pertain to the organization's operations within the DTES. Nonetheless, many instances of respondent deposition were either confirmed or contrasted independently in VCH policy documents, extant scholarship, and journalism. The conclusions that I have drawn about my research topic were determined and justified by the content of the textual data that I analyzed and the external circumstance and context to which it referred.

While this project seeks to provide an account of some of the manners by which certain non-arbitrary or key actors within VCH itself understand the organization's role in the DTES, relative to the period of time surrounding the Second Generation Strategy, I acknowledge that how area's the shifting landscape of health care services and interventions are experienced by its consumers is a serious matter that ought to demand significant attention from critical social scientists, community activists, and service providers. Nonetheless, my investigation alone generated a substantial volume of data that could comfortably sustain a much larger document. As a result of my interests discussed previously in the "Positionality" section, the demands of concision relative to the complex, multifaceted and intersectional nature of circumstance in the DTES and the parameters afforded in undertaking a master's thesis, accounts from clients/patients

were not pursued. Yet, it is clear that such projects are valuable and ought to be pursued.

Overall, the value of conducting the kind of research within the current document lies in its account of the situated reasons and values that have animated and given form to a set of geographically specific practical activities whose ends attend to life in some ways and not others. It is an analysis of an historical instance of a localized set of reasons and strategies that actualize the understood obligations of the social contract in a liberal democracy, and therefore an inquiry into how asymmetrically positioned deliberation informs and works to produce concrete circumstance.

Chapter 3.

Problems

> Governing takes place *through* particular problematizations. [Bacchi 2012: 5]
>
> …cities and the problems they raised, and the particular forms they took served as models for the governmental rationality that was to apply to the whole territory. [Foucault, 1996: 336]

The most basic mechanisms of analysis employed in this project are investigations into the nature of problems. I employ a post-structuralist analysis of problems and problematizations in order to critically examine the governmental rationalities of health service delivery and planning in DTES. In this chapter I outline a theoretical perspective derived from a trajectory of problematizing called biopolitical governmentality. This is the interpretive lens I use in my analysis of respondent data. Biopolitical governmentality refers to the conjoined teleological and technical rationalities that pertain to practices of government that are directed at the valuation and management of human life. My position is such that the particular 'arts of government' that are operationalized in the name of *universal rights to health care* and *life and security of persons* derive their ends through imperatives that are founded in problematics that arise from the multiple and often highly unequal ways that the biopolitical "make-live" is planned, practiced and produced. The strategies and asymmetries that obtain from the imperative to make-live as an end of government are defined as biopower. Biopolitics, then, refers to the complex interplay amongst the various means and ends by which populations are governed through rationalities and techniques that regulate, manage, discipline or optimize the vital and biologic functions and capacities of individuals and populations [Foucault, 1980: 141-142, 1997: 243-5]. I read the adjacent concept of governmentality to refer to the means, the technical rationalities and practices, by which specific instances of biopolitics are realized. It is a device that explains "the how of biopolitical measures" [Hannah et al, 2020:9]. This is in contrast to investigations and research into *why* something is the case. Rather, governmentality analysis and research is done with a focus on "how" questions of

government - how problems of rule, management or policy are framed, with emphasis on strategies, plans, ambitions, and goals [Dean, 2010 : 33; Rose and Miller, 2008: 6]:

> If the conduct of individuals or collectivities appeared to require conducting, this was because something in it appeared problematic for someone. Thus it makes sense to start by asking how this rendering of things problematic occurred. The term 'problematizing' was a useful way of designating that as a *process*, for it removed the self-evidence of the term 'problems.' It suggested that problems are not pre-given, lying there waiting to be revealed. They have to be constructed and made visible… [Rose and Miller, 2008 :14]

3.1. Problematization

Gilles Deleuze writes that, "A problem does not exist, apart from its solutions" [Deleuze, 1994: 163]. If we work backwards and consider how solutions themselves function, we derive novel insights into the reasons, thoughts, and circumstance which work to formulate the problem at hand: "What we propose to do about something indicates what we think needs to change and hence what we think is problematic" [Bacchi, 2016: 8]. The influence of Deleuze's work on the nature of problems, as formative instants that structure conceptualizations such as 'thought,'[14] are evident in Foucault's writings in the late 1970's and early 1980's, where he develops the concept of problematization, and his mature ideas about power.[15]

Analyses of problematizations are investigations into conditions of possibility. Problematizations function to both query how modes of thought and classification emerge as answers or solutions to circumstance, as well as the circumstance that occasion action or inquiry as answers or solutions. In an interview shortly before his death, Foucault outlined problematization as follows:

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[14] "It cannot be regarded as a fact that thinking is the natural exercise of a faculty, and that this faculty is possessed of a good nature and a good will. 'Everybody' knows very well that in fact men [sic] think rarely, and more often under the impulse of a shock than in the excitement of a taste for thinking. Moreover, Descartes' famous suggestion that good sense (the capacity for thought) is of all most equally distributed rests upon no more than an old saying, since it amounts to reminding us that men [sic] are prepared to complain of lack of memory, imagination or even hearing, but they always find themselves well served with regard to intelligence and thought." [Deleuze, 1994: 132]

[15] It has been argued that this particular facet of Deleuze's thinking impacted Foucault much earlier, albeit less explicitly. Koopman cites a review of *Difference and Repetition* by Foucault in 1970: "We must think problematically rather than question and answer dialectically…" [Foucault, cited in Koopman, 2016: 105]

> […] it is a question of a movement of critical analysis in which one tries to see how the different solutions to a problem have been constructed; but also how these different solutions result from a specific form of problematization. And it then appears that any new solution which might be added to the others would arise from current problematization, modifying only several postulates or principles on which one bases the responses that one gives. [Foucault, 2003: 24]

The passage above describes problematizations as both objects and acts, noun and verb [Koopman, 2016: 107]. As a noun, a problematization can constitute what Koopman calls, "a nominal object of inquiry" [Koopman, 2013: 98]. A problematization is a thing we can examine (object *p* is a problematization resulting from circumstance *q*). As nominal objects of inquiry, problematizations can either serve to render old practices problematic, or act as problematic bases for new practices to develop [Koopman, 2013: 100-101]. The basic aim of studying problematizations is to demonstrate that any "given system of thought […] was the result of contingent turns of history, not the outcome of rationally inevitable trends" [Gutting & Oksala, 2018 : 3.3]. Analyses of problematizations intend to show that concepts and categories of thought, as well as their material effects or physical consequences, are emergent, historically contingent products of social and cultural processes, rather than simply pre-established givens. This approach enables us to "stand back" from our conventional understanding of our object of analyses and consider its points of historical emergence [Bacchi, 2012: 4]. Given this, two definitive components of problematization as a critical tool are emphases on "contingency and complexity" in states of affairs [Koopman, 2013: 48].

As a verb, to problematize is to engage in "an act of critical inquiry" [Koopman, 2013: 98]. It is a method of thinking problematically [Bacchi, 2012: 4]. To problematize something is to either elucidate or clarify the nature of an existing set of problems, or to serve as a mechanism that enables a "normative intensification of problems" [Koopman, 2013: 100-101]. That is, the act of problematizing is used to demonstrate the contingent and non-necessary nature of an issue at hand as a means to further trouble or destabilize conventional conceptions or understandings [Koopman, 2013: 100-101]. In this way, to problematize is to upset the appearance of self-evidence in conceptual frameworks. Thus, "problematization is more a description of thinking as a practice than a diagnosis of ideological manipulation" [Bacchi, 2012: 1]. Problematization based analysis is not directed towards the discovery of truths or falsehoods. Rather, the aim is to elucidate and render intelligible the initial conditions of how something or some state

of affairs has become an issue, hence its central role in critical genealogy. It is an analysis of how a given problem, or set of problems, have become a "particular object for thought" [Bacchi, 2012: 1].

Problematization based analysis is referred to as being nominalist because it rejects the existence of abstract universals.[16] Commitment to a nominalist position structures analysis to focus on basic constituent elements without appeals to transcendent unities. In so doing, it rejects ahistorical and pre-social classifications and categorizations. It "puts their presumed natural status in question and allows us to trace the relations," that work to construct and produce various understandings and forms of relating [Bacchi, 2012: 2]. Because social and historical specificity are entailed in any demonstration of a problem's contingent constitution, problematizations give us a conceptual framework with which we can situate, ground or anchor critique within a given cultural mileu. "Cultural critique is immanent critique because it is an inquiry into conditions of culture from a point of view that is also located within the culture whose conditions are being investigated" [Koopman, 2013: 93]. Problematizations as instances of thinking in practice are situated perspectives – partial, embodied and finite rationalizations from somewhere. They work to repudiate the "god-tricks" of simultaneously "being everywhere and nowhere" that inhere in both appeals to universal objectivities and radically particularist relativisms, and enable the situatedness of perspective (i.e. gender, race and class) to count as a relevant factor in the production of knowledge – as opposed to a presumed neutrality of an ideal generic observer (which is often white and male) [Haraway, 1988: 584]. Instead, as both actions and object of thought, problematizations enable us to acknowledge our position and entanglement with the subject matter at hand. This has evident epistemic as well as ethical implications, insofar as their "primary aim is not to demonstrate *that* our present is contingently formed but to show *how* we have contingently formed ourselves so as to make available the materials we would need to constitute ourselves otherwise"

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[16] The debate about the existence of abstract universals (for example, the number 5) in contrast to concrete particulars (the chair I am sitting on) is an a ongoing topic in metaphysics [Rodriguez-Pereyra, 2019]. My commitments overall are agnostic, especially toward the existence of numbers. Of value for the current context is the suspension of and/or suspicion toward universal, essential, ahistorical, or transcultural categories of being, specifically with regards to their diagnostic powers. My position is such that categories like 'addict,' 'schizophrenic,' or 'health' are socially, culturally and historically specific designators that do not transcend their function in the power-laden concrete circumstances of lived and performed lexicons - technical, vernacular or otherwise.

[Koopman, 2013: 44, italics in original]. Activities of problematization constitute both a) self-reflexive practices of situated critique (as demonstrated by Foucault's later interest in practices and disciplines of the self) and thus a form of ethical engagement [Osborn, 2003: 11; Foucault, 1985], as well as b) critical analyses of various problem-solution dynamics at play in the external world, with the former folding back onto analyses of the latter. As such, they constitute a crucial element of investigations into the strategic social asymmetries that we understand as power and how it operates upon us and through us in specific places, contexts and times. In the investigation of the historical contexts of health initiatives, problematizations help to delineate rationalities that have worked to value lives in some ways and not others, as exemplified through the barbaric and segregationist Indian Hospitals that crafted Canada's colonial modernity [Lux: 2016] or the uneven effects of the War on Drugs.

3.2. Power

> "The central problem, then, is that 'power' does not pose a problem at all." [Lemke 2019: 51]

Foucault's account of power is itself a problematization. Power, as a nominal object of inquiry, is not a substance or entity. Rather, "it is the name that one attributes to a complex strategical situation in a particular society" [Foucault, 1978: 93]. In this sense, the term power is an improper noun that functions as a solution to the problem of naming general and indefinite modes of social asymmetries. In the *Will to Knowledge*, Foucault describes power as a relational dynamic that produces asymmetrical force relations: "Power's condition of possibility […] is the moving substrate of force relations which, by virtue of their inequality, consistently engender states of power" [ibid.] While it is perhaps commonplace to read the term 'force' as a principal indicator of violence, as in the phrase, "police use of force," Lambert's discussion of Foucault's axiomatic geometrical method, permits a reading of this conceptualization of power as an attempt to generate a sufficiently abstract and nominalist vocabulary in order to advance an account of a relational ontology [Lambert, 2020: 19]. [17] For the present purposes, however, I am not

[17] Deleuze's interpretation of Foucault's use of the term is consistent with this reading. However, in his analysis he argues that the concept of resistance precedes power [Deleuze, 1988: 89]. The geometrical method Lambert references is post-Cartesian. Consider Leibniz's use of the concept: "I found, then, that the nature of substantial forms consists in force, and that from this there follows

interested in forwarding a robust definition of power per se. Rather, I take it as sufficient to present a conceptualization which understands power as expressed and actualized through multiple and different relational dynamics immanent to social reality. Further, I argue that power has no essential components, structure, or form [Foucault, 1978: 93]; is a generative process whose negative or subtractive capacities (killing, imprisonment, oppression, etc.) are specific instantiations and intensifications of more generalized and complex phenomena [Foucault, 1978: 92]; that power is intimately entangled in forms of knowing, knowledge production, as well as techniques and strategies of its applications and goals [Foucault, 1995: 27]; and, finally (but not exhaustively), that power is not antithetical to notions and practices of freedom [Rose, 1999: 65].[18] A later formulation of power is presented when Foucault began to shift his focus of analysis from biopower to governmentality, understands it as the "action on the action of others" [quoted in Protevi, 2016: 122]. My position is that these two accounts of power are not inconsistent, but rather operate at differing levels of abstraction. In fact, Protevi notes that Foucault's refusal to provide a finalized definition of power is likely a deliberate strategy to avoid any essentialist commitments [Protevi, 2016: 122 n6].

3.3. Biopower and biopolitics

From the conceptualization of power in the *Will to Knowledge*, Foucault derives the concepts of biopower, biopolitics, and governmentality. They are generated as a response to the problematics posed by modern practices of government and rule. If power names complex strategic situations and asymmetries, then biopower designates a range of strategies and asymmetries that specifically relate to the problematics of life and living as primary qualities of social existence. The historical shift in the ends of government that initiate the era of biopower, the "threshold of modernity," is summarized in the well known formula "to make live and let die" [Foucault, 1978: 143, 1997: 240]. Biopower here is understood as the myriad strategies of investment, across societies, in forms of knowledge, technologies and practices that are directed toward the regulation, control, optimization, enhancement or containment of the biological conditions of their

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something analogous to feeling and desire" [Leibniz, 1998: 145]. See also, Connelly [2021, forthcoming].

[18] In fact, in Rose's account the concept of freedom is itself a highly variable set of culturally and historically located problematizations that attempt to provide solutions to problematics such as economic order, personal autonomy, social cohesion, etc. [Rose, 1999: 62ff].

subject or target populations [Foucault, 1978:139]. Foucault writes, "[…] one would have to speak of bio-power to designate what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transforming human life" [Foucault, 1978:143]. According to Rabinow and Rose, "At its most general, then, the concept of 'biopower' serves to bring into view a field comprised of more or less rationalized attempts to intervene upon the vital characteristics of human existence" [Rabinow and Rose, 2016: 196-7]. As a problematization, biopower serves to both (a) render intelligible historically emergent sets of phenomena intensified by the problems posed by populations and the rise of biological sciences (as exemplified in the history of DTES as space of racial segregation, to the more contemporary context of the emergence of harm reduction and HIV treatment in the DTES), as well as (b) provide a means to intensify analyses and conceptualizations of strategies and asymmetries as they relate to biological and life-focused practices (as exemplified in the ways that particular kinds of harm reduction practices challenge carceral prohibitionism in hegemonic drug policies). Crucially for the project of this thesis, Foucault identifies biopower with the emergence of a pattern of strategies coextensive with the rise of urbanism in western societies, in the 18th and 19th centuries[19]: "It is through the efforts involved in the operation and management of cities and other clusters of human settlement that populations become objects whose biological functions and physical well-being sit at the center of the productivity and vitality of the state" [Foucault, 1997: 245]. Here we can begin to see how the DTES, as a social and material space, is produced through the confluence of racialized marginalization, poverty, drug use, and contagion that emerged in the area and provided the initial conditions for the formation of a specific set of problems from which contemporary governmental strategies and practices were organized to attend to the lives and biological condition of the local demographic in particular ways and not others.

Foucault uses the term biopolitics to name the diverse array of techniques and strategies employed by states and other governing institutions that operate on social

[19] Scholars such as Neil Brenner differentiate between the urban, as a more general multi-scalar spatial condition that results from integrated networks of production and distribution (especially as a function of globalization), and the city, as localized instantiations of specific agglomerations [Brenner & Schmid 2017: 186ff]. It is possible to consider Foucault's use of the term 'cities' literally, but also in an expansively naïve sense, as the effects of globalization had not been robustly conceptualized in his lifetime, to also refer to the urban condition more generally.

formations to actualize the ends of various instantiations of biopower [Foucault, 1978: 141]. Lemeke refers to biopolitics as, "[…] the historical process within which 'life' emerges as the 'object' of political strategies" [Lemke, 2011b: 165-6]. In Foucault's initial formulation, biopolitics is advanced on two fronts: through "anatomo-politics" of discipline exercised on individual bodies, and "techniques of power" that operate at the level of the population [ibid; Foucault, 1978: 141]. The term biopolitics itself predates Foucault and has been used to designate a number of concepts that relate to the intersection of biology and politics – most notably the idea that political existence is a function of the human species' biological constitution [Lemke 2011a 1-3]. Such conceptualizations, which in some contemporary discourses might be more palatably referred to as sociobiology, have historically been used to advance both eugenics programs and racial theories of social hygiene (as in National Socialism or the varieties of racial superiority in colonial projects), to the policing of reproductive health, establishing gender norms, the regulation of sexuality, as well as the myriad iterations of biologistic determinations of the late-liberal era which have variously sought to provide reductive and simplistic explanations for complex behaviour and phenomena (via hormones, genes, neurotransmitters, or fad diets). Foucault pays specific attention to the issue of race as an object of state biopolitics in the 17 March 1976 lecture in *Society Must Be Defended* [Foucault 2003: 239ff]. The distinguishing and crucial insight, however, of Foucault's concept of biopolitics and biopower is that life,[20] as a biological fact, as a field of knowledge and existential coordinate, *emerges as a problem* for the myriad rationalities and practices of social administration, management, and development:

> […] life as a political object was in a sense taken at face value and turned back against the system that was bent on controlling it. It was life more than the law that became the issue of political struggles, even if the latter were formulated through affirmations concerning rights. The 'right' to life, to one's body, to health, to happiness, to the satisfaction of needs, and beyond all the oppressions or 'alienations,' the 'right' to rediscover what one is and all that one can be, this 'right' – which the classical juridical system was utterly incapable of comprehending – was the political response to all these new procedures of power which did not derive, either, from the traditional right of sovereignty. [Foucault 1978: 145]

[20] Ehlers and Krupar write that life refers "to the conditioning of biological capacities of the individual and the population and how these capacities are inextricable from the logics of governing." [Ehlers & Krupar 2019: 2]

In this regard, health authorities and the services they provide have emerged as significant but historically specific mechanisms by which our society attempts to actualize and structure strategic solutions to the problems that human life poses through its status as a political object. The productive capacities entailed in power relations that give form to various iterations of biopolitics are actualized through practices of affirmation that value specific kinds of life-making and dying over others. As evidenced in the trope of the figure of the impoverished drug-user in the DTES, particular forms of living and ways of dying are valued and thus cultivated, administered and attended to differently and unequally. Ehlers and Krupar call this "*regulatory politics of affirmation*" [Ehlers & Krupar 2019: 2]. Thus to locate biopolitics as an urban phenomenon, unequal and variable forms of regulating the lives of populations and individuals are, for example, affirmed and instanced in public health initiatives such as housing policies, food security strategies, sanitation planning, clinic locations, neighborhood mobility and street safety design, as well as the uneven distribution and availability of resources for marginalized women or queer and trans youth. In the context of the present inquiry, then, biopolitics and biopower render intelligible particular dimensions of the asymmetries and tensions in the life-making practices of health service delivery in the DTES. How specific life and death making strategies are realized and practiced, therefore, occurs through particular kinds of conduct and activity, or what might be referred to as modes and means of government.

3.4. Governmentality

Not long after Foucault developed the concepts of biopower and biopolitics, his focus shifted to analyses of the power dynamics inherent in the acts and ends of governing, especially liberal forms of government, with the term governmentality [Foucault, 2007: 108]. As stated above, my intention is to present a reading of governmentality which understands the term to designate phenomena that are means to actualize biopolitical ends. I use governmentality to refer to the diverse means by which populations and individuals are ordered and order themselves so as to be governed. In the context of the DTES, a particular range of governmental activity orders and guides conduct through a diverse set of biomedical, juridical, and social initiatives that attempt to make people live and die in some ways and not others. A crucial passage from Foucault's famed governmentality lecture from 1 February, 1978, outlines 3 meanings of

the term. The first is a direct extension of his concern with biopower: “the ensemble formed by institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has population as its target, political economy as its major form of knowledge, and apparatus of security as its essential target” [Foucault, 2007: 108]. Second, governmentality refers to modes of power in “the west” that use technologies and knowledges to enact “government” [ibid]. And, third, he refers to the historical trajectory of political power emerging from the middle ages into modernity [ibid: 108-109].

3.4.1. State nominalism

It is from analysis of the third meaning of governmentality, however, that Foucault derives his proposition that, “the state is inseparable from the set of practices by which the state actually became a way of governing, a way of doing things and a way to relate to government” [Foucault, 2007: 277]. This is referred to as state nominalism. The argument here is that what we refer to as ‘states’ are simply the sum total of the effects of various complex interactions of localized and specific activities - “an individuation of […] a system of differential elements and relations involved in ‘incessant transactions” [Protevi, 2016: 122]. Emphasis on state nominalism enables us to grasp the variety, depth and complexity of the multitude of historically contingent components and activities that coalesce to form what we commonly understand as ‘the government’ or ‘the state’: “the state is nothing else but the mobile effect of a regime of multiple governmentalties” [Foucault, 2004: 77]. State nominalism intensifies the problematic of government because it renders intelligible the particular factors and affairs which make up the strategies and asymmetries that operate to direct and structure conduct, as well as situate (spatially and historically) practices of government. This perspective notably provides a rejoinder to both the “state phobia” that is characteristic of a number positions on both the left and right [Protevi, 2016: 122], as well as state fetishisms, especially, in the context of this project, in critical analyses of the function of nongovernmental organizations as actualizers of specific life-making practices [cf. Elliot, 2010: 187ff]. Moreover, the concept of state nominalism offers a fluid and multi-scalar mechanism to analyze how material and social interactions work to produce, enact or construct various kinds of spatial relations (for instance, how neighborhoods are constituted as complex intersecting assemblies of jurisdictional and regulatory practices, commercial

technologies, informal and spontaneous activities, or spaces of abandonment, segregation, or containment).

3.4.2. Applications of governmentality

Governmentality provides a conceptual framework for the critical analysis of institutions and practices of management and administration in entities such as VCH [McKinlay & Pezet, 2016: 411; Harvey, 2016: 317]. Researchers who have used governmentality have developed the concept beyond Foucault's formulation. They are keen to note that it is foremost a modifiable analytic tool designed to guide empirical research that enables different ways of thinking about social relations, especially with a view toward challenging dominant narratives, knowledge practices, and perspectives of institutional frameworks [Rose and Miller, 2008: 10, Rose, O'Mally and Valverde, 2009: 24]. Rose, O'Malley and Valverde describe how governmentality has been taken up by practitioners of various socially-focused professions, "… [for] low-status regions of applied knowledge such as social work and nursing […] [governmentality] would enable them to make sense of the situations in which they found themselves: the ways of thinking and acting that they were obliged to enact and the cramped spaces and conflicting practices that they inhabited" [Rose, O'Mally and Valverde, 2009: 17].

3.4.3. Episteme, Techne, Telos

The basic elements of governmentality research consist of analyses of rationalities (episteme), techniques (techne), and ends (telos) [Rose and Miller, 2008: 15; Bacchi and Goodwin, 2016: 41; Dean, 2010: 27]. Rationalities are various ways of "representing and knowing" [Rose and Miller, 2008: 15; Bacchi and Goodwin, 2016: 43ff]. Following Rose and Miller, the emphasis on the plural of the term is intended to denote multiplicity and variations of thought and thinking within networks of power that produce, sustain, structure and direct the operation of social institutions [Rose and Miller, 2008: 15]. Likewise, "technologies tend to reflect specific rationalities," - they are the instruments employed in the achievement of the ends of government [Bacchi and Goodwin, 2016: 44]. Technologies consist of a diverse array of calculated operations, interventions and mechanisms: biochemical, architectural, psychosocial, economic, and

infrastructural, which operate “to shape, normalize and instrumentalize the conduct, thought, decisions and aspirations of others” [Rose and Miller, 2008: 32]. As such these technologies of government operate to direct and conduct specific kinds of racialized, sexed, gendered and abled bodies and selves in diverse and unequal ways. Ends, the teleological orientations of the arts of governing, are the goals (political, moral or otherwise) that rationalities attempt to realize in the employment of various technologies. Thus specific lives are made to live and worked upon in asymmetric manners in order to optimize, contain, mitigate, enhance, protect or secure. Appeals to ends are used to justify or are justified by various techniques and reasons and therefore work to structure the problematic forms by which governing takes place [Rose, 1999: 281]. Here we can see that the ends and goals of specific strategies of government are propositions and activities that express what someone thinks ought to change in a given set of circumstance and therefore indicate trajectories of problematization.

3.5. Biopolitical governmentality

Both biopolitics and governmentality have been extensively theorized and used by a large number of researchers across the social sciences and humanities. In contemporary continental philosophy, biopolitics has become its own ontological position [Prozorov, 2017: 328]. [21] I employ biopolitics as a concept that facilitates analyses of the manners in which life, biological process, but more specifically health, well-being, and the rights to life, bodily integrity and security are constitutive objects and processes of specific sets of governmental rationalities that are enacted on a neighborhood scale. Similarly, I employ the concept of governmentality to work squarely within the empirical tradition of interrogating rationalities of government and the capacities and mechanisms used to direct conduct. My position here contrasts with readings that understand Foucault’s later thought to have moved to replace biopower and biopolitics with the purportedly more developed, robust, or expansive conceptual tool of governmentality introduced in the *Security, Territory and Population* lectures [Lemke, 2011: 173]. I

[21] There are a number of influential authors, especially Italian, who have developed their own interpretations and uses for these concepts. The most prominent theorists are Antonio Negri and Michael Hart (productive mobilizations of the new proletariat) [Hart and Negri, 2000], Georgio Agamben (subtractive power of sovereign) [Agamben, 1998], Roberto Esposito (regimes of immunity) [Esposito, 2008], Davide Tarizzo (genealogy of ‘life’) [Tarizzo, 2017], Achille Mbembe (war and race) [Mbembe, 2019].

believe it is more fruitful, at least from the perspective of a qualitative social researcher, to consider biopower and biopolitics as modes by which conduct directing rationalities, programs, techniques, mechanisms and institutions derive their impetus to operate, direct, organize and control a variety biological and life-centric fields. Biopolitical Governmentality, therefore, designates a more explicit and nuanced analysis of the complex factors at play in the government and management of life in particular social contexts.

Thomas Lemke draws on the substantial body of current conceptualizations and uses of biopower and governmentality to provide an argument for how the concepts can be better integrated and expanded upon. He outlines two basic tendencies that comprise current biopower research: The first consists of the analysis of power dynamics in the interventions of biology and the life sciences (investigations into things like bio-piracy, the social ramifications of synthetic biology, xenotransplantation, sex selection, reproductive technologies, the production of gender etc.). The second consists of analyses of the broader mode of politics directed toward the vital aspects of social being (comprised of issues like the social construction of race, detention of migrants, extra-judicial rendition, child welfare, food distribution, etc.) [Lemke, 2011:166]. While this project focuses substantially on the latter trajectory, there are occasional attempts to bridge both domains of research (for instance when considering the asymmetries engendered by opioid replacement therapies or antipsychotic intramuscular injections as governmental technologies and elements of place-making practices). From this initial distinction, Lemke then proposes that "biopolitics […] be understood as an 'art of government' that takes account of the relational network of power processes, practices of knowledge, and forms of subjectification" [Lemke, 2011: 173]. The term subjectification provides a crucial conceptual upgrade to issues pertaining to the asymmetries engendered by practices of conduct, management and control. Subjectification refers to the ways in which individuals are both reciprocally created as subjects of specific forms of direction and control, but also enact their own subjectivity from practices and conducts that obtain from various forms of self-knowledge[22]: "It is not

[22] Subjectification then also entails the categories of biosociality – practices of belonging and mutual identification as a result of shared biological realties [Rabinow, 1992], and biocultures: "those cultural spheres where biomedicine extends beyond the formal institutions of the clinic, the hospital the lab and so forth and is incorporated into broader social practices and rationalities" [Ehlers and Krupar 2019: 1]

because we are prevented from being what we otherwise might be (or at least not primarily because of that) but rather because, in our practices and in the knowledge that these practices involve, we are being molded daily as certain kinds of doers and knowers that we become subject to that which governs us" [May, 2014 :498-99].

Alongside subjectification, Lemke adds Agamben's analytic distinction between Zoê - life as it pertains to the physicality of the body - and Bios - life as it pertains to the agential, moral, political and social dimensions of embodied existence [Lemke, 2011: 174-5].[23] In concert these concepts expand the analytic capacity of investigations into specific problematics of how life-making practices are both rationalized and actualized. There are three basic dimensions to this analytic which consists of a) "a systematic knowledge of life and living beings," b) knowledge about "how power strategies mobilize knowledge about life," and c) an "account of the various forms of subjectification – the way subjects are brought to work on themselves guided by scientific, medical, moral, religious and other authorities and on the basis of socially accepted arrangements of bodies and sexes" [Lemke, 2011: 176].

Finally, to complement and enhance the biopolitical governmentality analysis described above, I employ Richard Sennett's distinction between *ville* and *cité*. Similar to Agamben's use of the Aristotelian distinction between Zoê and Bios, in my analysis of the political problematics of the government of life as they relate to cities and the urban condition, ville represents the built environment as both raw physicality and deliberative product and process, whereas cité denotes the dynamic intersubjective life-worlds that emerge-from, flow-through and sustain urban spaces: "Cité-consciousness can also represent how people want to live collectively […] the *cité* stands next to *citoyenneté*, the French word for citizenship" [Sennett, 2018: 1-2 italics in original]. These final two concepts, then, add a further dimension to studies of life-making practices by linking the asymmetries of embodied biology with the relational dynamics involved in social and material practices of place-making.

[23] A note about Agamben: while I consider the introduction of the concepts Zoê and Bios a welcome and helpful addition to biopolitical theorization, I remain skeptical of and/or do not agree with many of his philosophical commitments.

3.6. Conclusion

The Foucault-influenced strand of post-structuralist analysis that I employ contrasts to other methods of problem analysis - such as positivism, interpretivism, and critical realism [Bacchi, 2012, 2015, 2016] – insofar as it is anti-essentialist, critical, self-reflexive, and explicitly ethical and political in orientation. It is anti-essentialist for at least two reasons. First, it does not admit the existence of ahistorical or pre-social facts or concepts.[24] Second, it does not admit "foundational subjects, who stand outside of and shape 'reality,'" by virtue of their position as observers [Bacchi, 2015: 3]. Rather, this perspective holds that "realities emerge in practices" [Baccchi, 2016: 8]. This position's epistemic stance, therefore, is also an ontological stance because it holds that our observations and analysis, our ways of knowing, "mediate between an object and its representations" [Mol, 2002 quoted in Bacchi, 2016: 2]. There are no things-in-themselves. Reality and knowledge are produced through encounters and entangled actions. An empirical endeavor, then, is a socially and historically situated intervention which actively produces new relations between things and persons, and engenders new trajectories of thinking, however modest they may be. As such, this perspective is consistent with intersectional social science as "it strives to understand what is created and experienced at the intersection of two or more axes of oppression (e.g. race/ethnicity, class, and gender) on the basis that it is precisely at the intersection that a completely new status, that is more than simply the sum of its individual parts, is formed" [Hankivsky & Christoffersen, 2008: 275]. Second, such an approach is critical because it is an analysis into the conditions of possibility for the existence of specific modes of thought, instrumental reason, and practical activity. Its criticality is not derived from attempts to vindicate truth or falsity, or rightness or wrongness, or the necessity of something being one way or another. Rather, it is critical because its object of analysis focuses on how knowledge claims and instrumental rationalities constitute and are constituted by power relations [Lemke, 2019: 369]. And, by doing so, "proposes that different rationalities are possible" [ibid: 370], and that the possible differences between these rationalities effect the way power dynamics circulate and crystalize within a society or culture. Third, this form of analysis is self-reflexive for two interrelated reasons. As it

[24] "Such a perspective allows us, in the first place, to break with biologistic concepts and confront a still enduring tendency in the social sciences to treat bodies, biology and nature as pre-social objects" [Lemke 2011: 178]

admits no claim to certainty or universal truth, this mode of critique intrinsically entails revision and promotes the proliferation of alternate forms of conceptualization [ibid: 375]. By definition, “it can never be sure of itself” [ibid: 375], things can always be claimed to be otherwise. Given this, its focus on particulars - the socially and historically specific positions and locations of its objects of analysis – impels the individuals who conduct this kind of analysis to acknowledge that these very conditions apply to their own position [Bacchi & Goodwin, 2016: 20]. Finally, fourth, political and ethical dimensions are entailed from critical and self-reflexive positions through an appeal to generate prescriptive claims by virtue of our culturally embedded and embodied relations to concrete circumstance: “In order to identify […] obstacles to a ‘better society,’ we must have experienced them as practical realities, not as theoretical principles” [Lemke, 2019: 376]. From this I will now, therefore, depart from this chapter’s consideration of theoretical principles and move to present an examination of some of the practical realties that animate problematics that pertain to the recent historical context of life-making governance in the DTES.

Chapter 4.

Context

The DTES's material and social constitution are expressions of an historical trajectory of uneven development and distributive disparities inherent in the realization of the ends of liberal governance, colonialism, and the global War on Drugs. This chapter aims to contextualize the empirical research presented in the proceeding chapters by locating the conceptual space that I refer to as the service landscape. I do this by examining some of the literatures that explore the recent history of social problematics in the DTES. The development of the service landscape from the late 1990's onwards is the social and historical context that frames my research. I consider crises, and the particular ways that crises become framed, as the foundational problematics for the biopolitical governmental interventions in the DTES that produce affirmations that give form to the service landscape and its various life-making practices. In this section I ask the question: What are the basic problematizations that have enabled the service landscape to come into being? How these problematizations are produced by experts and policy makers generate the affirmative conditions of possibility for the continued roll-out and development of the health services in the area.

4.1. DTES as problematization

The City of Vancouver's 2014 *Downtown Eastside Local Area Plan* identifies the DTES to comprise the space bounded by Burrard Inlet to the north, False Creek Flats to the south, Clark Drive to the East and Richards Street the west [City of Vancouver (a): 15]. It is the eastern space immediately adjacent to the central business district and the downtown core. Under this schema the neighborhood is composed of seven distinct sub-districts: "China Town, Gastown, Industrial Area, Oppenheimer District, Strathcona, Thornton Park, and Victory Square" [ibid: 5]. On occupied unceded Coast Salish land, the area of the DTES is the location of some of Vancouver's oldest urban settlements as well as historic exclusions and expulsions: "the Chinese Head Tax, the forced displacement and internment of the Japanese-Canadian Community during the Second World War, the displacement of First Nations and the residential school policy" [ibid:17],

as well as the deliberate erasure of the historic Black community of Hogan's Alley through the development of Georgia and Dunsmuir Viaducts [ibid:57].

At times referred to as the "poorest postal code in Canada," the social reality of the DTES has long been cast as threatening or overly burdensome to the dominant social order. Jeffery Sommers' 2001 dissertation, *The Place of the Poor*, traces this history across a fifty-year period that begins with the post-World War II constitution of the area as "skid row." Sommers dispels the myth of a neighborhood with an "innocuous proletarian past" that had been corrupted by the vice and deviance of an underserving drug-frenzied poor, and renders visible an enduring history of privation and the consequent strategies and conflicts wrought by a multitude of actors who have sought to govern and shape the DTES [Sommers, 2001: 10]. Writing at the height of the health crises of the late 1990's, where increased HIV rates and opioid-fueled overdose deaths gave rise to a range of biopolitical interventions in the neighborhood, he begins with the problematic figure of the "single homeless man" to show how the population of the area has long been the object of segregationist, regulatory, remedial, corrective, or emancipatory governmental rationalities and techniques [ibid: 50]. In the narrative of the political and "scientific re-coding of the moral division between the deserving and underserving poor," Sommers articulates an historic governmental problematic that oscillates between solution-driven rationalities that prescribe changes to the material and social environment, and interventions upon the deviant or disordered biology of individuals as means to either rectify social morbidity or to protect adjacent communities [ibid: 53, 200]. Throughout this project I refer to various iterations of this oscillating duality as the *problematic of environment and bodies.*

Out of the urban politics of the 1970's that surrounded iterations of the problematic of environment and bodies, the specific toponym "Downtown Eastside" was produced as an instrument to name a proper space. This act of naming legitimated the area's residents "occupational rights" and entitlement to basic resources such as health care and community amenities [Blomley & Sommers, 2002: 38; Sommers, 2001: 189ff]. This change was driven by the now-defunct Downtown Eastside Residents Association (DERA) who understood the power of place-naming as a governmental strategy that can mobilize specific organizational and distributive trajectories by linking together material and social contexts, local actors, and ways of doing in a single space [Giraut & Houssay-Holzschuch, 2016: 7-9; Beasley, 2019: 190]. In marked contrast to the social reality of

the neighborhood today, DERA's emancipatory ethos sought to positively transform the community from the bottom-up through demands for distributive justice, practices of localized self-determination and community empowerment that are succinctly expressed in the sentiment: "We want to eliminate social services"[25] [quoted in Sommers 2001: 200]. DERA were significant in shaping local politics and activism in the area at the time, but also functioned as a key actor in the initial conditions that have rendered the current material and social context of the DTES possible.[26] Writing twenty-six years later, in 2002, Blomley and Sommers note that increasingly the DTES, "functions as a site for intensifying regulation of the outcast poor" [Blomley & Sommers, 2002: 42]. A recent news article describes the situation for the poor and marginalized in the DTES to have significantly deteriorated:

> There's been a lot of gentrification in that area," said Dr. Mark Tyndall, a leader with the province's Opioid Overdose Response team. "It's really changing, it's pushing people more out on the streets ... and *what we consider the DTES has dramatically shrunk*," said Tyndall […] "It's kettling," said Karen Ward, a community advocate and drug policy adviser for the city, referring to the controversial police practice of confining a large group of protesters to a small area. [my italics, McElroy, 2019]

This brief quote clearly articulates the contingent role of toponomy as an instrument of government through designation: as an object in municipal policy the DTES is a static, fixed and bounded territory, in popular consciousness and social practice the DTES has come to name, more generally, the fluid, malleable and increasingly compressed space of aberrant inner-city poverty.[27] These divergent toponomies indicate a fracture between the rationalities and practices that pertain to the built environment (ville) and the highly variable and unequal practices of the administration and management of conduct of the lived social reality within the city's space (cité). The marked contrast generated by this fissure reveals a bare life situation of Vancouver's marginal and poor that is sustained by particular conditions of crises.

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[25] Citation in Sommers: Vancouver Province, 1976, "DERA to Fight City Knockdown," The Vancouver Province, January 24

[26] PHS Community Services, the largest non-profit operating in the area, with an annual operating budget of approximately 40 million dollars, has its origins in DERA. https://www.phs.ca/about/ [Apr. 2021] [Lupick, 2017].

[27] See Sommers: 245, re. Blomley "aberrant physicality".

4.2. Crises: asymmetries and legitimacy of government

Crises and government intimately entwine.[28] The space of the DTES, as a governmental problematic, is produced through emergent and sustained social relations that are defined through crises and privation. The claim that government, "realizes itself as crisis prevention and management, performs continual reinterpretations, produces unintended effects, and necessarily falls short of its own goals" [Bröckling, Krasmann & Lemke, 2011: 19] articulates a threefold reality: that the process of government is both finite and fallible; that the framing, legitimation, and response to what counts as crises happen through conducts and counter-conducts of governmental activity and reason; and that government derives its legitimacy through a set of capacities which act as solutions to problems engendered by crises. The DTES is certainly a social geography of crises. But who defines those crises and how they are attended to happens in asymmetric ways and gives shape to specific governmental practices of life-making.

A year after Sommers completed his dissertation the serial killer Robert Pickton, who murdered upwards of 49 women, was apprehended. Geraldine Pratt writes of the indifference by local authorities to the concerns of reports of missing women, many of whom resided in or had ties to the DTES [Pratt, 2005: 1058]. A crisis of exceptional abandonment was actualized by a pervasive structural indifference[29] that let these women die. The intersection of gender, race, class, geography, drug use, and survival sex animate exclusions where exposure to death is justified as a function of one's corrupted constitution. The apathy that reduced these women in the DTES to bare and disposable life obtains from the belief that, "simply being in this space is taken as

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[28] Consider, for instance, Hobbes' state of nature as war of all-against-all as the primordial crisis of early modern political imaginaries that legitimates the sovereign social compact: "It followeth, that in such a condition, every man has a Right to every thing; even to one anothers body. And therefore, as long as this natural Right of every man to every thing endureth, there can be no security to any man, (how strong or wise soever he be), of living out the time, which Nature ordinarily alloweth men to live." [Hobbes, 1981: 190].

[29] I take phrase structural indifference from McCallum and Perry's recount of the circumstances that killed Brian Sinclair in an emergency department of a Winnipeg hospital in 2008. Sinclair was an Indigenous man who sought care for a simple infection but was "literally ignored to death" [McCallum & Perry, 2018: 12]. Hospital staff dismissed him as a destitute and intoxicated person for 34 hours, before his easily treatable affliction killed him in the hospital's waiting area.

evidence of the woman's degeneracy" [Pratt, 2005: 1062]. This harrowing and tragic history demonstrates the seriousness and variable scope of the asymmetries that are involved in urban governmental biopolitics, the framing of crises, and the scope of affirmations about what kinds of lives are made to live and how they are allowed to die. It exposes both the stakes and the unequally positioned stakeholders involved in the legitimation of crises, particularly as they pertain to how obligations toward rights to life and security of persons in the governing social contract are recognized and practiced.

While indifference, abandonment and exclusion figure prominently in histories of the way dominant political institutions relate to the DTES, as the case of DERA makes clear, the neighborhood has long been the site of community organizing and grass-roots activism that have substantially challenged structural indifference.[30] Despite the compression and social stratification articulated by Karen Ward's "kettling" comment above, local activists and community groups continue to be instrumental in the development of programs, services and efforts to direct the narratives of neighborhood self-definition relative to the manifold crises that befall it. Two recent counter narratives and practices of resistance to colonial indifference and the historic let-die status quo are the erection of the Survivor's Totem Pole in Pigeon Park as a means "to honour the survivors of the DTES, the survivors of colonialism, gentrification or poverty," [Pawson, 2016] and the release of *Red Women Rising: Indigenous Women Survivors in Vancouver's Downtown Eastside* [Martin & Walia, 2019] which stands as a powerful voice of indigenous women's experience and resilience. These voices and actions work to dispel simple narratives of tragic passivity by articulating and affirming both present and historical realities of subaltern urban life-worlds, and asserting a claim to space through the transformation of the built form.

An "epidemic logic," however, persists to give-form to the dominant governmental rationalities and practices in the DTES [Sommers 2001: 257]. Three major crises-problematics structure the current interventionist toponomy that animates the biopolitical dynamics of the neighborhood. A poisonous illicit drug supply, long-term structural neglect of mental illness and disability, and a massive regional housing deficit bring

[30] Some notable examples of this are DERA (as noted earlier), Vancouver Area Network of Drug Users (VANDU), Western Aboriginal Harm Reduction Society (WHARS), Life is Not Enough (LINES), Carnegie Community Action Project (CCAP), the SRO-Collaborative, and the Drug Users Liberation Front (DULF).

together specific actors and practices which render possible significant portions of the material and social realities of the neighborhood.

1) A poisoned supply of illicit drugs animates the first crisis. The astronomical rate of poisoning, overdose, and death that have resulted from the addition of high-potency synthetic opioids (most notably fentanyl and carfentanyl) into the supply of illicit drugs that flow into the DTES have hastened the creation of safe consumption spaces in the area and forced re-orientations of policy in health care, criminal justice and city planning[31] [Lupick, 2016; Vancouver Police Department, 2019; Vancouver Coastal Health, 2018]. This crisis of poisoned supply has been further exacerbated by illicit drugs cut with benzodiazepines. Like opioids, benzodiazepines depress the central nervous system. But their effects cannot be reversed or managed with receptor antagonists such as naloxone. Further, benzodiazepines are dependency forming agents whose withdrawal symptoms can cause life-threatening seizures [British Columbia Center on Substance Use, 2020].

2) Vancouver's 'mental health crisis' was inaugurated by the Vancouver Police Department in 2008 with the release of a report titled *Lost in Translation: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources* [Vancouver Police Department: 2008].[32] Popular narratives describe this crisis to have emerged as a result of the deinstitutionalization of psychiatric patients from antiquated programs and facilities,[33] largely left to fend for themselves in the austere climate of an eroded social safety-net. As a result, a rift in prescriptive rationalities across popular discourses divides itself along those favoring a return to or an expansion of carceral institutionalization [Vancouver Police Department, 2013:17; Bramham, 2020], and those who advocate for an integrative community-focused approach which understands mental health crises as both exacerbated and caused by environmental and social disparities [CCAP, 2018; Boyd & Kerr, 2016]. The dominant social discourses that frame issues about mental health and illness in Vancouver and

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[31] https://vancouver.ca/people-programs/drugs.aspx [Mar. 2021] This website details the City of Vancouver's overall response to the crisis, and provides statistics about weekly deaths and service calls to suspected drug overdose and poisoning.

[32] A 30 percent growth in emergency calls to police for mental health emergencies over the past 10 years has created a long-standing tension between the health administrators, community members, and the police, [Griffiths, 2020].

[33] Two current examples of this narrative [Simpson, 2021; Dhahan, 2021]

the DTES, more specifically, have been largely directed by the police who have leveraged themes of dangerousness to prioritize carceral solutions [Boyd & Kerr, 2016: 12]. The widespread availability and use of methamphetamines over the past 15 years is understood to have further complicated the issue [Bach et al., 2020; Krausz et al., 2013; Merali, 2017]. Currently, there is public debate initiated by the police force themselves, yet met with skepticism, over their continued role as first-responders to calls related to mental health crises [Griffiths, 2020].

3) A housing crisis has seen the numbers of homeless people in Vancouver swell.[34] The DTES has long had a notable street culture of visible poverty, but in recent history it has also been the site of a number large intentional homeless encampments, or tent-cities – notably in Oppenheimer park, in the vacant lot at 58 W. Hastings Street, and in Strathcona Park [Brown, 2018; Winter 2020; Zussman & Filippone 2014]. This has served, in some quarters, as an indication of a crisis in sound urban governance and policing, in others it demonstrates the continued indifference, exclusions, and abandonment that are symptomatic of an austere, prohibitionist and colonial, competition-state [Rufo, 2020; Wattson, 2019; CCAP, 2016(a)]. Despite a previous mayor's proclaimed ambitions to end homelessness in the city by 2015 [McElory & Mieszner, 2014], tent cities as provisional and informal settlements proliferate across urban spaces within the Cascadian economic corridor, and beyond[35] [Jaywork 2018; Fletcher 2020].

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[34] The City of Vancouver 2015 annual homeless count on March 24th identified on single night that there were 1746 total, of which 1258 accessed shelters, 488 were on the street. Whereas on March 4th, 2020, 2095 persons in total were counted, 1548 accessed shelters, 547 were on the street. https://vancouver.ca/people-programs/homeless-count.aspx#:~:text=2020%20Homeless%20Count,-This%20year's%20homeless&text=The%202020%20Metro%20Vancouver%20count,hospitals%2C%20with%20no%20fixed%20address [Dec. 2020]

[35] https://cob.org/services/safety/emergencies/covid-19/city-county-addressing-tent-encampment-and-emergency-winter-shelter-needs [Mar. 2021]

4.3. Two frontiers

4.3.1. Gentrification frontier: exclusion

DTES endures and bears the brunt of several iterations of gentrification which has worked to shape the neighborhood in specific ways that unequally imbricate social and material realities. For instance, a generations-long strategy of divestment - largely from municipal and provincial governments - begun in the late 1970's, effectively abandoned efforts to maintain safe and affordable SRO housing stock for the area's poor. Instead a "wavering in governmental SRO oversight," through withdrawal of public health measures and deliberate failures to act on bylaw infractions, has long incentivized private property owners to neglect aged and degrading buildings while continuing to extract rents[36] and await buy-outs and development offers in Vancouver's inflated real estate market [Masuda & Right to Remain Research Collaborative, 2021: 2].

A threefold movement of uneven development traces the recent history of the DTES's politics of dwelling. Twenty years ago Blomley and Sommers wrote that "the open market[37] along Hastings street appeared at precisely the same time that condos were being built in Gastown" [Blomley & Sommers, 2002: 53]. Twelve years ago Ley and Dobson reported that the DTES had managed, despite "conventional expectations," to resist the prevailing force of city-wide gentrification [Ley & Dobson, 2008: 2481] concluding, "that local need and local activism together have created a moral culture in the Downtown Eastside legitimating sustained public involvement despite active forces promoting gentrification" [ibid. 2486]. A current eastward wave of inner city repopulation and redevelopment is marked by an intensification of private spaces via processes of "suburban involution." Here, market logics of suburban private property fold back into the inner city in the form of densified condo towers that function as vertical gated communities [Peck, Siemiatycki, & Wyly, 2014: 405ff]. Notably, this "folding-in" and

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[36] In 1975 as a response to how the City of Vancouver fined SRO owners who neglected their property, "Alderman [Harry] Rankin wrote that 'To spend $50 or $100 for a fine rather than to spend $500 or $1000 to clean up or repair premises is good business." Quoted in [Masuda, et al., 2021: 9]. The article opens with a discussion of the recent condemning of the Balmoral and Regent Hotels on the 100 block of East Hastings St., and subsequent eviction of their tenants, in 2017, as a result of the City of Vancouver's chronic failure/refusal to use bylaws established forty years prior to maintain safe habitability of the buildings.

[37] The "open market" referred to here is the concentrated informal economy of drugs, material goods, and sex sold openly on the street.

"deepening complexification" of the area undulates outward from the monumental Woodwards development that was completed, with a controversial social mix, at the tail end of the sub-prime financial crisis [ibid; Enright: 2010]. Concomitantly, deregulated financialization continues to yield property speculation[38] which further fuels exclusions and animates Vancouver's status as a global hedge city [Drofmann, 2015].

Two surveys from the Carnegie Community Action Project (CCAP) provide concise empirical metrics of gentrification and detail its effects on the social reality in the DTES. Both circumstances described by these studies have been worsened by the long stagnant rates of government issued income assistance and shelter allowance [Ivanova & Ellis, 2020]. The cost of rent for low-income accommodations in the area relative to the shelter-rates provided by government income assistance reveal that people either succumb to predatory rents and spend more than their shelter allowance to live precariously in over-crowded spaces, become displaced from the area, or are simply rendered homeless [CCAP, 2016]. There is an ongoing loss of affordable market housing options for people with fixed incomes, and many of the remaining private SRO's in the area have increased their monthly rents to rates well beyond those covered by BC Social Assistance Shelter Allowance [CCAP, 2016]. The social supplement to the highly eroded low-income housing stock admits many frustrations and ambiguities for the displaced and unhoused: a years-long centralized waitlist animated by the invasive vetting process of the Vulnerability Assessment Tool,[39] government mandated ratio and quota satisfaction,[40] as well as heightened levels of surveillance and enforced restrictions (especially around guests) [Boyd, Cunningham, Anderson & Kerr, 2016]. The second CCAP survey inventories the changing retail landscape in the neighborhood, and shows how low-income people are economically dislocated and excluded from participating and accessing commercial amenities in the area as a wave of higher-end

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[38]Consider the Sequel 138 building on south side of the 100 block of East Hastings St. located between the Regent and the Brandiz Hotels. Sequel 138 was developed, in part, to serve younger moderate income households with ties to the community. Journalists revealed that the building's market housing units, initially priced and sold at below-market-value for $250,000, have succumbed to speculation, due to lack of any enforcement mechanism, and are selling at almost double the original cost [St. Denis, 2018].

[39] https://www.bchousing.org/research-centre/library/transition-from-homelessness/vulnerability-assessment-tool-vat-full-evaluation&sortType [Nov. 2020]

[40] When tenanting social housing, there are prescribed ratios that determine the percentage of street homeless, under-housed, age-range, gender, physical and mental capacity that are housed in each project.

businesses continue to encroach [CCAP, 2017]. Precaritization of the urban poor is furthered by the steady rise of boutique shops and destination eateries in the area that leverage an economic frontierism through voyeuristic revitalization as a facet of Vancouver's post-industrial tourism-oriented service economy [Burnett, 2014].

4.3.2. Service frontier: inclusion

Neil Smith's articulation of frontier narratives that propel gentrification through the creation of imaginaries that seduce property owners and investors with fantasies of path-breaking and adventurous forays into exotic and wild urban territories [Smith, 1996:12ff] only explains a part of the asymmetric social dynamics currently operating in the DTES. Blomley and Sommers expand on Smith and write that frontier metaphors give form to rationalities that justify remedial and revitalist interventions. The inner-city frontier then, "speaks to a much deeper, ingrained middle class and elite response to the disorder of the city. The imaginary of the urban wilderness heralds the domestication of urban life" [Blomley & Sommers, 2002: 45]. The frontier cannot only be configured as an adventurous geo-economic imaginary, but also a new horizon for the value rationalities of progressive policy, expressed, in part, through emergent medical and public health interventions that work, through inclusive practices, to modulate and transform human bodies. Frontierism, then, also figures in representations and narratives of medical and social welfare practices of community-level service providers in the DTES and works to produce the service landscape in operation today. In contrast and complementary to the property frontier, the medical and social welfare rationalities and practices initiated and established by particular forms of entrepreneurial humanism and locally cultivated understandings of the minimal obligations entailed in the social contract, have tended to focus on the bodies of the poor, rather than addressing the conditions of poverty itself [Honer et al 2017; Elliot, 2010].

4.3.3. Service landscape

The *service landscape* refers to the social-spatial context within which health care and social-welfarist practices are enacted in the DTES. Landscapes refer to both material spaces and modes of visual practice [Blomley, 2004: 53-74]. Material landscapes are produced through relations of networked assemblies of differential and uneven multiplicities which construct and give-form to capacities and potentials of

particular spaces. As visual practices, or ways of envisioning the world, landscapes compose both affective objects and spatial rationalities that animate power dynamics. This is exemplified, in cultural history, by landscape painting's emergence coextensive to European industrial capitalism and its colonial projects, as well as in the governmental practices of mapping which legitimate territory through processes of enframing [Berger, 1972: 105-8; Blomley & Sommers, 1999; ibid]. The institutions and actors that together constitute the service landscape in the DTES are socially and ideologically heterogeneous, and range from official state apparatuses (policing and courts, the health authority and emergency services, income assistance, etc.) to large faith-based and secular nongovernmental organizations, and small philanthropic start-ups. Unlike the exclusions and dislocations produced by the successive waves of gentrification, the actors and institutions that compose the service landscape enact various kinds of care-based practices of inclusion.

Through critical research into how health practices in the DTES align with progressive and leftist politics, Danielle Elliott detailed three paradoxes sustained by the existence of the service landscape [Elliott, 2010: 180]. First, unlike other spaces with high levels of inequality and poverty, the DTES has experienced a rise in investments in health and social services. Such investments are described as "completely uncharacteristic of the neoliberal state […] [and] challenges the notion that social welfare programs and health care are simply being cut or withdrawn" [Elliott, 2010: 189]. Secondly, while the neighborhood is often considered a site for the abandoned and excluded, there exist intensive practices of surveillance and social control [Elliott, 2010: 181]. Further, the purportedly burdensome and blighted class of the inner-city poor "are embedded in multiple and powerful overlapping global economies" such as the illicit drug trade and intensive streams of social and medical research [Elliott, 2010: 182]. And, despite high levels of investment and funding for services, significant levels of suffering, privation and entrenched inequality persist [Elliott, 2010: 180].

Writing around the same time as Elliott, Gordon W. Roe's paper *Fixed in Place: Vancouver's Downtown Eastside and the Community of Clients* [Roe, 2010] critically chronicles processes that led to the concentration of services in the DTES and the resultant social stratification that animates the contemporary context. Roe argues that the service landscape's origin is an outcome of the history of activism and advocacy in the neighborhood. In order to secure needed services and achieve practical goals for the

area's population, activist organizations and community groups tempered their radical positions and capitulated to the demands of the political status quo: "Such groups gave concrete form to the new relationship between the state and the 'community,' serving as both representatives of the latter and, to the extent they were financed by the former, as mediating devices between the two" [Roe 2010: 6]. Thus, the DTES became "divided between the community of services and clients, on the one hand, and the community of businesses and citizens, on the other" [Roe 2010: 1]. The concentration of the broad spectrum of services within the community and the deliberate failure to address the root problems of social inequality and poverty have progressively worsened the situation [Roe 2010: 6]. While in this account the complexity of human agency and social reality are reduced to the binary citizen (bios) / client (zoê), it serves to articulate a major tension and key governmental problematic that exists between local capacities and practices of self-determination, and expert-controlled strategies and technologies of population management.

4.3.4. Data gaze

The DTES and its inhabitants have long been the objects of the gaze of clinical, academic, and credentialed administrators. This gaze and its fact-extractive intentionality renders the DTES's population the subject of a multitude of technically rationalized outcomes. Corollary to the social marginality referenced in popular discourse, as Elliott noted eleven years prior [Elliott, 2010], the lives and bodies of the neighborhood's inhabitants are prominent knowledge-producing resources and source of moral capital for a number of instrumental and technical endeavors, as much as their containment, management, stabilization, and amelioration serve as the ends of the techniques themselves. Indeed, a number of the established services in the area have been historically funded to operate on the basis of a "research agenda" [Elliott, 2014: 15].[41] The Urban Health Research Initiative (UHRI), Vancouver Intravenous Drug Users Study

[41] Elliot discusses the basis for the continued operation of Insite to have been dependant on its *Section 56* exemption under the *Controlled Drugs and Substances Act*: "This exemption was a scientific exemption, as opposed to a medical exemption, which means the site could not legally operate without the research component" [Elliott, 2014: 15-16]. In this instance the auspices of empirical research was used as a political mechanism to render precarious a particular initiative.

(VIDUS),[42] The Hotel Study, [43] North American Opiate Medication Initiative (NAOMI) and Study to Assess Longer-term Opioid Medication Effectiveness (SALOME)[44] are some of the larger and more well-known research programs to have operated in the area. The *DTES Research Access Portal* is a recent initiative by the University of British Columbia designed to democratize and render accessible the large amount of information generated by research into the area and its inhabitants.[45] As a counter-conduct, and adjunct to research guidelines form Vancouver Area Network of Drug Users (VANDU) and Western Aboriginal Harm Reduction Society (WHARS), *Research 101: A Manifesto for Ethical Research in the Downtown Eastside* asserts the right to dignified inclusion and consideration in community focused research: "Research has long-functioned as a tool of colonialism, and colonial research practices continue in the ways that researchers exploit, exhaust, and extract from Indigenous and other marginalized communities" [Boilevin et. at, 2019: 2].

4.3.5. Active citizens vs. target population

Representations of the DTES and its inhabitants, therefore, influence forms of knowledge and power. Activity and passivity in accounts of the DTES are persistent themes and tensions that structure the neighborhood's biopolitical epistemologies. Carol Bacchi distinguishes between social and biomedical representations of health whereby subjects are then parsed into active citizens or target populations [Bacchi 2009: 128, 135]. Two articles considered below contrast the different power-dynamics that result from the varying epistemological representations of either active citizens or the passive biomedical subjects of target populations. They showcase different iterations of the problematics in power-knowledge between individuals and environments. In so doing, they render intelligible different intentional frameworks by which the problematics of life in subaltern contexts of Vancouver's inner-city are considered.

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[42] VIDUS: https://www.bccsu.ca/vidus/ [Mar. 2021]

[43] Hotel Study: https://psychiatry.ubc.ca/2013/07/03/the-hotel-study/ [Nov. 2018]

[44] SALOME: https://www.providencehealthcare.org/salome/about-us.html [Mar. 2021]

[45] https://dtesresearchaccess.ubc.ca/ [Mar. 2021] Thanks to Trevor Wideman for initially drawing my attention to this.

First, a paper from *The Hotel Study* presents results of a multi-year initiative designed to provide a detailed look at complex health issues ("multi-morbidities") that afflict the low-income residents of the DTES who live in SRO housing [Honer et al.: 483]. The paper sits at a nexus between psychiatry and policing as it examines its subjects' rate of interactions with the police as a result of the *Mental Health Act* [ibid: 484]. While this paper represents an instance of a set of concrete biosocial circumstance, it also implicates a particular set of values and social positions that direct instrumental rationalities which advance forms of paternalist institutionalization. The authors acknowledge the role of poverty and economic privation as a significant factor that determines health outcomes, but they do not challenge its causes, nor do they attribute any meaningful agency to their target subjects [ibid: 490].

Conversely, Fast and Cunningham's *We Don't Belong Here* presents an ethnographic vignette of the lives of youth living within the service landscape of Vancouver's inner-city. The authors highlight a tension of "perpetual dislocation" brought about through the institutional displacements of youth who are moved from one form of supported housing to another, and the "fragile sense of home" that their subjects experience [Fast & Cunningham, 2018: 239]. Fast and Cunningham articulate the intricacies of the daily lived reality of individuals drawn into highly asymmetric practices of inclusion within the service landscape. They detail hopes, tragedies, rebellions and resignations of young lives caught-up within variable, often contradictory, and unequally regulated spaces and in so doing express their agency (bios), however limited.

4.3.6. Inside and outside

Masuda and Crabtree detailed how the DTES functions as a site of refuge for many of its residents. They forward the concept of the *therapeutic landscape* whereby (inter)subjective experiences of material environments and built forms entangle in subtle and complex ways to provide forms of sanctuary [Masuda & Crabtree, 2010: 657]. They explain that "the therapeutic potential of place is neither universal nor fixed, but is a relational construct, a negotiation where people must find ways to reconcile their perceptions of health with their experiences of their local environments and circumstances, even under conditions of relative depravity" [ibid: 658]. Masuda and Crabtree's paper details the "paradoxical relationship" that many living in the DTES have with their community insofar as experiences of belonging, support and solidarity exist

alongside lived conditions of squalor, stigma and paternalist control [ibid: 661]. They conclude that therapeutic landscapes and their associated benefits are procedural and that "the community members of the DTES possess their own expertise on what constitutes a healing place in their neighborhood and do not depend on those interventions designed by outsiders" [ibid: 664].

Yet, the problem of the outside is complicated by the fact that the DTES has gained recognition internationally as a place that has resisted, challenged and offered solutions to the stigmas and legislated harms related to illicit drug use. The area has become, largely by way of the service landscape, an influential node in a variable global network of activists, policy makers and service providers. The work of Eugene McCann has identified "parts of elsewhere" that compose reciprocal dynamics between local and non-local ways of doing and knowing that disrupt essentialist understandings of localised action and place-based identity formations [McCann, 2011: 114, McCann, 2008; McCann & Ward, 2011; McCann and Temenos, 2015]. The parts of elsewhere that circulate through policy mobility currents usher variable knowledge practices and social technologies that animate asymmetries which contribute to form the neighborhood's governmental constitution, as will be discussed in chapters 6 and 10.

As a voice from elsewhere, Jarett Zigon celebrates localized practices of place-making that are structured by the counter-conducts of organized resistance to the global War on Drugs that have emerged in Vancouver's DTES. Writing slightly prior to the official declaration of the public health emergency related to the overdose crisis, Zigon describes the integrated and networked harm reduction services that have materialized in the DTES as sites of "experimental politics" that enable new capacities for bodily autonomy and practices of collective life-making [Zigon 2014: 519].[46] As a witness and knower from outside of the DTES, Zigon's research both understates the nuanced and non-innocent power dynamics that make the service landscape possible, but also points to disparities and differences in other locales as they pertain to conditions of subaltern subjectivities animated by problematics of illicit drug use, poverty and mental illness. A

[46] Zigon uses the concept of biopolitics differently than I do. My reading of his use of the term is such that it designates alienated and hierarchical practices of population management. Whereas I use the term to refer to any politics sustained by life-focused problematics.

consideration of the DTES's constitutive outside, therefore, draws attention to the highly complex and emergent singularity of the neighbourhood space itself.

4.4. Conclusion

In this chapter I have presented an exploration of some of the key governmental power-dynamics to have emerged in recent history in the DTES. While the neighborhood has long been the site of highly racialized and gendered exclusions, remedial interventions, and containment strategies, a persistent and forceful culture of community activism, resistance and organizing has worked to challenge governmental hegemony with variable degrees of success. A prevailing epidemic logic unevenly operates upon three entangled crises that form the basis for the current iteration of governmental rationalities and practices in the area. Gentrification and socio-economic stratification are increasingly and dramatically, yet specifically, pronounced in the neighborhood. Informal, common and public spaces continue to erode and are replaced with exclusive private properties, alongside a suite of progressively clinical and medicalized socio-managerial interventions for the area's poor and marginal. This has worked to produce an increasingly formalized space of urban governance that attends to poverty, drug-use and mental health in specific ways. Over the course of recent history, the inhabitants of the DTES have been the object of considerable research which has produced and operationalized variable representations of human agency and autonomy, as well as worked to sustain complex and unequal connections with elsewhere spaces and actors. Building on this context, the next chapter presents an analysis of some of the asymmetries and problematics that pertain to how VCH, as a significant actor within the service landscape, is situated within the space of the DTES.

Chapter 5.

Siting and situation of VCH in the DTES

VCH runs and funds a variety of unique facilities and programs throughout the DTES.[47] This chapter examines two basic themes: the site and situation of VCH in the DTES. In the first section of this chapter I consider how location functions as a problematic that animates rationalities about service delivery in the DTES. The second part examines how respondents understood VCH's services to be situated relative to other communities within and outside of VCH's administrative territory. Locations, demographics, and social institutions are dynamic entities that intersect in complex and often conflicting ways. In what follows I outline rationalities that detail how VCH considers its operation relative to its siting and situation in the DTES.

5.1. High complexity of needs

Respondents explained that VCH operates in the DTES, either directly or through contracted programs by nongovernmental organizations, because conventional market derived solutions fail to deliver sufficient health services for an inner-city demographic with a high incidence of complex care needs (R1, R2, R3, R4, R8). It is understood that these complex needs are the result of the effects of poverty, problematic illicit drug use, homelessness, substandard housing, and mental illness.[48] Because of this, VCH's role in the DTES was described by the respondents as an enhanced supplement to the

[47]Among them are primary care services which operate out of Downtown Community Health Clinic (DCHC) at 569 Powell St., Heatley Clinic (as well as the Strathcona Mental Health team) at 330 Healtley Ave., Pender Clinic at 59 West Pender St.; and Connections Clinic at 623 Powell St. Partnered services which operate with VCH and non-governmental organization employees together include Community Transitional Care Team (CTCT), "an acute care clinic in a residential setting that provides transitional care and IV-antibiotic therapy to patients who have been released to community care from St. Paul's and Vancouver General Hospitals" https://www.phs.ca/project/community-transitional-care-team/ [July 2020] located at 412 Carrall St.; Insite safe injection facility at 139 East Hastings St.; located above Insite to provide low-barrier and rapid access to respite and early recovery is Onsite Withdrawal Management and Onsite Transitional Housing.https://www.phs.ca/project/insite-supervised-injection-facility/ [July 2020]

[48] Some of the common high complexity needs experienced by those living in the DTES are conditions like: COPD, HIV, Hepatitis C, diabetes, Cellulitis, osteomyelitis, endocarditis, chronic pain, mental illness (psychoses, depression, PTSD), substance use disorders, multiple disabilities.

private fee-for-service system (R3, R4, R8): “VCH provides almost all the primary care services down there – either directly or indirectly, or through contracts. That doesn’t happen in other neighborhoods in this city” (R3). Rather, most primary care throughout Vancouver happens via fee-for-service arrangements with private practice clinics,[49] where medical entrepreneurialism is used to strategically decenter the state as a principal planner and provider of services while it retains its role as the funder. Though this kind of compensation arrangement is designed to incentivize private care providers to increase the volume of patients they treat, there is a dis-incentive to treat complex or longstanding co-morbid conditions (evident with common clinic signage “One issue per visit”).[50]

The scope of care VCH delivers in the DTES was reported to be consistent with the broader expectations of service detailed in their mandate prescribed by the BC Ministry of Health: “We may have to address a lot of co-morbidities. But, I would say that, really, the foundations are the foundations, and they’re not necessarily foundational service offerings that we have a lot of latitude” (R8). The mandate functions to ensure that obligations of a larger social contract are met. VCH’s mandate is a governmental strategy structured by federally dictated requirements under the Canada Health Act (CHA) that the provincial governments “provide reasonable access to medically necessary hospital and doctors’ services.”[51] The particulars and nuance contained within the scope of the interpretation of what is ‘reasonable’ and ‘necessary’ under the CHA are left to the autonomy and internal politics of the provinces and territories.[52] ‘Reasonable’ and ‘necessary,’ then, refer to a highly variable domain of services and goods that may be used to purportedly ensure a basic guarantee of access

[49]The fee-for-service model is one of two principal models of physician compensation in British Columbia. https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/physician-compensation [July 2020]

[50] Consider: “In the last decade, the average doctor went from earning three-and-a-half times the average Canadian worker’s salary, to earning nearly four-and-a-half times as much, a more than 25 per cent relative increase. In constant dollars, today’s average Canadian physician is earning about 30 per cent more than he or she was just a decade ago. All of this has occurred while physicians have actually provided slightly fewer services to patients.” [Grant and Hurley, 2013:1]

[51] https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html#a5 [July 2020]

[52] In British Columbia this is realized through the Health Authorities Act: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96180_01 [Jun. 2021]

to health care, and by implication degree of security of person, across the overall population (the biopolitical correlate being the apparatus of security). Provincial autonomy and the health authority's discretion function as particular factors that attend to the specific problems that pertain to a given population and space. The ways by which VCH interprets and implements its mandate will variably affect the material and social constitution of its respective Communities of Care and Health Service Delivery Areas. In this context, "high complexity of needs" forms the basis of a biopolitical rationality about the identity and disposition of a demographic to be acted upon or governed and made to live and die in specific ways. The spaces where these "high complexity of needs" are located and the people who have them, however, are dynamic entities. In what follows I examine the problematics around 1) how the health authority is involved in the shifting material conditions that affect the placement of its service locations in the DTES; and, 2) how the health authority is situated in relation to the area's demographic flows and places outside the DTES.

5.2. Siting

VCH is an actor entangled within a significant developmental reconfiguration occurring throughout the eastern portion of Vancouver's inner city. The material constitution of the DTES is becoming ever transformed by an accelerating eastward movement of development emanating out of the city core, as well as from projects in adjacent areas. In this section, I first detail some of the shifting material conditions affecting the service landscape within the DTES. From this I consider some of the basic issues respondents reported to pertain to site location and forthcoming VCH developments in the area. I then look at some of the significant developmental trajectories in areas adjacent to the DTES.

5.2.1. Interior

In the DTES a "kneading process" of developmental involution integrates and hybridizes suburban private property logics with the entrepreneurial, managerial, and clinical strategies and techniques that animate the current trajectory of the service landscape within the DTES [Peck, Siemiatycki, & Wyly, 2014: 410]. The transforming material conditions of this instance of gentrification are exemplified by a number of key

projects that animate an emergent inner-city social mix that is structured by an imbrication of supported social housing projects, targeted health services, street-level retail and condominium development. This trend is notably anchored by the redeveloped Woodward's building and successive storefront revitalization on its adjacent blocks. An upgrade and retrofit of the historic Merchants Bank building that fronts onto Pigeon Park (Pioneer Place) at the corner of Hastings St. and Carrall St., and the redevelopment of its neighboring lot to the north, threatens to co-opt the park as a public space and displace the area's residents who use it daily. The Stanley-New Fountain at 30 West Cordova/ 36 Blood Alley Square, a property previously held by PHS Community Services Society,[53] was demolished and a new facility that is scheduled to be completed in the fall of 2021 will have a social-mix design similar to the Woodwards building. This development will contain 80 separated units of social housing, 62 units of market rental housing and basement and ground level commercial spaces.[54] An 11 storey mixed-use building for members of Vancouver's urban Indigenous community, to be operated by Rain City Housing in partnership with Lu'ma Native Housing Society, will be developed on the parcel of land that housed Pigeon Park Savings, at 52 E. Hastings [55]: "The building's ground level will be utilized as a Vancouver Native Health Society healing centre, community food centre, and a 'Long House' gathering space" [Chan, 2019b]. A parking lot on the north east corner of Hastings and Abbott located across from the Crosstown Clinic, "the only clinic in North America to offer medical grade heroin,"[56] will be developed into a 10 storey building [Chan, 2019a]. First United Church, a longstanding shelter and community resource for the area's marginal, located on the south east corner lot of Hastings St. and Gore Ave., has formalized plans to redevelop its site with a building that will contain 105 social housing units and community amenity space.[57]

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[53] This buildng was the site if the first instantiation of the CTCT, the Stanley Hotel SRO, and the New Fountain and Cordova Street shelters.

[54] See: https://westbankcorp.com/body-of-work/blood-alley [May, 2021]

[55] "Pigeon Park Savings is a unique collaboration between Vancity credit union and PHS. It provides access to basic financial services to people living on low incomes in the Downtown Eastside." https://www.phs.ca/our-services/pigeon-park-savings/ [May, 2021] Pigeon Park Savings has recently relocated east of Main St. to 346 East Hastings St.

[56] https://www.providencehealthcare.org/hospitals-residences/providence-crosstown-clinic/overview [Oct. 2020]

[57] https://firstunited.ca/redevelopment/ [Nov. 2020]

The material constitution of the DTES is dramatically changing as a result of significant development. This context lead me to question the role service providers in the DTES play in the developmental dynamics affecting the life-worlds of the inner-city. During the early phase of this project's conceptualization, my attention was drawn to the possibility that VCH might be intentionally undergoing a strategic spatial reallocation of its services in tandem with the goals of private developers and City zoning programs currently gentrifying the area. Concerns arose from inferences related to the City's identification of the Oppenheimer District as the main location for investments in social housing, while the western districts of Gastown and Chinatown were slated for private ownership and market-priced rental housing developments [City of Vancouver (b): 97]. This inference was further supported by the fact that VCH had just opened the Connections and Heatley clinics in the Oppenheimer district. I asked respondents whether VHC might be strategically moving its service locations eastward, to accommodate, facilitate, or respond to the increasing gentrification and new commercial development in the area closest to the city core, R1 stated: "No, it's not deliberate. It's just that that's what we have. […] we have a couple of buildings in the area: […] 58 Hastings, and the Buddhist temple […] we're redeveloping to bring some of these clinical services. […] So, we're not going any further east […] it's just the nature of what we have in terms of space." Similarly, R8 discussed the associated challenges of service location planning with a limited budget. Many of the buildings that house services in the neighborhood are deteriorating due to age. Developmental constraints from land values determined by Vancouver's costly and speculative real estate climate were noted to be intensified by the perennially sensitive issue of how tax-payer dollars are spent: "we have to be really really careful about that…" (R8). Service locations were described to be largely the result of opportunism, rather than strategic deliberation: "We end up being on the receiving end of whatever opportunity is coming our way at that time […] we're just trying to figure out, where is there space? Who can we partner with?[58] What do you bring? And, what do we bring?" These comments from respondents around land-use are

[58] Partnership, as a governmental rationality and strategy, is a key theme discussed throughout this project. From a nominalist conception of government as the sum of conduct directing practices, the term 'partnership' denotes a conceptual framework of relating that gives form to a large assortment of special interests, technical capacities, and material and social resources that exist externally to VCH, but that it must connect with, negotiate and make-use-of as a means of advancing its goals in the DTES.

helpfully contextualized by accounts of the recent histories of the two sites mentioned above by R1, and how their near futures will work to transform the neighborhood.

The building located at 301 E. Hastings has remained a vacant property held by VCH since 2001 and was once a Salvation Army hall and then a Buddhist temple [Mackie, 2020]. VCH's ownership of this property has generated controversy because no organizations or groups have been permitted to use the facility to serve the community. Some considered this decision to have contributed to the exclusive socio-economic trajectory of the neighborhood by depriving the area's poor residents of common space amenities (especially because the area's SRO's contain little common spaces). Moreover, the current proposal will demolish the historic art deco structure. As Vancouver overall struggles to protect its heritage buildings from development pressures, the impending project has generated criticism from community groups that have described the practice as, "demolition through neglect" [ibid]. Provincial government briefings have stated that the site will be repurposed for a mixed-use development that will consist of social housing and health care services (likely a relocation for either DCHC or the Heatley Clinic) [ibid]. To date, however, no work has begun and the site continues to be unused.

Having sat vacant since 2007, the lot at 58 W. Hastings has been a site of contention and space for community resistance against displacement and developmental exclusions for some time [Crompton, Ling, & Shane, 2018]. Concord Pacific had recently held this parcel of land, but exchanged it with the City of Vancouver for increased development capacity on the south side of the Cambie St. bridge.[59] It is located between the Portland Hotel (a purpose built supportive housing facility designed by famed architect Arthur Erickson) at 20 W. Hastings and the Grand Union Hotel (a degrading century old three storey building containing SRO units and a ground-floor country and western bar) at 74 W. Hastings, and across from the now shuttered Army and Navy department store.[60] Currently a worksite, the lot recently hosted the Hastings

[59] See: *Changing City,* Andy Coupland & John Atkin, book updates section, October 11, 2017 https://changingcitybook.wordpress.com/2017/10/11/58-west-hastings-street/ [Nov. 2020]

[60] Which at the time of writing is now operating as a 60 bed homeless shelter. https://www.phs.ca/locations/the-osborn/ [Jun. 2021]

Urban Farm, Hives for Humanity, and DTES Street Market.[61] The development underway is a partnership with the City of Vancouver to build a 7 floor facility that has 231 social housing units on its upper levels, with retail and health care facilities on the first three floors.[62] This development is contextualized by a promise made by then Mayor Gregor Robinson who capitulated to demands for housing from a recent tent city, where activists, the unhoused and their allies, had occupied the site in 2016 [Ip, 2016]. The completed facility will be the new location for the Pender Clinic, which currently operates in an aged and deteriorating building on the south-west side of the same block, at 59 West Pender St..

5.2.2. Exterior

As sites closest to the city core become redeveloped, the eastern inner-city social service and housing landscape is shifting to inhabit spaces peripheral to and outside of the DTES. This is exemplified by development occurring in the adjacent south-eastern brownfield and light industrial areas that comprise the False Creek Flats [City of Vancouver (c)]. The most significant and transformative development on this front will be the new campus for Saint Paul's hospital, operated by the Catholic nongovernmental organization Providence Health. This project will be located on a "18.4-acre" parcel of land that abuts Station and Prior Streets at the eastern end of the

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[61] The Hastings Urban Farm "is a horticultural therapy and social enterprise project in Vancouver's Downtown Eastside (DTES). We produce veggies, fruit, flowers and honey on 1/2 acre of donated land (58 Hastings W). Our farmers are locals, who face multiple challenges in life (drug addiction, extreme poverty, mental/physical health issues, etc), that result in barriers to employment, housing, and personal stability." https://www.awesomefoundation.org/en/projects/18491-hastings-urban-farm-huf [Jun. 2021]

Hives For Humanity are "a non-profit organization founded in the Downtown Eastside of Vancouver, British Columbia, in 2012, that supports inclusion and builds belonging through the culture we build around each bee hive. Through mentorship based programming at 19 Therapeutic Apiaries, in partnership with local organisations, we create flexible opportunities that deepen self-worth, community pride and connectivity to nature. We participate in local sustainable economies. We support at-risk populations of people and pollinators." https://www.hivesforhumanity.com/ [Jun. 2021] The DTES Street Market "supports hundreds of vendors to be more independent, less clientized, and to make much needed extra money for themselves to supplement their social assistance." https://vancouver.ca/files/cov/dtes-street-market-brochure.pdf [Jun. 2021]

[62] The housing in this building will be operated by the non-profit S.U.C.C.E.S.S., a local community service society that offers a diverse range of supports. Their website states that, at present, they operate 600 units of social housing across the Metro region. https://successbc.ca/ [Oct. 2020]; https://rezoning.vancouver.ca/applications/58whastings/index.htm [July 2020]; https://www.chinatownfoundation.org/58-w-hastings/ [July 2020]

Dunsmuir Viaducts (which are due to be eliminated, themselves). The new hospital is part of a strategy to increase the number of jobs in the largely industrial and commercial area from "8000 to 30,000."[63] Another development at the eastern edge of the False Creek Flats that is scheduled to be opened within a similar timeframe as the new hospital, is a building to replace and upgrade the Vancouver Detox facility, currently located at 377 East 2nd Ave. The new building will be located on the north east corner at the intersection of 1st Ave. and Clark Dr., span half a city block, contain, 50 treatment beds, and an additional 97 units of co-located social housing. [64] Respondents (R1,R2, R8) discussed the forthcoming development of the new withdrawal management facility to be a significant capital investment from VCH, and an important instance of a successful collaboration with the City of Vancouver. In this particular case, City Council unanimously approved the project despite vocal opposition by community members [Boynton, 2019].

In addition to the forthcoming developments discussed above, since 2017 the BC Government has initiated rapid development of new modular housing projects, on various parcels of land throughout the city, as a response to crisis levels of homelessness and housing precarity.[65] For example, a new modular housing facility at 1580 Vernon Dr. - directly west of the new detox facility site - is expected to open shortly after the time of writing.[66] The implementation and operation of these initiatives are mainly divided between the BC Housing Corporation, the City of Vancouver, and a number of nongovernmental housing providers. Yet, R2 described that VCH plays an important role in their operation either by providing targeted funds for programs, offering embedded clinical services, or through the use of outreach teams to connect the buildings' residents to medical and social services.

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[63] https://thenewstpauls.ca/about/ [Jun. 2021]

[64] https://rezoning.vancouver.ca/applications/1636clark/index.htm [Oct. 2020] At the time of writing, however, the lot still remains occupied by a tenanted low-rise apartment building and several large multi-suite homes. [Jan. 2021]

[65] https://vancouver.ca/people-programs/temporary-modular-housing.aspx [Nov. 2020]

[66] https://vancouver.ca/news-calendar/temporary-modular-supportive-housing-approved-for-1580-vernon-drive.aspx [Jun. 2021]

5.2.3. Summary

In Vancouver's eastern inner-city, a more dispersed, yet formally administered, territory of population management is emerging. Though constrained in its ability to strategically manipulate the built form to affect socio-spatial dynamic in the DTES, VCH nonetheless still exerts influence. A social-mix developmental dynamic of supported social housing and health care amenities contributes to the erasure of the degraded, hybrid, informal, and spontaneous frontier spaces that were characteristic of the effects of capital flight, devaluation, and abandonment of the industrial and working class segments of Vancouver's inner city in the 1980's and 1990's. Here a regulatory politics of affirmation sustain services and developments that actualize particular forms of inclusion, amidst an influx of new investment and resettlement of middle and upper class demographics in the downtown area.

5.3. Situation

Alongside the changing material and social environment in the DTES there are regularly leveled criticisms that claim that the concentration and kinds of services offered in the neighborhood create conditions that attract a particular demographic (poor, racialized, drug-user, criminal, pathological, socially burdensome, etc.) to the area. Various commentators argue that the current configuration of the service landscape in the DTES both perpetuates the severity of 'social disorder' and visible drug-use long prevalent in the area, and sustains the adverse conditions and harms it was originally intended to address [Rufo, 2020; Watson: 2019; Hopper 2017; Sommers et al. 2015]. The common conclusion derived from this line of reasoning is that the service landscape needlessly wastes tax payer dollars as sizable sums of government funds are funnelled into budgets for social services, health programs and nongovernmental agencies that ostensibly fail to 'solve' the aberrant poverty which blights the inner city [Hutchinson et al, 2014; McMartin, 2016; Bennett, 2020]. Such perspectives construe the service landscape in the DTES as a destructive attractor: a system that draws vulnerable or poor people into the neighborhood and in so doing continues to evolve its initial conditions. Yet, this kind of resentment obfuscates far more complex dynamics that are shaped by 3 key factors: displacement and rights to remain; capacities for social mobility; and

regional disparities in health and social services. In what follows I present an account of how the respondents understood VCH to situate itself within this dynamic.

Respondents discussed the current demographic constitution of the DTES. R1 cited a VCH commissioned study and internal data sources to have identified a regular demographic pattern in the area: “we know that roughly one third of the people come to Vancouver’s DTES for a short period of time and then they leave and never come back. Another third stays there forever, that’s their home. And another third come and go” (R1). R2 mentioned the relative novelty of this information for VCH and its value as a factor that informs on-going service delivery in the area: “a few years back we really lacked the data to know where the clients had come from, where they stayed, how long they stayed, whether it was their permanent place of residence, whether someone’s there transiently?” This understood tripartite division (permanent resident, itinerant resident, or transient visitor) was a common point of reference (R1, R2, R3, R5) that informed respondent rationalizations about the area: “if they’re there transiently, there’s a variety of reasons for that. It could be that they’re there for a service, because they can’t seek the service elsewhere. Or, it could be that they are there to obtain […] housing, right? Because of the poverty, right? So it’s sort of more psychosocial” (R2).

In delivering services largely contextualized by poverty, precarity and mental health to the DTES, VCH finds itself forced to contend with an expansive set of complications that are often referred to as “psychosocial” – a word which designates anything that has to do with social and psychological factors that influence health. Psychosocial, therefore, is a jurisdictional pivot: It is a technical term that functions to outline some of the thresholds of what may or may not be designated as the purview of conventional health care or biomedicine, but nonetheless might exert significant influence on health outcomes. It is a specific operator in current power/knowledge formations that demarcate particular institutional forms of classification and evaluation, and legitimates or disqualifies phenomena and practices of intervention. It is a term in the biomedical idiom of government that renders “reality thinkable” in particular ways [Rose & Miller, 2008: 59]. In this context, the demographic constitution of the DTES motivates rationalizations that pertain to the problematic of bodies and environment, wherein the designation “psychosocial” emphasizes the significance of non-medical circumstance in giving form to novel services and amenities that are not available elsewhere. Here, psychosocial demarcates politicized thresholds of slippery-slope

rationalities that oscillate between health equality and equity. The matter can be formulated as follows: there are circumstances such that it would be unreasonable to provide amenity (x) to population (p) because of extant resources or their facility in being obtained; while conversely, there are deprived circumstances for population (q) where it ought to be necessary that amenity (x) be provided, lest significantly poor health trajectories ensue.[67] The question health service planners are consistently tasked to address, then, is: what are the thresholds by which various circumstances become relevant to merit investments in services and interventions that address psychosocial needs from the health authority? R2's quote, in the last sentence of the previous paragraph, about housing as a psychosocial intervention forms a significant part of the problematic of environment and bodies grappled with by VCH in planning service delivery, and exerts influence on the DTES's material and social constitution. The topic of housing is addressed in further detail in Chapter 8.

5.3.1. No good services outside of the DTES

R1 emphasized that, "as you can imagine *there's no good services outside of the DTES*. I say good in the sense of accessible or flexible as they should be, although I would say in the last maybe couple of years maybe things are improving in other areas – Fraser Health and Surrey area and so on" [My italics]. R1 explained that the services and their quality (i.e. augmented primary care, harm reduction focused, as well as trauma and culturally informed practices of care) are not available elsewhere. As a result many peoples' needs are not being met in other communities. R1 maintained that VCH has an obligation to provide services in the DTES, that the service needs there are legitimate, and recognized that the area provides a positive community space for many of its members. R1's notion of what is considered a 'good service' represents a crucial problematization on behalf of the health authority. The 'good services' unique to the DTES are the result of particular ways of knowing and valuing that have been contested, fought for, and developed within the community over the course of recent history. They are the result of the community's longstanding "local moral culture" that demanded that official instruments of government actualize specific kinds of life making practices [Ley &

[67] The dynamic outlined here can be proportionately modified to fit an indefinite number of circumstance. However, let population (p) = Yaletown condo owners, (q) = people sleeping in parks, and amenity (x) = showers and breakfast.

Dobson, 2008: 2486; Roe, 2010; Lupick, 2017]. The expression “no good services outside the DTES,” therefore, forwards a twofold critique.

The first critique addresses failures in governmental planning, service deficits and shortfalls in other places. The scope of this critique can be extended to other regional health authorities and municipalities within BC as well as service provision in other provinces. Here health services and interventions in the DTES markedly contrast with other regional systems of care. For instance, disparities in the availability of harm reduction and low-threshold services for substance use disorders in other locales are widespread (though R1 was careful to note progress in the Fraser Health region). Despite the mounting death toll and ample evidence of the effectiveness of services like supervised consumption sites [Potier et. al, 2014: 48-68], most provincial governments, and to a lesser extent other regional health authorities, continue to remain committed to an indifferent approach to crises engendered by adulterated supplies of illicit drugs and simply let people die.[68] Of note specifically are recent policies in Alberta, Saskatchewan, and Ontario,[69] where political indifference and hostility toward harm reduction and the destigmatization of drug users has created conflicts that pit municipal governments and health authorities against provincial governments.[70] Hostilities toward strategies other than prohibitionism are often contextualized by politicians through weasel worded discourse about alternatively shifting government energies and focus on ‘treatment,’

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[68] “16,364 apparent opioid related deaths occurred [nationally, in Canada] between January 2016 and March 2020.” https://health-infobase.canada.ca/substance-related-harms/opioids/ [Oct. 2020] In 2019 Dr. Mark Tyndall sated: "It would require quite a major investment, and I don't think there's much appetite for that.... Ten thousand people have actually died in Canada [from overdoses] in the last three years and it seems like we haven't mounted hardly any response, […] We really haven't taken this seriously enough. And if 10,000 people dying doesn’t change it, I guess I can’t be that optimistic” [McElroy, 2019].

[69] Alberta has recently closed the busiest safe consumption site in North America [Labby, 2020]; the Saskatchewan government has refused to fund safe consumption sites [Shield, 2020]; and, the Ontario government has aggressively pursued defunding of safe consumption facilities [Weeks, 2019].

[70] Some examples of this dynamic can be found in Saskatoon, Lethbridge, Thunder Bay, Toronto. See articles cited above. In Saskatoon there was a campaign to raise $60,000 to employ a single paramedic in a modest safe consumption site despite ample strain on government funded emergency first response services, while the provincial government refused to concede any support [Latimer, 2020]. In contrast, Insite has approximately 4 registered nurses working per day.

'recovery,' or 'prevention' without any corroborating substantive policies or investments [Collier, 2009][71].

The second critique advanced by the phrase "no good service outside the DTES" is an internal critique of the way that VCH has concentrated, limited, and confined a number of novel services to the DTES while neglecting other communities within its own administrative territory. R2, R3, R5 discussed how stigmas and social exclusions that happen at the intersection of poverty, drug use and mental illness are widespread, and therefore need to be appropriately confronted and addressed in other locations. R3 questioned why the health authority had not worked to establish similar services in other areas of the city until quite recently. The novelty of having established a supervised consumption site at St. Paul's Hospital was noted, while bewilderment was expressed at the historic lack of Indigenous-specific health services available elsewhere in the city. Ten years prior, Elliot presented a similar critique: "The clustering of health services in the Downtown Eastside, or more importantly, the lack of health services focusing on inner-city issues like HIV, addictions and mental illness, in other areas of our city robs citizens of the basic rights that the rest of us are afforded – specifically geographic mobility and adequate health care" [Elliot, 2010: 189]. This scenario was acknowledged to have created conditions that have forced people with specific needs to migrate to the area: "we've actually driven people to that neighbourhood and they may not want to do that." Likewise, R2 understood that maintaining services in the DTES remains a reasonable pursuit, but expressed concern that their continued uniqueness to the area will unnecessarily attract more people in search of care and overwhelm resources: "the unfortunate thing about the DTES is that it's a victim of its success, right? […] if we don't provide the services elsewhere, everybody's going to come to the DTES." R5 explained that they believed that there are many excellent services and programs in the DTES but that continued emphasis and focus on furthering their concentration in the area stifles their efficacy, underserves other communities, and creates further obstacles in efforts to promote modest capacities for upward social mobility. R5 claimed of some organizations in area "that their bread and butter is to make sure that they keep people in the DTES. And, they're actually, almost, enabling people to stay there or disabling them from being able to move out, without even realizing it." This latter claim also reveals a significant set

[71] For example, quote from ex-Federal Health Minister, Tony Clement, states "A better thing to do is treat people, to prevent them going on drugs in the first place." [Collier, 2009]

of tensions in competitive contracted nongovernmental services that have established themselves in the DTES – usually as a response to conditions of abandonment that have characterized the area, and often operate in uncertain and austere funding climates and conditions of resource scarcity. Further attention is given to this state of affairs in chapters 6 and 9.

Respondents, however, spoke about the paradoxical or deeply complicated aspect of designing and implementing services both inside and outside the DTES. It is recognized that there are tensions and conflicts between promoting conditions that allow people the ability to remain in place, in part, by providing inclusive models of care, and the significant deficiencies in distribution of similar resources and services across VCH Communities of Care and the greater metropolitan region. R3 explained that it is understood that similar services need to be located elsewhere and that people should not have to leave their community in order to access life-saving supports for substance use or mental health. Yet, despite the possibility of "some negative outcomes," it was recognized that the DTES has historically been a space where conventionally marginalized people experience a sense of belonging, "and that's a good thing. […] but we need to get rid of the stigma in other communities, so that people don't feel they have to move to the DTES to feel that they have a community that supports them. So, it's complicated" (R3).

Operating along axes of gender and class, R6 used the example of Sheway,[72] a resource for expectant mothers and women with children in the DTES, to describe the complexities that surround how the spatial location of services that VCH provides to the target demographic is conceptualized. R6 mentioned VCH's interest in having the neighborhood remain affordable for Vancouver's inner city poor, but then discussed the ambivalent nature of providing site-specific services like Sheway: "that program is so vital, and it works because of its location, but it also doesn't work because there's some folks who could use those services, but they don't." R6 outlined that there are: 1) women who have chosen to leave the DTES because they a) no longer identity with the

[72] VCH website describes the program: "Sheway is a Pregnancy Outreach Program (P.O.P.) located in the Downtown Eastside of Vancouver. The program provides health and social service supports to pregnant women and women with infants, who are dealing with drug and alcohol issues. The focus of the program is to help the women have healthy pregnancies and positive early parenting experiences." http://www.vch.ca/locations-services/result?res_id=900 [July, 2020]

community there, or b) they have fled adverse circumstance, like an abusive relationship; or that, 2) there are women with no connection to the DTES and do not want to be there, but could significantly benefit from the kind of services offered by Sheway. Sheway's location was certainly understood to benefit women in the DTES and the surrounding inner-city spaces. Yet the ability to establish an equivalent service elsewhere for women with similar support needs was noted to be difficult because there were no other areas in the city with comparable demographic concentrations to motivate similar investments. The complexity of the issue was further contextualized by R6 who recounted a conversation they had had with a women's advisory group where the participants expressed their ambivalence toward the area:

> […] they were talking about how, this dichotomy, they would like nothing better than to be able to leave the intensity of the DTES, and get a break from it, because it's so intense, but when they go for a walk on the seawall or something, they feel completely othered and judged and every single person that passes them is looking at them in a certain way. And so, you know, it's this crux of their sense of belonging and connection exists in this neighborhood, that is often really intense and hard to live in, but then leaving that neighborhood, you lose that sense of belonging and connection. And what is worse? So this is what we're dealing with.

This quote troubles simplistic thinking about the subjectification inherent in life-making practices and rationalities of inclusion by drawing attention to the complexity of the relationship between space and identity as self-conception and social performance. It demonstrates the difficult balance between scale of service delivery for individuals and populations, and the challenges of negotiating and attending to vulnerabilities within the larger and variable social field. R6's example demonstrates that VCH planners are, in some instances, reflexive about the subject positions of their target demographic and understand that interventions designed to jointly promote well-being and dignified citizenship were also recognized to have the potential (in this instance via location) to have the opposite effect by way of drawing attention to a person's physiological difference as both an indicator of and qualifier for being out-of-place.

5.3.2. Repatriation

When discussing the problematics of service location and demographic circulation in the DTES many respondents (R1, R2, R3, R5) proposed establishing a repatriation strategy or mechanism that would send people back to their community of origin. While this theme was advanced in the interviews during discussions about the DTES's demographic constitution, it was given independently of any prompting for solutions. This suggests that mechanisms of repatriation are possibly being seriously considered as a forthcoming strategy. Respondents proposed a repatriation strategy as both a solution to the continued circulation and intensification of the target population into the DTES, as well as a means to influence change in the constitution of services elsewhere. It was understood that such a course of action would work to both support and motivate communities elsewhere to develop and establish similar resources, as well as work to alleviate high levels of demand in the DTES and adjacent health services – especially in relation to acute care and mental health services. This latter issue is significant and is discussed throughout the following chapters.

Urban Indigeneity, particularly, was mentioned in this context by R5, where they understood the higher Indigenous demographic in the DTES to be, at least in part, related to the service landscape and its role in liberalizing drug-use: "I don't know if it's the glamour of the downtown... there's a lot of attraction there that we have built as a system, which I think we need to unravel a little bit." Migration to urban centers from hinterlands is a well-known global trend (if not a cliché). However, Vancouver has the third highest population of urban Indigenous peoples among large cities in Canada.[73] In popular settler consciousness, "[t]here has been a long history in Canada of assuming that aboriginals and cities are mutually exclusive. It is often assumed that aboriginals in cities are merely transient […]" [Pratt: 1059]. The history of urban Indigenous communities in East Vancouver, and the DTES specifically, is understandably complex and beyond the scope of this project. Nonetheless, it is important to note that the history of urban Indigenous communities have been notably determined by the gendered violence of a colonial project that, for example, drastically restricted Indigenous women's

[73] "Winnipeg (25,970), Edmonton (18,210) and Vancouver (15,080)." https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm [Nov. 2020]

rights and forced many to migrate to inner city neighborhoods in search of sustenance and opportunity [Blomley, 2004: 150-151]. This indicates an enduring tendency in medicalized service delivery rationales to struggle to seriously consider community and culture as complex sites of belonging, refuge and therapy [Masuda & Crabtree, 2010: 663]. Yet, R5's quote also importantly underscores the vast deficit of health services that many peripheral urban and rural, but especially, Indigenous communities are subject to. R5's position, therefore, furthers R1's critique of "no good services outside the DTES" by articulating legitimate grievances about equitable burden of care provision across the province.

5.3.3. Summary

Two basic problematics that relate to VHC's service delivery in the DTES were identified by the respondents in this section: the ongoing needs of the existing community in the DTES which are, in part, animated by a regular influx of new residents; and, a deficit of similar services in other locations, both within VCH's Communities of Care and external places, more generally. A "critical mass" of a target demographic was identified as a threshold factor for investments in services within and outside the area. While the notion of "enabling people to remain" addresses a complex problematic within developmental dynamics and rationalities of care. For someone *to remain* can refer to both *remain in place* and *to remain as they are*. Rights to remain in place were affirmed by respondents, but supplemented with proposals for a repatriation strategy with a goal to affect services elsewhere. *The right to remain as one is*, however, addresses complex dynamics in the administration of care, and animates an interventionist problematic that is structured by ethical dimensions of expected duties of self-conduct and treatment as cure versus treatment as management.[74] In the present context, *the right to remain as one is* antagonizes conventional abstinence and prohibitionist approaches to illicit drug use, in favor of harm reduction and low threshold services, which understand that

[74] This particular problem of was highlighted by Elliott: "In fact, none of these medicines are known to cure any disease – including antiretroviral therapy that, while keeping people alive, are only a temporary solution and frequently result in side effect requiring additional pharmaceuticals" [Elliott, 2010: 192]. While ARV's are certainly employed to manage HIV, they are not 'temporary solutions' but a life-long course of treatment that enables people, for instance, to die of old age rather than succumb prematurely to complications relating to AIDS. The relationship between curing and management is a complex dynamic in medical ethics that is expressed in more highly politicized fora through practices of exclusion and inclusion [see also, Poland et al., 1998: 787].

"curing" problematic substance is highly problematic in-itself. Respondents recognized the DTES to be a complex and often ambiguous site, a position, as demonstrated by R6, that has been informed by the reported recent experiences of the health care consumers themselves.

5.4. Conclusion

Service rationalities that attempt to remove barriers to provide marginalized people with access to care, colloquially referred to as 'meeting people where they are at,' are governmental strategies that seek to actualize life-making and saving practices that are predicated on value-rationalities that challenge conventional thresholds of social inclusion.[75] Taken in the context of the ongoing Drug War, proliferation of overdoses, and the entrenchment of the marginalized poor in the criminal justice system,[76] what kinds of service are offered, where they are located and who can access them has life and death consequences. Irrespective of the massive wave of change affecting the material constitution of the neighborhood, or the complexities that shape demographic flows in-and-out of the area, respondents identified a continued role and need for the health authority to provide and fund services in the DTES: "we're going to continue to see that population. That's not going to disappear. But it will probably, given the gentrification process, will probably get smaller, but it will not… it will remain significant and health will have a bigger role" (R4). Since its inception in 2001, VCH has emerged as significant institution that gives shape to the material and social constitution of the DTES. Yet, the social constitution of the neighborhood likewise gives form to new rationalities and practices within the health authority that highlight deficiencies in service in other locales. However, R3 identified that there had been no overarching or grand strategy within VCH as it relates to the DTES, until the advent of the Second Generation Strategy, which began its planning and consultation exercises in 2011-2012. Rather,

[75] For instance, the antiquated practice of denying an intoxicated or substance using person a shelter-bed or making the availability of safe housing contingent upon abstinence from drug-use. Such regional disparities that result from service rationalities structuring exclusions that reduce people to bare-life and expose them to death were recently showcased in Prince George where winter temperatures have fallen to -30c, "asking people why they are outside despite the cold weather. They say addiction is preventing them from getting into shelters." [Kurjata, 2021]

[76] See [Sylvestre, Blomley, and Bellot, 2019] The risk of suffering an overdose after a period of incarceration is substantial. One study found that former inmates were 40 times more likely to die form an opioid overdose [Ranapurwala et al., 2018].

historically, services were reported by respondents to have developed more-or-less individually in response to the various crises, needs, or community demands, and as they are required by the provincial mandate: “I don’t think there’s been a deliberate strategy that VCH has had in the DTES, despite the Second Generation Strategy, [and] it’s never really gotten traction because of other things that have happened, like the opioid crisis, that have taken over.” Having, therefore, considered contemporary circumstance that pertain to how VHC sites and situates itself within the neighborhood, will I now turn to examine the associated forms of problematization that pertain to VCH’s Second Generation Strategy for the DTES.

Chapter 6.

Strategy: Second generation

> Government is a contingently failing operation: the sublime image of a perfect regulatory machine is internal to the mind of the programmers. […] Whilst we inhabit a world of programmes, that world is itself not programmed. We do not live in a governed world so much as a world traversed by the 'will to govern,' fueled by the constant registration of 'failure,' the discrepancy between ambition and outcome, and the constant injunction to do better next time. [Rose and Miller, 2008: 71]

This chapter examines Vancouver Coastal Health's Second Generation Strategy for the DTES. I begin by considering the historical context that initially motivated the development of the strategy and some of the broader problematics that it is intended to address. How respondents variably conceptualized the nature and intent of the strategy is contrasted by consideration of its reception from community members and local service providers. Reported contingencies and hindrances that affected the implementation of the Second Generation Strategy are then presented.

6.1. Overview

VCH's Second Generation Strategy for the DTES was a neighborhood scale policy initiative to restructure the health authority's service operations more effectively in the area. The Second Generation Strategy can be understood as the first attempt at articulating a coherent and unified strategy for health care delivery in the DTES. It was begun in 2011- 2012, after a period of consultation with clientele, VCH staff, contracted service providers, neighborhood residents, and a number of other stakeholders [Vancouver Coastal Health, 2013: 4]. This consultation period resulted in VCH's release of a series of documents that outline the beginnings of a new phase of service provision named the "Downtown Eastside Second Generation Health System Strategy" [ibid].[77]

[77] http://www.vch.ca/about-us/accountability/quality-care/service-reviews/downtown-eastside-health-strategy [Nov. 2020]

From the outset the Strategy aimed to be both ambitious and historically significant, as evidenced in its self-comparison to the Four Pillars Strategy[78] [ibid]. The strategy was announced after a number of historical events such as the 2010 Winter Olympics (which generated protest and left a legacy of over-policing of the poor and unrealized promises of social housing windfalls) [Eby, 2009: 411; Hyslop, 2010; Currie, 2020]; the September 30, 2011 Supreme Court victory that enabled Insite to continue to operate permanently [Canada vs. PHS Community Services Society]; and, in 2014, the release of the City of Vancouver's *DTES Local Area Plan*, which outlines the vision for the development and use of the neighborhood space over a 30 year timeframe [City of Vancouver, (a)]. The Second Generation Strategy is relevant for two interrelated reasons. First, it serves as a conceptual break for the health authority itself and provides a new point of reference to contextualize aspirations or challenges that pertain to service delivery in the DTES. Second, it is the principal set of policy rationalities which guide the empirical focus for this project. It allows me to examine the manners by which, in recent history, VCH has problematized the DTES.

The Second Generation Strategy is a pivotal event in the area's biopolitics of place-making. It is a way that the DTES has been rendered "thinkable" so as to be acted upon and administered in manners and fashions that befit the governmental capacities of a health authority [Rose & Miller, 2008: 62]. As an act of naming, it formalizes and gives order to specifically technical interventions and value rationalities that operate at the neighborhood scale. The Second Generation Strategy, therefore, represents an increment in the shift from the novel encounters of the service landscape's frontier space, founded through disparate and uncoordinated services, towards greater territorial management of an inner city population of aberrant poor. Understood in this manner, the historic break inaugurated by the Second Generation Strategy renders the contingent and changing nature of the medicalized problem-space of the DTES intelligible.

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[78] "The four pillars approach to drug addiction was first implemented in Europe in the 1990s, and is based on four principals: Harm reduction, Prevention, Treatment, Enforcement. Successfully used in such cities as Geneva, Zurich, Frankfurt, and Sydney, this four pillars approach has resulted in a: Dramatic reduction in the number of drug users consuming drugs on the street; Significant drop in overdose deaths; Reduction in the infection rates for HIV and hepatitis." https://vancouver.ca/people-programs/four-pillars-drug-strategy.aspx [Oct. 2020]

6.2. Historical context

After the initial interventions that followed from the declaration of the public health crisis in 1997, a system re-think for health care in the DTES was prompted by information from a basic biopolitical category – the population mortality rate. On the surface, the story appears straightforward enough: in just over a decade VCH had implemented systems and services that, once measured, enhanced and extended the lives of the population in the DTES. The Second Generation Strategy is understood as the first attempt to develop a deliberate overall approach to health service provision in the area (R3). The name itself was created to mark a new phase of service delivery design that would build from the growth of resources and interventions established during this period (R4). As the overall population health was understood to have been improved, and the initial crisis-response began to transform into a problem of longer-term population health management, the means of delivery needed to be re-evaluated and better strategized: “Particularly because we came from that time when we really were responding to a crisis. We were patching all the holes that we could find, and we lacked coordination and integration” (R1). Services operating in the DTES are reported to have had many redundancies. Health care consumers had to negotiate situations such as repeatedly reporting their life stories and personal circumstances with each care provider visit. There were often break-downs and miscommunications amongst clinical staff and between services. The care model was also not attuned to the specificities of the realities, experiences and cultures of Indigenous peoples. This latter point is especially important since health care in Canada has historically functioned as a mechanism of colonial oppression [Kelm, 1998; Lux, 2016], and continues to be fraught with anti-Indigenous bias in practice [Turpel-Lafond, 2020; McCallum and Perry, 2018]. Women and the LGBTQ2 community were likewise historically underserved.

The success of the initial interventions begun in the 1990’s translated into a commitment to more effectively address the larger problematics of service delivery for less exceptional medical conditions. It may be claimed that there was a momentary shift in the general speed of required interventions across the population as a whole on two fronts. First, there was a pause from the urgency needed to contain the spread of HIV. This resulted from initiatives that provided easy access to harm reduction amenities (viz. clean syringes and water) and the development and distribution of Anti-retroviral (ARV)

drugs. Second, the establishment of a safe injection site worked to buttress the latter and helped quell the mounting deaths from overdose. A shift from outright crisis response enabled VCH to slow down and focus on interventions that manage and attend to less spectacular, but nonetheless significant chronic conditions that began to more substantially present themselves among the population as a result of newly established longevity.

The focus on simplification and enhanced coordination between services was described as a move toward a more client centered model of care. This individually enhanced model of care was described as being an advantage in directing response to the 'overdose crisis' which was to emerge during the Second Generation's late phase of conceptualization and early roll-out: "in order to have life-saving interventions, it's important to have connections to people and to have a person-centered approach" (R4). This is an important claim to consider when examining governmental rationalities that seek to leverage and optimize individual freedoms and autonomous capacities for choice. There has been historical mistrust from community members and others in socially marginal positions towards people in positions of authority [Goodman et al., 2017]. R4's quote touches on a complex integration of strategies related to the 'make-live' of specific bodies and population. By linking service integration with specific forms of social and personal engagement, a particular form of subjectification is attempted. This occurs through the development of community specific services and cultures of practice that are designed to have the target demographic positively identify with and autonomously seek-out and engage those services as a means to enhance both individual and population health outcomes. This arrangement aims to create a positive feedback loop of self-recognition and identification from the consumer towards providers of direct care and harm reduction services. This particular form of subjectification is intended to be realized, in part, by a systemic reconfiguration of primary care services in the DTES.

The system transformation of primary care intended by the Second Generation model of community care design is informed by a policy mobility that draws on the 'Nuka model' of health services that was developed by the Southcentral Foundation. As a private Indigenous health authority from Alaska,[79] the Southcentral Foundation markets

[79] https://www.southcentralfoundation.com/nuka-system-of-care/ [Nov. 2018]

its system's efficiency as a result of its unique "relationship-based" and "consumer-owner" model of care [Gottlieb 2013: 1]. The Nuka model reports to have significantly improved the well-being its Indigenous community member-owners by offering culturally appropriate wrap-around care services in their clinics. Serving a population of 65,000, in Anchorage Alaska and related rural communities, a testimonial metric on the foundation's website explains that the community, "experienced a dramatic decrease in ER visits after transformation – 40 percent from January 2000 to 2017. In addition, hospital stays have decreased by 36 percent during that same period."[80] Though not replicating the consumer-owner model developed by the Southcentral Foundation, these are the kinds of outcomes VCH is striving to obtain in the DTES by emulating the wrap-around services of the Nuka model of health care. R2 described the foundation of primary care redesign that VCH emulated from the Nuka model as a network rather than centralized hub: "rather than having one big clinic that people walk into and then see whichever nurse or physician was up next, they had smaller teams and you were assigned to those teams, so you're more likely to know the people who treat you."

6.3. Conceptualization, reception, implementation

Though there were no significant points of disagreement in the interview data about the strategy, emphasis on its overall focus varied amongst respondents. In one important respect this can be attributed to the different occupational roles and duties preformed by each of the respondents. Mutability in response can be taken to indicate the different scope and scale of focus that each respondent works with relative to their position within the health authority (for example, respondents working in primary care tended to emphasize clinic redesign, whereas those affiliated with public health had more to say about harm reduction initiatives). It is reasonable to infer that this affected emphasis of what is central and important in the policy. Variability in thematic emphasis can also be taken to indicate the magnitude of the shift in organizational thought, culture and practice that is being attempted through the strategy, as well as the complexity of the bio-social reality of the neighborhood.

[80] https://scfnuka.com/our-story/#toggle-id-2 [Nov. 2020]

6.3.1. Conceptualization

Overall, the respondent data is generally consistent with the five "New approaches and actions" presented in the official *Design Paper*: "Strengthen our relationships;" "Expand care team and competencies;" "Integrate services to provide better coordinated care;" "Align services with client demand;" and, "Achieve performance excellence" [Vancouver Coastal Health, 2013:7]. Despite some variability amongst the 8 respondents, three basic categories emerged from the interviews that pertained to how the strategy was conceptualized. They are: Sustainability of the acute care system, optimization of collaborative efforts with community partners to harmonize and integrate goals, and as a platform to develop and innovate practices of care. In this section each of these categories will be discussed in turn.

1- *Sustainability of acute services*:

As alluded to by the outcomes from the Nuka model described above, the sustainability of the acute care system is a significant priority across all areas of VCH. As health care is a demand driven service, demand-reduction keeps costs down. R2 described the overall reason for the Strategy as a way, "to ensure that the system is sustainable at a reasonable cost and still preserve the acute care system." One of the questions I posed to all respondents was about how health services are planned in the context of finite resources relative to a demand driven service that resists succumbing to a margin of diminishing utility. In this conceptualization I postulate that health care, generally, is more likely to be able to usefully absorb indefinite sums of money and resources than other government services. That is, under ideal circumstances (viz. barring corruption or incompetence), no matter how much funding you provide health services, they will always reap a benefit.[81] Following from the design of the Nuka model, R1 discussed a strategy whereby VCH would reinvest existing funds toward more coordinated clinical teams and services in the neighborhood: "Meaning that if I'm

[81] See also, Robert Nozick's "utility monster" though experiment: "Utilitarian theory is embarrassed by the possibility of utility monsters who get enormously greater sums of utility from any sacrifice of others than these others lose. For, unacceptably, the theory seems to require that we all be sacrificed in the monster's maw, in order to increase total utility." [Nozick 1974: 41]

attached to a team – a doctor, a nurse, a social worker – that I know I'm more likely to go to them than I am to emergency or neglecting my health and needing admission [to hospital]." In this framing of the Second Generation Strategy, values that pertain to rights to life and well-being are integrated with and balanced against other sets of rationalities that are concerned with problems of resource scarcity, service optimization, accountability, and efficacy of intervention.

2 - *Optimization of collaborative efforts and integration of goals and values with community partners and stakeholders*:

R6 described that they understood the "original vision of the Second Generation Strategy" as an emphasis on collaboration and partnership. Such sentiment is exemplified in the discussions contained within the policy documents themselves.[82] Prioritizing a commitment to partnerships as a governing practice indicates the intersectional, multidisciplinary and networked nature of the reality of service delivery in the DTES. Administering and governing health outcomes and services cannot be accomplished by VCH alone. Nonetheless, this particular category exposes the tensions and asymmetries between kinds of contracted service delivery through market oriented governance and the community activism that occurs in the area. This theme is significant for this thesis and is explored in more detail in chapter 9.

3 - *Expansion of mandate to develop innovative and new ways to deliver care:*

The Second Generation was, as R7 notes, at least partially, understood as a platform for speculative projections of possible activities and interventions; especially those considered to be the purview of the domain of the social determinants of health or psychosocial need. Not everything, then, was intended to be realized. This is exemplified by R7's comments about the health authority's plans to develop a comprehensive housing strategy and an overall strategy for food security in the neighborhood as being, "way more aspirational than we could have ever taken on," as well as outside the service expertise of the organization: "honestly, what you're looking at with the Second

[82] "Partnership is nowhere more critical to Vancouver Coastal Health's success than on the Downtown Eastside. […] Government agencies such as Vancouver Coastal Health must be politically neutral. As such, it is often hard for them to innovate effectively in a politically charged community. So it's no surprise that non-profit societies and community agencies have led most initiatives to improve health on the Downtown Eastside and that risk, improvisation and shared effort on a shoestring budget have defined those efforts." [Vancouver Coastal Health 2012: 8]

Generation is a bit of a metaphor for healthcare policy and planning, broadly." In this context, the speculative features of the Second Generation Strategy can be understood as abstractions to be refined, focused and translated into actionable particulars of practical activity.

Indeed, The Second Generation Strategy was conceived as a means of implementing change in practical services and interventions designed to affect improvements in the health and well-being of a target inner-city population. As R4 discussed prior, specific tactics of subjectification are used as elements in practices of inclusion. There are various strategies and social technologies employed in the realization of inclusive practices. R8 provided an example of a systematized response intended to address some of the issues posed by R2 and R1 around acute care demand and system sustainability. R8 described the nuanced balancing involved in operationalizing subjectified life-making practices. It was acknowledged that there are significant pressures placed on acute care services as a result of consistent critically high volumes of demand. Across all VCH communities of care, there are efforts to considerably reduce overall acute care use. Two specific groups of people residing in the DTES and Vancouver's inner city were identified in this context. The first consists of a group that does not readily engage with acute care services but possess significant medical conditions which are often only partially attended to in conditions of crisis or extreme duress. Conversely, a second group of people were identified that have high frequencies of hospital visits but do not receive the appropriate care their conditions require. R8 then explained that data which focused only on the volume of a particular cohort's hospital utilization was too simplistic a measure to indicate whether a given intervention or set of services were successful. The Women's Intensive Case Management Team (WICMT) was used as an example of how a particular kind of engagement can affect this dynamic. It was explained that when the team initially engages with marginalized women in the DTES that there are often higher rates of hospital visits. Yet, over a longer period the volumes of admission and interaction with acute services substantially decrease as a result of the relationships the women established with their care team. R8 explained:

> If you're just looking at one metric. If you're just looking at acute utilization, you'd be looking at that and say 'oh-my-goodness, this is a failure!' But we were saying 'these are women who are so traumatized by the health care system, they're not going to the hospital. This is a win.' And so, that was

> the pattern we were hoping to see: an initial upswing in acute utilization and then a gradual reduction as we work to stabilize them. And that's what we saw. So, that's where I think that the access to those services, it's not… it's not such a simple formula.

This quote describes a strategy that is part of a larger initiative to shift the culture of health care delivery and its experience by those at the margins from what is often experienced as a quasi-consensual disciplinary operation, encountered in moments of crisis and urgent necessity, to that of a process of active participation and voluntary autonomous engagement built on trusting relationships, with the ends being both overall health improvement and fiscal sustainability. Here, a particular kind of biopolitical subject is shaped through the confluence of biological and economic circumstance.

The Second Generation Strategy documentation, however, is reflexive about the fact that this crisis-of-care results from structural violence engendered by continued erosion of social safety-nets, systemic divestment from and devaluation of mental health services, unrelenting loss of affordable housing, and stubborn attachments to prohibitionist policies that criminalize drug users. This reality is directly acknowledged in the document entitled "A View From the Front Lines," written by well-known activist and founding member of Vancouver Area Network of Drug Users (VANDU) Ann Livingston: "[DTES residents] know their health is a function of constant arrests, surveillance, disrespect, addiction and poverty, as they move from shelter to squalid SRO, with no hope of getting a real home" [Vancouver Coastal Health, 2014: 29-34]. Three sequentially intersecting problems motivate this service delivery orientation and focus: a crises of distributive justice converge with stigmas and exclusions to contribute to a crisis of acute care sustainability. Adjustments to health care service models, therefore, become understood as solutions to larger issues of social inequality experienced by the inner-city poor in Vancouver. But while VCH has been self-reflexive in their relational approach toward more effectively addressing the complex medical needs of many of Vancouver's inner-city poor, their commitment to the suite of services that are understood to foster safe and healing environments, and thus offset or mitigate some of the conditions which influence and drive negative health trajectories in the DTES has been called into question [Lupick, 2016a & 2016b].

6.3.2. Reception

While innovation, engagement and partnerships figure prominently as values animating service redesign, the Second Generation Strategy was initially received with anxiety and suspicion from stakeholders over potential cutbacks and service restructuring.[83] Indeed, the threat of retrenchment was explicitly stated in 2013. VCH explained that it was, "operating in a period of prolonged fiscal constraint. Services provided across the region are being reduced and in some cases eliminated. We are currently taking steps to reduce our administrative costs, with the consequence of job losses" [Vancouver Coastal Health, 2013a: 19]. These declarations appear to confirm anxieties and longstanding grievances that VCH has acknowledged are held by community partners [Vancouver Coastal Health, 2012: 8]. Somewhat predictably, this led to conclusions from within the community that the Strategy is driven by neoliberal logics of austerity. Authors of one critical article wrote that the Second Generation Strategy "signals a shift towards a professionalized, clientelistic, individualist and authoritarian approach that treats people as patients and the neighbourhood as a clinical site rather than a community and a refuge" [Masuda & Chan, 2016: 591]. R3 extrapolated, "that money has to come from somewhere, so other services may have been cut. And there were absolutely contracts that were lost to some service providers."

The existence of these quite legitimate fears about cuts and austere restructuration are acknowledged by VCH as significant obstacles to maintaining effective relationships with community partners and stakeholders.[84] One of the most contentious cuts linked to the Second Generation Strategy was the elimination of the Drug Users Resource Centre (DURC, formerly Lifeskills Centre) that was located on the south west corner of Cordova St. and Dunlevy Ave., across from Oppenheimer Park [Siebert, 2017]. Shaped by the culture of Oppenheimer Park[85], DURC was an almost

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[83] "All the groups I spoke with want to improve their working relationship with Vancouver Coastal Health. Yet many fear it's about to get worse – that Vancouver Coastal wants to cut expenditures and more directly control service delivery" [Vancouver Coastal Health, 2013b: 8]

[84] "Communication, respect and trust are big problems, and that doesn't make for good partnerships." [Vancouver Coastal Health 2012: 10]

[85] "Despite the long historical importance of Oppenheimer park, it is widely regarded today among Vancouverites as a haven for the homeless and addicts to participate in unsightly or unruly behavior. […] its status as a communal gathering space that is welcoming to marginalized people in a way most other public spaces in the city are not." [Masuda and Crabtree 2010: 663] In recent

entirely peer-run drop-in center that offered a range of programing and harm reduction services to the community as well as meals, laundry and showers. Its website, still up at the time of writing, gives a litany of innovative and empowering activities that were offered: "Political Action Group, Jib Users Group, Rock Therapy for Crack Users, Young Users Unite, Women's Action Group, The TRANS Collective, Acupuncture, Cree Class, Drinker's Lounge, Brew Co-op and Alcohol Exchange for illicit drinkers, Harm Reduction 101, First Nations Sacred Space and Drum Group, Music Workshop and Recording Studio, Beekeeping, Women and Men's wellness groups, Homeopathy and much more."[86] DURC also offered a clinic, built a safe consumption room, and notoriously boasted its crack pipe vending machine [McIntyre, 2014]. This service cut was substantial. The loss of DURC remains a touchstone of regret felt by many of the respondents (R3, R6, R7). During the process leading up to the elimination of the program local activist Dean Wilson to proclaimed that, "VCH has blood on its hands" [Siebert, 2017]. The cut was hardly a cost savings operation. PHS ran the facility for $634,000. VCH awarded a new $1 Million per a year contract to the Lookout Society, a longstanding community housing organization with little experience in providing harm reduction services, whose new facility, the Powell Street Getaway, has failed to attain the capacity or impact originally delivered by DURC [ibid]. Perhaps, though, because DURC offered much evidently 'psychosocial' supports that are easily taken for granted by the non-marginal, rather than strictly clinical interventions, its location on the spectrum of the problematic of *'what is health?'* made it an easy service to devalue: "You'd argue that there are some psychosocial issues that are relevant, that are not necessarily measurable in health, but that have an impact. For sure, we agree on that. But that investment should be coming from other budgets, not from the healthcare system. So that's what we've tried to do is realign the investment from health care, to what is primarily our responsibility, which is health care" (R1). This rationality describes a psychosocial pivot that indicates a biopolitic that retracts from life-making practices that work to produce active citizenry (bios), to focus more narrowly on technical valuations of managing pathological bodies (zoê). In this regard, if the rationality of health optimization through restructured investment is to be taken at face value, then it is representative of a deadlock in institutional conceptualization of the interconnected

history Oppenheimer park has been home to two large and long running tent cities [Winter 2020; Zussman and Filippone 2014]

[86] DURC: http://www.durc.rocks/about [Nov. 2020]

nature of the social and biological realities experienced by Vancouver's marginalized. Further, such claims have precedent in the history of Canadian health policy discourses whereby similar rationalities of 'divestment as a means to more efficiently re-invest' have been instrumentalized to "fit well politically with the current mantra of 'deficit reduction' and the downsizing of the welfare state […]" [Poland et al., 1998: 788].

6.3.3. Implementation: what was delivered

Despite extensive reflection and community engagement on the health authority's behalf, the respondents' discussion about the implementation of the Second Generation strategy is varied, with acknowledgment that there was either a lack of clear communication about what had actually changed (R8) or that the strategy itself had failed to come to fruition altogether (R1, R3): "[…] we really haven't delivered on anything."

One of the significant services, however, that was implemented but was also identified as not being well communicated as part of the Second Generation Strategy was the opening of the Connections Clinic, a place where people could have rapid access to methadone prescriptions (R8). Establishing a low-barrier clinic for opioid users to have rapid access to methadone was identified as a priority and fairly straightforwardly attainable goal that was historically frustrated by underfunding and lack of commitment from VCH leadership [Vancouver Coastal Health, 2013a: 23]. In March 2017, Connections Clinic opened at 623 Powell Street. It operates as a drop-in center where people are given rapid access to oral Opioid Agonist Therapy (OAT).[87] The significance of methadone and similar OATs[88] as biopolitical technologies that pertain to specific life-making strategies and sustain biosocial identities cannot be understated. The asymmetries and complications inherent in OAT (and more recently iOAT and

[87] http://www.vch.ca/about-us/accountability/quality-care/service-reviews/downtown-eastside-health-strategy [Sep. 2020]

[88] There is a spectrum of opioid agonists employed in managing opioid use disorders. Some common examples are: methadone derivatives such as methadose and metadol-d; suboxone – a combination of buprenorphine and naloxone; slow release oral morphine (SROM) known as kadain.

TiOAT[89]) are born out through the contrast between the territorial determinations denoted in the expression "liquid handcuffs,"[90] their prophylactic effect of mitigating overdose risk, the aspirations of managing social order and direction of individual conduct by diminishing participation in the illicit drug market, as well as the more commonly known practice of aiding recovery by managing cravings.

Yet, to get a clearer sense of what was actually implemented under the banner of the Second Generation Strategy, the *Theory of Change* document is usefully revealing, because it presents a concise and practical guide to actualized deliverables [Vancouver Coastal Health, 2015a]. It outlines 7 distinct "inputs" that constitute the services VCH sought to enhance, change, or introduce in the DTES. With the corresponding projects that I am currently aware of placed in parenthesis, these are: Low threshold Addictions Clinic (Connections); Drop in Contract (Powell St Getaway, to replace DURC); New Clinic Sites (Heatley Clinic, operating at 330 Heatley Ave. in addition to the longstanding Strathcona Mental Health team); Integrated Care teams (ICMT, ACT, OOT); Embedded Peers (various projects, many funded by VCH but run by a non-profits - especially at Connections, MOPS, OPS, etc..); Housing Contracts (various services); Food Contracts[91] (various services). Along with this, as was discussed with the Nuka model, services offered at existing primary care clinic sites were redesigned to offer expanded capacity, extended hours of operation, better coordination and culturally focused care with access for Indigenous persons to Elders and ceremony.[92]

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[89] Injectable opioid agonist therapy and tablet injectable opioid agonist therapy, respectively.

[90] Because the drugs that comprise OAT are controlled narcotics with the potential for abuse and can be fatal if improperly administered, doses are usually dispensed through some form of witnessed ingestion, often requiring a daily trip to a pharmacy or clinic. Further, travelling, especially crossing borders (both regional and international) with a limited carry script (if your prescriber will write you one), can be both stigmatizing or downright criminalizing. In this regard such treatment is spatially constraining.

[91] Food security in the DTES is a contentious issue. VCH contracts food services for some of its facilities and contracted programs (Connections, CTCT, Onsite and others). The Second Generation Strategy focused on nutritionist certified menus as well as competitive and cost effective contracted delivery.

[92] http://www.vch.ca/about-us/news/news-releases/new-clinic-and-new-model-of-care-on-dtes [Nov. 2020] As a service provider in the area, my perception was that the changes to the clinic model were an immediate improvement. But due to the high volume of demand for primary care, they reached capacity rather abruptly.

6.4. Hindrances

The realization of the Second Generation Strategy was detailed to have been hindered by a variety of complex circumstance that were often indirectly or entirely unrelated to the DTES. Respondent accounts that detail the number of hindrances the strategy experienced varied in relation to their organizational role. Some hindrances were reported to be internal to the workings of the health authority and others arose from unanticipated, black swan type, events.[93] For example, a flood at DCHC during a critical phase of the clinic redesign roll-out was the result of aged infrastructure. This significantly complicated and delayed service implementation. While, the disruption in service was relatively short lived, it does reveal the reality of the long term degradation of material assets and indicates the need for future investment in capital resources, (some of which were detailed to be in development in the previous chapter).

Staff shortages and worker burnout were identified by respondents as factors frustrating service delivery in the DTES. While the articulation of staffing shortages as a result of regional unaffordability is not particularly surprising, the issue of worker burnout is worth discussing because it highlights a significant politics of privilege within the labour hierarchy of the service landscape. R1 discussed challenges of managing a labour force that serves "a very challenged population," and claimed that, "I don't let them work fulltime, even if they want, because I know that over a period of time they will burn out." Here, R1 is talking about physicians[94] – not nurses, social workers, or front-line health care workers, let alone "peers". This latter sprawling heterogeneous multitude must negotiate "burn out" or the associated long-term occupational hazards like post-traumatic stress, chronic anxiety, fatigue, major depression, and emergent or relapsed substance use disorders through direct relations with their employer or via union

[93] A 'black-swan' event is described as the occurrence of an event with a low probability of occurrence, but which exerts significant impact. [Taleb p.xxii-xxiii]

[94] Note that in British Columbia, "the average physician received $284,918 in gross payments from the provincial government in 2015/16—more than five times the annual employment income of the average full-time worker in BC ($55,776). Payments to the average physician (not necessarily working full-time) were significantly higher than incomes of workers in any other health occupation (with non-physician pay averaging $58,114), including nursing ($71,168) and non-nursing health professions ($74,008)." [Longhurst, 2019].

contracts. In considering the power dynamics in governmental rationalities and practices, it is important to recognize the sometimes ambiguous referent of labour class that is being designated when interventions and service delivery in the DTES are being discussed. While physicians and specialists occupy the upper echelons of the service system hierarchy, their labour contribution toward the actualization of deliverables in practices of care is relatively nominal in comparison. Likewise, the figure of the "peer" – originally meant to simply designate someone with a shared set of experiences with which a set of health care consumers might better relate to – has increasingly referred to a precaritized and sometimes tokenistic low-wage labour force comprised of current or former persons who use drugs. While in one respect the biosocial rationality behind peer work is expressly to provide solidarity and enhance inclusiveness in service design for consumers, as well as build economic capacity in the community and some degree of individual financial independence, peer work has increasingly functioned as an alternative or supplement to the higher-paying but often lower-skilled[95] work (i.e. uncredentialed, or requiring little formal education) of program or community health care workers whose job security and material benefits are protected by unions.[96]

Another hindrance to the Second Generation Strategy was discussed by R3 as the re-prioritizing of responses to other demands within the health authority, more broadly, because of new directives from the Ministry of Health, as a result of a change in provincial government from a recent election: "we're part of a bigger healthcare system, so at the same time we're trying to do all this, all of a sudden the Ministry of Health tells us you've got to redesign all your primary care services" (R3). This refers to the larger integration of primary care networks across VCH and the development of Urgent Primary

[95] It is, however, important to note that care-work has historically been undervalued and is a significantly gendered and racialized labour category. Poland et al. note "that in periods of retrenchment […] within the health care system, it is those at the bottom of the status hierarchy within the health care system who are most affected – typically these are the less well paid 'caring' positions in community care, public health nursing, etc. – which are overwhelmingly staffed by women" [Poland et al., 1998: 787]. See also, Pratt's discussion of Philippine women in domestic care roles in Canadian households in both contrast and comparison to missing and murdered Indigenous women in the DTES [Pratt, 2005].

[96] It should be noted that a number of the peer workers with PHS Community Services voted to unionize, though the attempt to do so was challenged by the organization [St. Denis, 2021a]. This issue is quite complex and should be a subject for future research into stratification and asymmetries in social mobility. Certainly some benefits and inclusions will be enabled through this arrangement. Access to particular kinds of care, and a number of other opportunities such as flexible and accommodating labor arrangements that factor diverse range of capabilities, however, will be foreclosed.

Care Centers in key locations across the city.[97] Much like the Second Generation Strategy more generally, the goal is to alleviate burdens on acute care services by providing better (i.e. preventative) primary care and creating more accessible 'urgent care' (viz. non life-threatening issues) resources in neighborhoods across the city. This demonstrates the contingent and changing nature of community health service planning, especially as it functions relative to changes in elected Provincial Governments.[98] The health issues in the DTES, in this context, are a fraction of a number of competing regional issues that vie for resources across the health authority's spectrum of services. This demonstrates how resource scarcity and competition of interests affect local spaces and planning. It also makes clear that the longer-term viability of the acute care system in Vancouver is not simply a function of the burden wrought by urban poverty and illicit drug use in the DTES.

A number of respondents identified that a series of leadership changes over a period of time obstructed consistency of vision and created incongruity in the Strategy's overall goals (R3, R6, R7, R8): "if you were to ask me, or even our CEO, or a board member, what's happened with the DTES Second Generation Strategy, they might not be able to tell you where it's at" (R3). While the accounts of leadership change indicate conflicting or inconsistent values within the organization, they also reflect that goal-frustration can occur as a result of mundane and contingent circumstance such as break downs in communication, stifled momentum, shifts in focus, and staff turnover or reassignment: "the person who was leading it at that time left and a new person came in, new directors got involved" (R6). Such a series of events showcase the "contingently failing" realities that befall practices of government and programs of management from the inside [Miller & Rose, 2008: 71]. R7 alluded to the fact that many budget and politically sensitive policy makers still endorse more fiscally or socially conservative thinking when it comes to issues like poverty and substance use. As much as universal health care is understood to be driven by evidence-based practice and economic compromise, it was reported that there remain deep ethical and political sentiments which inform policies that structure disparities in life-making practices: "where some

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[97] Urgent Primary Care Centers: http://www.vch.ca/your-care/urgent-and-primary-care-centres https://news.gov.bc.ca/releases/2020HLTH0280-001735 [Nov. 2020]

[98] This redesign is the result of an new initiative from the BC NDP party that succeeded the Liberals in 2017. See https://news.gov.bc.ca/releases/2020HLTH0280-001735 [Nov. 2020]

people wanted to see it [Second Generation Strategy] go, there wasn't really the appetite. […] how people see that neighborhood and what should happen there, I think, is divisive. It's divisive" (R7). Divisiveness about service planning in the area can be attributed to a number of factors: competing rationalities about appropriate use of health resources and funds, apprehensions over the circulation of people into and out of the area and the increasing agglomeration of services; political pressure from developers and enfranchised community members (viz. tax-payer lobby groups); pressure from the police; and, individual moral perspectives that see harm reduction and low-barrier services as enabling vice.

Indeed, adding to the admitted divisiveness in governmental rationalities of the DTES's service landscape was the forensic audit of the PHS Community Service Society in 2014.[99] R3 reported that the audit and the events that transpired as a result, created a climate of scrutiny by the health authority and exacerbated existing tensions and sentiments of distrust by VCH toward partnered or contracted service providers. This is understood to have set back the collaborative focus of the strategy, as well as amplified the divisive sentiments from the public toward service interventions in the area: "I think it stopped the process of thinking about how we can engage our non-profits in a different way, and led to, actually the opposite: we need to make sure our contracts are more accountable and do more audits of them, more language in there, legal language, to hold them to account because of that audit" (R3).

The audit is a significant event in the history of DTES politics. Following tactics of the Harper-led federal Conservatives at the time, that aggressively audited non-profits and charities they ideologically opposed [Beeby, 2014] [100] after the discovery of financial irregularities, the Government of British Columbia threatened to place the PHS in receivership, if their senior leadership team did not immediately resign.[101] The audit's revelations were widely covered by the press in a manner designed to stoke public

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[99] The elimination of the DURC program, under the auspices of the Second Generation redesign, has been understood, in some circles, to be punishment of the PHS by VCH owing to the results of this audit.

[100] The ruling United Conservative Party in Alberta recently used the audit-as-weapon tactic to close the busiest safe consumption site in North America. See [Anonymous, 2020].

[101] Liz Evans, one of the society's founders and moral figurehead, claims to have been told by BC Housing CEO Shayne Ramsay, "The Portland is going to be dismantled. We're going to burn the village. Unless you all leave." [Lupick, 2017: 361]

outrage to sell an image of the organization's founders and executive management team as corrupt actors who expropriated tax dollars intended to serve the vulnerable and marginal for their own gain [cf. Bula, 2014].[102] Yet, at the time the PHS was well known regionally and internationally for its activism around poverty and harm reduction. Protests that surrounded possible funding cessation for the New Fountain Shelter and the actual defunding of the sole women's-only recovery program in the DTES, located at the Rainer Hotel, are reported to be critical events that catalysed the BC Liberal Government to pursue the removal of a group of long-time political antagonists [Lupick, 2017: 330-339]. A VCH director reported that the removal of PHS leadership was less likely a consequence of those specific actions, as much as it was due to a new executive leadership team at VCH refusing to tolerate belligerence from a non-profit they fund and partner with [Lupick, 2017: 367]. In a premonition of what was to come, The Second Generation *Discussion Paper #1* states that the PHS "has achieved great things but does not always play well with others" [Vancouver Coastal Health, 2012: 12]. The effect of all this has been a prolonged crisis in executive governance within the PHS.

At this point, I must acknowledge my specific position and bias towards these events. I worked nights at the New Fountain shelter during the first round of possible funding cuts. I have actively voiced my opposition to the withdrawal of funding for both programs. To further speak to the concerns raised by defunding the program at the Rainer, for the past five years, I have managed a withdrawal management and early recovery facility. The overall deficit of accessible low-threshold services for people seeking respite, stabilization or recovery from problematic substance use, as well as the availability of a spectrum of long-term safe and supportive environments is nominal. The dearth is compounded for women, persons of colour, and youth as well as the LGBTQI and indigenous communities. The reality of this situation, for women specifically, initially appears to have been lost on VCH leadership. "Women's Health and Safety in the Downtown Eastside" (2016) and "Downtown Eastside Women's Health and Safety Strategy" (2019) were released as companion documents to the original *Second Generation Design Paper* several years after its release and take up issues initially

[102] Evans states that, "I was told, pretty directly, that the government was just fed up with us fighting for things and embarrassing them and making them look bad. […] I was told by bureaucrats within VCH and BC Housing and not just once but many times." [Lupick 2017: 366] Evans was one of the key figures in the fight to open Insite, which at the time of its inception it is noted that VCH had little interest in supporting [Lupick 2017: 259].

omitted in the earlier papers. The fact that such an oversight occurred is indicative of a dominant set of patriarchal presuppositions (that is, the assumed neutrality of a generic observer relative to the subject matter) around how health is framed and for whom. Speculation around the value-neutrality of evidence-based technical interventions aside, as will be discussed further in the next chapter, policy makers continue to evidently remain challenged to effectively respond to or more robustly address women's issues in the area despite longstanding and ongoing concern for women's health and safety in the DTES.[103]

Finally, the Second Generation Strategy was substantially obstructed and significantly overshadowed by the poisoned supply of illicit drugs that currently generate the overdose crisis sweeping across North America. Precipitated by the adulteration of the illicit drug supply with the highly potent synthetic opioids fentanyl and carfentanyl, the volume, complexity, and acuity of overdose symptoms as well as the proliferation of sudden deaths amongst drug users in the area, compelled the health authority to abruptly refocus its priorities in late 2016. The Mobile Medical Unit (MMU), described as a "high-tech hospital on wheels,"[104] was deployed for a time to the lot at 58 W. Hastings, functioning as both an ominous gesture to acknowledge the reality of the unfolding calamity as well as an effort to offset the potential burden of triaging recent overdose victims in the emergency department at St. Paul's Hospital [Baker, 2016]. Urgent response from the health authority initially came in the form of permission: non-clinical workers could administer naloxone and oxygen to people presenting with overdose symptoms. Community-initiated overdose prevention sites were first tolerated and then indefinitely funded [Lupick, 2016c]. However, deaths from overdose in British Columbia had been consistently rising as of 2012[105] and, from personal experience, had sharply intensified in both frequency and presentation in the spring and summer of 2014. That a public health crisis was declared two years after a dramatic rise in overdose suggests an inattention to crisis conditions that had not gone away, but rather abated and then intensified as the potency of unregulated supply increased. In this sense the rightful

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[103] Two recent news-worthy incidents that highlight this reality. On April 23rd 2020a, woman gave birth alone in a portable toilet on the corner of Main and Hastings, the infant was found deceased by passers by [Crawford, 2020]. Recent video has emerged of a man apparently sexually assaulting a woman on the north east corner of Main and Hastings in broad daylight [Bramham, 2020a].

[104] http://www.bcmmu.ca/ [Jan. 2021]

[105] http://www.bccdc.ca/about/news-stories/stories/public-health-emergency-in-bc [Jun. 2021]

emphasis on the HIV epidemic as crisis of contagion, along with pervasive moral predispositions towards mental health, and drug use eclipsed the discrete but endemic harms of an unregulated illicit supply.

6.5. Conclusion

The Second Generation Health System Strategy is a significant event in the history of the biopolitics of the DTES. As a formalized rationality intended to effectively reorient health services in the area, it serves as a conceptual break and a new point of reference to contextualize life-centered practices of government. It was reported that policy mobilities informed particular attempts at inclusive practices of subjectification to both attend to complex individual medical needs and longstanding deficiencies of care throughout the community, as well as means to buttress efforts intended to maintain the sustainability of the city's acute care sector. Efforts to enhance collaborative relations with contracted community partners was identified as a longstanding goal, but remained variable and challenged as a result of mistrust owing to a substantial audit of a key nongovernmental organization, fiscal restraint and emphases on clinical interventions that tend undervalue the role of environmental and social factors in shaping health outcomes. Many respondents stated that they believed that the Strategy either had stalled or failed. However, redesign and enhancement of primary care, especially with a focus on Indigenous specific services, and the opening of a methadone clinic were identified to be principal deliverables that were realized. While in some respects it was understood that the Strategy served as a speculative forum for developing innovative practices, respondents identified that a number of initiatives were hindered in their realization as a result of a regional labour shortage, a degrading built environment, a larger scale health system redesign as a result of a newly elected Provincial Government, internal leadership changes, a crisis of governance within the largest nongovernmental organization in the area, and the crisis conditions generated by a highly adulterated supply of illicit drugs. The context presented in this chapter demonstrates how contingency affects and structures planned practices of governance, often in sub-optimal ways. From this, I now turn to examine how values influence the relationship between knowledge and practical activity in life-centered government in the DTES.

Chapter 7.

Knowledge/Practice

> …both life and death are political concepts […] because they underlie the articulation between a scientifically conceptual space, and a political space which is no longer solely defined by sovereign decision. [Paltrinieri 2014: 35]

In this chapter I examine how asymmetries in knowledge and practice give form to a range of possible life-making strategies and capacities in and around the DTES. My aim is to decentre narratives that pertain to the primacy of technical knowledge as the ultimate factor in determining the actualization of service and care, and instead render intelligible a service landscape that is sustained by a biopolitics of uneven value-practices. Health care interventions are structured by both techno-scientific knowledge practices as well as a range of ethical, political and social values. Values can refer to what communities or persons want or what they believe they are due, as well as the scope of obligations understood or assumed to be entailed in interpretations of the social contract by elected officials or administrators who direct budgets, mandates, and resources. In this chapter I introduce the central problematics of a biomedical politics of knowing and practicing that operates in the DTES and its adjacent spaces. I then examine the problem of speed and timeliness of response to crises as a function of knowledge translation. From the latter I consider data collection as an objectivist knowledge practice that contrasts with subjectivist positions of qualitative accounts of well-being. I close the chapter with an analysis and comparison of two divergent modes of crisis response that relate to interventions that address mental illness and the overdose crisis, respectfully.

7.1. The problematic between Public Health and Direct Service

In this section I explore the biopolitical problematic of individual care and population health by examining elements of a key passage from my conversation with R2. The framing of circumstance here articulates an important dynamic that is structured by competing value rationalities within the health authority as they relate to the politics of service delivery in the DTES. R2 described that health initiatives in the DTES are funded and operated through two different divisions within VCH: Community Care (what R2 refers to as direct service) and Public Health. A large portion of the harm reduction services in the area are funded and resourced through Public Health (for example, Insite and the overdose prevention sites) whereas primary care clinic sites in the DTES operate through VCH Community Care. R2 claimed that an over-emphasis on population health initiatives might work to neglect the specific needs of individual health care consumers. The relationship between the two divisions with regards to duties to provide care and sustain service allocation is described as complex: “I think it’s still very entangled. It is something, I believe, that we haven’t actually worked out yet.” Debate amongst clinical practitioners, between prioritizing treatment for substance use disorders and resourcing harm reduction initiatives, was described as an intricate and nuanced issue that cannot be easily collapsed into an either-or binary, and their mutual relevance and plasticity in design was affirmed: “I think the answer is in embracing both. I don’t think there are any rules that stipulates how you would embrace both.” R2 then explained that the manner in which services and interventions are actualized have substantial political dimensions: “direct health care is less politicized […] Because it’s what’s known and the treatment paradigm is well established. But, Public Health are always responding to a crisis.” Because of this governments will often issue VCH targeted funding that can only be allocated to particular kinds of initiatives: “often, the type of initiative is directed in terms of what you can and cannot do. And that might be disconnected with what people who are working on the ground believe should be the best for the clients, particularly people who have worked with the population for a long time.” R2 then claimed that many governmental decisions around actualizing harm reduction initiatives are done without sufficient evidence to support their efficacy, which has reportedly led to confusion by a number of local clinical practitioners. The conclusion, then, was that: “even though public health and direct services [are] within the

health authority… its strings are being pulled from different sources, right? So, that becomes very messy and not coherent."

R2's claims above elucidate a localized instantiation of the governmental problematic expressed in the quote from Paltrinieri at the introduction to this chapter – the relationship between scientifically validated technical expertise and political decision making as they relate to the management of life. The claim presented, then, is about the proportion and scope of force that particular kinds of values exercise on decision making in the allocation and administration of care in the DTES. Values here can be parsed into the analytic distinction between epistemic-values – values that pertain to optimal criteria and categories used in scientific research ("features of theories like simplicity and coherence and scope") and non-epistemic values (moral, political, cultural, aesthetic) [Stegenga, 2018: 130 – 131]. From a strictly Evidence Based Medicine (EBM) perspective non-epistemic values should not play a role in properly scientific investigations. This is called the "value-free ideal" [ibid].[106] But the value-free ideal is simply that – an ideal. On the public health side of the current "opioid crisis" the reality of the matter has been determined by the urgent need to provide life-saving care and to rapidly implement interventions that will significantly off-set harms[107] and limit deaths due to a polluted supply of illicit drugs. The complexity and urgency of concrete circumstance in the crisis-context of a polluted drug supply and the proliferation of severe life threatening overdoses as a new baseline for community existence make the value-free ideal an unobtainable burden for adequately responsive solution-focused rationalities. Yet, there is a further political dimension to this story, because at the center of much community-based harm reduction activism and practice there is an ethos and politic of bodily autonomy surrounding the right and freedom to safely consume drugs independent of the stark choice between clinical interventionism or the risk of death [cf.

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[106] The most substantial challenge to the value-free ideal in medical science and policy making is *the argument for inductive risk*, which aims to demonstrate that non-epistemic values are unavoidable in most scientific reasoning. "For science that has clear non-epistemic impacts, being 'value-free' is not a laudable goal. […] Inductive risk […] is the chance that one will be wrong in accepting (or rejecting) a scientific hypothesis. […] when non-epistemic consequences of error can be foreseen, non-epistemic values are a necessary part of scientific reasoning." [Douglas 2000: 560-1, 578; see also Stegenga 2018: 131-134]. The crucial claim in this line of reasoning is not simply that non-epistemic values are unavoidable in most scientific endeavors, but that the value-free-ideal is itself largely undesirable.

[107] Notably, the potential hypoxic brain damage sustained by survivors of overdoses, but also the trauma and grief that follows and is compounded after such incidents should not be understated as a legitimate harm in-itself.

Hart, 2021]. In this regard, appeals to technical expertise and legitimation of activity through EBM work to obfuscate the political dimensions that inhere in refusals to fund, grant permission, or resource services. Assent to the presumed neutrality of facts masks the values that structure the intentions which actualize or deny resources and capacities. Biomedical expertise therefore does not occupy a position outside of politics, rather it is a particular mode of power that structures various forms and instances of knowledge based governance.[108]

In the account above, the relationship between what I refer to as the *domain of intervention* and the *rationalities of health* are problematized, insofar as the problematic nature of their relationship is intensified [Koopman, 2013: 100-101]. This problematization is structured through five dualities: three that correspond to the field that I name the *domain of intervention* (the object of intervention, the intervention platform, and technologies of intervention), and two that correspond to the field I call the *rationalities of health* (how health is defined and how health is known). The dualities, as R2 explained in relation to VCH services in the DTES, are not either/or choices, but operate in varying degree and proportion across all fields of health care. Below are the dualities that give form to the problematic outlined by R2:

Domain of Intervention:

1) Object of intervention: Population – Individual

> Are the health interventions intended to be generically applied to a target population as a whole or uniquely tailored for specific individual needs? This is a basic dualism that operates between 'the one and the many.' (Recall, similarly, the biopolitical distinction between the anatomo-politics of individual bodies and population strategies.)

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[108] One historical commentator has written: "My concern is not with positivist, as one approach to knowledge development, so much as with its underlying assumption that its research can be value-free and factual, generating causal laws that can, or should, be generalizable for all people in all situations at all times. This assumption historically arose with, and reinforces, the 'power-over' technical rationality of the state. This is the very rationality that health promotion, in its emphasis on 'starting where the people are,' challenged as disempowering. It risks telling people that the statistics gathered, analyzed and used by state officials are hard, objective and true, while their own lived experiences and how they name or explain them are soft, subjective and opinion" [Labonte, 1997: 15].

2) Intervention platform: Public Health – Community Care

Public Health and Vancouver Community are divisions internal to VCH that both provide and fund services within the DTES. Which one does what is generally, but not necessarily, a function of the object of intervention: population or individual.

3) Technologies of Intervention: Harm Reduction – Treatment

In VCH service delivery in the DTES, many of the harm reduction initiatives are directed and funded through the public health division. Often colloquially thought of as oppositions, harm reduction and treatment interventions can and do co-operate across spectra of care and at varying scales relative to populations and individuals. It is however important to note that prohibitionist and abstinence-oriented values are the dominant forces shaping the biopolitical landscape of drug policy globally. Both terms, 'harm reduction' and 'treatment,' designate complex and contested sets of practices, values and rationalities. At their poles, an advocate for harm reduction might claim that harm reduction is treatment[109] or that any effective treatment is not possible without incorporating harm reduction practices (positions that I endorse), whereas proponents of conventional substance use and orthodox addiction treatment might maintain that strict abstinence and prohibitionist measures more effectively reduce harms because they eliminate the harmful substance, and by implication associated behaviours, altogether.

Rationalities of Health:

4) Rationalities of Health (a): Naturalism – Normativism

The terms naturalism and normativism refer to *what* factual states of affairs are designated as health. Naturalism, referred to as a "negative" conception of health, is the position that definitions of health are "value-free" insofar as

[109] Consider the common adage: someone cannot "recover" from addiction if they are dead. Here it is also important to recognize the highly variable – individual and context dependant – nature of what the term "recovery" designates in the context of problematic substance use. Prohibitionist discourses tend to fetishize states of recovery through reductive models of abstinence-based conduct.

they are a function of biological and physiological properties (health as absence of biophysical pathology) [Stegenga, 2018: 8-9]. Conversely, normativism is defined as a "positive" conception of health, where overall well-being and quality of life are considered the primary markers of health [ibid: 11-13]. This distinction has significant ramifications for how access to care and investments in services are legitimated and valued – especially in contexts referenced as cultural, psychosocial, or environmental.[110] Likewise, there is a correlation, but not equivalence, between these terms with the biopolitical concepts of Zoê (basic physicality of life) and Bios (cultural, social and political dimensions of agential life).

5) Rationalities of Health (b): Objectivism - Subjectivism

Objectivism and subjectivism refer to *how* factual states of affairs that pertain to health are determined [ibid: 19]. Objectivism privileges third-person evaluations and accounts of health. An external examiner's assessment of circumstance is prioritized in determinations of health and well-being. Medical paternalism and non-consensual practices of care, for instance, are animated by objectivist perspectives. Subjectivism, conversely, prioritizes first-person accounts of distress or well-being in health [ibid: 19]. The presentation and state affairs of one's physiological constitution are (largely) irrelevant to reports of individualized claims of well-being. Objectivism and subjectivism are not analogous or equivalent to naturalism and normativism [ibid]. The former are diagnostic, whereas the latter are descriptive. In the context of this project, objectivist normativism (the position that overall well-being is valued, "but that whether or not a state in fact does this is to be assessed from a third-person perspective" [ibid: 19]) is especially common in practices and power dynamics related to mental health, harm reduction and supported housing in the DTES. Objectivist normativism then is a way of knowing that significantly shapes both the social and cultural life world (cité) and built from in the neighborhood (ville).

[110] In my reading of it, the argument for inductive risk would indicate that given medical science's clearly significant impact on the non-epistemic domain of lived reality that normativism be assigned priority in determinations of what factors constitute health for both individuals and populations.

In R2's account above, dualities 1, 2, and 3 are explicitly discussed, whereas 4 and 5 are contextually implied. How these conceptualizations are aligned and expressed through the concrete circumstance of practices, resource allocation and service delivery, structure the field of possible life trajectories in the DTES. As R2 makes clear, their description of affairs as "still very entangled" is not an argument for or against harm reduction or public health over community care. It is a claim that how these elements operate in proportion to and with one another will determine who and what are included and excluded from a range of life-making practices. How the elements of the domain of intervention interact is a function of how scientific knowledge, in this context the rationalities of health, and (non-epistemic) values are synthesized. This problematic remains a substantial biopolitical dynamic that animates and structures activities of allocation, capacities for access, and permission to practice specific activities in the DTES (and elsewhere) because the emergent and contingent nature of the social and material space forecloses any possible resolution. Services and interventions, so long as they are maintained as a public good (i.e. democratically valued and designed to be universally accessible) will continually have to reconfigure and adapt in varying proportions to an ever-changing set of circumstances. How this occurs will depend on how scientific knowledge and ethical, social and political values are allocated priority in their interaction. Indeed, various arrangements of such priorities of interaction in relation to concrete circumstance can be observed in the speed or timeliness of response to conditions of crisis by the health authority.

7.2. The problem of response speed and knowledge translation

The concept of crisis usually implies the need for some kind of urgent activity. The speed or timeliness of response to crises in the DTES from VCH are instances of power dynamics that involve the intersection of knowledge production and values, which work to actualize, prohibit or impede capacities to perform interventions or access care. Both R1 and R2 identified a lag in response to crises in the DTES from the health authority as a function of how particular kinds of knowing are used to legitimate action and services. R1 discussed being involved in direct care during the late 1990's when the DTES was beset by a sudden and massive increase in HIV positive cases: "we were seeing a problem and we were sounding the alarm, but it took a while for the system to

react." Similarly, R2 explained that the process of knowledge-translation that affects change in practices of service delivery can often take between 10 and 15 years, but that such discrepancies are clearly not effective when confronting the immediacy of an unfolding crisis. Witnessing alone, in both respondents' accounts, is understood as an insufficient knowledge practice. This politics of legitimation of knowledge-power was directly addressed by R1 in the context of resource allocation and capacity for action granted to non-profits that provide frontline services in the DTES: "obviously you are at the front line, they are at the front line, so they are seeing things that we are still not seeing." R2 suggested that the health authority develop a means to rapidly "conduct small experiments to see if a certain initiative has efficacy," and concluded that "there's actually not much innovation that's occurred," in response to the current crisis landscape. In this account the health authority is slow to respond appropriately because its capacity to collect and interpret information is slow. R2's statement about a knowledge translation mechanism is made in reference to the current context of the overdose crisis, but also serves as a general statement about how the health authority evaluates facts about the world and translates them into practical activities. Response, as contextualized by R1 and R2, clearly denotes activity undertaken in reaction to medically adverse states of affairs. But response is not simply directed by an impartial scientific perspective that discovers pathologies in the world that then works to rectify them once the appropriate facts have been established. What alarm is being sounded? Who sounds the alarm? For whom is it being sounded? Who listens? These all depend on interactions between pre-established values, norms, conventions, available resources, and various ways that forms of knowledge and knowing are validated.

The form (technology), scope (space and population), and speed of response (rate of implementation of intervention) to crises can be understood to significantly depend on the manners in which objectivist and subjectivist epistemologies interact with naturalist or normativist conceptions of health in order to contextualize a given problem. For example, through interventions directed at HIV and hepatitis C, as a means to stop and control the spread of specific pathogens, a particular kind of objectivist naturalism was used by public health (platform) to justify the implementation of harm reduction initiatives (technologies) [Boyd, Carter, MacPherson 2016: 103]. This particular rationality's object of intervention is the biological integrity of the general population, and crucially structures the prevailing "epidemic logic," discussed prior in the Context chapter

that Sommers' predicates of the interventionist practices begun in the DTES in the late 1990's [Sommers, 2001: 257]. Subjective accounts of individual or local states of well-being are either secondary or irrelevant to the biological constitution of a mass of human organisms, which then may or may not be considered a risk to the health of the greater population by potentially spreading a bloodborne contagion. This line of reasoning, then, also helps explain both the lag and deficit in harm reduction focused services available to address the needs of people who drink (especially non-beverage alcohol) or who smoke drugs. R3 was emphatic on the VCH's failures to properly supporting individuals with alcohol use disorder: "We do a terrible job for alcohol use disorder! So, we're putting all of our funding into opioid treatment, we need to also provide some money for programs for people with alcohol use disorder, because they're dying of opioid overdoses!" My position is not that one way of rationalizing health is *necessarily* better or worse than another, in itself. Rather, my point is that how specific rationalities are employed in relation to a given health problematic will work to produce specific states of affairs and exclude others. The example of an appeal to an objectivist naturalism to justify harm reduction initiatives, on the basis of epidemiological modeling, contrasts with the immediacy and intimacy of the direct lived experience of witnessing (mentioned above by R1) to demonstrate the variable and unequal ways that particular kinds of knowing are valued and inform kinds of life-making. In the section that follows, I proceed to consider some of the basic problematics and asymmetries that exist between objectivist and subjectivist forms of knowledge as they pertain to health initiatives that relate to the DTES.

7.3. Objectivism and Subjectivism

7.3.1. Data collection as an objectivist knowledge practice

In the current context, objectivist knowledge practices are understood simply as matters of fact arrived at through third-person accounts of affairs. R1, R7 and R8 identified that objectivist knowledge of facts, that operate at a population-scale, about neighborhood health are complicated by the inadequacy of the data collection mechanisms used by VCH. This deficit in data collection makes it difficult to gain accurate knowledge about the nature of local and more general states of affairs: "anybody in health care in BC will tell you that data is our Achilles-Heal – we have shit

data systems. […] and we have, like, 20 of them and they don't talk to each other" (R7). R4 described the historical circumstances that occasioned the disjunction amongst data systems as being the result of the local applications of systems for site-specific needs, rather than larger-scale information gathering across the system as a whole. R8 further contextualized the deficits in data-gathering as a result of the fact that most of the systems are designed to serve hospitals and acute care services, but "don't translate so well into the community sector." R1 similarly expressed frustration at this state of affairs, "these are things that we should be doing right now, as a system, but we haven't," and noted that there is an effort under way to transform the data processing systems.[111]

Similarly, R3 discussed generic blind spots in knowledge production across health services. Service providers are often limited by having access, primarily, to the data generated by populations already known to them. This leads services to only "operate within their walls" and to not "think more broadly about the community in which they reside and the population they serve." Opening a new service that differs from existing models, however, can change the health authority's knowledge of the population because other people might access the service: "when we opened Insite, all-of-a-sudden people appear." Specific services, therefore, affect what kind knowledge is produced, which in turn affects how services are rendered. This can be called institutional bias. This institutional bias exposes the dense entanglement of an entity's constitution (in this case, a health authority) and the objects it interacts with (individuals and groups of people). How an object is known here is primarily a function of how it interacts with the institution. Yet, this also reveals a particular power dynamic in the field of health care consumption because it exposes the reality that some people will not or cannot access care because of the way that certain services are designed and performed. What R3 refers to as "Illness care data," provides a limited picture of circumstance, and skews inferences about the broader social and environmental contexts that might influence conditions that drive the use of heath care resources. VCH attempts to offset this deficit through the use of vital statistics and surveys – information that would not normally be gathered as a result of the course of their regular operations.[112] Through this kind of data

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[111] The commitment referred to by R1 is called the Clinical and Systems Transformation Project (CST), and is listed in the VCH Service Plans at a cost of $282 million, with an expected completion sometime in 2020. https://cstproject.ca/ [Oct. 2020]

[112] A survey of note is the *My Health, My Community* "The central objective of the Canadian Community Health Survey (CCHS) is to gather health-related data at the sub-provincial levels of

gathering R3 described how VCH was able to demonstrate that, before the current opioid crisis, the life expectancy of DTES residents had improved. This improvement is reported to have been accomplished through the twin strategies of implementing harm reduction services along with making antiretroviral therapy available to HIV positive drug users: “for a while people with HIV who are injection drug users didn’t get treatment” (R3).

For individualized care, however, there are systems that enable effective and rapid data sharing. One of the information systems that VCH uses across their spectrum of services is called CareConnect, established prior to and independent of the Second Generation Strategy. The VCH website describes CareConnect as a “view-only Electronic Health Record [that] offers healthcare providers access to an integrated, provincial view of patient-centric information.”[113] R4 reported that the goal of this system in managing and prioritizing individual client care is to enable the provision of immediate and consistent health information across the spectrum of care providers in the area – from hospitals to VCH community services to private fee-for-service providers.[114] In relation to the problematics of health in the DTES, R4 described that CareConnect can be especially useful: “if someone has a crisis in hospital, that their community partner can actually respond to that and do some crisis prevention, rather than waiting for a fax that may or may not get caught.” In established clinical settings, this system provides a consistent set of objective information about individuals that enables more comprehensive and rapid responses to their medical needs.

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geography (health region or combined health regions).” https://myhealthmycommunity.org/ [Feb. 2021]

[113] http://www.vch.ca/for-health-professionals/resources-updates/careconnect [Oct. 2020]

[114] “One health care provider working at a Downtown Eastside health clinic explained to me that she is aware that no one likes the ‘Big Brother’ system of constant surveillance where people are carefully tracked and monitored through new techno-scientific electronic systems” [Elliott, 2010: 191]. Eleven years later, however, the ubiquity of surveillance capitalism should make clear that it is not simply that one is tracked, but by whom and for what ends? Here, admittedly flawed and limited biomedical data-harvesting and surveillance as governmental strategies that attend to the vital capacities of Vancouver’s marginal and poor might be juxtaposed or contrasted with programs for smart-city planning and emerging social credit systems whose goals are envisioned as total control. Indeed, it is possible to make the opposite argument: deficient data harvesting and digital surveillance tools indicate how undervalued this population is, because they are not tracked enough.

Conventional objectivist data collection is understood, therefore, to be largely limited to health care consumer interaction with established systems and services, and therefore much more focused on bio-physical dimensions of health and well being. How that translates into capacities for activity and service provision depends on values internal to the health authority and the values that structure its Government issued mandate. However, kinds of first-person and situated accounts from outside VCH are acknowledged by the respondents as important but often undervalued and contentious sources of knowledge which can work to guide and structure the authority's operations.

7.3.2. Under-valued knowledge practices: the problem of the subject

The issues of women's health and community engagement are two examples of how qualitative data relates to asymmetries of life-making practices in the DTES. I contend that qualitative forms of knowledge production are more directly linked to value rationalities sustained by subjectivist and normativist conceptions of health, and as such work to structure moral and political existence (bios) in specific ways. Knowledge practices that have been historically and conventionally undervalued by medical institutions have the possibility to disrupt, reorient, and inform dominant rationalities of health practices as well as shift the spectrum of criteria that shape health care problematics and enable different kinds of life making.

Women's health

R7 reported that qualitative data gathered about the specificities and differences that pertain to women's gendered experiences is not valued by many planners and policy makers at VCH. Rather, because the available data indicates that men have higher incidence of negative health outcomes in the DTES, VCH has shown reluctance to invest in women-specific strategies. R7 attributed this directly to an understanding that qualitative data, which reports differences in women's experience of health, is not considered a sufficient mode of knowing to merit action and resource allocation: "There's so much qualitative data in the world that demonstrates the kind of lived experience and different, very gendered, health-based, lived experience of women – Indigenous and

non-Indigenous[115] – in the DTES. That body of knowledge is thick, and we've written a paper summarizing it, and tried to put it on power-points in various different ways, and one-pagers… trying to make this case. But it's hard to make the case in the way that it's understood and valued by a health authority."

Recall the discussion about the generic perspective (mis)guiding norms of health policy rationalities in the Second Generation chapter. If this statement is read in the context of the statistics around overdose deaths wherein men within a specific age group have a higher risk of dying, the case seems (albeit somewhat naïvely) clear.[116] But consider this quote from Anne Livingston in *Discussion Paper #3*, where she writes about the harms of being over policed, "For women in particular, warrants for minor offences put them at risk because the possibility of arrest prevents them from seeking help when they need it and allows them to be exploited" [Vancouver Coastal Health 2014: 31]. Indeed, this claim is supported by recent qualitative analysis of the effects of over-policing of DTES residents: "Indigenous and racialized persons, particularly Indigenous women, are disproportionately impacted by street checks (i.e. the stopping, questioning, and recording individuals when no specific offence is being investigated). […] the risk of punitive repercussions weakens the effectiveness of public health intervention" [Collins et al, 2019: 205]. The disconnect appears to be in the health authority's inability to robustly consider gendered variations in experiences of the social determinants of health in as serious a manner as it should. In this context an objectivist naturalism toward data that represents the basic physicality of persons and population (zoê), rather than the intricacies of their social being (bios) are given priority of value, and is reflected in the asymmetries of the life-world of the urban space (cité). This demonstrates the limits and kinds of fallibility that objectivist perspectives are susceptible

[115] Consider, conversely, an objectivist naturalist position: "In a review of coroner case files for illegal drug overdose deaths of individuals in B.C. between 2001 and 2005, it was found that Aboriginal peoples were overrepresented and Aboriginal women were more likely than Aboriginal men to die. The place of death for Aboriginal women was most likely to be the Downtown Eastside" [Boyd, Carter, & MacPherson, 2016: 34].

[116] "Over 4,000 British Columbians have died of overdose since the start of 2016. More than 80% of people that died were men, mostly aged between 30-59." https://www.stopoverdose.gov.bc.ca/theweekly/why-are-so-many-men-dying-overdose [Jan, 2021] Consider that in 2019 the DTES had the highest rate of overdose death (>100) per 100,000 than anywhere else in the province. http://www.bccdc.ca/resource-gallery/Documents/Statistics%20and%20Research/Statistics%20and%20Reports/Overdose/Illicit_Drug_Overdose_Death_Maps_2019_by_CHSA_No_Counts.pdf [Jan, 2021]

to as they often miss or ignore larger social contexts, amplify institutional bias, and – in this instance - discredit the voices of marginalized women. However, it is important to recognize, in the context presently being discussed, the fact that public policy briefs and VCH directors both acknowledge this state of affairs. This admission by VCH, in both formally published documents and through confidential interview contexts, reflects the health authority's nominalist constitution as the sum-total of a complex networking of agents, actions and exchanges, and thus exposes some of its internal conflicts and animating asymmetries in the planning and delivery of care.

Community engagement

R3 reported that community engagement and consultation initiatives across VCH communities of care - despite being lauded as effective, but still nonetheless underused, practices in the Second Generation Strategy - "have almost all been eliminated." This was described as a result of cuts, a prevalent emphasis on clinical or biologistic aspects of care, and a shift to more abstracted forms of consultation composed of patient representatives on committee boards across various ministries. R3 exclaimed that this current arrangement is "not meaningful community engagement," and went on to note a prevalent paternalism in community or population-focused knowledge-practices by the health authority: "we think that services in the DTES […] 'we need to provide x, y, and z,' and it's often very oriented towards a medical model. That may not be what the community wants." The withering and devaluing of community consultation functions to further cement a technical paternalism that is guided by a generic perspective of presumed neutrality (via objectivist naturalism or normativism). The loss of frequent community advisory committees is an indicator of the erosion, more generally, of practices of social democracy performed by public institutions, likely as a result of emphases on cost-efficiency measures in service delivery that structure obligations to promote well-being in narrow and highly medicalized ways. Such omissions have a significant impact on life-making practices because they indicate either a presumptuousness about or indifference towards other modes of valuation and forms of service conceptualization beyond generic clinical perspectives.

7.3.3. Summary

The above discussion shows how objectivist and subjectivist positions work to limit or expand the way specific social groups, demographics and communities are constituted as objects of knowledge and practices. Withdrawal from community engagement, in this context, signals a particular kind of objectivist bias that privileges increasingly atomistic, individualized and expert mediated conceptions of health service delivery. An emphasis on overtly biologistic data, with a presumed observational neutrality, overlooks the nuance, intricacies and difference of lived realities. On a large scale and expanded timeline, such thinking and practice has the potential to disrupt, fragment or redirect currents of biosocial identity making, practices of solidarity and collective action amongst community groups and organizations operating within and adjacent to the DTES. Conversely, revalorization of interactive and qualitative forms of knowledge production can function to sustain expansive, pluralist and open concepts of health as well-being (normativism); in so doing, also work to sustain conceptualizations of life as citizenship and community (bios), which in turn more justly affect the dynamic the life-world of the cité and its inhabitants (and quite possibly reduce admissions to the Emergency Department). In what follows I present two different examples of how knowledge practices that affect the problematics of service delivery in the DTES are structured by different modes of valuing.

7.4. How value-knowledge structures conduct: two crises

R2 and R6, respectively, gave accounts of how different knowledge-practices are used to respond to particular problems with specific solutions. The first story details how individuals with disruptive mental illness, often compounded and exacerbated by methamphetamine use, are managed. In this instance, solutions to the problem are proposed through the use of rigorous networked metrics to develop reliable “common performance indicators” that then either punish or reward service providers depending on the pattern of outcomes generated. The second story describes a strategic response to the proliferation of overdoses in the DTES from a tainted illicit supply of drugs. In this case, the health authority empowers community actors to both inform and actualize solutions. Here the solutions are derived from qualitative knowledge and often first-hand accounts, while response is produced by community-based activity. These two accounts

show some of the variable ways that knowledge and values structure and inform the actualization of practical activities as they relate to two of the major crises-problematics afflicting the DTES.

7.4.1. Mental Health

After the crises of the late 1990's and prior to the synthetic opioid crisis, "Vancouver's Mental health crisis" was declared [Vancouver Police Department, 2013]. The standard narrative is that this crisis was precipitated in the DTES by the twofold factors of 1) mass-deinstitutionalization, the removal of support structures for people with significant mental illness, and the availability of inexpensive SRO accommodations in the DTES, alongside 2) the rapid rise of the availability of crystal methamphetamine in the mid-2000's [Boyd & Kerr, 2016]. R2 explained that because mental illness is not considered a public health issue that it has not been attended to with the kind of urgency or resources that a contagion like HIV has. While HIV and mental illness are irreducible in their complexity, the overall lack of action on substantially supporting the latter indicates differences between how mental health and personal well-being are evaluated compared to conventional medicine's focus on the physical body: "I think because the HIV was more of public health crisis, and 'oh no! We couldn't let it spread,' to someone suffering from psychosis, well if the people with the ability to change things couldn't feel the effect of it, maybe they weren't so quick to move on it." The problem, then, is not that there happens to be serious psychoses in-itself, or the suffering endured by afflicted individuals, rather it is the problems that psychoses cause for the functioning of regular policing and acute care services that motivate response. R2 described that the health authority created the Assertive Community Treatment (ACT) and Assertive Outreach Teams (AOT) to address problems of severe mental illness only after the Vancouver Police Department had initiated and expressed grievances about the increased volume of mental health related incidents that they were attending to, especially incidents allegedly involving the use of crystal methamphetamine as an agitating factor. R2 reported that the issue of addressing serious mental illness had "settled into equilibrium" and that the health authority is still somewhat apathetic toward the issue: "it is an area that I think probably hasn't been addressed as well as it should, alright?"

In this context the mental health crisis emerges as a political crisis about the equitable allocation of resources amongst institutions to manage disordered and

disruptive conduct, rather than an intervention to address and treat a set of disabilities or pathologies that significantly impact the quality of life of discrete persons and which further increases their overall likelihood of sustaining harm.[117] Considering the problematic of environment and bodies, it is significant that the most commonly proposed and circulated solutions for those who experience significant mental illness oscillates between stricter law enforcement measures and involuntary confinement in a hospital [ibid]. The problematic in this instance is animated by the fact that acute care facilities have an incentive to rapidly discharge patients with mental illness, because of their consistent bed-pressure, while community care services are overwhelmed and challenged with managing crises and disruptive behavior. Hence the revolving door of mental health. As a response to this, R2 explained that the government had initiated a Pay-For-Performance (P4P) model across all acute care faculties as a means of incentivising change in this particular service deficiency. In this conceptualization, because P4P has been demonstrated to be susceptible to manipulation in other instances, the model to be used was described as employing a sophisticated suite of indicators to measure the "medium and long-term status" of psychiatric patients in order to ensure that results are not unfairly manipulated to favorably reflect improved performance of particular facilities. The trajectory of reason and action described here by R2 shows how the application of a variant of objective naturalism produces significant social asymmetries. It demonstrates the kind of service-centered values that animate how the response is directed towards a particular problem as a bias toward physiological conceptions of health (zoê). And, it names the kinds of applied knowledge that motivate and structure practice and conduct: police reports, discharge summaries, and targeted financial incentivization via P4P modeling.

7.4.2. Opioid crisis

Conversely, after the declaration of a public health emergency in the spring of 2016 as a result of the proliferation of overdose due to a poisoned illicit drug supply, VCH worked to mobilize a rapid response to the crisis in the DTES. R6 described how

[117] "… police routinely emphasize dangerousness to legitimize intervention and institutionalization […] The Canadian Mental Health Association (CMHA) discounts popular myths characterizing people with mental health issues as perpetrators of violence and instead argues that they are more likely to be a target for violence: […] 'people with mental illness are two and a half to four times more likely to be the victims of violence than any other group in our society.'" [Boyd & Kerr, 2016: 11]

public health initiatives aimed to rapidly address the high volume of overdose in the DTES are structured and guided by experiential and qualitative knowledge practices from community members and consumers of services themselves. The basic 'know-how' for VCH to respond (in both establishing and funding services and interventions) to the proliferation of overdose was explained to have been derived from solutions provided directly to them by members of the Vancouver Area Network of Drug Users (VANDU). After describing the role that community knowledge played in directing crisis response, R6 made brief mention of legitimating life-making capacities through the governmental practice of granting permission: "they wanted to set-up a tent [for supervised consumption of drugs] at the time, we couldn't let them. So, it was like, could we do something that's on the move – that's really how the bike outreach, and then also, they were doing foot outreach before they did the fixed site." This kind of asymmetry in permission to actualize specific capacities that attend to urgent matters that pertain to security of persons in the inner-city details a politics of space as it relates to kinds of place making and circulation (mobile services vs. fixed location). This politic of permission-granting serves to highlight some of the significant ways that VCH governs locations and manners of life-making activities in the DTES.

Yet, unlike R3's account above, which details the overall decline in VCH community engagement, R6 emphasized the strategic importance of valuing the experiences and practical knowledge of people whose existence and reality are threatened by this crisis: "I think if we're doing our jobs right, we're going first to people who are on the ground." In this specific context, community engagement was reported to be of critical importance in establishing an effective rapid response to the overdose crisis. R6 attributed the possibility of such a response to the planning and re-conceptualization of community engagement in the Second Generation Strategy: "we have a much more of mobilized peer workforce, and so we have people with lived experience participating in program design at tables, and obviously program delivery. […] I think the people with lived experience voices are extremely strong. So there's more avenues to hear those voices and have them inform decisions." However, this conflicts with the account above from R3. This incongruity in account from senior-level VCH officials that oversee service delivery in the DTES indicates that the kind of engagement precipitated by the overdose crisis response in the neighborhood, and which succeeds the early engagement strategies that gave form to the initial conceptualizations of the

Second Generation Strategy, might be an exception to a larger overall pattern of withdrawal from community consultation by the health authority.

The community response to the opioid crisis detailed by R6 also contrasts with the delays in crisis response described above by R1 and R2. The latter respondents attributed lags in response times to urgent matters as resulting from insufficient knowledge translation mechanisms on the behalf of the health authority. Rather, by way of a weekly call-in phone meeting, a simple and inexpensive mechanism to rapidly share and integrate information across a diverse range of actors and stakeholders was established. R6 described how it guides service and strategies: “it’s just, ‘what is everyone seeing on the ground this week?’ And then Fire and Ambulance will give their stats. … the minutes from that meeting tell us what we need to be focusing on, what we need to be doing.” In this context, witnessing and first-hand accounts of community members and front-line service providers are validated as legitimate sources of knowledge and are used to modify and structure responses accordingly.

The particular context detailed by R6’s account of opioid crisis response initiatives in the DTES demonstrates how subjectivist and qualitative knowledge can be used to effectively guide community health initiatives. While community outreach teams are tasked with responding to the bare life context of spontaneous life-threatening overdose (zoê), usually on the street, in an alley, or park (ville), there is an affirmation of citizenship through the combination of the use of horizontal experiential knowledge, shared biosocial identity and empowered action in practices of care (bios). Though it is understood and should be emphasized that such initiatives are in operation as a result of exceptional circumstance, this particular process of knowledge-power actualizes urgent life-making practices that affect the social constitution of the DTES in a way that challenges administrative paternalism and empowers communities, however nominally, in the face of a devastating crisis (cité).

7.4.3. Summary

These stories are two examples of kinds of knowledge translation mechanisms that function to structure solutions to different problems that figure prominently in the inner city neighborhood of Vancouver’s DTES. One is a deficiency in service created by an incentive to defer treatment, reflected by institutions with goals that do not align with

specific kinds of individual needs. The other describes how to implement immediate responses to an epidemic of life threatening events (respiratory arrest) as a result of a contaminated supply of illicit drugs. In each case there are different degrees of emphasis between the intervention platform - direct service and public health - that reveal how different forms of knowledge, values and prescribed practices operate in relation to a number of key dualities: body versus mind, population versus individuals, and community versus institution. A key consideration to be drawn from these two contrasting examples is the manner in which the “epidemic logics” proposed by Sommers reveals the variable kinds of values operating to direct particular forms of crisis response. In the case of mental illness, access to appropriate care for afflicted individuals can be understood to be undervalued and poorly resourced because afflictions such as psychoses are neither contagious, nor best treated through corporeally focused bio-physical models of care. Yet, conversely, an epidemic of urgent life-threatening events as a result of a poisoned supply of illicit drugs is, in part, attended to by leveraging subjective accounts of affairs in operational strategies.

7.5. Conclusion

This chapter introduced elements of a biomedical problematic that pertains to the politics of knowing and practicing in operation in the DTES and its adjacent spaces. This problematic is composed of a dynamic arrangement between elements of a *domain of intervention* (consisting of objects, platforms and technologies) and descriptive and diagnostic *rationalities of health*. The problem of speed and timeliness of response to crises, as a function of knowledge translation, was considered and recognized to be sustained by particular and variable configurations of ways of knowing and valuing. Data collection as an objectivist knowledge practice was reported to be limited by infrastructural deficits and institutional bias and was then contrasted with subjectivist positions of qualitative accounts of well-being. The examples of institutionally internal struggles for better care through the use of qualitative data in relation to women’s health strategies in the DTES, as well as the retreat from community engagement strategies by the health authority more generally, were understood to be undervalued by VCH overall, but were recognized by respondents as important issues that could be configured in otherwise manners. The chapter closed with a comparison of the variable responses to crises in the treatment of mental illness and community response to an overdose crisis

that results from a polluted supply of illicit drugs. These two cases of variable crisis response demonstrate how asymmetries in the interactions of knowledge and values give form to different life-making strategies and capacities in and around the DTES. My aim in this chapter was to render intelligible a service landscape that is sustained by a biopolitics of uneven value-practices by challenging the primacy of techno-scientific narratives as the foremost factors in the determinations of service and care actualization. Health care interventions are unequally structured by both techno-scientific knowledge practices as well as a range of ethical, political and social values. A pinnacle end that animates the values of liberal government is the actualization and satisfaction of individual needs. In health care contexts the individual is framed through the figure of the client or patient. I will now move to direct the focus of my analyses towards how VCH understands its relation to the problematics of the client-figure in the DTES.

Chapter 8.

Client Centered Care

This chapter considers aspects of how a medical rationality, central to the Second Generation Strategy, called 'Client Centered Care' operates within the DTES. My analysis of client centered care examines how individuals are thought about, acted upon and encouraged to conduct themselves as both objects and subjects of specific medical rationalities. As a value rationality applied to the problematics of health care in the DTES, Client Centered Care is implicated in processes of place-making (the activities of dwelling that generate the specificities of the social constitution of communities and neighborhoods in urban life-worlds), because it works to produce particular kinds of medical subjectivities and therapeutic spaces. A key asymmetry in this context is the balance between authority and paternalism in the apparatus of care and the patient's self-identification as a medicalized subject with agency and autonomy. Here, respondents' conceptualizations of how paternalism and autonomy operate through specific value-rationalities that pertain to practices of care and intended health outcomes in the DTES are examined.

8.1. Definition

R2 reported that a key focus of the service reconceptualization in the DTES Second Generation Strategy is a client centered care model that focuses on key social determinants of health such as housing. Client or Patient-Centred Care[118] names a specific set of rationalities and strategies in health care delivery that pertain to any

[118] The official public policy documents consistently refer to this rationality as 'patient-centered care.' There is a power semantic at play in the strategic use of either term. A quick Google search reveals debate about their appropriate use. In an effort to clear ambiguity, one physician argues that the appropriate term is decided by the level of consent and participation an individual has in directing their care, with 'patient' (derived from the Latin 'pati,' meaning suffering) indicating little consent and 'client' indicating active partnership [Ratnapalan 2009]. An internally circulated VCH policy document that landed on my desktop recently states that, "'**Clients**' means all people receiving care or services from VCH and includes patients and residents."

service issue. British Columbia's Ministry of Health intends to have provincial health systems, "strive to deliver health care as a service built around the individual not the provider and administration" [Ministry of Health, 2015a: 1]. The Ministry of Health defines patient-centered care to consist of five principles: "self-management; shared and informed decision making; an enhanced experience of health care; improved information and understanding; and, the advancement of prevention and health promotion activities" [ibid]. It is a strategy of inclusion with a recognized "natural power imbalance," that pivots on the expectation of service providers, "to shift their values, attitudes and behaviors to make patients true partners in the process of making care decisions," while also "balancing the needs and expectations of patients and families with the needs of the health care providers to complete their work" [ibid: 3].

8.2. The problematic of the client voice and the reality of service delivery

R2 frames their overall conceptualization of Client Centered Care as a highly individualized approach to the provision of services: "sure, each organization can come and sit at the table, but overall there isn't any advocate for the client directly, right?" Though while it is known that the figure of the individual is a foundational element in liberal reason [Rose, 1999: 25], this is a potentially radical position to adopt in the context of the DTES. The many activist and advocacy groups (such as VANDU or WAHRS) in the area that are run by drug users and the under-resourced have long understood and experienced the paternalist power of medicine. While patient advocacy groups, more broadly, are forms of biosociality that exist across a variety of biocultures and communities (support and advocacy groups for people living with HIV/AIDS, cancer, lupus, chronic pain, bipolar disorder etc.) [Ehlers & Krupar, 2019: 25], activist groups in the DTES contest stigma, neglect, punitive regulations and regimes of prosecution and criminalization. Demands that marginalized people have a significant voice in their care, especially through the elimination of prohibitionist, restrictive and discriminatory prescribing practices, as well as better access to life enhancing amenities, appears to be a radical perspective from the stand-point of conventional practices of care. They are demands that have long been voiced by the consumers and community members

themselves.[119] R2 nonetheless remained elusive and speculative about how this would actually be implemented, and suggested that VCH staff members might embed themselves in the organizations "to direct initiatives that are patient or client centered," but that ultimately care is best directed on an individual basis: "I think the future is ensuring that the client is directly at the table, other than their, sort of, consulting role… as part of a committee, right?" Consider, then, the strategy implemented by the BC Government between February and March of 2014, wherein individuals on methadone maintenance treatment were forced to switch to a more concentrated formula called methadose [British Columbia Ministry of Health, 2013: 2-3]. This switch resulted in widespread adverse effects amongst people who had otherwise been stable on methadone, and led to a backlash amongst community members because they were not consulted.[120] R6 detailed an instance of how client voices operate asymmetrically within presumptuous and paternalist power-knowledge dynamics in an exchange between a Peer Navigator[121] and a physician in a presentation:

> […] she said that when they made the change from methadone to methadose, lots of people were coming in and saying, 'this isn't working for me, it doesn't have legs, blah, blah, blah,' and she said it was only when

[119] "VANDU challenges traditional client/service provider relationships and empowers drug users to design and implement harm reduction interventions. /VANDU believes in every person's right to health and well-being. We also believe that all people are competent to protect themselves, their loved ones and their communities from drug-related harm. / VANDU is committed to ensuring that drug users have a real voice in the creation of programs and policies designed to serve them. / VANDU understands that drug use ranges from total abstinence to severe abuse – we recognize that some ways of using drugs are clearly safer than others." https://www.vandu.org/about-us/ [Mar.2021].

[120] Laura Shaver of the BC Association of People on Methadone, "said on methadone, her withdrawal symptoms were kept at bay for about 24 hours, but returned in 16 hours on Methadose. […] Ryan McNeil, a researcher at the B.C. Centre on Substance Use, says some Methadose users reported withdrawal symptoms in as early as 14 hours, putting them at risk of seeking illicit opioids. […] 'It's an important thing to consider how the methadone formulation change functioned to impact people in the long-term in relation to their methadone treatment and subsequently has been one of the contributing factors to people overdosing from fentanyl or fentanyl-adulterated drugs,' he says" [Bains 2017].

[121] "The [VCH] Peer Navigator Program leverages the expertise of individuals who have lived experience with mental illness, substance use or addiction and who understand the social support and health services available in Vancouver." http://www.vch.ca/about-us/news/news-releases/peer-navigator-program-to-change-how-vancouver%E2%80%99s-health-care-system-is-navigated [Mar. 2021]

> she herself said to the doctors on the team she's working on, 'yeah, that's actually happening for me, too.' So as the Peer Navigator, she was like, 'yeah, I'm having the same effect,' that the doctors were actually like, 'oh, maybe this is something.' So, it was interesting, because it's both disrespectful and also powerful … that it speaks to the power of incorporating people with lived experience onto your clinical team, because they can deepen the knowledge and understanding of patient care – like what the patients need. It's also, you know, incredibly insulting … it's that whole, the patient's voice still isn't really heard until somebody with a bit more, um… […] another very concrete example of why we make better decisions as healthcare providers if we're incorporating the perspectives and incorporating the leadership of people with lived experience.

As a life-management technique, Client Centered Care is explicitly intended to foster a medical culture that gives more credence to the reports and desires of those individually seeking care. In theory, this means that if this ethos is pursued in earnest in the DTES and in other communities of marginalized peoples, openness to new and alternative ways of knowing and valuing that relate to bodily autonomy and conceptions of well-being will be an expected aspect of clinical practice. However, there is precedent to approach this iteration of Client Centered Care discourse with a degree of skepticism. Critical scholarship published a decade ago makes clear that similar patient-centered care rhetoric and conceptualization on behalf of the health authority, with a focus on alleviating acute care sector burdens, had worked to enact a "biomedicalization of social life" of the urban poor through the roll-out of competitively funded services that offered substantial benefits for a number of area residents, but did little to enhance their agency in directing their care, or likewise affect the overall suffering wrought by conditions of privation and exclusion [Elliott 2010: 185-187].[122] Elliott's critique is relevant to the current context discussed here because it shows how a particular discursive formation relates toward a target demographic and endures various intentional iterations. The use of the phrase 'Client Centered Care' operates, in part, to designate an individualized focus on the pathologies afflicting discrete bodies, while sustaining a silence toward the environmental, economic, and social conditions that work to promote those pathologies.

[122] The particular facility discussed in Elliott's analysis is the Community Transitional Care Team (CTCT), which originally operated on the New Fountain side of the Stanley-New Fountain amalgam building on Cordova Street. The building continued to significantly degrade until its condemnation in 2017 and demolition in 2019. At the time Elliott's article was published, that site had been operating as a low-barrier homeless shelter since the winter of 2009 and the CTCT had moved into a purpose-built retrofit on second floor of the Pennsylvania Hotel at 412 Carrall Street.

8.3. Optimal management equals system sustainability

Health care is a demand driven service. Though focused on individuals as discrete or nominal units of administration, the problematic of patient or client-centered care is explicitly animated by a focus on the overall long-term sustainability of the health care system [Ministry of Health, 2015b: 8].[123] The focus on the individual is also, therefore, a focus on the population. As such, the individual is an element in the balance and negotiation of rationing limited and finite goods against a duty to care. The Ministry of Health has developed a spectrum of identification that classes individuals into basic units of health service consumers [Ministry of Health, 2014: 21-25; 2015b: 5-6]. As an instance of power-knowledge, the class of consumers or target demographic primarily written about in this thesis are referenced in the official *Patient Centered Care* literature as those "Living with illness and/or Disability: Disability (physical or developmental); Patients Complex Mental Health; Substance Use; Low, Medium to Complex Chronic Conditions; Cancer" [Ministry of Health, 2015b: 6]. As a means of balancing individual needs with the demands of system sustainability R1 outlined a basic strategy of proactive engagement. R1 extrapolates from their work in the DTES with HIV in the 1990's a means of also addressing problematic substance use and untreated mental illness. In this strategy, all known individuals not on a particular treatment regime will be engaged and encouraged ("not to force anyone, because this is not about forcing") to pursue options offered by the health authority both, "for the benefit of themselves, the client, the patient, and then for the system." From this, R1 postulates that if individual care is optimally managed, system sustainability will be achieved, "that's how we will reinvest dollars." But this strategy raises questions about the multifaceted ends of medical government and life-making practices. A basic analysis of this strategic rationalization prompts the need for further critical inquiry into how particular forms of economic modeling animate the scope of obligations to care and what persons are due in capacities of access to care, especially as they relate to the roles of environment and culture as factors that shape and condition inequality and poverty. In this vein, R1

[123] In a statement that ought to dispel the narrative that marginalized people constitute an existential burden on publicly accessible health care, the BC Ministry of Health identifies that health system sustainability has been imperiled by high demands for service from aging baby boomers who have driven hospital bed use "from 85 per cent of funded capacity to now often in excess of 100% capacity for significant periods of the year (especially for larger hospitals)" [Ministry of Health, 2015b: 8].

detailed the systemic challenges of engaging a marginal population in the DTES, and used the treatment of hepatitis C as an example. R1 framed the issue as a problem within the structure and culture of conventional direct service providers, rather than the inner-city residents themselves who have historically been resistant to engage with health services or attend clinics. Recounting their exchange with physicians working in the inner-city R1 explained that "they said, 'oh well, don't worry […] we treat your clients well when they come to see us, we treat them really well.' And I said, 'that's the problem: *when they come to see you*, [respondent's emphasis] and they often cannot come to see you for a variety of reasons, we need you to go there.' And of course, they were not interested to doing that. […] the health authority always puts the lens of looking at how we close those gaps that exist in outcomes of particular populations."

8.3.1. Outreach teams

One of the ways VCH has attempted to "close the gaps" is through the use of outreach teams that are designed to directly connect with people in the community – in their home, on the street or in shelters, etc. VCH has had a number of iterations of outreach team models in the recent history of the DTES and are endorsed by all respondents as effective mechanisms for health service delivery in the area.[124] As a result of the density and walkability of the neighborhood, and the volume of service providers operating housing services in the area's SROs and other purpose built facilities, the capacity to provide basic primary care services alongside psychosocial supports in spaces other than fixed clinics is relatively easy to achieve. Outreach teams, therefore, form a significant part of what R1 means by "offering them options." These techniques of engagement and support of client choice appear to reflect how progressive value-rationalities intersect with the material structure of the inner-city to realize kinds of life-making practices. Because of this, outreach teams in the DTES also act as important elements in strategies and practices of subjectification. In one central respect, the teams provide a mechanism for trust-building (i.e. breaking down the barriers of the clinic walls) so that people might recognize within themselves the capacity to voluntarily interact with the health system, and thus become more empowered agents

[124] A fulsome examination of the history and function of VHC outreach teams is beyond the scope for this project. However, some examples of teams currently in operation are: Intensive Case Management Teams (ICMT/WICMT), Overdose Outreach Teams (OOT), Assertive Community Treatment (ACT), Assertive Outreach Team (AOT, with VPD), and STOP HIV/AIDS Team.

in actualizing their own care. Conversely, the teams contribute to an established culture of surveillance and paternalistic control that operates throughout the neighborhood - from the regulated and monitored spaces of supported housing, the spatial determinations of agonist and maintenance therapies, to the increased presence of street policing. Past criticism, however, has also been leveled at the health authority that such initiatives have functioned to “contain and segregate” the aberrant and disordered poor who are generally considered “unwelcome in a tertiary care system that other Canadians are afforded as public right as citizens” [Elliott 2010: 188]. As a rejoinder to this line of criticism, I argue that the intent from the health authority is less containment and segregation, as it is a pronged attempt to engage an (often rightfully) resistant population with care, as much as it is an attempt to alter a culture of care that has conventionally stigmatized, shamed and excluded people on society’s margins. This process of subjectification, therefore, goes both ways, albeit unequally. The use of outreach teams also works to modify conceptualizations of identities and roles of health service workers, themselves, and the understood spaces of medical practice within the inner-city spaces of advanced liberalism. Indeed, this is an example of an internal power-dynamic that renders intelligible the procedural and nominalist constitution of the health authority itself. R3 framed the process in terms of enhanced continuity of care and an emphasis on preventative strategies, rather than reactive crisis management: “‘look, you’ve got clients who, you know, have opioid use disorder and many cases you’re giving them treatment, what happens if they don’t show-up for an appointment? Do you send someone out? Do you worry? Do you go out and find them?’ Guess what? They weren’t doing that. Well, they’re starting to change that now.” Here there is an attempt to minimize circumstance that often results in hospitalizations, with a reframing of the roles of community health providers as proactively oriented in client care management and practices of prevention. This demonstrates how client well-being, along with system sustainability and management form a dynamic that operates on a number of practices, conducts and identities in the pursuit and administration of life-making practices that affect community constitution in complex but nonetheless specific ways.

8.4. The problem of mental health

Patient or client centered interventions that attend to mental illness in the DTES present an ambiguous state of affairs with respect to personal autonomy and paternalist

practices. VCH operates a number of outreach teams designed specifically to address mental illness. Assertive Community Treatment (ACT), Assertive Outreach Team (AOT), and the Vancouver Intensive Supervisory Unit (VISU) attach to people to manage individual care either as a result of the BC Forensic Psychiatry Act, the BC Mental Health Act, or from Criminal Code generated court orders. Two common interventions exercised, that both mobilize particular territorializations, are reside-as-directed orders which mandate where a person must live (usually a particular supportive housing facility) and the administration of involuntary intramuscular injections of antipsychotic medication (usually on a monthly or bi-monthly basis).[125]

Crystal methamphetamine use, specifically, is identified as a factor that exacerbates or amplifies disruptive and disordered behavior and thinking.[126] Behavior that is considered sufficiently disordered or disruptive, and/or refusal of psychiatric medication can lead to a person being involuntarily detained under the Mental Health Act. R5 reported that involuntary certification and conditions of "extended leave" (a conditional release of an involuntary psychiatric patient to community) that can lead to being "recalled" to the hospital (involuntarily re-admitted), if disruptive or harmful behavior continues, are drastic measures.[127] Patient's Rights frameworks, therefore, direct mental health teams and care providers to attempt to avoid this course of action

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[125] Sections 30 to 40 of the British Columbia Mental Health Act detail the conditions whereby a person may be detained and ordered to live or reside in specific facilities as a result of criminal behavior or acts that were deemed to be "not criminally responsible on account of mental disorder." See: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96288_01 [BC Mental Health Act, Current to May 19, 2021]. "The *Mental Health Act* provides for compulsory treatment of all involuntary patients. The director may authorize treatment for patients who are mentally incapable of making a consent decision about the proposed treatment" [British Columbia Ministry of Health, 2005: 19]. Compulsory treatment for people released to community after an involuntary detention under the Mental Health Act can take the form of slow release intramuscular injection of antipsychotic medication (usually monthly or bi-monthly). A commonly used medication is Paliperidone. See: https://www.healthlinkbc.ca/medications/fdb1706 [May , 2021].

[126] My intent here is not to perpetuate stigmas around stimulant use but to explicate a basic power dynamic. Drugs do provide many benefits to people. For context, recent research in the DTES identified the following benefits: "(1) pain relief and management; (2) alleviating mental health issues; (3) fostering social experiences; (4) pleasurable embodied experiences" [Ivsins & Yake 2018]. However, particular contexts and pre-existing conditions can create unintended harms. Psychotic disorders, for example, are diagnosed through symptoms that are referred to as positive and negative. Positive symptoms are expressed via hallucinations and disordered thinking. Common negative symptoms are disassociation, anhedonia, and lethargy. Some people self-medicate negative symptoms through stimulant use. This can induce or exacerbate positive symptoms which can lead to disruptive conduct and states of distress [Lindenmayer et al., 2013].

[127] Conditions of "extended leave" and involuntary "recall" to hospital are detailed in [British Columbia Ministry of Health, 2005: 28-39].

("How can we be as least intrusive as possible?"). R5 outlined a problematic cycle of granted individual autonomy and coercive paternalism that, in part, animates the revolving door of mental illness related hospitalizations discussed in the previous chapter: individuals are admitted to the hospital often involuntarily, their symptoms resolve, further treatment is refused, they leave, drug use resumes and they return to the hospital. Recent studies detail that the majority of psychiatric patients in Vancouver's acute care facilities "suffer from both concurrent mental illness and often high-risk substance use" [Krausz et al. 2021: 3; Krausz et al. 2013].[128] R5 reported that traditional psychiatric models of care remain challenged, a decade after a crisis was declared, to effectively address the complications, especially brain injury, that result from the intersection of heavy long-term methamphetamine use and pre-existing mental illness: "it's just changed our whole landscape."

Similarly, in discussion about the treatment and management of concurrent disorders, R7 reported on some of the challenges that exist with rationalities of institutionalizing people with serious mental illness and substance use disorders alongside the significant pressure to discharge psychiatric patients from acute care settings, and expressed a desire for a more collaborative working relationship with the hospitals. R7 identified that there was a "massive gap" of "any appropriate options for folks who do need to be institutionalized," but that "in 90 percent of the people that I've seen, they're people who should not be living in a hospital. And [that] the risks of living in a hospital, to your health, are phenomenal." While patient's rights frame works understand unnecessary involuntary detention to be a harm in-itself, the risk of developing further medical complications (specifically, nosocomial infections) from, for example, anti-biotic resistant bacteria (e.g. MRSA) is significantly higher in acute care settings.[129] R7 discussed an extant paternalism in many care providers around

[128] The term 'concurrent disorder' or 'dual diagnoses,' as used in this context refers to the co-occurrence of mental illness and substance use disorders in individuals. My understanding of the terms themselves is such that they exemplify the partial and historically contingent reality of medical knowledge power. A concurrent disorder is less an object, and more a reference to a particular class of asymmetrically positioned actors and social technologies that govern a broad spectrum of behaviors.

[129] See: Provincial Infection Control Network of British Columbia, https://www.picnet.ca/surveillance/about-hai/ [May, 2021]

perspectives pertaining to abstinence and well-being, “they use words like ‘clean’[130] and … ‘they’ve been clean for two weeks!’ And you’re like ‘it’s chronic and episodic!’” as well as conflicting strategies about patient control and personal autonomy: “half the clinicians are, like, ‘he can’t go back to the DTES, we should put him in a long-term care facility that’s locked. […] And we’re, like, no! If that human wants to go back to the DTES and spend the last years of his life engaging in drug use with his community that is his right!’”

Both R5 and R7 advance perspectives on individualized care that fit into the category of objectivist normativism. The problematic revealed by the interview data from R5 and R7 questions how third-person conceptions of overall well-being are reconciled or understood to be consistent with or subordinate to values that pertain to notions of individual freedom and bodily autonomy as they relate to mental well-being and personal behavior. Their accounts express the complexities and competing values that operate within the health authority that animate power dynamics which pertain to life-making strategies about dwelling in and around the DTES. It is a problem expressed by the question, where should someone be?

8.5. Housing as Client Centered Care

Housing, like outreach teams, was also universally acknowledged by all respondents as being one of the most significant factors that influence health and well-being in the DTES. R2 was direct in explaining that challenging the health authority to attend to issues of “housing and other social needs” is a key component of the kind of client centered care that the Second Generation Strategy strives to achieve. In the context of service provision discussed in this chapter, questions of appropriate housing revolve around conceptualizations of individual vulnerability and precarity. But governmental rationalities for the operation of housing for the marginal also revolve around how much care a person requires, how disruptive or disordered they might be understood to be and what kind of burden this might place on the existing community in the building, or if there are appropriate staff resources to effectively and safely manage their care. As an expensive and finite resource fraught with overwhelming demand, the

[130] Moral and pseudo-technical discourses toward drug-use and addiction have long had explicit themes of purity and contamination. In a number of contexts, it is common for people to refer to periods of sobriety and abstinence as being “clean,” with the implication that during periods of substance use an individual is soiled or dirty [Sottish Drug Use Forum, 2020: 25].

issue of housing availability is, predictably, a significant determination in strategies of allocation and access, as well as its suboptimal derivatives like street homelessness and shelters. Housing, then, is a key dimension in practices and strategies about how people are made to live and allowed to die.[131] In this particular regimen of population management, individuals are processed through an administrative network of housing providers and social workers who use standardized methods of evaluation and basic bargaining and bartering[132] to secure housing for individual clients.[133] The issue of housing as a health care intervention in this context is animated by a tension in forms of service modeling and funding that structure the scope of obligations about what people are due with respect to publicly funded health care. R7 described both the novelty and contentiousness of VCH's approach to funding housing and shelter services: "no other health authority funds shelters. […] in a way we do embrace that as part of our mandate. I mean, we've got millions and millions and millions of dollars in housing as a health authority. But, internally we struggle with it, because it doesn't fit the normal narrative of 'what's health care?'"

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[131] There is a current controversy about statistics that pertain to the number of recent annual deaths of unhoused people in Vancouver [St. Denis, 2020(a)]. However, a BC Coroners Service report for homeless mortality between 2007-2016 details deaths amongst the unhoused in the Vancouver Coastal and Fraser Health regions to have risen sharply between 2014 and 2016 [BC Coroners Service 2019: 7]. Likewise, as a result of measures surrounding COVID-19 deaths in Vancouver's supported housing doubled in 2020 [St. Denis, 2020(b)] Consider, further, that there is only one hospice in the DTES, May's Place at 333 Powell Street, that provides end of life care to people with mental health and substance use issues. http://www.vch.ca/pages/May's-Place-Hospice-details.aspx?res_id=1366 [Mar. 2021] As of writing May's Place does not permit illicit substance use during end of life care, however. While much is rightfully made about keeping people alive in the DTES, analyses of the politics of death and end of life care for marginalized peoples would be revealing.

[132] Housing providers will sometimes negotiate swaps, trades or similar concessions with certain tenants either facing eviction (issues can include overly disruptive behaviour or unmanageable hoarding), identified as too vulnerable (easily taken advantage of by neighbors), or progress to require higher levels of care than is available in their initial facility. For example, housing project (a) might absorb a troublesome tenant from housing project (b), and in exchange housing project (b) will absorb an older, or less troublesome tenant from project (a).

[133] All housing projects operated or funded by the BC Housing corporation are tenanted through a centralized system of allocation. Of note here is the biopolitical technology of the Vulnerability Assessment Tool (VAT). The VAT is a metric the BC Housing Corporation uses to direct housing models, tenancy ratios, and justify the efficacy of its interventions. It consists of a survey that purports to provide an assessment of a person's degree of vulnerability. Appropriateness of housing is based on how individuals score. In order to be considered to qualify for social housing offered and funded by the BC Government, individuals must complete a VAT with a worker trained in its administration. The information collected ranges from history of sexual trauma, annual hospitalizations, patterns of substance use, cognitive capability, and frequency of housing tenure. [See: Canadian Observatory On Homelessness, 2016].

R7's quote expresses a particular moral tension between naturalist and normativist conceptions of health at the population scale. For instance, various care homes exist, are commonplace, and their existence as legitimate health interventions is relatively uncontroversial in-itself (homes for people with dementia or severe disabilities, etc.). [134] Yet, bias towards particular pathologies in historical conceptions of service provision that pertain to responsibility, autonomy, and expectations of specific forms and capacities of self-regulation in conduct created a kind of "sanitary citizenship"[135] that worked to include some while abandoning others [Pigg 2017: 17; Krausz et al. 2013: 1239; Roe 2009/2010: 17]. This is the kind of problematic that animated values which pursued the de-institutionalization of psychiatric patients without providing them any alternative to the asylum. There are people who need specific kinds of supported living arrangements because of their complex needs and circumstance. Yet, to effectively address these needs respondents explained that an expansive kind of normativist conceptualization of health and care needs to be adopted.

Highly clinical models of housing as health care tend to replicate institutionalizing and oppressive practices [Masuda & Crabtree 2010: 657; Boyd et al. 2016]. Environmental and social interventions as practices of therapeutic care need to be constructed and planned differently in order to be effective [Krausz et al. 2013: 1240]. Various models of supported housing offer opportunities to provide effective interventions in manners that have historically been counter intuitive to health planners and policy makers. In one respect, from an exclusively health-focused perspective, as all respondents in this study made clear, this is because there is an understanding amongst them that housing has historically not been within the purview, mandate or even expertise of health care providers - though as Masuda et al. demonstrate, there had been a localized public health initiative mandated specifically for SRO housing in Vancouver's inner-city that was dismantled [Masuda et al., 2021]. Further, housing is an expensive resource. In the 1990's all levels of government in Canada divested their

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[134] Ehlers and Krupar reference supported geriatric housing in North America as "extrabiomedical sites" and "shadowland" spaces of abandonment [Ehlers & Krupar, 2019: 112]. Such an assessment is vindicated recently in Eastern Canada by the staggering tragedy of systemic neglect in care homes during the first wave of the COVID-19 pandemic. A recent news article details how acute care protectionism in Ontario and Quebec led to mass infection and death amongst elderly residents in long-term care, and labeled the practice senicide [Haines, 2021].

[135] Sanitary citizenship "describes an eligibility for societal benefits and civil rights […] based on a 'proper' relationship to public health." [Pigg, 2017: 17]

support and subsidies across all facets of the public housing spectrum with the belief that market centered initiatives, directed specifically at ownership and capital appreciation, would grow the economy, reduce taxes, and provide optimal resource allocation [Hulchanski, 2006: 225]. Property values and rents have risen dramatically as a result of widespread speculation, and homelessness has metastasized throughout all major urban areas.[136] The result has strained budgets and resources of municipalities and publicly funded direct service providers. Yet rationalities and practices such as *Housing First* have been in operation since the 1990's and demonstrate that it is, overall, less expensive to house people than not.[137] In this model people are allocated secure housing and then offered a range of supports relative to their needs as opposed to being 'stabilized' first through various treatment and transition regimes of intervention.[138]

The Housing First approach has been rightfully lauded as one of the best (and obvious) method to address homelessness, but it has only very partially and unevenly reached its objectives in Vancouver and the DTES. Rather, Housing First and similar initiatives have generally stagnated for two basic reasons. The first reason stems from failures to properly and adequately invest in appropriate and sustainable supports and services. The second reason is a result of failures to commit to long-term planning and vision around capacities to build community. This situation is, in part, a function of the competition logics, inherent in bidding instruments like RFP's that guide service rationalities. R3 and R7 both voiced criticism that these kinds of bidding processes, intended to incentivise cost and resource efficiency in housing and health services in the

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[136] Steve Pomeroy writes: "***for every (1) one new affordable unit created, at considerable public cost, fifteen (15) existing private affordable units (rents below $750) were lost!*** […] These losses are driven chiefly by the financialization of rental housing – an asset class attracting investment from both large capital funds, as well as smaller investors, both seeking to capitalize on dramatically rising rents." http://www.focus-consult.com/why-canada-needs-a-non-market-rental-acquisition-strategy/#_ftn1 [Mar. 2021]

[137] "Significant research has been done that explores the cost [directly via tax burden and government expenditures, and indirectly in greater health utilization and police interactions] of housing someone in jail, hospitals or the shelter system compared to housing them in social or supportive housing – and the difference is quite shocking. In a 2005 study by Pomeroy which looked at costs in four Canadian cities, institutional responses (jails, hospitals, etc.) cost $66,000-$120,000 annually, emergency shelters cost $13,000-$42,000 annually whereas supportive and transitional housing cost $13,000-$18,000 and affordable housing without supports was a mere $5,000-$8,000." https://www.homelesshub.ca/about-homelessness/homelessness-101/cost-analysis-homelessness [Feb. 2021]

[138]HousingFirst:https://www.canada.ca/en/employment-social-development/programs/homelessness/resources/housing-first.html [Mar. 2021]

DTES, have in many instances become deficiencies that exacerbate the problems they are purported to address: “What’s required is to take four steps back and to think big picture and to see what’s coming in the future […] the whole RFP process […] anybody could put anything on a piece of paper!” (R7).

Even though the current health planners in the DTES challenge recent biomedical orthodoxy and assert a prescriptive case for housing and shelter as a legitimate intervention or therapy under a particular interpretation of an ethos of Client-Centered Care, the current realities of such interventions are acknowledged to be under resourced and critically stressed. Consider R1’s earlier claims about creating system sustainability. Even though engagement and support are understood as key to system sustainability, in a system that has a recent history of little or no new investments, R5 and R7 both described the system as already excessively strained and in need of more supports and resources: “our programs are maxed as it is” (R5).[139] In the context of the crisis-of-care as it relates to mental illness, R5 and R7 both emphasized the importance housing’s role in keeping people out of acute services. There are two dimensions to this. R7 was explicit that to keep hospitalizations low, housing is the principal therapeutic intervention required. R7 explained that the health authority should be directly involved in its operation because, “nobody else is going to prioritize housing with our funding, the most complicated, medically complicated. […] mental health, addiction […] it’s nobody else’s mandate other than health care, right? Other than non-profits, who just take it on because they believe in it.” Second, R5 detailed the need for more resources and better strategies to diminish and prevent duress or harms to individuals who need care by constructing circumstances in housing environments that lessen hospitalizations, and stressed that most mental health crises ought to be managed in community rather than in institutions: “we’re saying, ‘okay, let’s do urgent primary care, let’s do outreach, let’s do different types of interventions.’” At issue here is the reconceptualization of the role of institutionalization (and its neoliberal analogue of outright abandonment) as a deliberative intervention in the management of what has historically been identified in moral economies as both socially deviant as well as economically burdensome. It is a re-assessment of how the material and social environments are understood as ways to

[139] Recall the claim about worker burn-out mentioned by R1 in the Second Generation chapter: the asymmetries that surround the under-resourcing of mechanisms to make-live discussed here are borne by a large moderate-to-low-wage workforce.

make-live. Yet both R5 and R7 describe and corroborate what I understand and have witnessed as stagnant housing first initiatives: While the optimal location for complex mental health interventions is understood be in the community, through housing, the means and space to perform and support these kinds of interventions are either non-existent or have been truncated and under-resourced.

8.5.1. Subjective solutions

Respondents detailed that often the most effective interventions to treat mental disorders are not biomedical: "I think people with psychoses need more of a social type of intervention, which we're not providing" (R2). R5 spoke at length about the importance of an individual's right to remain housed in place, in community. This is often understood as a challenge to the paternalism of experts or clinicians in mandated treatment and their preconceptions about what might be best for the individual, "they do better, and then we shift them and they decompensate.[140]" In this context, an ethos of supported client or patient centered care should be understood to acknowledge and honour the individual's subjective autonomy and capacity to evaluate conditions of their personal well-being. As such, this rationality supports a subjectivist normativism that demands responsiveness and self-reflexivity on behalf of the service providers. In as much as the client centered health interventions in the DTES are understood to act on individuals of the target demographic in ways that promote them to act on and for themselves as medicalized subjects, they also require, in asymmetric fashion, that service providers reconceptualise their own identities and actions in an expansive context of entangled material and social realities. R5 described how presumptuous interventions, especially in paternalist attempts at innovation, by medical staff can lead to detrimental outcomes: "Instead of having specialists who can manage this population, we need to have generalists who are trained who can deal with those people." Here, an expansive, integrative and holistic approach to care was endorsed: "when we keep separating our

[140] To decompensate refers to the degree to which a system succumbs to a set of stressors or pathologies, as opposed to a system appropriately compensating to ensure functionality. A psychology dictionary referees to it as "a failure of coping behavior" [Stuart-Hamilton, 1995: 82] Whereas, a medical dictionary defines it as "a condition in which an organ such as the heart cannot cope with extra stress placed on it and so is unable to perform its function properly" [Bloomsbury, 2005: 101]. In frontline work in the DTES, decompensate is a practical term in a pseudo-technical lexicon often used to reference instances of decline in a person's mental health.

services, that's actually not what integration is with our society. […] Our clients who are accessing them are people, and they need to be treated like people."

8.6. Consent, privacy, and standardization

R2 discussed how outreach teams work to coordinate client care with community housing providers and advocated for better and more frequent communication between the two services: "there needs to be a better mechanism for [housing] staff to flag health care issues. I think there's issues around, maybe, consent and privacy." When asked about how this is reconciled with dwindling options in affordable private market housing stock and the saturation of much more surveilled and controlled supported housing in the area [Boyd, Cunningham, Anderson & Kerr 2015; Fast & Cunningham 2018], R2 emphasised the importance of consent to services ("It's not an incarcerated space, right?") and proposed the development of a standardized means of care coordination: "Sure, certain buildings may have different levels of surveillance, but I think that if there is a certain standardized means of knowing who consented and who didn't, having the data at your fingertips, and then you can actually respond on the wishes of the resident."

Standardization is a particularly powerful technology of government[141] that when applied to practices of care within housing and live-in service contexts enables some forms of conduct and resource allocation while prohibiting others. Standardization structures fields of possible activity by its capacity to formalize and crystalize practices and procedures. Although standardization is appealing to the administrative class, the practical realities of these kinds of arrangements are much more complicated. While standardization fulfills its primary function as a means to shield care providers from liability risk and ensures specific kinds of benchmark service quality, there are instances where these facility standards sustain exclusions, inequalities and maintain or exacerbate harms of those at the margins seeking access to care. Barriers to care can be created, for example, by rigid interpretations and expectations of client behavior in standardized safety protocols, or curtail innovation or flexibility by prohibiting or restricting forms of operation (for instance, by limiting the administration of medicine to

[141] See, for instance Easterling, 2014: 171ff.

particular classes of credentialed medical staff).[142] This has very real consequences for determining who can access care, services, and shelter, and who is excluded. A move toward universalized standardized practices of care in supported housing in the DTES would significantly shift the biopolitical art of governing Vancouver's marginal and inner-city poor in at least two ways. First, it would have a significant impact on the operational autonomy and discretion of the independent service providers and neighborhood nongovernmental organizations, by limiting their capacities to respond to the needs of some of the city's most marginal people. Second, it would work to further intensify the trajectory of the DTES as a highly medicalized space that is administered and governed by clinical technicians and various forms of supplementary regulation. My argument here is not intended to be one that is outright against standardization in-itself. Rather it is a warning against trends of thought that understand the solution to the variably intersecting problematics of mental illness, drug use, and poverty to lie in highly formalized and clinically mediated spaces and services.

8.7. Conclusion

In this chapter I considered how rationalities and practices of client centered care operate within the DTES. There are at least two dimensions to this. First, there is a focus on the intrinsic value of individuals as self-directing autonomous actors. Second, Client Centered Care is a set of practical rationalities that are instrumentalized to leverage modes of individualized treatment and care as means to off-set burdens on the overall health system, with a specific focus on protecting the acute care sector. Client Centered Care practices in the DTES, as exemplified through the use of outreach teams and housing initiatives, were reported to be designed to engage and build trust with marginalized people who are often resistant to participate and interact with conventional health platforms. A clear strategy of subjectification was identified as a means to achieve the goals of broader system sustainability. Yet, alongside this strategy, specific value

[142]For example, the *Community Care and Assisted Living Act* accredits a broad range of care facilities by issuing operating licenses with conditions and standards that service providers must comply with. A concrete example of this is someone with managed epilepsy. In a licensed care facility, they can only be given certain anticonvulsant medications by accredited clinical staff. If the facility has 24hour staffing, but limited clinical care (because it is expensive), this individual is potentially ineligible to receive care at that facility, even though in a market housing setting they might otherwise self-administer their own medication. This reality is particularly compounded for the city's marginal by extant conditions of service scarcity.

rationalities that pertain to conceptualizations of personal and bodily autonomy, and the scope of obligations in duties to care – especially as they pertain to housing and mental illness – function as internal forces within VCH that challenge and work to reorient conventionally established norms and practices. Secure tenure in housing was identified as a principal therapeutic intervention to advance the health and well-being of individuals with complex care needs that relate specifically to mental illness, disability and ongoing substance use. Similarly, investments in appropriate housing are identified as significant means to relieve strain on acute care facilities. The extant services and interventions, however, were described as significantly under-resourced and in need of further expansion and integration with supports conventionally understood to be outside the purview of conventional health care. Whereas, a proposal to standardize practices of operation and care within and across supportive housing facilities in the DTES was identified with a potential to promote unnecessarily exclusive environments that would underserve their intended demographic, and also limit or restrict the autonomy of housing providers in the area. This presents a picture of place-making practices occurring within the service landscape of the DTES to be both stratified and conflicted. But it is also a picture of a space where the power dynamics that inhere in this conflict and stratification are reflexively considered by actors within VCH, and might then be actualised otherwise. Perhaps future rationalizations of Client Centered Care, for those on the margins in spaces like Vancouver's DTES, might work to better integrate models of service provision that emphasize democratization, greater degrees of community and individual empowerment, alongside networks and supports that enhance social mobility, in order to address the deficits in the environmental and social conditions that drive adverse medical circumstance. Given this, my analysis will now shift to an examination of some of the ways VCH operates as a mechanism of government in the DTES relative to key external partners – notably the three levels of formal government and the area's nongovernmental service providers.

Chapter 9.
Government

Life-making practices in the DTES are actualized through myriad actors. This chapter delineates elements of a biopolitical art of government in the DTES that operates at an intra-institutional scale. How VHC integrates, resources, responds to, and directs rationalities and values that pertain to life-making practices from a multitude of external operators is considered. VCH enacts a particular governmental territorialisation in the DTES by its control of key aspects of the economic and biologic constitution of the neighborhood, via funding and service provision. Organizations that operate in the area must collaborate (in some capacity) because of the many intersecting and overlapping issues that afflict the shared target demography require coordinated approaches to service delivery. Key themes that occur throughout the respondents' narratives in this chapter are complexity, interconnectedness, and collaboration. Consistent with a commitment to state nominalism, governmental power is understood here to be produced through associations and relations. Active capacities are determined by the degree of variability, consistency or stability that inhere in those relations [Blomley & Sommers, 1999: 266-7]. The form that governmental action assumes is dependant on how particular relations are produced. That is, how these relations are rendered "durable and stable" amidst the flux of "incessant transactions" is a function of how values animate specific kinds of instrumental reason [ibid; Protevi, 2016: 122; Foucault, 2004: 77].

The structure of this chapter is organized into four sections that reflect the assembly of the descending hierarchy of formalized systems of government as they pertain to the DTES. The first section introduces the basic problematics and shared contexts that pertain to VCH's interactive and collaborative function as a mechanism of government. The second section presents a discussion about how the Provincial government affects the delivery of health care in the DTES. The Provincial government is fundamentally different than the City of Vancouver and the nongovernmental organizations operating in the area because it legislates and makes possible the existence of universal public health care in British Columbia. It directs funding to health authorities as well as the BC Housing corporation and the BC Ambulance Service, and structures the health authority's mandate. The third section presents a discussion of the

relationship between VCH and the City of Vancouver as it relates to the area. The City supports the possibility of VCH's operation by the way it administers use of space,[143] funds the Fire Department and Police Force, and reflects and responds to the interests of the local electorate. The fourth section considers how VCH understands its role in supporting and negotiating the operation of neighborhood and community governance with the area's nongovernmental organizations. Through this particular conceptual arrangement each governmental tier is understood to be comprised of actors entangled in situated practices of asymmetrical co-constitution. In this context the differential and often unequal interactions amongst the various actors work to continually produce their identities.

9.1. Basic problematics and shared contexts

The term "partners," here, refers to the actors, any entity or individual, external to the health authority that have operational relations with VCH in the DTES and adjacent communities. It designates the differentiated multiplicity of actors that have individualized and unequal technologies and strategies of conduct direction that work to structure and operate on human life in specific ways. Examples of key actors that operate as partners in this service landscape are: a) conventional emergency responders like fire, police and ambulance (the former two are funded by the City of Vancouver, while the latter is funded by the Province); b) the panoply of community and civil society based services which range from housing, to outreach teams, to medical and social programs; and, c) various other state institutions that include the provincial and municipal governments, and their myriad administrative divisions (for example the Ministry of Social Development and the Ministry of Children and Family Development).

The contingent nature of political and social reality was indicated by respondents by their identification that there are no established guidelines for how collaboration amongst various organizations ought to occur: "so we sometimes go nose in and not necessarily having all the understanding we need. And then of course, the other partners teach us very quickly what can be done and what can't be done with the population" (R2). R2's assertion describes an understanding that service interventions and

[143] Consider, in this context, the politics of the Vancouver Park Board as it relates to controversy of enduring persistence of homeless camps in city parks. See for instance [St. Denis, 2021].

operations that require partnership with actors outside the health authority sometimes occur in improvised manners and operate in an environment and social context that is often unpredictable or incompletely defined. That specific parameters for capacity to act in relation to a target population are admittedly, at least in-part, taught to VCH by partnered agencies indicates a manner in which asymmetrical co-constitution occurs (what I understand here to be a mode of institutional subjectification that results from external trajectories of force).

The problem of essentialism in institutional identity and function was discussed by respondents as occasioned through problems of overlap in scope of responsibility and jurisdiction. In the managerial discourses that reference budgets and operational planning, this is called “siloed thinking.” A complex and dynamic social ecology in the DTES, however, challenges essentialist and fixed conceptualizations of organizational identity and operation. Services often perform (often informally, under duress, or with stretched resources) activities or respond to circumstances that challenge conventional or rigid understandings of their particular roles. Examples of this pertaining to VCH were discussed previously around issues of housing and psychosocial supports. R4 explained, “I think it’s very difficult to pick apart those things, but that’s how our whole world of supports is designed, in these siloes of income, of housing, of health, of […] community activity and that sort of stuff, […]” Health care here composes something akin to a fuzzy set of technical rationalities and practices amidst a spectrum of services that have variable capacities for action. There are two basic dimensions to this: internal and external. As I have shown earlier, purported difficulties that pertain to internal conceptualizations of service delivery within VCH can be attributed to interpretations of various iterations of normativist and naturalist conceptions of health in mandate and service design. Oscillations between naturalist or normativist conceptions of health work to delineate the operational and organizational thresholds of VCH. Service rationalities that focus too heavily on medical naturalism are overly biologistic (as was previously discussed with DURC, mental health, and housing). Whereas an overly normativist conceptualization of health and well-being could assume that all aspects of well-being are the purview of the health authority which would then, absent a robust multitiered

Health in All Policies[144] approach to population well-being, explode to overwhelm an already strained system. Indeed, this latter point is perhaps the internal key biopolitical problematic of modern liberal government,[145] as it addresses the overall security of a governed population as a function of the optimization of life and vital capacities.

The target demographic in the DTES certainly requires higher than currently established levels of support and investment in environmental, social, cultural and financial goods. This is the reality that structures their poverty. External to the health authority, a vicious cycle is maintained by deficiencies in resources and capacities amongst agencies that comprise the DTES's service landscape. Insufficient levels of income support and housing allowance are allocated to people with long-term disabilities or without employment,[146] the ever mounting inability of the housing system to appropriately shelter our society's most vulnerable, and the chronic and systemic criminalization of those on society's margins (especially drug users) challenge and fail to meet the most basic needs of community members. An overall situation is produced that either maintains or intensifies trajectories of social inequality that directly contribute to and exacerbate health problems of those living on the margins in Vancouver's inner-city.

Collaborations and partnerships are identified, therefore, as a means to leverage varying kinds of expertise across service providers to address deficiencies and complex issues in the DTES. The situation for maintaining coordinated leadership amongst different entities like the BC Housing Corporation, City of Vancouver, and numerous nongovernmental organizations, however, was understood to be challenging due to the complex nature of circumstance and the overlap in jurisdiction of interventions: "VCH can't fully resolve all these issues, right? We don't have the mandate, we don't have the resources, we don't have necessarily all the expertise. Right? So, it's about that collective partnership, which is challenging but I see happening all the time" (R4).

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[144]Health in All Policies is an approach to government that seeks integrative or cross-sectoral focus on health in decision making, planning and policy making. https://www.who.int/healthpromotion/frameworkforcountryaction/en/ [May 2, 2021]

[145] I understand the that the key external problematic to population security in liberal governments would then be territorial integrity regulated by treaties, border controls, and defence infrastructure.

[146] Though, at the time of writing the rates are set to increase by 175$ a month, the largest increase in-recent-history.https://news.gov.bc.ca/releases/2021SDPR0024-000483#:~:text=Effective%20April%202021%3A,increases%20of%20%24350%20per%20month. [Mar. 2021]

9.2. Three official levels of government

The three official levels of government – federal, provincial, and municipal – were identified by respondents to have different concerns and priorities which are then reflected in their relation with the health authority. Federal and Provincial governments were both criticized for their unwillingness to challenge the status quo in illicit drug policy (R2, R3, R6). The federal government was understood to respect the autonomy of the provinces in delivery of health, and thus generally has an indirect influence on local specifics. The significant exception, however, was around Insite[147] and the *Controlled Drugs and Substances Act* which controls access and use of illicit and other controlled substances and is therefore key to any form of legal reform in the War on Drugs.[148] Policies and services that the federal government disagreed with were noted to be punished through measures such as the allocation of targeted funds that restrict the Province's ability to exercise discretion over how resources and services are structured. The Provincial government's relation to service delivery was more explicitly discussed in the context of election cycles. R3 mentioned that the currently elected socially progressive NDP government's restraint or hesitation toward bold policy in health care resulted from its precarious status as a minority government. Conversely, it was reported that the previous Liberal government's position as a majority enabled the Minister of Health, Terry Lake, to initiate far bolder policies. The City of Vancouver was noted to be of significance in its responsiveness to initiatives and collaboration in service delivery because of the aligned values of their constituents and leadership. Whereas nongovernmental organizations that operate in the area were acknowledged to be of significant value due to their responsiveness, flexibility and capacity to operate across disciplines in ways that state agencies cannot. In considering capacities for action, R3 summarized a historically particular strategy of a localized art of government envisioned

[147] As evidence that Canada's national police force harbours partisan political commitments consider: "The RCMP funded [a non-peer reviewed and widely discredited paper by Colin Mangham] studies critical of Vancouver's supervised injection site (Insite), encouraged officers opposed to Insite to phone a popular radio talk show, and may have attempted to conceal these advocacy efforts from public view, according to allegations by the Pivot Legal Society. […] The Harper government has repeatedly cited the RCMP-funded studies as justification for its repeated efforts to close Insite." [Paulsen, 2008; Mangham, 2008] Mangham's paper was published by a socially conservative think tank from the USA that has an explicitly prohibitionist agenda that seeks to maintain the criminalization of drugs and drug users: https://www.dfaf.org/journal/ [Apr. 2021].

[148] https://laws-lois.justice.gc.ca/eng/acts/c-38.8/ [Mar. 2021]

for the DTES that leverages the current mayor's support for decriminalization and drug reform with the local nongovernmental organizations' capacity for leadership in responsiveness and innovation. This was understood to be in opposition to the inaction of higher levels of government, whose reluctance to implement bold reforms results from concerns that changes might anger voters or otherwise imperil their position in the legislature: "it's a good point that politics really plays a role in what's happening and the reluctance …, even in the face of a serious crisis, to actually do something. You know, I could tell you frustrations dealing with the opioid response, things that are obvious, that we can't get the Provincial government to do. Obvious things."

This helps contextualize Elliott's assertion and curiosity towards the nongovernmental service landscape in the DTES where she notes that, "Neoliberalism works not only through conservative or reform policies but also through politics and policies of the left" [Elliott: 2010: 190].[149] The formulation of R3's response in the paragraph above describes a particular strategy that considers non-state actors – various kinds of private organizations, specifically non-profits and charitable organizations[150] – whose greater autonomy and capacities for action are understood to be more effective at providing solutions to problems in the area. This particular context exposes a complex and localized iteration of a much larger problematic of social contractualism, especially as it relates to obligations towards autonomy and integrity of persons and social security, that has its origins in the crises of Keynesianism from the 1970's. Civil or humanitarian entrepreneurialism is understood here as a significant

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[149] Neoliberalism as an ideology and practice of market oriented governance is not by-necessity wedded to social conservatism. In fact, there has been historical debate amongst proponents of market-oriented governance about the rights to bodily autonomy – especially with regards women's reproductive autonomy, and sexual freedom. Conventional neoliberal thinking in the United Sates, however, has tended to align itself with various forms of social conservatism. For a genealogy of the relation between neoliberalism and the conservative movement in the USA, see: Cooper, 2017.

[150] In the current context, for the purpose of simplicity, all non-profit civil society organizations are referred to as 'non-profits,' as per the respondent usage. However, under Canadian federal tax law there is a distinction between entities considered 'non-profit' and 'registered charities'. "Registered charities are charitable organizations, public foundations, or private foundations that are created and resident in Canada. They must use their resources for charitable activities and have charitable purposes [that include] the relief of poverty; the advancement of education; the advancement of religion; other purposes that benefit the community." Whereas, "Non-profit organizations are associations, clubs, or societies that are not charities and are organized and operated exclusively for social welfare, civic improvement, pleasure, recreation, or any other purpose except profit." https://www.canada.ca/en/revenue-agency/services/charities-giving/giving-charity-information-donors/about-registered-charities/what-difference-between-a-registered-charity-a-non-profit-organization.html [Mar. 2021]

solution to the problem of ineffective government because of its ability to instrumentalize private freedoms[151] and differential capacities for competition [Foucault, 2004: 145]. That solutions for demand-driven services are inferred to be optimally derived from competitive contractualized market logics should not be immediate grounds for dismissal, or condescension (or conversely, celebration). Rather, in the current analytically-focused context, they should be understood as the emergent effects of trajectories of various historical attempts to respond to localized of problems through use of the most effective prevailing reasons and techniques available at the time.[152]

If we are committed to anti-essentialist concepts of state and selfhood, there are no foundational ethical subjects or institutions that should be deferred or returned to. Instead, ethical-becomings are realized through imperfect and contested activities of asymmetrical co-constitution. Nonetheless, eleven years after Elliott had remarked at the neoliberalization of what appear to be "leftist" or progressively-oriented services in the DTES, particular trends have intensified while others have receded. Many of the organizations operating today are governed and operated by actors without significant historical or cultural ties to the area (myself being one of them). Interventions that largely arose from within (the most direct example being the early problematizations mobilized by DERA in the late 1970s and early 1980s), are now ever-increasingly directed by experts from elsewhere. This should raise concern about the long-term ramifications that the crystallization of specific kinds of service models, designed to address the symptoms of poverty and individual and endemic illnesses, will have on social mobility, community participation, urban citizenship and democracy more broadly in the face of increasing social stratification. A situation quite different from the "emergent community based forms of governance," written about by Blomley and Sommers twenty years ago

[151] Rose writes at length about the historically contingent and variable ways that 'freedom' as a virtue and capacity has been historically framed, and notes the predominant sentiment that freedom as absence of government obfuscates freedom as a capacity to conduct one's self otherwise. It is freedom in the capacity to actualize otherwise conduct that interests me here as an animating logic of market oriented governance [Rose, 1999: 62-65].

[152] My position here is not intended to vindicate or apologize for market oriented strategies of government, but to demonstrate that particular instantiations of its application have enabled the possibility of some kinds of life-making when other modes of governance were incapable or unwilling. I understand the broader trend toward the neoliberalization of 'essential services' of government to be a process counter to social democracy. Nonetheless, a comparative analysis of consequentialist ethical theories versus deontological positions (specifically, certain kinds of Marxism) about the legitimacy and scope of particular neoliberal philanthropic or humanitarian interventions as moral or sustainable practices of government could be controversially enlightening.

[Blomley and Sommers, 1999: 273-4] has assembled in the area. The emerging material and social landscape of the DTES has shifted ever more dramatically toward a formally regulated and socially stratified space of population management that is imbricated amongst the exclusive logics of suburban involution.

9.3. Province

Respondents (R4, R8) spoke favorably about what they, broadly, perceived as the continuity of vision and aligned values in the delivery of health care between the previous Liberal government and the newly elected NDP government. Whereas R8 mentioned confusion about the scope of authority and jurisdiction of the newly established Ministry of Mental Health and Addiction: “It was complicated when it was first introduced, and I don’t think it’s gotten a whole lot clearer about who we’re supposed to [laughs] report to! Whose report and strategy do I follow?” While there was confusion about the introduction of a new governing body there was no concern from respondents about the differences between either government in their interpretations of the foundations of the overall mandate and scope of obligation in the social contract toward responsive and accessible public health care.

R3 criticized the provincial government, however, for not appropriately engaging the regional health authorities in the development of local health policies and strategies that are intended to support specific communities. R3: “If they’re setting the policy and we have to deliver, but they don’t engage us over the best policy, we may not come up with a good policy.” Yet, reports on how this occurs relative to the DTES were conflicting. R3 discussed the mandated switch from the use of methadone to methadose in opioid maintenance therapies. R3 drew attention to the fact that it was the Province of BC that acted unilaterally and failed to consult consumers, which then led to the widespread de-stabilization of people who were previously on therapeutic doses of methadone. Conversely, it was acknowledged that, absent an intervention from the Ministry of Health which enabled it to remain open, VCH would have cut the prescription heroin program at the Crosstown clinic (operated by Providence Health)[153] after the

[153] “Providence Health Care is a non-profit organization, providing services in partnership with the Vancouver Coastal Health and the Provincial Health Services Authority.” https://www.providencehealthcare.org/about-providence [May, 2021]

SALOME study concluded in 2015.[154] Instead the Provincial government mandated that it continue. This case alludes to competing priorities and variability of values within the health authority, itself.[155] Here it was understood that health planners' strategies were more likely to prioritize acute care services over obligations toward community level response to mental illness, problematic drug use and complications from subsistence poverty. R3 then stated that while there was no specific strategy for the DTES from the Ministry of Health, the Provincial government would not want VCH to divest or divert funding from the area: "So that's why we said, [in the Second Generation Strategy] we didn't say that there was any new funding, but if we said we're going to move funding out of that neighborhood and move it elsewhere, they [BC Ministry of Health] would not have liked that." The suggestion here is that VCH would have most likely pulled funding and resources to protect acute care facilities, if not for the Provincial mandate which tasks VCH with attending to mental health and substance use, with the DTES having the largest concentration and demand for services in the region. These competing cases, then, showcase some of the strategic tensions between VCH and the Government of British Columbia, as well as their variability in valuing ways of living and life-making. It is remarkable that, on the cusp of a major public health crisis, VCH might have cut, rather than enhanced, a leading and innovative service proven to both save and stabilize lives.

9.4. City of Vancouver

Respondents reported that over the course of recent history VCH and the City of Vancouver have nurtured a good relationship which has helped them develop aligned goals and values (R1, R2, R3, R8). It is certainly not always given that a municipal

[154] Discussions of the recent history of the public health emergency declared in 2016 due to the high level of overdose often fail to mention that the volume and severity of overdoses had dramatically risen in the years preceding. My first-hand experience of working in Stanley Hotel was such that during the summer of 2014 we went from having at most two overdoses a month, to attending to, on average, two or three a day either within the building or in the adjacent Blood Alley Square courtyard. A recently released coroner's report on drug toxicity deaths in BC shows a consistent increase in drug related deaths from 2011 onwards [BC Coroners Service, 2021: 3].

[155] Both the NAOMI and SALOME studies were, however, not without out controversy or critique from the enlisted participants themselves. The mode of Heroin Assisted Treatment (HAT) offered was experienced as highly clinical and overly medicalized. It was noted, for example, that "the NAOMI trial was problematic on many fronts, including the absence of an ethical exit strategy, the lack of informed consent without duress, and the failure to provide a permanent program" [Boyd & NAOMI Patients Association: 2013].

government will have a good relationship with an institution like a Health Authority or Crown Corporation, especially in relation to the kind of services delivered in the DTES, as is evident in other regions.[156] R8 mentioned: "I hear what goes on in other jurisdictions and I just feel so fortunate that we actually can plan together."

In the context of the politics that pertain to localized delivery of specific kinds of health services, the municipal government occupies a unique position of power. Respondents identified that the City does this in at least four important ways: land use, small response teams, as a lobby group, and as a mechanism of accountability. It was identified that the City leverages land-use practices through targeted zoning and permitting for capital projects. As noted in Chapter 5, most respondents discussed the significance of the development of a new multi-use facility for withdrawal management. Despite much opposition by community members, council unanimously approved the development: "there was a lot of push back from the community, because, you know, 'not in my backyard! That's fine, but not here.' But, we actually were successful" (R1). Respondents similarly discussed collaborations with recent developments of modular housing throughout the city. Second, while the City of Vancouver does not have the budget or mandate to provide health services, it has developed teams in response to two of the health crises the city is currently experiencing: the Opioid and Mental Health Task Forces.[157] Third, it was identified that the City lobbies the Provincial Government directly to buttress initiatives they believe to be in their interest as well as the best interest of community. Both Gregor Robertson and current mayor, Kennedy Stewart, were noted to have supported the implementation of a regulated safe supply for users of illicit drugs, and since the early 2000's the City has been, in a surprisingly non-partisan manner, supportive of harm reduction practices and strategies, more generally.[158] Finally, the City

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[156] In comparison, the City of Maple Ridge (a suburb of the Vancouver Metropolitan region) has recently been embroiled in a long battle between its enfranchised residents and poor and homeless community members. A strong lobby group, with significant populist, illiberal and authoritarian inflexions, have been instrumental in stifling initiatives to address some of the social determinates of health and provide housing. (See: https://www.actionmapleridge.com/ [Oct. 2020]) Consider also the ethical folly in these headlines and their chronology relative to the synthetic opioid related publich health emergency: "In Surrey, 'harm reduction' drug approaches a hard sell" (Sept. 26, 2014) [Katic & Fenn, 2014]; "Surrey Mayor rethinking harm reduction"(Jul. 19, 2016) [Daikiw, 2016].

[157] https://vancouver.ca/people-programs/drugs.aspx [Mar. 2021]

[158] Sam Sullivan, Vancouver's centre-right mayor (2005-2008) prior to Robertson (2008-2018) has been a vocal, but controversial advocate for drug policy reform and harm reduction, especially as a key ally during his time in office. Recently, however, he wrote an editorial claiming with the evidence from the advent of safe-supply initiatives that, "Safe injection sites are no longer

was also described as being a mechanism of accountability, wherein VCH representatives are called to Council to explain rationalities behind service cuts and policies that might negatively impact the community directly, as was noted to be the case when concern was raised by the City about VHC's cutting of the Drug-Users Resource Centre program. R3 stated that they often tell City Council that they "have greater impact on heath than the provincial government which funds health services." This is because it is understood that "they're the most responsive level of government, because they allow the public to come and make presentations directly to them." This is a kind of democratic accountability not capable of being practiced at the Provincial or Federal levels, and is therefore a unique power the municipal government can operationalize to transform and direct various life and place making contexts.

The municipal government, however, is also an actor that contributes to a growing cycle of poverty and precarity. While the City of Vancouver can craft strategic zoning ordinances and mitigate NIMBY opposition to key medical and social welfare amenities, generations of local government have been instrumental in actualizing policies – consistent with both Federal and Provincial governments – that hollow-out and precaritize the city's rental housing stock, with the objective of stimulating economic growth through development and private home equity appreciation [Hulchanski, 2004; Condon,(a) 2021, (b) 2021; Masuda et al., 2021].[159] The evictions, precarity and outright homelessness created by a political climate that prioritizes private asset growth above inclusive and just conditions of habitability, even if it does generate significant tax revenue, has worked to overwhelm and strain the essential services provided by both VCH and the City of Vancouver (i.e. the police and fire departments) that those tax dollars fund. The City of Vancouver finds itself responding, with limited means and at considerable expense, to complex crises that are intensified, in part, by its own conflicting interests and priorities. As mentioned in Chapter 4 (Sec. 4.3.1), the City of

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harm reduction; they are now centers of harm production. People engage in crime to get money (harm production) then support organized crime to buy street drugs (more harm production) then risk injecting harmful substances (even more harm production). No thinking person can support such an obscene and twisted idea." [Sullivan, 2020] This statement, of course, intends to diminish the lived complexity of poverty and drug-use in order to stoke the revanchist sentiments of enfranchised condominium owners in Yaletown, as a means to galvanize to support to shut down a safe injection facility in order to safe-guard home equity.

[159] Consider, for instance, the current politics of predatory zoning being confronted in the cooperative housing laden South False Creek area [Renger, 2021].

Vancouver has historically neglected to hold private SRO owners accountable for the degraded building conditions throughout the inner-city. Direct links can be made between harmful and problematic substance use, environmental distress and housing privation. VFD describe challenges in its *Strategic Plan 2019-2021* that both: “Significant number of single room occupancy (SRO) buildings due to the large number of lower income and homeless citizens […] Abundant medical responses due in part to the current opioid crisis, pose a serious threat to our resources” [Vancouver Fire Rescue Services 2019: 5]. Such a sub-optimal state of affairs can, more generally, be attributed to the “contradictory” roles occupied by city planners who are simultaneously tasked to work to facilitate ideal circumstance for inclusive community living, while attending to the interests of corrosive and indifferent strategies of accumulation, as is evidenced in City’s DTES Local Area Plan which was released commensurate to the final stages of the Second Generation Strategy’s planning [City of Vancouver (a); Hern, 2016: 226; Stein, 2019: 14-15; Harvey, 2016: 245ff].

9.5. Nongovernmental governance

The contracted service landscape of nongovernmental (NGO) operators in Vancouver’s DTES is large. This high volume of contracts is unique to VCH as a health authority, and therefore also an arrangement unique to Vancouver: “It is huge. It’s unprecedented across the province” (R8). Respondents explained that VCH frequently uses contracted services in the DTES due to their effective and innovative service delivery, and their ability to offset potential risks. Somewhat counter-intuitively, R8 explained that contracted service delivery in the DTES is not done as a cost-savings endeavor per se, but as an investment in efficiency: “if that’s the only thing your organization does, you’re probably going to do it really, really, really well, and so let’s acknowledge that expertise” (R8). Alongside this, the health authority is admittedly risk averse. Partnerships with the non-profits offset this: “the health authority is bound by a set of rules and bureaucratic layers that makes it difficult to innovate, […] partnering with agencies […] in the community is the way for us to move forward” (R1). This was described to be exemplified by the changing dynamics in primary care created by newer fee-for-service clinics that cater their service delivery to directly meet the needs of the DTES population: “one of the new primary care clinics that’s arisen in the last decade

has been Dr. Christie Sutherland's clinic, at Portland Hotel [PHS community services];[160] and, I would argue that she has done a better job, and she's getting no funding for that, almost, it's fee-for-service and being very nimble in being and able to provide care, compared to the bureaucracy of a health authority run clinic" (R3).

However, problems with VCH's relationship with partnered NGO's were widely discussed. Respondents (R3, R7, R8) described a history of variable but often contentious relationships between the health authority and nongovernmental organizations and community partners**.** Earlier relations with nongovernmental organizations were characterized as too top-down and transactional (a grievance also identified seven years prior to my interviews in The Second Generation Strategy policy documents [Vancouver Coastal Health, 2012: 5]). According to the respondents, this remains a situation that VCH still has not effectively addressed. R3 stated that: "we haven't changed how we, in a meaningful way, how we work with the non-profits that we fund. It's still very top-down, it's not as true partners always, in the delivery of health services." As discussed in the Client Centered Care chapter, current funding models are acknowledged to create an adversarial and uncertain environment: "So the way we do our contracts […] you know, the RFP process, which pits people against one-another…" (R3). Competition logics, therefore, work to structure possibilities for kinds of social services and life-making practices of government, and exclude others insofar as it incentivises austere (or "lean") budgets,[161] as well as certain forms of non-cooperation and self-preservationist activity amongst organizations in the area [Wood, 2019: 27-28].

Service cuts to programs that were identified as being ambiguously within the scope of VCH's mandate, but where clients' health was directly impacted by their removal, were described as enacted without due consideration to how they would affect either the service provider or clients. Likewise, it was reported that there were no attempts to help resource the affected organizations or persons in response to the new deficits in means of care: "we said, 'we're cutting all your home support services, because we don't provide housekeeping.' You know… […] and we've got these clients

[160] The clinic is located at 350 Columbia Street, in the ground-level space of the Irving Hotel. The actual facility called the Portland Hotel is located at 20 West Hastings St..

[161] This can render contracted programs to be vulnerable to under-performance or serious precarity in the face of contingent circumstance. More generally it is a logic that depresses quality in favor of corner-cutting.

who are hoarders! and that's actually needed for their mental health! [...] It's fine to contract out, but we could work with non-profits in a more of a partnership way" (R3).[162] Consistent with the challenges of siloed or essentialist thinking discussed above, there is a pattern of VCH cutting (or intending to cut) funding to services without considering the longer-term or larger-scale ramifications (as was the case with DURC, or potentially was the case with Crosstown iOAT program).

All respondents claimed that VCH values the nongovernmental organizations in the DTES for their vision and service. It was noted that the current tensions between the health authority and its contracted service providers are healthy: "I would say in the last 3 to 4 years those are probably very healthy tensions" (R1). I take this statement to designate a range of productive antagonisms that sustain competitive behaviour understood to generate innovation in service delivery toward the problematics of the neighborhood. This might include disagreements that are either sustained or resolved in manners which enable both parties to effectively pursue, mutually or independently, established goals. However, it is not clear whether or not these "healthy tensions" are the result of a more stable funding climate, adjusted expectations of nongovernmental leadership, or closer allegiances forced by the immediacy of crisis and a duty to care. The overdose crisis was indeed reported to have necessitated supporting a community response that required intensified partnerships and collaboration: "what I think the overdose response has required us to do and also enabled, is to really ensure that the community mobilization is at centre" (R6). Respondents then also discussed the pursuit of mutual goals through building on each organization's unique strengths. In this regard, there was consensus that VCH ought to work with community organizations to build a mutual vision based on aligned values which draw-on the diversity of strengths and capacities that are unique to the institutions. R3 emphasized the importance of better recognizing the role of non-profits as partners and the possibility of VCH strategically supporting organizations and increasing permissiveness toward initiatives like heroin compassion clubs: "it's that recognizing you're in a different space, and that's a value

[162] To add more context to this example, providing home-support services for people with hoarding disorders is far more than a mental health intervention. Physical health is significantly imperiled by environmental hazards. Falling objects can fall and bury, or crush a person, or catch fire and impede egress. Excessive and long-term accumulation of biological material (food, bodily fluids and solid waste) can cause serious infections as well as infestations of insects and vermin. Independent of the individual living in those conditions, this can severely jeopardize the facility's physical constitution and well being of the overall community [Lauster et al. 2016; Baker 2016(a)].

and we can respect each other for the services that we can and things we can't do." This "different space" held by actors external to VCH is realized in their variable values and capacities that are applied to a commonly agreed upon set of problems. It expresses the dynamic of a governmental assemblage defined by a multiplicity of relations toward the complex external problematic known as the DTES. The idea of appropriately leveraging operational differences amongst nongovernmental partners to more effectively govern the DTES through coordinated service delivery was discussed: "one of the huge advantages of that could be that there's certain things that service providers can do, in terms of asking for systems change, that I can't do from where I'm sitting. And, there's certain things that I have access to" (R7). Here, a diffuse but more coordinated assemblage of actors that perform a particular kind of government in the DTES is proposed: "What portion should each organization be able to control? […] this isn't actually different things. We all want to make something work" (R7). However, the strategic complexity of synchronized values and goals in this context should not be understated. The overall tolerance of dissenting government-funded non-profits and charitable organizations has declined [Beeby, 2014; Wood, 2019: 29-30]. While planners at VCH understand that they are limited by an obligation to political neutrality that can be offset through the use of allied nongovernmental organizations as proxies, a balance of risk looms [Vancouver Coastal Health, 2012: 8]. Given recent historical events, especially the experience of PHS Community Services in 2014, outwardly nongovernmental leaderships are highly incentivised to temper their positions to satisfy and placate funders as a means of self-protection. Likewise, internally, the nongovernmental managerial regimes which direct amenity and service provision in the DTES are also incentivised to create organizational cultures that depoliticize and naturalize the social stratification and class positions they are funded to attend to [Wood, 2019: 30-31].

However, R7 admitted that there remains a substantial legacy of distrust animated by "vitriol anger" amongst organizations and community groups in the DTES toward VCH. The reasons for such anger was described as being "very old" and "quite outdated." R7 described that internal efforts by current VCH leadership involved in the DTES to direct the organization toward a more collaborative manner of operation with an explicit focus on social justice issues was not an orientation that "resonates" with the larger corporate culture of the health authority. R7 then explained that the need to

cultivate such an orientation within VCH is strategically motivated by both external and internal factors. Externally, it was understood that such configuration would help establish and maintain greater levels of trust within the community. Internally, it was understood to work to augment morale and off-set burnout amongst the staffing body that often operates in under-resourced and over-worked conditions amidst mounting crisis conditions within the neighborhood.

9.6. Conclusion: Situated practices of asymmetrical co-constitution

What is indicated by the fact that the respondent narrative, generally, tells a story that: partnerships are necessary; but that they have not been managed well, historically; that they are committed to improving their relations/making them better; and that VCH ought to be more forthright in their commitment to social justice? Taken non-cynically, this represents a positive instance of what I refer to as situated practices of asymmetrical co-constitution: a process whereby powers from outside fold reasons and values back into the corporate assemblage that is VCH to produce a new kind of emergent institutional subjectification that affirms specific practices of life-making over others. Exterior forces from adjacent institutions work to direct and give shape to newly interiorized kinds of reasons and values. The argument is simple: Nongovernmental and partnered service providers provide some services better than VCH and some services that VCH does not. Partnerships require collaboration. Collaborations are practices of value-making (good or bad). Value making is life-making and place making. How VCH moves forward with collaborations, therefore, affect the development of its values as an organization, as well as the constitution of its partners and the neighborhood, however unequally. Yet the emergent context of intensified inner-city development, the dislocation of precaritized poor, the agglomeration of services and a steady flux of migration of service-consumers to the area challenges the activist ethos of the now established community-based forms of government with supplementary rationalities of management and competition codified by the term innovation. The evolving relations of asymmetric co-constitution amongst the health authority, various levels of government and its contracted service providers attend to the problems manifest through the space of the DTES in ways that contribute to and engender stratified and unequal inner-city life-worlds.

Chapter 10.

Conclusion

10.1. Closing thoughts: interventions elsewhere and future trajectories

To conclude this project I consider an account from R6 who outlines the increasing complexification of the current problematics animating the service landscape in the DTES. Here, reflection on “a nominal object of inquiry” - the conditions that merit health care interventions in the DTES - functions to elicit “a normative intensification of problems” that defy simple resolution [Koopman, 2013: 98, 100-101]. Yet, the possibility of constructing circumstance to be otherwise was detailed through an account of “obstacles experienced as practical realities” [Lemke, 2019: 376]. R6 described their understanding of the current response to the crisis context of the DTES to be similar to “the early days of HIV activism” that drove the initial thrust of harm reduction initiatives and the availability of ARV’s to individuals in the neighborhood and its adjacent inner-city spaces. They noted, “I don’t think that there was a single new case of HIV in the DTES last year.” However, mental health, addiction and substance use disorders were acknowledged to be substantially distinct from the epidemiology of HIV transmission: “we have to be ensuring that there’s this whole gamut of treatment options because there’s so many different needs.” An inventory of resources and interventions, different from those that structured the epidemic logics of the past, are required. Decriminalization and access to safe supplies of illicit drugs was, therefore, recognized to be far more of a political and economic problem than a medical issue that is otherwise best managed through public health initiatives. Current treatment, management, and mitigation initiatives such as iOAT are recognized as important interventions, but were recognized to be limited by the complexities of poly-substance use and other co-morbid conditions, as well as determinations in social and spatial mobilities.

As an instance of a regulatory politics of affirmation [Ehlers & Krupar, 2019: 2], recent success with decriminalization and regulation of illicit substances in Portugal was

discussed in comparison to the situation in the DTES. Two important distinctions were raised. First, the Portuguese initiatives were actualized through a process of divestment in criminal justice and policing services. The funds and resources were then applied to drug treatment programs and social service amenities – some of which require involuntary participation from individuals cited with possession of, or disruptive issues related to, a controlled substance. Second, while opioids and stimulants like cocaine and methamphetamine are still illicit in Portugal, it was noted that the illicit supply is not similarly polluted with synthetic opioids. So far, Portugal has been spared from the crisis of overdose and death that has unevenly plagued communities across North America. R6 concluded that given the current problem-context in the DTES, "the treatment pathways" - the ways of envisioning or directing solutions - "are not as straightforward as HIV."

The new iteration of emergent crises that contextualize the space of the DTES are much more multifold and complex. In the mid-2000's crystal methamphetamine overtook cocaine as a preferred stimulant because of its less expensive production and distribution costs as well as its significantly longer-lasting effects. As a result, along with the widespread availability of clean injection equipment in the DTES, the spread of bloodborne pathogens has decreased, also, in part, because methamphetamine is injected far less frequently. Yet, crystal methamphetamine's ascendance has increased incidents of acute psychological distress and problematic behaviour that has overwhelmed already scant mental health services and emergency departments. The illicit supply of opioids continues its trajectory of becoming further adulterated with novel synthetic depressants, such as atypical benzodiazepines. Coextensive to this, the grey economy and depreciated housing stock that sustained lower income and marginalized peoples in deprived but nonetheless generally autonomous conditions, but enabled higher levels of community activism and solidarity, have receded. This neighborhood landscape has been replaced with a limited, variably regulated, but centrally allocated housing stock, for those in receipt of social assistance. Here dwelling space is increasingly woven into a development matrix of exclusive condominiums and boutique retail and dining amenities. If mental health and addiction have become the central problematics that are attended to by the actors that comprise the service landscape in the DTES, as was noted by Fast and Cunningham [Fast & Cunningham, 2018: 242], then the 'biopsychosocial' nature of the matter casts the DTES as a particular instance

of a larger and growing set of “wicked problems” that surround trajectories of mounting inequality and poverty in Canadian society. These are problems that cannot be solved by biomedical and entrepreneurial humanitarian interventions alone.

10.2. Findings

The research undertaken for this project set out to better understand some of the manners by which Vancouver Coastal Health has problematized Vancouver’s DTES. The key findings from the five chapters that analysed respondent data are outlined as follows:

1) VCH situates itself in relation to the high complexity of medical needs experienced by the target demographic that resides in the DTES. It is understood that needs in the DTES will persist. The neighborhood demographic was identified to be comprised of a tripartite division of permanent resident, itinerant resident, or transient visitor. Services deficits in other locations, created in part by the health authority’s own policies, were identified to underserve communities and potentially drive certain health care consumers to the DTES. Respondents described that they understood the DTES to be a complex space that operates on personal identity in complicated and often contradictory ways. Investments in the built form that enhance established services in the area, are ongoing and work to transform the space of the DTES into an increasingly formalized territory of targeted population management.

2) The Second Generation Strategy for the DTES was described to be unevenly and partially realized. The Strategy itself is an historic instance of a particular trajectory of problematization. Analysis of the conditions surrounding its actualization shows how contingent circumstance affects planned practices of governance. Policy mobilities informed particular attempts at inclusive practices of subjectification. This was done to attend to complex individual medical needs, service deficiencies within the community, and to support the sustainability of the city’s acute care sector. Enhanced collaborative relations with contracted community partners was identified as a goal, but success in achiving this remained variable and challenged as a result of historic mistrust, fiscal restraint and emphases on clinical interventions that tend to undervalue environment and community as factors that shape health outcomes. Many respondents believed the Strategy to have stalled or failed. Yet, primary care redesign with a focus on Indigenous

specific services, and the opening of a methadone clinic were identified to be principal deliverables that were realized. Some respondents understood the Strategy to have served as a speculative forum to explore potential pathways for innovation. A number of initiatives, however, were hindered in their realization due to regional labour shortages, a degrading built environment, a larger scale health system redesign, internal leadership changes, a crisis of governance within the largest nongovernmental organization in the area, and crisis conditions generated by a highly adulterated supply of illicit drugs.

3) The speed and degree to which crises are attended to were detailed to be as much a function of moral and political values as they are understood to be informed by bio-technical assessments of pathological conditions that merit interventions or resources. There is a lingering bias towards conceptualizations of harm reduction and medical interventions in the DTES as public health measures designed to mitigate contagion risks. This is expressed in negative bias toward afflictions such as psychoses, alcohol use disorder, and non-injection drug use which have been historically neglected or underserved by environmental and psychosocial initiatives, and harm reduction measures, respectively.

4) Enhanced individual care is reported by respondents and official documentation to be understood as the optimal means for population-level health system sustainability. How this is realized is variable. Iterations of Client Centered Care narratives have been predicated on services in the DTES for some time. Issues around autonomy and paternalism in direction of care were deliberated by respondents. Tiered strategies of subjectification as complex practices of conduct direction aimed at both consumers and producers of medical services are pursued. Attempts to build trust and enhance the target population's voluntary engagement with health services were also understood to operate upon clinical practitioners' self-understanding in asymmetrical and unequal manners relative to the spaces and environmental contexts in which they operate. Investments in environmental determinants such as housing were recognized as key interventions for individual and population well-being, as well as overall health system sustainability, but are challenged to be more robustly realized as a result of funding limitations and narrow conceptions in the scope of what is designated to be within the proper domain of health care.

5) The three official levels of government variably affect interventions in the DTES. The Federal government regulates drug laws and historically has had hostile moral attitudes toward harm reduction services. The Province was likewise detailed to be apathetic towards drug law reform, but directs VCH's mandate to attend to mental health and substance use, as well as primary care. The City of Vancouver leverages land use, lobbying, and City Council as mechanisms to hold VCH accountable for its local activity. In contrast to the understood inefficiencies of the official branches of government, regional nongovernmental organizations have historically challenged the health authority to reorient their conceptualization of service provision in the neighborhood. There was recognition of the significant limitations of essentialist or siloed thinking by the health authority toward practices of government and technologies of intervention. Relations between the health authority and the nongovernmental organizations in the area continue to be described by respondents as top-down and transactional, rather than collaborative, despite historically voiced intents by VCH to change this state of affairs. Inattention to the effects of changes and cuts to services were described to be on-going. Further, recently established political contexts have incentivized nongovernmental organizations to operate in competitive and a-political fashions. Historic mistrust and grievance from community members and groups remained, despite various internally and externally focused efforts from members of VCH leadership to reform relations and steer the organization toward more explicitly socially-just orientations.

10.3. Summary

This study presents an attempt to answer the question *How does Vancouver Coastal Health problematize Vancouver's Downtown Eastside?* Analysis detailed a service landscape formed by a biopolitics of uneven value practices. The biosocial problems that reveal and express themselves through the space of the DTES are attended to in manners that sustain and produce stratified and unequal inner-city life-worlds. A spectrum of life-making affirmations and strategies were enunciated by respondents. This enabled me to show how solutions to the problematic conditions of life in the DTES are animated by a complex and dynamic set of values and practices from within VCH that variably conceptualize and actualize the ends of social medicine. The primacy of techno-scientific narratives in determinations of service was challenged by

evidence that shows how health care interventions are also unequally and significantly structured by a dynamic and internally contested spectrum of ethical and political values. Entangled practices of identity formation were detailed to occur on at least two scales. Strategies of subjectification were shown to be leveraged to influence identities and behaviors of both individuals within the target client demographic as well as health authority employees tasked with administering care. Emergent institutional identities of Vancouver Coastal Health and its contracted service providers were described to evolve through relations of asymmetric co-constitution. Practices of life-centric government operate within the larger flows of urban process. The containment and epidemic logics that animated earlier governmental biopolitics in the DTES (for instance the historic transition from the *cordon sanitaire* to *cordon thérapeutique* proposed by Masuda et al., 2021) are increasingly integrated with and transformed by strategies of social-mix managerialism which are components of a larger process of developmental involution transforming the eastern segments of Vancouver's inner city.

10.4. Further research

To close I offer two further trajectories for possible research. One evident route of investigation is to apply of this kind of analysis to the nongovernmental organizations operating in the DTES. What are the more specific ways that different nongovernmental organizations use their variable autonomy to actualize life-making practices? What are some of the power dynamics and unequal social relations that are sustained and engendered by these organizations? How do various non-state entities that attend to localized problems understand their role as instruments of government? What are some of the variable rationalities and values that underlie conceptions of civic duty that animate kinds of nongovernmental (and, by implication 'non-profit') entrepreneurialism? How have these reasons and values changed over time? And what are some of the strategic and contingent instances that have motivated these changes? How does competition, bidding, and the push to 'innovate' structure possible capacities for action and various social asymmetries?

A second trajectory for research lies in examining the politics and consequences of the BC Housing Corporation's ongoing housing initiatives in comparative inner-city contexts like Vancouver and Victoria. How has this entity been used by various iterations of Provincial governments to respond to problematic living circumstances like tent cities,

vehicle encampments, and other informal living arrangements? What are the values, reasons and ends that have motivated recent housing initiatives? How have the BC Housing corporation's recent acquisitions, investments and developments been used to create or contribute to an emerging form of dwelling-centric government of urban poverty within the involutionary contexts detailed by Peck et. al.? How have these initiatives emerged and become entangled within contested and conflicted residential and developmental landscapes? What ways of life are created and what is excluded?

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Appendix A.

Interview Guide

Below are the basic questions that were posed to the respondents in the semi-structured interviews. The respondents were encouraged to discuss different topics at variable length. With the exception of variations of the first question, which was used to introduce my topic, the order of the questions varied in each interview.

1) I am interested to learn about how the Downtown Eastside (DTES) is framed as a problem requiring solutions by Vancouver Coastal Health. How does the health authority affect the constitution of the neighborhood?

2) Julian Sommers had co-authored a paper on the migration into the DTES, and one of the findings that he had looked at was that there was a tendency among individuals with concurrent disorders that had experienced or have been living with homelessness, ended up being funnelled into the DTES and having, what they saw by looking at the aggregate data was having worse health outcomes. What, from coastal health's perspective, or your perspective as a director within costal health, do you make of these kind of claims about the concentration of services within the DTES and the effect of overall trajectories?

3) You can continue to pour a lot of money into healthcare and people will still reap a lot of the benefits, almost regardless of the population. People age, or get cancer and you can always pour more money into these services. How is it that the health authority understands the DTES in relation to allocating limited resources, with competing services elsewhere - especially in relation to significant forms of social inequality, which often contribute to or worsen serious health issues?

4) While it is not the health authority's responsibility, necessarily, to deal with social inequality, how is it that the health authority acknowledges the role that social inequality plays? Because it obviously impacts the way that you operate and strains resources.

5) How do you see Coastal Health's operation within the DTES changing policy elsewhere or being exported to other areas of the world? How do you see those policies and interventions and services that we have developed in the DTES changing into other spaces and other communities?

6) I am curious to learn about some of the tensions, or the difficulties of being innovative within the Health Authority and the need for having non-governmental partnerships, or even other governmental agencies, like BC Housing. Can you elucidate some of the issues around that?

7) Can you talk about how the health authority considers mental health in the DTES?

8) Where do you get your data on the DTES?

9) What motivated the policy rethink called the Second Generation Strategy?

10) Second Generation Strategy says that it is not going to involve any new funding. Has the change in government affected the Second Generation Strategy's funding model?

11) Do you have any insight on the Nuka model of healthcare that that the Second Generation Strategy was based on?

12) Where do you see things having gone wrong with the Second Generation strategy?

13) With the DCHC and Heatley clinic redesigns, it seemed like there was a move east of Main. Was that a conscious move, was that deliberate?

14) There is an increased degree of social polarity in the DTES. Perhaps 30 years ago it was a very different neighborhood than it is now. What is the relationship between the Vancouver Coastal Health Second Generation Strategy and the gentrification that's happening in the neighborhood? How does Coastal Health consider the DTES in terms of its dynamic?

15) How do organizations such as VANDU or WAHRS factor into Coastal Health's decision making in the DTES?

16) How does the Health Authority work with the City of Vancouver?

17) What is the relationship between the second Generation Strategy and the DTES Local Area Plan? Was there any consultation?

18) There are a variety of different services that Coastal Health provides in the DTES. Can you talk about their particular strategies and the relationships between the different kinds of services as they exist in that space?

19) In the DTES is a community with many unique health services. However, there is a trajectory towards certain forms of control, surveillance, and regulation. Could you talk about that?

20) One of the things that I am curious about is the role that acute care facilities play in managing a lot of the complexities that individuals have when they are residents of the DTES. I understand that mental health is a pretty significant component of admissions to emergency rooms. Could you talk about this?

21) How has the role of crystal meth affected the way in which mental health is considered?