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Int J Drug Policy. Author manuscript; available in PMC 2016 July 01.

Published in final edited form as:

Int J Drug Policy. 2015 July ; 26(7): 645–652. doi:10.1016/j.drugpo.2015.01.015.

"WE NEED SOMEWHERE TO SMOKE CRACK": AN ETHNOGRAPHIC STUDY OF AN UNSANCTIONED SAFER SMOKING ROOM IN VANCOUVER, CANADA

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Abstract

Introduction—Many cities around the globe have experienced substantial increases in crack cocaine use. Public health programmes have begun to address crack smoking, primarily through the distribution of safer crack use equipment, but their impacts have been limited. More comprehensive safer environmental interventions, specifically safer smoking rooms (SSR), have been implemented only in select European cities. However, none have been subjected to rigorous evaluation. This ethnographic study was undertaken at an 'unsanctioned' SSR operated by a drug user-led organization in Vancouver, Canada, to explore how this intervention shaped crack smoking practices, public crack smoking, and related harms.

Methods—Ethnographic fieldwork was undertaken at this SSR from September to December 2011, and included approximately 50 hours of ethnographic observation and 23 in-depth interviews with people who smoke crack. Data were analyzed by drawing on the 'Risk Environment' framework and concepts of 'symbolic', 'everyday', and 'structural' violence.

Findings—Our findings illustrate how a high demand for SSRs was driven by the need to minimize exposure to policing (structural violence), drug scene violence (everyday violence), and stigma (symbolic violence) that characterized unregulated drug use settings (e.g., public spaces). Although resource scarcity and social norms operating within the local drug scene (e.g., gendered power relations) perpetuated crack pipe-sharing within unregulated drug use settings, the SSR fostered harm reduction practices by reshaping the social-structural context of crack smoking and reduced the potential for health harms.

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Conflict of Interest Statement

The authors report no conflicts of interest.

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Conclusion—Given the significant potential of SSRs in reducing health and social harms, there is an urgent need to scale up these interventions. Integrating SSRs into public health systems, and supplementing these interventions with health and social supports, has potential to improve the health and safety of crack-smoking populations.

Keywords

crack cocaine; harm reduction; safer smoking rooms; drug use; qualitative

INTRODUCTION

Over the past two decades, a significant increase in crack cocaine smoking has occurred in many regions around the globe (Fischer & Coghlan, 2007). People who smoke crack experience disproportionately high levels of morbidity, such as chronic and infectious diseases, physical health problems, and mental health challenges (Falck, Wang, Siegal, & Carlson, 2004; Fischer & Coghlan, 2007), even in comparison to other drug-using populations (Fischer et al., 2006). Crack smoking is independently associated with HIV and hepatitis C (HCV) infection (DeBeck et al., 2009; Roy et al., 2001), and the incidence of HIV and HCV among crack-smoking populations has been documented to be as high as 7.5% and 35.3%, respectively (Kral, Bluthenthal, Booth, & Watters, 1998; Scheinmann et al., 2007). Crack-smoking populations are also severely socially marginalized, and disproportionately impacted by intersecting social inequities that function to increase their exposure to violence and compromise their health (Bungay, Johnson, Varcoe, & Boyd, 2010; Fischer & Coghlan, 2007).

Previous epidemiological studies have been particularly concerned with the identification of risk behaviours linked to adverse health outcomes among crack-smoking populations. These have demonstrated that sexual risk behaviours, such as sex-for-crack exchanges, commonly occurring in crack-smoking settings contribute to the transmission of HIV and other sexually transmitted infections (Edlin et al., 1994; Ross et al., 2002). More recently, this research has sought to identify health consequences of crack pipe-sharing, positing that this behaviour may serve as a vector for infectious disease transmission among the 47% to 80% of people who routinely share pipes (Fischer et al., 2010; Ti et al., 2011). However, while crack pipe-sharing has been linked to outbreaks of respiratory illnesses (e.g., pneumonia, tuberculosis) (Gardy et al., 2011, Boyd, Johnson, & Moffat, 2008), research has also demonstrated a plausible link to HCV transmission although the evidence is less robust (Fischer et al., 2008).

There is growing acknowledgement that these risk behaviours, along with the broader harms experienced by crack-smoking populations, are produced by interactions among social, structural, and physical-environmental factors (Rhodes et al., 2005). The physical and social contexts in which these environmental factors converge to shape drug-related harms have been termed ‘risk environments’ (Rhodes et al., 2005). Viewed from this perspective, the risks and harms experienced by people who smoke crack are the product of environmental factors, which are further framed by intersecting forms of social violence operating at the ‘structural’, ‘everyday’, and ‘symbolic’ levels. These forms of violence constitute a

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continuum that illuminates how social structures, practices and norms perpetuate the suffering of particular populations (Scheper-Hughes & Bourgois, 2004), and are of particular relevance in the context of drug-using populations (Bourgois, 2009).

Symbolic violence refers to the tendency among vulnerable populations to misrecognize their suffering as 'natural' and blame themselves for adverse outcomes (Bourdieu & Wacquant, 1992). Powerful cultural stereotypes of '*crack addicts*' that construct crack smoking as deviant lead people who smoke crack to view the harms they experience as justifiable 'punishment' (Bourgois, 1996). Everyday violence refers to the normalization of violence and suffering in any particular context due to its pervasiveness (Scheper-Hughes, 1992), and unfolds in distinctly gendered patterns (Bourgois, Prince, & Moss, 2004). Physical violence is common in crack-smoking risk environments, and often driven by gendered power dynamics (i.e., social-environmental forces) that render women particularly vulnerable to forced crack pipe-sharing and physical or sexual assault (Bungay et al., 2010). Finally, structural violence refers to the harm inflicted upon particular populations by socio-political arrangements within society (Farmer, 2003), and is embedded within the poverty experienced by crack-smoking populations and policies undermining their access to crack pipes (Ti et al., 2011) and regulated crack smoking settings (Shannon et al., 2006), which perpetuate pipe-sharing and public crack smoking.

Despite the considerable and diverse harms experienced by people who smoke crack, crack smoking has been characterized as a neglected public health problem (Fischer & Coghlan, 2007). The public health response to crack smoking has been impeded by an emphasis on drug law enforcement. This has reinforced the barriers that crack-smoking populations encounter to accessing health services, and served to further undermine their health, safety, and opportunities to enact risk reduction (Bungay et al., 2010). Meanwhile, although localized harm reduction interventions targeting people who smoke crack have been implemented in some settings (Haydon & Fischer, 2005), these interventions have prioritized addressing risk behaviours serving as potential vectors for infectious disease transmission (e.g., crack pipe-sharing) rather than the wider range of environmental factors that drive risk and harm among crack-smoking populations. For instance, public health programmes in various settings have sought to discourage pipe-sharing by distributing safer crack use kits (SCUK), which typically include crack smoking equipment such as Pyrex® stems, mouthpieces, and brass screens (Strike et al., 2011). While these programmes have produced modest reductions in crack pipe-sharing (Leonard et al., 2008), as many as half of people who smoke crack in these settings continue to share pipes (Malchy, Bungay, Johnson, & Buxton, 2011; Ti et al., 2011). This may be in part explained by the difficulty of these interventions in addressing social-environmental factors operating within crack smoking settings (e.g., gendered power dynamics) that perpetuate crack pipe-sharing (Bungay et al., 2010), while increasing exposure to other harms (e.g., violence).

The limitations of these programmes point to the need to scale up safer environmental interventions for crack-smoking populations – that is, interventions that reshape the settings in which drug use occurs to promote risk reduction and safety, broadly considered to encompass exposure to social violence (McNeil & Small, 2014). Safer smoking rooms (SSR) are one type of safer environmental intervention with the potential to minimize the

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diverse harms associated with crack smoking (DeBeck et al., 2011; Duff et al., 2013; Shannon et al., 2006). These interventions are modeled on supervised injection facilities, in which people are permitted to inject pre-obtained drugs in accordance with harm reduction practices and under medical or, in some cases, peer supervision. Similarly, SSRs are regulated environments where people can access safer smoking supplies and, sometimes other services (e.g., healthcare and drug treatment), and smoke pre-obtained drugs. To date, SSRs in several European settings (e.g., Germany, the Netherlands) have been integrated within existing supervised drug consumption facilities, but these are unevenly distributed and have limited capacity in comparison to supervised injection services (Hunt, 2006).

In contrast to the considerable evidence outlining the success of supervised injection services in mitigating the health risks and social harms (Marshall et al., 2011; Wood, Tyndall, Montaner, & Kerr, 2006), SSRs have not been the subject of rigorous evaluation. Several studies have briefly examined inhalation drug use (typically heroin smoking) simply noting its prevalence within SSRs (Hedrich, 2004; Schatz & Nougier, 2012; Zurhold, Degkwitz, Verthein, & Hassen, 2003) or noted challenges that “difficult” or “aggressive” crack-smoking populations pose the operation of these facilities (Zurhold et al., 2003). While this research has suggested the need to align the operating procedures of SSRs with the needs of people who smoke crack, the latter studies risk characterizing crack-smoking populations as ‘high-risk’ or ‘irrational’, and thereby reinforcing social perceptions that foster symbolic violence. Meanwhile, there remains an urgent need for research that more closely examines how SSRs re-shape risk and harm among crack-smoking populations, including engagement in pipe-sharing and public crack smoking, as well as exposure to social violence, to understand their functions and inform the optimization and scale-up of these interventions.

Vancouver, Canada has experienced a dramatic increase in crack smoking since the 1990s (Werb et al., 2010), concentrated in the ten-block area that comprises the Downtown Eastside neighbourhood. An estimated 27% of the neighbourhood’s drug-using population smoked crack daily in 2011 (Urban Health Research Initiative, 2013), and approximately half of the crack-smoking population has reported sharing crack pipes (Ti et al., 2011). Although a sanctioned supervised injection facility (Insite) operates in the Downtown Eastside, efforts to expand services to accommodate crack smoking have been repeatedly blocked by the federal government (n.b., a legal exemption is required to provide supervised drug consumption services). This is despite feasibility studies highlighting the potential of SSRs to produce reductions in pipe-sharing and public crack smoking, particularly among those who lack access to private spaces in which to smoke crack (Collins et al., 2005; DeBeck et al., 2011; Shannon et al., 2006).

In January 2011, the Vancouver Area Network of Drug Users (VANDU), a democratic drug user-led organization comprised of more than 1000 current and former drug users, began operating a peer-run safer smoking room (SSR) in connection with the opening of an ‘unsanctioned’ supervised injection room within their facility in the Downtown Eastside (see McNeil et al., 2014a). VANDU has a longstanding history of engaging in advocacy and activism to promote social justice, and has been instrumental in driving the scale up of harm reduction programming in Vancouver (Kerr et al., 2006). The organization currently

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operates within a storefront location in the Downtown Eastside that serves as a drop-in for people who use drugs, and is an authorized harm reduction supply distribution site of the British Columbia Centres for Disease Control. Its supervised injection room was opened to increase responsiveness to the needs of its members, who are sometimes unable to access Insite due to operating procedures imposed on this facility by the federal government (e.g., prohibitions of assisted injections) (McNeil et al., 2014a), and perceptions of safety in the area immediately surrounding Insite (McNeil et al., 2014b). VANDU revised its harm reduction policy at that time to accommodate crack smoking and adapted a small washroom within its facility equipped with a ventilation system into a provisional SSR (n.b., while permitted, other drugs were rarely smoked within the facility).

This provisional SSR operated in accordance with harm reduction policy set out by the Board of Directors until its closure in December 2013 and, to the best of our knowledge, represented the only SSR in operation outside of Europe. We undertook this ethnographic study to explore how the SSR impacted crack smoking practices and exposure to harm (including social violence). We were also interested in how social violence within the local drug scene shaped crack smoking practices and related harms. Finally, we sought to identify limitations of the current SSR to generate insight into how they could be overcome to further promote risk reduction and safety.

METHODS

We conducted ethnographic fieldwork at VANDU from September to December 2011 as part of a larger study of the unsanctioned supervised drug consumption services operated by the organization (McNeil et al., 2014). We met with VANDU's Board of Directors prior to commencing this study to discuss the study parameters, and obtain permission to access the facility for research purposes. We obtained ethics approval from the research ethics boards of Providence Healthcare/University of British Columbia.

We undertook more than fifty hours of participant-observation across twenty days, as well as formal and informal interviews with people accessing this facility. Observational sessions were conducted by the lead author on varying days and times in recognition that community drug use patterns vary over the course of each month (Riddell & Riddell, 2006). Verbal consent was obtained from the peer volunteer responsible for overseeing the facility prior to commencing observation sessions, and also obtained from those using the facility while conducting fieldwork. Observation sessions were primarily conducted in the lobby and front desk area and lasted two to three hours. These areas provided a vantage point from which to observe the room's operations. However, direct observation of crack smoking practices within the SSR was not possible because the small size of the room meant that one person could only occupy it at a time. Informal interviews were conducted during observation sessions, with verbal consent obtained using an approved protocol. Brief notes were recorded during observation sessions and elaborated afterward.

Semi-structured interviews with twenty-three people who smoke crack were conducted by two research team members (McNeil and Small). Interview participants were initially recruited through referral by VANDU staff (n=7) and the lead author recruited the remaining

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participants (n=16) during observational sessions. We oversampled women relative to their representation among VANDU's membership to explore gendered dimensions of drug use. Interviews were conducted in private offices at VANDU or a nearby research office. Participants provided written informed consent prior to these interviews and received an honorarium ($20 CAD). An interview topic guide was used to facilitate discussion of environmental influences on crack smoking practices and related harms within and outside of the SSR, including social norms surrounding crack use, drug scene violence, and street policing. Furthermore, additional lines of inquiry explored during the interviews were informed by the observational fieldwork, which helped to facilitate discussion regarding the operational context of the SSR. Interviews were recorded and lasted approximately 45 minutes. Interviews were transcribed verbatim by research assistants and checked for accuracy by the lead author.

Our analysis focused on how the SSR shaped crack smoking practices and related harms. We began to analyze our data during the early stages of fieldwork, meeting regularly to discuss emerging themes. A preliminary coding framework was developed based on these discussions. Data were imported into NVivo qualitative analysis software (v. 9) to facilitate data management, and coded using an inductive and iterative process. We met regularly to revise our coding framework until the final thematic categories were established. We drew upon the "Risk Environment" framework and concepts of social violence when interpreting our findings. Finally, we presented our findings to VANDU's Board of Directors to enhance the study's interpretive validity.

RESULTS

Sample characteristics

The 23 individuals participating in semi-structured interviews included 11 women and 12 men. The median age was 40 years of age (range 27–59 years old) and 35% of participants self-identified as members of a visible minority (Aboriginal, African-Canadian, or Indo-Canadian). Participants generated income through social assistance (n=22), paid volunteer work at VANDU and other organizations (n=8), and sex work (n=8). Demographics were not collected on individuals observed or informally interviewed.

The social violence of public crack smoking

Our findings illustrate how homelessness and poverty restricted access to private or safe spaces in which participants could smoke crack. Although participants expressed a preference for smoking crack "*at home*", most were homeless or marginally housed and had "*no choice*" but to smoke crack in public spaces (e.g., alleyways). For example:

> *I never used to smoke outside ever. I've sort of just been forced into this situation… It's not my choice that I want to be downtown living like this* [i.e., in an emergency shelter]. *I have no other alternative…I'm kind of just stuck down here* [i.e., Downtown Eastside]. [Participant #6, White Female]

Furthermore, many participants expressed frustration that SSRs had not been integrated into the public health system. Many participants emphasized how this lack of supports left them

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without access to regulated drug use settings, leading them to smoke crack in public spaces. As one participant noted:

> *We've got nowhere else to do it. The ones who are homeless, where else can we go? I mean, Insite doesn't let us smoke crack there. We want to do a hoot* [i.e., smoke crack] *there's nowhere to go. We need somewhere to smoke crack too.* [Participant #20, White Female]

Most participants usually tried to conceal their drug use (e.g., hiding in alleyways) to minimize their exposure to the social violence that characterized public crack smoking. First, many participants articulated how people who smoke crack are highly stigmatized and characterized as "*no good junkies*", noting that, "*if they* [i.e., non-drug users] *see you doing that* [i.e., smoking crack], *they immediately look down at you*" [Participant #21, Aboriginal Female]. Some participants internalized this stigma in describing how they were '*irresponsible*' for smoking crack in public despite lacking access to alternate drug use settings. In turn, they sought to conceal their drug use to "*be responsible*" and thereby increased their exposure to other forms of violence. Second, public crack smoking increased their exposure to drug scene violence. Most participants had experienced physical violence from other drug users seeking to "*rob them*" when smoking crack in public. Although participants were often compelled to smoke crack in isolated or poorly-lit public spaces (e.g., alleyways) that they viewed as "*dangerous*", they used the aforementioned strategies to hide their crack smoking, and minimize the likelihood of violent confrontations and the loss of resources. Finally, while no participants had been arrested for public crack smoking, some reported that police had required them to "*throw away*" their drugs and destroy their pipes under the threat of arrest. Given that participants had limited access to resources to replace their drugs, they sought to conceal their crack use to avoid encounters with police.

The social production of crack pipe-sharing

Participants articulated how pipe-sharing was common within the drug scene, and produced by social norms shaped by gender inequities and material deprivation. While participants were able to access crack pipes through VANDU and other organizations, many still reported borrowing or loaning pipes. The reasons for pipe-sharing were threefold. First, many people did not routinely carry crack pipes, particularly those who purchased crack opportunistically (e.g., immediately after generating income). These individuals sought to smoke crack without delay, which limited their access to crack pipes through harm reduction programmes. Some participants loaned their crack pipes to these individuals in exchange for money, drugs or to "*build a push*" (i.e., accumulate crack residue in their pipe that could be later smoked) thereby ensuring access to crack despite limited resources. For example:

> *I've shared my pipes. It's a good thing to do. Just sit around a drug dealer and wait for people to buy crack and ask, "Can I use your pipe?" You can build a quite a good push in your pipe from people using your pipe.* [Participant #10, White Male]

Second, many participants emphasized the social benefits associated with pipe-sharing. Some participants indicated that pipe-sharing strengthened relationships among drug users in settings where collective crack smoking took place by alleviating their social anxiety. In this regard, participants reported that pipe-sharing functioned to promote social cohesion

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and minimize group tensions among people who smoke crack by structuring their interactions. As one participant noted, "*What's the difference between ten people all sharing one pipe and passing around than having their own pipe? Sharing actually stops a lot of stress in people*" [Participant #22, Aboriginal Female]. Finally, some women articulated how pipe-sharing was framed by everyday violence in emphasizing how they were "*forced*" to share drugs and crack pipes by men threatening them with violence in unregulated drug use settings. Among our participants, the consequences of gender-based violence were severe, with multiple women arriving at VANDU seeking support after having been physically assaulted when smoking crack in nearby alleyways.

Practical solution to operational and public health challenges

VANDU opened the SSR to respond to the high demand for a "*safe place*" to smoke crack and challenges that the organization experienced in managing crack smoking within its facility. While people frequently sought to smoke crack at VANDU prior to the opening of the SSR, crack smoking was not permitted. Most people tried to avoid detection by smoking crack in the washroom and, in the words of one participant, "*were always using in the bathroom and were tying up the bathroom*" [Participant #13, White Woman]. This sometimes led to verbal altercations between those smoking crack and peer volunteers, which were disruptive to the organization's operations. Furthermore, participants expressed that those smoking crack in the washroom were less willing to request crack pipes from peer volunteers so as to not draw attention to themselves, thereby increasing their likelihood of pipe-sharing.

Concerns regarding disruptions and adverse health outcomes stemming from rules prohibiting crack smoking in VANDU prompted the Board of Directors, which is comprised of and elected by current or former drug users, to move to accommodate crack smoking in the washroom following the decision to open the supervised injection room. During this period, the Board of Directors outlined operating procedures for the SSR in accordance with harm reduction principles. Specifically, only one person at a time was permitted to access the SSR for a period lasting up to five minutes. Crack pipe-sharing was prohibited within the facility and peer volunteers distributed crack smoking equipment at the front desk that was adjacent to and served as the entry point to the SSR.

Participants viewed the accommodation of crack smoking within VANDU as a 'practical solution' to an organizational challenge resulting from the lack of environmental supports for crack-smoking populations and social violence of public crack smoking. Furthermore, many participants emphasized how the policy change represented the formalization of practices that were already taking place within the facility (i.e., crack smoking) to foster an enabling environment for risk reduction. As one participant explained:

> *We can't say what people are gonna do in the bathroom so obviously it's been going on since the place has been around but it hasn't been that long that it's actually been allowed… There is actually ventilation in the bathroom so they decided to allow it in the bathroom because they can't stop it.* [Participant #5, White Male]

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However, most acknowledged that this provisional SSR was an incomplete solution because it was not specifically designed for this purpose (i.e., small washroom equipped with a fan), and thus had limited operational capacity and did not include other services (e.g., health care staff, support services, and referrals). In turn, participants articulated how these limitations lessened the impact of the intervention, and emphasized the need for further SSRs in the neighbourhood. For example:

> *We don't have the money to run it like the way we would like to. We're letting you use the bathroom and saying you can smoke. We're not really providing an inhalation room because, well, it has a fan but it's not* [a SSR]. [Participant #23, White Female]

Balancing demand and access

Peer volunteers balanced the need to manage demand for the SSR against the need to provide access to a low threshold setting where people could enact harm reduction. Most days, people began arriving at VANDU when the facility opened at ten o'clock in the morning (four o'clock in the afternoon on weekends), and demand for the SSR remained steady until the facility closed at eight o'clock at night. Someone wanting to access the SSR would approach the peer volunteer stationed at the front desk to be added to the queue (n.b., no physical waitlists were kept in order to protect privacy and confidentiality) and their name would be called out once the room was available. It was common for four or more people to be waiting to access the SSR with wait times between fifteen and thirty minutes. Demand was greatest in the days surrounding the monthly disbursement of social assistance payments, when people were more likely to undertake "*crack binges*" (i.e., short-term periods of intensive crack smoking). During these periods, many people visited VANDU for the first time and wait times lengthened, sometimes leading people to leave the facility in pursuit of alternate, often public, crack smoking settings.

Those accessing this facility were expected to follow the five-minute time limit, which the Board of Directors and peer volunteers determined was a sufficient amount of time to consume crack. The time limit served as the primary mechanism used by peer volunteers to regulate the SSR, and ensure as many people as possible were able to access it. Peer volunteers communicated the time limit to people before they entered the SSR, and reinforced the rule by knocking on the door when time expired. Peer volunteers also communicated that people were permitted to access the SSR multiple times per day and it was not unusual to observe people accessing the room multiple times during single observational sessions.

While most people respected the time limit, those who characterized the rule as "*unfair*" would sometimes "*push the time limits* [and] *take too long*" [Participant #20, White Female]. This typically occurred among people in the midst of crack binges or '*tweaking*' (i.e., experiencing drug-induced compulsive behaviours including obsessively emptying one's pockets or scratching one's body). Peer volunteers exercised discretion in enforcing the time limit, typically extending it by five to ten minutes, to provide support to these individuals while minimizing the potential for altercations. While this approach was generally successful in managing these situations, anyone routinely ignoring the time limit or verbally

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abusing peer volunteers would be temporarily banned from accessing the SSR until meeting with the organization's Board of Directors to review the rules. For example:

> *We normally say five minutes, but we do allow up to ten* [minutes]. *After that, "Come on! There's people waiting."* […] *There are some people that are ongoing problems…It's not barring them, but* [temporarily suspending them] *until they come to the board* [i.e., organization's Board of Directors]…*They have to present their case and then we'll see if we let them back in.* [Participant #14, Aboriginal Female]

However, peer volunteers exercised caution in temporarily suspending people and only one person received a temporary suspension during our fieldwork. In addition, the Board of Directors indicated that they gave out suspensions lasting more than a few days only in the most extreme circumstances, such as when an individual threatened peer volunteers with violence.

Escaping the social violence of public crack smoking

All participants reported that their decision to smoke crack in the SSR was motivated by the need to minimize their exposure to the social violence within unregulated crack smoking settings. Most participants viewed the SSR as a setting where they could experience a temporary reprieve from the structural (e.g., drug law enforcement) and everyday (e.g., drug scene violence) violence associated with public crack smoking. These participants viewed the SSR as '*safer*' than street-based drug use settings, with many emphasizing how the SSR alleviated the stress associated with the fear that they may be arrested or assaulted. For example:

> *It's a place where I can go in hiding for a minute, get my trip, come out of the bathroom, and sit back. I feel safe…I don't have to worry about getting on my hands and knees to see who's on the other side of the door or be on guard against the cops.* [Participant #17, African-Canadian Male]

Among participants who emphasized the stigma associated with public crack smoking the SSR was positioned as a 'legitimate' setting in which they could smoke crack without judgement. In explaining why he accessed VANDU, one participant explained, "*I find addiction to be very embarrassing and I don't like to flaunt it – just the stigma of being an addict…I don't want that impression going into anybody's head or kids to see me*" [Participant #15, White Male].

Peer volunteers also worked to minimize exposure to social violence by discouraging public crack smoking near VANDU. During observation sessions, peer volunteers were observed approaching people smoking crack outside, and encouraging them to access the SSR. While peer volunteers were partly motivated by the need to avoid drawing police attention to VANDU and this 'unsanctioned' intervention, they emphasized the importance of reducing the risk of arrest or violence among their peers. As one participant explained:

> *The guy was just standing right outside the door puffing away and I said, "Look buddy, as much for your own good as for ours, since they're* [the police are] *probably always watching us. You probably wouldn't want them* [to see you

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smoking crack in public], *you know, and not to mention you're drawing a lot of heat to us.* [Participant #5, White Male]

Disrupting social norms shaping crack pipe-sharing

The SSR disrupted social norms that shape pipe-sharing, thus promoting the adoption of risk reduction practices within this crack smoking setting. Whereas many participants expressed limited awareness of the potential health risks associated with pipe-sharing, the harm reduction policy was consistent with local public health priorities in prohibiting pipe-sharing within the SSR. In addition to providing a regulated crack smoking environment, the organization further promoted risk reduction practices through SCUK distribution at the front desk. Although the these kits were sold at the outset of our fieldwork due to the cost of the materials, peer volunteers did not deny access to these harm reduction supplies to those unable to pay ($2 CAD). In the final months of our fieldwork, the local health authority began to expand the distribution of SCUKs, which allowed peer volunteers to freely distribute harm reduction supplies to anyone accessing the SSR.

While most accepted that pipe-sharing was not permitted within VANDU, some people nonetheless tried to share their pipes. The harm reduction policy provided peer volunteers with a mechanism to disrupt pipe-sharing and educate their peers regarding the associated health risks. During observational sessions, some people sought to loan their pipes in exchange for money, drugs or to '*build a push*'. Their actions underscore how the immediate rewards of crack pipe-sharing (e.g., money, crack resin) conflicted with public health messages prioritizing 'hypersanitary' crack smoking practices that were promoted within the facility. Peer volunteers approached those offering to loan their crack pipe to prevent this from happening. While peer volunteers were successful in discouraging crack pipe-sharing within the facility, and used these opportunities to reinforce these public health messages, our data suggest that any impacts on crack pipe-sharing likely only occurred within the facility itself. Notably, many of the participants who reported voluntarily or involuntarily sharing crack pipes in unregulated settings were among the most frequent users of the SSR.

DISCUSSION

In summary, our findings underscore how the SSR emerged in response to social violence experienced by people who smoke crack in the local drug scene, and minimized the potential for health and social harms by reshaping the environmental contexts of crack smoking. Whereas pipe-sharing was common in unregulated crack smoking settings, and shaped by resource scarcity and social norms, the SSR disrupted these practices and enabled participants to enact risk reduction. Importantly, we found that the SSR enabled participants to minimize exposure to social violence that characterizes unregulated smoking settings, and thus was perceived as a "safe place".

To date, only limited attention has been paid to the mechanisms that produce public crack smoking. Consistent with research into public injecting (Rhodes et al., 2007; Small, Rhodes, Wood, & Kerr, 2007), we found that intersecting forms of social violence framed public crack smoking, and functioned to increase vulnerability to harm. Poverty and anti-drug laws (i.e., structural violence) constrained access to private and regulated smoking settings (e.g.,

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apartments), leading people to smoke crack in public spaces and thus rendering them vulnerable to drug scene violence (i.e., everyday violence) and stigma (i.e., symbolic violence). Our findings underscore how people who smoke crack in public settings enacted strategies to minimize their exposure to social violence, and yet suggest that these strategies (e.g., smoking crack in alleyways) may have functioned to increase their vulnerability.

Against this backdrop, it is perhaps unsurprising that participants were primarily motivated to access the SSR by the need to limit their exposure to the social violence associated with smoking crack in public and unregulated settings. Understanding the motivations of crack-smoking populations to access SSRs represents a critical step toward better aligning these interventions with their lived experience. While previous studies have characterized supervised injection facilities as "*refuges*" from structural and everyday violence (Fairbairn et al., 2008; McNeil & Small, 2014; McNeil et al., 2014a; Small, Ainsworth, Wood, & Kerr, 2010), our findings demonstrate how, as opposed to more conventional public health concerns (e.g., infectious disease transmission), safety from social violence was viewed as their most important function by people who smoke crack.

Whereas previous studies have underscored how those people who smoke crack who are homeless or have had recent police encounters will be most likely to access SSRs (Collins et al., 2005; DeBeck et al., 2011; Shannon et al., 2006), our findings underscore how this might be related to the perceived role of these interventions in limiting exposure to social violence among those without access to private space. To achieve this level of safety in the local context, there is an urgent need to scale up SSRs to meet the high demand and ensure that they are sufficiently high capacity to accommodate intensive crack smoking and peak periods (e.g., days surrounding 'cheque day'). Similarly, in other locales where people who smoke crack experience comparable levels of social violence (due to overlapping social, structural, and environmental inequities) SSRs may provide opportunities to improve the safety and well-being of crack-smoking populations.

It is noteworthy that our findings suggest that SSRs have significant potential to engage people who smoke crack who are particularly vulnerable to poor health (e.g., those who are homeless or involved in sex work). In this regard, these interventions have the potential to occupy a critical role in mediating access to resources necessary to improving the unmet health and social care needs of crack-smoking populations. For example, integrating medical care (e.g., healthcare and drug treatment) and social services (e.g., housing program referrals) into drug consumption facilities that include SSRs would possibly bring about additional public health improvements (DeBeck et al., 2011; Shannon et al., 2006). Complementing health and social care programming with a wider array of peer-based services (e.g., peer support, peer health navigation services) may further minimize barriers to SSRs stemming from 'client-provider' that enforce expectations out of sync with the lived experiences of people who use drugs (Moore, 2009).

Our findings build upon recent research exploring how pipe-sharing is structured by social norms and resource scarcity stemming from social and structural inequities (Bungay et al., 2010; Ivsins, Roth, Benoit, & Fischer, 2013). Importantly, consistent with previous research (Bourgois, Prince & Moss, 2005; Bungay et al., 2010), our findings illustrate how pipe-

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sharing within unregulated crack smoking settings was produced by gendered power relations that subordinate women, and thereby function to render them vulnerable to violence and disease transmission. Furthermore, our findings illustrate how pipe-sharing was often economically motivated, with people loaning their pipes in exchange for money, drugs, or "*build a push*". In an ethnographic study among heroin injectors in San Francisco, Bourgois (1998) found that 'moral economies' structured the sharing of syringes and injection-related paraphernalia. Despite awareness of the associated health risks, the mutual obligations formed by sharing 'tastes' of heroin (i.e., residue remaining in injection-related paraphernalia) enabled these men to gain access to the drug when lacking resources or coping with opiate withdrawal. The dynamics of pipe-sharing were distinct in several ways. Notably, whereas the situated risk perceptions of heroin injectors meant that syringe-sharing was rational despite the accompanying health risks due to the urgent need to manage opiate withdrawal (Bourgois, 1998), the lack of perceived health risks associated with pipe-sharing suggests that these risk calculations did not factor into decision-making. Furthermore, consistent with previous research (Ivsins et al., 2013), we found that, whereas heroin injectors expressed solidarity in assisting one another in managing opiate withdrawal (Bourgois, 1998), our participants exploited opportunities to loan their pipes to gain access to drugs without the expectation that they return the favour. Our findings thus illustrate how 'hypersanitary' public health messages (e.g., do not loan or borrow crack pipes) may not be aligned with the more immediate needs of people who smoke crack, and thereby have only negligible impacts on risk behaviours in most crack smoking settings (Bourgois, 1998; Bourgois, Prince, & Moss, 2005).

Nonetheless, our findings suggest that, while the risks associated with crack pipe-sharing had at best a negligible role in prompting crack-smoking populations to access the SSR, this intervention nonetheless promoted harm reduction despite the fact that people who smoke crack were not primarily concerned with health risks, by reshaping the social-structural environmental context of crack smoking. For example, whereas economic motivations and social norms perpetuated pipe-sharing within the local drug scene, the operating procedures of the safer smoking environment prohibited these practices. Among vulnerable people who smoke crack, such as women involved in street-based sex work, this enabled them to exert greater control over their crack smoking practices in this setting, although it is important to consider that pipe-sharing remained a defining feature of most local crack smoking settings. In turn, our findings suggest that, although SSRs should be pursued as an intervention to promote risk reduction, it is likely necessary to temper expectations regarding their impact on pipe-sharing within the broader context of drug scenes. Combination interventions will likely be needed to bring about more comprehensive reductions in these risk behaviours (e.g., safer crack use education campaigns, scaling up the distribution of crack pipes), and will likely need to be augmented by environmental supports aimed at minimizing everyday violence among women and other vulnerable people who smoke crack (e.g., women only spaces).

As a postscript to this study, despite evidence that VANDU's supervised drug consumption services reduced health and social harms associated with drug use (McNeil et al., 2014a), the organization ceased operations of these services (including the SSR) in December 2013 after

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receiving a cease and desist letter from its primary funder, the local health authority. Because the organization's services were not exempted under the federal Controlled Drugs & Substances Act and sanctioned by the local health authority, the organization was requested to immediately stop providing these services. The closure of VANDU's supervised drug consumption services illuminates the challenges posed in implementing evidence-based and peer-run harm reduction models within the context of drug criminalization and the medicalization of harm reduction. Peer-run supervised drug consumption services are not possible in many contexts due to legal and regulatory frameworks requiring that these services be situated within the health care system and operated by health care professionals. In Canada, while supervised drug consumption services currently require a legal exemption issued at the discretion of the federal Minister of Health, and the Federal Government has recently introduced legislation (expected to become law in 2015) which further raises the threshold for such exemptions by requiring, for example, police support (Zlotorzynska, Wood, Montaner & Kerr, 2013). This legislation is counter to the spirit of a Supreme Court of Canada ruling that such exemptions *should be granted* as necessary to protect the security of person of people who use drugs. In this regard, our findings underscore how peer-run supervised drug consumption services (including SSRs) are in line with this ruling and should be pursued to address the harms experienced by people who use drugs.

This study has several limitations that should be considered. First, our findings are specific to the study participants and are not representative of the wider crack-smoking population in the Downtown Eastside. Second, we were unable to directly observe participants while they smoked crack because the small size of the provisional SSR meant that only one person could occupy it at a time. We subsequently relied on self-report of crack smoking practices within the SSR, which was the best available method to explore crack smoking practices. Certainly, self-reported data regarding 'risk behaviours' has limitations, and further research involving direct observation of crack consumption would provide a more complete picture of crack smoking practices within SSRs. Finally, our research was undertaken in a neighbourhood that is distinct in many ways (e.g., comprehensive harm reduction services, history of drug user organizing) and might not be transferable to other settings. Notably, while local police have exercised a certain degree of discretion in drug law enforcement since the opening of supervised injection facility (DeBeck et al., 2008; Small et al., 2012), police in other jurisdictions might be more likely to enforce these laws.

In conclusion, our study demonstrates the significant potential of SSRs to attract highly vulnerable people who smoke crack and minimize their exposure to the social violence that characterizes public and unregulated crack smoking settings. Despite demonstrating modest potential to reduce crack pipe-sharing, the significant ability of SSRs to engage crack-smoking populations is likely to provide opportunities to address health and social inequities that perpetuate harm. In turn, integrating health and social care services into drug consumption facilities containing SSRs, and complementing these with additional supports and environmental interventions (e.g., scaling up crack pipe distribution, providing safer crack use education), will likely maximize their benefits and improve the health and well-being of crack-smoking populations.

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Acknowledgments

This paper is dedicated to the memory of Bud Osborn, VANDU co-founder, poet, and activist. The authors thank the study participants for their contribution to the research. This study was supported by the US National Institutes of Health (R01DA033147). Drs. Ryan McNeil and Will Small are supported by the Michael Smith Foundation for Health Research.

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Highlights

1. Explores operations and impacts of peer-run ‘unsanctioned’ safer smoking room (SSR)
2. Crack-smoking in unregulated drug use settings characterized by social violence
3. Demand for SSRs driven by the need to minimize exposure to social violence
4. SSRs demonstrate potential to address health & social harms of crack smoking