

STILL “AT RISK”: AN EXAMINATION OF HOW STREET-INVOLVED YOUNG PEOPLE UNDERSTAND, EXPERIENCE, AND ENGAGE WITH “HARM REDUCTION” IN VANCOUVER’S INNER CITY

Final version published as: Bozinoff N, Small W, Long C, DeBeck K, Fast D. Still "at risk": An examination of how street-involved youth understand, experience, and engage with "harm reduction" in Vancouver's inner city. *International Journal of Drug Policy*, v.45 July 2017, 33-39. <https://doi.org/10.1016/j.drugpo.2017.05.006>

**ABSTRACT**

**Background:** Vancouver is an international leader in implementing interventions to reduce harms related to drug use. However, street-involved young people who use drugs continue to be vulnerable to overdose death, hepatitis C (HCV) infection, and high rates of syringe sharing. In order to understand why young people in this setting continue to experience drug related harms despite an intensive public health response, we examined how young people understood, experienced and engaged with harm reduction in the context of drug scene involvement and marginalization.

**Methods:** Twelve semi-structured interviews were conducted in 2013 with thirteen young people (ages 17-28) recruited from the At-Risk Youth Study, a prospective cohort of street-involved and drug-using young people. These interviews were embedded within a larger, eight-year program of ethnographic research and explored participants' understandings of harm reduction, their use of specific services, and their ideas about improving their day-to-day lives. Interviews were transcribed verbatim and a thematic analysis was performed.

**Results:** Young peoples' understandings of and ideas about harm reduction were diverse and expansive. Many young people articulated the limitations of existing programs, indicating that while they are positioned to reduce the risk of HIV and HCV transmission, they offer little meaningful support to improve young peoples' broader life chances. Young people described strategies to mitigate risk and harm in their own lives, including transitioning to drugs deemed less harmful and attempts to access addiction treatment. Finally, young people indicated that spatial considerations (e.g., distance from Vancouver's Downtown Eastside) strongly determined access to services.

**Conclusions:** In Vancouver, a large, well established harm reduction infrastructure seeks to reduce HIV and HCV transmission among street-involved young people. However, young peoples' multiple understandings, experiences and engagements with harm reduction in this setting illustrate the limitations of the existing infrastructure in improving their broader life chances.

**Word count: 296**

**KEY WORDS: Vancouver; harm reduction; needle exchange; youth; addiction**

## INTRODUCTION

**Street-involved young people who use drugs face a number of potential adverse health outcomes, including HIV (Roy et al., 2000), hepatitis C (Roy et al., 2001), and fatal and non-fatal overdose (Kerr et al., 2009; Roy et al., 2004).**

Vancouver is an international leader in implementing interventions to reduce harms related to drug use, **including among young people**. In the late 1990s, faced with a surge in incidence of HIV among people who inject drugs (PWID) (Strathdee et al., 1997), an increase in overdose fatalities, and demand for action by local activists (D. Small, Palepu, & Tyndall, 2006), Vancouver's regional health authority began pursuing a comprehensive harm reduction strategy. This strategy included the scaling up of needle exchange programs (NEPs) beginning in 2001 (Bardsley, Turvey, & Blatherwick, 1990; Hyshka, Strathdee, Wood, & Kerr, 2012), and the establishment of North America's first supervised injection facility in 2003 (D. Small et al., 2006; Wood & Kerr, 2006a), **both of which are widely accessed by young PWID (Hadland et al., 2014)**. In response to continuing overdose deaths among drug users in the province of British Columbia (BC), in 2012 the BC Centre for Disease Control implemented a large scale take-home naloxone program to increase training and access to life saving naloxone kits (Tzemis, Al-Qutub, Amlani, Kesselring, & Buxton, 2014). Several peer-based programs are operating in Vancouver's Downtown Eastside (DTES) neighbourhood, including needle sweeps, alley patrols, and an injection assistance program (W. Small et al., 2012) as well as a peer run brewing co-op designed to minimize use of non-beverage alcohol (Hopper, 2014). Other notable harm reduction initiatives in the city have included a managed alcohol program for individuals with **alcohol use disorder unresponsive to traditional therapies** (Pauly, Reist, Belle-Isle, & Schactman, 2013), an unsanctioned safe inhalation

room operated by the Vancouver Area Network of Drug Users (recently closed) (McNeil, Kerr, Lampkin, & Small, 2015), and crack pipe vending machines, among other forms of pipe distribution (Hopper, 2014).

The majority of Vancouver's harm reduction services are physically located in the DTES neighbourhood, which is one of Canada's poorest urban postal codes. Over half the city's PWID are estimated to live in single room occupancy hotels in the DTES (UHRI, 2013). The neighbourhood is characterized by an "open," street-based trade in opioids, cocaine, crack cocaine, and crystal methamphetamine, and a "shadow economy" propelled by sex work, drug dealing, and the exchange of stolen goods (Wood & Kerr, 2006a). The Downtown South neighbourhood of Vancouver is within easy walking distance of the DTES and is also the site of a thriving, albeit more "closed," drug market (Fast, Small, Wood, & Kerr, 2009). This mixed residential-business-entertainment district is a popular destination for young people who use drugs on the streets, including opioids, cocaine, crack cocaine, and crystal methamphetamine (Bungay et al., 2006; Werb et al., 2010).

Harm reduction services in the city of Vancouver – most notably, the city's NEPs and supervised injection facility – have received significant research attention and evaluation. Among adults who inject drugs, harm reduction initiatives have been associated with dramatic declines in rates of syringe borrowing, from 20.1% in 1998 to 9.2% in 2003 (Kerr et al., 2010). The prevalence of HIV and HCV among adults who inject drugs has also plummeted (BCCDC, 2013; UHRI, 2013). **Although NEPs and Vancouver's safe injection facility are commonly utilized by street-involved young people (Hadland et al., 2014),** it remains unclear whether harm reduction interventions

are succeeding to the same extent in reducing drug-related harms among this youth population as they have among adults. **Among young people who inject drugs in our setting, as many as 1/3 have reported sharing syringes at least once in the last six months (Lloyd-Smith, Kerr, Zhang, Montaner, & Wood, 2008) and, alarmingly, the incidence of HCV among street-involved young people in Vancouver was recently estimated to be 10.9 per 100 person-years in females, and 5.1 per 100 person-years in males (Puri et al., 2014).** Furthermore, numerous gaps in the provision of health and social services for street-involved young people have been well documented in our setting (Barker, Kerr, Nguyen, Wood, & DeBeck, 2015; Phillips et al., 2014), underscoring the challenges policy makers and program providers face in meeting the needs of this population.

As a city with an extensive harm reduction infrastructure, Vancouver offers a unique setting in which to explore the potential limitations of harm reduction services for marginalized young people. In order to understand why young people in this setting continue to experience drug-related harms in an environment of intensive public health intervention, we consider how these young people understood, took up, negotiated, and at times resisted harm reduction programming in the context of entrenched drug scene involvement and marginalization.

## **METHODS**

Participants for this study were recruited from the At-Risk Youth Study (ARYS), a prospective cohort of street-involved and drug-using youth that has been described in detail elsewhere (Wood, Stoltz, Montaner, & Kerr, 2006b). **To be eligible, participants**

**had to be between the ages of 14 and 26 years at the time of enrollment, self-report the use of illicit drugs other than or in addition to cannabis in the past 30 days, and report being street-involved. Young people who were homeless or using services designated for homeless young people were considered “street-involved” in this study. As the ARYS cohort is a longitudinal cohort, some participants were older than 26 at the time of their participation in qualitative interviews for the present study.** Any ARYS participant who visited the ARYS research office between July and August 2013 was eligible to participate in a semi-structured qualitative interview on the topic of harm reduction. These targeted interviews were designed to build upon insights gained from an ongoing, eight-year program of qualitative and ethnographic research conducted by DF with a subsample of approximately 75 ARYS participants.

**Recruitment stopped once thematic saturation had been achieved, in the sense that interviews did not produce any change in the codebook (Guest, Bunce, & Johnson, 2006).**

Interviews were conducted with thirteen young people over a two-month period. Interviews were undertaken by two trained interviewers (DF and CL) and facilitated through the use of an interview guide encouraging broad discussion of young peoples’ experiences with harm reduction. Participants were asked to articulate their ideas about what constitutes “harm reduction” in the Vancouver setting, about their use of specific harm reduction services (e.g., Vancouver’s supervised injection facility), and how they thought their day-to-day lives could be meaningfully improved. Semi-structured interviews lasted between 40 and 80 minutes. All participants provided written informed consent and received a \$30 honorarium for their time. The study was undertaken with

ethical approval from the Providence Healthcare/University of British Columbia Behavioural Research Ethics Boards.

As is common in qualitative and ethnographic approaches, data collection and analyses occurred concurrently as the study progressed. Interviews were transcribed verbatim and back-checked for accuracy. NVivo software was used to code and manage the data. **An initial codebook was generated by NB that captured broad emergent themes and analytic categories (e.g. “the limitations of existing harm reduction programs”). Subsequent fieldwork and in-depth interviews were used by DF to refine the codebook through the addition of new codes (e.g., “the role of place in shaping access to harm reduction”). Over the study period, evolving interpretations of the data were discussed with a broader subset of young people in the field by DF, and more formally during subsequent in-depth interviews by DF and CL. In addition, the research team discussed the content of interviews and fieldnotes throughout the data collection and analysis processes. Inter-coder agreement was assessed between two coders (DF and NB) on a portion of coded data and coding discrepancies resolved before the entire data set was coded.** We use narrative excerpts from specific interviews to highlight themes we identified across interview accounts and fieldnotes. All names appearing below are pseudonyms.

## **RESULTS**

In total, twelve interviews were conducted with thirteen participants aged 17 to 28 years (one interview included two participants). Participants included 11 young men and two young women. Ten participants self-identified as Caucasian and three self-identified

as Aboriginal. **Young people identified a number of drug-related harms that were affecting their day-to-day lives, including the impact of drug use on their physical and mental health; the risk of overdose death; the poverty associated with severe addiction; altercations with police and other people who use drugs; and the loss of relationships with family and friends.**

### *Expansive understandings of harm reduction*

Overwhelmingly, young people were able to articulate conventional definitions of harm reduction in the Vancouver setting. They identified services such as Insite (Vancouver’s supervised injection facility), NEPs, and the distribution of crack pipes and condoms as examples of harm reduction programs, and understood the purpose of these programs to be a reduction in the spread of infectious diseases and overdose deaths. Some young people were actively involved in delivering harm reduction programs – as peer outreach workers who engaged in “needle sweeps” (i.e., picking up used and discarded syringes), for example. These young people were the most likely to articulate understandings of harm reduction that closely mirrored public health definitions.

However, young people consistently emphasized that “harm reduction” is more than the utilization of particular programs and services, and frequently defined it very broadly. For example, Andy explained:

*Well, [harm reduction is] not just needles... it could be anything from recovery houses to sex addicts anonymous or drug addicts anonymous. (Age 28, male, Caucasian)*

Young people also described the multiple ways in which they attempted to mitigate risk and harm in their own lives. This included strategies for mitigating the risks

and harms stemming from addiction, drug scene involvement, poverty and marginalization. For example, cannabis, alcohol and over-the-counter cough medication (containing dextromethorphan) were described as less harmful drugs that could be used to reduce or eliminate use of drugs young people consistently considered more harmful, such as crystal methamphetamine, crack cocaine, and opioids (including heroin, Oxycontin, and Fentanyl). The former substances were understood to aid the process of “self detox” by mitigating withdrawal symptoms. As Joseph reflected:

*One thing I think actually that could be [good], not for everyone, but for me I find it useful, is medical marijuana, for detoxing. 'Cause I find that it takes the edge off a lot of the pain and what not – the emotional and physical. (Age 26, male, Caucasian)*

The use of less harmful drugs in place of crystal methamphetamine, crack cocaine, and heroin sometimes involved a transition to a less harmful route of administration – usually away from injection drug use and toward intranasal, oral or inhaled routes. Some young people also described transitioning to less harmful drugs as a kind of “maintenance therapy” that prevented them from relapsing back into the use of more harmful forms of drug use and routes of administration. As Ryan reported:

*I think it [marijuana] is definitely keeping me [from using more harmful drugs] – I've tried to stick with the weed, right. I've been doing some other drugs lately but nothing like shooting up [injecting]. (Age 24, male, Caucasian)*

**Many young people also described their attempts to access addiction treatment as a means of mitigating harm in their daily lives. However, study participants frequently experienced difficulties accessing these services due to waitlists, the concentration of addiction treatment services in ‘triggering’ neighbourhoods (discussed further below), the unrealistic or overwhelming**

**expectations of particular programs (e.g., the expectation that they should simultaneously be looking for work while undergoing treatment), an inability to keep their existing housing upon entering particular treatment programs, and an inability to attend treatment with their romantic partners:**

*[What would be nice would be] having the opportunity to just get out of the city – or like going to rehab right away [i.e., without being put on a waitlist], or like having something to keep you off the drugs if you feel that’s what you need right away. (Age 24, male, Caucasian)*

*[Barring couples] prevents us from going to treatment ... they have this idea that, that if you’re a couple and if you abuse together as a couple that you’re not gonna be able to make it as a couple, clean together... And I don’t know if it’s different for younger people than older people but, like, I can’t even tell you how many times I’ve heard, like, ‘I’m not going to treatment without my boyfriend or my girlfriend’... it deters a lot of people from accessing harm reduction in the form of treatment. (Age 24, female, Caucasian)*

For other young people, drug use itself was a form of harm reduction. It was frequently understood as a strategy for ameliorating negative affective states such as depression and anxiety, as well as the physical, psychological and emotional pain that can accompany drug scene entrenchment and marginalization.

*When I was high, it sort of let the ease come in...it helped de-stress from all that hard, like, black and white – you know, emotion that I was going through. Like, how many drugs can I get, how much money can I make, who can I fuck over, who can I cheat, who can I lie to, who can I manipulate? How can I get those shoes off your feet? (Age 23, male, Caucasian)*

*[Addiction] has to do with chronic depression for your entire life ... when I do drugs and even when I try to get off drugs, my depression will be worse... then I’ll use drugs as an escape from that [depression] so it’s kind of an ever repeating cycle.*

*That's why I use drugs. First of all, I want to escape my emotional trauma, and now I'm sort of stuck in a cycle. (Age 26, male, Caucasian)*

*A lot of people use drugs because they're in pain about something. Something happened to them, you know, sexually, mentally, physically and it's what they were drawn to, you know? 'Cause you don't just wake up one day, and like [decide], 'oh, you know, I'm, I'm gonna go, you know, smoke four points of methadone.' (Age 25, male, Aboriginal)*

### *The perceived limitations of existing of harm reduction programs*

Young people articulated both the benefits and potential limitations of existing harm reduction programs in Vancouver. They clearly understood the content of public health messaging around the use of sterile needles and where and how to inject safely, but it was also apparent that they did not always find themselves in environments that supported safe drug use. As Matt described:

*If I can't hit myself [find a vein to inject into] – and so I'd, like, use my jug [jugular] or something, you know? Like, I can't really follow the instructions and maybe they're just not working and...Everything's not always going to go by the book every time. (Age 26, male, Caucasian)*

The reasons that young people were not always able to actualize harm reduction “by the book, every time” were diverse. Some found themselves in withdrawal from a severe opioid addiction, shaky and unable to hit a smaller vein – a practice that they knew to be less risky than a jugular injection, which can cause numerous medical complications including embolic stroke. For other young people, access to sterile equipment was not always possible. This was particularly the case for those who spent significant periods of time outside of downtown Vancouver (see below). Unstable or undesirable housing environments oftentimes meant using drugs more hastily in alleyways and other semi-public places, in order to avoid confrontation with building residents, social housing

building managers and staff, as well as police and other drug users. Hasty injections in outdoor venues often meant skipping a number of the “steps” promoted by harm reduction programs, such as cleaning the bodily injection site with an alcohol wipe and tying off. As Joseph described,

*“If I’m downtown, I’ll go to Insite or one of the harm reduction sites usually. If I literally can’t access anything then usually I’ll do my drugs in like a mall washroom or just a washroom somewhere...I try to stay off the streets because, well, one, the law, and two, it’s not as safe. You know, people can assault you, and you’ll have all these chances of [using drugs hastily] therefore the harm goes up.” (Age 26, male, Caucasian)*

The imperatives of opioid addiction in the context of extreme poverty (i.e., the need to continually consume drugs in order to stave off withdrawal) meant that young people might use “left-overs” from someone else’s syringe, regardless of the acknowledged risks of doing so. **Untreated mental health conditions could also make safe drug consumption difficult. For example, finding sterile syringes was observed to be a low priority if an individual was experiencing drug-induced psychosis or another kind of mental health crisis.** Pete wondered about improved integration of harm reduction, addiction treatment and mental health services in the Vancouver setting:

*They have nurses at Insite, but there’s no real mental health aspect to it. I know a lot of people who are addicted to drugs and homeless...who have mental health issues at their core and that’s sort of what’s pushed them in that direction [drug addiction]. So I think there could be a lot more, like, mental health related things that they could improve upon. (Age 22, male, Caucasian)*

Routinely, young people criticized what they perceived to be a unilateral focus on harm reduction and safer drug consumption on the part of health service agencies and funding bodies, arguing that the availability of harm reduction supplies and places like the supervised injection facility do not go far enough in improving the day-to-day conditions of their lives. Young people felt that a focus on drugs and drug use detracted attention from what they “really needed” to keep themselves healthy and safe. This broader conception of health and safety included, first and foremost, safe and adequate housing. As Kyla put it:

*Harm reduction is good but... people [who access harm reduction in the places where they live] get labeled as junkies....And just because an SRO [single room occupancy hotel] has harm reduction supplies doesn't mean the building should be like a piece a crap, you know? (Age 24, female, Caucasian)*

This participant expressed her frustration at the social housing she qualifies for – that is, social housing designated for “hard to house” residents who use drugs, which is often run-down, and stigmatized as a ‘junkie’ space. For Kyla and a number of other young people, the presence of harm reduction supplies inside their social housing buildings could actually contribute to experiences of self-stigmatization. Similar to Kyla, Andy (age 28) felt that his social housing agency-operated building did well at providing access to sterile needles, but little else:

*Everywhere you look there's harm reduction ... but [it's] not like they're doing anything [to change his overall living conditions] ...Even though they charge us \$375 a month for rent, they give us under-underequipped rooms. Like, my room's got gaps between the fucking doors. (Age 28, male, Caucasian)*

***The role of place in shaping young people's engagement with harm reduction services***

Overwhelmingly, young people associated the delivery of harm reduction services with Vancouver's DTES neighbourhood. This neighbourhood was highly stigmatized by many young people as a "junkie" space, even as many regularly spent time and used drugs there (Fast et al., 2009). As a result of the stigma connected to the DTES, a number of young people made periodic attempts to avoid or move out of the neighbourhood, which made accessing harm reduction services and the safe consumption of drugs more difficult. As Kyla explained:

*The building we're in now – and it is here, in the West End [adjacent to the Downtown South]. Like, it's hard to get, like, harm reduction supplies. Like, you ask for clean rigs [syringes] and they give you, like, two, and if you ask for them again later they say 'we already gave you some'... One night [the front desk staff member], like, she only gave us, like, two [syringes] each and she's like, 'Well there's only ten left for the whole night for the whole building' – like, that wouldn't happen on the East Side [DTES]. (Age 24, female, Caucasian)*

Kyla's experience of being denied clean syringes is in contravention of the Vancouver Coastal Health Authority's official policy on needle exchange, which supports unrestricted and unlimited access. Yet, participant accounts referenced a number of similar incidents, underscoring differential access to syringes in spaces outside of the DTES.

Participants suggested that concentration of services in the DTES was not limited to needle exchange, and included other services for people living in poverty as well. Joseph, who was living in a suburb of Greater Vancouver at the time of the interview, said:

*Community resources are really um – they're really centered around [downtown] Vancouver itself... I think that*

*there needs to be – sort of more services more evenly spread [out], ‘cause I only have one food bank by my house and they’re only open on Wednesdays from ten to twelve so if I don’t have – if I miss that, and I don’t have food then I’m hooped. There’s nothing that I can do. (Age 26, male, Caucasian)*

Young people were routinely caught between the need to access services that are, by and large, only available in downtown Vancouver, and in the Downtown Eastside neighbourhood in particular, and a desire to leave downtown Vancouver in order to reduce the harms they associated with that area. Andy explained the irony of having to go to the DTES to see his methadone doctor while trying to remain abstinent:

*Yeah, well I just don’t want to be around all that ‘cause I’m trying to get away from them [people he knows in the DTES]. And I got to go back down to get my medication – I got to be right – seeing the same people I’ve seen for ten fucking years shooting up beside me. Like, I don’t really want that. That’s just driving me to go back and get high. (Age 28, male, Caucasian)*

## **DISCUSSION**

Vancouver is the site of a large, well established harm reduction infrastructure that seeks to reduce drug related harms such as HIV and HCV transmission, including among street entrenched young people. However, young peoples’ diverse understandings, experiences and engagements with “harm reduction” in this setting illustrate the limitations of the existing infrastructure, which is primarily located in Vancouver’s DTES.

The young people who participated in this study were highly resourceful when it came to mitigating the numerous risks and harms associated with drug use in their own lives, and had diverse understandings of harm reduction. **Previous theoretical work has**

**suggested that young peoples' relative powerlessness as a result of their age and experiences of marginalization may lead them to engage in risk-taking behavior, both as a means of resisting dominant social norms and seeking to effect choices in their otherwise chaotic lives (Denscombe, 2001; Miller & Lyng, 2005; Pound & Campbell, 2015). It is not surprising, then, that young people in our setting often elect to manage risk in their own lives by exerting control in the ways that are easily available to them within the context of entrenched poverty (Denscombe, 2001).** For example, young people described using what they perceived to be less harmful drugs in order to “self-detox,” reduce the severity of their addiction, or transition from more harmful routes of administration, such as intravenous use, to oral, inhaled or intranasal routes. In particular, cannabis was routinely cited as a substance of choice for attempting to make these transitions. Cannabis use remains highly prevalent among street involved young people in British Columbia, with an estimated 76% of these young people using cannabis (Saddichha, Linden, & Krausz, 2014). Consistent with young people’s own strategies for reducing harms, research with drug-using adults in other settings has demonstrated that cannabis can aid in reducing total opioid dose (Kral et al., 2015; Peters, 2013). Among a cohort of low-intensity heroin injectors followed longitudinally in San Francisco, for example, those who maintained low heroin use, or eventually transitioned off heroin, reported using cannabis and other drugs to facilitate this transition (Wenger, Lopez, Comfort, & Kral, 2014). Elsewhere, individuals have also reported using cannabis to reduce their use of alcohol or prescription drugs (Lucas et al., 2016).

However, young peoples' description of cannabis use as a strategy for self-detoxification may also reflect their difficulty accessing addiction treatment (Phillips et

al., 2014; Phillips et al., 2015), including medically supervised detoxification. This was also evident in our findings. The results of this study, as well as a large body of literature from our setting and others indicates that barriers to addiction treatment for young people are numerous, and include long wait lists (Hadland, Kerr, Li, Montaner, & Wood, 2009) insufficient use of evidence based pharmacotherapies (e.g., methadone, buprenorphine-naloxone) (Pecoraro, Fishman, Ma, Piralishvili, & Woody, 2013; Yang et al., 2011), institutional barriers such as age restrictions (Barker et al., 2015; Brands, Leslie, Catz-Biro, & Li, 2005; Hudson et al., 2010), and experiences of stigma and discrimination, particularly among young people of Indigenous ancestry and LGBTQ+ young people (Brands et al., 2005; Hudson et al., 2010). **Our findings also point to the need for protected income assistance and housing while young people are undergoing treatment, locating youth dedicated treatment settings outside of ‘triggering’ neighbourhoods, as well as treatment options for young couples.** Taken together, these findings indicate that the scaling up of accessible, appropriate addiction treatment, specifically designed to meet the needs of young people, is urgently needed in our setting.

Consistent with previous research in our setting and others (Fast, Small, Krusi, Wood, & Kerr, 2010; Feldman, 1968; Mayock, 2005) young people also described using drugs to mitigate negative affective states such as depression and anxiety, and the daily stresses of life on the streets. Many young people connected their drug use with the mediation of negative affective states, and periods of mental health crisis were observed to negatively impact young people’s abilities to enact harm reduction practices “by the book.” Previous work with street-involved young people has demonstrated that they experience significant barriers to accessing mental health services in Vancouver (Barker

et al., 2015). This is particularly the case for those with concurrent disorders (Kozloff et al., 2013). As with addiction treatment, the findings of the present study underscore the need for more accessible, appropriate mental health services in our setting, tailored to the diverse needs of marginalized young people.

Consistent with previous work by our team (Fast, Shoveller, Shannon, & Kerr, 2010), place mediated young people's access to harm reduction and other social services in important ways. Although young people often actively engaged with harm reduction programs in the DTES, whether through utilizing Insite, NEPs, or working as peer outreach workers, they also highlighted the degree to which associating themselves with these services, or having harm reduction supplies available in one's place of residence, could lead them to feel stigmatized as "junkies" and "drug users." The stigma they attached to particular services, and the DTES neighbourhood more generally, could lead them to avoid these services (Fast, Shoveller, et al., 2010). **Stigmatization of place was superimposed on the stigmas of poverty and addiction, and perpetuated through both the "discourses of vilification" (Wacquant, 2007) reflected in media and political portrayals of the DTES neighbourhood, and through geographic delineations of "junkie" spaces by youth themselves (Fast, Shoveller, et al., 2010). Stigmatization of place is known to have pernicious health impacts for residents of these spaces (Keene & Padilla, 2010; Kelaher, Warr, Feldman, & Tacticos, 2010), and therefore it is perhaps not surprising that avoiding the DTES became an important harm reduction strategy for many youth as they tried to improve their wellbeing. Young people distanced themselves from the DTES both when they were attempting to become abstinent or reduce their drug use, and in order to prevent relapses into harmful**

**forms of drug use.** As they attempted to distance themselves from the DTES, however, access to sterile drug use paraphernalia, addiction treatment, and other kinds of support (e.g., food banks) became more difficult. In this way, young people were routinely caught between the need to access services in the DTES to stay well, and the need to avoid the area in order to minimize harm. Our findings underscore the importance of considering the spatial distribution of existing services when planning new harm reduction, health, and social services, so that marginalized young people who are actively trying to distance themselves from the DTES are equitably served.

At a more general level, young people's critiques of Vancouver's harm reduction infrastructure echo previous literature on the limitations of harm reduction approaches in settings of urban poverty. Young people described how drug consumption could not be "by the book, every time," underscoring how a focus on the individual "rational" and "responsible" drug consumer fails to take into account the social, structural and environmental contexts that powerfully constrain the "choice" to use drug use safely (Bourgois, 2000; Keane, 2003; Moore & Fraser, 2006; Rhodes, 2002; Roe, 2005, 2009). In particular, young people referenced addiction severity, periods of mental health crisis and extreme poverty as factors that constrained their ability to make "good" choices when it came to using drugs more safely. **Additionally, and consistent with the literature (Briggs et al., 2009), unstable and undesirable housing environments were described as pushing young people out into the streets and public settings, where they faced an increased risk of being robbed or stopped by police, thereby resulting in rushed injection practices and reduced attention to safety. These findings**

**underscore that policy interventions to increase the availability of appropriate and stable housing for young people would help reduce drug-related harms.**

At this more general level, young people also frequently described a sense that existing harm reduction services did little to improve their broader life chances in the city, beyond minimizing the immediate health risks associated with the consumption of drugs. Of course, the mandate of harm reduction services in Vancouver is to reduce drug related harms, and services are constrained in their ability to facilitate young people's access to housing, income, and addiction and mental health services. Nevertheless, it is important to recognize the significance of improved living conditions and quality of life within the narratives of the young people who participated in this study, which suggest that efforts to improve their lives through other kinds of health and social services (e.g. housing, mental health and addiction services) should be prioritized. Importantly, harm reduction services such as NEPs and supervised injection facilities have previously been shown to facilitate entry into addiction treatment (Brooner et al., 1998; Strathdee et al., 2006), demonstrating the feasibility of strong linkages between harm reduction services and the other kinds of health and social services that young people highlighted.

This study has several limitations that warrant acknowledgment. Most significantly, our study was limited by a small sample size, and participants were primarily male and Caucasian. However, we were able to ensure a good level of thematic saturation by embedding this interview series with an ongoing qualitative and ethnographic study which explores similar topics and themes. It should also be noted that the harm reduction infrastructure in Vancouver is relatively unique, which may limit the generalizability of our findings to other settings. **Additionally, the young people**

**involved in the semi-structured interviews were between 17-28 years of age, and are therefore developmentally distinct from younger youth populations, which may impact the generalizability of our findings to other populations of young people who use drugs.**

**In conclusion, street-involved young people in Vancouver navigate a complex harm reduction landscape, in which their own definitions of harm reduction were diverse and expansive.** Our findings highlight critical gaps in access to addiction treatment, mental health care and housing among young people in our setting, as well as differential access to services outside the DTES. Most significantly, these findings are a call to action to address the broader social determinants of health for marginalized young people who use drugs in our setting.

## **ACKNOWLEDGEMENTS**

The authors thank the study participants for their contribution to the research, as well as current and past researchers and staff. The study was supported by the US National Institutes of Health (R01DA033147) and (U01DA038886). Dr. Nikki Bozinoff received support through the Research in Addiction Medicine Scholars program (R25DA033211) and the Conrad N. Hilton Foundation through a Next Generation Award. Dr. Kora DeBeck is supported by a Michael Smith Foundation for Health Research (MSFHR)/St. Paul's Hospital Foundation-Providence Health Care Career Scholar Award and a Canadian Institutes of Health Research (CIHR) New Investigator Award. Dr. Will Small is supported by a MSFHR Scholar Award. Dr. Danya Fast is supported by postdoctoral fellowship awards from CIHR and MSFHR.

- Bardsley, J., Turvey, J., & Blatherwick, J. (1990). Vancouver's needle exchange program. *Can J Public Health, 81*(1), 39-45.
- Barker, B., Kerr, T., Nguyen, P., Wood, E., & DeBeck, K. (2015). Barriers to health and social services for street-involved youth in a Canadian setting. *J Public Health Policy, 36*(3), 350-363.
- BCCDC. (2013). *HIV in British Columbia: Annual Surveillance Report 2012*. Retrieved from <http://www.bccdc.ca/util/about/annreport/default.htm>
- Bourgois, P. (2000). Disciplining addictions: the bio-politics of methadone and heroin in the United States. *Cult Med Psychiatry, 24*(2), 165-195.
- Brands, B., Leslie, K., Catz-Biro, L., & Li, S. (2005). Heroin use and barriers to treatment in street-involved youth. *Addiction Research & Theory, 13*(5), 477-487. doi:10.1080/16066350500150624
- Briggs, D., Rhodes, T., Marks, D., Kimber, J., Holloway, G., & Jones, S. (2009). Injecting drug use and unstable housing: Scope for structural interventions in harm reduction. *Drugs-Education Prevention and Policy, 16*(5), 436-450. doi:10.1080/09687630802697685
- Brooner, R., Kidorf M Fau - King, V., King V Fau - Beilenson, P., Beilenson P Fau - Svikis, D., Svikis D Fau - Vlahov, D., & Vlahov, D. (1998). Drug abuse treatment success among needle exchange participants. (0033-3549 (Print)). doi:D - NLM: PMC1307735 EDAT- 1998/12/16 MHDA- 1998/12/16 00:01 CRDT- 1998/12/16 00:00 PST - ppublish
- Bungay, V., Malchy, L., Buxton, J. A., Johnson, J., MacPherson, D., & Rosenfeld, T. (2006). Life with jib: A snapshot of street youth's use of crystal methamphetamine. *Addiction Research & Theory, 14*(3), 235-251.
- Denscombe, M. (2001). Uncertain identities and health- risking behaviour: The case of young people and smoking in late modernity. *The British journal of sociology, 52*(1), 157-177.
- Fast, D., Shoveller, J., Shannon, K., & Kerr, T. (2010). Safety and danger in downtown Vancouver: Understandings of place among young people entrenched in an urban drug scene. *Health & place, 16*(1), 51-60. doi:<http://dx.doi.org/10.1016/j.healthplace.2009.07.004>
- Fast, D., Small, W., Krusi, A., Wood, E., & Kerr, T. (2010). 'I guess my own fancy screwed me over': transitions in drug use and the context of choice among young people entrenched in an open drug scene. *BMC public health, 10*, 126.
- Fast, D., Small, W., Wood, E., & Kerr, T. (2009). Coming 'down here': young people's reflections on becoming entrenched in a local drug scene. *Soc Sci Med, 69*(8), 1204-1210.
- Feldman, H. W. (1968). Ideological Supports to becoming and Remaining a Heroin Addict. *Journal of health and social behavior, 9*(2), 131-139.
- Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough? *Field Methods, 18*(1), 59-82. doi:10.1177/1525822X05279903
- Hadland, S. E., DeBeck, K., Kerr, T., Nguyen, P., Simo, A., Montaner, J. S., & Wood, E. (2014). Use of a medically supervised injection facility among street youth. *J Adolesc Health, 55*(5), 684-689.

- Hadland, S. E., Kerr, T., Li, K., Montaner, J. S., & Wood, E. (2009). Access to drug and alcohol treatment among a cohort of street-involved youth. *Drug Alcohol Depend*, *101*(1-2), 1-7.
- Hopper, T. (2014, Feb 19, 2014). Vancouver drug centre teaching alcoholics to brew their own beer so they'll stop drinking mouthwash. *National Post*. Retrieved from <http://news.nationalpost.com/news/canada/vancouver-drug-centre-teaching-alcoholics-to-brew-their-own-beer-so-theyll-stop-drinking-mouthwash>
- Hudson, A. L., Nyamathi, A., Greengold, B., Slagle, A., Koniak-Griffin, D., Khalilifard, F., & Getzoff, D. (2010). Health-seeking challenges among homeless youth. *Nurs Res*, *59*(3), 212-218.
- Hyshka, E., Strathdee, S., Wood, E., & Kerr, T. (2012). Needle exchange and the HIV epidemic in Vancouver: Lessons learned from 15 years of research. *International Journal of Drug Policy*, *23*(4), 261-270.  
doi:<http://dx.doi.org/10.1016/j.drugpo.2012.03.006>
- Keane, H. (2003). Critiques of harm reduction, morality and the promise of human rights. *International Journal of Drug Policy*, *14*(3), 227-232.  
doi:[http://dx.doi.org/10.1016/S0955-3959\(02\)00151-2](http://dx.doi.org/10.1016/S0955-3959(02)00151-2)
- Keene, D. E., & Padilla, M. B. (2010). Race, Class and the Stigma of Place: Moving to “Opportunity” in eastern Iowa. *Health & place*, *16*(6), 1216-1223.  
doi:10.1016/j.healthplace.2010.08.006
- Kelaher, M., Warr, D. J., Feldman, P., & Tacticos, T. (2010). Living in ‘Birdsville’: Exploring the impact of neighbourhood stigma on health. *Health and Place*, *16*(2), 381-388. doi:10.1016/j.healthplace.2009.11.010
- Kerr, T., Marshall, B. D., Miller, C., Shannon, K., Zhang, R., Montaner, J. S., & Wood, E. (2009). Injection drug use among street-involved youth in a Canadian setting. *BMC public health*, *9*, 171.
- Kerr, T., Small, W., Buchner, C., Zhang, R., Li, K., Montaner, J., & Wood, E. (2010). Syringe sharing and HIV incidence among injection drug users and increased access to sterile syringes. *Am J Public Health*, *100*(8), 1449-1453.
- Kozloff, N., Cheung, A. H., Ross, L. E., Winer, H., Ierfino, D., Bullock, H., & Bennett, K. J. (2013). Factors influencing service use among homeless youths with co-occurring disorders *Psychiatr Serv* (Vol. 64, pp. 925-928). United States.
- Kral, A. H., Wenger, L., Novak, S. P., Chu, D., Corsi, K. F., Coffa, D., . . . Bluthenthal, R. N. (2015). Is cannabis use associated with less opioid use among people who inject drugs? *Drug Alcohol Depend*, *153*, 236-241.
- Lloyd-Smith, E., Kerr, T., Zhang, R., Montaner, J. S. G., & Wood, E. (2008). High prevalence of syringe sharing among street involved youth. *Addiction Research & Theory*, *16*(4), 353-358. doi:10.1080/16066350701823094
- Lucas, P., Walsh, Z., Crosby, K., Callaway, R., Belle-Isle, L., Kay, R., . . . Holtzman, S. (2016). Substituting cannabis for prescription drugs, alcohol and other substances among medical cannabis patients: The impact of contextual factors. *Drug Alcohol Rev*, *35*(3), 326-333. doi:10.1111/dar.12323
- Mayock, P. (2005). ‘Scripting’ risk: Young people and the construction of drug journeys *Drugs: education, prevention and policy* (Vol. 12, pp. 349-368).
- McNeil, R., Kerr, T., Lampkin, H., & Small, W. (2015). “We need somewhere to smoke crack”: An ethnographic study of an unsanctioned safer smoking room in

- Vancouver, Canada. *International Journal of Drug Policy*, 26(7), 645-652.  
doi:<http://dx.doi.org/10.1016/j.drugpo.2015.01.015>
- Miller, W. J., & Lyng, S. (2005). Adolescents on the edge: The sensual side of delinquency. *Edgework: The sociology of risk-taking*, 153-172.
- Moore, D., & Fraser, S. (2006). Putting at risk what we know: reflecting on the drug-using subject in harm reduction and its political implications *Soc Sci Med* (Vol. 62, pp. 3035-3047). England.
- Pauly, B. B., Reist, D., Belle-Isle, L., & Schactman, C. (2013). Housing and harm reduction: what is the role of harm reduction in addressing homelessness? *Int J Drug Policy* (Vol. 24, pp. 284-290). Netherlands: 2013 Elsevier B.V.
- Pecoraro, A., Fishman, M., Ma, M., Piralishvili, G., & Woody, G. E. (2013). Pharmacologically assisted treatment of opioid-dependent youth. *Paediatr Drugs*, 15(6), 449-458. doi:10.1007/s40272-013-0041-5
- Peters, D. C. (2013). Patients and Caregivers Report Using Medical Marijuana to Decrease Prescription Narcotics Use. *Humboldt Journal of Social Relations*, 35, 24-40.
- Phillips, M., DeBeck, K., Desjarlais, T., Morrison, T., Feng, C., Kerr, T., & Wood, E. (2014). Inability to access addiction treatment among street-involved youth in a Canadian setting. *Subst Use Misuse*, 49(10), 1233-1240.
- Phillips, M., Richardson, L., Wood, E., Nguyen, P., Kerr, T., & DeBeck, K. (2015). High-Intensity Drug Use and Health Service Access Among Street-Involved Youth in a Canadian Setting. *Subst Use Misuse*, 1-9.  
doi:10.3109/10826084.2015.1058825
- Pound, P., & Campbell, R. (2015). Locating and applying sociological theories of risk-taking to develop public health interventions for adolescents. *Health Sociology Review*, 24(1), 64-80. doi:10.1080/14461242.2015.1008537
- Puri, N., DeBeck, K., Feng, C., Kerr, T., Rieb, L., & Wood, E. (2014). Gender influences on hepatitis C incidence among street youth in a Canadian setting. *J Adolesc Health*, 55(6), 830-834.
- Rhodes, T. (2002). The 'risk environment': a framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, 13(2), 85-94.  
doi:[http://dx.doi.org/10.1016/S0955-3959\(02\)00007-5](http://dx.doi.org/10.1016/S0955-3959(02)00007-5)
- Roe, G. W. (2005). Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction. *Critical Public Health*, 15(3), 243-250.
- Roe, G. W. (2009). Fixed in Place: Vancouver's Downtown Eastside and the Community of Clients. *BC Studies*(164), 75-101.
- Roy, E., Haley, N., Leclerc, P., Boivin, J. F., Cedras, L., & Vincelette, J. (2001). Risk factors for hepatitis C virus infection among street youths. *CMAJ*, 165(5), 557-560.
- Roy, E., Haley, N., Leclerc, P., Lemire, N., Boivin, J. F., Frappier, J. Y., & Claessens, C. (2000). Prevalence of HIV infection and risk behaviours among Montreal street youth. *Int J STD AIDS*, 11(4), 241-247.
- Roy, E., Haley, N., Leclerc, P., Sochanski, B., Boudreau, J. F., & Boivin, J. F. (2004). Mortality in a cohort of street youth in Montreal *JAMA* (Vol. 292, pp. 569-574). United States.

- Saddichha, S., Linden, I., & Krausz, M. R. (2014). Physical and Mental Health Issues among Homeless Youth in British Columbia, Canada: Are they Different from Older Homeless Adults? *J Can Acad Child Adolesc Psychiatry*, 23(3), 200-206.
- Small, D., Palepu, A., & Tyndall, M. W. (2006). The establishment of North America's first state sanctioned supervised injection facility: A case study in culture change. *International Journal of Drug Policy*, 17(2), 73-82.  
doi:<http://dx.doi.org/10.1016/j.drugpo.2005.08.004>
- Small, W., Wood, E., Tobin, D., Rikley, J., Lapushinsky, D., & Kerr, T. (2012). The Injection Support Team: a peer-driven program to address unsafe injecting in a Canadian setting. *Subst Use Misuse*, 47(5), 491-501.  
doi:10.3109/10826084.2012.644107
- Strathdee, S. A., Patrick, D. M., Currie, S. L., Cornelisse, P. G., Rekart, M. L., Montaner, J. S., . . . O'Shaughnessy, M. V. (1997). Needle exchange is not enough: lessons from the Vancouver injecting drug use study. *AIDS*, 11(8), F59-65.
- Strathdee, S. A., Ricketts Ep Fau - Huettner, S., Huettner S Fau - Cornelius, L., Cornelius L Fau - Bishai, D., Bishai D Fau - Havens, J. R., Havens Jr Fau - Beilenson, P., . . . Latkin, C. A. (2006). Facilitating entry into drug treatment among injection drug users referred from a needle exchange program: Results from a community-based behavioral intervention trial. (0376-8716 (Print)). doi:D - NLM: NIHMS36559
- D - NLM: PMC2196224 EDAT- 2005/12/21 09:00 MHDA- 2006/12/16 09:00 CRDT- 2005/12/21 09:00 PHST- 2005/07/24 [received] PHST- 2005/11/12 [revised] PHST- 2005/11/15 [accepted] PHST- 2005/12/20 [aheadofprint] AID - S0376-8716(05)00358-3 [pii] AID - 10.1016/j.drugalcdep.2005.11.015 [doi] PST - ppublish
- Tzemis, D., Al-Qutub, D., Amlani, A., Kesselring, S., & Buxton, J. A. (2014). A quantitative and qualitative evaluation of the British Columbia Take Home Naloxone program. *CMAJ open*, 2(3), E153-161.
- UHRI. (2013). *Drug Situation in Vancouver*. Retrieved from [http://www.cfenet.ubc.ca/sites/default/files/uploads/news/releases/war\\_on\\_drugs\\_failing\\_to\\_limit\\_drug\\_use.pdf](http://www.cfenet.ubc.ca/sites/default/files/uploads/news/releases/war_on_drugs_failing_to_limit_drug_use.pdf)
- Wacquant, L. (2007). Territorial Stigmatization in the Age of Advanced Marginality. *Thesis Eleven*, 91(1), 66-77. doi:10.1177/0725513607082003
- Wenger, L. D., Lopez, A. M., Comfort, M., & Kral, A. H. (2014). The phenomenon of low-frequency heroin injection among street-based urban poor: Drug user strategies and contexts of use. *International Journal of Drug Policy*, 25(3), 471-479. doi:<http://dx.doi.org/10.1016/j.drugpo.2014.02.015>
- Werb, D., Kerr, T., Fast, D., Qi, J., Montaner, J. S. G., & Wood, E. (2010). Drug-related risks among street youth in two neighborhoods in a Canadian setting. *Health & place*, 16(5), 1061-1067. doi:<http://dx.doi.org/10.1016/j.healthplace.2010.06.009>
- Wood, E., & Kerr, T. (2006a). What do you do when you hit rock bottom? Responding to drugs in the city of Vancouver. *International Journal of Drug Policy*, 17(2), 55-60.
- Wood, E., Stoltz, J. A., Montaner, J. S., & Kerr, T. (2006b). Evaluating methamphetamine use and risks of injection initiation among street youth: the ARYS study. *Harm Reduct J*, 3, 18.

Yang, J., Oviedo-Joekes, E., Christian, K. W., Li, K., Louie, M., Schechter, M., & Spittal, P. (2011). The Cedar Project: methadone maintenance treatment among young Aboriginal people who use opioids in two Canadian cities. *Drug Alcohol Rev*, 30(6), 645-651. doi:10.1111/j.1465-3362.2010.00258.x