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Harm Reduction in Canadian Health Care: A Qualitative Study of Caring and Compassion in a Supervised Consumption Clinic

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Harm Reduction in Canadian Health Care: A Qualitative Study of Caring and Compassion in a Supervised Consumption Clinic

by

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A THESIS

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Abstract.

This autoethnographic research explores my lived experiences within Calgary's only supervised consumption site, Safeworks, and those of program, staff and clients. In this thesis I am attentive to the everyday, the minute, and the details of lives lived within real time, in specific moments, and in actual situations. Drawing on several months of participatory observations within the supervised consumption site and 21 in-depth interviews with program staff and clients, I discuss how supervised consumption services offer more than a reduction in drug related harms; rather, these services fulfill an essential social void in the lives of people who use drugs – that of interpersonal recognition and respect. I offer consideration into caring relationships as they are cultivated at Safeworks – exploring the difficulties and tensions of caring for a population that is regularly publicly denounced and denied. Further, I offer a reflection of the ethical dilemmas present in the course of providing care; what may be felt to be intuitively just by some staff is seldom shared by all those involved in the delivery of supervised consumption services. What moral predicaments arise when clients present at Safeworks with more needs than staff can ever hope to meet? The burdens borne by staff, I argue, exist because they are not shared. In the absence of a collective vision of mutual recognition and resemblance with persons who use substances, care providers at Safeworks must work overtime: supporting clients to feel less stigmatized and less isolated, above attending to their daily needs in states of dependency, despair, and overdose, while simultaneously extending their reach to cover gaps in service delivery that manifest in societies indifferent to the plight of those overwhelmed by addictions.

Preface.

This thesis is original, unpublished, independent work by the author, J. Van Dyke. The University of Calgary's Conjoint Health Research Ethics Board approved the project "A Qualitative Study of Supervised Consumption and Harm Reduction in Calgary's Urban Core" on August 30, 2018.

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Dedication.

To my sister, Julie, who has given me everything I've ever needed, effortlessly. I love you.

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Chapter 1: Introduction.

It is my aim in this thesis to encourage readers to recapture the "lost sense of the immediate, active, ambiguous 'plenum of existence' in which all ideas and intellectual constructs are grounded" (Jackson and Piette 2015) – to reintroduce "life as it is lived" into sociological literature (Jackson and Piette 2015). Supervised consumption services are subject to so much moral indignation and political contention (Bochner and Ellis 1992) that the existential and embodied experiences of people involved in these services are seldom considered or explored. Therefore, this research focuses on my lived experiences of ethnographic fieldwork at Safeworks Supervised Consumption Services and on those of my participants. There is much to be gained sociologically by using existential and personal perspectives in my research and in my text; by writing of my participation at Safeworks I can make visible the nuanced changes and instantaneous transformations (Jackson and Piette 2015:3) I experienced and continue to unravel as a result of my fieldwork**.** Here, I raise the difficulties and embodied complexities of life as it is lived at Safeworks. I have no privileged access to the subjective realities of other people tangled in the delivery of these services other than what they have offered me in conversation. Consequently, I discuss the issue of being at Safeworks through direct engagement with the understandings of a particular human being: myself (Jackson and Piette 2015:3). This narrative is "consciously self-revelatory, but my purpose in writing it is sociological, not confessional" (Richardson 1992:125). It takes as its starting point my own lived experience of supervised consumption services and those of my participants: What is it like to live through work that places you in the midst of uncertainty, doubt, contradiction, and ambivalence (Bochner and Ellis 1992:97)? How does one cope with the embodied tensions of care as it is lived and practiced? What emotional landscapes remain uncharted in the delivery of these services? How does one

make sense of the specific moments, trivial conversations, and the everyday details of a particularly veiled aspect of social life? My ethnographic fieldwork placed me directly in the heart of the supervised consumption experience. I, quite literally, existed (from the root ex-sistere, "to come forth") at Safeworks; first, "standing out" in my strangeness, then "emerging" – altered (Jackson and Piette 2015:5). Recognizing that existing literature rarely reflects the "meanings and feelings embodied by the human side" (Bochner and Ellis 1992) of supervised consumption services, my desire in this narrative is to bring forth and observe the messiness and "particularities of affect, cognition, moral responsibility, and action" (Biehl, Good and Kleinman 2007:1) that I grappled with at the site.

Many months of intensive fieldwork at Safeworks SCS left me transformed. The person who entered the site was not the one who left; my time at Safeworks compelled a shifting selfhood, a splintering of self-identity (Coffey 1999:26). My fieldwork challenged me, bringing me to the limits of my understanding. I was "thrown open to new ways of experiencing [my] being-in-the-world, new ways of connecting with others" (Jackson and Piette 2015:8). I entered the consumption site with a limited practical understanding of substance use; interacting naturally with Safeworks clients proved to be, at least initially, an even greater mystery. When I left, I was comfortable – no, confident – in the space; I was both an altered and augmented version of myself. My fieldwork at Safeworks encompassed bearing witness to the suffering of others, compelling me to a "new kind of responsible life in a previously unimaginable skin" (Biehl and Locke 2017:29). What could I do with this awareness that refused to sit still; that could not be limited to the confines of my consciousness? In many ways, my fieldwork forced a continual change in how I viewed the world; my purpose, in this text, is to be faithful to these experiences – to demonstrate Safeworks' influence in reconfiguring my realities, and along the

way, readers might also question their own beliefs. I started this research trying to comprehend supervised consumption services and their impact on my life; on what I ought to make out of my experience, and what I owed to those I spent time with at the site. I found myself reluctant to write of and for others, and so I settled on a narrative that brought both myself and my participants to the fore. Any story I have of supervised consumption is the consequence of shared experience. Therefore, this text is as much about staff and clients at Safeworks as it is of me. As a child I thought in prose; as a researcher I bring our time together at the site to life. I would like to preface this work with a line from Italo Calvino's novel, 'If on a Winter's Night a Traveler,' that emphasizes the infiniteness of narrative; the expansiveness of a single life.

> What I want is for you to feel, around the story, a saturation of other stories that I could tell and maybe will tell or who knows may already have told on some other occasion, a space full of stories that perhaps is simply my lifetime, where you can move in all directions, as in space, always finding stories that cannot be told until other stories are told first (2012:109).

The stories of delivering supervised consumption services I tell in this text are not complete; they resist forms of sense making – of imposed coherence – regularly found in academic prose (Biehl and Locke 2017). Every time I share an anecdote, know that there is always more I could have said, another illustration I have withheld, if only because every story that appears on these pages is complicated by countless others. This is, of course, why we are taught to read between the lines; to realize the weight of what is left unsaid. The stories I tell here exist because they resonate with me; they may align with the experiences of my participants, or they may chafe against them, but either way, our stories – of supervised consumption, of 'minor' acts of care, of weariness and misery, of connection – are joined together, however briefly, in text. Stories speak to experience, the specifics of which may never be felt again. This is why my individuality, the 'I' in my storytelling, is characteristically sociological; I am "never completely eclipsed in any

collective activity [at the site], and the collective has no reality apart from the persons that comprise it" (Jackson and Piette 2015). My fieldwork is its own shared experience; not just my time at Safeworks, but ours – mine and my participants' – even if our accounts of these moments differ. Thus, this research grants a complement of perspectives; an attunement to the everyday, the microscopic, and the details of lives lived within real time, in specific moments, and in actual situations (Jackson and Piette 2015:4). In sum, "these moments and stories are incomplete views onto subjects and lifeworlds in the process of becoming. Taken together, they make up an ethnographic sensorium: a multifaceted and affective point of contact with worlds of inequality, hovering on the verge of exhaustion while also harboring the potential for things to be otherwise" (Biehl and Locke 2017). My work is to invite you in; to stretch your imagination (Biehl and Locke 2017:29; Jackson 2013b).

Supervised consumption services are deceptively simple in their purpose and are still largely misunderstood. Fundamentally, Safeworks is a place where people can use drugs in a monitored, hygienic environment to reduce the harms associated with substance use (Alberta Health Services 2019). Supervised consumption services are designed to diminish the transmission of disease and infection, reduce instances of public substance use, and, necessarily, to limit overdose deaths (Alberta Health Services 2019). Though this description is clinical and slightly sterile in its delivery, it is, nonetheless, accurate in its summations and widely applied in academic and public conversations. Yet, the above definition is predictably uncomplicated; it fails to capture critical differences in the design of supervised consumption services across local social contexts and, in what I venture to explore, distinctions in how these services are understood, realized and experienced by those involved in their elaboration. A tentative articulation of supervised consumption services requires becoming sensitive to these differences;

it demands more than ‘simply accurate’ and ‘redundant’ explanations of what supervised consumption services are assumed to do and instead rouses sensitivity to differences in how these services are perceived and animated in practice (Latour 2004: 215). A richer understanding of Safeworks must attend to the granular ways in which the local existence of the site is understood and acted upon by individuals in the course of providing or receiving care (Biehl and Petryna 2013:133). In this text, it is my intent to avoid repeating what is already known (Latour 2004:215) – to render differences perceptible, to introduce complications onto the page, to offer the same complexity to persons at Safeworks that we afford ourselves in our inner worlds. An articulation of supervised consumption services provides “a little more allowance for the unexpected” (Biehl and Locke 2017: 338) – greeting granularity in experience with enthusiasm. This work does not expect interpretations of the site – my own, those of Safeworks staff, those of clients – “to converge into one single discussion with a statement that would be a mere replication” of the original description (Latour 2004:211), but rather, my description of care at Safeworks delights in the complexities experienced by people in given, localized space. The more contrasts added through experience, the more these services become something tangible, something meaningful. Nonetheless, the practice of chafing against the multiple imaginations of supervised consumption services– of how they should be run, of the wherewithal it takes to enter the space – requires first learning to be affected by the work (Latour 2004), learning to live inside another social life. Consequently, understanding how the site operated preceded any other intimate knowledge I might have hoped to gain. Supervised consumptions services are meant to save lives - and they do - it has been demonstrated in literature, evidenced in studies, and witnessed, by me, at Safeworks, day after day. Safeworks staff saves lives - but that is not all they do. There is so much more, and, in saying that, I am left perplexed. Is there anything else

that needs to be said? Should saving lives not be the only thing that matters? Need there be a better reason to offer supervised consumption services than the preservation of life?

And yet, as a sociologist, to leave it at that is to leave so much of this particular social world unexamined. Model explanations conceal as much as they reveal, and thus, following Biehl, it is my intent to "shake loose, to whatever degree possible, from determinants and definitions" (2013: 581) – to elucidate, rather the erase, the social processes through which individuals come to form their own interpretations of what Safeworks should do and how it ought to function. It is in that complexity, the subtle space that exists between the definition and actualization of supervised consumption services, that I became situated. It is in this gap that this text settles; it is in bridging this crevice that we are left. Consequently, it is my aim in this thesis is to explore aspects of work at the site that are less overtly recognized; to notice the "great, blooming, buzzing confusion" (Jackson and Piette 2015) of caring for persons in a particular social realm saturated with structural injustice, prolonged substance dependence, and among real public contention over the worth of Safeworks' very presence. In effect, I would like to write about what is missing and, in doing so, create new possibilities (Schwarcz 2017) for understanding care practices within supervised consumption services. Following Frank (2009), I define care provisionally as "an occasion when people discover what each can be in relationship with the other," though the specificities of such will be explored later, and lure out of these caring relations embedded tensions, contradictory moral feelings and the importance of genuine human connection in the lives of Safeworks clients.

In the remainder of this introduction, I describe the theoretical underpinnings of my study into supervised consumption services. Next, I explore the socio-political context within which Safeworks is situated; briefly examining the local social conditions that made the advent of

supervised consumption services in Calgary probable. Further, I survey, if only briefly, the philosophical foundations of harm reduction practice, and the ways in which supervised consumption services represent an alternative to exclusively prohibitive drug policy in Canada and elsewhere. I consider, too, the specifics of supervised consumption services in Calgary, and the particular challenges associated with opening a supervised consumption site within an existing health centre and against a broader social context wherein supervised consumption services remain contested.

Studying, and Studies of, Supervised Consumption.

In the fall of 2018, I began a study exploring the delivery of supervised consumption services at Safeworks – the first supervised consumption site to be opened in the province within a publicly funded health care center. I sought to qualitatively examine the ways in which supervised consumption services unfolded within this socially situated space; to what extent did the provision of harm reduction programs and services within a health care center alter the lives and practices of health care providers? How might people who use drugs conceptualize this space, and how could its existence suggest an alternative health care experience for this socially vulnerable and marginalized population? I pondered how Safeworks staff and clients might come to form relationships with each other; and questioned the difficulties of subjective experience, wherein individual perspectives vary in accordance with personal life histories and social positionalities. The queries I had were best explored, I knew, using qualitative research techniques, a broad an inclusive label that Ellis defines as:

> A variety of research techniques and procedures associated with the goal of trying to understand the complexities of the social world in which we live and how we go about thinking, acting, and making meaning in our lives. These research practices emphasize getting close to those we study, attempting to see the world through participants' eyes, and conveying the experience in a way that is faithful to their everyday life (2004:25).

In advance of beginning my research, I rifled through the literature on supervised consumption services – hoping to determine how I might frame my project; searching for forms of authorship in which the intricacies of these services evaded being seen. In what ways could my qualitative study be of use for both those intimately involved in the research and for a wider academic and civic readership? After months gathering as much published information as possible, it was evident that academic research on harm reduction was plentiful across a range of academic disciplines. My thesis was buoyed by the efforts and dedication of scholars and community and peer organizations who had established the value of supervised consumption services in Canada and elsewhere long before I became invested in this work (Kerr et al. 2017; Fairbairn et al. 2010; Wood et al. 2006) Though these studies and others differed in accordance with the philosophical underpinnings of the discipline, the individual researcher, and the associated methodological approaches to the examination of research questions (Neuman 2007), many were fixed on the implementation and evaluation of supervised consumption services. Further, much research was quantitative in form; that is, attentive to numerical and statistical trends as evidence for the effectiveness of incorporating harm reduction programs and practices within particular localized contexts (Mancini et al. 2008:382). These reports did consider the realities of people who use drugs, but they did so through "a statistical and classificatory lens in which…the individual is massed into a distant and undifferentiated cast of thousands" (Rhodes 2009), thus rendering a person's individuality and distinctive personality unseen. Nonetheless, this body of research was and is exceedingly important: it provides substantial support for the potential of supervised consumption services to effect material differences in the lives of people who use substances, and the capacity of these services to prevent many of the individual and collective harms associated with drug use (National Treatment Strategy Working Group 2008).

Still, I was discouraged by the relative absence of qualitative autoethnographic research on the delivery of supervised consumption services within the sociological literature. While ethnographic research on drug use has helped advance scientific understandings of substance use (Small, Maher and Kerr 2014:157) over the past forty years, an autoethnographic approach to studying supervised consumption – wherein the researcher draws on their own emotions and experiences to complement their observations of the social scene under study – is rather new. What I hoped to find was an abundance of emotionality; I yearned to know the people studied, to slip into the complexities of their lives, to include myself, as a reader, in the reciprocal "relationship between self, field and text" (Coffey 1999). What initially drew me to study sociology, and subsequently, into the social field of supervised consumption services, was the desire to "listen to people – their self-understandings, their storytelling, their own concept of work – with a deliberate openness to life in all its refractions" (Biehl 2013:576). I am drawn to groups I am not habitually a part of, as they "allow us to return to the place where thought is born" (Biehl 2013:577) – to permit parts of ourselves to be altered by previously unknown others. What I am saying is that I longed to be affected by the subjects in harm reduction research – to think, act, and feel differently than I had before coming to know them on paper (Latour 2004:210). What troubled me about the predominance of quantitative studies in harm reduction research is that it permits us access to only part of the story; in effect, the research seemed to circle around, and eventually settle on, a single articulation of what supervised consumption services do and how they ought to be seen. Where were the vivid, detailed accounts of people's lived experiences? How were researchers themselves affected? I sought to respond to my own desire for difference in the literature – to approach my project using a method of qualitative inquiry that would render "talkative what was until then [largely] mute" (Latour

2004:217); to allow the people who work within and the people who use these services to effect change in me, in you; to move us – to unsettle something so deep within us that we are never again quite the same. I knew then that I would have to do more than enter the field – to do more than exist in the specific social location in which supervised consumption takes place – in order to learn about these services, to better understand those implicated in their delivery, and to become vulnerable to all that I did not know (Foltz and Griffin 1996:302). I needed to involve myself in the job and, later, write of my experiences in the text. "You need to know how this place works" MM, a peer support worker with Safeworks, told me, when I first started my research, "all of the pieces, admin, nursing – not nursing, nursing – but what an overdose looks like, how to get people moving on, how the chill room works, and then some of the politics that goes on, okay?" For this story of daily life at Safeworks to be understood by those unfamiliar with supervised consumption services, as I was, I return, now, to the fundamentals of the site, so that you too, can understand how 'this place works'.

Background: Social Perspectives on Drug Use

Unlike other health concerns, substance use disorders are the user's fault, something they have done purposely and with choice. So too is recovery their responsibility; they must quit their drug use to achieve a 'normal', healthy and productive life (Duff 2015:84). These, at least, are the popular conceptions of people who use drugs, and so clients carry their weight in shame and suffer the loneliness of marginalization.

"We're not the scary monsters that everybody seems to think we are," A told me, resentfully, sitting on a bench out front of the health centre, her matted blonde hair partially concealing the open sores on her face.

With her, I was made watchful of my surroundings; a police officer crossing our path left me on high alert.

"Let's say the seniors were being discriminated against and no longer allowed to belong," A continued, "it would be an outrage."

A makes a valid argument. No other socially differentiated group is held as responsible for their plight; seniors cannot help their age, just as people with substance use disorders cannot will their way into recovery. "We still live in a moral model over a disease model [of addiction]," ST, a peer support worker, said, relating his lived history of drug use and his education in addictions to come to this determination, "and it is people who get trapped and stigmatized." Beyond living in conditions of physical and material deprivation (Mackenzie, Rogers and Dodds 2013:1), the site's users are acutely aware of the social condemnation accompanying their drug use; regularly referring to themselves as "junkies" and "addicts," having internalized deep social shame.

Drug use has long been framed problematic, and this social understanding continues to mark Safeworks clients. In 1971 President Richard Nixon declared a "war on drugs", proclaiming that America's "number one public enemy…is drug abuse. In order to fight and defeat this enemy, it is necessary to wage a new, all-out offensive" (Nixon 1971). The United States' war on drugs escaped its own borders; the view that drugs were inherently problematic became lodged in social thought and the formation of public policies in many other countries, including Canada (Gordon 2006:59; Jensen and Gerber 1993:453). It follows that if illicit substances are demonized, so too are the people who use them; as Gordon argues, drug prohibition [in Canada] was "not about the drugs as much as it was about the communities that sold and used them" (Gordon 2006:63). It is held by many that "the widespread criminalisation and punishment of people who use drugs also means that the war on drugs is, to a significant

degree, a war on drug users" (Mexico United Against Crime 2018:21). Dr. Gabor Maté, writing of his experiences treating chronic substance users in Vancouver's Downtown East Side, argues that "there is no 'war on drugs'." One cannot make war on inanimate objects, only human beings…Here is a war on drug users, who are often the most abused and traumatized people in society. In other words, our culture punishes people for having suffered, and for using substances to ease their pain" (Maté 2018).

Prohibitive drug policies are thus not without their critics; institutions, professions, non-profit organizations, and people who use drugs are challenging entrenched 'drug war' positions within the organization of Canadian policy and practice. Studies questioning whether the 'war on drugs' has been effectual unequivocally conclude that it has, in fact, "failed to control drug abuse as a social problem, has failed to deter drug use, and has created serious new problems" (Alexander 1990).

> …data from Canada and elsewhere show that this approach fails to meaningfully reduce supply of – or demand for – drugs and results in many unintended negative consequences. Chief among these have been human rights abuses (such as harassment, coercion, compulsory screening, and denial of life-preserving care) often committed in the course of enforcing the 'war on drugs' and even in the name of drug 'treatment' (Hyshka et al. 2012:125).

Consequently, there has been some movement away from the sentiment that drug use is always and everywhere an issue; many people who use drugs – occasionally or otherwise – do not consider their use problematic. Further, substance use that was previously considered unlawful – consider, for example, alcohol – is now woven into the composition of Canadian culture despite its potential for dependence, suggesting the socially organized character of illicit substance use. In response, many countries have begun to shift away from the primacy of enforcement and towards public health objectives (Hyshka et al. 2012); prevention, treatment, and harm reduction

are now recognized by the Canadian government to be of equal importance in an evidence-based and compassionate national drug strategy (Health Canada 2018). The shift away from 'war on drugs' perspectives and policies was largely informed by research on the value of harm reduction in Canada, detailed elsewhere (Kerr et al. 2017; Hyshka et al 2017; Watson et al. 2020) and the dedication of peer-led groups and local activists who forced change in convention and established un-sanctioned supervised injection facilities in Vancouver amid the 1994 provincial overdose crisis in British Columbia (Kerr et al. 2017; Boyd et al. 2020). The inclusion of harm reduction initiatives within Canadian policy and practice has disrupted conventional understandings of substance use; these strategies are necessarily predicated on the reality that "not everyone is willing or able to enter treatment at all times" (Health Canada 2018) and that persons who are actively using substances are similarly worthy of services and supports. Acknowledging the futility of eradicating drug use as a social practice creates opportunity for reimagining its management; social and political institutions now separate the intrinsic risks of substance use from those that are the product of remediable social policies.

Harm Reduction and Supervised Consumption in Alberta.

Supervised consumption services in Calgary were established in the midst of emergency (Health Canada 2017); in 2016, there were more than 2,800 suspected opioid-related deaths in Canada, and in 2017, preliminary data suggested that more than 3,000 Canadian lives would be lost in the coming year (Health Canada 2017). Western Canada was – and continues to be – primarily affected. In Alberta, a significant increase in numbers of apparent opioid related deaths was observed between January 2016 and June 2017, prompting the provincial government, under the leadership of then premier Rachel Notley, to declare a public health crisis and to respond accordingly. Subsequently, the Minister's Opioid Emergency Response Commission was

established on May 31st, 2017 to support the government's response to the overdose crisis overwhelming the province (Government of Alberta 2019). The commission guided and implemented urgent coordinated actions to address the epidemic; further propelling harm reduction initiatives into the provincial collective consciousness (Health Canada 2019). Community Based Naloxone is one such program and provides the public with lifesaving Naloxone kits. Naloxone, a drug that blocks opioid actions and is used to reverse the effects of opioid overdoses, is used within spaces of supervised consumption and, as of March 2016, was made more widely accessible to the public (Government of Canada 2020). Supervised consumption is another example of harm reduction policy in practice; these services help prevent opioid poisoning deaths and other harms associated with substance use and are a complement to other harm reducing programs in the province.

For those who are unfamiliar, harm reduction is both a stance and set of strategies that offers a value neutral shift towards drug use in policy and practice. As a social practice, harm reduction is deeply grounded in justice and human rights; premised on the recognition of the inherent worth of people who use substances (Harm Reduction International 2020). Harm reduction draws a fundamental awareness to the value of human life; responding to an "ethical call to action in the presence of another in peril" (Jennings 2018a:555) by offering nurture, protection and service. Harm reduction is rooted in the recognition that people are "authors of their own acts and lives, despite their need, impairment or limitations" (Jennings 2018a:560), wherein the "duty to protect must be informed by the overall background aim of enabling the development of, or fostering, autonomy whenever possible," (Jennings 2018a:560) to guard against unwarranted paternalistic forms of intervention (Mackenzie 2013). Compassion is a relationship among equals; support for persons who use substances should therefore not be

conditional – it endures, rather than domineers. Accordingly, harm reduction approaches are reorienting the questions we ask about the nature of the 'problem' and the nature of possible solutions (Jennings 2016:12; Tronto 2005:130). What if, in providing safer spaces for people to engage in risk behaviour, we foster their autonomy – not just to maintain their dependencies, as the public critique unfolds, but to enter into novel social relations, where people's options are manifold, and willingness to make change is theirs to own? To meet individuals where they are, as those practicing harm reduction do, is to receive them fully; in the absence of forced action, options expand.

Accordingly, community organizations and user groups, recognizing the value of supervised consumption in addressing the opioid crisis, produced convincing statements on the need for these services in Alberta. In Calgary, HIV Community Link prepared a report for Calgarians summarizing findings from their needs assessment and research. They offered evidence-based recommendations to help address the opioid crisis and advocated for supervised consumption in Calgary (HIV Community Link 2018). With the support for this evidence-based practice within Alberta Health Services, funding was provided for Safeworks to introduce supervised consumption services in Calgary (Alberta Health Services 2020). Despite the public polemics associated with supervised consumption spaces, the existence of these services is not novel. There exists a wealth of academic research on the value of supervised consumption services and a demonstrated need for these services in Calgary (HIV Community Link 2018), prompting Health Canada to grant Safeworks a full federal exemption from the Controlled Drugs and Substances Act (Government of Alberta 2017) so that they could begin operations. Safeworks SCS officially opened on October 30th, 2017 in a temporary trailer space outside an inner-city Health Centre in Calgary (Government of Alberta 2017). On January 15th, 2018 the

provisional location closed, and the permanent facility began operations (Alberta Health Services 2019). By the end of April 2018, Safeworks SCS began offering services twenty-four hours a day, seven days a week. Safeworks is a nurse-led program; SCS staff consist of health care providers (Registered Nurses, Licensed Practical Nurses, and Paramedics), a complement of allied health care professionals (a Registered Social Worker, a Dietician, and call on Addictions Counsellors), Administrative Support staff, and Peer Support Workers (persons with lived experience of substance use, homelessness, and/or mental health disorders) working under the direction of Safeworks' leadership team. The SCS presents itself as an anomaly; while the built environment is decidedly clinical, the supervision of drug consumption that takes place within the site is practical, often improvised and, for many people outside the site, incomprehensible.

Setting up Safeworks.

"Bringing on the service of supervised consumption was a brand-new undertaking for [our program]," L, program coordinator for Safework*s*, told me.

"We actually were the first [SCS] to open our doors in Alberta, so that was pretty exciting. The whole process started back in spring of 2017. [We had] conversations with different stakeholders, government and things like that, to get this underway. We had a very short period of time to get the site up and running."

Given the very real time constraints they were under, Safeworks was "pretty supported, internally throughout AHS, [and] externally looking at the city, city police, you know…various different stakeholders…we were pretty well supported to do the work."

However, even with support, "nobody's ever opened a supervised consumption site in Alberta Health Services, let alone in Alberta, so we were modeling it, I mean after other existing

programs throughout the world, and so there's been a lot of learnings from our experience to what other [consumption sites] might have experienced."

Safeworks SCS is distinctive in its service; though "borrowed" and "modeled" after other supervised consumption sites, the SCS is very much its own origination. Situated within a particular societal and geographical context, Safeworks SCS is distinctive – confronting challenges unique to both its built environment and Calgary's micro- political climate. The SCS is embedded within an existing urban health center; claiming space to "support folks with really complex care needs… [who] rarely or not at all accesses healthcare." Its location provides ease of access to other mental health and substance use disorder supports and services; SCS clients make frequent use of urgent care, the Opioid Dependency Program, and the Injectable Opioid Agonist Therapy Program, all located within the same building. Other public assistances, such as the Sexually Transmitted Infection clinic and the Alberta Health Services Identification program – both particularly relevant for Safeworks clients – are available on-site.

Consequently, as L maintained, "being embedded in a health care facility is really important." Still, situating the SCS within an existing heath care centre prevents its expansion. "I think it would be good if we could offer [clients] a place to smoke…I think we need to offer them a place to go at night, if we're going to be open at night," LA, a nurse widely versed in vulnerable populations, argues. "We don't have shelter for them. We don't have food security here." Safeworks SCS does not have the capacity to provide clients with a smoking room, as ARCHES, in Lethbridge, does; persons who typically smoke their drugs must do so outside the site. Nor is there the possibility of providing clients with onsite detox, transitional housing services, and dedicated medical clinics within the same building, as Insite can, though staff can and do provide thousands of referrals for clients to these necessary social services.

That said, the location of the SCS was chosen purposely based on need – there were significantly higher rates of apparent accidental drug poisoning deaths in Calgary centre compared to the city average (HIV Community Link 2018) – although the space is not without real limitation, as program staff acknowledge, nor are the services provided immune to public criticism. The permanent site is designed to accommodate up to 18 clients at a time; an improvement from the temporary trailer space in which Safeworks first began offering services. R, a long-time client, a "veteran," of supervised consumption, as he calls himself, laughed when describing the initial space, calling it "a shack in the middle of the parking lot." Still, he had been thrilled to realize that it was not "just a temporary thing," or "a pilot," and that it would be moved to a permanent location within the health centre. That the trailer existed at all was novel for clients; that it was to be made permanent alienated many of the city's residents.

Where users were surprised by the permanence of the consumption site, the public reception to its existence was cautious, at best. Nowhere was this sentiment more evident than in the Beltline district where the site is situated; Safeworks SCS is at the centre of intense public discord, fostered, in part, by the local media and politically divisive social policies.
Political will to reform health and social policy to accommodate supervised consumption services in the city is tenuous. A change in government during my fieldwork altered the provincial conversation on harm reduction; new UCP leadership preferring rehabilitation over supervised consumption; working from the belief that such forms of social assistance are "dependency perpetuating" (Jennings 2018b:21). Public opinion within the community is equally mixed. Some beltline residents professed support for supervised consumption services, arguing that the site's presence relieved them of the trauma of witnessing public overdose and that SCS clients cannot be overlooked as members of the community; equally worthy of consideration.

Nikki Reimer, who lives in close proximity to Safeworks, is quoted in the Calgary Herald saying, "fearmongering has painted a bleak picture of the area and doesn't accurately represent reality" (Smith 2020). "We are not swimming in needles," she continued. "It upsets me that the focus has been on the fear, crime and social unrest versus how we can make sure that everyone is able to thrive…I think we have to realize that everyone has a right to this space and everyone has the right to exist in this city" (Smith 2020). Reimer's understandings of supervised consumption are somewhat of a rarity in a local social context wherein the site is often held uniquely responsible for the alleged increase in property crime, the rise of drug paraphernalia in the surrounding area, the perpetuation of drug dependences, and an increase in general social disorder. Despite strong international evidence that spaces of supervised consumption "reduce public drug use, the discarding of drug supplies in public spaces, lessen the transmission of disease, and have little effect on crime in the area surrounding a service," (HIV Community Link 2018) the social script fixing Safeworks SCS to a host of negative impacts in the vicinity is influential. "I'm not a supporter of this facility because it is destroying the community that I live in," Jeff Cotton claimed, angered by the SCS's presence in his neighbourhood, "life safety doesn't just apply to the users of this facility but also the residents" (Smith 2020). Mr. Cotton is not alone in his stance towards supervised consumption and the clients who make use of the service; Counselor Jeremy Farkas, whose ward borders the Health Centre, said "businesses and residents in the area are being sacrificed for the greater good" (Smith 2020). Evidently, these arguments are a manifestation of broader differences in social, moral and political thought in the city; some people understand supervised consumption services as a means to alleviate social suffering and as a necessary response to public health crisis, others are firm in their insistence that the advent

of Safeworks SCS produces a hierarchy in the community, wherein clients' lives take precedence over their own (Morrissey and Jennings 2016:62).

Coupled with the recognition that prohibitive drug policy heightens many of the social and individual harms associated with substance use is a growing awareness of the root sources, psychology and neurobiology of addiction, especially of substance dependence (Maté 2018). Addiction is not a choice, but nor is it primarily a disease, genetic or acquired. "Addiction," says Maté, "originates in a person's attempt to solve genuine human problems: those of emotional loss, of overwhelming stress, of lost connection. It is a forlorn and ultimately futile attempt to solve the dilemma of human suffering" (Maté 2018). My experiences at Safeworks SCS illuminate the truth of Maté's statement; seldom do clients present at the site without past and present suffering, some manifest on the surface but most of which goes unseen, if not intentionally ignored. It is so much simpler to locate the source of substance dependence within individual susceptibility or moral culpability – as the conventional story unfolds – than it is to assess the failings of a humanity wherein social suffering is left unassisted. Safeworks clients are caught in a public deceit that holds them responsible for their predicament; the collective response to substance dependence is one of learned indifference rather than shared responsibility. Such public sentiments are particularly accentuated for Safeworks clients; they endure the stigmatization of substance use, to be sure, but also contend with the influence of our cultural inclination towards individualism, wherein a person's social value lies in their ability to sustain themselves independently. Reliance on governmental assistance, social provision, and supportive housing, as many Safeworks clients are, is habitually met with condescension; where those who manage to do without such dependencies figure that it is their right to pass judgment. That is to say nothing of the socially structured vulnerabilities tied to indigeneity, gender expression,

sexual preference, and socioeconomic status that contour our clients' lives. Consequently, the most deserving of assistance are those who are too frequently repudiated and denied.

As A contended, "we are a throwaway society, we're not looked at like most people and it's really quite sad."

Just as Safeworks clients are vulnerable to public contempt, so too is the SCS; despite the tremendous effort it took to launch supervised consumption services in Calgary, and the people staff support and even save, the work Safeworks does is very rarely admired.

"We don't get to celebrate that very much, we're a silenced group," L told me, sadly. "So that's the disappointing thing about this service, it's not a big ribbon cutting, and that's really unfortunate."

Thus, while the public questions why they should care about people who use drugs, and whether supervised consumption ought to exist at all, the SCS forges on, determined to provide necessary health services to a very marginalized population. Clients continue to independently seek services, and staff persevere to deliver these services within a fairly hostile social environment. Still, where many can only speculate on the happenings within the consumption site, I found my way in. Here, I draw attention to what is not already known; to invite readers into the particulars of a social world different than their own.

To do so, I offer a consideration into caring relationships as they are cultivated within Safeworks Supervised Consumption Services. Through this narrative, I bring our lives together to light; speaking to the difficulties in caring for a population that is so regularly socially denounced and denied – and illume the ways in which program staff endeavor to support clients in need of recognition and attention. The capacity to stay present with another in peril, to perceive the immensity of their pain and lack the capacity to act, is a learned competence; one

that I struggled with but gained over time. In my third chapter, I present the practicalities of the consumption site, of how I immersed myself in the work, and how I came to understand the "sheer badness" of clients' situations. In my fourth chapter, I offer a reflection of the ethical dilemmas present in the course of providing care; what may be felt to be intuitively just by some staff is seldom shared by all those involved in the delivery of supervised consumption services. I am interested here in the nuance and sentiment of minor moments wherein program staff – and, to an extent, where I – contend with moral predicaments associated with caring; where clients' needs sometimes run counter to the functionality of the site or are otherwise difficult for a single service to meet. Where does our responsibility, placed in a position to care, "really, truly care," for clients, begin and end? Does it find its conclusion in the successful supervision of consumption? In a recommendation or referral? In the safety of enforcing rules and regulations? Or does care – if it is to be good – journey further? Those who care for Safeworks clients must decide how and in which ways to care, and then come to live with the significances of their decisions. And in my fifth chapter, I contend that clients ask of me – of program staff – to see them individually, to recognize their suffering but to also see past it, for they have so much of themselves to offer, and we are sometimes the only few who are fortunate to know. For as much as care is given at Safeworks, it is also received. I present an understanding of compassion, as it is practiced at Safeworks, as a relationship among equals wherein support for clients is not conditional or patriarchal. Clients are given affirmation and attention; a recognition of the value that their lives – whether they use substances or not – possess now and in the future, and that this care reduces another sort of harm in clients' lives: of being socially isolated and alone.

Chapter Two: Methods.

Autoethnography, an 'alternative method and form of writing', can make for difficult and emotive reading (Denshire 2014:831). It is an approach to research that seeks to thoroughly describe and analytically examine personal experience in order to understand specific social practices (Ellis, Adams, and Bochner 2011:273). Accordingly, it is an approach that intertwines features of autobiography with more traditional ethnographic methods to accomplish its research goals. Autoethnography is, therefore, a method that challenges the façade of neutrality in social science research, encouraging, instead, an authorship that is highly visible within its pages. In this approach to qualitative sociological inquiry, the researcher demonstrates the extent to which they are embedded within a specific sphere of social life through the use of evocative stories, self-reflexive practices, and an acknowledgement of their own subjectivity, emotionality, and influence on the research rather than evading these matters as if they did not exist (Ellis et al. 2011:274). The joy of autoethnographical research is in its intrinsic invitation to explore the intimacy of experience – to render perceptible differences in personal understandings across multiple social actors. I chose authoethnography as both the process and the product of my qualitative research into Safeworks Supervised Consumption Services – or, rather, it may be more truthful to say that the method found me – given the depth with which I fell into the work and, later, the ways in which I felt myself compelled to write of these experiences. At the outset, my intent was not to compose a paper that included personal accounts of my relationships with staff members and with clients at Safeworks Supervised Consumption Services – I had other ambitions, the sorts of plans one imagines as a graduate research student.

I endeavored, with the undeniable naiveté that learners often possess, to study Safeworks Supervised Consumption Services using more conventional ethnographic methods (Berg and Lune 2012:196). I had, of course, been granted access to the site – and I envisioned myself devotedly collecting observations – emerging and receding periodically from the space with natural ease. I thought I might slip in and out of social experience, record these instances in the form of detailed field notes, and return to the business of living my life outside the site. I also planned to gather interviews as a means to enhance my observational data – to heighten my participants' own voices in the linguistic "telling" of their story (Ellis et al. 2011:277). I did not come into this social world opportunistically, as is the case for many social scientists wherein "group membership precedes the decision to conduct research on the group" (Anderson 2006:379). Instead, I came to Safeworks Supervised Consumption Services with the modest intention of collecting data but found myself falling – tumbling – into a social world I had only meant to study (Anderson 2006:379). The force with which I fell into my experiences at Safeworks took me by surprise; I felt myself wedged in the crevice between what I imagined to be two different obligations: those belonging to my academic discipline and the affinity I held for the clients and for the staff at the site. I even found myself resentful, at times, when my status as a researcher was brought to the fore. I felt differentiated by my role – never quite attaining complete membership in the group, despite giving so much of myself to the work, and I longed to be considered part of the team. I also worried what this might mean for my study. Was my data no longer useful, given my personal involvements in the research? What was I to make of the 'objectivity'; of the 'validity' that respectable, more positivist, sociological research requires (Denzin and Lincoln 1994:13)? I feared that I was becoming too present, too visible, too much; a suspicion I sensed confirmed when I heard the prominence of my own voice in interviews.

Still, so much of what I was confronting at the site felt valuable. I was brimming with experiences that I ached to share. The purpose of my research was the same throughout; "to raise consciousness, to give people a voice that before writing, they may not have felt they had (Ellis et al. 2011:280)" – and yet, when I began to write, I struggled to capture these moments, these months spent at Safeworks Supervised Consumption Services, in ways that evoked the energetic push and pull of experience; to narrate a story that I had very much been a part of. I sought out an alternative approach to "what research is and how research should be done" (Ellis et al. 2011:274); choosing to pursue, instead, autoethnography as a means of "producing meaningful, accessible, and evocative research grounded in personal experience, research that would sensitize…readers to experiences shrouded in silence, and to forms of representation that deepen our capacity to empathize with people who are different than us" (Ellis et al. 2011:274). Reading autoethnographies proved to be pivotal for me as a qualitative researcher (Denzin and Lincoln 1994:11) – it allowed me to contour and characterize my study in ways that I had not yet dared imagine. Carolyn Ellis and Arthur Bochner, two prominent symbolic interactionists working with poststructuralist sensitivities, urge students and scholars to write within this emerging genre (Anderson 2006:374), and conscious of this, I thought that falling head first into my work at Safeworks was not so methodologically unfortunate. It would allow me to invite readers into the dynamism of human experiences as they are lived within a particularly ambiguous social space; complexities that more mainstream discourses have rendered inarticulate (Kiesinger 1998:73). Much like Safeworks is vulnerable to public criticism in their delivery of supervised consumption services, I, too, could similarly expose myself to risk through 'methodological innovation': to write into the unknown, with hope for what can be done – with a wonder for what

minds might be altered – through the use of a more honest and personal narration of my ethnographic work (Anderson 2006:374).

I assumed my role as a researcher at Safeworks Supervised Consumptions Services in November 2018, with the intent of assembling an ethnographic study of the lived experiences of program staff and clients. Gaining entry to Calgary's only supervised consumption site was facilitated by Dr. Katherine Rittenbach and her connections within the local harm reduction community. The need for a qualitative evaluation of Calgary's supervised consumption site as a harm-reduction practice had been pre-established prior to my entry in the field; Dr. Rittenbach and the leadership team at Safeworks felt that a qualitative study of the site would add a depth of understanding to existing literature on supervised consumption services in Calgary. Thus, I was able to gain privileged access to the site as a student researcher. Although my admission into the field had been secured and the study approved by CHREB, it took some time to gain the trust of staff members and clients, and to delve more deeply into the local social life (Neuman, 2007, p.431).

In truth, all I knew of ethnography I had learned in lectures and read in textbooks; I understood the methodological terms associated with the approach and held appropriate knowledge of the vibrant and, at times, troubling history of ethnography within the social sciences (Ellis et al. 2011:273). I had the idea that simply existing in the space would be enough – that attaching myself to the sterile walls of the clinic would permit sufficient entry into this novel world. I tried to hold myself at a distance – not because I was startled by the work, although part of me feared my own exposure, dreaded being seen – but because I was very much aware that as a 'participant observer' I should keep myself at arm's length. That is not to say that I was not moved by what I witnessed at the site, only that I felt these sentiments were to be dealt

with on my own time; held separate from the research and surely not an essential part of it. Initially, I obediently recorded field notes – mostly jottings of what I had heard, scenes I had witnessed – but I did not know enough to make sense of what I had written down. The trouble, I thought, was that I was trying to somehow capture these experiences without living them first – the effect of which felt like being swept up in a storm; smothered under the weight of what I did not know. More than that, I sensed my detachment was a barrier to connection; it indicated indifference towards already profoundly marginalized clients and a consequent alienation from program staff. The realities of daily life at Safeworks and the interspersed moments of intense crises roused something in me and summoned me into more involved participation. Safeworks was not the sort of place where I was contented to stand aside; the work necessitated a team and I felt compelled to join in. Much like Ellis in the course of her graduate ethnographic fieldwork, I grew personally invested in the lives of Safeworks staff and clients, entwined in some aspects of the delivery of consumption services, and self-reflexive of the ways in which "my participation with others clearly was a part of what I was observing" (2004:10). Before I was consciously aware of the distinction, my methodology had taken an autoethnographic turn. I realize now that I could not have done this research nor told this story any other way.

Autoethnography.

That is not to say that autoethnographic research just happens or that it is somehow less methodological in its approach. On the contrary, autoethnography has become an established, though critiqued, form of qualitative research in the social sciences (Ellis et al. 2011:283; Wall 2008:46). Over the last thirty years there has been a meaningful increase in research that "has been variously referred to as auto-anthropology, autobiographical ethnography or sociology,

personal or self-narrative research and writing, and most commonly, autoethnography (Anderson 2006:373). As a method, autoethnography combines elements of autobiography and ethnography and "challenges canonical ways of doing research and representing others" – focusing instead on processes that produce "meaningful, accessible, and evocative research grounded in personal experience" (Ellis et all 2011:273). This body of scholarship has been linked to various "moments" in the history of qualitative research (Denzin and Lincoln 1994:9-11): the turn towards a blurring of boundaries between the social sciences and the humanities in the 1970's, the postmodern problematization of hollow representations of self and others in text, and the re-imagination of traditional objectives and forms of social science inquiry (Anderson 2006:373; Denzin and Lincoln 1994:9-11; Ellis et al. 2011:273). These rifts in history were productive; out of them new relationships between authors, audiences, and texts originated and novel forms of expressing social and emotional worlds were pursued. The above-mentioned developments also coincided with increasing skepticism towards positivistic notions of absolute objectivity and scientific neutrality (Berg and Lune 2012:197). Scholars called into question the "facts" and "truths" that scientists "found" and demonstrated how they were intimately tied to the languages and paradigms the scientists used to represent them (Ellis et al. 2011:274; Kuhn 1996). Wariness towards the generalization of knowledge claims legitimated the reframing of social scientific research to accommodate subjective experiences, affect and emotions, and the use of complex, interpersonal stories as "meaningful phenomena that taught morals and ethics, introduced unique ways of thinking and feeling, and helped people make sense of themselves and others" (Ellis et al. 2011:274).

Hence, autoethnography, emerging from postmodern philosophical thought, in which the "dominance of traditional science and research was questioned and many ways of knowing and

inquiring were legitimated" (Wall 2008:38), presented qualitative researchers with the opportunity to claim their own voices in the advancement of sociological understandings rather than write around themselves as if they did not exist. Though earlier ethnographers often had autobiographical connections to the research, "they were neither particularly self-observational in their method nor self-visible in their text" (Anderson 2006:376) – however, gradual shifts were occurring, particularly as scholars Carolyn Ellis and Arthur Bochner "experimented with and exemplified variations of autoethnography" (Anderson 2006:373). Their work encouraged other researchers to settle into this emerging genre; evidence of which can be found in the texts of Laurel Richardson (1994), Lisa Tillmann-Healy (1996), and Robert Murphy (1987) among others. By considering both culture and self, these authors' move through 'different layers of consciousness' (Ellis 2004:37) – turning their sociological gaze outwards on the social and cultural aspects of their personal experiences in ethnographic fields, then folding back into themselves, contemplating a "vulnerable self that is moved by, and may move through, refract, and resist cultural interpretations" (Ellis 2004:37). Here, self-reflexivity is as much a part of the lived experience of doing fieldwork and writing through these experiences, as it is a preparatory step in the research process. Still, the extent to which an autoethnographer accentuates themselves within their prose varies. Following Wolcott's definition of ethnography as part art and part science, but also something entirely its own, Ellis describes autoethnography as part culture and part self and something different than that – a product greater than its singular parts (2004:32).

Accordingly, autoethnographies exist across a literary spectrum – from emotively uncomfortable and reminiscent memoirs to "personal and self-observant ethnography" that rises "above idiographic particularity to address broader theoretical issues" (Anderson 2006:379).

Choosing between the many documented autoethnographic approaches is up to the researcher; their particular orientation towards the social world, and the stories they feel bound to tell. However, an author's decision to write autoethnography – no matter in which direction the prose is pulled – is assuredly a difficult one; it is a method that demands that the author render "personal experience meaningful and cultural experience engaging" (Ellis et al. 2011:277). More than that, it asks of us, as writers, to break free from the determinants and conventions of our respective disciplines – to become noticeable, and therefore accountable, in our written work – open to criticism that extends beyond our academic efforts and into our personal histories and vulnerabilities. It is a method that forces qualitative researchers to explicitly confront the ethnographic 'I' (Ellis 2004) – to circumvent writing over or speaking for participants when baring myself in the text, always aware that the "boundaries between reflexivity and self-indulgence are fragile and [often] blurred" (Coffey 1999). We must offer instead textured accounts that interlace many voices and perspectives to tell richer, if not more complex, stories. Ethnography is, most of all, intersubjective – it brings about intricate and always unfinished constellations of relations between our identified selves, the people with whom we grow to know and better understand in socially situated – and, at times, socially differentiated – spaces and, of course, the parts of us that we have not met but come to discern as a result of these profound connections with others. Hence, what differentiates autoethnography from more traditional ethnography is the thoughtful inclusion of this once unknown self in the text – simply engaging with the complexity of people's lives is not enough; an autoethnographer must also critically reflect on how another group's existence inevitably alters one's own.

Up until this point, I have portrayed the pull of my participatory experiences at Safeworks Supervised Consumption Services as if they had happened by chance. While I had

envisioned a more conventional ethnographic method at the start of my research, wherein explicit self-reflection is often done prior to the project and then "bracketed" once in the field so as to remain value-neutral and the future use of an "authorial voice" in written prose probable (Kolker 1996:134), I realize now that such an approach would have been disingenuous to who I am and my respective orientation towards the social world. Moments of self-disclosure are scattered throughout my writing; disturbances to what would have otherwise been an authorless script, barring my name, in fine print, below the title of this text. Including myself as a research subject would not have been my first inclination – but withholding myself was also not an option; to do so would be to perpetuate the disillusion that ethnographers can "stand above and outside what they study" (Ellis and Bochner 1996:19). I am, instead, working from the premise that "we are our own subjects. How our subjectivity is and becomes entangled in the lives of others has always been our topic" (Coffey 1999:13). I remain deeply affected by my experiences at Safeworks; to disregard this reality would have been dishonest to all those involved. My relational involvements at Safework*s* have been an essential part of the research process (Ellis and Bochner 1996:18) – these understandings, rather than detract from the value of my work, have enriched and strengthened my autoethnographic efforts.

Sharing in the realities and difficulties of supervised consumption services alongside my participants forced me open. Bearing 'witness' (Denzin 2004) to people within this socially contested space meant more to me than I could have envisioned. Engagement and empathy took precedence over observation – I heard and felt participants' stories long after they had been told, holding their histories in my hands. My time at Safeworks encouraged me to engage with people in more real and demanding ways. It forced me to use methods that care. Therefore, this research defies more 'realist' approaches to social scientific study (Ellis 2004:29), electing instead to:

> Tell stories that show bodily, cognitive, emotional, and spiritual experience. The goal is to practice an artful, poetic, and empathetic social science in which readers can keep in their minds and feel in their bodies the complexities of concrete moments of lived experience. These writers want readers to be able to put themselves in the place of others, within a culture of experience that enlarges their social awareness and empathy (Ellis 2004:30).

As an interpretive ethnographer, my ambitions in this work differ from that of more traditional social science. I hope to invoke emotional experiences in readers by inspiring them to engage with supervised consumption services in more complicated ways; to attend further to the specificity of people's everyday experiences (Biehl 2013:574), particularly those whose spirited selves are traditionally obscured in social scientific inquiry, and to "improve readers', participants', and 'authors' lives" (Ellis 2004:30). These are, admittedly, lofty goals. They ask me to contemplate the strength of my storytelling, to rouse identifications of self in others, and to understand my writing "as a site of moral responsibility where [I] acknowledge and celebrate previously silenced actors (Richardson, 1997)". The weight of this expectation rests heavy on my shoulders; I am willing to carry it.

To write autoethnography is to compose narratives expressed in first-person (Ellis 2004:59). Such an approach challenges the conventional way of translating academic research to text, wherein the author figuratively fades out of focus in order to accentuate the lives of socially and culturally differentiated others. Initially, I struggled to move past the conventions of my discipline to write myself into the story. I worried that my presence would overwhelm the text and that I might perpetuate the marginalization of Safeworks clients and peer support workers by including myself in their story. Would this be the literary equivalent of suppressing those most deserving of being heard, of reproducing dated systems of domination (Richardson 1997:57)? Similarly, I did not want my experiences to stand in for those of program staff. My reflections

are my own; it is not my intention to presume that I can fully understand the complexities of how and in which ways they care. As Coffey noted, autobiographical ethnography is often criticized for being "self-indulgent writing of the self" (1999:156) and there is issue as to "whether these personalized accounts actually constitute ethnographic writing" (1999:125). These are genuine concerns that I have not taken lightly. However, to remain a silent author in this work is to deny my actual existence in the field and in the lives of my research participants. I aim to make myself explicit; I want to show up in these pages as I have done in my research. I am skeptical of academic composition that does not, in some fashion, do the same. Texts are, after all, "authored and peopled by a participating self" (Coffey 1999:127); we cannot, as social scientists, claim reflexive practices in our methods only to leave them there, as if this convention is but an obligation to be dealt with, then cast away once we are done. Hence, writing in the self can be a strategy for more reflective practice throughout our ethnographic work (Coffey 1999:127). Nevertheless, in authoring this way, I assume heightened responsibility for my presence in the text. Recognizing that something might be gained by incorporating my own subjectivities (Ellis 2004) into my work does not negate the importance of the lives, selves, and voices of my research participants; it is because of them I have these experiences to reflect back on and meaningful stories to tell. Still, writing the 'ethnographic I' (Ellis 2004) is the most honest and ethical move I can make. In doing so, I am holding myself publicly and vulnerably accountable (Denzin 2003:137) for the creation of certain social realities of supervised consumption services and the coincident effacement of others. The chance of superseding broader analytical accounts is ubiquitous, to be sure, but receiving readers into the richness of my experiences is worth the risk (Denshire 2014:835). In writing this text, my main concern was rendering my ethnographic data into a literary piece that resonated with my research participants. I wanted to avoid filtering

their voices through my own; as if they could only speak effectively through me. Telling this story in the first-person addresses this apprehension; I do not have the authority to speak for anyone else, but I can write as myself.

Data Collection.

In what follows, I share my methods of data collection as they pertain to my autoethnographic research into supervised consumption services at Safeworks. Before beginning, however, I will echo Coffey in saying that:

> Fieldwork is personal, emotional, and identity work. The construction of and production of self and identity occurs both during and after fieldwork. In writing, remembering and representing our fieldwork experiences we are involved in processes of self-presentation and identity construction. In considering and exploring the intimate relations between the field, significant others and the private self we are able to understand the processes of fieldwork as practical, intellectual and emotional accomplishments (Coffey 1999:1)

My research involved seven months spent at the site conducting observations and participating in life at the site; the people I met within those walls left me forever altered and I continue to make sense of this new self. I was present at the site for several hours at a time – initially for a period of three hours and, later, upwards of eight hours per observation session – several days a week for months. Towards the end of my fieldwork, I was frequenting the site five to six days a week. Though I make no claims to having touched the lives of Safeworks staff and clients, I trust that my continual presence, if only momentarily, shifted emerging and well-established relationships within the site (Ellis et al. 2011:279). I started my fieldwork at Safeworks on November 20th, 2018 and the site had just opened in its permanent location the previous January. I fit well within the creases; still in its infancy, the delivery of supervised consumption services within the site had barely begun. That is not to say that my habituation to the work came effortlessly, only that I

found myself willingly enveloped both in the delivery of consumption services and in the difficulties, complexities and the tentative joys of clients' daily lives. Over time, I became friendly with staff; the professional boundaries between us blurred. Consequently, my experiences at Safeworks challenge more customary notions of ethnographic fieldwork, wherein researchers are directed to keep an analytical distance between themselves and the social field under study, lest they taint the legitimacy of their observations with their own subjectivities. I had, intuitively, become thoroughly and emotionally immersed in the social setting under study. My role at Safeworks changed the more I became habituated to life at the site. At first, I was content to simply observe, but as my comfort and presence within the site solidified, I was given – and accepted – additional work responsibilities. I took on several tasks, including client intake, overdose response, and supervising the post-consumption room. These work experiences are laced throughout my observations, they emerge in the context of my interviews with participants, and I consider them to be part of "meaningful and fruitful fieldwork" (Coffey 1999:20). Rather than view these emotional and practical aspects of my research as methodological issues to be acknowledged and, if possible, dealt with, I used them productively to tell a more evocative, artful story (Coffey 1999:6). They are representative of knowledge gained that would have otherwise remained partial or opaque (Coffey 1999:33).

Interactive Interviews.

As Ellis contends, "all stories are potentially about more than our own experience, but it is up to us to tell them in a way that makes that apparent" (2004). Therefore, this research rests on more than my subjective involvements in social life as it unfolds within the context of

supervised consumption services. I am not the central focus of this study, though I have had to handle lettering in the personal to "invoke readers to enter the emergent experience of doing…research" (Ellis et al. 2011:279). The stories captured in these pages are those of my participants, as they have been told to me over the course of lightly formalized and recorded interview sessions. By including twenty-one interviews with both Safeworks staff and clients, I hope to encourage "new understandings and prompt new conversations" (Kiesinger 1998:74) about supervised consumption services, the lived and embodied experience of drug use and the challenges associated with providing novel forms of care for vulnerable populations within antagonistic public environments. I chose a reflexive, dyadic style (Ellis 2004) for my interviews with research participants – a consequence of my autoethnographic orientation to data collection. As such, these interviews took a more conversational form in which I tried to "tune in to the interactively produced meanings and emotional dynamics within the interview itself" (Ellis 2004:84). My attention in these discussions was fixed on the interviewee and the interviewee's story, though I considered my own words, thoughts and feelings relevant forms of information (Ellis 2004:84). While I have used my emotional reflections and shared identifications with people I interviewed to add nuance and gradation to their stories, my experiences are not the focal point of this work, nor do I wish them to be. I considered my thoughts a complement and, at times, a contrast – to what my participants unveiled about themselves and their subjective realities but remained cautious when writing in my narrative so as to not overshadow theirs.

I held eleven dyadic and introspective interviews with Safeworks staff as a principal method of data collection in my autoethnographic fieldwork. Interviews with various members of program staff varied from forty-five minutes to two hours in length and were conducted over the course of several months beginning in January of 2019. Verbal consent was attained prior to

our interviews and they were recorded for the purposes of transcription. The methodological choice to spend a substantial amount of time at Safeworks before beginning any interviews was purposeful (Neuman 2007:272); it allowed me to form requisite connections with program staff before entering into more intensive, emotional conversations. Over the course of my fieldwork I developed relationships akin to friendships – albeit mediated by my role as a researcher (Coffey 1999:45) – with many staff members. Shared experiences within the site prompted bonds that otherwise might never have formed. Consequently, engaging health care providers to participate in interviews about their work was easier than I had anticipated; many willingly offered to contribute their time to the project in advance of me having to ask. I had heard from others that this was a testament to the tentative respect I had gained at the site. Inserting myself, as an ethnographic researcher, in the midst of an already established and insular social life had been difficult (Biehl 2013:284) – especially given my unfamiliarity with supervised consumption as it is lived and practiced – and seeing buds of acceptance begin to flourish was flattering. Still, I wanted to provide the chance for all staff members involved in the actualization of consumption services to participate in an interview – by the time I found myself in the field Safeworks staff had grown to over one hundred permanent and casual employees, some of whom I had never met – so circulating a letter of recruitment via email in order to reach all program staff proved necessary.

Nevertheless, I was personally familiar with all eleven staff members I interviewed. As such, our conversations were more or less unstructured (Berg and Lune 2012:116). They were, however, all grounded in the delivery of supervised consumption services and the associated tensions, complexities and gratifications of this work – efforts that remain misunderstood and profoundly unsung in the current local climate. In these interviews I hoped to gain a more

intimate understanding of various staff members' experiences within the site. As an involved participant at Safeworks, I was able to witness them work – to note their interactions with clients, to watch newer staff grow into their roles and to learn from more senior members as I adjusted to the space – and now they had the opportunity to bring forward their own stories, their own distinctive modes of understanding. I probed into their professional and personal lives with questions that were partly motivated by my own curiosities (Harris 2015:1690): Did they worry about clients outside of work? In what ways did they realize their roles, and did they feel the same sort of defeat after a particularly trying conversation? In turn, I was receptive to queries posed of me and answered as honestly as I could, although I *was* uneasy talking about myself and mindful of my disclosures (Ellis 2004). As a consequence of this interview style, both my participants and I are manifest in conversation. I could be criticized for showing up in my interviews, and appropriately so, for it necessarily altered the data collected; but is this not what autoethnography, as a mode of inquiry, is all about? Unseating the idea of the distanced and detached observer (Ellis and Bochner 2006:433) that gives "voice" to persons who may never have been heard before (Sandelowski 2002:105) with a more honest account of how, as researchers, we are as much a part of what we study as the groups we are trying to understand?

My insecurities concerning interviews with staff members were only magnified when it came time to officially interview Safeworks clients – as should be the case when engaging vulnerable populations in academic research (Small et al. 2014). I formally interviewed ten clients from Safeworks SCS in the same "reflexive dyadic" interview process I used with program staff (Ellis 2004), in which I was "open to responding to questions and, if appropriate, sharing [my own] relevant experiences" (Harris 2015:1691). Verbal consent was attained prior to my interviews with clients and they were recorded for the purposes of transcription. However,

personal conversations with clients often transpired outside the structure of an actual interview session; these unprovoked emotional disclosures carried me into clients' experiences – their subjective and material circumstances – more authentically than a formalized interview might have allowed, given that they arose in absence of expectation. Such unstructured conversations have been used in other ethnographic research with structurally vulnerable populations (Boyd et al. 2020) as a basis for rich engagement with participants. Clients proffered their stories; I bared witness. The "emotional and relational investment" (Kiesinger 1998:77) I had to make in order to hear these realities was intense; they formed an assemblage of trauma, chronic drug use, homelessness, protracted illness, assault, frequent loss, and, rooted throughout, the undeserved shame of social judgement. Clients offered themselves in their full humanity; their pain and suffering, certainly, but they also shared with me their curiosities and histories, their artistic capabilities, their tempers, and their empathy. Consequently, in this research, I have chosen to include all varieties of communication with clients as interview 'data'; these varied interactions implored me "to attend more closely to the specificity and the world-historical significance of people's everyday experiences" (Biehl 2013:574). I would argue that my engagements with clients – most all of them long-term drug users precariously surviving, sometimes amazingly so, amid crisis – demanded a more flexible methodology, one where all forms of conversation count. If I constrained my narrative to what was created within my more formal interviews with clients, I would be simultaneously negating other forms of telling; willing to hear only in ways conventional qualitative methodology allows.

Still, my interviews with clients proved revealing and they warrant an equal amount of methodological attention. Though my interview style was consistent in my conversations with clients, I found that it was them that led discussion. Dissimilar to my interviews with staff

members, where some exploratory questioning on my part was necessary to elicit dialogue, clients simply wanted to talk. I wondered how long it had been since they had had the opportunity to sit down, in stillness, with someone who genuinely wanted to listen to all they had to say, and I allowed them to take the conversation to places I might not have anticipated. Attending to my participants' life stories challenged and deepened my understanding of my own life and privilege; it taught me the meaning of a reflexive interview, wherein "another person's world of experience inspires critical reflection of our own" (Ellis 2004). Such methodological understandings cannot be taught but through lived experience; thus, multiple meanings and understandings of our distinct but overlapping social and personal worlds emerged. Further, I had, prior to beginning my interviews, special ethical considerations pertaining to Safeworks clients' ability to participate: how much would psychoactive substances enact an existence (Harris 2015:1693)? Would their use be an evident "third presence" (Harris 2015:1693) in the room, interfering with our ability to communicate? I interviewed clients' after they had used; this did not matter. By the time I began interviews spring hung hesitantly in the air. I knew clients well enough to discern their temperament, to appreciate their capacity to participate. I realized that a mode of caring – an ethics of care – was what was truly required in this situation (Mol 2006; Denshire 2014:842; Bochner and Ellis 2016:49). I provided monetary compensation for clients' time – thirty dollars, or the equivalent of two hours at minimum wage – in recognition that time spent with me in an interview was also time away from life-sustaining activities (Canadian HIV/AIDS Legal Network 2005; Boyd et al. 2020). As Ellis maintained, "a researcher figures out in each situation how to create the most ethical relationship and outcome for participants" (Bochner and Ellis 2016:3). I am reminded of the interview I held in the park across from Safeworks; seated beside a client on a blanket he pulled from his tattered hockey bag. I

recall the way the sun held strong in the sky as we chatted, long after my recorder had been tucked away, and how he said he could not recollect a more pleasant afternoon. My interview methods therefore contested the hierarchal social contexts in which they were located; challenging the academic impression that one must keep an analytical distance to uncover sociological significance.

Field Notes and Participation**.**

I kept records of my experiences and observations at Safeworks dating back to the first day I stepped in to the consumption room (Ellis 2004:138). Though in-depth interviews formed my principal method of data collection, they were complemented in this study with observational techniques (Adler & Adler, 1999, p. 273). My observations initially took the form of conventional field notes: hurried jottings of events and social practices that I recorded in a small notebook and expanded upon in detail soon after leaving the field (Emerson, Fretz and Shaw 2011:23). As mentioned, I felt this method awkward; I needed the use of my hands, my body, to partake in the provision of services. Existence at Safework*s* was as much an embodied experience as it was relational, observational. Consequently, my body in the field was a participating body (Coffey 1999:70). Crises meant movement: How soon could I reach a client falling to the floor? "Can you grab the Narcan?" staff would call, and, before overdoses became routine, fear would propel me forward, my fingers fumbling to open the metal cabinet door. Daily existences, too, became embodied. The circulatory manner with which I navigated space – bringing clients in through the side door, curving past the supply buffet at the back of the consumption room, dropping off a chart, to complete the loop, at the nurse's station. Carrying a notebook proved cumbersome but, more embarrassingly; it typified social differentiation and

stood in as a barrier to connection. So, after several visits to the site, I discarded the notebook and pen. Still, I wanted – needed – to process these intensely emotional and interpersonal (Coffey 1999:120) experiences. Audio dictations succeeded my exploratory attempts at taking notes in the field. In these narrated summaries I express the way my experiences were perceived, sensed and lived (Ellis and Bochner 1996:18). The recordings also comprised witnessing Safeworks staff and clients; through them I learned to be 'affected' by their work. Further captured in my dictations are the daily activities and social practices of clients and staff; the everyday moments some might deem inconsequential, the shared mischiefs and the frustrations of trying to survive. However, all my accounts are partial, and my records will never fully capture the complexity of human experience. Following Sandelowski (2002), who maintains that social researchers must not treat the qualitative research "naively", nor should they claim to "give" voice to their research participants, I employed the use of my observations in this study with the understanding that the data emergent is constructed in nature and the product of our particular social interactions (Sandelowski, 2002, p. 106). Every story is necessarily fragmented and situated (Ellis 2004:139). Consequently, my purpose, in the use of these recordings, is to "capture and convey the meanings attached to experience" to tell a story that readers can feel and be a part of; to evoke in them emotions I felt, to nudge them into considering their lives in relation to supervised consumption and the people intimately involved in these services (Ellis 2004:139). Data emergent from my dictations is used in this research to fashion vignettes, encourage reflexivity throughout the writing process and add layers of intricacy to experience (Ellis et al. 2011:279).

Analysis.

My data took the form of recorded and transcribed interviews with 21 research participants, half of whom were staff members and the remaining ten participants were regular clients of Safeworks. Verbal recordings of my observations were also transcribed and analyzed as a complement to my interview data. My approach to data analysis was inductive in nature –the specifics of data analysis were unknown at the outset of my project, and I began the process of looking for patterns and relationships while collecting the data itself (Neuman 2007:509). Consequently, data analysis within my project was less a distinct final stage of the research as it was an on-going process of discovery, as is the tradition in the grounded theory approach (Neuman 2007:70) often used in qualitative research. More specifically, my research involved the abstraction of general themes and concepts from my transcribed interviews and field notes. I moved towards larger thematic understandings of the specific textual accounts of my experiences at Safeworks through a process of qualitative data coding, wherein I reviewed the data on multiple occasions (Neuman 2007:511). An initial open coding scheme was used, which allowed me to bring themes to the surface from the depths of my data. These themes were preliminary in nature and guided by my initial research question(s), a review of the literature, and my reflections while in the field. These themes were then specified into preliminary analytical categories, which were used as the basis for a second stage of coding (Neuman 2007:512). During this phase of analysis, I was less preoccupied with the specificities of my data then I was with my initial codes and their conceptual and structural order (Miles & Huberman 1994:62). I searched for clusters of categories and concepts to determine whether they could be subdivided into dimensions or into more general constructs. It was in these moments of data analysis that some themes were strengthened, and others lost their initial importance. The frequency with

which some codes appeared served to solidify the significance of several larger themes – a situation "analogous to the idea of multiple indicators described with regard to reliability in the measurement of variables" (Neuman 2007: 514) when compared to quantitative sociological investigation. Connections between the themes I had unearthed within the data and the frequency with which they appeared in my empirical evidence served to strengthen their substantive significance and sociological importance. A "last pass" (Neuman 2007:514) through the data was performed after my concepts were thoroughly developed and explored in order to elaborate major themes and to underscore the meanings and implications of my larger conceptual categories on care practices within spaces of supervised consumption. In sum, data analysis involved a continuous process of reflection, redirection, and specification over the course of my research study and, though laborious and time-intensive, allowed for an intimacy with my data that I might have otherwise never known.

Ethical Considerations.

When we conduct and compose research, we implicate others in our work (Ellis et al 2011:281). This is expressly true when writing personal and emotional texts where our inner worlds and vulnerabilities unfold openly throughout the pages. We are always scripting our lives in relation to others; "relational ethics" are thus a heightened concern for autoethnographers (Ellis et al. 2011:281). Any personal story included in this narrative is not solely my own, and as Andrew Sparkes states: "in the process of writing about ourselves, we also write about others" (2013:207). Safeworks staff and clients are therefore always and everywhere present in this text, at times expressly so, as is the case when using direct quotes drawn from an interview to craft an evocative story, but also indirectly, when showing up in my personal depictions of pivotal

moments or particularly poignant conversations. Naturally, my participants may be unaware of the extent to which their lives have influenced my own and are thus unknowingly implicated in a narrative over which they had little control. Furthermore, I have maintained and value interpersonal ties with my participants, becoming friends with several staff members throughout the research process, subsequently "making relational ethics more complicated" (Ellis et al. 2011:281). I care about my participants; they are not "subjects" from whom I have simply gathered data and then hastily fled. Rather, leaving my role at Safeworks was a gradual and achingly painful process. The ethical concerns I hold for my participants are therefore as prevalent in the writing process as they were when I was actively involved at the site. To protect their identities, I have given my participants pseudonyms (in the form of initials) in this text. Where necessary, I have purposefully avoided specifying the particulars of their role(s) to avoid identification. I am also conscious of the influence of this work when putting voice to services habitually silenced. In what ways will this story be used and understood? What makes me fit to tell it? In writing this prose I must continually ask if I am of service; am I doing my part to contribute honestly and self-consciously to wider conversations of supervised consumption services? Further, I am aware that peer support workers' (people with lived experience of drug use) involvement in research is "often limited to recruitment, consultation, and reporting back, rather than a genuine collaboration…" (Brown et al. 2019) How can I avoid the dangers of working with people who use drugs for my own educational betterment? How can I write this story in such a way that honours my participants' important contributions? Here, I recognize peer support workers as active participants within this research (Brown et al. 2019); my understanding of harm reduction and supervised consumption was driven by people who have or who currently

use drugs, and they are due acknowledgement for their work within the site and in policy, health services, and in research.

My role in this prose is to show up, as I am, and offer of myself my 'otherness' – to write honestly about my experiences so as to invite readers in. My authorship answers the moral call for authenticity; if my stories of supervised consumption services as they are lived and practiced do not lead you, as a reader, deeper into yourself, then I have not chosen the right methodological path.

Chapter Three: First Fieldwork and Learning to be Affected.

The supervised consumption site is animated with activity when I step in. Moments ago, I had been standing behind the closed door of Safeworks Supervised Consumption Services, mentally preparing myself for what might be waiting on the other side. I paused in the hall of the health center before swiping in, my ID badge dangling from the blue lanyard around my neck, straining to hear staff members' voices above the music beating in the background. I performed this ritual before each visit to the site – even months into fieldwork – hesitating before entering, trying to predict what, exactly, the next few hours might hold. I used small indicators – the chit-chatter among colleagues, a muffled, familiar laugh, an unnerving quiet – to make my determinations. Silence disturbed me – had there been an overdose? Was something wrong? I associated flutters of activity with normalcy and had been relieved to hear snippets of conversation emerging from inside the supervised consumption room. I stood in the corridor, apprehensive, gathering the resolve to enter the site, assured I would not walk into crisis. I might have to claim myself, once again, as a researcher, an observer, a quasi-staff member, should I meet somebody for the first time, but over the last few months the frequency of these introductions had diminished. More often than not, people knew my name, and I delighted in the recognition. It had taken time to feel comfortable in the space – to move freely between the consumption room and the reception desk, to sit, without invitation, at the nurse's station, to pull my chair next to a familiar client and ask them the details of their day.

I vividly remember the first time I was thrown into work. I had been standing off to the side of the consumption room, making myself as unassuming as I could. I held my body close to the clinic's walls, reinforcing, tangibly and symbolically, the barrier between the outside world

and the designated space in which supervised consumption takes place. I imagined this to be my obligation as an observer – to stay out of the way – when MM approached me on his way out of admin, three thick file folders in his hands.

"Ready to bring some people back?" MM asked, smiling – smirking? – and, before I could respond, he opened the door to the waiting room and called the names of three clients.

MM asked me to get the clients their supplies and I panicked, unsure who needed what, unfamiliar with the sorts of materials one used to do drugs. There was not just one client, either, but several entering at once, and I was caught off guard. I envied the ease of other staff members, who instinctively knew what each client used for supplies, had the items ready before they had even chosen a booth.

"How do I know what they need?" I asked MM, gesturing to the buffet of supplies set up in the back corner. I felt charged with apprehension, aware that this task surpassed my abilities.

"Ask them!" MM said, amused, as he readily guided the clients into their booths, sliding their charts into slots at the nurse's station along the way.

Something in me shifted. I felt chastised; of course, I could ask them, why had I not? I had never been exposed to substance use before, at least like this. Unlike many staff members at Safeworks, I was unversed in the language; I lacked the lexicon that they appeared to possess when discussing the particulars of their work. "What gear do you need?" J, a tall young nurse, would ask, easily, as clients collapsed into their seats, the weight of their belongings falling, for a brief half hour, to the floor. Their answers – a couple longs, a short, cookers, waters, and ties – seemed to make intrinsic sense to those around me, but I struggled to match their requests to the items Safeworks offered. Now, I was being forced to learn. MM, unlike some of the other staff members, never let me stand by. He took it upon himself to invest in my harm reduction

education, unwrapping the fundamentals of supervised consumption services only to fold me back in. As a peer worker, MM's "knowledge and expertise were garnered from lived experience" (Boyd et al. 2020); he, along with other peers at the site, had been impacted by social stigma, discrimination, and structural violence. It seemed his role at Safeworks held dual purpose: to support clients, undoubtedly, but also to amend the ways in which more "traditionally trained" staff relate to people who use drugs. "It's just about bridging that gap between clients and staff and understanding what both sides of the fence are like, and excelling in them," MM had said once, and I wondered whether he bared a disproportionate responsibility for the functioning of the site.

Still, MM had charged me with gathering the correct supplies, and, after asking the clients what they needed, I fumbled through the process, emerging with a fistful of needles and a budding confidence in my ability to help out. The clients had been patient with me; directing me towards the supplies they needed.

"No tie," one client said, as I held up an orange tourniquet, "just two longs, a cooker, and water." I collected the sterile water, two long-tipped needles, and a small red cooker and deposited the items on the client's booth. He had been waiting for his turn to use the site for some time. I was grateful for his patience.

"How'd it go?" MM asked, moving to stand beside me, chuckling, enjoying my discomfort.

"Fine," I replied, simultaneously relieved that it was over and pleased to have contributed something to the site other than my presence.

MM's insistence that I participate first in the structured life of the site defied my understandings of what an observer should do but made sense in this particular context. Inhabiting space in Safeworks comes with certain responsibilities. Gathering supplies for clients was one aspect of

this, but so too was recognizing the signs of overdose: the labored breath, the greyish hue of people near death, the slackness of bodies in booths. I was shown how to pull and file charts according to year of birth – paper charts, their edges worn with use – and I began to differentiate between various substances and their bodily effects. I often had the sense that MM guided me through Safeworks much like he would a new hire – pushing me to know more, to try harder. I always felt this to be more for the benefit of the clients than for me, but as someone who had never been exposed to harm reduction – to supervised consumption – as it is lived and practiced, I needed the teaching.

That had been in early December, about a month into my research. Winter held the city in its grasp, declining to let go, no matter how many times Calgarians shoveled the snow and ice away. Now, in the almost-heat of summer in the city, I barely recognize the person I was back then: slightly overwhelmed, undoubtedly inexperienced, but genuinely invested in gaining an understanding of the work. Of course, providing clients with sterile supplies is only a small part of what is accomplished at the site, one of its most basic – though no less important – functions, but acquiring familiarity with substance use equipment allowed me to converse with clients in a language we both understood. Words carry worlds, and I was slowly entering theirs. Meeting clients' requests for supplies or a Naloxone kit provided the means for exchange; interactions that brought our visibility – theirs and mine – into sharper focus and formed the basis for future connections. Over time, I became increasingly self-assured at the site, fully entangled in the many strands of what supervised consumption services might look like, and still, I felt my chest tighten each time I swiped in.

"I can't explain it", KE, always so full of warmth and purpose, had confided in me, "but the longer I'm away, the harder I find it to walk in."

I struggle to identify what makes me falter, but I am curious if a similar mix of feelings prompts KE's own apprehension. I wonder if the same sentiment erupts in all of us, as we scan our badges, wait for the tiny light in the corner to flash green, and push our way in.

Spaces of Supervised Consumption.

If it were not for the sizeable yellow needle drop box and the small cluster of people huddled together on the concrete sidewalk outside the urban Health Center, the public entrance of the supervised consumption site might easily go unnoticed. Clients enter the site by street access; they ring a small doorbell and administrative staff grant them entry to the waiting room. Following Health Canada's stipulation, only six people can be waiting for a booth at a time. This seems reasonable in principle but challenging in practice, as most SCS staff attest. Admission can be hectic; both for clients, eager to come in, and for administrative staff, who work to maintain order in what is often a chaotic environment.

"It's such a high traffic area," KA, an administrative assistant, calm in disposition but skilled in her work, told me, speaking of the waiting room, "people are in and out, and somebody leaves and, you know, the next person is ringing the buzzer, and five people come in…all of a sudden you have a full queue right, and it's not like they line up and wait!"

"They're screaming from the end of the room and you can't even hear what they're saying," KA explained, laughing, and I considered the scene she was describing.

To sign up for a booth, clients are asked to provide their birthdate and initials. This becomes their unique identifier and facilitates staff's ability to keep a record of their visit history. Impatient to use, clients will sometimes mumble, and other times yell their birthdate, while staff rush to jot down their information and pull their chart. KA, much more experienced than I, does

this with ease; she has memorized the birthdates of regular clients, their preferred method of use, and their substance of choice. I envy the calmness with which she commands the room; I am easily flustered in the same situation.

"Take your time," KA counsels me, whenever I take a turn at the front desk, "don't let them rush you."

Reception is, however, not always hurried. There are moments of stillness and remnants of remarkable conversation contained within the small space. The waiting area is separate from the rest of the site; and in that room, where clients anticipate their turn, they occasionally confide the minutiae of their days, present their art, or request a favourite song be played. Those are the moments that matter to me most.

Any banter that takes place in the waiting room is halted when clients are called in to the consumption room; this is the main purpose of their visit. Once inside, clients choose an available booth and staff provide them with sterile supplies. Clients can snort, inject, or orally consume their drugs; smoking is not permitted. Six booths are lined up against the long edge of the consumption room, and every cubicle contains a table, a seat, and a sharp's disposal container; each is artificially lit. The booth becomes the client's personal dwelling for thirty minutes, after which, barring any incident or overdose, they are asked to move on to the post-consumption room. Where administrative staff cope with the commotion and demands intrinsic to the waiting room, health care professionals monitoring the consumption space combat the clock.

"You know," KA told me, referring to supervising the consumption room, "I find the time limits a challenge. [Clients] will get their shot in in 20 minutes, right? And then they have ten minutes left and then [staff] are already on them, giving a warning, and I heard from clients too, they're

like, ‘you know what, I take my shot, I just want to sit there and enjoy, I don’t want to have somebody say ‘hey times up, you gotta go, you gotta go…’”

Other times, clients will doze in their booths in spite of the bright fluorescent lights; either exhausted from having been up all night or swept up in the sedating effects of their substances. How can staff realistically incite an awareness of – and an urgency concerning – the time in a lethargic client?

“I’m still trying to figure out how to approach that,” AD, a newly hired young nurse, said, when I questioned the difficulties of enforcing the time limits, “moving clients from the booth to chill without it being a confrontation, with it being an interaction.”

Fixed time limits are further complicated when clients reach out for support from staff; their lives involve more than substance use.

Consequently, it is sometimes unclear where to draw the line; what if a client has finished using but is wanting to talk?

As DI maintains, “I know that we need to stick to that boundary, [the time limits] but, some people just really need to talk and that’s also the reason why they’re there…”

I too, would find myself at the nurse’s desk, mindful of the room but relaxed, when a client would initiate discussion. I would hear of the day’s events, or their relationship troubles, or even of the remote communities they once called home. I would listen as D, an older client, told me stories of his childhood; running rampant in the wilderness of the prairie town in which he grew up. He spoke of his parents, teenagers when they had him, and how his mom resented his intrusion; caring for an infant an unwanted interruption to her own youth. I am almost surprised by clients’ willingness to confide in me; it takes me time to open up. To inject drugs, an act often

perceived by clients as deeply shameful (Rance and Fraser 2011:121), in front of non-judgemental others fosters a strange sort of intimacy.

"It's a very personal thing, right? It's a very shameful thing," JE, a peer support worker, explained wearily, speaking from experience. "Most of them will cover up all their arms in the ninety-degree heat, their legs, everything, and they don't take care of their skin properly, so a lot of infections, because they don't want to show people the track marks, the scars, there's just stigma around it…"

Clients thus expose Safeworks SCS staff to the most intimate parts of themselves; after which, a comfort takes shape and the above-mentioned disclosures originate (Rance and Fraser 2011:121). Supervised consumption services are about creating safer conditions for drug use; they also raise the possibility of insightful moments of conversation and the feeling that one belongs. I am sometimes stunned by the personal trauma clients are willing to reveal, but as JE said, they have already shaken the shame that condemns them to hide their substance use by accessing the SCS; met with acceptance, why not continue to share? Accordingly, deciding what takes precedence – intimate but lengthy conversation or the more frequent monitoring of people's consumption – is a challenging task for staff to balance.

Occasionally, clients need practical assistance preparing their substances or locating a viable vein. The SCS sees many clients with structural vulnerabilities, such as the young woman whose inability to self-inject renders her dependent on her abusive partner, or people who are otherwise abled, making self-injection difficult. Staff can help prepare substances for consumption, but they are not able to offer hands-on assistance.

"Some people are quite surprised when I say I can't actually poke your skin, because they're like 'well then why am I here?'" DI, a nurse with a more traditional medical background, explained to me, early on in my fieldwork.

What staff can offer is harm reduction education, verbal assistance, and visual guidance. Nevertheless, such education is vital.

"The teaching part of it is really important," DI maintained, "some people will keep their rubber band on or their tie on their arm for half an hour and there's like no blood flowing. Or changing the needle because [the one they are using] is pretty dull, and then prompting… sometimes people aren't in best head space to think 'oh there's a blood clot in the syringe' or something like that, and we suggest changing the syringe."

Another frequent misconception of the SCS is that clients are provided with drugs; in reality, they must bring in substances attained on the street. Clients are barred from sharing dugs with each other, or 'passing,' within the site; the consequence of which is a temporary suspension of services, or what is regularly referred to as a 'ban.' Suspensions are also given for smoking on site, for verbal harassment or violence towards staff or fellow clients, and for violating rules tied to the functionality of the site, such as persistently overstaying in their booths or in the post-consumption room.

However, not all consumption experiences are without incident; in addition to issuing suspensions, staff deal with the real possibility of overdose. Substances acquired on the streets are unpredictably potent. One cannot begin to appreciate supervised consumption services without understanding overdose response. Safeworks secures the space and fortifies the capacity for staff to act in the event of an overdose; within the consumption site itself there has not been a single death. Safework*s* provides protected space for clients to use substances; rather than use,

alone, in the tight confines of public washrooms or concealed behind concrete walls to use drugs, people come to Safeworks.

"I feel safer using in this space," R confided in me, "I've seen a lot of people revived and saved, like, countless times. Knock on wood, or whatever, but I haven't heard of, I think one person, that passed away around here. And that's too bad. You've got to consider the risks, it's serious. If they were outside, in a back alley, or something, you know? They might not be here."

R knows better than I do the risks associated with substance use; like other clients, he has witnessed firsthand the devastation of the opioid crisis and, contrarily, the relief of people, often his friends, attended to. W, one of the site's older clients, well into his fifties, has received direct care as a result of using at the site:

> I died ten times… and they brought me to, now, had that happened to me in some stairwell or down by the river point nobody would have found me until morning and I'd be dead, so I have great, great respect for the site and for the people that work there.

R and W speak to a particular form of care being well provided; they also stress that such practical care is fairly limited to Safeworks. If someone were to overdose "in a back alley," or "in some stairwell," or "down by the river point," unnoticed, death is a very real probability. As I sit to write this narrative, thousands of people have died in Alberta from opioid poisoning since early 2016 (Laing 2019); numbers are but an abstraction. Hidden beneath this impersonal figure are real people, many of whom could have been the clients familiarized on these pages, had they not come to use at Safeworks. My fieldwork exposed actualities that I did not fully comprehend before throwing myself into experience: coming to care for clients – really caring for them – and then watching them go slack, unresponsive, inhaling the thinnest of breaths. Relief is too soft a sentiment to capture what I felt when clients' overdoses were reversed at the site; surely, we

would have lost them otherwise, and the world would have suffered their absence, sentient or not.

The language of overdose minimizes the truth of experience; it is not only an 'overdose,' but a person experiencing an overdose. The distinction is needed; Safeworks staff intervene to save the lives of people they know and have a relationship with – individuals with a voice, a history, a name. Consequently, responding to an overdose is both routine and emotionally disruptive for program staff and other clients on site; as B put it, "even though there's an urgency, there's such a casualness to it." I am careful not to write away the aftermath; it is true that overdoses are anticipated, even usual, but they can also be deeply alarming, particularly when considering the potential consequences if the overdose had occurred outside the site, instead.

"I've seen a lot of people revived and saved, like countless times," R said, "it's good that you guys are here, because you guys are on it."

W, too, is thankful for staff. "They're all very well versed on assisting people and saving lives," He told me, "I think it's one of their top priorities."

In the course of providing routine care at the SCS, thousands of clients' lives have been saved; they continue on in living, a reciprocal reward. Clients knowingly choose to use within the site; staff intervene to mitigate the most permanent effects of drug use: overdose death. As AD, a young nurse, recently hired, said, "clients make a really positive decision to access the site," and for now, that is enough.

Once clients have successfully used and are free of any visible signs of overdose, they are asked to move on to the post-consumption room, snack in hand, where clients are monitored for an additional thirty minutes in case of any adverse effects. It can be difficult to get people to

move along once settled in the space; it is, for some, the closest thing they have to home. “I felt like I belonged, I found a sense of belonging, first time in my life,” A, who experiences such profound stigmatization outside the site SCS, explained to me. “I actually had a place where I could go, where I fit in.” And is that not the definition of home? Not where you are from, but where you are wanted? It is in the post-consumption room that clients come together; “this is more than just a site or clinic or whatever you want to call it,” L acknowledges. “It’s a community. People meet their peers here, they make connections here, and they look forward to that social time and that space, it’s protected for them to be comfortable in themselves.” The centrality of social relationships and feelings of acceptance are vital to the service’s effectiveness (Rance and Fraser 2011:131).

“I think it’s a lot bigger than we even imagine,” DI confided in me, “it’s not just about community, it’s about clients’ psyche, and about knowing that you’re not alone in this world.” Thus, Safeworks clients rely upon a community that offers – through its services – caring, dignity, and the assurance that here, they have not been excluded (Jennings and Hanson 1995:8). Still, there are limits; staff cannot allow unlimited time in chill, despite the sense of community cultivated within the space. Supervised consumption services are paradoxical; to be effective there needs to sociality amongst staff and clients and between peers, but not so much that it interferes with staff’s ability to perform their most evident function: supervising drug use. Consequently, notwithstanding their awareness of clients’ plight outside the site, and the amiability encouraged within the space, staff must urge clients to move on, returning them to city streets.

‘Sheer Badness.’

I recall Christmastime at the site, when I first grappled with the extensiveness of vulnerability present at the site; confronted the “sheer badness” of clients’ situations and the lives they endure outside our walls (Slote 2007). The expanse of clients’ needs eclipsed what I, or Safeworks, as a supervised consumption site, could ever hope to provide. It was the evening of December 23rd, and I was seated in a chair in chill next to a young male client. His blonde hair unruly; hardship his most prominent feature. He was dressed in a red plaid shirt; a quintessential Canadian outfit, if there is such a thing. The upcoming holiday, he told me, was no cause for celebration; he was alone, had no one with whom to spend the day and, more disturbingly, no place to sleep when moon lit sky. There was only a handful of us gathered in the post-consumption room: me, this young man – whom I would never see again and always wonder his name – and two other male clients. One was pulling back the seal on a fruit cup; the other, RY, meticulously rubbing the dirt off his boots. We were all aware of the melancholy permeating the room; a holiday tends to bring with it an awareness of what one has lost, and, for some clients, a sense they no longer belong to a world that celebrates. I attempted help; asking the client if he could stay in a shelter for the night.

“I’m on a ban from the drop-in,” he said, “and a lot of the ones here you have to be sober to stay.”

“Where have you been sleeping?” I asked, concerned for his welfare.

“In an apartment vestibule, but they chased me out last night.”

I saw this client, asleep, huddled in an entranceway. I imagined him startled awake, forced to flee his makeshift residence. Winter is not sympathetic to the homeless; nor are some of the city’s residents, more frightened of a person, deprived of home, seeking refuge, than they are of a

society compliant with people living in such forbidding conditions. My pulse picked up on his behalf; the client appeared resigned, more troubled by his loneliness over the holiday season than by having been displaced. His needs, expansive; where I was focused on his material deprivation, he was firmly settled in the emotional impact of familial rejection made acute by the holiday season, social ostracism, and the shame of public humiliation (Mackenzie, Rogers and Dodds 2013:1). He came in to use substances; afterwards, a spoken expression of basic care left unmet.

"Sucks, man," RY, said, briefly gazing up from his muddy footwear.

The younger client nodded his head in agreement, intuiting a mutual understanding; their experience one I could not penetrate.

Admittedly, if it were up to me, I might have let this client stay in the chill room longer, allowing him to nap; proximate to his predicament, extra time indoors was all I could offer by way of shelter. But I am not a staff member; the organizational pressures to enforce the site's policies not stalking my decision-making. Technically, thirty minutes is all clients are allowed. Where some staff might impose the time limit – "it is the right thing to do, the client needs predictability, stability" – others may relax the boundary, conscious that this client had gotten little, if any, sleep the previous night, and that he would surely struggle to secure rest in the hours to come. These sorts of moral dilemmas are commonplace at the site, and an aspect of care that I will examine more closely in the following chapter. Another client, BK, purposefully makes use of the site nocturnally; skirting the dangers, as a single, middle-aged female, of remaining in her camp at night.

“I’m safer in here than I would be out there,” she told me, sitting in chill, attempting to charge a phone, “especially if somebody wanted my stuff, what am I gunna do if I’m high, if I’m all high, and they wanted my stuff, I’m just like, here take it, cause I don’t want to get hurt…”

I recall BK fiddling in her seat, saying that the phone “doesn’t have a SIM card,” but that she could use it to call the police.

“Is that something you would do?” I asked.

“Yeah, at times there’s been people around that I’m, I tell em ‘I’m gonna call police on you if you come here, if you come near that’ and especially at night…”

“You sleep outside, right?” I confirmed, constantly trying to keep up with clients’ living situations.

“Yeah…I’m a single female, and either they’re horny for some reason, they’ve been drinking, doing drugs, whatever, and they’ll come to me...”

“Do you get scared at night?” I asked, uncomfortable, imaging the scenario BK left unspoken.

“Oh yeah, yes, I’ve had to carry around, like, broomsticks and stuff…”

My understanding of what good care is for these clients is not immediately clear; they have more needs than I can ever hope to meet, and yet, they are both here, now, at the site, and I am in a position of some obligation. Where one client has been chased from his improvised living space, the residence not his own, the other is pursued, her encampment “not safe” from the threat of assault. Holding an awareness of both situations calls for some form of responsiveness; but what is Safeworks able to provide? Even if I were able to “bend the rules,” offer an additional few minutes refuge, it would not be sufficient to cover the extent of their need; what should be basic rights for Safeworks clients are “frequently eroded or disregarded” (Mackenzie 2013:55). Many

clients live in conditions less than what is necessary for a "minimally decent life" (Mackenzie 2013:54); what should Safeworks staff do with such an alertness?

Clients' suffering is, undeniably, always present at Safeworks. Supervised consumption services are borne out of the reality and brutality of addiction; a health service predicated on the belief that all people who use substances deserve access to life saving care. Safeworks supports a particularly vulnerable and marginalized population (Alberta Health Services 2019). Many clients are chronic drug users, living out their lives against localized conditions of social and economic disadvantage; struggling to cope with the materiality of life's necessities (Duff 2015:83). One need only to glance at the designated parking for shopping carts in front of Safeworks to comprehend the differences between us (Alberta Health Services 2019): my car is, primarily, a method of transportation; clients' carts, if they have them, are home. Their lives are inherently precarious; many of Safeworks clients are tirelessly managing the anxieties and uncertainties of life on city streets. The material depravations I have witnessed at the site are, at times, beyond my initial comprehension: clients' hands so cold they swell immovable, fumbling, often failing, to open packaging of sterile supplies; improvised belts made of string or tie holding up pants several sizes too big; encampments fitted under bridges – temporary dwellings built under permanent cement ceilings. Somehow, clients manage the demands of daily life in spite of the city's hostility – owning the practical know-how needed to survive in it, if little else (Biehl and Locke 2017:29). Safeworks staff attend to the specificities of supervised substance use; they also contend with the problematic of individuals living in conditions of chronic homelessness, impoverishment, dispossession, and with the ceaseless threat of assault or arrest. Bearing witness to clients' material scarcities is only just a start; the physical consequences of long-term drug use and the emotional effects of trauma are so prevalent at Safeworks I fear them familiar. How

does a single health service, designed, in principal, to lessen drug related harms, attend to it all? How do I?

Coping with Injustice.

L, a nurse established by years caring for socially marginalized populations, is painfully alert to the breadth of need present at the site and morally burdened by her inability to appropriately help:

> I think what's interesting is that we're…if we really want to support the clients and the addictions component, we need to be able to offer more, we need to expand…I think we need to be able to offer them a place to go at night, if we're going to be open at night. We don't have the wraparound service, we talk about it, but it's complicated because we don't actually provide the service right here, we don't have shelter for them, we don't have food security here."

I observed, more than I heard, L's desire to deliver more comprehensive care than what Safeworks was designed to provide: "housing, somewhere to go," and, primarily, "case management." When LU, a well-known client, undeniably chaotic but a keen conversationalist – chit-chatting her way through the site – injured her leg, L firmly encouraged her to visit urgent care. After repeated failed reminders, and LU's pained leg worse the next afternoon, L had had enough; she called the admitting nurses in urgent care, which is located in the same building as Safeworks, hurriedly gathered LU's paraphernalia – which was somehow strewn across the chill room floor – into LU's bags and walked LU to urgent herself.

"The solution is not for them to have to go to the source because they're not capable," L told me, after returning to the consumption room, satisfied that LU's immediate medical need was being addressed, "their lives are so scattered, fragmented, chaotic… what we need to do is actually provide services [complex wound care, shelter, etc.] right here and when they need it."

For L, clients' pervasive troubles have a "salience, [a] conspicuousness, and [an] immediacy" (Slote 2007:23) which she cannot ignore, nor can she fully remedy within the built confines of the site.

"I can honestly say that I won't be able to stay in this position for too long," L confided in me, "because I'm not doing enough."

Even those slightly removed from the front-lines understand the ache of ineffectiveness when up against the weight of injustice:

> Staff have been stretched and, and tried and see all the, all types of social injustice and that's very morally, emotionally draining for them to see that, to see somebody caught in the system cycle, incarcerated you know, bouncing around three different departments, so for somebody to witness that…

It is fitting that the above statement trails off into an ellipsis, left unfinished. What *does* it mean for Safeworks staff to bear witness to so much suffering – "we who can do so little," (Jackson 2013c:231) but care, desperately, anyways? Staff are not only confronted with clients suffering the painful physical effects of addiction and substance use; they see in clients "all those morally unacceptable vulnerabilities and dependencies which we should, but have not yet managed to, eliminate" (Mackenzie 2013). As STE said, "there's a lot of things that Safeworks is trying to make up for that everything else is lacking…" Safeworks is a site which makes salient the harm and suffering that accompanies the social failings to meet basic human needs: adequate shelter, daily nutrition, and clothing, reasonable levels of health, social interaction and support, and "opportunities to develop and exercise our capacities for human agency" (Mackenzie 2013:54). In a position to care, but undeniably limited in their ability to help, staff are subject to emotional strain and often, as a consequence, leave the site:

> I do think the work; this work has a bit of an expiration date on it…

Working here…I'm watching it destroy you, so you should move on…

The moral obligation felt by Safeworks staff to help people in need is pressing; for some care providers, such as L, this commitment extends beyond the provision of supervised consumption services and will require eventually leaving the site in pursuit of other work:

> I can't do really much of my scope, which is, historically, my role in community nursing, with marginalized populations, has been a lot of counselling, has been a lot of harm reduction strategies with the individual, here you know, that's not here, here the role of the nurse is to keep the people alive…

L is not wrong. In principle, Safeworks is intended for supervised consumption; for individuals to access services related primarily to their drug use: observation from staff, the assurance that they will not be using alone, the procurement of sterile supplies, and the receipt of harm reduction education and take-home naloxone. The peripheral – and slight – benefits associated with using the site – a snack, specified time inside, the use of a washroom – are present, and are, as I first observed and, on these pages, expressed, the cause of much difficulty, but are not a part of the site's intended purpose. The trouble with Safeworks, KAT once told me, is that the perimeters of work are not well-defined. In her previous position, KAT said, new clients would be handed an intake form and asked to check off the reason for their visit, selecting one of three available options, and she would be able to respond appropriately. Here, no such determinations of need can be made. Care at Safeworks is fraught with conflict; clients present with more needs that can ever be met, and deciding which needs are important inevitably involves slighting others (Tronto 2012). Caring for clients is consequently filled with inner contradiction; Safeworks staff, in their professional capacity, have a moral obligation to help people in need, but struggle personally to reconcile whether this responsibility ends at merely supervising consumption. AD, too, knows she cannot provide comprehensive care; "even if

[clients] disclose everything awful that's happened in their life, there's a limit to what we can do to support people..." Life at the site unfolds in an ambiguous zone between received or given views of responsibility and program staff's – and my – encounters with the often unpredictable exigencies of clients' distinct situations (Jackson 2005a). Where staff fashion individual interpretation out of obligation, Safeworks leadership maintain that "the key to this service is to understand your purpose and stick to it." The difficulty is that the purpose of the site, to "keep people alive," is merely a starting point, or, as G told me, "a chance…at least we're still gonna be alive to have that chance…no matter what the future holds." But, once given that chance, clients often return to their lives of contingency and crisis.

Chapter Four: Questions of Right or Wrongful Conduct

Moral Predicaments.

My aim in this chapter is to further explore the relations of care made possible at Safeworks and the distinct moral dilemmas experienced by program staff in the course of their daily work. Because the care practiced at Safeworks is as novel as the site itself, there exists definite ethical and moral ambiguity over how best to relate to people in need, on what is just in any given situation, and on whether "questions of right or wrongful conduct" (Jackson 2005a: xxix) are in fact felt to be matters of life and death. I ground these 'micro-ethical moments' – by which I mean a mundane situation, an occasion, a happening, "where something vital is [nonetheless] at play and at risk" (Jackson 2005a: xxix), when Safeworks staff are called to exercise a moral judgement in absence of precedent and in the midst of actual and seeming uncertainty – in everyday life at the site. In this text I maintain that the "struggle for being, and for caring, [at Safeworks] plays out in small ways" (Jackson 1993c:225), and that negotiating how best to care is a persistent challenge for Safeworks staff. As Joan Tronto (1993:137) argues, "the moral question an ethic of care takes as central is not – what, if anything, do I (we) owe to others? But rather – how can I (we) best meet our caring responsibilities?" Where individuals in the wider community in which the site is situated struggle with questions of: "Why should I care? Why should I help? Why should I contribute to the public provision of [people who use substances]?" Safeworks staff ask, "Why shouldn't we?" (Jennings 2018b:20) Accordingly, Safeworks' very existence presumes an accountability for clients' lives; it is understood at the site – among those employed at Safeworks – that people who use drugs are owed the dignity of recognition, that their well-being is important, and that their existence matters. What remains unresolved is a "determination of what [these] caring responsibilities are, in general…and a

focus upon the particular kinds of responsibilities and burdens we might assume because of who, and where, we are situated" (Tronto 1993).

My time at Safeworks was necessarily ensnared in these tensions; I cared for clients and struggled to know how best to meet their ordinary and more complex daily needs, and to do so effectively with limited resources and in situations over which I had very little control. I am only one; transient to life at the site. As such, I strive to locate my thinking in "the lifeworlds of my contemporaries" (Jackson 2013a:21). To what extent are Safeworks staff capable of separating their care practices within spaces of supervised consumption from their knowledge of the wider structural constraints exerting pressure on clients' lives? Must they? How can they not? What tensions are borne by Safeworks staff not of the inability to help, but because doing so would be to breach a different set of organizational responsibilities, many of which are themselves in flux? I raise these issues because they plead to be explored. There is, of course, the provision of more direct care in the face of immediate need, which is more readily attended and understood; simpler for staff to determine if care delivered is adequate. This is the sort of attentiveness and responsiveness one might equate with caregiving at a consumption site; concrete tasks associated with the supervision of intravenous and other methods of drug use, the clinical management of overdose, and the provision of sterile supplies. Nonetheless, care, at Safeworks, encompasses much more; clients' care needs when presenting at Safeworks are as infinite as they are elusive to meet (Tronto 2013). In this chapter, I offer consideration to what William James called 'the more' – embracing experiences of offering care – beyond interpersonal recognition, which I embrace as the beginning for all other aspects of care – that "unsettle, fringe and transgress the boundaries of what is conventionally focused, thought, and expressed" (1912:71; Jackson 2005a: xxvii) in discussions on spaces of supervised consumption. How might my fieldwork better

account for the practices of care existent at the site, wherein decisions must be made despite considerable moral uncertainty and where best care may always be contested by Safeworks staff and difficult – if not impossible – to provide?

I have spoken of care at Safeworks as "an occasion when people discover what each can be in relationship with the other" (Frank 2009); where staff and clients are brought into mutual visibility and rendered vulnerable. Safeworks is a space where individuals who use substances are made to feel that they matter. I stressed the importance of recognition from staff in clients' lives; camaraderie lessens a different kind of harm they experience – the fear of being left alone and the shame of being ignored. Intimacy with difference fosters its accommodation (Solomon 2012). Standing in solidarity – the few that do – with people who use substances is a fundamental aspect of care at the site; one that is seldom unearthed and brought to public light. Nevertheless, so that I may add complexity to the care animated at Safeworks, I now wander more profoundly into our shared life together over the course of my fieldwork. I ground this chapter in the nuance and sentiment of minor moments wherein program staff – and, to an extent, where I – forge and negotiate moral predicaments in providing care, as best we are able, to clients, while assuming, and sometimes chafing against, the practicalities of managing a new supervised consumption site. Second, I explore the ethical quandaries that surface, too, when negotiating the individualities from within which staff view the world and the purpose of their harm reduction work; where people alternately exist at the site "intentionally or in tension with others" (Jackson 2013a:18). My fieldwork at Safeworks established for me that "opening up new horizons of understanding places enormous demands not only on one's intellectual abilities, but on one's physical, psychological, and moral resources" (Jackson 2013a:28). I sought to gain insight into the specifics of supervised consumption; I had not anticipated grappling with the

ethical distress and complexity of everyday situations arising in life at the site (Jennings 2016:14). Moral judgements made by staff do not occur in isolation; they are dependent on intersubjective relations present at the site and are situated within a specific societal context, wherein supplementary social services are made available for clients, or not (Jennings 2016:13). To articulate these situated, 'micro-ethical moments' within which decision-making takes place, I draw on my lived experiences at Safeworks and extract stories; modeling moral sensitivity to what makes each situation at the site unique and each decision difficult.

Taking on Responsibilities.

I felt dazed and differentiated in my earliest experiences of life within supervised consumption services. There was doubt in the way I carried myself at the site. The longer I remained at the site, the more these arbitrary boundaries dissolved into fragments of my imagination; holding myself back in my fieldwork proved to be self-limiting and the most significant barrier towards understanding local life at the site. Gradually, I unfastened my hesitation; taking on small and mundane, and then much greater, responsibilities where I saw fit. The first of these – passing out snacks to clients on their way out to 'chill,' as the post-consumption room is casually called – came to be seen playfully by some staff as 'my job'. Now, I think this description of my work at the site is thin, but at the time I delighted in having a recognizable role. I would position myself by the locker storing snacks, careful not to accidentally tear at the art taped to the cabinet doors. I jumped at the chance to ask clients what they wanted – an ensure? A fruit cup? Peanut butter and crackers? – and waited, patiently, as they pondered the selections, which were, unfailingly, the same, day after day. Other times, I would partner with KE, Safeworks' dietician, to assemble grab bags with the extra food she received from the food bank. Over piles of crumbly nature-valley granola bars, pudding cups,

and juice boxes, KE and I would chat. Sometimes, A, who found so little encouragement outside the site, would join us, her productivity fueled partly by her drug use but mostly by her fierce spirit. Occasionally, we spoke of life: KE's children, the shores of the east coast, activities we enjoy outside of work. Other times, we discuss her job. I learned that KE worked determinedly to secure a contract for Safeworks with the food bank.

"The food bank," KE clarified, "generally only deals with non-profit organizations. I think we're the only AHS clinic, if you will, that actually has a formal agreement with them. Despite the fact that Safeworks is government funded, our clients have a high need for food bank product."

KE's brown eyes shone when she spoke of her success.

"I was pretty proud that I was able to move that forward, the food Bank relationship continues to be really valuable for our clients."

The value KE sees in her role – as a dietician working in supervised consumption and, consequently, with an often food-insecure population – "is actually putting food into people's hands," after all, "they eat what they have access to." Nevertheless, transferring the meaning of her position to suit the needs of Safeworks clients was not a clear process; Speaking of the transition from clinical dietetic employment to working in supervised consumption, KE described the complications:

> I mean it was good, but it was difficult and still remains to be difficult some days, in terms of trying to define my own role, right…so not a nurse, not a social worker, I don't have the lived experience…so I am a dietician, almost every dietician that I know that works with Alberta Health Services, we don't actually work with food, we just talk about food, so I found out very quickly that this client population, I really and truly to this day, still believe that most of them don't want to talk about food, they want access to it.

My first 'duty' at Safeworks was exactly that: "putting food into people's hands." Simple as it may seem, no task at Safeworks is purely instinctive. Staff at Safeworks regularly

confront situations in their care practice where moral dimensions are encountered (Brazil, Kassalainen, Ploeg and Marshall 2010: 1687). Contained within every offer is a directive: come in to use but spend no more than half an hour in the booth; have a snack but choose only one. These policies lend form and predictability to the program; they are not, however, resistant to the will of individual discretion. Ethics "describes matters of difficult judgement, [and are] hence frequently sites of indecision and anxiety" (Lambek 2015:77). One might wonder if passing out snacks to clients, as I was doing in my early days at the site, is a source of uncertainty for staff and if so, how morally troubling could such a task truly be? However, as Albert Piette points out, what might initially appear a trivial event often becomes a catalyst for decisions, or generators of various consequences (2015:183). Certainly, there are more pressing decisions to be made in the course of providing care at Safeworks, and what is experienced as a moral predicament varies widely, but in the spirit of attending to the "particular [small] details of human presence" and the local moral world (Jackson and Piette 2015:5) existent at the site, I tug at the seams of my memory and unravel examples that, while mundane, incite in me, to this day, a nagging sense of unease.

M always asks for the same snacks; either a chocolate ensure – never vanilla – or canned peaches. I fling open the cabinet door and stand to the side, as M dramatically surveys her options; eyes darting from shelf to shelf, eventually settling on a choice.

"I guess I'll have peaches," she tells me, and I smirk, not at all surprised.

M flicks her hips and saunters back to her booth. I trail behind her, snack and grab bag in hand. M is a local expert at the site; she has been using at Safeworks for some time. She counts herself as original to supervised consumption, familiar with Safeworks' rules and greatly annoyed when they change; M is nothing if not vocal. M knows that she is permitted one snack and a water

bottle per visit; extra donations from the food bank, if we have them – canned goods, ramen noodles, oatmeal packets – are there for the taking. It is not uncommon for clients to ask for more; coaxing staff into dropping extra peanut butter packets into their open bags – because, why not?

"You're out of water," another client, unfamiliar to me, says, as I pass him the fruit cup he asks for, "so that means I get to have an ensure, too." His calloused hand held out, expectantly.

"One or the other" I tell him assuredly, despite the discomfort stealing space in my chest.

I am not used to enforcing the site's rules. I sense he is testing me; waiting to see if I will relent. I am caught in complications; to concede is to fall short of predictability, opening up the prospect that clients can – at least with me – manoeuvre around the site's rules and regulations. Where is the safety – the care – in that? Nevertheless, I am acutely aware of the meagre social milieu within which clients survive outside the site; lurking just below the surface of my definitive 'one snack' answer is a personal desire to do something – "recognizing and reconciling the painful truth" (Jackson 2013a:24) that I am withholding nourishment from people who routinely go hungry. Though Safeworks is where I spend most of my time; the whole of life is my investigative field (Denizeau 2015:234). Consequently, I cannot absent myself from my – albeit limited – knowledge of clients' lives outside this space. The proximate immediacy of clients' present circumstances makes me "empathize more strongly with [their] plight and [is] critically relevant to the strength of [my] obligation to aid" (Slote 2007:27). Acting against my desire to hand out additional snacks to those in need is its own, albeit minor, moral struggle.

M, aware of the rules, does not normally plead for more than permitted, and so I am pleased to see her excitement when she discovers her favourite chocolate bar in the grab bag K assembled earlier that afternoon.

“I love these ones!” M exclaims, turning eagerly to the client in the booth next to her. “Hey BY, can I have yours too, if you get the same one? I’ll trade you for something!” BY is about twenty years M’s senior and much less impressed; he picks up his lighter, first a flicker then a flame, and shrugs in response. Knowing BY, he will later toss his chocolate bar M’s way and expect nothing in return. It is not unusual for clients to look out for each other, to care for one another, as many staff members have mentioned to me during my fieldwork:

> A lot of them are so helpful to each other, it’s crazy. They all don’t have that much so they don’t mind giving to each other, they’ll give each other coats, they’ll give each other food, a lot of them just give each other their drugs, like if somebody comes in and they’re super sick, they’ll give them some of their drugs, and you don’t even know what they did to get those drugs, and they just give it out, to somebody, a fellow homeless person…so you see the way they treat each other, I mean, when they’re not fighting.

I remember when M told me that she used to work with pastry chefs; how she helped make flaky croissants, and rich shortbread, and for some reason, I stood just short of surprised. Not yet twenty years old; M has already lived a lifetime. Fittingly, many of our conversations involve food: M, talking about herself as a young teen, holed up in her bedroom, surviving off bags of sour candy. In turn, I say that I dislike Chinese food and M laughs, telling me that “I’m not normal…” SHA, joins our banter, readily agreeing with M. I am not surprised; SHA and M share a love of all things culinary, and suddenly, I am the strange one. I take pleasure in M laughing with SHA at my expense; for her to feel the warmth of inclusion. Bordering our lighthearted conversation is the seriousness of M’s situation; unpredictably sheltered, dependent on substances, and doubtlessly hungry. Having once occupied a proverbial seat at the table, the needless societal shame and degradation attached to substance use and homelessness has pushed her chair away. M is left – in our company – to savour the taste of her memories. B, an administrative assistant for Safeworks, young herself but incredibly savvy – commanding the

front desk with the level-headed composure I long to possess – confided in me once how hard it is for her to "imagine what clients go through…being homeless, especially in a rich city, fighting for food." Faded is M's presence at the table, in the bakery; her recollections appear to me now like washed-out photographs worn down by history. In truth, M's job must have been recent; only here, under bright florescent clinic lights, does it seem *so* far away.

As much as clients enjoy chocolate, fresh fruit is openly appreciated, perhaps preferred. KE sometimes brings in apples, oranges, and bunches of bananas for clients, which are given out in addition to the snacks routinely provided. It troubles me to see clients hungry; it upsets me more to witness their gratitude over a single ripe banana. Clients' sincere appreciation brings the injustice of their situation into sharper focus; where Safeworks is able – through struggle – "to put food into people's hands," it is, unsurprisingly, never enough, nor is it exactly the site's purpose. As Safeworks' leadership maintains, "fundamentally we're here to prevent and intervene when there's an overdose and all the other pieces around harm reduction and education," but still, it is recognized by management that program staff, "end up doing so much more**."** It is in 'the more' that considerable care at the site takes place; 'the more' is where the bulk of moral decision making originates. So, several days later, it is not altogether unexpected when I am thrown back into a choice.

"We have fruit, too, M" I say, cabinet door open, snacks once again on full display. She already has a bottle of chocolate ensure tucked firmly into her pocket and, after surveying her options, asks for a banana, which I give her.

"Can I have some peanut butter? To go with my banana?"

I barely hesitate before grabbing a couple peanut butter packets and handing them to M.

"Do you want a plastic knife?" I ask, thinking she might need one to spread the peanut butter.

“Sure!” M says, cheerfully.

I know I am technically breaking the rules, but peanut butter and banana is a classic combination; how can I say no? In this moment, I feel close to M; oddly protective over the delight she finds in something so ordinary. She deserves these sorts of simple pleasures.

What is our Obligation?

I hold onto that small gratification all afternoon until I meet AD, after shift, for tea. We had scheduled an interview as part of my fieldwork, and I was looking forward to expanding my understanding of work at the site; becoming sensitive to differences in our imaginations. In a sense, talking to numerous care providers at Safeworks freed me of my observations of supervised consumption so that I might acquire others; compelling a making and remaking of my thinking (Deleuze 2004:176). Still, the processes whereby one is emotionally and intellectually displaced in conversation, however willing they may be, “can be so destabilizing that one has to fight the impulse to run for cover, to retrieve the sense of groundedness one has lost” (Jackson 2013a:10). AD, a registered nurse, newly hired, affected such a shift in me, unsettling what I considered permissible when engaging – informally – with Safeworks’ policies and procedures. Over the grinding of coffee beans, AD speaks of the pressures of her work.

“I can do everything to make it [Safeworks] a welcoming environment, I can make sure they’re [clients] supported and happy there, that it’s a place they want to be, but I also recognize that I have a responsibility within that space and have to try to balance that.”

“For me,” I tell her, “it’s interesting, because I can come in, and talk to somebody. And observe, but...”

“Your responsibility looks different” AD interjects, and I nod, taking a sip of tea.

“I don’t have to ask people to leave, and if I do, it’s very gentle, I don’t have to force anything. There are other people to call upon, I’m not shouldering that. Whereas, employees do...” I say, agreeing with AD, aware of the limits of my experience at the site.

“You have a different role” A tells me, before continuing on with her thoughts, “I do kind of think that people who bend the rules, we touched upon this in orientation, when you do something, it’s like, who’s cup are you trying to fill up? If I bend the rules for you, and say ‘fine, you can have an extra snack,’ am I doing that to make myself feel good? Like, ‘I’m so nice, I’ve done this really nice thing for you’, or when people are like, ‘it’s really cold out, I’m going to give them an extra 15 minutes,’ you’re doing that for yourself. And then, down the road, when they [clients] escalate because ‘so and so let them stay 15 minutes, why is it different?’ And now they’re excluded...”

I pause, considering AD’s perspective on Safeworks’ procedures; distinct from my own. Immediately, I think of M, and my willingness to give her an extra snack. At the time, it did not occur to me that I was acting in my benefit; it felt to me a thoughtful gesture. Here, sitting across from AD, I question my motivations. Did I relax the rules for M because I would want the same? Was the hunger I was satisfying my own? Did I choose leniency over consistency as a practice of care, and was my decision setting M up for failure in the future, when, and not if, another staff member rightly denies her request? Even worse, why had I given extra to M, and not to the other client, the one whom I had only just met?

“For some clients there are exceptions made for them, and for some there aren’t. I hate that.”

As if voicing what I can barely bring myself to think, AD resumes our conversation. “I’m sure you can think of people who are usually allowed to stay a bit longer.”

“Sure,” I say.

"I've been guilty of it too, 'it's so and so, they'll go soon...'"

AD is moving towards the crux of our conversation, which will, unbeknownst to me at the time, become the voice with which this chapter speaks; articulating the making of moral judgements in caring for clients and the complications of doing so. Being new to the site, AD distinguishes differences between her decision-making and those of other program staff.

"I think it's a different attitude I have, compared to some other staff," she says, "I think…very much in deadlines and absolutes, and not everybody does it that way. It's not how everyone operates". There is a measure of discomfort in my role as researcher; at the site I am attuned to my being-in-the-world, but I am similarly attentive to the practices and interactions of those around me. This dual presence unsettled my thought; I confronted the elusive and complex character of belief. We exist, as Michael Jackson maintains, "as both singular beings and participants in wider fields of being that encompass other people, material things, and abstractions, our relations with ourselves and with others are uncertain, constantly changing, and subject to endless negotiation" (Jackson 2013a:9). The more I was exposed to at Safeworks, the less I felt I knew; "unsettling and questioning what I customarily took for granted or considered true (Jackson 2009:234). I had witnessed AD's adherence to the rules, had seen her reliably, even "strictly," apply the program's procedures. I also heard how much AD struggled to reconcile her desire to follow program procedures without coming across as "insensitive":

> I'm still trying to figure out how to approach things, like moving from the booth to chill, or from chill to outside, without it being a confrontation, with it being an interaction. I think that to me, is the hardest part, because it comes off as insensitive. And I don't know if it's the way I'm approaching it, or if it's because I'm still new and they don't know me yet, or if they're just frustrated with their circumstances or what.

Initially, AD's actions struck me as unfamiliar, even cold; I had absorbed, in my first few weeks at the site, the importance of flexibility, of seeing supervised consumption services in all shades of grey.

"We work in a grey subculture," ST, a peer support worker, admitted, "there is no black and white. Why can't we use judgment calls, why do we have to adhere to such stringent rules?" D too, considers gradation where other staff might see homogeny.

"It's hard, I think it's hard for the staff that are a bit more…seeking a bit more grey." Firm observance to Safeworks' rules can feel, at times, D says, "petty and vindictive."

If the site is not busy, I would sometimes hear, what is the harm in allowing a client to stay – warm, more at ease than they would be on city streets – longer than their allotted half hour in chill? KA, an administrative staff, manages similar pressures related to moral decision-making while working within the context of a larger – and ever-changing – team:

> If it's cold outside and somebody's asking, you know, can I just warm up for five or ten minutes? I'm like absolutely, have a seat, you know warm up, whatever, but you know some staff will come and if they're [in] charge they'll be like oh who's that, like are they signed up for a booth, I'm like well, no, and then they go, well, they need to go.

Much like D, KA, and ST, I was habituated to the elasticity of Safeworks' rules in practice; considering clients requests on a case-by-case basis. However, in my conversations and encounters with more Safeworks staff, and AD in particular, it became palpable that decision-making at the site is borne and justified differently; where questions of what is right, of what caring ought to look like, are variably answered. My interview with AD necessitated a reconsideration of my previous understandings; I held, in that coffee shop, a "a view from in-between, from the shared space of intersubjectivity itself" (Jackson 2013b:270). At the time of our conversation, AD considered care to be consistency; the moral foundation for the decisions

she made at the site, where what is ethical refers to conformity to predetermined codes of behaviour (Tronto 1998:15). It would not be fair, she said, to relieve the rules for some clients and not others, nor is it just to practice leniency when it cannot be sustained. To do so would be to care, not for the clients, but for oneself; the difference between caring and self-concern. I had not, at first, thought her firm adherence to program procedures sympathetic. AD's clarification encouraged me to broaden my understandings of her actions and to reconsider the integrity of my own. Still, as AD recognizes, "compassion looks differently to everybody, and what one person considers compassionate, I may not."

For some staff members, best care for clients involves the use of "critical judgement" and "leeway" in their decision making; where structure is collapsed in favour of solidarity and the "call to ethical action in the presence of another in peril" (Jennings 2018a:555) cannot be ignored. Such was the case for KA, in using her judgement to momentarily shelter a client from the cold, despite this being against program policies. Similarly, J makes decisions on a "case-by-case" basis.

> We're dealing with, like, individuals on a case-by-case basis, you know…I do make exemptions for people. No one is supposed to wait in the waiting room unless they're waiting for a booth, but if we're not busy and you know, I have a client who is having a rough time…there are times and places when I definitely bend those rules

For KA and J, caring, in "addition to being responsive to temporal and also perceptual immediacy," (Slote 2007:27) is to be alert to the "sheer badness" of someone's situation. It is one thing to send a client forth from the site with the knowledge that they have somewhere else to go – a shelter, a dwelling, a home; it is another matter altogether to force a person's exit into the harsh expanse of city streets. The choice to allow clients access to Safeworks' waiting room, despite them not planning on using substances, suggests an assessment by staff of clients' needs

in a social and political, as well as personal, context (Tronto 1993). Safeworks is a place intended for supervised consumption; what often happens is that it becomes home for clients with multiple vulnerabilities and care needs. Clients come in to "warm up," to find "companionship," and, as G pointed out, "people get banged up and it's really important for them to get looked at and taken care of," and, at Safeworks, "the nurses are pretty good for that." Clients will attempt to use drugs but end up dozing off, exhausted, in their booths; safer here than anywhere else they might have to go. Staff assume attentiveness to more than just clients' substance use; they perceive the full range of human need and are placed in a position of responsibility to meet those needs (Tronto 2005: 130). Thus, the care that takes place at Safeworks always involves thinking: who is responsible for what caring, and what does that responsibility mean, in practice? The above vignettes demonstrate the extent to which Safeworks staff are caught up in moral predicaments not of their own making: "bend the rules," in a direct effort to – momentarily – alleviate (some) of clients' suffering, knowing that such concessions will not be enough, or, to be "really consistent with everybody, and to stick to it," pushing aside all that is left unaddressed, however personally challenging such a task may be. I felt, through sustained practical and social engagement at the site, that there may be no intrinsic "wrongness" in staff holding either point of view; only distinct ways of understanding Safeworks' rules; as principles to be applied or as practices to be interpreted (Jackson 2013b:274; Jennings 2018a:554).

Situating Vulnerability.

Here, I call attention, again, to what rests uncertain: what particular kinds of responsibilities and burdens might Safeworks staff assume because of who, and where, they are

situated (Tronto 1993:137)? Following Tronto, to be sufficiently responsive, to take care of, requires situating clients' vulnerabilities within a larger social and political context (1993:138). I have attempted to elicit the moral predicaments present when negotiating how best to care for clients who are coping with homelessness, food insecurity, and the routine degradation of poverty within the margins of what the site is able to provide but have not explored a significant burden assumed by staff: the commitment to "keep people alive". Within Safeworks this responsibility is foreknown and fulfilled but, for some staff, the obligation to protect clients' lives escapes the confines of the consumption site.

> I feel it is life or death, and in some situations I back my fellow staff mates, but in another sense, I'm like, we should have the parents' numbers of some of these kids and have the nurse call and tell that mother that their [client] is not allowed to use safely, so, cause it's life or death. So, if I can de-escalate a situation, or try to work through a situation with a client, rather than them getting suspended, cause I've um, responded to incidents outside, which I'm not allowed to anymore, and we've had deaths outside

Program staff hold an understanding of what waits for clients separate the safety of this space: in the midst of the opioid and methamphetamine crisis, the very real threat that drug use could result in death; the risk is more pressing now than ever.

This awareness complicates a central aspect of work at the site, which has, up until now, alluded my consideration: the onus on staff to suspend clients for breaching the site's rules and the judgments they make in deciding whether adverse behaviour warrants a suspension and, if so, for how long? Just as staff are undecided and divided as to whether certain circumstances warrant "bending the rules," for clients – such as permitting people extra time in their booths, or an extra snack – they are, at times, equally torn-up when issuing a ban from the site. Here, "the context in which caring work occurs also presents moral problems" (Tronto 1998:18). For some

staff, and most notably, for those employed in peer support, banning a client from the site for violating the rules – especially for months at a time – is akin to a death sentence.

> Some of those rules, which I totally agree with, like the health Canada exemptions, don't drug deal on site, don't open the back door, no passing…but, like, I get 24, 48, even three-day bans, like, in three days, that's a really good opportunity for growth and learning, but after a month…

For MM, quoted above, there is no logic in suspending a client for a month. Having experienced the depths of addiction himself, he understands what life is like on city streets:

> I know what it's like to be homeless, and to be an IV drug user, and just to have like, the disease of addiction, and substance abuse active in my life, and that cycle of like trying to get drugs, getting drugs, using drugs, being dope sick, trying to get more drugs, and it's vicious, and like, the lifestyle, too. Can't trust anybody, everybody is out for their own, and like, not to mention, the trauma that gets you into that situation, so…

MM is acquainted with clients' desperation; familiar with "the effects of denigration, humiliation, ostracism, and disrespect" (Anderson 2013:141). He knows, as Anderson argues, that clients who are "subjected to these and other forms of misrecognition typically experience agentic impairments. The pattern is familiar: the humiliated become passive-aggressive, the ostracized become depressive, the physically violated or neglected become alienated from their bodies and feelings" (Anderson 2013:141). Where MM concedes that some rules are essential to the site, notably, those related to Safeworks' capacity to operate, he fights to reconcile how clients' language is justification for suspension; in their world, he told me, calling someone "a fucking bitch is like saying hello." Even if there is a situation with a particularly bad-tempered client, "there's always a better way than letting a confrontation escalate to the point where somebody gets banned for a month." I recall saying that a month was a long time, and MM agreeing.

> It is, it is. I don't think – what these people don't understand, it's not like, you're banned for a month, we'll see you in a month, it's like, you're banned for a month go out there and fucking die – and like, that's the reality of it. And I think, especially in the moment, when people are emotional, like they're unable to examine reality objectively, and like, for a lot of those guys, that's what it's like. It's like, okay, go die. You know? Which is fucking harsh.

Allow, for a moment, MM to set the scene; a client, out of viable options, suspended from the site:

> It's the middle of winter, it's negative forty with the wind chill, so fuck you, go do your drugs somewhere else, and the thing about doing it safely, is that you shouldn't do it alone, and you shouldn't do it outside, in this weather, anyway, so like, what are your options? Can't do it at alpha house, can't do it at the DI, those are the two main shelters…and you can't, definitely can't, do it at the mustard seed, so those are the three main shelters, so fuck you, there…
>
> …and you can't go in to any washroom with another person in this city, if someone is even remotely paying attention, even if it's a customer, so fuck you there, too, and most restrooms and bathrooms anywhere in the core, if they see a homeless person going to the washroom, they'll be all over them right away, and tell them to get out, or they won't even let them use the washroom, and sometimes it's for legitimate washroom use, and sometimes – a lot of the time – it's for drug use, and fair enough, but when you institute a ban, that's what those guys have to face.
>
> Yes, they were getting along fine before Safeworks, well, I wouldn't say fine, but they were getting along before Safeworks, but a lot of them were just dying, in McDonald's bathrooms, in parks, in alleys…in the vestibules of apartments…it's just shitty.

MM speaks with the empathy that springs forth from experience and from his attention to the wider social context in which clients live out their lives. Peer staff are drawn to Safeworks due to their involvement in communities troubled by "marginalization, discrimination, criminalization" and considerable collective trauma (Greer et al. 2016). Decision-making, for MM, particularly regarding suspensions, involves the recognition that Safeworks clients are due accommodations "appropriate to their particular needs, vulnerabilities, and circumstances" (Jennings 2018b:20);

staff should not implement a ban without acknowledging the antagonistic social circumstances that predispose clients to casualty. As MM says, "with great power comes great responsibility."

Just as I learned in my conversations with AD, not every staff member at Safeworks shares MM's convictions; such is the "paradox of plurality and the ambiguity of intersubjective life" (Jackson 2013a:9). Protective services, for their part, are oriented to a different social actuality. The protective services team came into their role at Safeworks during the height of my fieldwork; I felt the ground shift beneath my feet. Although many staff I spoke with struggle with uncertainty when applying the rules, which are, themselves, in flux, I sensed that most staff appreciated the autonomy to do so. Where before protective services came to the site when called, they now occupied a permanent position among program staff; charged with ensuring the safety and orderliness of the site. I once asked ADA, a member of the protective services team, why security had been brought in permanently, and he told me that "there was a concern that rules weren't being met or followed, and that there was a level of abuse to the staff from clients." What ADA sees as "abuse" towards the staff, MM considers par for the course. I assumed a deliberate openness to others' experience; a readiness to hear stories of the ways that people evaluate, discuss and negotiate social and ethical strategies for making life at Safeworks viable (Jackson 2005b). To attend to ADA's experience of his world and work – to gain better insight into his sense of moral responsibility – I sought out an interview with ADA:

> I don't think I'm particularly law enforcement based, like I don't want to go out busting tickets, arresting people but I am heavily rule based so when there's a violation of the rules…I want to enforce them. There are some nurses and staff who are on the same page as that, and then there are some who are not at all.
>
> …so for, a specific example would be the time limits in the booths right, so depending on their care plan there's usually 30 minutes in the booth, 30 minutes in chill, some people who are slow, or 45 minutes in the booth and 15 minutes in the post consumption room, but ultimately it's an hour, and we can't just go handing out suspensions every time

> someone's an hour and five minutes but when someone's been in the post consumption room for two hours, they've unpacked their entire life, they're refusing to leave, it's an abuse of services, it breeds, like a sense that they can do whatever they want, and if nurses or peer supporters go, oh it's fine, like they'll be on their way, and then a day later someone comes over and enforces that rule they may be violent towards the person now enforcing it when they're used to someone not enforcing it…

ADA's perspective, revealed in the quotes below, runs counter to MM's and I let myself dwell in the contrast:

> … I know the biggest argument, is well if I suspend them they may die on the street. That is 100 percent valid, like especially with the drugs that are going around right now, with massive overdoses, and I know [clients] all have Narcan kits and they all say they know how to use them, but maybe that's not true or maybe they're alone, or maybe the Narcan, especially in the winter I mean it's, if it freezes it's no longer as effective.

> I totally get that, if we suspend them they could die on the street but my whole philosophy is, as bad as it sounds, that one death would be better than having the place shut down and having all of them at risk of death, so even if Safeworks had super strict rules but it saved ten lives a year it's still saving more than it would if it wasn't there.

For ADA, care is contained to the site. To safeguard Safeworks' viability calls for the consistent enforcement of rules, even if suspended clients, "as bad as it sounds," were to die on city streets. I struggle to absent myself from clients' situations once they leave Safeworks; MM actively involves himself in their lives external the consumption site, thereby expanding the moral terrain of his harm reduction work. I became familiar with the processes by which staff, as individuals, forge and negotiate moral predicaments: ADA's responsibility at the site is to, "keep my team, your team and the clients safe, and that's ultimately the end goal for everybody." Although it may be true that keeping everyone safe is "the end goal for everybody," what this means, how it feels, in practice, is decidedly different.

Complications of Care.

It was apparent to me at the time that Safeworks staff hold distinctive understandings of what caring for clients ought to mean (Tronto 1993) and that moral predicaments at the site do not admit of any resolution (Jackson 2015:156), despite the fact Safeworks' purpose is apparently well-defined. The moral quandaries that discomfort program staff do not so much arise out of supervising consumption – as L says, the work can be very rewarding "in the sense that you see direct impacts on the services that we do provide," for example, when reversing an overdose – but emerge when caring for people coping with pronounced social, material and emotional deprivation. Under conditions of social injustice, care practices are strained to their limits and often beyond them. Safeworks clients present with more needs than can ever be met. Working in supervised consumption, for many staff members, and for myself, brings forth a "fundamental awareness…and an ability [or lack thereof] to respond to a call to ethical action in the presence of another in peril – another who is a moral subject, a being with a visage, a gaze, an ontological claim to stake…a place of membership rightfully to occupy" (Jennings 2018a:555). It is not from a place of detachment that staff provide care, rather, their practice dwells in the proximate and intimate knowledge of injustice or danger intruding upon the life of the other (Jennings 2018a:557). An understanding of clients' lives outside the site – the predicaments they must navigate, the routine degradation of poverty and despair, the threats of social and physical injury – shades every interaction with complication and renders even the most minute of tasks questionable.

As Jennings maintains, "care, like all practices…should not be defined as good or just in all circumstances and in all its forms" (2018a:559); rather, the provision of good care, if it can be so described, entails the important work of "ethical specification and judgement." (Jennings

2018a:559). In writing of the care that takes place at Safeworks, I return us to actual human experience, where "every act we undertake or undergo is consequential and we have to live with the consequences" (Denizeau 2015:216; Lambek 2015:77). The minor decision making I did at the site – whether it entailed "bending the rules" for clients or choosing not to – was never negligible. It always demanded an awareness of the "sheer badness" of clients' situations and a determination of where to place my caring obligations: on the side of the site, in upholding, consistently, the programs' rules and regulations, or with clients, attempting to respond more fully to the complexity of their needs. These two sets of responsibilities are not mutually exclusive, but nor are they harmonious; determining where to home my concern was a cause of considerable moral strain for me and, more consequentially, for program staff, who bared the brunt of substantial decision-making. Further, as is the condition of shared life, not all staff think similarly; in practice, caring responsibilities are imagined very differently. Meanings of best care are plural and, as I discovered, "multiple interpretations can be equally valid" (Denizeau 2015:219), though unspoken tension is occasionally freed from its silence when people's understandings of good care conflict. Where some staff view flexibility in the rules practical and the use of "critical judgement" in every situation crucial, others, such as AD, are inclined to see these actions as a formula for inconsistency. Consequently, despite the specified purpose of supervised consumption services, the care that takes place at Safeworks always involves thinking: what does [our] responsibility mean, in practice**?** ADA's sense of his duty is to protect everybody within Safeworks' walls; MM releases his concern for clients from the built confines of the site. What appears most burdensome for program staff is the unavoidable drawing of moral boundaries; where does their responsibility, placed in a position to care, "really, truly care," for clients, begin and end? These issues are evident in action, for example, in choosing to

shield clients from threat and the temperament of season and clearer in contemplation: they do so not because staff presume it a component of supervised consumption, but because of their awareness of clients' situations in a broader political and social context (Tronto 2013). Proximate to such need is the pull of responsiveness; Safeworks staff answer this call, to the best of their ability, and despite considerable moral ambiguity.

Chapter Five: Compassionate Care.

How to Deal with the Suffering of Others?

I spent months of fieldwork acquiescent to the hurt of others; Safeworks is a small space, there is only so much room for human suffering. Clients' distress is so pronounced, so *proximate*, that it must, without falter, take precedence. MM's succinct evaluation of our clients' lives might as well be pinned to Safeworks*'* front entrance:

> They're always going to be the most vulnerable population, they're always going to be having something going on, and with suffering that we can barely wrap our heads around, On a daily basis.

In what follows I pen how I, and those of us at Safeworks, deal with the suffering around us – "we who feel we can do so little about it yet cannot dismiss it from our minds" (Jackson 2013a:231) and observe the ways we come to care and ache as a result of the effort. My conversation with B, a regular client at the site, one Sunday evening in March is suggestive of many similar exchanges at Safeworks, but that solemn night-time dialogue was a defining moment in my fieldwork. It was, undoubtedly, the first instance I felt worn out; nothing distressing had happened that shift, but somehow those microscopic, real-life minutes shifted my stable sense of self; normally contented in the presence of others, I suddenly felt overwhelmed and engulfed (Biehl and Locke 2017:5; Jackson and Piette 2015). I am no visitor to empathy; but this – this conversation felt different. It was made of what Jackson terms "intersubjectivity" – relations that are "harmonious and disharmonious, peaceable and violent, fixed and fluid" (Jackson and Piette 2015). It was, for me, a difficult lesson in having my humanity defined without my involvement; an experience with which Safeworks' clients are all too accustomed.

One evening, after I had finished my shift at Safeworks, B, a woman whom I had known for a while, caught my gaze with her shadowy brown eyes and held it, beckoning me into discussion. B has dark hair – brown, but almost approaching a shade of black. She is unusually well kempt: dark liner resting just above her lashes, dressed in blue denim jeans still sewn tightly at the seams. She moves sluggishly, bent at the waist**.** Her carefully packed shopping bags hang from her arms; their contents all she can claim as her own. It strikes me, sometimes, how much B's struggles are worn on her body; draped over her shoulders in absence of warm winter clothing. I wonder if it is literal or figurative baggage that is weighing her down. I am on my way out, having picked up a decaf Americano from the cafe for the trip home, when I chance B's glare in the hallway. B is presently suspended from the clinic but still takes shelter in the halls of the health center. There are not, I imagine, very many places she can find refuge in the city, and the dreary plastic chairs scattered in the entryway seem as good a tenancy as any.

"Hi, B" I greet her, reluctantly.

It had been a long day and I am eager to crawl into bed, to comfort myself with chocolate, the coffee that is quickly cooling in my hands, and mindless reality television. It can be hard to pull away from conversation with B – she holds me captive with her complaints, her irritations, her pain, and is often unwilling to let go. It is a privilege to share in her stories, in her life, but her insistence on focusing on everything wrong in her world can be draining. There is only so much I can do to help, particularly outside the confines of the site. Not that it is fair of me to expect B to be cheerful – her life is more difficult than I can ever comprehend – but B's negativity is, at times, all consuming. And yet, as a researcher, and more importantly, as the person I aspire to be, I remain in our conversations – meeting B's storytelling with a deliberate, though hesitant, openness (Biehl 2013:576); with a willingness to hear all that she has to say.

Tonight, she wants to talk about how she has been wronged. How she left a friend with her belongings, and her friend took everything. She says she cannot trust anybody; what is the point of it all; things are never going to get better. I try to commiserate, but she calls me out. "Have you ever been dope sick?" She asks, accusingly, spinning the conversation around so quickly that it takes me a few moments to adjust.

"No," I answer, and she scoffs at me.

"You don't know what it's like." B says, daring me to say otherwise.

"I don't, but I can imagine it's awful" I reply, sympathizing, conscious of the futility of my answer. I wish I had more to offer.

B shoves my attempt to the side, irritated. "You can't imagine, you've never been through it, you don't know."

B's words are soaked in bitterness; with her, there are no assurances, no need to pretend everything is fine; and certainly not for my sake. She is right, of course, I do not know. My body has never been dependent on drugs, never known the embodied urgency of withdrawal (Bourgois 1996). S, a shy male client – just barely into his twenties – once told me he would rather die than be dope sick; that he spent his time in fear of it; using opioids only to evade its catastrophic grasp. Dope sickness hangs heavy in the air – stale, sour; a looming threat that clients are incessantly trying to escape. How can I begin to comprehend such an agony where death is seen as a more favorable alternative? I know enough to compare dope sickness to the flu – albeit the worst, most enduring flu existent – but fight to move past the knowledge that, like all things, it will, eventually, pass. Was it really worse than death? And yet, as much as I wanted to pretend otherwise, a small part of me can relate to the desperation in S's situation. I too, have been caught between illness and an impossible state of health. I could not imagine living a minute

longer in disorder; nor could I see myself surviving past the effort it would take to recover. I wonder, also, if it is not the dope sickness that seems intolerable, but the clear-headed confrontation with reality that will, inevitably, follow? Enough. I think, irritated with myself. This conversation is for *B*; does it matter if I believe I can relate? I force myself out of my head, focusing instead on the hypothetical responses to B's statement twirling on my tongue. I must be careful to voice the right one, in case I offend her again, but B fills the silence with another ambush of allegations; lamenting my privileges, pushing me away with her difficulties, defining the space between her and me.

B is perpetually entrenched in her gloom. Our discussions never tend to the pleasing; they are fixed on grievances – concerning staff, and how they treat her, annoyances with herself, and, at this particular moment, her exasperation with my failure to truly reflect her wounds. I am heated with defeat; it has been forty minutes and I see no way of reassuring B that I care, and, besides, the sky has darkened, and I am restless to go home. I know that people consider me kind, but the gentle words I am offering fall to the floor; too soft to support the weight of B's problems.

"Just because I can't relate to your experiences doesn't mean I haven't gone through other things" I tell her, risking a harsher tone, expressing my frustrations.

"There are many sorts of pains. Sometimes you can empathize with a feeling and not a situation, you know."

B lifts her eyes to mine, startled by the shift in my voice, but says nothing.

I am angry. Not necessarily with B, but at how she forces me to simultaneously confront and belittle the hurt of my life; it takes effort to reminisce memories I would rather forget, even more strength to come to terms with their limitations in these sorts of situations. Even though I

know it is not my place, I cannot help but hold on to my human need for recognition; "a deeper need for some integration" (Jackson 2013a:184) between my personal world and the wider world of others at the site. B does not see the possibility of similarity, and so, I have nothing but the warmth of my presence to offer. It will not be enough to see B through the night.

"I guess you're right" B interrupts my irritation with a concession, and I wonder if my assertiveness means more to her than the high, sweet pitch of my voice.

I sense that B has warmed up to me, to our conversation – having unburdened her frustrations up until the limits of my tolerance. Perhaps recognizing that I have reached the inner edges of my empathy B relaxes, but her verbal ceasefire comes too late. I want to go home, to get away from the consumption site, the urgent care centre and, most guiltily, from B.

"I have to go, now, B" I say, the moment she asks me to examine a seemingly non-existent sore on the nape of her neck, an intimate request for her, "I'm sorry, but it looks okay to me."

I have the sense that I am walking away the minute she is willing to let me in.

I drive back to my apartment silently; the city streets dimly match my mood. The coffee I had bought as a treat earlier sits untouched in my cupholder, bitter after being ignored. All the comforts of home that had seemed so enticing now feel frivolous; as if errant of me to go home knowing B cannot do the same. Rationally, I know that her angst does not negate my own problems, but B's persistent reminders of my privilege cling like unwelcome companions to my Sunday night plans. Faced with the entrenched inequality shaping Safeworks' clients' lives and the apparent impossibility of drastic societal change, I fell back on "[my] emotions, [my] own thoughts, [my] own suffering – what Coleridge called "inner goings-on," (Jackson 2013a:233) after my conversation with B. That is to say, "when action on the world around us proves impossible, we have recourse to action on our own emotions and thoughts, thereby transforming

the way we experience the world" (Jackson 2005a:233). Indeed, I am drawn to introspection; my response to B's misery, which I cannot discount, is to "focus less on what [I] might do alleviate the suffering than on [my] own sympathetic reaction to it" (Jackson 2013a). There is very little achievement in my conversation with B; no matter how compassionately I hold her stories, no matter how welcoming I may seem, I cannot effect change in her social circumstance, nor can I console all her private troubles, or remedy her physical and emotional hurt.

Affirmation.

My conversation with B in the vestibule of the health centre reveals an essential aspect of employment at Safeworks that is often publicly unsung: "being present with another in the face of their need, vulnerability and suffering" (Jennings 2018a:561). Supervising substance use is a central aspect of work at the site; it is, conversely, only the starting point for the practice of care. Witnessing the elaboration of care at Safeworks made manifest what is silenced in public voice on supervised consumption services. As Jennings maintains, what the recipients of care need and the agents of care provide is affirmation and attention; a recognition of the value that clients' lives – whether they use substances or not – possess now and in the future (2018b:23).

I often think of R's reflection of himself when he stares in society's mirror; "a junkie, not smart, doesn't have anything going for him." MM, a peer support staff, devoted to his work, restless in his eagerness to help, understands, more intimately than most, how clients are viewed:

> We treat them, well not we, but I think a lot of people look down on our clients, and treat them like an inconvenience, or, you know, a safety concern

Socially, this script runs rampant in our clients' lives, interpersonally, they are too often avoided and ignored – both are terrible; feeling invisible worse. William James, writing the Principles of Psychology, captured the sentiment best:

> No more fiendish punishment could be devised…than that one should be turned loose in society and remain absolutely unnoticed by all the members thereof. If no one turned round when we entered, answered when we spoke, or minded what we did, but if every person we met "cut us dead," and acted as if we were non-existing things, a kind of rage and impotent despair would ere long well up in us, from which the cruellest bodily tortures would be a relief; for these would make us feel that, however bad might be our plight, we had not sunk to such a depth as to be unworthy of attention at all (1950).

Offsetting such a feeling is a profoundly caring act; I know understand that B sought me out to voice her struggles – more than that, she needed a brief remit from self-reliance, from "having to fend for [her]self" (Jennings 2018a:559). She was looking for interpersonal recognition – perhaps, if only slightly, at my expense. Though I was fixated on content in the immediacy of our conversation – what had happened, how could I best respond, was what she said about me true? – I now understand B's scowl as an expression of her need for attention. Conversing with B is a simple way of joining her in her existence; it may not be much, but it is a moment's reprieve from the precariousness and unpredictability of a life lived l beyond my understanding (Jackson 2013a:264). The circumstances of clients' lives are "neither universal nor inevitable" (Jennings 2018a:559). They are potentials in the human condition that the practice of care was invented to prevent (Jennings 2018a:559); the question then becomes: who is it that cares?

Safeworks staff provide the commencement of novel caring relationships and services; coexisting with the subject of one's concern, sustaining an engagement over time, on clients' own terms, and trying not to escape into clients' suffering (Jackson 2013a:236; Jennings 2018a:559). The outside social ground is not a place where considerate relationships are cultivated for clients; it is within Safeworks that people who use substances are given due attentiveness, preferably "accommodated in ways appropriate to their particular needs, vulnerabilities, and circumstances" (Jennings 2018b:20). This is by no means easy; still, it must be done. G, respectful, soft-spoken, irritable only when there is a long wait to use a booth – and

who could blame him? – visits Safeworks regularly and spoke of his hesitancy accessing other places in the city where care might take place:

> Some of the agencies where they send you like, a lot of us don't access the agencies and stuff so much as other homeless people do just because we figured it's our fault, bad experiences, or that kind of thing, or some of us just don't like the way they do things or whatever the reason…when you feel like you're not getting treated right…there's real shame. It makes it a lot easier when you can access services through a place where you feel alright doing what you're doing.

For G, walking into Safeworks, putting himself in the companionship of specific health care providers, is a relief. He is not walking into the site thinking nurses might view him as a "junkie with a big abscess, crying cause there's dope in [his] arm." At Safeworks, clients' anxieties of being shamed due to their drug use are lessened; the site's very existence presumes substance use – thus removing the indignity of hiding one's self, one's use, from the situation. G's feeling of humiliation when sitting in an emergency room is not fundamentally or "necessarily connected to guilt or wrong-doing; it arises, as Sartre observed, when the recognition of who one is…comes to be determined by one's appearance in the eyes of others, filled with indifference or hate" (Jackson 2013b:82). In such circumstances, G's distinctiveness as an individual comes to be eclipsed by an external definition of what [he] is in the eyes of others (Jackson 2013b:82); his experience of social life is such that he must explicitly state that he is "human too." While there are many existing agencies in the city tirelessly providing essential services for our clients – shelter, meals, transportation, community based medical care – none profess as their purpose a safer place for drug consumption. It is a slight distinction but one that makes a meaningful difference; other agencies aid despite clients' substance use, Safeworks offers services because of it. Dedicated spaces for supervised consumption are needed on multiple fronts; most fundamentally, they are a long-awaited invitation in for people who are not comfortable opening

any other door. For clients, Safeworks is an intermediary between two distinctive lifeworlds; one shrouded in silence and secrecy, the other, made of mutual recognition and resemblance (Jennings 2018b:23).

Recognition.

We speak of the lives saved at Safeworks, but not of the lives recognized. Safeworks staff offer respite: "relief from pain, suffering, fear, or despair" (Jennings 2018b:22); a setting sympathetic of the magnitude of "social contact and friendship" (Jennings 2018b:22) in clients' daily lives. R is drawn to Safeworks for interpersonal recognition rather than the more obvious purpose of supervision:

> Even if I'm, not using right at that moment, I'll still pop in, say hello. See who's working, and just chat. You know? It's definitely more than the drugs. Because I'd be doing the drugs anyways. But it's the people here that make the world of difference.

What is given to R, and all clients, as recipients of care, is supporting to feel less stigmatized and less isolated (Frank 2004:3); this form of care allows the "grim prospect of abandonment [to] recede in [clients'] imaginations and hence palliates the suffering – often in the form of dread, anxiety, and loss of self-confidence and self-esteem – they experience" (Jennings 2018a:560). Rescue occurs at the moment of social acknowledgment. Nonetheless, Safeworks is not a stand-in for the shortcomings of the world in which clients live*,* though in a sense those employed at Safeworks are compelled to be. Safeworks staff act as a tether to a kinder, gentler world; they cannot afford to fall apart.

Supervised consumption services exist within a larger, more hostile social context wherein clients are aware of how they are seen. I am shaken at how alert clients are of their public image, though I should not be; "being human means, first, that we possess consciousness

of ourselves and of our world" (Jackson 2005a: xiii). R, tall, artistic, articulate – a client with whom building rapport came easily, a natural flirt, acknowledged his widely pictured personhood:

> People automatically think junkie, he's a degenerate, you know, not smart, didn't go to school, doesn't work, doesn't have anything going for him, he's just a waste of space, a loser, suspicious, you know, whatever. And that's not the case.

It pains me to hear the resignation in R's voice. While he might say that these descriptions are "not the case," he knows not everyone around him agrees. He is, in part, constituted through social experience; one in which his individuality is so thoroughly overlooked (Biehl, Good and Kleinman 2007:13).

I have the privilege of knowing G and R not as "junkies" with "bad addictions," to use their words, though I am hesitant to do so, but as "normal humans." Rather than see clients "simply as faces in a crowd, as an anonymous mass," (Jackson 2013a) as they are socially abstracted, Safeworks staff draw attention to their individualities; weaving connections out of sorrow, amusement, and fellow feeling. A client who was once a stranger suddenly "possesses a voice, a history, [a birthdate], a name" – and what transpires between us changed my life forever (Jackson 2013a). In that I see G's uniqueness, enter into dialogue with him, I have come to understand his story, if always only partially; we have drawn his trajectory through what has repeatedly proven to be an unkind world. What is more, G is, at least momentarily, during our booth side conversations, equally invested in me: he asks about my education, and what I hope to do after university; on whether I will become a "guidance counsellor;" he compliments me on my tenacity to pursue a graduate degree, even if it is "a long time for school;" and wants to know how I am faring in my hockey pool. Because of G, I knew which evenings the flames would be playing last season, and that hockey is his favourite game. I understood G well enough to freely

tease him when he walked into the consumption room, the day after his team's failed play-off run, wearing a flames jersey, unperturbed by their loss.

He offered me a small smile, peered up from under his ballcap, shrugged his shoulders, said, silently, "What can you do?" No stranger to defeat, G took the result of the game in stride; not originally from Calgary, G faithfully cheers for the home team, despite the city proving itself inhospitable to him. Safeworks is a distinctive space that brings me and G into the same line of sight; here, we are made visible to the other, as equals.

Likeness with Clients.

I am similarly moved by clients' ability to retain their sense of humor, their playfulness, their theatrics, and their willingness to relate to my interests, in spite of the discomfort of much of their lives. I laugh with them as I have my friends – but something about sharing in their joys feels infinitely more special. It is a curious form of heartbreak; cheerfulness so lovely only precisely because its absence is to be expected. Contemporary discussions on drug use are often riddled with the language of addiction, habit and despair (Duff 2015:81); a social script shadowed by the scarcity of potential, absent of the strength of the human spirit. These discourses rarely seek to shape something beyond suffering; the raw effects of economic and social inequalities accompanying chronic drug use are stated and defined, offered without sentiment. These stories are noticeably limited and incomplete. My relationships with Safeworks clients have necessitated something more; an attunement, certainly, to the private anxieties and wider social tensions shading their lives, but also a situational shedding of this awareness – to see them complexly, to attend to the normalcies of their being. I am hesitant to speak of clients' suffering in totalizing terms; they are people – irreducible to the constraints of their lives,

multisided in their personhood (Jackson and Piette 2015:10). I connect with them from a place of mutual ease and understanding, not one borne out of shared experiences of substance use – as is the case with many of the peer support workers at Safeworks – but one crafted despite this difference. My interactions with clients occasionally hinge on superficial matters, such as my latest manicure. "Not really the green I had in mind!" M says cheekily, as I show off the matte army green nail polish she suggested I get, "but I like it, it goes with everything, it's fitting for the season." She assumes – rightly – that I am looking for her approval. M reminds me of my little sister: dramatic, entertaining, witty, and still *so* young. It is her similarities to my much-loved baby sister that make M so amiable, but I cannot help my affection when I see her come in. Later, she will beg me to let her do my makeup, in exchange; I am to take her to get her nails done. I will be tempted to agree.

I am mindful that M's attentiveness to my nail polish, to my outfits, is more significant than it may seem; she too strives for similar adornments, which, for her, are harder to locate; more fraught, socially, to wear. Not everyone is willing to accept her gender identity.

"Do you like my boots?" M asks, as I sit by her booth in the consumption room. "They're the only ones I could find in my size. I know they're not pretty, but they have a heel! Do you know how hard it is to find cute heels in an adult's size 13?"

I glance at her latest footwear: her boots hit at the ankle, made of brown faux leather and lined with soft fur. I adore them.

"They look great, M!" I say, genuinely, as she stands up to saunter around the room, taking pause from preparing her shot, her supplies strewn across the stall, showing off her new shoes.

If I were staff, I might remind her that she is running out of time; the clock whines half past two, and her thirty-minute limit in the booth is up. M is unaware; the knowledge sits heavy on my

chest. Instead, I smile, enjoying M's excitement. Besides, the coward in me is reluctant to mention the time; it would, certainly, ruin the tentativeness of the moment, and I do not want to be the one to bring her down. In these instances, I am grateful for my researcher role – able to fully share in clients' lives without having to enforce the site's rules. My rapport with M always seems unstable, anyways; sometimes cheery and care-free, other times, fraught with tension, her, begging me to let her off the hook, as she digs through piles of garbage in desperate search for the drugs she is sure she has accidentally thrown away, me, anxiously aware that her behavior is not exactly permissible at Safeworks, yet uncertain of what to say. Nevertheless, M is usually apologetic after these incidents; when she is upset with me, I carefully back away, offering her space, and once she has calmed, she will say sorry, that she did not mean what she said, and I will be quick to forgive. Besides, I have grown accustomed to her mood swings. I have shared with M so much laughter; and that alone is worth the instability of the ride.

I cannot express how wonderful a feeling it is to beam at a client and see them light up; knowing my smile is meant, entirely, for them. How often, in the drudgery of their days, are these individuals lit with kindness? I know I am not alone in the effort. D, an experienced nurse who steered me through the haze of harm reduction when I first started at the site echoed my sentiment:

> I can joke around with clients and you know it's the little things like when they say, they tell you, you know how much they appreciate you but then you can see them like, they come in and you know that you might be the one good thing that's happened in their day.

Safeworks clients, as I said, are regularly denied the simplest decency of being seen as sharing a common nature with others (Geertz 1983:16); they are cast aside, denied, as if city streets are an entirely appropriate place in which to carry out a life. A nearby corner store bars their entry; a white paper sign tacked to the door reads 'no druggies allowed.' I remember a minor public

outcry when the store's warning first appeared, but the reality is, whether explicitly stated in wobbly black ink or not, the sentiment saturates much of the inner city, particularly in the communities neighboring the consumption site. Even Safeworks denies entry; serious transgressions result in client suspensions – for hours, days, even months at a time. I walk this city accepted, and I know it – I am welcomed; clients are regularly scorned.

Differences Between Us.

So, as affable as my relationships with clients might be, I am mindful of the underlying unfairness in our interactions. Relating to clients validates their actual presence as multidimensional people in the world; even in their lightness our conversations serve an essential purpose: amending the "sense of being isolated or trapped within one's own existence" (Jackson 2008). I receive individual recognition separate from the site, for clients, my reality may not hold true. Attuned to asymmetries of this kind (Biehl and Locke 2017:28); I felt every relation at Safeworks significant. There is a taxing power in holding presence – in caring – for a population so regularly repudiated; every minor act, whether or not one is consciously aware, has consequence. Within Safeworks, clients are particularly sensitive to being ignored; no more wounded expletives can be heard than when program staff fail to catch something a client has said:

> Were you listening?
> Did you hear what I said?
> I **t**old you not to ask me if I wanted a water bottle, it's written in my chart,
> can't you read?

Slight or serious distractions might pull our attention away; an unruly client arguing with security at the front door, the open bag spilling dark squares of chocolate onto the nurse's desk, another client's request for supplies, and a snack, and could they also use the washroom? Paper

charts propped open with ball-point pens, partially filled-in, and the nagging knowledge that M has definitely gone over her allotted time in the booth, and could someone please remind her to move along? In the midst of daily practical life at the site, it is impossible to attend to every question, every mumbled-under-their-breath request, but to miss something a client has said can be deeply upsetting.

> …[clients] get very offended if they don't see you listening, they think you don't care, just like everybody else. That's what they deal with all day, right?

When clients have begun, slowly, arduously, to expect recognition from staff, from me – a tentative remit from the emotionally draining struggle to sustain dignity independent the site (Jennings, Callahan, and Caplan 1988:6) – the impact of staff's additional work responsibilities can splinter rapport.

> Other times it's like you don't care at all, yeah I've seen, I've seen where, somebody's having trouble, I think can't really ask you guys because you guys are in the middle of a conversation…

Where I am contented to wait for an opening in discussion, comfortable knowing that I will have a chance to speak; clients are swift to sour. Neglecting a client's immediate need for response, even if inadvertently, must mean "we don't care at all." Staff are forever in an active relation with clients: "with what has gone before and what is imagined to lie ahead" (Jackson 1996:11); sadly, antecedent our moment of distraction is a plenitude of times that clients have been shunned, denied, ignored – the merest hint of it happening again, here, offends. History is a wound; "that which has been always leaves a trace" (Jackson 2013a:11). With so much at stake in every interaction; coming up short is a sure thing. The chaos of sheer demand, the impossible dilemmas of caring for people – for whom personal attentiveness is a sporadic experience – is compounded by doubt (Frank 2004:118). We feel it when we hesitate:

> Did we handle this situation appropriately?
> Does this constitute a suspension?
> Was I too firm? Too lenient?
> Could we have done something differently?

It is a particularly heavy burden for staff to assume; attending to the immediacy of need while remaining conscious of the wider structural context within which clients feel and live – one that imprints its stain of discrimination, of disregard, of isolation, onto the delicate fabric of each conversation. As Denizeau reasons, "each situation contains within itself reminders – traces, echoes – of other situations" (2015:229), which together make up individual being. The essence of my conversations with Safeworks staff can be distilled into this:

> I really care for them. I really genuinely care for them, especially ones that have allowed me to get close to them.

Support Without Expectation.

Here, I return again to B, and my worries in the wake of our Sunday evening meeting. What is the care she needs? I think of her material scarcities; the stresses of daily substance use; her struggle of being-in-the-world (Jackson 1996:41), and my failure to attend to it all. I reflect on our earlier conversation; my halted attempts to relate to B as a person whose situation can – and should – be ameliorated but cannot, in its immediacy, be structurally transformed (Jennings and Dawson, 2015:36). I think, too, of what I have learned about compassion, and care, and how, despite the stress of her life, B is capable of making her own choices. The essence of care is that it does not dictate; it offers instead, support and companionship and the reassurance that one is not alone.

I am at the site the following Sunday, sitting in the post-consumption room, the sun, dwindling fast from winter's sky, the room's florescent lights picking up the slack, when B's brown eyes met mine.

"There's a Sunday dinner this evening at the church…"

"Oh really? Are you going to go?"

"I don't know, no, no, I don't know how to get there, and what are the hours, anyway?"

I pull up my phone and google the nearest church; many offer a Sunday meal in the evenings.

"It ends at 5:30" I say, glancing up at the clock, knowing B will not have much time to make her way over.

"Well, I don't know how to get there."

I drag my worn upholstered chair next to B, and we examine the map I have pulled up on my phone, mindful to switch the settings so that Google knows B will be walking.

"It looks pretty easy, B, go down the street, and take a left…"

"Why do you want me to go so bad?" B's voice punctures through my instructions.

No longer surprised by her irritation, I shrug my shoulders, unaffected, "It's up to you, B. I'm not trying to force you to go, I'm only letting you know where it is."

B says nothing but studies the map on my phone, handing it back when she is done. I sense B would like to go for dinner; she has mentioned it to me several times. Regardless, I do not push the issue, getting up from my chair and letting myself back into the consumption room, busying myself by handing out supplies. I feel B's anxiety as if it were my own. There are gaps between our worlds; poorly captured in words, but still, all people resemble each other, and B's apprehension – showing up to the church, alone, uncomfortable and surrounded by people – mirrors my own unease entering the site. I am unlocking the washroom for another client when I

notice B packing up her things. Even though it is nearing five, B moves slowly, folding and refolding items – her personal belongings stowed just so.

"I think I am going to go." B calls out from her seat.

I grin, happily, inwardly, lest I dramatize her decision.

"Okay, B, that's good. Let me know how it goes."

I pull the brass key out of the lock, allowing the client to enter the washroom and, once my back is turned, I allow myself a small smile. I am proud of B and, if I am honest, pleased with myself, too.

I have almost forgotten that B has left; the evening has been hectic, and I am swept up and immersed in life at the site. For as much as ethnography consists of observation, "one cannot, at the same time, be actor and audience, player and spectator – deeply involved in an event and disinterestedly observing it" (Jackson 2012:8). At Safeworks, I cannot help but become absorbed in the work. Stars blur the sky iridescent, and I am set to leave. I make my way through the space; saying good-bye to everyone at the site. It is in the post-consumption room that I notice B, or, rather, she finds me – edging her way into my sight – and I am compelled to give her my full attention, having not seen her return.

"I went to the dinner."

I am touched that she sought me out to tell me; despite her best intentions, I was unsure whether B would find the courage to attend.

"And?" I ask, apprehensively, awaiting her response.

"It was okay. I think I'll leave earlier next time, there wasn't much left."

"I'm glad you went, now you'll be more comfortable going again..."

B, smiles, self-consciously, the softest I have seen her.

This time, when I walk away, I have the sense I might have done something right.

This moment between us is informing of the practice of care; the meeting of two individuals, of two lifeworlds, with "each side having a voice and engaging in a give and take of initiative and response" (Jennings 2018a:560). Every client at Safeworks has an unmet need for care; "the suffering they experience takes place against an ever-present prospect of being left alone" (Jennings 2018a:560; Tronto 1993). Thus, at the heart of Safeworks is the provision of care that offers, to the best that program staff are able:

> …nurture, protection, provision, and support for the other. It does not so much domineer as give the person receiving it a new insight about his or her life…it sustains purpose in the face of diminution. Care among humans is a transaction among individuals who are the authors of their own acts and lives, despite their need, impairment, or limitations. But they are symbiotic, not solipsistic, authors. (Jennings 2018a:560)

The primary care practiced at Safeworks interrupts an on-going form of life for clients – an existence where they are regularly rendered lesser, if not unseen, living the routine degradation of poverty and despair – and offers, instead, an alternative. A reality where their presence is made to matter, and where companionship is offered in the face of their "need, vulnerability, and suffering" (Jennings 2018a:561). Writing of essentials, Simone Weil maintains that "to feel one…is indispensable [is a] vital need of the human soul" (1949). It is worth repeating; rescue occurs at the moment of social acknowledgment. I think of B, and how eager she was to tell me that she made it to the church's Sunday supper. To know that I was someone she could confide in; to think I might have been the only one she had to tell. The lone person who knew she had pushed herself and succeeded. This is what it means to bear witness; not just to clients' suffering, but to their everyday triumphs, to practical activities, to critical events, to hear of their lives as they are lived.

> In every human society people fare forth at the beginning of each day from hearth or homeplace and, at the close of each day, return to such place to rest, recover, and, most importantly, recount their experiences, both common place and curious, solitary and shared, of what has befallen them (2013b:50).

Consequently, care, at Safeworks, distills into this: we see you, and you matter.

I have implied in this chapter that the practice of care at Safeworks moves beyond the routine, yet essential, provision of supervised consumption services and meanders into the murkiness of lived complexities. Caring for Safeworks clients involves paying attention to; opening our eyes, listening actively, leaning in (Jennings 2018a:559). Work within supervised consumption spaces begins with witnessing people in their suffering and offering them companionship, and on some occasions the work may end there (Frank 2016), though it often does not. Attentiveness when presented with clients' stories of limitation, loss, and suffering can be, at times, oppressive. Accordingly, my experiences with B forced confrontation with the struggle of caring for socially marginalized others while permitting myself, in both my pain and privilege, to be similarly worthy of consideration. It compelled me to question where the border between 'me' and 'you' begins, and how much of clients' suffering could I and, most importantly, Safeworks staff, realistically take in? Such intersubjective boundaries are progressively muddled when working within a wider communal context where clients' needs are too often repudiated and denied. In the absence of a collective vision of mutual recognition and resemblance with persons who use substances (Jennings 2018b:23), care providers at Safeworks must work overtime: supporting clients to feel less stigmatized and less isolated (Frank 2004:3) above attending to their daily needs in states of dependency, despair, and overdose, while simultaneously extending their reach to cover gaps in service delivery that manifest in societies indifferent to the plight of those overwhelmed by addictions. Care, as it is practiced at Safeworks, is so compelling because it is rare; no other service in the city creates space for

people to come, as they are, where they can use the substances they do, and to enter into relations where they are individually seen, not in spite of their drug use, but because of it.

Chapter Five: Discussion and Conclusion

It has been my intention in this narrative to capture everyday experiences as they occur in spaces of supervised consumption; to start with events that involve the interactions and movements of people – myself included – in a particular social environment and to draw out of these situations the beginnings of more nuanced contemplation, the bare, bleached bones of a story (Jackson 2013b:83; Verghese 2010). Hence, my thinking is grounded and rooted in my personal involvement in supervised consumption services; stories are necessarily lived before they are told. My writing is an artifact of the time I spent within this social sphere, though it by no means offers a complete account of supervised consumption as it is lived and practiced. As Jackson argues, "no [view of the site] ever encompasses or covers the plentitude of what is actually lived, felt, imagined, or thought," by me or others, despite the pronounced concern I have given this research (2013c:42). Consequently, I have narrowed the scope of this story; perching my attention on the branches of compassion. It soon became apparent to me that Safeworks staff care for persons who use drugs without the shadow of pity or paternalism, relating to them from positions of commonality and, through them, I learned to do the same. In tune with considerations of this sort, I was struck by the ways staff effect change in clients' experience in and of the world; moving them, sometimes flawlessly, from the loneliness of stigmatization and the indignity of social scorn into the warmth of acceptance. Clients are welcomed as they are, for who they are; recognition is a vital human need, and expressly for Safeworks clients, who are routinely turned away. Care practices, as they pertain to supervised consumption, are tied to the provision of harm reduction supplies and the availability of medical intervention; I realized, as I came to harmonize with staff and clients at Safeworks, that the care

that takes place within the site is this and something else, something much less tangible but more meaningful. Program staff offer attentiveness, conversation or, if preferred, the amiability of shared silence. This is a care veiled by intimacy and rarely socially celebrated; apparent at the site only because everywhere else it is absent.

In this dissertation I have offered consideration and complexity to care practices as they are animated in spaces of supervised consumption. Now, I turn our observation outward; drawing attention to social arrangements that disappoint Safeworks clients and soften the significance of work performed at the site. My aim in this chapter is not to criticize any one person or structure; it is to show the paucity of support offered to individuals who use drugs and those who care for them. Accordingly, I maintain that a richer understanding of harm reduction is necessary in Alberta; where persons who cannot end their drug use are still afforded options. A fuller acceptance of harm reduction philosophy in the collective conscious naturally harvests the potential of people who use drugs; their value is no longer contingent on their ability to abstain from substances. I hope, here, to move between individuals and social structure; to situate clients within our humanity and to show how we ought to collectively do better to ameliorate their social situation.

Reflecting on the care that takes place within Safeworks made obvious what is lacking for those marginalized in our city and in society more broadly. What Safeworks clients need, and staff provide, is affirmation and attention; a recognition of the value that their lives – whether they use substances or not – possess now and in the future (Jennings 2018b:23). Staff within the SCS receive clients unconditionally; “we’ll accept them as they are,” DI explained to me, emphatically, “no strings attached.” “I think,” DI said, “that meeting people where there is huge for feeling included, or feeling loved, really.” The service is grounded in the conviction that

support for persons who are actively using drugs need not be hinged on their capacity to reduce or discontinue their use; instead, staff promote the safer consumption of substances by permitting clients to use as often as needed in a supportive, protected environment. Those who object the site's existence often do so on the basis of public disturbances or that it perpetuates substance dependences; complaints reverberate in the inner-city, begrudging supervised consumption services for their complacency in accommodating drug use and its ill effects (Smith 2020). Sustained lived experience within Safeworks – and my personal relationships with clients – inform my belief that the site has not 'facilitated' their drug use, only altered its public expression.

> I think it's important to realize that there is drug abuse out there and some people want to quit, but honestly, you know it's, you want to, you have tried to quit, and honestly, it's just hard to quit, like some things are more powerful than you think.

Many clients, such as G, quoted above, have tried to stop using drugs several times. "I had to go all the way up to Edmonton just to get on methadone," he explained, "and it wasn't just make a phone call and go it was make a phone call and register, then phone once a week for up to six to nine months before they said yeah and gave you a date to be up." Arranging to telephone a clinic on a timely basis for months when one lives on the streets is almost impossible; such an existence is lived in more immediate terms, as an instinctive, emotional, and chaotic reality that often defies organization. Still, G persevered.

"I tried to straighten out," he continued, "I even went and lived with my brother for a bit, but it just never seemed to work out, it was too late. My life expectations changed, that's for sure."

If G – or any client – expressed a desire for some form of treatment, program staff would be delighted to support his decision; connecting him to available social services and supports. I do not hold any expectations for change, but I believe in G's ability to do so. Nevertheless, I am

contented when G walks through Safeworks' doors; he has made a choice to use within our space, in the presence of others, and with the added assurance of supervision.

> A lot of [clients] have been living this lifestyle before the SCS opened, they're going to continue living this way, and if it comes to a point where they want more support, then it's available, but they're going to have to come to that point by themselves. It's similar to their choice to walk in that door. They made a really positive decision to access the site.

As AD upheld, "[clients] haven't given up on themselves, or else they wouldn't be at the site." "It's here," W mentioned to me once, or "in some stairwell or down by the river." G uses at the SCS rather than "in a bathroom downtown."

"I mean these are public places," he said, shaking his head, "there's kids there, there's families there, they don't need to see that shit."

Program staff do not focus on dramatic or immediate achievements for Safeworks clients; rather, they accept them as they are and revel in any small success, which includes, but is not limited to, accessing the consumption site. What is more, there is no urgent effort to 'rescue' people from their addictions; the emphasis here is on recognition. Acceptance forms the foundation of harm reduction, but so too is it the essence of any caring relationship. The harm reduction that takes place at Safeworks need not only be applied to substance use; nor should the value of the site be hinged on notions of recovery. To orient oneself to this belief is to miss what is most beautiful about the site.

Instead, I urge readers to envision the anguish of rejection, the fear of abandonment and the sustained societal neglect associated with poverty, homelessness, and dependence. To imagine the ostracization that one feels when enduring chronic substance use, and to wonder if these injuries are the source of much of our clients' suffering. Pain is the beginning of empathy, and bearing witness to the effects of profound, socially cultivated sorrow favors care. Here,

Safeworks staff alleviate another, more pressing, kind of harm; the sense of being isolated within one's own experience and the fear of being deserted in the world (Jackson 2013b:84). I experienced a particular emotional pull towards clients over the course of my time at the site, not only because I value them as individuals, but out of recognition that so few do. The "public realm is [supposedly] a space of shared interest, where a plurality of people work together to create a world to which they feel they all belong" (Arendt 1958:50-52). Sadly, not everyone does. Too often, the lives and voices of those most marginalized are denied public recognition; robbed of their vital need for interpersonal recognition. When clients are noticed outside the consumption site, people deliberately cross the street. Many Safeworks clients have lost the structures of belonging that they so desperately crave; the immediate 'rescue' staff provide is a social acknowledgment that begins with clients' drug use but does not end there. As Arthur Frank suggests, "medical care both sets and reflects standards for caring relationships between individuals and society" (Frank 2009). Supervised consumption services work to alter this relationship entirely – reorienting clients' experiences with or in the world. The greatest damage our society can and does inflict on clients is to reduce them in their own eyes to the status of a non-entity, whether it be because of their substance use, visible homelessness, or poverty. Clients live in a world where they feel they must emphasize that they are "human too." Program staff seek to mend this wound, though it is not without great effort, nor should it be an individual one. What is absent is a communal awareness of clients' personal troubles as largely problems of social structure (Jennings 2016:15). However, the public sustains a symbolic distance from clients' plight. The immediacy of clients' need is evident, and yet, people shy away, refusing to see themselves in such a situation. Accordingly, the capacity for responsiveness is contingent on

the ability to relate to clients, not as other, but as an equal. If one does not avert their eyes, there is more than deprivation to be found.

When asked of my research at the site, my immediate responses had surprisingly little to do with drug use; rather, I wanted to speak about the people I had met, the anecdotes that animated our conversations, and the trust I had been gifted, by both staff and clients. Work within the supervised consumption site can be challenging; it extracts a particularly emotional toll. Still, in this space, for all indication of despair, hope springs eternal (Biehl and Locke 2017). On city streets, where unsettled people vie for very little, it is clearly difficult to be decent. The astonishment is that most clients are good, and that many try to be (Biehl and Locke 2017).

> When there's an overdose that's going on, it's clients that are alerting staff about the person next to them that's going down, like you've got to come help this person. It's an incredible community.

Caring for Safeworks clients yields, for me, as many joys as sorrows, and when I reflect on my time within the site, I am startled by the warmth of my memories. I think of R, and his desire to give back to the wider community.

"Maybe some sort of community programming," he had suggested, "to turn the stigma around. I would be fully involved, I would spearhead that ship. [We] go across to the park. Get a bunch of people, meet here, and go walk through and clean up the garbage or something. That would really change the community's, urgh, they'd be like, well these guys, they're doing their drugs, but they're doing something positive also. I think that would be important."

R's genuine longing to give back to a public that begrudges his existence is suggestive; despite R's struggle, it is his consideration for others that defines him. I consider W, aged beyond his years, who asked that we go to Good Earth for coffee, and then insist he pay. Or DD, who sits himself next to me, content in my presence, and smiles a toothless grin as he pokes fun at my

disposition. Ten minutes will pass, in silence, then DD will leave, and I have the sense that familiar companionship is what he needed. Or of LY, who, when I asked him the name of his favourite artist, said that he could not remember the last time someone had been interested in his answer. It was startling to discover the depth of his musical interest. It is in these minor moments of attentiveness that I find the most satisfaction, where a small gesture from either person – a slight smile, a touch, a hand being held – can lift even the saddest of spirits. The relationships cultivated at Safeworks are some of the loveliest I have discovered, and I cannot determine who benefits from them the most.

> It's a really valuable experience and I feel really grateful that people have opened up to me like they have, even if it's not every single person that comes through, the one person that opens up to me on a shift, you find meaning for coming into work every day, cause you have some sort of meaningful interaction.
>
> It's hugely meaningful, those relationships I have with clients, they start to trust me and open up and we'll talk about other things that are important to them.

The harm staff lessen is therefore also one of lost connection; for clients, who have grown accustomed to intolerance over acceptance, and for staff, who genuinely appreciate and enjoy the companionship of people who access Safeworks' services, which comes, at times, as a revelation.

I would not have felt as strongly about the value of supervised consumption services had I not spent a sustained amount of time at the site, or if I had assumed the study of supervised consumption as a detached observer. My experiences altered my understanding of substance use disorders, homelessness, and poverty, and I thought myself empathic to begin with. Familiarity with difference, as Andrew Solomon explains, fosters its accommodation (Solomon 2012), and the dissimilarities between me and Safeworks clients faded in the absence of social distance. But how one affects this change in persons without such commitment is confounding; that "others"

matter remains the most difficult moral quality to establish in practice (Solomon 2012). At precisely a time when we are called to collective action to address the opioid and methamphetamine crisis in our province, political momentum is moving in the opposite direction of supervised consumption and other harm reduction programs. Unfortunately, these public health interventions remain at the margins, as do the persons who need them the most. Supervised consumption services have been structurally difficult to implement, and their existence met with bitter opposition; a discouraging indication of the underlying social assumptions, practices and policies that structure which supports are offered in our city, and for whom. We need, but do not have, a collective desire to contribute to the wellbeing of others, and particularly people who use drugs (Jennings 2018b:22). As the community wonders why they should care, why they should contribute to the public provision of people who use drugs (Jennings 2018b:20), staff at the supervised consumption site do not turn away. They remind us that that we are all in need of human connection and individual affirmation, and that persons who use substances ought to be met with acceptance rather than reproach.

Still, these sentiments are stronger when the relationship is fuller (Solomon 2012). I care for Safeworks clients, and implore others to do the same, for it is tiring work when done in isolation. Caring relationships of this nature need social support. As L reasons, "it's really unfortunate that there's not a lot of community partners seeing this as their work as well." More than individual effort on the part of program staff is required; we must address collective responsibility for nurturing our lives and those of dissimilar others. I have endeavored to vivify the complexities of care practiced at Safeworks; how it is fraught with moral conflict, that clients present with more needs that can ever be met, and that deciding which needs are important inevitably involves slighting others (Tronto 2012). How can staff, placed in a position to care,

really care, assume accountability for it all? For many people at the site, acting ethically is to be responsive to clients' needs in a social and political, as well as personal, context; mindful of social structures that too often fail our most vulnerable. Thus, the moral question staff consider central is not – what, if anything, do [we] owe clients? But rather – how can [we] best meet our caring responsibilities (Tronto 1993:137)? Safeworks is a safer space for many of our city's most marginalized to settle; it is also a single health service, intended for the supervision of consumption and unprepared to address the sheer "badness" of clients' situations. Still, program staff persist; offering what they can – and sometimes more than that – until they are "stretched, tried…and morally and emotionally drained."

> Some people, I watch them come in, and they're so vibrant and passionate, and like, ready for this, but they don't have good techniques, you know? And the clients just wear them out, wear them down…

> I think anybody who works in health care, all of us are at risk for PTSD, all of us are at risk for compassion fatigue, all of us are at risk for so many things, and we need to be there for each other, and we need to support each other.

Caring implies the acceptance of some form of burden; nonetheless, there are limits. Program staff confront the unboundedness of clients' needs and are sometimes disheartened by their failure to provide adequate relief (Tronto 1998:18).

Safeworks staff respond to the call to ethical action in the presence of another in peril – rather than diverting their gaze, they listen actively, they lean in – sometimes to their own detriment. Their pain is two-fold. It begins with bearing witness to clients' struggles and is strengthened by the scarce social reinforcement of their efforts. Safeworks is a space that makes salient the human suffering resulting from our society's failure to meet everyone's basic needs: adequate shelter, daily nutrition, and clothing, reasonable levels of health, social interaction and encouragement, and, for Safeworks clients, a full complement of addiction and mental health

supports (Mackenzie 2013:54). Safeworks staff are conscious of and proximate to persons who are socially abandoned; left to fend for themselves in circumstances of scarcity, need, and affliction. In its full moral promise, care offers nurture, protection, provision, and support for the other (Jennings 2018a:560); staff attempt to meet this ideal, but it is an impossible goal. Caregiving is less of a burden when it is shared; and care for the vulnerable need not be limited to dedicated spaces and programs but present in a collective responsiveness to human need. Safeworks staff cannot support their clients alone, nor can Calgary's shelters assume the place of home, or the food bank replenish a persistent hunger. What we need, but do not have, are social and ethical strategies for making life viable for everyone; a care for others that surpasses mere obligation and finds its full potential in the pleasure of supporting another. For this to happen, the care practices nurtured at Safeworks will need to be accompanied by transformations at the institutional and structural level (Jennings 2016:15); whereby individual 'failings' are understood within the context of clumsy social structures that promote the flourishing of some and augment the vulnerabilities of others. Until then, Safeworks clients rely upon a community that offers – through its services – caring, dignity, and the assurance that they have not been abandoned (Jennings and Hanson 1995:8).

Conclusion.

It has long been the purpose of sociology to substantiate the connection between personal troubles and problematic social structures (Mills 1959); it is much more demanding to effect real change in the sedimented systems of belief that distinguish our society. I am aware that care for "others" is outstandingly difficult to establish in practice, and yet, for all evidence otherwise, at Safeworks, such care is plentiful. What is often stifled in our discipline is the capacity to draw readers in; to move them into the gentle embrace of another's lived experience. I sought, here, to

encourage a transformation from intellectual contemplation into emotive engagement with an unfamiliar world. My research into supervised consumption services encouraged me to write persons who use drugs and the people who care for them into existence; revealing their voices, their histories, their names, if only always partially. I sought to engage the sequestered and bring their stories to life; for it is in intimacy that commitment is found. I had no previous experience with drug use when I entered Safeworks and, as such, my capacity to relate to clients was cultivated in practice and flourished over time. If, over the course of this study, my commitment to the importance of supervised consumption services in Calgary intensified, could I not impress on others the same? To make things loved by making them known? Persons who use drugs are rarely offered the depth of personhood as vulnerable, failing and aspiring human beings when portrayed in academic research (Biehl, Good and Kleinman 2007:14), and I aspired to do better. While research into supervised consumption services is plentiful, there is a part to everything that is concealed. Persons existing within spaces of supervised consumption are absented from conversation, and it has been by hope in this narrative to bring them into focus and animate the complexities of their lives, even if only slightly.

However, for as much as I learned of others, I also gained a greater understanding of myself. My ethnographic research into Safeworks supervised consumption services was a deeply personal endeavor and I am a better person for having done it. When it came time to write of my research, my emotions clung to every page. The obvious suffering in spaces of supervised consumption should have diminished my spirits, but I found it often had the opposite effect. I was continually overwhelmed by clients' ability to accept adversity and endure it; maintaining a capacity for humour, compassion, and concern for others despite the difficulty of much of their lives. I cared for clients without expectation of reciprocation and found myself touched when it

occurred. I came to recognize the strength of small but crucial interventions – the warmth of a calloused hand held, the meeting of a gaze normally averted, calling someone by name – to effect meaningful change in one's experience of and in the world. We think the influential among us great leaders without realizing our own potential; for example, conveying kindness when one expects otherwise. Similarly, we have in each of us the power to do great damage. Thus, caring, and its contrary, contempt, plays out in small ways and in everyday life, and consideration is owed to every gesture, for we most certainly have an impact. I have aspired, in this narrative, to bring forth the strength of supervised consumption services to effect change in clients' lives, though this transformation has less to do with drug use and instead lies at the heart of their social experience. What I discovered, too, as I became immersed in my research and subsequent self-reflection, was how much Safeworks staff and clients have altered my own experience in the world; in what I thought myself ignorant I swiftly became confident, and in what I believed myself learned I found I lacked. I imagined my time spent within supervised consumption services would help me understand persons who use drugs; instead, it was them who led me to a better self. Should readers dare open themselves up to what they presume to already know, they too, may be surprised at what, and who, they find. How can we, in the various ways in which we work and live, alone and with others, affirm life in the face of overdose death, salvage life in the face of adversity, and make life fulfilling rather than empty of meaning?

References.

Adler, Patricia and Peter Adler. 1999. “Social reproduction and the corporate other: The institutionalization of after school activities” Pp. 273-303 in *How It’s Done: An Invitation to Social Research,* edited by E. Adler, & R. Clark. Boston: Wadsworth.

Alberta Health Services. 2019. ‘Supervised Consumption Services’. Retrieved January 3rd, 2020. (http://albertahealthservices.ca/Blogs/BTH/Posting330.aspx#.Xg9mzUdKi70)

Alberta Health Services. 2020. ‘Safeworks Harm Reduction Program.’ Retrieved on April 4th, 2020. (https://www.albertahealthservices.ca/findhealth/Service.aspx?id=1702&serviceAtFacilityID=1035079).

Alexander, BK. *Peaceful Measures: Canada’s Way Out of the War on Drugs.* Toronto, ON: University of Toronto Press.

Anderson, Leon. 2006. “Analytic autoethnography.” *Journal of Contemporary Ethnography* 35(4):373-395.

Anderson, Joel. 2013. “Autonomy and vulnerability entwined” Pp. 134-161 in *Vulnerability: New Essays in Ethics and Feminist Philosophy,* edited by C. Mackenzie, S. Dodds and W. Rogers. New York, NY: Oxford University Press.

Atkins, Zohar. 2018. *An Ethical and Theological Appropriation of Heidegger’s Critique of Modernity: Unframing Existence.* New York, NY: Palgrave Macmillan.

Berg, Bruce L. and Howard Lune. 2012. *Qualitative Research Methods for the Social Sciences.* 8th ed. Upper Saddle River, NJ: Pearson.

Biehl, João, Byron Good and Arthur Kleinman. 2007. “Introduction: Rethinking Subjectivity.” Pp. 1-33 in *Subjectivity: Ethnographic Investigations.* Berkeley, CA: University of California Press.

Biehl, João. 2013. “Ethnography in the way of theory.” *Cultural Anthropology* 28(4):573-597.

Biehl, João and Peter Locke. 2017. “Introduction: Ethnographic Sensorium.” Pp. 1-38 in *Unfinished: The Anthropology of Becoming,* edited by J. Biehl and P. Locke. Duke University Press.

Bochner, Arthur and Carolyn Ellis. 1992. “Personal narratives as a social approach to interpersonal communication.” *Communication Theory.* 2(2):165-172.

Bochner, Arthur and Carolyn Ellis. 2016. *Evocative Autoethnography: Writing Lives and Telling Stories.* Walnut Creek, CA: Left Coast Press

Bourgois, Philippe. 1996. *In Search of Respect: Selling Crack in El Barrio.* Cambridge, NY: Cambridge University Press

Boyd, Jade, Jennifer Lavalley, Sandra Czechaczek, Samara Mayer et al. 2020. “ ‘Bed bugs and beyond’: An ethnographic analysis of North America’s first women-only supervised drug consumption site.” *International Journal of Drug Policy* 102733.

Brazil, Kevin, Sharon Kassalainen, Jenny Ploeg and Denise Marshall. 2010. “Moral distress experienced by health care professionals who provide home-based palliative care.” *Social Science and Medicine* 71:1687-1691.

Brown, Graham, Sione Crawford, Gari-Emma Pery, Judy Byrne et al. 2019. “Achieving meaningful participation of people who use drugs and their peer organizations in a strategic research partnership.” *Harm Reduction Journal.* 16(1)

Calvino, Italo. 2012. *If on a Winter’s Night a Traveler.* New York, NY: Harcourt

Canadian HIV/AIDS Legal Network. 2005. “‘Nothing About Us Without Us.”’ Retrieved May 2nd, 2020. (http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Greater+Involvement+-+Bklt+-+Drug+Policy+-+ENG.pdf)

Coffey, Amanda. 1999. *The Ethnographic Self: Fieldwork and the Representation of Identity.* Thousand Oaks, CA: Sage.

Cohen, Marlene Z., David L. Kahn and Richard H. Steeves. 2000. *Hermeneutic Phenomenological Research: A Practical Guide for Nurse Researchers.* Thousand Oaks, CA: Sage.

Deleuze, Gilles. 2004. *Difference and Repetition.* New York, NY: Continuum.

Denizeau, Laurent. 2015. "Considering human existence: An existential reading of Michael Jackson and Albert Piette." Pp. 214-236 in *What is Existential Anthropology?* edited by M. Jackson and A. Piette. NY: Berghahn Books.

Denshire, Sally. 2014. "On auto-ethnography." *Current Sociology Review* 62(6):831-850.

Denzin, Norman. and Yvonna Lincoln. 1994. "Introduction: Entering the Field of Qualitative Research." Pp. 1-17 in *Handbook of Qualitative Research,* edited by N. Denzin and Y. Lincoln. Thousand Oaks, CA: Sage.

Denzin, Norman. 2004. "The war on culture, the war on truth." *Cultural Studies ←→ Critical Methodologies* 4(2):137-142.

Duff, Cameron. 2015. "Governing drug use otherwise: For an ethics of care". *Journal of Sociology* 51(1): 81-96.

Ellis, Carolyn. 2004. *The Ethnographic I*: *A Methodological Novel About Autoethnography.* Walnut Creek, CA: Rowman & Littlefield.

Ellis, Carolyn and Arthur P. Bochner. 2006. "Analyzing analytic autoethnography." *Journal of Contemporary Ethnography* 35(4):429-449.

Ellis, Carolyn, Tony E. Adams and Arthur P. Bochner. 2011. "Autoethnography: An overview." *Historical Social Research* 36(4):273-290.

Emerson, Robert M., Rachel I. Fretz and Linda L. Shaw. *Writing Ethnographic Field Note.* 2nd ed. Chicago, IL: University of Chicago Press.

Fairbairn, Nadia, Will Small, Natasha Van Borek, Evan Wood and Thomas Kerr. 2010. "Social structural factors that shape assisted injecting practices among injection drug users in Vancouver, Canada: A qualitative study." *Harm Reduction Journal.* 7:20.

Farmer, Paul. 2009. "On suffering and structural violence: A view from below." *Race/Ethnicity: Multidisciplinary Global Contexts* 3(1):11-28.

Foltz, Tanis G. and Wendy Griffin. 1996. "She changes everything she touches." Pp. 301-329 in *Composing Ethnography: Alternative Forms of Qualitative Writing*, edited by C. Ellis and A. P. Bochner. Walnut Creek, CA: Sage.

Foucault, Michel. 1990. *The Use of Pleasure,* vol. 2 of *The History of Sexuality,* trans. by R. Hurley NY: Vintage.

Frank, Arthur. 2004. *The Renewal of Generosity: Illness, Medicine, and How to Live.* Chicago, IL: University of Chicago Press.

Frank, Arthur. 2009. "Why I wrote…The Wounded Storyteller: A recollection of life and ethics." *Clinical Ethics* 4(2): 106-108.

Frank, Arthur. 2016. "Truth telling, companionship, and witness: An agenda for narrative ethics." *Hastings Centre Report* 46(3):17-21.

Geertz, Clifford. 1983. *Local Knowledge: Further Essays in Interpretive Anthropology.* New York, NY: Basic Books Inc.

Gordon, Todd. 2006. "Neoliberalism, racism, and the War on Drugs in Canada." *Social Justice* 33(1):59-78.

Government of Alberta. 2017. 'Responding to Alberta's opioid crisis public progress report: 2.' Retrieved on April 4th, 2020. (https://open.alberta.ca/dataset/274226b9-b947-401a-93de-b34212824b03/resource/c52c20c8-08b8-4c4e-865f-a8830b2a1706/download/CMOH-Opioid-Progress-Report-2-2017.pdf).

Government of Alberta. 2019. 'Minister's Opioid Response Commission.' Retrieved on November 3rd, 2019. (https://www.alberta.ca/opioid-emergency-response-commission.aspx).

Government of Canada. 2020. 'Frequently Asked Questions: Access to naloxone in Canada (including NARCAN™ Nasal Spray.' Retrieved on April 7th, 2020. (https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/announcements/narcan-nasal-spray-frequently-asked-questions.html).

Greer, Alissa M., Serena Luchenski, Ashraf Amlani, Katie Lacroix et al. 2016. "Peer engagement in harm reduction strategies and services: A critical case study and evaluation framework from British Columbia, Canada." *BMC Public Health* 16(1):1-9.

Harm Reduction International. 2020. 'What is harm reduction?' Retrieved on April 4th, 2020. (https://www.hri.global/what-is-harm-reduction).

Harris, Magdalena. 2015. "Three in the room": Embodiment, disclosure, and vulnerability in qualitative research." *Qualitative Health Research* 25(12):1689-199.

Health Canada. 2017. 'Government of Canada Actions on Opioids: 2016 and 2017.' Retrieved on April 4th, 2020. (https://www.canada.ca/en/health-canada/services/publications/healthy-living/actions-opioids-2016-2017.html).

Health Canada. 2018. 'Harm Reduction: Canadian Drugs and Substances Strategy.' Retrieved April 4th, 2020. (https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/harm-reduction.html#a2).

HIV Community Link. 2018. 'Supervised Consumption: A Report for Calgarians.' Retrieved on April 4th, 2020. (https://hivcl.org/wp-content/uploads/2018/06/Calgary-SCS-Public-Document.pdf).

Hyshka, Elaine, Janet Butler-McPhee, Richard Elliott, Evan Wood and Thomas Kerr. 2012. "Canada Moving Backwards on Illegal Drugs." *Canadian Journal of Public Health* 103(2):125-127.

Hyshka, Elaine, Jalene Anderson-Baron, Kamagaju Karekezi, Lynne Belle-Isle *et al.* 2017. "Harm Reduction in Name, but not Substance: A Comparative Analysis of Current Canadian Provincial and Territorial Policy Frameworks." *Harm Reduction Journal* 14(50):1-14.

Jackson, Michael. 1996. *Things as They are: New Directions in Phenomenological Anthropology.* Bloomington, IN: Indiana University Press.

Jackson, Michael. 1998. *Minima Ethnographica: Intersubjectivity and the Anthropological Project.* Chicago, IL: University of Chicago Press.

Jackson, Michael. 2005a. *Existential Anthropology: Events, Exigencies and Effects.* New York, NY: Berghahn Books.

Jackson, Michael. 2005b. "Storytelling events, violence and the appearance of the past." *Anthropological Quarterly* 78(2):355-375.

Jackson, Michael. 2009. *The Palm at the End of the Mind: Relatedness, Religiosity, and the Real.* Durham, NC: Duke University Press.

Jackson, Michael. 2012. *Between One and One Another.* Berkeley, CA: University of California Press.

Jackson, Michael. 2013a. *Lifeworlds: Essays in Existential Anthropology.* Chicago, IL: University of Chicago Press.

Jackson, Michael. 2013b. *The Politics of Storytelling: Variations on a Theme by Hannah Arendt.* Copenhagen, Denmark: Museum Tusculanum Press.

Jackson, Michael. 2013c. *The Wherewithal of Life: Ethics, Migration, and the Question of Well-Being.* Berkeley, CA: University of California Press.

Jackson, Michael and Albert Piette. 2015. “Introduction: Anthropology and the Existential Turn.” Pp. 1-29 in *What is Existential Anthropology?,* edited by M. Jackson and A. Piette. NY:Berghahn Books.

James, William. 1912. *Essays in Radical Empiricism.* New York, NY: Longmans, Green and Co.

James, William. 1950. *Principles of Psychology.* New York, NY: Dover.

Jennings, Bruce, Daniel Callahan and Arthur L. Caplan. 1988. “Ethical challenges of chronic illness.” *Hastings Centre Report* 18(1):1-14.

Jennings, Bruce and Mark Hanson. 1995. “Commodity or public work? Two perspectives on health care.” *Bioethics Forum* 3:3-11.

Jennings, Bruce and Angus Dawson. 2015. “Solidarity in the moral imagination of bioethics.” *Hastings Centre Report* 45(5):31-38.

Jennings, Bruce. 2016. “Reconceptualizing autonomy: A relational turn in bioethics.” *Hatsings Centre Report* 46(3):11-16.

Jennings, Bruce. 2018a. “Solidarity and care as relational practices.” *Bioethics* 32:553-561.

Jennings, Bruce. 2018b. “Solidarity and care coming of age: New reasons in the politics of social welfare policy.” *Hastings Centre Report* 48(5):19-24.

Jensen, Eric and Jurg Gerber. 1993. “State efforts to create a social problem: The 1986 War on Drugs in Canada. *Canadian Journal of Sociology* 18(4):453-462.

Kerr, Thomas, Sanjana Mitra, Mary Clare Kennedy and Ryan McNeil. 2017. "Supervised injection facilities in Canada: Past, present and future." *Harm Reduction Journal.* 14(28): 1-9.

Kiesinger, Christine E. 1998. "From interviewing to story: Writing Abbie's life." *Qualitative Inquiry* 4(1):71-95.

Kolker, Aliza. 1996. "Thrown overboard: The human costs of health care rationing." Pp. 132-159 in *Composing Ethnography: Alternative Forms of Qualitative Writing*, edited by C. Ellis and A. P. Bochner. Walnut Creek, CA: Sage.

Kuhn, Thomas S. 1996. *The Structure of Scientific Revolutions.* 3rd ed. Chicago, IL: University of Chicago Press.

Laing, Zach. 2019. 'Fentanyl responsible for record proportion of Alberta opioid deaths, report finds.' Retrieved on January 3, 2020. (https://calgaryherald.com/news/local-news/fentanyl-responsible-for-record-proportion-of-alberta-opioid-deaths-report-finds)

Lambek, Michael. 2015. "Both/And" Pp. 58-83 in *What is Existential Anthropology?,* edited by M. Jackson and A. Piette. NY:Berghahn Books.

Latour, Bruno. 2004. "How to talk about the body? The normative dimension of science studies." *Body & Society* 10(2-3):205-229.

Mackenzie, Catriona. 2013. "The importance of relational autonomy and capabilities for an ethics of vulnerability." Pp. 33-59 in *Vulnerability: New Essays in Ethics and Feminist Philosophy,* edited by C. Mackenzie, S. Dodds and W. Rogers. New York, NY: Oxford University Press.

Mancini, Michael A., Donald M. Linhorst, Francie Broderick and Scott Bayliff. 2008. "Challenges to implementing the harm reduction approach." *Journal of Social Work Practice in the Addictions.* 8(3):380-408.

Maté, Gabor. 2018. *In The Realm of Hungry Ghosts: Close Encounters with Addiction.* Toronto, ON: Vintage Canada.

Mexico United Against Crime. 2018. “Ending the War on Drugs: How to win the global policy debate.” Retrieved April 4th, 2020. (https://transformdrugs.org/wp-content/uploads/2018/12/Global-Drug-Policy-Debate_0-1.pdf).

Miles, Matthew and Michael Huberman. 1994. *Qualitative Data Analysis: An Expanded Sourcebook.* Thousand Oaks, CA: Sage.

Mills, Charles Wright. 1959. *The Sociological Imagination.* New York, NY: Oxford University Press.

Mol, Annemarie. 2006. “Proving or improving: On health care research as a form of self-reflection.” *Qualitative Health Research* 16(3):405-414.

Morrissey, Mary-Beth and Bruce Jennings. 2016. “Introduction to conceptual issues in health and society: Neglected social and relational experiences and care approaches.” *Journal of Theoretical and Philosophical Psychology* 36(2):61-63.

Murphy, Robert F. 1987. *The Body Silent.* New York, NY: W.W. Norton.

National Treatment Strategy Working Group. (2008). *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*. Ottawa: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada

Neuman, Lawrence. 2007. *Social Research Methods: Qualitative and Quantitative Approaches.* 7th ed. Boston, MA: Pearson.

Nixon, Richard. 1971. *Remarks About an Intensified Program for Drug Abuse Prevention and Control*. Washington: The White House.

Piette, Albert. 2015. “Existence, minimality, and believing” Pp. 178-213 in *What is Existential Anthropology?,* edited by M. Jackson and A. Piette. NY: Berghahn Books.

Rance, Jake and Suzanne Fraser. 2011. “Accidental intimacy: Transformative emotion and the Sydney medically supervised injecting centre.” *Contemporary Drug Problems* 38(1): 121-145.

Rhodes, T. 2009. “Risk environments and drug harms: A social science for harm reduction approach.” *International Journal of Drug Policy* 20(3):193-201.

Richardson, Laurel. 1992. "The consequences of poetic representation: Writing the other, writing the self." Pp. 125-140 in *Investigating Subjectivity: Research on Lived Experience,* edited by C. Ellis and M. Flaherty. Newbury Park, CA: Sage.

Richardson, Laurel. 1994. "Writing: A method of inquiry." Pp. 516-529 in *Handbook of Qualitative Research,* edited by N. Denzin and Y. Lincoln. Thousand Oaks, CA: Sage.

Richardson, Laurel. 1997. *Fields of Play: Constructing an academic life.* New Brunswick, NJ: Rutgers University Press.

Sandelowski, Margarete. 2002. “Reembodying qualitative inquiry.” *Qualitative Health Research* 12(1):104-115.

Schwarcz, Lilia M. 2017. “I was cannibalized by an artist.” Pp. 173-196 in *Unfinished: The Anthropology of Becoming,* edited by J. Biehl and P. Locke. Duke University Press.

Slote, Michael. 2007. *The Ethics of Care and Empathy.* New York, NY: Routledge.

Smith, Alanna. 2020. “Some say it’s ‘a mess’, others see improvement around the Sheldon Chumir,” *Calgary Hearld,* February 13.

Solomon, Andrew. 2012. *Far From the Tree: Parents, Children and the Search for Identity.* New York, NY: Simon & Shuster.

Sparkes, Andrew. 2013. “Autoethnography at the will of the body: Reflections on a failure to produce on time.” Pp. 203-211 in *Contemporary British Autoethnography,* edited by N.P Short, L. Turner and A. Grant. Rotterdam: Sense.

Tillman-Healy, Lisa M. 1996. "A secret life in a culture of thinness." Pp. 76-108 in *Composing Ethnography: Alternative Forms of Qualitative Writing*, edited by C. Ellis and A. P. Bochner. Walnut Creek, CA: Sage.

Tronto, Joan C. 1993. *Moral Boundaries: A Political Argument for an Ethic of Care.* New York, NY: Routledge.

Tronto, Joan C. 1998. "An ethic of care." *Generations* 22(3): 15-20.

Tronto, Joan C. 2005. "Care as the work of citizens: A modest proposal." Pp. 130-145 in *Women and Citizenship,* edited by M. Friedman. New York, NY: Oxford University Press.

Tronto, Joan C. 2012. "Partiality based on relational responsibilities: Another approach to global ethics." *Ethics and Social Welfare* 6(3):303-316.

Verghese, Abraham. 2010. *Cutting for Stone.* New York, NY: Random House.

Wall, Sarah. 2008. "Easier said than done: Writing an autoethnography." *International Journal of Qualitative Methods* 7(1):38-53.

Watson, Tara Marie, Gillian Kolla, Emily van der Meulan and Zoe Dodd. 2020. "Critical studies of harm reduction: Overdose response in uncertain political times." *International Journal of Drug Policy.* 76:1-6.

Weil, Simone. 1949. *The Need for Roots: Prelude to a Declaration of Duties Towards Mankind.* New York, NY: Routledge.

Wood, Evan, Mark Tyndall, Julio Montaner and Thomas Kerr. 2006. "Summary of findings from the evaluation of a pilot medically supervised safer injecting facility." *Canadian Medical Association Journal.* 175(11):1399-1404.