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Research paper

Living with addiction: The perspectives of drug using and non-using individuals about sharing space in a hospital setting

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ABSTRACT

Hospitals seem to be places where harm reduction approaches could have great benefit but few have responded to the needs of people who use drugs. Drawing on recent theoretical contributions to harm reduction from health geography, we examine how the implementation of harm reduction is shaped by space and contested understandings of place and health. We examine how drug use and harm reduction approaches pose challenges and offer opportunities in hospital-based care using interview data from people living with HIV and who were or had recently been admitted to a hospital with an innovative harm reduction policy. Our data reveal the contested spatial arrangements (and the related practices and corporeal relations) that occur due to the discordance between harm reduction and hospital regulatory policy. Rather than de-stigmatising drug use at Casey House Hospital, the adoption of the harm reduction policy sparked inter-client conflict, reproduced dominant discourses about health and drug users, and highlights the challenges of sharing space when drug use is involved. The hospital setting produces particular ways of being for people who use and those who do not use drugs and the demarcation of space in a drug using context. Moving forward, harm reduction practice and research needs to consider more than just interactions between drug users and healthcare providers, or the role of administrative policies; it needs to position ethics at the forefront of understanding the collisions between people, drug use, place, and space. We raise questions about the relationship between subjectivity and spatial arrangements in mediating the success of harm reduction.

Introduction

Increasingly, harm reduction is included as a constituent element of international, national and local drug policies (Stoicescu, 2012) with implementation of interventions in community settings across the world (Marlatt & Witkiewitz, 2010). However, harm reduction has yet to reach most hospital settings. This is concerning because people who consume drugs in problematic ways are admitted to hospital and emergency departments more frequently than the general population (French, McGeary, Chitwood, & McCoy, 2000; Haber, Demirkol, Lange, & Murnion, 2009; Kerr et al., 2005; Palepu et al., 2001). Within hospitals, people who use substances encounter significant barriers to accessing care (McCreaddie et al., 2010; Monks, Topping, & Newell, 2012). They are often labelled as being 'challenging, manipulative, drug-seeking and demanding' by healthcare workers (Ford, 2011; N. S. Miller, Sheppard, Colenda, & Magen, 2001), encounter stigma and receive substandard care, and frequently leave hospitals against medical advice (Chan et al., 2004; Pecoraro et al., 2013; Ray et al., 2013; Saitz, 2002).

For people living with HIV/AIDS (PLHIV), having access to care is essential for their health and survival (Cunningham, Crystal, Bozzette, & Hays, 2005; Cunningham et al., 1998). Those able to access care are living longer and have improved health thanks to antiretroviral medications. However, with this increased lifespan, PLHIVs are experiencing chronic episodes of acute HIV-related and other types of illness that can require hospitalisation and/or supportive care arrangements. These medical needs can be complicated by substance use. Research suggests as many as 70% of people living with HIV/AIDS (PLHIVs) used illicit drugs or reported hazardous alcohol use in the previous year (Korthuis et al., 2008; Sohler et al., 2007). Illicit drug use is associated with negative outcomes for PLHIVs, including: lower adherence to antiretroviral therapy, poor immune suppression, disease progression, and mortality (Balsa, French, Maclean, & Norton, 2009; Brubacher et al., 2008; French et al., 2000; Haber et al., 2009; Kerr et al., 2005; Neblett et al., 2011; Palepu et al., 2001). A Vancouver-based study found that, when accessing hospital-based care, PLHIVs who injected drugs had high

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rates of leaving against medical advice (AMA) (Chan et al., 2004). Leaving AMA is problematic because the health issues that led to the admission can worsen after leaving (Chan et al., 2004). Overall, when PLHIVs who use substances are not able to access effective care they are more likely to disengage with the healthcare system, become non-adherent to antiretroviral drugs (ARVs), and increase high risk substance use behaviours, resulting in negative health outcomes and potential transmission to others (Gardner, McLees, Steiner, del Rio, & Burman, 2011).

To be effective, drug policy interventions need to be implemented in the settings where drug use occurs (Moore & Dietze, 2005) and hospitals seem to be places where a harm reduction approach would be of benefit for PLHIVs and others who use drugs. However, noticeably absent in the literature are studies regarding the implementation of harm reduction in hospital settings (Mofizul Islam, Topp, Day, Dawson, & Conigrave, 2012). The current literature provides little guidance regarding implementation of harm reduction in settings such as hospitals that provide acute and emergency care. Current literature focuses mostly on implementation of harm reduction in community-based programs such as needle and syringe programs, methadone maintenance, supervised injecting facilities and heroin prescription programs (Marlatt & Witkiewitz, 2010). While needle and syringe programs do not manage onsite drug use, supervised injecting facilities and heroin prescription programs do manage onsite drug use demonstrating its feasibility within health care settings. Furthermore, other programs such as managed alcohol programs (Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006) and "Housing First" programs (Appel, Tsemberis, Joseph, Stefancic, & Lambert-Wacey, 2012; Bean, Shafer, & Glennon, 2013; Hawk & Davis, 2012; Srebnik, Connor, & Sylla, 2013; Substance Abuse Mental Health Services Administration (SAMHSA), 2007; Tsemberis, Gulcur, & Nakae, 2004) demonstrate that substance use can be managed in settings where clients stay overnight and sometimes for extended periods, suggesting that harm reduction approaches to substance use may be possible in hospital settings. However, managed alcohol and Housing First programs differ from hospitals in terms of mandate, target population (i.e., specific groups versus general population) and scope of medical care on-site.

The overarching goal of our investigation was to examine the potential and related challenges of implementing a harm reduction policy in a hospital-based environment. Haber et al. (2009) promote a non-judgmental and problem-solving approach to improve relations between people who use drugs and care providers in hospital. However, there is little discussion how this might be achieved. Further, McNeil, Small, Wood, and Kerr (2014) recently examined the experiences of injection drug users in hospitals and found they were subjected to surveillance, harassment, and neglect, and that these supposedly therapeutic contexts became risk environments for marginalised persons.

We draw on theoretical contributions from health geography and medical sociology to examine drug use in a hospital with an innovative harm reduction policy. We start by introducing key themes from the literature on space, place, and health to provide a theoretical framework and complement this with critical insights from Foucault's (1979, 1996a, 1996b) writings to centralise power in our analysis. Next we turn to empirical data to examine these issues in relation to the provision of care for people living with HIV who use drugs in a shared hospital setting, and the complex interpersonal dynamics created therein.

Space, place, and health

According to Duff (2007), drug policy research has failed to consider context beyond the macro structural forces that enable and constrain behaviour and/or fashion context much like a backdrop within which drug use occurs. Tuan (1975, 1977), Lefebvre (1991), and Bachelard (1994) contend that space is socially constructed through encounters between people, objects, and their subjective experiences. Making an early distinction in geography between space as a quantifiable empirical construct, and place as subjective and experiential, Tuan (1979, p. 387) explained:

> Place incarnates the experiences and aspirations of a people. Place is not only a fact to be explained in the broader frame of space, but it is also a reality to be clarified and understood from the perspectives of the people who have given it meaning.

For Agnew (2002, p. 5) space signifies a field of practice (for our purposes the hospital) and place represents encounters within those spaces that give them meaning for groups: space is top-down, and place is bottom-up. Extending the study of space and place to health, Kearns (1993) influentially proposed that geography should centre place in analyses of illness experiences and health service provision. Furthermore, Cummins, Curtis, Diez-Roux, and Macintyre (2007) have emphasised the need for quantitative, qualitative, and theoretical research on health that recognises the relational dynamics between people and place. Of relevance to our current project, Tempalski and McQuie (2009) use the concepts of "drugscapes" to describe the myriad social, cultural, and structural factors that work across spaces and places where people inject drugs to increase the risk of HIV transmission. Returning to the importance of context, Duff (2012) has emphasised the need for drug research that is attuned to how the assemblage of objects, actors, and spaces shape the social contexts of drug use. Following the work of Latour (2005) which challenged notions of a single structuring context, Duff (2012) argues for the importance of recognising the way spaces, objects and actors are involved in the relational production of context. For our purposes, we are interested in the way hospital spaces become meaningful places (or lose that status) within a context where drugs are being used. We find these theoretical insights from health geography helpful but we are especially interested in Poland, Lehoux, Holmes, and Andrews (2005) discussion of space, place, and health in relation to Foucault's description of healthcare as an apparatus that captures, directs, and organises. We turn next to a discussion of Foucault's work.

Governing place and the body

Foucault (2008, p. 70)was interested in the effects of what he termed the "general apparatus (*dispositif*) of governmentality," a framework that accounted for the ways power is orchestrated through "institutions, procedures, analysis and reflections, calculations, and tactics. . ." (2007b, pp. 108–109). With governmentality as a conceptual backdrop Foucault (1996a) examined the ways power has been historically exercised and deployed to discipline individual bodies and regulate collectives through medical, psychiatric, and juridical discourses. These technologies of governance are not solely discursive, operating in the ether, but serve to strategically shape individuals' practices and bodily comportment, their material conditions, and the organisation of social institutions (P. Miller & Rose, 2008; Rose, 2007). While often overlooked in governmentality studies, Foucault claimed that space is ". . .fundamental in any exercise of power" (1984, p. 252) and described his interest in "medical knowledge. . .architecture. . .spatial organisation. . . [and] forms of surveillance. . ." as central to the study of governmentality (Foucault cited in Elden, 2007, p. 67). Our analysis uses Foucault's (2005, p. 252) latter conception of governmentality, which accounts for power relations, the government of self and others, and the

relationship of self to self, to connect together questions of politics and ethics. Foucault helps us think about how individuals are governed through their interactions with institutions like hospitals, and the ways they concede or resist, and what this says about larger political forces that extend beyond individuals, spaces, and places. Finally, Foucault invites us to think about conceptions of ethics that emerge within the constraints of governance, that is, how subjects stylise themselves in relation to the range of constraints and opportunities around them. Or, in the current study, how people living with HIV who use drugs in hospitals are governed through policies and procedures and conduct themselves; all of which serves to create a unique context.

Overall, a Foucauldian approach invites a critical engagement with the study of health and place in a way that surfaces and interrogates power relations and forms of resistance in the shaping of a drug using context. In critical public health and addictions studies Foucault's work has been used to problematise the delivery of harm reduction programs and addictions services (Fischer, Turnbull, Poland, & Haydon, 2004; Keane, 2009; P. Miller, 2001; Moore, 2004). Our subsequent analysis builds on this work by examining power and complexity in harm reduction in a hospital setting. Cognisant of Foucault's (1978, p. 95) claim that "where there is power, there is resistance," we challenge the tendency to offer a solely negative reading of the operations of power. Indeed, most hospitals and other clinical spaces are easily constructed as panoptic and disciplinary, but this does little to advance our understanding of how power circulates within their walls and what is produced and enabled. Following Conradson (2003, p. 510) we are interested in the way "socio-spatial environments may at times enable enhanced or more positive forms of human subjectivity" despite the presence of techniques for governing the individuals within. We now turn our attention to empirical data collected as part of an exploratory community-based research project.

The setting

Casey House Hospital, a sub-acute 13-bed speciality hospital, located in Toronto, Ontario, provides inpatient services to PLHIVs and implemented a harm reduction policy in 2008 to address drug and alcohol related issues among clients. Clients typically have multiple diagnoses, complicated medication regimes, and psycho-social challenges, and with an average length of stay of 45 to 60 days. Amongst admitted clients 87% have active mental health issues and 77% are poly-substance users (unpublished chart data). With little empirical research having been conducted on integrating harm reduction outside of community-based programming contexts at that time (Rachlis, Kerr, Montaner, & Wood, 2009), Casey House Hospital developed their approach through consultation with various stakeholders (management, clinicians, and clients) and in partnership with other organisations serving similar clients. The harm reduction implementation plan involved extensive training of staff and clinicians regarding harm reduction in general, the specifics of the Casey House Hospital policy, a weekly harm reduction discussion group hosted for clinicians to discuss successes and challenges, and distribution of a harm reduction brochure to clients.

Methods

This project developed following consultations with Casey House Hospital clients, staff and managers who identified the need to explore the impacts, positive and negative, of the implementation of the harm reduction policy. These early consultations also revealed an interest in arts-based research methods amongst clients. After further consultation, we used photo-elicitation as the method to develop and answer our research questions amongst clients (Angus et al., 2009; Bagnoli, 2009; Fleury, Keller, & Perez, 2009; Lorenz, 2011; Oliffe & Bottorff, 2007; Radley & Taylor, 2003; Reinhardt et al., 2011). To recruit clients, a notice was posted in the hospital and also in the hospital newsletter and invited Casey House Hospital community members (i.e., current and former inpatients being seen by Casey House Hospital nurses in the community) to call or approach the study coordinator about the study. After clients came forward, the coordinator explained the study, the consent procedure, answered questions and invited those interested.

We asked participants to attend an orientation session where we discussed the objectives of the study; provided instructions regarding the use of the disposable camera; and where the basics of photographic composition (e.g., light, rule of thirds, content) were taught and discussed (Wang and Burris, 1997). At the end of the orientation session, participants were given the following instruction:

> Using the cameras provided to you, take a series of photos that show how you feel about or have experienced harm reduction as an inpatient or client at Casey House Hospital. You may also want to explore how you experience or feel about harm reduction as a person living with HIV. *These photos should relate to how you feel about drug use by Casey House Hospital clients and inpatients.*

After completing their assignment, participants were invited back for a one-on-one interview lasting 45 to 60 min to discuss their photographs in relation to their experience of harm reduction at Casey House Hospital (e.g., what can be seen in the photos, what is happening and why). Participants provided informed consent and were given a $15 CAD honorarium for the orientation session and $30 CAD for the one-on-one interview. Additionally, participants received a copy of all photos they had taken for this project. This project was part of a larger initiative to evaluate models of engagement and research methods suitable for people living with acute illness and receiving hospital care. With the agreement of the community, it did not have the typical 'action' component where photos are exhibited for policy and decision-makers, and other members of the community are invited to attend. We did however host separate exhibitions of the photographs for clients and managers and staff members.

During the orientation session, we did not instruct the participants to consider issues of space when taking photographs. Many of the photographs taken were used to represent aspects and/or the trajectory of health and well-being associated with Casey House Hospital and sometimes in direct reference to substance use (e.g., drug paraphernalia, drug dealer's feet, friends and partners) but not the socio-spatial issues related to the implementation of harm reduction. However, the centrality of socio-spatial issues in regard to the implementation of harm reduction at Casey House Hospital surfaced during the first interviews. Most often socio-spatial issues were raised by the participants after they had selected and answered questions about their photos. For others, these issues were raised in between discussions of individual photos. While most photos did not attend to the socio-spatial issues we examine below, one glaring exception was a photo of a bench used by a participant to literally show why and where drugs were consumed in proximity to the hospital (Fig. 1). With the exception of the bench photo, we made a deliberate decision to focus the analyses below on the interview transcript data. This decision is not unique within the corpus of photovoice and photo-elicitation studies. A 2010 systematic review of photo voice in health research (Catalani and Minkler, 2010) revealed that while all projects involve the production of photographic images and discussion of these images, most typically

Fig. 1. Photo of bench taken by participant through a haze of smoke.

use interview/discussion transcripts alone to answer the research questions.

We used 'situational analysis' described by Clarke (2005) to locate our empirical findings in relation to Foucault's theoretical writings. Using situational analysis, we explored the data to identify all human and non-human elements of concern in the situation. Of the data we asked: "What and who are in this situation? Who and what matters in this situation? What elements make a difference?" (Clarke, 2005, p. 561). Within the larger project we conceptually 'mapped' the discourses and debates that matter in this situation. Using this method, situational analysis allows for a theoretically informed analysis of the governing effects of the medical apparatus (including various discourses about health, addiction, and regulatory policies) but with an attention to the relational, embodied, and spatial aspects of drug use which produce conflict and discontinuities in a hospital setting. We used the theoretical literature to sensitise us to potential patterns in the data. Next we used memoing techniques to analyze linkages and relations between the elements within the situational analyses. Analyses centre on moments in our data when the relational dynamics between space, place, actors (patients, clinicians, and staff) and objects (benches, mobility devices, and drugs) simultaneously affirms and negates the need for harm reduction in a hospital.

Results

Our results are presented with an attention to the ways a particular context is created through the contestation of space and place and the discordance between harm reduction and hospital regulatory policy. Central to shaping notions of whether Casey House Hospital is a "safe place" and for whom, are the relationship between using and non-using clients, clients higher and lower on the drug hierarchy, and interactions with clinicians. As clinical space becomes place for one group, place is reduced to space for another who no longer feel safe. Rather than de-stigmatising drug use at Casey House Hospital, the adoption of the harm reduction policy sparked inter-client conflict, reproduced dominant discourses about health and drug users, and highlights the challenges of sharing space when drug use is involved.

Casey House Hospital as a drug using space

For those familiar with problematic drug use, positioning hospital settings as spaces where people use illicit substances may not seem as jarring as when presented to those who are unfamiliar with illicit substance use. People with highly problematic drug use patterns, including physical dependence, will desire to, and do, use in these settings (Rachlis, Kerr, Montaner, & Wood, 2009). However, as set out above, these same people are likely to be ill-treated when accessing care. Casey House Hospital set itself the goal of changing this experience for their clients by introducing a harm reduction policy. The harm reduction policy recognises that:

> . . .clients served may present with substance use and mental health issues and behaviours. It is recognized that these issues and behaviours have both biological and psycho-social components. In partnership with the client, the interdisciplinary team will establish a set of goals that reflects desired substance use and mental health outcomes within the broader context of HIV/AIDS care (Casey House, 2008, p. 5)

While "using, sharing, trading and dealing illicit/illegal drugs on the premises at Casey House Hospital is prohibited" the organisation remains committed to "utiliz[ing] a range of practical strategies which are relevant to harm reduction, including: motivational interviewing, application of trans-theoretical model of change, counseling, relapse prevention, education to maximize safety for clients, staff and environments of care, needle exchange, distribution of condom packages, methadone bridging therapy, opiate replacement therapy, smoking (nicotine) reduction and connect clients to community programs that offer distribution of safer crack kits, needle exchange and narcan kits." Overall, the approach espoused is holistic and inclusive, and attempts to recognise the roles and respective needs of all stakeholders: clients, clinicians, management and volunteers.

Participants described how the harm reduction policy made it an acceptable place to discuss drug use openly at Casey House Hospital. In describing a past experience of leaving Casey House Hospital "AWOL" to use a combination of "uppers, downers, sideways," for a special occasion this participant described the shame he experienced when returning to Casey House Hospital, but:

> People were using substances and they were pretending they weren't using. Or if you've used, you felt bad about coming back to Casey House Hospital because you were inebriated. And what they did is they opened the door and they acknowledged the fact that you had used. . . [Casey House Hospital is] giving us the opportunities to be open and not pretend that we're not using.

He explained the policy started informally to allow that after using:

> You were to go to your room and close the door, not interact with anyone else until you felt safe or until other people felt safe. So they, that's how it originally started in my mind and recollection. Because then before, if you were hiding, you didn't want to come into the house.

In a very notable way, the harm reduction policy changed the practice of disclosure and opportunities for a dialogue between clinicians and clients were opened. In doing so, the framing of substance use within the organisation changed. Clinicians could now discuss substance use in relation to specific medical (e.g., drug interactions) and personal (e.g., preparing for discharge) needs. Elsewhere, making drug use visible through such interventions as safe injection sites has been critiqued as a strategy for governing drug use by imposing conceptions of order and proper citizenship (Fischer et al., 2004). However, as we discuss below, the shift to more open discussions of substance use at Casey House Hospital produced the opposite effect, introducing an element of disruption and disorder.

Whose space is this?

Casey House Hospital is located within a converted mansion; its hallways and corridors are narrow and the client rooms are small. There is little privacy in the shared spaces. The lack of privacy has been further complicated by drug use being less hidden and secretive. With the average stay lasting 45 to 60 days participants described inevitability "getting to know each other's business" and the tendency to judge and be judged. This new transparency created more comfort for some clients but also increased conflict and raised questions about whose comfort matters more. At Casey House Hospital the flow of different clients through the facility during any given period shaped individual clients' experience of the space, their sense of ownership, and feelings of personal safety. This participant reflected on his perception of this coming together of different client groups:

> It was a safe, quiet place to be. And then when the mandate changed... we were seeing more drug users enter the house and it became more difficult.

This client's narrative reflected a sense of loss over perceived ownership (the way it used to be) described by some long-term clients at Casey House Hospital in relation to the encroachment of a disruptive drug using *other*. The 'chaotic' and disruptive drug using subject is regularly evoked in public and policy discourse about drug users to differentiate them from the supposedly stable and 'normal' behaviour of non-users (Fraser & Moore, 2008; Moore, 2009). Importantly, many clients come to Casey House Hospital multiple times and over many years and in doing so had marked Casey House Hospital as a place of their own. This conflict over Casey House Hospital also reflects an important distinction between space and place. This distinction is seen in the ways people attempt to make abstract space into the comfortable and familiar, a place with boundaries of one's own. Hospitals and clinical settings are expected to be orderly and stable, where time and space is managed to achieve optimal cleanliness and efficiency–in many ways different from a home. In this case the hospital space was also attributed some of the characteristics of a home-like healing place that developed despite the presence of various medical technologies and the realities of illness and death. The introduction of a 'chaotic' person disrupts this view and turns it into neither hospital nor home. It is in this collision of meanings that place comes into focus as produced by more than just the bricks, the walls, the furniture but also the intersecting people, meanings and work to make it habitable. Here the space becomes a constitutive element of relations between clients.

Following the introduction of the harm reduction policy, this sense of ownership and understanding of who can be in the space and what practices are acceptable was challenged when the number of clients who openly discussed and/or used drugs increased. During the interviews, we surfaced contradictory and conflicting discourses about drug using clients. Some participants characterised clients who used drugs as previously present but hidden within the space, whereas others viewed substance users as "new" to Casey House Hospital. Both groups differentiated between drug using and non-drug using clients suggesting a clear binary existed between the two. However, this binary was challenged by a client:

> We've got everyone from pot smokers, alcohol, heroin, there's everyone addicted to something in here.

At Casey House Hospital, the vast majority of clients use prescribed and non-prescribed substances in different ways to augment their care and as a coping mechanism. For clients, the intersection between the harm reduction policy and the existing space necessitated positioning themselves in relation to drug use, differentiating between current and past use; drug of choice; volume of use; reasons for use; and visibility of use. Clients invoked a hierarchy between those who only used drugs as prescribed to them (e.g., opiates for pain management), those who used marijuana, and those who used multiple prescribed and illicit substances. Marijuana users were further differentiated between those with and without a medical marijuana license. This positioning emerged in relation to the ways in which particular clients (or bodies) came to be framed as deserving or threatening to the sense of place for some.

Dangerous addicts and good drug users

Originally, Casey House Hospital served primarily gay men dying from AIDS-related complications and seeking palliative care. Reflective of advancements in HIV drug therapies and improved health outcomes for people living with HIV, Casey House Hospital now offers a range of services and is understood by clients as a place for respite, care, and healing. Most are now admitted and discharged alive from Casey House Hospital. In our interviews 'newer' clients who fit a different demographic (including those who may be street involved) and are more open about drug use were positioned as betraying Casey House Hospital's mandate. These next quotes reflect a popular sentiment that, when in care, clients should abstain from drug use and focus on their health:

> I just feel like this place is amazing and a lot of us wouldn't be alive if we didn't have it. They're not using it *[Casey House Hospital]* for the right reasons. It's being abused. And all they do is get up in the morning, go out and get high all day. Then they come back, eat, sleep and do it again. So how can that be, we're just enabling them. We're not helping them by any means.
> ...
> I think when they're in the *[Casey]* house *[Hospital]*, that shouldn't be their focus... Their focus should be on getting better and not disrupting everyone who is trying to get better.
> ...
> ...we're here to get better and they seem to be sabotaging themselves.

These notions about the "good patient" were prevalent throughout many of the interviews and suggest the internalisation of neoliberal discourses about health seeking and personal responsibility (Ayo, 2012; Brown & Baker, 2012; Galvin, 2002). A 'good' patient is understood as someone who is compliant with medical directives and does not compromise their care by using illicit substances. In particular, judgements about who is 'deserving' and 'undeserving' in relation to the type of substance used circulated, as expressed by this participant:

> 'So, I mean, there is a hierarchy of drug use anyway, whether people would like to admit that or not. Even I suffer from the hierarchy of drug use. Injection drug users are almost seen as like the lepers of drug use, the same with crack smokers... People might think it their business to get in on your business. You know? I have this saying "Don't try to iron my dress when yours is all wrinkled."

The influence of the rhetoric of deserving patients was further evident in discussions about some clients "taking up beds" that could be better used by more 'deserving' clients. Some participants evoked the discourse of the "dangerous addict" to further their claim that the 'new' clients to Casey House Hospital did not belong:

> You know, we have people here that have never been around street stuff, like, you have a guy in here who's like, a lawyer or something, or you know, like a real estate agent, or somebody, like, professional people that have now become ill, who don't, you know, that haven't been around stuff like this.
> ***
> "People were tying the doors up, and they were shooting up in their rooms. And they were smoking crack in the closet. There [were] clothes in there, and you're asleep and they could be burning up the closet next to you. You just don't know."

Within this contextual arrangement of space, illness, and encounters, the discourse of the violent, predatory drug user was reproduced and reinforced. In keeping with Sibley and Van Hoven's (2009) study of space in a prison, participants often framed drug users as having contaminated both real and imagined spaces and places. However, descriptions of the chaotic and disruptive drug user were contrasted by some participants who talked about the 'good drug user' who is conscientious about their use and considerate of other's personal space:

> The harm reduction rule basically means... don't bother other people with your usage. Keep it to a minimum or at least off the property or if it's smoking, in the back. So that will keep it away from inside the house and nobody else has to put up with your situation.

These 'good users' tended to use marijuana and were contrasted with crack smokers positioned as 'disruptive.' Interestingly, injection drug use, while a pressing concern in terms of public health, did not emerge as a dominant issue in these interviews. Both marijuana and crack smoking were much more visible because consumption required users to leave, smoke, and come back. In their comings and goings they were likely to interact with other clients and staff:

> Well, I did marijuana, so I'm relatively a calm person anyhow. But there was a lot of people near the end of my stay, that were really hooked on crack. And everything they did bothered everybody. They were walking in people's rooms, or just annoying in every sense... [they] were really obnoxious and taking advantage of everything. And they were stoned out of their head constantly, right?
> ***
> ...most of the people that I know in the house, over the years, are aware of the medicinal benefits of marijuana, even if they don't smoke it. They understand why other people do, even if they don't. I just think it's as big a deal. I don't think marijuana tends to make people violent and agitated and jumpy and aggressive, where other drugs do.

In this particular rendering, a 'good' drug user is discrete and uses common space in ways that do not cause disruption or discomfort for others. One participant in particular described the way he moderated his crack use, limiting it to special occasions and restricting the amount he bought and consumed, as well as making sure to schedule use in a way that would not interfere with medical appointments at Casey House Hospital. This differentiation between acceptable forms of use, including amongst drug users, has been reported elsewhere (Slavin, 2004). Yet, in community settings drugs users can congregate based on their drug-use preferences and patterns whereas at Casey House Hospital different kinds of users and non-users alike must share the same common, entry/exit, and outdoor spaces.

Disrupted place

When trying to sort through these narratives about 'deserving' clients, it became apparent that this issue surfaced most often in relation to when substance use of any kind became disruptive in the space. Drug use that negatively influenced an individual's sense of safety and comfort created the most tensions between clients. While some clients who used drugs managed their use discreetly, other participants described encountering disruptive behaviour as a result. The consequence for users and non-users from disruptive drug use included feeling badgered for money to help support others' drug use:

> Yeah, I think you expect to come here, and for me, this place is like a second home. So it was hard for me to feel comfortable having people, that I knew were doing drugs, or under the influence of drugs, in my home.

And people that aren't on drugs can have peace... and not worry about... being badgered for money and cigarettes all day, every day, over and over.

While Casey House Hospital was often described to possess home like qualities or an oasis of healing, clients' health and physical limitations could make it feel claustrophobic at times. Participants described their frustration with the space when wanting to use or wanting to avoid others' use. This participant describes both sides of the issue:

> I was in the house for three and a half months, and it was winter. It was miserable, last winter, and cold, so you're trapped. And now you're trapped with some drug users and it was difficult. And then the other [side], their point is sort of like, 'Well, I'm stuck in the house for three and a half months. I have the right to go out and do what I want to do.' So, I don't know. And I don't have any answer really (laugh) to the problem, like the problems that sort of come up.

The small physical space often combined with acute illness and limited or no mobility left few refuges from behaviours experienced as disruptive and/or threatening. As well, tolerance for disruptions tended to be lower when feeling sick and some participants responded by retreating into their rooms and not engaging with programs:

> I remember being threatened; I was threatened here, at one point. I know other *[inpatients]* that were threatened here. You hear about cases where nurses were abused and stuff. You don't like to hear about those things going on in the house *[i.e., Casey House Hospital]*. I felt at times in the house that I just wanted to keep my head down, and stay in my room and not get involved in the bigger picture, because I felt it was just too dangerous at the point where I was at. You know?

The combination of Toronto winter weather, personal health limitations, and the small physical space combined to create conflict between some clients and a sense of alienation and feeling trapped. Some participants, especially those who were not using drugs, could retreat to their rooms and avoid much of this. However, for those who were using they had to leave their rooms to obtain and use illicit substances because of hospital regulations. As we discuss next, outside of the hospital they were exposed to various dangers.

Hospital regulations and risk

Casey House Hospital is subject to the Ontario Public Hospitals Act (Government of Ontario, R.S.O., 1990, Chapter P.40) and despite its harm reduction policy cannot permit smoking of tobacco, marijuana or other substances within the house. Unlike managed alcohol programs or supervised consumption facilities, clients wishing to consume substances that were not prescribed to them and/or to smoke any substance, including those prescribed (e.g., medical marijuana) were required to do so off site. While a hospital admission may have reduced the harms from untreated medical problems, for active drug using clients, an inpatient stay, interrupted drug use practices and created new spaces for danger for those previously unaccustomed to using outdoors. However, for those who had previously used drugs outdoors, the hospital admission did not alter this pattern, and reproduced outdoor drug using risks. This participant reflected on the difficulties of using when he was not feeling well and a time before regulations governing indoor tobacco smoking came into force:

> To use your marijuana... you have to go outside. That's the challenge... If I'm really nauseous in the middle of the night... there's no where I can go in the house... although, I was here at a time when there was a smoke room downstairs.

This excerpt reflects the informal acceptance of marijuana smoking before tobacco control regulations led to the prohibition of indoor tobacco smoking, the closure of indoor smoking rooms and forced all smokers outdoors. These next participants offered descriptions of becoming targets of harassment, exploitation, and violence. Also, these descriptions and the photo in Fig. 1 highlighted the production of hierarchies of users with some perhaps more entitled to use in safe places than others:

> Like I'd be sitting on the bench, people are coming in to buy crack next door, or here even... they look at you a little different right? You'd be the prey.
>
> ***
>
> And behind here is the building right here, where everybody goes and they're all screwed up on crystal and crack and everything in there too. So, it's a very shifty place to be sitting with these people behind you at night, when you're smoking a joint.
>
> ***
>
> Because there was a guy in the wheelchair smoking crack out front all the time, and people were taking his money to go get it and they wouldn't come back. So they were robbing him. They'd come by here to rob 'the idiot' in the chair. Right? Poor guy, he could have got hurt at one of those times... but it is kind of dangerous if you're sick and you can't defend yourself.

Our results have been bracketed with a discussion of Casey House Hospital as a drug using space at the beginning and as a non-drug using space at the end, with different relationships to place throughout. In our discussion we try to make sense of this duality and the opportunities and challenges that emerge within this shifting context.

Discussion

Important critiques have been levied against harm reduction claiming that while it is certainly preferable to current drug policies, it nevertheless promotes techniques for governing drug users (P. Miller, 2001). We appreciate that harm reduction interventions, can and do, serve to discipline drug users and make them more docile and governable (Bourgois, 2000). However, at Casey House Hospital the power exerted through such programming and interventions was regularly challenged to produce a constant negotiation and boundary pushing between clients, and between clients and clinicians and staff. Our analyses surfaced how the implementation of harm reduction is shaped by space and contested understanding of place and health. In particular, the organisation of space, bodies and practices creates and recreates both safer and more dangerous places to be ill for people who use and do not use drugs. At Casey House Hospital this resulted in particular ways of being for drug 'users/non-user' (with related codes and practices), and the demarcation of space in and around the facility. These constraints posed barriers to effectively addressing the needs of drug-users and caused tension between users and non-users who are temporarily housed together to receive medical care.

While investigation and exploration of harm reduction in hospitals is generally lacking within the literature, the few examples that do exist tend not to consider the struggles over space within these settings. At Casey House Hospital the introduction of a harm reduction policy brought drug use to the forefront and enabled more open discussions of drug use and reduced the shame experienced by some clients. However, the introduction of the policy combined with the proximity of diverse patients within this small setting led to interpersonal conflict between supposed users and non-users, which for some made it an inhospitable environment. While we agree with Lianping and Kerr (2013) that hospitals have a role to play in harm reduction, including through the integration of safe consumption rooms, there needs to be a broader discussion about what to do beyond preventing drug users from leaving against medical advice. Setting up a formal consumption site, or even allowing the informal use of a bench behind a building, has broader effects when people who use drugs have extended hospital stays. Our analyses highlight what can transpire when people who use drugs are encouraged to stay but their use brings them into conflict with other clients. Specifically, we observed the ways in which space and place are not neutral but become highly politicised and contested within a hospital setting where 'people should be getting better.' Despite organisational support for the harm reduction policy, clients, including current and former users, took issue with the encroachment of other 'disruptive' and openly using clients in the facility. This created a situation in which marginalised individuals started engaging in a dual process of governing themselves and others. This entailed demarcating certain spaces as safe and unsafe, certain people as users or non-users, and modifying their behaviour, including drug use patterns, to fit within the new culture or to resist it.

A limitation of our study is the lack of perspectives from users who were more actively drug using–the clients who leave their beds empty for days at a time, who disrupt a movie night by changing the channels, and who wander into other people's rooms in the middle of the night. These clients were not easily recruited but we would have liked to know more about their experience of re-entering the space after having to leave to use. How would they describe their interpersonal encounters and the way hospital regulations shape their substance using practices? Within the narratives of mostly self-described 'non-users,' we heard how hospital regulations limited spaces where drugs can be consumed and forced *other* clients to use in adjacent communal, outdoor spaces. This put some clients at personal risk and even exposed the organisation to unwelcome attention within the area it is located. Casey House Hospital represents a micro-risk environment comprised of physical, social, economic, and policy related risks for drug users (Rhodes, 2009). This does not mean that harm reduction is not appropriate for hospital settings, but that introducing it within existing environments may produce new risks and exasperate existing ones. Thus harm reduction in a hospital setting represents both an important

addition to a holistic modality of care and a set of related "dangers" to those within it. Hospital regulations are not absolute or immutable as we see in other settings where consumption of substances is managed or supervised with prescriptions drugs and/or exemptions from criminal codes are acquired. Ultimately, with enough organisational, clinician, and client commitment, the benefits may outweigh the challenges.

Further recognising the limitations of our small sample we are reluctant to offer broad policy and practice recommendations based on our study. However, following the findings of our study, Casey House Hospital is committed to develop policy and improving practice in the following ways. First, in response to fear and adverse events perceived or related to the interaction of substance users and non-users it may be beneficial for Casey House Hospital to revisit their client 'code of conduct' and the process for dealing with clients who do not adhere to the code. This will need to be complemented with training and support for staff and clients so individuals feel safe and supported in the enforcement of the code and its consequences. Second, acknowledging the new risks that may be introduced when clients go off-site to use substances, Casey House Hospital will explore interventions and opportunities for providing clients with additional safety precautions for using off-site. This will require Casey House Hospital to examine factors that influence substance use (i.e., availability, social contexts, money) within the hospital environment. For the Casey House Hospital, developing the harm reduction policy was an important first step to addressing the realities of clients' substance use needs, but implementation will require further, and ongoing, consultation with various stakeholders (e.g., clients, clinicians, and staff) and continuous reflection in practice. The lessons shared here are meant to encourage other hospitals to do the same.

We would be remiss to prescribe a course of action for the diversity of hospital contexts, each with their own relational and spatial milieu, but we would like to end by reflecting on where this initial project has led us and future research directions. First, we have become interested in further examining the idea of the "conscientious" drug user and related practices. Drawing on Foucault's (2007a) interest in how subjects come to govern themselves, we see that at Casey House Hospital that space and one's relationship to their health invited users and non-users alike to cultivate their sense of self in relation to whether they could maintain the veil of order. Duff (2004) has argued there is room for "a more Foucauldian 'use of pleasure' in the consumption of illicit substances across a range of diverse settings" and the potential for promoting moderation and self-restraint within programming. We do not mean to suggest promoting moralising cultures about drug use, but that in a shared setting there may need to be discussions about how to manage one's substance use to maintain a shared sense of community and safety. Indeed, drug users who ascribe to a harm reduction philosophy may still promote certain forms of self-control and the privileging of some substances over others (Gowan, Whetstone, & Andic, 2012). This should not be taken as an inherent threat to current community-based harm reduction programming, but represents a set of trade-offs that may be necessary for making harm reduction transferable to a setting like a hospital where different substances are being used, with different effects on the group culture and sense of cohesion. Here some compromise will be necessary for space to retain a sense of place and meaning for all those who enter it. Returning to Duff's (2012) invitation to think about context as fluid, we intend to further pursue the tension between space and place at Casey House Hospital in relation to other drug using contexts–the surrounding neighbourhood and others in proximity (each with their own substance consumption patterns), other care and social service settings accessed by clients, and clients' homes–and how these influence each other and overlap.

Second, we have identified a gap in the existing clinical and public health literature examining the ethical dimensions of caring for people who use substances. Currently, the clinical ethics literature identifies a tension between the requirements of hospital service user welfare and their autonomy (Dostal & Schmidt, 2007). Physicians are bound to the ethical principles of "nonmaleficence (do no harm to the patient), beneficence (do all one can to help the patient), and fiduciary duty (place the patient's needs above all other considerations)" (Dostal & Schmidt, 2007, p. 9). However, these requirements can become secondary when there is concern about substance use and 'drug seeking' or when substance use interferes with the ability to receive and provide care due to unruly and disruptive behaviour. This literature has not adequately considered how substance use, and related techniques for managing use, can be integrated into care. While one might expect answers in the harm reduction literature, the traditional framing of harm reduction as a "value neutral" practice has limited such discussions (Erickson, Riley, Cheung, & O'Hare, 1997). Fry, Treloar, and Maher (2005) have argued that the lack of an explicit moral framework in harm reduction has privileged technical skills and knowledge over discussions about the ability of practitioners to respond to the ethical challenges they encounter in their work. Specifically, that "researchers, practitioners and policy makers in the harm reduction field frequently have ethical concerns, but there is a general lack of ethics knowledge, training opportunities and resources, and formal opportunities for dialogue on these concerns to inform ethical decision-making" (Fry et al., 2005, p. 453). Further lessons may be gained from relational approaches which have been advanced in clinical and public health ethics (Baylis, Kenny, & Sherwin, 2008; Sherwin, 2000). Within the relational framework dialogue, interaction, and reciprocity is privileged over principles or simple decision-making frameworks that reduce the complexity care to a checklist of factors. However, while we appreciate the importance of thinking relationally, we remain mindful that relationships are sites where power is exercised and serve to govern both clients and care providers. In Foucault's (1994) terms ethics is socially and historically mediated and links the subject to various forms of governmentality and the government of self and others. We call for future research to position different conceptions of ethics at the forefront of understanding the collisions between people, drug use, spaces and places we have described above. Moving forward, harm reduction practice and research needs to consider more than just interactions between drug users and healthcare providers, or the role of administrative policies. Future research needs to better account for the full complement of spatial and relational factors that shape the contexts in which drugs are used, prohibited, and enabled, and the impact on users/non-users and care providers. These findings then need to be further examined in relation to other systems and strategies that produce risk environments.

Conflict of interest statement

None of the authors have a conflict of interest to report.

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