“Arrest Us or Consider Us Healthcare”: Towards Understanding the Counter-Conducts of Overdose Prevention Ottawa

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Abstract

North America has seen a dramatic increase in overdose deaths since 2016. Cities across Canada have responded to the growing opioid epidemic in a myriad of ways. Safe consumption sites have been one of these interventions, however the uptake of harm reduction services and safe injection sites has been inconsistent across regions leading to a patchwork of care. In the absence of access to sanctioned services, people who use drugs and grassroots activists have developed and administered a host of harm reduction services including unsanctioned injection sites. Ottawa, Ontario was host to one such unsanctioned site run by an organization known as Overdose Prevention Ottawa (OPO). This work provides a case study on OPO, examining their direct actions and rejections of medical practices. Through seven semi-structured interviews with OPO organizers and managers of sanctioned sites, this project aimed to interrogate the contestations of practices, knowledges, and logics which govern substance use and related care. The resulting analyses pertain to the contestations of practices from outside the site, as well as within, exploring relations visibility and invisibility of drug use and public consumption, positioning of medical and experiential expertise, and how protest actions engaged external onlookers. Care practices within the site highlight non-totalizing rejection of medical logics and practices, and articulated care on the fringes of medical regimes. This positioning is explored in a comparative analysis of sanctioned and unsanctioned replacement opioid programs. Ultimately these analyses provide insight into the counter-conducts of Overdose Prevention Ottawa, suggesting alternative practices and logics of care for people who use drugs.
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Dedication
This work is dedicated to the community, to chosen family, and the far too many friends lost along the way. Jenn, it is not lost on me that this project is completed almost exactly 12 years to the day – I promise I still smile when I see blue roses. The topics contained within this research are more than just activisms or politics, more than questions of medical knowledges and practices, more than intellectual musings. These are the lives of our friends. I wish to dedicate this work to those who no longer stand with us. I hope you know you are loved and will always be with us. May you find the quietness you have long deserved and sleep softly.
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Chapter 1: Introduction

The Opioid Crisis

Canada is in the midst of an overdose epidemic. Between January of 2016 and December of 2021, 29,502 persons have died of apparent opioid overdose deaths in Canada (Canada, 2022b). These numbers do not reflect the complete picture, as not all regions report overdose deaths (Canada, 2021b). The rate at which lives are lost is continually escalating (Canada, 2021a). Of these deaths, 7,560 were in 2021 alone – this is approximately 21 deaths per day (Canada, 2022b). 98% were deemed accidental (Canada, 2022b).

According to a report by the BC Coroners Service, the percentage of overdose deaths involving fentanyl rose from under 10% in 2012 to 83% in April of 2022 (British Columbia Coroners Service, 2022). In British Columbia, no overdose deaths have been reported to have occurred within sanctioned safer consumption sites (British Columbia Coroners Service, 2022). The provincial and municipal responses to these acute drug poisonings have been inconsistent and provided a patchwork of regionally specific solutions and interventions (Tyndall, 2018).

As part of these solutions, there has been an expansion of harm reduction interventions in Canada (Young, & Fairbairn, 2018). This has not been confined to state supported or regulated care. Critical here is that the history of harm reduction policy in many Western countries is characterized by clandestine care well in advance of similar governmental interventions (Kerr, et al., 2017; McLean, 2011; McNeil, et al., 2014). This pattern has been documented in the provision of unsanctioned supervised consumption (Kerr, et al., 2017; Foreman-Mackey, et al., 2019). The first and second safer consumption sites in Ontario were illegal – run out of Moss
Park in Toronto, and the other in Raphael Brunet Park in Ottawa (Crawford, 2018; Warnica, & Hauen, 2017). In Ottawa, these efforts were led by the grassroots organization Overdose Prevention Ottawa (OPO) (CBC, 2017).

Towards transparency, the author wishes to note a personal friendship with one of the Overdose Prevention Ottawa core organizers, and connections to others through extended interpersonal relationships. The author has participated in various harm reduction work in Ottawa, including working in sanctioned safer consumption sites.

Overdose Prevention Ottawa consisted of approximately 10 to 12 core organizers, and large number of volunteers. Responding from a place of grief and perceived immediacy of need, these individuals developed and administered an unsanctioned safer consumption site in a public park. This unsanctioned care site represented a substantial divergence from services available municipally and provincially at that time. The service consisted of a daily program offered out of borrowed tents, operating for approximately two and a half months, during which time two sanctioned injection sites were opened. A fuller history of OPO and their site is provided in the Histories of Overdose Prevention Ottawa chapter.

It is from this context that the current work takes shape. This work represents an exploration of counter-conducts from outside and within the site – the relations of (in)visibility and contestations observable from positions of exteriority, and the quiet de-medicalization and resistance to medical regimes present within OPO’s care practices. This work explores the counter-conduct as both a resistance to ongoing governmentalities and as medical dissent - exploring the creation of publics, scenes, and interplay of (in)visibilities of drug consumption and the articulation of care at the borders of medical regimes.
Borrowing key concepts from Foucauldian literature, this work positions Overdose prevention Ottawa as both a counter-conduct and a heterotopic site. Counter-conduct refers to a specific conceptualization of resistance, whereby shared practices, logics, knowledges, and subjectivities present within instances of resistance connect them to other resistances under a larger network of contestations (Foucault, 2007). This positions the resistances displayed within OPO’s site as connected to a wider breadth of sites, organizations, and instances of resistance through the similarities of their harm reduction practices, experiential knowledges, and distinct subjectivities (Foucault, 2007). This lens of analysis offers a nuanced understanding of resistance, where power and resistance are not oppositional and binary, but co-constitutive. Elements of the dominant governances are present within resistances, and practices of resistance are often re-articulated into dominant governances suggesting a model of non-linear change (Foucault, 2007). The current works integrate the concept of heterotopias as a territorialization of counter-conducts, providing a physical space of resistance (Foucault, 1986). These concepts are explored in greater depth within the Theoretical Frameworks chapter.

Situating Harm Reduction Practices

Towards contextualizing the current project, it is necessary to historicize harm reduction and situate these practices within networks of activisms and medical apparatuses. Fundamentally, harm reduction centers on the advocacy for and capacity of people who use drugs (PWUD) to access supportive care which intervenes on risks associated with substance use without moralization, medicalization, or criminalization (Solanki, 2019). It represents a departure from ideologies and practices endorsing the ideal of a drug-free society (Broring, & Schatz, 2008). Harm reduction has multiple definitions, for the purposes of this work it may be understood as both a social movement and a philosophy of care, with dispersed activists and
PWUD developing grassroots initiatives with similar practices and logics of care, and mobilizing under title of harm reduction (Solanki, 2019; Broring, & Schatz, 2008). Harm reduction is historically rooted in the activisms of the community of PWUD, at times integrating medically trained professionals (Kerr, n.d.). Over time some of these practices, and to varying degrees the logics, have been rearticulated by and integrated into medical apparatuses and sanctioned services administered through state agencies, non-profits, and charitable organizations (McLean, 201; Kerr, n.d.).

The origins of harm reduction are at times claimed to be rooted in the responses of public health apparatuses to HIV/AIDS epidemic in the 1980s (Des Jarlais, 2017; Riley, & O’Hare, 2000). However, this presents a limited understanding of the nature of harm reduction and its earlier emergence from community-based unsanctioned care. While it is true that needle exchanges arose, in part, due to the HIV/AIDS epidemic, these services were initially provided through illegal care practices by people who use(d) drugs. Further, the histories of harm reduction predate the advent of needle exchange programs and the purposes of harm reduction extend beyond the reduction in transmission of blood-borne disease and prevention of premature death (Blok, 2011).

The earliest record of peer-initiated community-based substance use services this researcher was able to uncover places harm reduction’s origins in the Netherlands in the 1960s (Blok, 2011). It seems likely that harm reduction practices predate this record. Drug user advocacy groups emerged in both Europe and Canada in the 1960s and 1970s. Such organizations presided over the administration of unsanctioned community-based health and social services (Kerr, Douglas, Peeace, Pierre, & Wood, 2001; Blok, 2011).
A clear articulation of the harm reduction model of care, prior to needle exchange programs, may be observed in a clandestine methadone clinic. In 1982, the Junkies Union of Rotterdam, with the assistance of a sympathetic doctor and pharmacist, obtained weekly allotments of methadone to disperse to the community of PWUD (Blok, 2011). The Junkies Union began running a clandestine methadone clinic with a distinct twist – the methadone was intended not as a maintenance or abstinence-oriented treatment, but as a free and immediate response to withdrawal symptoms. If an individual was experiencing withdrawal and did not have the financial means to immediately access their drug of choice, the unofficial clinic would offer methadone to temporarily alleviate the symptoms of withdrawal. Not only was there a physical location for this clinic, but an organizer would also carry an emergency supply on their person (Blok, 2011). Here, the outcome averted is not death, anoxic brain injury, or blood-borne infection – it is not an overt medical crisis but the alleviation of temporary symptoms of withdrawal. There is no intent to shift behaviours or cure an opioid use disorder, but simply to make the individual’s substance use related experience less unpleasant. This approach to care can be understood as caring for health while rearticulating medical practices administered by non-professionals based on experiential knowledges, and allows care needs to be determined by the individual consuming substances. It was health care at the fringes of medical regimes – a theme seemingly common to harm reduction and well observed within OPO’s opioid replacement program.

It is in this context and tradition that the emergence of needle exchange programs (NEPs) and the purported advent of harm reduction must be situated. Canada’s first sanctioned NEP opened its doors in Vancouver in 1989, shortly followed by Montreal and Toronto (CBC, 2004). Cities across the United States followed similar timelines (McLean, 2011). The positioning of
these timelines of medical and legal apparatuses altering their governances of substance use overlooks the practices’ clandestine histories. John Stuen-Parker, a medical school student with a history of heroin use, began dispersing needles directly to PWUD in 1983. Throughout the 1980s and 1990s he was arrested a total of 27 times across multiple states for this work (McLean, 2011). Clearly predating the sanctioned services, a member of the community of PWUD took direct actions to contest and resist ongoing governmentalities of use. These types of unsanctioned care are central to the histories of harm reduction.

Further, McLean elaborates that the adoption of sanctioned NEPs in the United States did rely in part of sympathetic partners embedded within medical apparatuses, but that this process risked “governmental appropriation” - the adoption of care provision by state apparatuses and rearticulation of practices of care in ways that do not reflect logics and practices of activism-based harm reduction and experiential knowledges (2011). Not all cases lead to a complete governmental appropriation, at times financial supports are provided to allow structures to transition from unsanctioned to sanctioned services. This collaborative transition can be observed in both the needle exchange program in Rotterdam in 1984 run by the Junkies Union and through the Moss Park safer consumption site in Toronto (Kerr, et al., 2017; Kerr, n.d.; Blok, 2011; Sheldon, 2018). Assistance from medical structures were provided to Overdose Prevention Ottawa as well, logistical support from Ottawa Public Health makes clear this type of sympathetic support, while the near immediate opening of the Ottawa Public Health safer consumption and treatment site suggest a governmental appropriation of practices. The Toronto Moss Park unsanctioned SIS was adopted by the municipality, supported, and eventually transitioned into a sanctioned service (Sheldon, 2018) this however was not the case for OPO.
Canada’s first sanctioned SIS, InSite, opened its doors in 2003. However, the unsanctioned histories of SIS in Canada can be traced to the alleyways of Vancouver well predating InSite - which itself walked a fine line between sanctioned and unsanctioned care (Harati, 2015). In 1995, a group of peers known as IV-Feed opened an unsanctioned site called Back Alley in Vancouver. This site was open for approximately one year before police services forced its closure (Kerr, et al., 2017). The road to InSite was marked with several more unsanctioned sites in Vancouver. Some of these unsanctioned spaces persisted afterwards, in attempts to address care needs unmet by sanctioned services (Kerr, et al., 2017; McNeil, et al., 2015; McNeil, et al., 2014). These programs and histories may be understood as the clandestine and unsanctioned origins of harm reduction as a philosophy of care, a social movement, and as a set of practices. As the practices were rearticulated within sanctioned programs and medical sites, they often shifted away from the prioritization of experiential knowledges and to varying degrees operated within medical regimes – harm reduction sites under the supervision of medical professionals and prioritizing medical logics is colloquially known as the “medicalized model” of harm reduction.

This case study of Overdose Prevention Ottawa aims to situate the site within these histories of unsanctioned care and peer-based knowledges and practices. Falling within a long history of harm reduction, OPO is here positioned as a counter-conduct – a resistance to the ongoing governmentalities of use, connected to a larger network of resistances unified through logics and practices. The organization was enacting care at the borders of medical regimes and as is common in the history of harm reduction their alternative practices were eventually rearticulated into dominant governances. OPO’s logics and practices stood in opposition to the war on drugs, abstinence orientations, and to some degree the pathologization of use. The
entanglements with healthcare and the reduction of negative health outcomes are interesting ones, as the unsanctioned site may be figured as on the fringes of healthcare as opposed to fully exterior to medical regimes. While resisting and figuring alternatives to some dominant practices, elements of other dominant practices and subjectivities were articulated within the site. The organization imperfectly navigated a process of de-medicalization while explicitly providing a service caring for the health of their guests. While drugs were permissible and use was not shamed, it did not necessarily encourage or promote substance use. Instead, it was accepted as a facet of life with associated risks. The heterotopic space presented an alternative set of logics, practices, and expertise intervening on said risks – mobilizing specific a blend of experiential and medical knowledges and practices, while constructing care largely outside of medical regimes and apparatuses, and de-medicalizing substance use.

As one participant declared, “Arrest us or consider us healthcare!” They succinctly encapsulated OPO’s articulation of counter-conducts. They overtly state a position of resistance to the legal frameworks and practices governing use, while entering into complicated entanglements with the process of de-medicalization. Here, they express resistances to the ongoing pathologizing and criminalizing governmentalities of use to such a point that they are willing to be arrested for these refusals. Repeatedly participants expressed a rejection of the medicalized model, however this participant requests to have the service understood as healthcare. In the most direct sense, they are rejecting practices, subjectivities, and logics of those pathologizing governmentalities, while integrating elements of the dominant healthcare logics into their heterotopic site. The concept of the counter-conduct and its position of resistance yet non-exteriority to the dominant governmentalities is perfectly summed up in this participant’s assertion “arrest us or consider us healthcare.”
Current Research

The current work is a case study of Overdose Prevention Ottawa. The organization’s contestations of governances of use and practices of de-medicalization are explored. Concepts of (in)visibility, publics, scenes, and medical regimes are mobilized in these analyses. Throughout this work, the unsanctioned site of counter-conducts is positioned as a heterotopic space – a space of distinction. Participants introduced the concept of “OPO Magic,” referring to the creation of a physical and social space of distinct logics, relations, and practices - namely the de-medicalizing and non-hierarchical logics internal to the site.

The first analytic chapter, Ch 5: Our Lives on Full Display, explores the relations of (in)visibility of public drug consumption, practices of normalization, and the development of publics and scenes. This analysis frames the counter-conducts of the site from the outside looking in – exploring what is seen and unseen and how these relations of visibility and secrecy challenge ongoing governances of use, formulate scenes, and ultimately call into being novel publics which extend upon and create new heterotopic scenes.

In the second analytic chapter, this work explores the internal practices of counter-conducts – how the practices within the site’s largely hidden program of opioid replacement may be positioned as a resistance to medical regimes, medicalization, and the dominant governances of use. Participants repeatedly draw attention to the interweaving of experiential and medical knowledges to produce a system of health and social care exterior to medicalization of use and the “medicalized model”. In these ways, the counter-conducts can be positioned as a form of medical dissent. These analyses probe the organization’s navigation of de-medicalization, harm reduction practices and knowledges, autonomy and self-determination of guests, and the discrepancies between unsanctioned and sanctioned care.
OPO’s own managed drug supply program (MS) is analyzed in reference to existing medically managed drug supply programs, Opioid Agonist Therapies (OATs) and Safe Supply (SS). These programs’ practices are probed to elucidate location of knowledges, positioning of expertise, autonomy of service users, and situate capacity to determine care needs. Ultimately, these analyses situate practices within or in exteriority to medical regimes.

The contributions of this work are multiple. The documentation of Overdose Prevention Ottawa’s actions and history contributes to the collective knowledges on the histories of harm reduction. This is important for the contextualization and historicization of the development of social and health care services for PWUD. While there exists an extensive body of research on sanctioned consumption sites, very little academic work explores the inner workings, histories, or existence of unsanctioned harm reduction programs (Kerr, et al., 2017; McLean, 2011; McNeil, Small, et al., 2014; Blok, 2011; Foreman-Mackey, et al., 2019). There are exceptionally few case studies of unsanctioned harm reduction programs, this work contributes to the growth of this body of literature and area of research.

Further, this work contributes to literature on counter-conducts and the role of Foucauldian theory in making sense of social movements. It brings a particular articulation of power and a practices-oriented analysis into a field of care minimally analyzed through this lens (Fischer, et al., 2004; Scher, 2019; McLean, 2013; McLean, 2011). This work contributes to a small body of literature drawing on elements of Foucauldian analyses to examine harm reduction services.

Finally, this research makes clear the non-linear evolution of medical practices and care. This work aims to make visible the distinctions and similarities of logics and expertise, knowledges, and service user autonomy within sanctioned and unsanctioned services. By
extension, this work directs readers attention to the intertwined activist and medical knowledges which co-produce sanctioned services. By making visible these governances and counter-conducts of care, this work emphasizes the non-linear and often de-medicalized histories of substance use and harm reduction services.

A Note on Language

The terminologies used within this work are specific and deliberate. These reflect consultations with participants on language preferences. Within this work the concept of the peer is central – the peer is a nuanced and often debated concept, articulated differently within each space. Generally, it is understood as a self-determined identity where the individual has previous or ongoing experiences which reflect the community they are serving. In this case, lived- and/or living-experience would refer to substance use and street-involvement.

The term substance use is employed, instead of addiction or use disorder to de-center the problematization of use and de-pathologize the acts of consumption. It represents an acknowledgement that not all use is inherently problematic and not all persons who use drugs wish to have their identities and actions medicalized. In the same vein, drug addict, drug user, and other such terms are not used, preferencing person-first terminology such as persons who use drugs (PWUD) and persons who inject drugs (PWID).

Terms used to represent those accessing care services are distinct. While patient, participant, service user, or client are fairly common, the preferred term within OPO’s site was guest. Accordingly, guest is used when discussing persons accessing OPO’s site, while client is used when discussing individuals accessing sanctioned care services. When referencing both sanctioned and unsanctioned services, the term service users is employed.
Finally, multiple terms for spaces of surveilled consumption are employed throughout this work. These distinct terms are indicative of the legal status of the site, as well as the services offered. Safe injection site (SIS) is a term broadly used for any site where surveilled injection takes place, these spaces often surveil insufflation as well. Safe consumption site (SCS) refers to any site where surveilled consumption is not limited to injection, inhalation may also occur in these spaces. Safe Consumption and Treatment Site (SCTS) refers to a federally sanctioned site, holding an exemption from section 56.1 of the Controlled Drugs and Substances Act. These sites require nurses to be present and are obligated to comply with various Health Canada policies (BC Centre on Substance Use, 2017; PIVOT, 2021). Overdose prevention sites (OPS) are sanctioned provincially, do not require nurses, and do not possess an exemption to the Controlled Drugs and Substances Act (PIVOT, 2021). At times, quotes reference safer instead of safe. This reflects that while the risks are lessened through harm reduction programs, practices of use are not without risk.
Chapter 2: Theoretical Frameworks

This work draws on various analytical frameworks to interrogate and explicate the actions of Overdose Prevention Ottawa. Power and practices are central to these analyses, as this work frames OPO as a counter-conduct – challenging dominant governmentalities of substance use. These works explore the physical and territorial manifestations of this counter-conducts through the lens of heterotopias. Relations of (in)visibility of public drug consumption actively challenge governances of use. Further, practices within the site articulate a process of de-medicalization of care through the resistances to medical regimes. Cumulatively, these practices and knowledges position the overdose prevention site as both a counter-conduct and heterotopia.

Positioning Power

The current work adopts the Foucauldian analytic tool known as the microphysics of power. This technique of analysis is predicated on a specific conceptualization of power. Here, power is understood as relational and dynamic, produced through of asymmetrical force relations. When these asymmetrical force relations are not limited to singular instances, but are embedded within a larger network of practices, knowledges, and technologies they are thought to produce power (Foucault, 1982). Power itself is productive, altering likelihoods of behaviours, prevalence of certain logics, and adoption and internalization of identities (Foucault, 1990). Through a myriad of mechanisms, dynamic asymmetrical force relations are present in interaction with others, state apparatuses, medical structures, and various institutions. It is when these practices are not isolated to the singular instance but connected to a wider system of practices and knowledges that they express forces of domination (Foucault, 1990; Brown, 2006). This is to say, the dispersed uptake of normative practices produces power (Foucault, 1982).
Within this framework, the analytics of power center on the mechanisms from which power emanates – the microphysics of power. It entails investigating the minutia of power, examining irreducible instances of these force relations and making visible the practices, subjectivities, knowledges, and technologies through which this power emerges (Foucault, 1977).

**Governmentalities and Counter-Conducts**

While power is effected through practice, it also fundamentally productive (Foucault, 1990). The intentional shaping of behaviours through norms, logics, knowledges, discourses, and subjectivities can be understood as governmentality (Dean, 1999). Foucault refers to this as the conduct of conducts – the orchestration of behaviours (2007). The self-management or self-direction in accordance with normative, professional, and culturally expected behaviours are included within this conduct of conducts (Dean, 1999). Any calculative attempts to shape intentions, desires, beliefs, and ultimately behaviours through a wide variety of practices represents this governance of conducts known as governmentality (Dean, 1999; Li, 2007).

Governmentalities are not limited to the institutional government of a nation-state, but may be enacted by a wide array of structures and apparatuses intervening upon behaviours – medical structures are included within this (Dean, 1999).

Governmentalities are non-totalizing and resistances are present. Foucault draws attention to the countering of these governances with the well-known adage, “Where there is power, there is resistance…” (Foucault, 1990: 95). However, power and resistance are not conceptualized as binary or in opposition. The remainder of this quote goes on to emphasize these interconnected forces, “…and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power.” (Foucault, 1990: 95) As power is produced through dynamic relations, so too
are resistances. Resistances may reflect or rearticulate some practices and logics of the dominant governmentalities they are countering (Death, 2010).

Foucault suggests that counter-conducts do not reflect a singular act or great moment of refusal and rebellion (Foucault 1998: 96). Instead, there are relational and dynamic expressions of resistance and refusals at the level of microphysics. These micro expressions of resistance are situated as nodes within networks of similar resistances united through practices, logics, and subjectivities, just as with power. Cumulatively, networks of resistances produce counter-conducts (Davidson, 2001). These refusals and resistances are productive, reifying alternative authorities, subjectivities, knowledges, and practices of the conducts managed (Foucault, 2007). In other words, counter-conducts reflect the desire to be led in accordance with different logics, towards different ends, and by different people than the dominant governances of the conducts in question (Foucault, 2007). This may arise through protest and the rejection of dominant political practices (Death, 2010). Foucault locates the origins of counter-conducts within contestations of the church, suggesting that resistances there may appear as the rejection of a certain type of salvation, enacted by specific persons, and through specific practices (Foucault, 2007). It may also take the form of medical dissent - rejecting the practices, interventions, and logics of medical professionals (Foucault, 2007). Further, Foucault draws attention to the mad, delinquents, and patients as a space to examine counter-conducts (Foucault, 2007). PWUD through various legal and medical structures may be positioned as mad (DSM-5 diagnosis of as a substance use disorder), delinquent (illegality of practices), and patients (pathologization of use). Both resistance to political governances and medical dissent may be observed within the context of Overdose Prevention Ottawa’s counter-conducts.
Counter-conducts are not simply acts of dissent or resistance but may elicit change within dominant governmentalities. To clarify this concept, Foucault presents an example of counter-conducts within anti-pastoral struggles in the Middle Ages (2007). He suggests that a myriad of sects and practices emerge at the borders of the Catholic Church. These sects resist elements of the Church – leadership, practices, obligations, etc., however they do not exist in opposition to Catholicism writ large. Elements of the dominant religion are integrated and re-articulated within these novel sects. Here we might observe the counter-conduct articulating new ways of practicing faith, novel relationships to God, distinct behavioural expectations and social obligations, and new leaders – without binary opposition to dominant governmentalities. Elements of the dominant governmentality are present within the counter-conduct. Practices and logics of these counter-conducts may too be re-articulated within the dominant governances, leading to changes in the dominant structure (Foucault, 2007).

Foucault focuses readers’ attention to this production of change, drawing again on the Church. The counter-conducts’ practices which were resistant to church governmentalities were eventually rearticulated into the practices of the church itself – such as engagement with scripture, eschatological considerations, community involvement, and mysticism. According to Foucault these divergent elements were present in counter-conducts to the Catholic church, and were later taken up by the church in attempts to articulate a counter-reformation. The counter-conducts at the borders of the Church mobilized resistant practices which were ultimately rearticulated by the Catholic Church, thereby effecting change within the dominant governmentality (Foucault, 2007).

It is clear from this example, that counter-conducts do not exist binary opposition to the dominant governances, but integrate elements of them. The sects of Christianity are clearly
related to the Catholic Church even if their practices, obligations, and leaders take distinct forms. These border elements of Christianity, the counter-conducts, are capable of producing change in the Catholic Church. We see the integration of practices from the fringes into the dominant governmentality. New combinations and hybrids of practices may emerge in the dominant governance as a result of struggles with counter-conducts.

Shifting towards social movements, Carl Death positions counter-conducts within the realm of protest. Resistances may be observed in “transgressions and contestations of societal norms, and in the reappearance of local popular, disqualified, and subjugated knowledges and the aesthetic of self-creation.” (Death, 2010: 238). In discussion of the analytics of protest, Death suggests that counter-conducts produce several specific outcomes. These include making visible spaces which are governed, however this visibility is incomplete. Protests render specific spaces visible while others are made less visible (Death, 2010). Death further suggests that counter-conducts mobilize and reify specific regimes of knowledge, reiterating that the practices of protest have established historical links to other protests and movements (2010). Finally, he suggests that counter-conducts of protest may be understood as undermining and rearticulating subjectivities, and redefining identities (Death, 2010). Visibility of refusals, and regimes of knowledge are explored in the analytic chapters of the current work.

**Heterotopic Spaces**

In an article published posthumously, Foucault muses on the physicality of resistances and spaces of distinction. The concept of the heterotopia emerges only twice in Foucault’s works (Hook & Vrdoljak, 2002; Dehaene, & De Cauter, 2008), in *Of Other Spaces* and the introduction to *The Order of Things* (Foucault, 1986; Foucault, 1989). Through these two texts he explores the notion of heterotopias in somewhat disparate ways. Hook and Vrdoljak position this as
evidencing an unfinished concept, in need of further elaboration and exploration (2002). The current work pulls predominantly from Foucault’s conceptualization of heterotopias explored in *Of Other Spaces*.

Foucault explores the notion of a heterotopia, as physical and tangible space containing relations which “suspect, neutralize, or invert” the relations of exterior spaces (1986: 3). Within this text, heterotopias are spaces of exception which house otherwise socially impermissible behaviours and practices. These alternative behaviours and practices are understood through juxtaposition with dominant practices external to the site. Further, heterotopic sites include the imaginary and idealized distinctions (Foucault, 1986). Heterotopias are characterized by six variables, addressing considerations of temporality, juxtaposition and exteriority, contingency, restrictive access, and polemity. Various subcategorizations of heterotopias are explored in *Of Other Spaces*, however these distinctions are not taken up in the current work. While Foucault espouses various principles within heterotopias which at times conflict or complicate its amalgamation with counter-conducts, the premise of territorialized sites of resistance is taken up within the current work. Recent re-theorizations help to further explicate of the concept of the heterotopia.

Dehaene and De Cauter suggest that urban heterotopias must distinguish space from non-space. These authors elaborate that the heterotopia provides a space of common experience (2008). They further characterize the heterotopic site in opposition to camps – spaces of bare life where law is suspended, providing homeless encampments as an example (Dehaene, & De Cauter, 2008). This conceptualization and example are wanting for the nuances of the varieties of encampments and diversity of lives lived within homeless encampments. This contrasting overlooks the potential these sites hold to be both spaces of bare life, of desperation and
immiseration, and also as heterotopic sites contesting socio-economic and cultural imperatives. It is this in between space that brings Dehaene and De Cauter’s understandings in contention with the unsanctioned supervised consumption site as a heterotopic space. While legal structures are actively contested within the OPO site, drug consumption is open and intoxication is rampant, and the bulk of guests were street-involved, the space nevertheless should be understood as heterotopic. It can certainly be located within narratives of necropolitics (Mbembe, 2003), failures of state structures, and neoliberal immiseration; however, to view the site solely through this lens is to overlook the substantial refusals, counter-conducts, and opportunities for change.

Despite deliberate attempts to act outside of medicalized models, OPO’s site may be better understood through Street and Coleman’s contextualization of the hospital as heterotopic, rather than the above-mentioned conceptualization. Street and Coleman discuss the hospital as a site of medical knowledge - cloaked in the shrouds of scientific rationalities and technical procedure which mobilize highly ordered structures to combat unruly forces of nature. (Street & Coleman, 2012). They endorse the hospital as a heterotopic site, both restrictive and public, with internal ongoings transforming the subjectivities of patients and providers, reshaping social orders. These authors position hospitals as a space of multiple logics – containing both scientific biomedical rationality and simultaneously reproducing exterior social relations. They are seen as sites of social control and of transgressions (Street & Coleman, 2012). In this conceptualization, the hospital is a bounded space of distinction with specific rationales, logics and practices, a space for transgressions and violations of social orders, and a reflection of the social dynamics of the wider society. The permeability of the borders undermines the boundedness of the heterotopic site itself. This conceptualization of a heterotopia as defined through a plethora of logics and capable of expressing transgression and domination simultaneously presents a
nuanced perspective on the co-constitution and rearticulation of external practices within counter-conducts. Interestingly, these transgressive and alternate practices of the hospital are largely those countered and resisted through OPO’s heterotopic site.

Hook and Vrdoljak explore South African gated-communities as heterotopic sites (2002). These authors advocate for the inclusion of textual and discursive spaces of distinction, suggesting that limiting heterotopic spaces to the physical and material fails to encapsulate the linguistic elements of heterotopias as explored in *The Order of Things* (Hook & Vrdoljak, 2002). Further, they suggest that the physical space might be understood as the discursive space materialized, and that the term heterotopia is less referential to a site but to an analytic lens with which to examine a space or text (Hook & Vrdoljak, 2002). In the case of OPO, this might be observed through the inclusion of digital spaces and online discourses as within the boundaries of the heterotopic site.

For the purposes of this work, heterotopic sites will be understood as territorialized, temporally limited, and physically-bounded spaces, which play host to a node of counter-conduct. It is noteworthy that this extends into the textual through the utilization of digital space, and that the borders of the heterotopic site are both malleable and permeable. Access to the unsanctioned site was apparently open but in practice restricted to specific subjects. The unsanctioned site was a space of distinct practices understood as in refusal of dominant external practices, and fundamentally an identifiable and visible resistance.
(In)Visibilities

Microphysics techniques of analysis aim to “make visible what is visible” (Orford, 2012: 618). But to what degree is visibility a requisite for resistance? To what ends are practices rendered visible? What utility does making visible serve?

The Western perspectives of knowledge acquisition have long included a dimension of visual perception (Brighenti, 2007). The relations rendering visible and invisible produces specific truths. What is seen becomes knowledge, while what is rendered unseen is not readily knowable (Ansems de Vries, 2016). Whether through the lens of a microscope or social media accounts of Wet’suwet’en land occupations, visibility characterises the process of making known. The question of visibility, however, is not simply a dichotomy of what is apparent and what is not, but deeply enmeshed in social relations and practices of obfuscation.

Brighenti suggests that visibilities are relational and asymmetric sites of strategy (2007). They position social visibility of marginalized communities as recognition. Below a certain threshold of visibility exists a state of exclusion. Here, to be unseen is to be excluded (Brighenti, 2007). De Backer explores the proposition of two opposing outcomes of visibility, recognition rendered through visibility and control through invisibility (2018). He explicates that practices of recognition may be understood as acts of resistances and that the creation of space and visibility for subaltern groups forms the basis of a resistance from marginality. De Backer further suggests that these positionings of (in)visibility are not opposing but deeply intertwined and situates asymmetrical relations of visibility within a Foucauldian lens (2018). They are not in opposition but relational and co-constituted.
In Henrique and Tschakert’s exploration of the political invisibility of Brazilian residents in floodplains, these authors suggest that the invisibility and exclusion of specific perspectives represents an erasure of those voices (2019). They further explore situated tactics of resistance which rearticulate the relations of (in)visibility. Thompson reiterates that visibilities open spaces of contention and resistance, suggesting that media plays a large role in crafting a new space of visibility (2005). This novel visibility can be extended into spaces of technological advancement. Hatuka and Toch discuss asymmetrical visibilities and surveillance in the age of smart technologies (2017). This concept must necessarily be extended to social media as both a site of domination and resistances through relations of visibility and surveillance. Brighenti suggests that digital presences do not only reshape the spaces of visibility, but reshapes timelines of visibility as well (2007). This is a vital consideration with the explosion of social media platforms, blogging, and podcasts. The capacity to articulate spaces of visibility for subaltern populations has been radically transformed. If we begin from the premise that to make visible is to make knowable (Ansems de Vries, 2016), then social media has massively expanded the capacity to see and know peoples and practices subject to erasure.

Expanding on (in)visibilities, the current work takes up discussions of secrecy. Jodi Dean explores the roles of secrecy and publicity in shaping public opinion and engaging with publics’ right to know. Dean elaborates that some practices of democracy formulate a continual searching, suspiciousness, and need for revelation – what is not subject to publicity becomes a secret to reveal (2001). Dean argues that there exists a politics of making public, centered on the concealment and unveiling of secrets (2001). The role of the media in these revelations, satisfies a publics right to know and incorporates an element of entertainment in uncovering secrets (2001). Eva Horn explicates various types of secrecy, exploring questions of legitimacy in
relations of secrecy and publicity (2011). She suggests a secrecy effect, as opposed to a binary of secret and public knowledge (Horn, 2011). These concepts of relational secrecy are deployed in the following analyses of (in)visibility of public drug consumption and affect elicited by visible counter-conducts of substance use.

**Medical Regimes**

A recurrent concept within this work is that of medical regimes. A regime may be understood as practices, knowledges, expertise, and subjectifications governing over a specific sphere (Joyce, James, & Jeske, 2020). This includes the principles which guide actors, decision-making apparatuses, normative expectations, and regulations. Cumulatively, these produce behavioural standards and a sense of obligatory compliance with said standards (Bradford, 2007).

Within the medical field, regimes are intertwined with the production and dissemination of knowledge and truth – including evidence, medical research, and authority to create and administer such knowledges. Medical regimes may be observed in the formation of policy and regulation, in the range of available services, and the infrastructures of care (Joyce, James, & Jeske, 2020). Highly professionalized knowledges determine the scope of acceptable interventions and practices (Joyce, James, & Jeske, 2020). Medical regimes embody logics of medical and scientific rationality, with truths produced through positivist research methodologies employed by highly-trained researchers, and embeds capacity to undertake the highly regulated practices of care within formally educated and licensed providers (Lorenzini, 2015).

For the purposes of this analysis, a medical regime may be understood as structures of care meeting the following criteria. Practices and provision of care are highly professionalized,
requiring accredited education and licensure through governing bodies. Behavioural standards and compulsory practices are outlined through licensing bodies and legislature. Practices are constrained by clinical protocols and treatment guidelines, informed by knowledge acquired through clinical trials and research. These truths are disseminated to practitioners through various healthcare institutions, and in turn to patients by practitioners. Embedded within this is a knowledge and power differential, determining the decision-making capabilities of prescribers and patients. The former is positioned as an expert and knowledge holder, capable of determining need and appropriate mechanisms of care, and the latter a somewhat passive recipient of this knowledge. It is notable that in this dynamic the patient retains some capacity for advocacy, however treatment remains at the discretion of the provider.

OPO’s heterotopic site represents a territorialized counter-conduct of the ongoing governances of drug use. The relations of (in)visibility served as a contestation of the dominant governances of use, drawing attention to specific refusals and practices while rendering others unseen. Further, the practices within the site constitute medical dissent – challenging the role of medical regimes in the management of practices and logics of consumption. OPO articulates care at the borders of medical regimes, embodying distinct logics, knowledges, and practices.
Chapter 3: Methods

Variables and Research Questions

The current research was fundamentally exploratory, with the aims of interrogating the practices, contestations, and logics of unsanctioned care through a case study of Overdose Prevention Ottawa. This researcher elected to interview both OPO core organizers and managers of sanctioned sites to ascertain a more complete picture of the landscape of harm reduction services in 2017 and how these have since evolved. Broadly, the topics of this investigation were the services available, and how these programs operated. Themes preferentially addressed by participants included the site as a space of distinct logics and practices, the nature of de-medicalized care, and creating a fundamentally inclusive space which prioritized the autonomy of guests.

Throughout the interview process, this author noted several key considerations which formulated the research questions and guided these analyses. The research questions are: 1) How did the services offered by OPO articulate practices and logics of care distinct from existing sanctioned services in Ottawa? 2) How did the services offered by OPO re-articulate practices and logics of existing sanctioned services in Ottawa? 3) How did OPO’s site contest ongoing governances of use? 4) How did OPO’s care practices contest governances of use? 5) How did OPO navigate medical and non-medical knowledges?

Questions one and two interrogate OPO’s positioning as a counter-conduct and situate OPO’s practices in relation to sanctioned care. The third question probes the territorial occupation of space by asking in what ways the physical site itself represents a contestation. This lends to the positioning of OPO’s site as a heterotopic space. The fourth question shifts the focus
of analyses from the physical site to the practices within, asking how the site operated and questioning how the internal practices serve as a resistance to and counter-conduct of the dominant governances of substance use. The final question draws attention to the de-medicalizing nature of unsanctioned care and is aimed towards the interrogation of intertwined experiential and medical knowledges and how these are mobilized within the site’s practices of care.

**Participants**

Two distinct participant groups were recruited – OPO core organizers, and managers of sanctioned supervised injection sites. A total of seven interviews were conducted, four were with current or former members of Overdose Prevention Ottawa and three with managers of sanctioned sites. OPO participants were required to have been involved in the organization and operation of the unsanctioned safe consumption site in Raphael Brunet Park at any point between August 2017 and November of 2017. The remaining three interviews were conducted with individuals who managed sanctioned surveilled consumption programs which opened during or shortly following OPO’s site.

Personal and professional affiliations with members of OPO and sanctioned sites were mobilized to recruit participants. Initial participants were recruited through email, online messages, and telephone contact using recruitment scripts. Participants were then asked to refer other potential participants to the researcher. A recruitment notice detailing the purpose of the study and contact information was provided via email to all participants. The researcher’s previous affiliations with Ottawa Inner City Health Inc. and involvement with an Ottawa-based SIS were disclosed both during recruitment and again immediately prior to the interview.
Seven interviews did not meet data saturation; the scope of the project, hesitancy and distrust of researchers, and logistical constraints were limiting factors in the number of interviews conducted. All participants were compensated with a $20 honorarium via e-transfer to minimize physical contact during the height of the Covid-19 pandemic. The snowballing recruitment method was chosen due to the insular nature of activist communities.

Issues of trust played an interesting role in recruitment. This researcher’s affiliations with the harm reduction community was a substantial factor in development of rapport and trust-building among participants. This relationship granted access to an insular community. However, the distrust of external researchers still permeated some researcher-participant interactions and hindered some recruitment efforts. Recruitment was easiest when personal affiliations were mobilized and/or the researched was vouched for by mutual acquaintances.

**Data collection**

Data were collected through semi-structured interviews lasting between approximately 60 to 90 minutes. Distinct pre-prepared interview guides were used in interviews with managers and core organizers groups. All questions were open ended, and prompts were used to encourage elaboration on relevant topics. The semi-structured design was chosen to ensure appropriate topics were addressed while respecting the nature of the interview as a living conversation and collaborative process of knowledge creation (Chilisa, 2011).

Interviews were conducted one-on-on via Zoom. Interviewing was done through this medium due to the COVID-19 pandemic. Some participants elected to turn off their cameras during the interview, likely resulting in the loss of some non-verbal communications. The ‘record’ function within Zoom was used to create a digital record of the interviews, and the
researcher took supplemental notes on non-verbal cues and observations. All records were stored on a password protected computer in the researcher’s key-locked office. No cloud servers were used.

The decision not to use focus groups was premised on several practical considerations. Participants working in healthcare settings may work on rotating shift schedules and work non-standard hours. Internet reliability and connectivity might have provided additional challenges when hosting a Zoom call with multiple participants. Lastly, the decision to use one-on-one interviews was intended to create an environment where participants were able to freely critique and challenge their own organization’s practices.

Interviewing was chosen for several reasons. Participants are holders of unique knowledges and perspectives otherwise inaccessible to researchers. The method provided depth of detail on the minutia of OPO’s activities, internal operations, and insights into their less apparent tactics.

Member checks were performed to verify the researcher’s understandings and analyses. Participants were able to alter or withdraw their responses at any time prior to January 1st 2022. This researcher practiced reflexive journaling throughout data collection and analyses. The nature of this project was interpretivist and exploratory; the relational and collaborative qualities of interviewing are acknowledged. The works produced offer an in-depth and highly contextualized co-produced knowledges of the unsanctioned site.

**Data Analysis**

Interview recordings were transcribed within 24 hours of the interview using NVivo transcription software. These transcriptions were manually compared against recordings to
ensure accuracy, and recordings were erased immediately following this process. Hand-written interview notes were entered into transcription files using red font to distinguish from verbatim transcripts. Notes for reflexive journaling were added in the margins. Transcription files were saved under a numeric code with all identifiers removed. Files were held until the completion of this study and will be erased in September of 2022 following the final draft submission. All transcriptions and analytic files were stored on a password protected laptop stored in a locked office. Digital consent forms were kept separately and will be erased in September of 2022. No physical copies were made.

Data analyses were performed using NVivo software. Elements of grounded theory provided a framework for analyses, employing an ongoing comparative analysis between coding and data and prioritizing the rich contextualization of findings. The initial stage of coding was open coding - as many codes as possible were created. Constant comparisons were made between incidents (Flick, 2019). No a priori code list was generated or utilized, allowing instead for codes to emerge from the data sets (Flick, 2019). The second stage was axial coding. This required the integration of codes into larger categories. While the first stage required inter-incident comparison of codes, the second stage necessitated the evaluation of incidents with the properties of categories (Flick, 2019). The third stage involved concretizing categories and the formation of theoretical associations between categories (Flick, 2019). Conclusions were then verified against transcription files and later via member checks. Attention was given to negative cases throughout the analytic process.

This methodological framework provided a structure, however adherence to this model was non-linear and stages were often revisited. The researcher used memoing and journaling as a reflexive practice, allowing for continual analytic engagement with emerging concepts.
Ethical Considerations

Ethical considerations were addressed in a myriad of ways. Professional associations with Ottawa Inner City Health Inc. were disclosed verbally and in writing. Due to this relationship, the voluntary nature of participation was repeatedly underscored. Topics were provided in advance of the interview through recruitment notices, communications with the researcher, and consent forms. Participants were provided with written consent forms at least 24 hours prior to their scheduled interview, and consent was verbally reviewed immediately prior to the interview. Participants were free to withdraw at any point during the interview process, or subsequently withdraw their transcripts prior to January 1st 2022. Participants were provided with a written and verbal debrief at the conclusion of each interview. All quotes used were de-identified.

During the interview process, no adverse emotional responses or significant distress were noted. A list of support resources pertaining to first-responder trauma and supportive counseling services were provided to all participants. Regional distress lines were not included and some services were care-provider specific as to avoid referring participants to services where they might have professional relationships with the care providers.

Challenges

The researcher experienced some challenges during the recruitment process. Some participants without direct interpersonal connections to the researcher expressed distrust or hesitancy around disclosing illegal actions. It is likely as an outsider to the organization, the researcher’s ability to accurately and unbiasedly portray the work of the organization came into question. When OPO organizers and/or mutual acquaintances were able to vouch for the researcher, recruitment was much simpler of a process. The distrust extended into the interview process, where the researcher had to reassure some participants that information shared would
not be attributable and their privacy would be maintained in the case of mutual acquaintances. This researcher’s positioning in the harm reduction community also served as a benefit, providing a communal understanding. Participants often suggested “you know what it’s like.” While this may have developed a capacity for mutual understanding, it may have hindered elaboration in some incidents.

In terms of logistics, two challenges were present. The technologies, software, and stability of internet connection at times complicated the interview process. Finally, one potential participant expressed frustration around the honorarium, noting that the expertise of participants should be valued at a higher rate. This individual suggested that such an expertise should elicit a rate beyond $20 per hour should researchers wish to utilize their specialized knowledges and understandings.

Cumulatively, this work represents the co-produced knowledges and perspectives of OPO core organizers, managers of sanctioned sites, and this researcher and harm reduction worker. The analyses produced were verified by participants and represent an earnest attempt to convey a highly contextualized and subjective understanding of the contestations of governances of use. The analytic chapters contribute to a fuller understanding of the minutia of contestations, while the following chapter contributes to the historicization of harm reduction and underscores the non-linear development of sanctioned substance use services. These histories further serve to contextualize the analyses and provide readers with a fuller understanding of Overdose Prevention Ottawa as a group, a site, and a service.
Chapter 4: Histories of Overdose Prevention Ottawa

OPO did not simply materialize, the program opened and closed its tents within a specific socio-historical context. The practices of the counter-conduct are best understood in a historically contingent lens. To contextualize such analyses, it is critical to understand the histories of the unsanctioned program.

On March 14th 2016, a health centre in downtown Ottawa, Sandy Hill Community Health Centre, announced its intention to open a safer consumption and treatment site in the upcoming year. The announcement sparked contentious debates amongst city councillors (CBC News, 2016; Ottawa Board of Health, 2016a; Ottawa Board of Health, 2016b). Sandy Hill’s safer injection program was originally intended to open in the spring of 2017, however this date would end up being pushed back several times, ultimately opening in the spring of 2018 (Raymond, 2018; Willing, 2017a; Yuyitung, 2017). These delays would prove deadly. In February of 2017 the opioid crisis arrived in Ottawa. The spring of 2017 saw a 68% increase in overdose deaths in Ontario, relative to the year prior (Ontario Ministry of Health, 2018a). Peers, community members, and frontline workers watched as more and more members of the community of PWUD passed away from acute drug toxicity. As the summer approached, the overdose deaths mounted; Sandy Hill’s opening date remained nebulous.

The 12th of August 2017 marked a significant shift in Ontario’s substance use care. The Toronto Harm Reduction Alliance opened Ontario’s first safer consumption site – an unsanctioned, community-run consumption site operating from tents erected in Moss Park, Toronto (City News Toronto, 2017). While this represents the first of such unsanctioned programs in Ontario, it falls within a longer tradition of unsanctioned supervised consumption programs in Canada (Kerr, Mitra, Kennedy, & McNeil, 2017). Ottawa organizers took note.
Days after the opening of the Moss Park site an overdose death occurred, taking the life of a well-loved individual in Ottawa community of PWUD. The weight of this death rendered the ever-mounting grief unbearable. That evening, one organizer to-be phoned another and demanded they act. Compelled by crisis and grief, these individuals decided to adopt a model similar to that of Moss Park. A few days later, approximately 10 to 12 community members, activists, and advocates met in Dundonald Park to begin planning what would become Ottawa’s first, and Ontario’s second, safer consumption site.

Over a two-week period, these core organizers met repeatedly in Dundonald Park to address the logistics of running an unsanctioned safer consumption site. Organizers did not comply with any of the legal and administrative requirements of a sanctioned safer consumption site. They stated that the planning and practices of the site were informed by concepts of non-hierarchical organizing, consensus-based decision making, and user-group created and driven services. Organizers aimed to embody a “for us, by us” approach in the development and provision of care. In principle, guests, volunteers, and core organizers were intended to be of equal standing with equal input into the site’s operational procedures, breadth of services, and conflict resolution processes. In actuality, participants noted that an ideal praxis was difficult to maintain and that some discrepancies were present.

Location was a key consideration for organizers in the development of the site. Raphael Brunet Park in the neighbourhood of Lowertown was chosen due the prevalence of ongoing public drug consumption. Raphael Brunet Park is a small, grassed area, bordering a parking lot, one residential building, and across from an unoccupied church where overdoses are common. This park contains no play structures, sports equipment, or bike paths, and was rarely used by the public.
All supplies and infrastructures were donated. Tents were acquired through acquaintances in the film industry. Drug paraphernalia were acquired through Ottawa Public Health and sanctioned harm reduction programs. Ottawa Public Health would prove to be an invaluable asset to OPO, providing material and structural supports to the organization through the provision of sterile supplies, naloxone, and the daily collection of biohazardous waste. At the time, naloxone was somewhat complicated to source in large quantities. While publicly available, there were more restrictions and limitations around acquisition. The overdose reversal medication was provided by harm reduction organizations, Ottawa Public Health, and at times obtaining “one-offs” at pharmacies.

During the week prior to opening, organizers held a press conference announcing their service to the media – omitting the location of the site. Then, on August 25th, less than two weeks after the launch of Moss Park’s site, Overdose Prevention Ottawa put up their tents for the first time. For several hours before launching their service, OPO hosted an open-house allowing media, curious residents, politicians, and police the opportunity to visit the site and ask questions. That evening, they launched their service. OPO would go on to operate a safer consumption site from 6 pm to 9 pm every day from August 25th through November 9th 2017, with the exception of three days due to inclement weather (Overdose Prevention Ottawa, n.d. b). Initially, the site catered only to injection and insufflation. In response to guests’ requests, OPO pivoted within days to provide supervised inhalation services as well.

The tents sparked a great deal of media attention. Ottawa Police Services and Ottawa Bylaw Services, however, minimally interfered with the site. Immediately after opening, Ottawa Bylaw officers advised the organizers that they were in violation of municipal bylaws, as they were occupying a public park without the appropriate permits. Beyond this, Ottawa Police
Services officers routinely surveilled ongoings from the parking lot immediately behind the site. The practice of police surveilling the community from this location precedes OPO and continues at the time of writing. Many participants voiced the belief that Ottawa Police Services were given a directive from municipal politicians not to interfere with the site.

In contrast with these relatively unproblematic relations with policing, OPO’s relationships with the mayor and municipal ward councillor were contentious. Rideau-Vanier Ward councillor, Mathieu Fleury, repeatedly threatened to shut down the site. Fleury and Mayor Jim Watson were invited by organizers to tour the site, both declined. Participants reported a dismissive and supercilious attitude expressed by Fleury and Watson towards the site and organizers.

Not all relations with municipal politicians were hostile. Councillors Catherine McKenny, Jeff Leeper, and Tobi Nussbaum all publicly expressed support for Overdose Prevention Ottawa and were in direct contact with organizers. As tensions with councillor Fleury heightened, councillors McKenny and Leeper privately informed organizers of Fleury’s intention to have Ottawa Police Services clear the unsanctioned site on a specified date. On that day, Overdose Prevention Ottawa organized a march to Ottawa’s City Hall. To ensure Mathieu Fleury would be present at the time of the march, an organizer arranged a meeting with Fleury under false pretenses – posing as a mother homeschooling her two children and wanting them to meet with him as part of a lesson in civics. Several dozen individuals gathered and marched to city hall carrying placards and empty naloxone kits. The intention of the crowd was to present 600 signed letters in support of OPO’s site directly to Mathieu Fleury. Fleury did not address or engage with the crowd. Later, he would meet privately with three core organizers to discuss the
potential of relocating the unsanctioned site. Organizers report this meeting to have been largely unfruitful.

Support and resistance of OPO were not limited to politicians and state agencies. The citizens of Ottawa made seen their views on the unsanctioned site. A collection of residents of Ottawa established a nightly meal train, providing homemade dinners volunteers and occasionally to guests. Material and financial donations were plentiful, with OPO’s Go-Fund-Me page accruing over $15 000. In contrast, resistances from residences took the form of direct actions in the face of police and political inaction on the site. A group of local residents planned a barbeque at Raphael Brunet Park, intending to occupy the site and prohibit OPO from utilizing the space. Approximately six individuals attended the barbeque. In response, nearly 100 volunteers formed a human chain surrounding the unsanctioned site to ensure the continuation of the service without disruption that night. In a further act of resistance, a neighbour illuminated the site with flood lights, removing elements of privacy for guests and volunteers. The most substantial direct action against OPO was enacted by a neighbour, Guy Annabele. Annabele collected horse manure and distributed it across Raphael Brunet Park, suggesting to reporters that this was an act of civil disobedience (Joseph, 2017). He has publicly stated that this was done in attempts to close the site after his pleas with municipal politicians for OPO’s closure went unheeded (Joseph, 2017). Interestingly, this is the same rationale of direct actions and civilian intervention in the face of political indifference that motivated OPO’s work. Organizers and volunteers removed the manure and opened the tents that day. Numerous participants characterized this act as biological warfare against guests of the site – a population which is often substantially immunocompromised.
A seemingly previously unplanned sanctioned site run by Ottawa Public Health opened one month after the unsanctioned site (Kupfer, 2017b; Ottawa Board of Health, 2017). This new site, known colloquially as Clarence Street, is located 220 meters from Raphael Brunet Park. Prior Ottawa Board of Health documents did not indicate any intention to open this now permanent site (Ottawa Board of Health, 2016a; Ottawa Board of Health, 2016b; Ottawa Board of Health, 2017). All participants, OPO organizers and managers of sanctioned sites, suggested that the Clarence Street site was created in direct response to OPO’s site. As Clarence Street was able to accommodate fewer clients than OPO, and did not permit inhalation, organizers did not feel the new site was capable of meeting service needs independently. OPO chose to continue providing unsanctioned care in tandem with the new sanctioned site.

Toronto’s Moss Park unsanctioned site received insulated military tents, heaters, and generators from the provincial government. These supplies were intended to facilitate the organization’s ability to provide unsanctioned care throughout the winter (Gray, & Giovannetti, 2017). Overdose Prevention Ottawa organizers requested similar supports; their request was granted by the provincial government. To intervene with municipal ongoings, the provincial government required approval from the City of Ottawa. On November 3rd, with no consultation of the city council, Mayor Watson declined the province’s support (Kupfer, 2017a; von Scheel, 2017). Watson and Fleury then publicly suggested that if these supplies were offered to a sanctioned site, they would approve the provincial aid (Kupfer, 2017a).

On November 7th, 2017, Ottawa Inner City Health Inc. opened The Trailer, a 24-hour 7 day a week safer consumption and treatment site located immediately adjacent an emergency shelter and within 250 meters of the OPO site (Schnurr, 2018). With the Trailer open, the cold weather drawing near, no prospects of the necessary infrastructure, and a growing sentiment of
exhaustion, 79 days after opening Overdose Prevention Ottawa took down their tents one final
time. November 9th was the last day the service operated (Overdose Prevention Ottawa, n.d. b). The originally promised sanctioned site – Sandy Hill, would not come to fruition until April of
2018 (Panico, 2018; Raymond, 2018), with Somerset West’s sanctioned site following in May
(Raymond, 2018). Throughout their operation, OPO documented methods of use and gender of
guests. These statistics were published on the Overdose Prevention Ottawa website, and managers of sanctioned sites suggested these reports allowed them to plan for the initiation of their sanctioned services. Overall OPO hosted 3676 visits, averaging 14 injection visits and 36 inhalation visits per day (Overdose Prevention Ottawa, n.d. b). The four sanctioned programs – Sandy Hill, Somerset West, Clarence Street, and The Trailer are all still in operation. At the time of writing, no additional permanent safer consumption and treatment sites or overdose prevention sites have been opened in Ottawa and no sanctioned inhalation programs currently exist in Ottawa.

This brief history of Overdose Prevention Ottawa aims to provide readers with an understanding of the organization, their actions and practices, and the unsanctioned site itself. It is intended to contextualize the following analyses and more broadly historicize the non-linear developments of sanctioned substance use services.
Practices of visibility were deeply intertwined with the actions undertaken in the fall of 2017. The counter-conducts of Overdose Prevention Ottawa and their heterotopic site integrated practices of making seen and unseen elements of substance use. Through territorialized and visible occupation of Raphael Brunet Park, OPO made seen and known the prevalence of public drug consumption. Processes of normalization momentarily alleviated some of the shame and stigma associated with the previously hidden act. While the white tents stood brazenly for all to see, the acts of injection and inhalation remained concealed. The logics of this invisibility were distinct from practices of invisibility external to the site. Invisibilizing highly dramatized and affect laden objects and practices worked to centre the attention of onlookers on what remained visible – the logics and governances of surveilled consumption. The manufactured unseeing further engaged with healthcare logics and served as an impediment to carceral repercussions. Collectively, these conditions coalesced to produce a scene.

Briefly, a scene is a site of ongoing action, mobilizing relations of visibility and eliciting affective responses in observers. A scene is mobilized by a set of actors however the scene does not stay completely within their control; practices direct and configure the attention of onlookers towards specific issues (Walters, 2022; De Genova, 2013). While it is noteworthy that not all scenes involve protest actions and the occupation of public land, scenes similar to OPO's may be noted in protest actions such as Occupy Wall Street, the Trucker Convoy in Ottawa, and Unist’ot’en in Northern British Columbia. Each of these represent a counter-conduct which attracts attention towards specific set of issues and actors shape discourse through relations of visibility – however counter-narratives are ever-present for each example. These scenes all
maintain a digital and physical occupation of space in which ongoing refusals may be observed, and elicit strong affective responses. Similarly, OPO’s unsanctioned site can be framed within this lens. A small group of core organizers initiated a territorialized counter-conduct, occupying a physical and digital space of ongoing action, directing attention through relations of (in)visibility of public drug consumption, and intertwining affect-laden objects and discourses.

Practices within the scene call into being contingent publics who were at times mobilized to act. Publics became interwoven into the scenes themselves through these actions, which served to expand the repertoire of elicited affects and occupied spaces of action, and further complicate relations of (in)visibility. Through making seen and unseen, OPO effected a scene. This scene in turn produced publics which became integral to the expansion and evolution of the initial scene.

**Making Visible the Act of Drug Consumption**

The occupation of a public park as a care site holds numerous implications for the visibility of drug consumption. Existing public drug consumption was relegated to somewhat unseen spaces, while OPO’s site was apparent and obvious. OPO made visible the practice of consumption within the public sphere. Ansems de Vries suggests that what is not seen is not known, that truths are produced through visibility. To make visible is to make knowable a truth (Ansems de Vries, 2016). The visibility of the space made clear the prevalence and normalcy of drug use. A largely unseen and unknown reality was brought to the fore. Through the normalization of use, the experience of shame was temporarily alleviated for guests of the unsanctioned site. By placing tents within a public park, OPO upended the relationship between public drug consumption and visibility of use.
The neighbourhood of Lowertown, where OPO established their site, has a long history of public drug consumption. The park in which the site was established sits across from a decommissioned church. The parking lot, staircase, and doorways of this church are infamous for public drug consumption. These spaces are often occupied by unhoused residents of Lowertown. While public use here long pre-dates OPO’s site, there is a distinct difference in the character of this visibility. Public drug consumption outside of OPO was marked by the act of hiding in plain sight. The act of consumption was overtly visible, however there was a deliberate unseeing by passers by. The city’s residents engaged in a willful overlooking the semi-concealed consumption within public spaces; injection or inhalation practices were visible should a passerby choose to look. In contrast OPO’s tents rendered public drug consumption unavoidably visible, but the act of consumption itself was not visible.

Pathologizing and criminalizing logics largely governed drug consumption (Robinson, & Adinoff, 2016). The stigma and legal status of drug possession, transactions, consumption, and public intoxication, as well as various neo-vagrancy laws discourage the overt occupation of public space by unhoused persons who use drugs (O’Grady, Gaetz, & Bucceri, 2013; O’Grady, Gaetz, & Bucceri, 2011; Herner, 2020; City of Ottawa, 2016). However, for unhoused PWUD, using in private spaces is a difficult task. Private homes are often not accessible, businesses actively restrict washroom use, and security guards surveil movements within accessible spaces such as shopping centres. The illegality, stigmatization, and inaccessibility of private spaces necessitate a practice of public drug consumption which is hidden in plain sight (Lister, Seddon, Wincup, Barrett, & Traynor, 2008). Drug use is relegated to semi-concealed spaces such as alleyways, stairwells, public washrooms, and parking lots. While consumption does not go entirely unseen in these locations, it is more easily overlooked, ignored, and left undisturbed than
use in more overt locations might be. The existing regimes and governmentalties of drug use produced a level of invisibility to the practice. While the invisibility was not totalizing, the scale and prevalence of the practice were obscured and thus largely unknown to those not involved with drug use.

The use of tents in a public park upended the (in)visibility of use. The publicity of the unsanctioned site actively challenged the hidden and ignored status of drug consumption. By occupying Raphael Brunet Park, the site brought a direct visibility to the practices of consumption, but not the act itself. No longer was it rendered invisible by alley ways, dumpsters, and parking lots, but in bright white tents and with greeters at the entrance, the site was visible – unavoidable even. The act of consumption itself was concealed; the knowable practices of consumption were ever-present - the explicit purpose of this site was known, thereby inverting the exterior relations of (in)visibility of public drug consumption. The overt visibility of large vinyl tents in a public park directly confronted the dominant practices of concealing drug consumption, forcing the residents of Ottawa, municipal politicians, and the media to attend to the issue of drug use.

The OPO site made visible what had previously been hidden in plain sight. By making visible the practice of drug consumption the site made known the scale of pervasive and continued drug use despite the dominant governmentalties of use, forcing an acknowledgement of prevalence of use. Through the occupation of public space and use in a visible realm, the site drew attention to the commonplace nature of drug consumption. Instead of a hidden practice, it was understood an observable, effecting a process of normalizing drug consumption. The perceived rarity and secrecy surrounding the practice had been removed.
By attending to the truth of ongoing use, and making apparent the ubiquity of the practice, OPO’s site presented logics of normalization surrounding the act of consumption. The logics and practices of criminality of use and pathologization – the perceived abnormality and deviance of consumption relegated use and those using to hidden spaces. The need to hide and obscure consumption led to an association of indignity and shame towards PWUD. The indignity, shame, and stigma further underscored the need to remain hidden. The experience of shame was temporarily alleviated within the OPO site as the visibility and normalization of use acknowledged drug consumption as commonplace and not needing to be hidden from others. The occupation of public space in a visible capacity undermines the affective response to internalizing the need to hide and logics associated with it. A core organizer explains, “I think that absolutely helps a person overall… hopefully that helps them to de-internalize all their shame – which I don’t know if it really did but hopefully for that moment it would.” They indicate that in contrast to the external experiences, the OPO site represented a space within which distinct logics would apply and use was not a point of shame or contention, but rather a normalized facet of life. The practices of visibility and by extension normalization render an affective element to the heterotopic site, a space of kindness and empathy towards PWUD.

Another organizer elaborated, “I work with people who either aren’t ready or will never stop… Even if they don’t, they just deserve kindness. I’m not here to make their lives more difficult, I’m here to make their lives kinder and softer.” Implicit in this, the criminalizing and pathologizing logics and practices may create conditions in which drug use is less visible but they do not expunge the practice. The abnormalizing logics are here positioned as imparting affective experiences of isolation, shame, and prejudice. The organizer identifies that regardless of the social conditions governing consumption, the practice of drug use will continue and
suggest an alternative logic is required – an empathetic and normalizing logic which strives not to impart suffering through indignity and shame.

The visibility of the tents in a public park conveyed a normalizing logic; making visible and knowable a truth of ongoing consumption of illicit drugs. While public drug consumption was commonplace prior to OPO’s site, the visibility of use was obscured and this reality was unseen and largely unknown by those external to the practice. Through the occupation of a park, and loud declarations of its purpose, OPO made knowable the practice of public drug consumption and effectively inverted relations of (in)visibility surrounding public use. The visibility of the site revealed the prevalence and commonplace nature of drug use. This normalization temporarily alleviated shame associated with logics and practices external to the site. The public occupation of the park with exceptionally visible tents presented a challenge to the practices and logics which previously obscured the visibility of public use.

**Making Invisible the Act of Consumption**

In stark contrast to the visibility of the tents, organizers intentionally concealed the act of ingesting illicit substance from external onlookers. While the brazen occupation of a park with bright white vinyl tents made known the ongoing practices of drug consumption within the Lowertown neighbourhood, these tents themselves cloaked the act of consumption. The issue of governances of use and knowability of use were apparent, while maintaining the invisibility of the individuals undertaking the act of injection and inhalation. While guests moved freely between spaces, the act of consumption was constrained to an injection tent and an inhalation tent. The architectural practice of concealing consumption and the management of visibilities of objects and persons served to de-dramatization drug use and the objects associated with use. Further, these practices served to maintain the privacy and dignity of the guest. The borders of
these walls were imperfect and penetrable, at times they were subject to the voyeuristic gaze and revocations of such privacy and dignity.

**Shock and Awe**

The restricted visibility of ingestion de-dramatized the act of consumption. This was accomplished by removing visibility of practices and objects strongly associated with affective and visceral responses. These include injection paraphernalia and the fears associated with needles, and the shock of observing an individual injecting fentanyl. Ansems de Vries suggests that the management of what is visible will produce specific sociopolitical outcomes (2016). Further Roser and Thompson explain that appeals to fear are capable of transitioning low-motivation publics towards protective acts (1995). By restricting the visibility of these practices, OPO is actively shaping the sociopolitical environments and space surrounding the practice of use. De-dramatization and management of visibility of affect-laden events, practices, and objects can be understood as reshaping the attention of onlookers, away from fear-based and visceral responses and re-centering on the issue of governances of use (Roser, & Thompson, 1996; Walters, 2022). The relations of (in)visibility emphasized the practices of surveilling use as opposed to the use itself. Further, the concealment of use rearticulates a practice of confidentiality within healthcare structures, taking the secrecy and hiding of use from a practice of indignity and shame to one of legitimized concealment. Finally, the invisibility of consumption allows guests some degree of protection from the legal repercussions of unlawful acts.

Needles and other paraphernalia may elicit substantial affective responses in unfamiliar observers. Beyond the relatively common fear of needles, needles in the context of substance use are imbued with addition layers of emotionality. Unsterile or “dirty” needles may induce a panic
regarding the potential contraction of blood-borne illnesses such as HIV and Hepatitis C – this is especially true in the context of needles used and disposed of within a park. The elicitation of affective responses would have been especially salient for the OPO site considering the high prevalence of blood-borne infections amongst unhoused persons who use drugs (Arum, et al., 2021; Anderson, et al., 2020), the growing concern surrounding fentanyl, and all of this within a public park adjacent to recreation centre. While these concerns are understandable, the do not reflect the realities that OPO organizers carefully managed the cleaning of the park each night and had daily disposal of biohazardous waste through appropriate channels. To see such needles elicit moral panic associated with substance use, well documented concerns for public safety, discomfort associated with erratic behaviours, and fears of escalating crime rates (Buchanan, & Singer, 2003; Willing, 2017b; Johnstone, 2019). While drug-related crime, public use, and public needle disposals have all been shown to decline after the implementation of SIS (Wood, et al., 2006; Wood, et al., 2004), the salience of emotion associated with needles might have redirected attention towards fear for onlookers. If fear is understood as strong motivator towards behaviours and actions perceived as protective (Roser, & Thompson, 1995), then visibility of such objects could have elicited a strong or vocal opposition to the unsanctioned site.

OPO’s practices of rendering needles invisible serves to de-dramatize the practice of use and to re-centre attentions towards what is visible – the distinct governances of use present within their site. Here, they are governing not only the visibility of persons and practices, but of objects as well. By containing the objects of fear and limiting the engagement of publics with them, the site was able to direct attentions towards the concept of surveilling drug use as opposed to the use itself. These practices actively construct an environment and context through which the issue of use is understood and discussed.
Similarly, the act of consumption itself was unseen by those external to the unsanctioned site. As use more generally has been relegated to relative invisibility, the action of injecting fentanyl or smoking crack-cocaine is unfamiliar to many. If these were rendered visible, it would likely produce a response of shock or disgust. To observe the preparation of the substance – boiling and breaking down powdered fentanyl over a burning disinfectant wipe, black smudges on the individuals’ hands from charring the “spoon”. Meticulously drawing up the coloured liquid into a needle. The at times bloody and lengthy process of finding or ‘digging’ for usable vein, pulling blood back into the syringe and the rush of dark red into the barrel. The slow push of injection. A used syringe lying uncapped on a table. The individual laying with their head down, heavily intoxicated from illicit opioids. This unfamiliar scene is undoubtably dramatic to those who do not inject drugs and would stir a strong affective response. The act of consuming substances is rendered invisible by the vinyl walls of the tents, de-dramatizing drug consumption by concealing such affect-laden and novel imagery.

This unfamiliar and unseen process may elicit an unease, a sense of shock, and feeling of disgust deeply mired in decades of anti-drug messaging (Livingston, Milne, Fang, & Amari, 2012). Onlookers might experience a sense of shock at the sight of something so novel to them, and deeply taboo. The sense of disgust might arise from exposure to blood, the process of finding a vein and the preparation of a strange and unknown purple powder. Entrenched stigmas and perceptions of addictions, street-life, and the uncleanliness of non-professionalized injections would certainly put the unacquainted in a state of discomfort. These affective responses are mitigated and minimized through the concealment of the injection process. The practice of making invisible acts of consumption detracts from the emotionality associated with the unfamiliar and stigmatized act. In this way, OPO was able to construct the narrative of their site.
around the visible practices of surveilled consumption as opposed to battling expressions of shock and disgust.

Needles and injections were not the only things concealed. In addition to these objects and practices, affect-laden events were also rendered invisible thereby de-dramatizing the site. The scene of an overdose is inherently a dramatic one. This may be characterized by an unconscious and cyanotic person slipping into respiratory depression (Ottawa Public Health, 2022). Those responding to an overdose might apply oxygen therapy, administer injections of reversal medications, and at times utilize techniques of CPR and defibrillation (Schiller, Goyal, & Mechanic, 2022). Observing an individual on the brink of death is undoubtedly dramatic and elicits strong emotional responses in the observers. OPO attempted to contain such events to the consumption tents by requiring persons use in these designated spaces. Controlling the visibility of highly dramatic, fear-laden medical events encouraged onlookers to not engage with the hysterical or dramatic but with what was visible – the tents themselves, the practices and governances of surveilling consumption.

The tents were visible, not needles, injections, or overdoses. The objects, practices, and events which draw fear, shock, and disgust in onlookers were concealed from Ottawa residents, media, and political figures. The visibility of the site contested ongoing governances of substance use, proposing instead the alternative practice of surveilling consumption. By enshrouding individuals’ consumption in vinyl walls, the focus remains on the challenge to governmentality of illicit drug consumption which the tents exemplify. The individual, the practice, the objects and the events are not made to be a spectacle of jarring, improper, and dangerous malefactions. The de-dramatization of use allows for specific engagements with
substance use. The dramatizing elements of the counter-conduct are concealed, and what remains visible is how the practice of consumption is governed within a surveilled space.

**Privacy**

In addition to de-dramatization, the injection tents created a privacy barrier for individuals consuming substances. This hidden publicity, however, is distinct from other practices of hidden public drug use. The logics of concealing use within the unsanctioned site were distinct from the external logics and practices which rendered drug use unseen. Concealment of use was not predicated on shame or risk of incarceration; within the site, concealment represented a rearticulation of the medical practices of confidentiality. The tent walls provided a barrier from stigmatization by external onlookers, allowing the guests a space of dignity. Finally, the invisibility of consumption serves as a protection from legal repercussions.

Confidentiality in care is a common practice within healthcare organizations. A patient’s involvement with care facilities, and the outcomes of the provided care are strictly confined to the practitioners involved with treatment (Mohammadi, et al., 2018; British Columbia Medical Association, 2017). Only those directly providing care to the individual and immediately requiring the patient’s medical information have access to it. This ensures the individual has the autonomy to disclose or conceal personal information as they see fit (Mohammadi, et al., 2018). OPO organizers rearticulated this logic and practice of confidentiality within their site. While the heterotopic space contests many practices of medical regimes, this is one clear example of rearticulated care practices borrowed from dominant logics and practices within healthcare structures. The concealment of consumption and the anonymity maintained within the
unsanctioned service produced privacy mirroring confidentiality in care, suggesting OPO’s provision of care from the borders of medical regimes.

This represents a shift in logics of invisibility, while hiding use in alleyways and under staircases may be understood through logics of stigmatization, shame, and criminalization, the deployment of healthcare logics allows for an externally acceptable practice of concealment. These medical norms, professional obligations of non-disclosure, and practices of invisibility were adopted within the unsanctioned care space.

The tent walls obscured the view of both external onlookers and law enforcement apparatuses. By disallowing passers by, neighbours, citizens, media, or residents to observe the individual guests, the practice of concealment partially shields guests from external logics which might stigmatize and shame them. In this way, concealment provides not only privacy but also a sense of dignity. Social stigma leads to ill-treatment of persons engaging in drug use (Livingston, Milne, Fang, & Amari, 2012). Outside of the site, interactions and observations of public drug use may lead individuals to contact police, in turn rendering use invisible again. The legal status of consumption, possession, and public intoxication place substantial carceral risks upon PWUD (O’Grady, Gaetz, Bucceri, 2013; O’Grady, Gaetz, & Bucceri, 2011; Herner, 2020; City of Ottawa, 2016). The inability to observe and document incriminating acts provided some level of protection against legal ramifications of public use. While public consumption had previously been concealed in part due to risk of incarceration, here the nature of hiding is related but distinct. The practices of consumption were made known though the overt visibility of the site, however the act itself was concealed. The concealment provided some degree of protection for guest from legal repercussions of use, while the site simultaneously acknowledged illegal activities were occurring within these tents. These relationships of (in)visibility protect the
individual - affording privacy, confidentiality, and dignity, while challenging the criminalizing and stigmatizing governances of use.

Through practices of concealment of objects, practices, events and individuals, attentions and affective responses of onlookers were managed; privacy, confidentiality, legal protections, and dignity were afforded to guests. Through the invisibility of needles, the fear and discomfort were minimized for those observing the site, effectively de-dramatizing use. By minimizing fear, the practice of concealment reduced the likelihood of resistance through actions externally perceived as protective (Roser, & Thomas, 1995). The practice of injection and the overdose event were obfuscated. Though these were known occurrences, they were imperceivable. This unseeing de-dramatized drug consumption and lessened affective responses to the objects, events, practices, and individuals within the tents. By managing visibilities, OPO constructed a realm of knowable truths. What was seen was the practice of surveilling consumption - an alternate system of governing use. In this way, the unseeing of consumption constructed limits on the context of the issue and discussion. Additionally, privacy of guests invokes a logic of confidentiality rearticulated from healthcare, positioning the concealment of use as a healthcare practice not one of shame and criminality. This invisibility further protected guests from the carceral and social outcomes of external governances of use, offering protection from legal repercussions and affording dignity through sheltering guests from stigmatization. This invisibility, however, turned out to be imperfect.

**Being Espied**

Attempts to dedramatize and conceal ingestion from the voyeuristic gaze were not always successful. While OPO organizers permitted media, politicians, and curious onlookers to tour the site and consumption tents prior to initiating their service, once in operation the tents were
exclusively for guests. Despite presenting this opportunity, the draw of the veiled transgressions took hold. Participants reported that mayor Jim Watson publicly questioned what truly occurred within the tents, suggesting an untruthfulness surrounding the unseen and dramatizing the site. The practices within the tents conveyed as unverifiable and left room for imaginations to run wild with greater improprieties than injection drug use. Concealed space was positioned as a secret, requiring revelation – endorsing curiosities as a “public’s right to know” and where media might be understood as alerting the public to misdeed (Dean, 2001). This enters a space where legitimate seccreties might hold space for corrupt uses. Where secrecy of concealment might be understood as a deferral of communications (Horn, 2011), the de-dramatization and intentional invisibilities allowed the management of discourse and public attentions towards governances of use. However, the concealment itself spawns an intrigue – creating a secret to be revealed through the limitations in access (Horn, 2011). What cannot be seen within the tents might well be nefarious acts to which OPO does not openly admit. Where there had previously been legitimate confidentiality, a secret is created through intrigue and revelation.

Shortly following these comments, a reporter entered the injection tent unnoticed and photographed guests consuming illicit substances without their permission. A local news outlet published one of these images. By taking this picture and publishing it, the journalist was simultaneously creating and revealing a secret – they are unmasking practices that had been hidden from the public and eliciting the strong affective responses associated with injection drug use. The practice of concealment shifts from logics of legitimate confidentiality in health care towards the revelation of secretive and shocking misdeeds. The revealed secret becomes a form of entertainment (Dean, 2001). The reporter actively made visible what OPO attempted to conceal and by extension re-dramatized the de-dramatized elements of the site. This act of
disclosure refocuses attention on the emotionality of the imagery. as opposed to the practices
governing substance use.

As dedramatizations were countered by deliberate acts of dramatization, so too were
practices of privacy upended. A neighbour of the park set up flood lights, illuminating the site.
This individual, in the most literal sense, shone a light on the activities within the site. This
brought visibility to the persons entering consumption tents and to those occupying other regions
of the site. While ongoings internal to the tents remained unseen, the flood lights made visible
the persons entering and exiting these spaces, effectively removing anonymity and
confidentiality of care. While consumption remained unseen, selling and purchasing substances,
preparing drugs, or occupying public space while intoxicated were now fully visible. Rendering
these practices visible subject guests to a criminalization and carceral repercussions that the
logics of privacy sought to undermine. The practice and act of illuminating the site was itself a
resistance to the logics and practices of privacy. While privacy practices within the site worked
to remove criminalizing, moralizing, and stigmatizing logics, the direct refuting of this privacy is
suggestive of a refusal of these logics. More specifically, the guests do not deserve privacy
because their use is an immoral, criminal, or pathological act. The visibility and direct removal
of privacy antagonises OPO’s attempts at creating and maintaining practices of privacy both as a
healthcare space and as protection from police and prejudices. While under these floodlights, the
accessing of services was not truly anonymous and all illegal acts beyond consumption were
rendered visible.

The inwoven relations of visibility and invisibility within the site create a context which
centers the governances of substance use and the practice of surveilling consumption. This is
accomplished in part through the concealment of objects, practices, events, and persons. A de-
dramatization is constructed through rendering highly affect-laden practices of injection, the needles themselves, and overdoses as unseen. This de-dramatization works to mitigate fear and shock responses associated with the elements of the service. By limiting visibilities, organizers frame public attentions on what is still seen – the tents. This structures discourses on the governances of use as opposed to the shock and awe surrounding injection drug use. Guests were provided with a legitimate practice of concealment – medical confidentiality, as well as some degree of protection from legal apparatuses and dignity in the face of stigmatization. Practices of external actors at times upended efforts to conceal and dedramatize, effecting a re-dramatization of substance use, and construction of use through external logics of criminality and immorality. Overdose Prevention Ottawa’s relations of (in)visibility did not fall entirely within the control of the organizers of the heterotopic space.

Making a Scene

The interplay of (in)visibility, affect, action, and attention suggest that OPO’s site may be understood as a scene. A scene may be understood as a visual spectacle, occupied space of ongoing actions, intertwined with affect, and embodies techniques of visibility to capture attention towards an issue (Walters, 2022; De Genova, 2013). De Genova’s conceptualization of the scene contains an engagement with the obscene – an unacknowledged underbelly of the scene (De Genova, 2013). While this presents an alternative avenue for understanding the relations external to and complicit in producing OPO’s scene, the current work focuses exclusively on the heterotopic site itself. Walters elaborates that scenes are the product of counter-conducts and emerge from a group of actors whose actions partially construct the narrative surrounding the issue at hand (Walters, 2022). It is clear this offers an opportunity to integrate relations of intentional (in)visibility and constructions of narrative into the concept of a
heterotopic space. Not all scenes are heterotopic and not all heterotopias are scenes, however the territorialization of counter-conducts the concept of heterotopias lends well to the production of a scene. The scene seems to present in a subset of heterotopic spaces which aim to alter or force engagement with the discrepancies of governances within and external to them. Walters suggests that this concept brings visibilities and political communications into counter-conducts (2022). Foucault’s *Of Other Things* does not require heterotopias to draw attention to a specific issue or attempt to alter relations of visibility to draw attention to itself (at times the inverse) (1986), however it is clear that a large subset of heterotopic spaces, namely counter-conducts of protests, political or social action, and certainly OPO’s site would meet the abovementioned conceptualization of a scene. In this way, the unsanctioned site was not only a heterotopia but also formed a scene.

Working from this understanding, OPO’s unsanctioned site clearly meets the criteria of a scene. Raphael Brunet Park was an occupied space in which actions represented distinct logics, practices, and expertise surrounding the practices of drug consumption. The site emerged from the actions of a group of approximately twelve core organizers. Narratives of use were conveyed through practices of (in)visibility and were at time disrupted by external actors (Walters, 2022). Invisibility was mobilized as a technique from managing affective responses to the site and directing attentions towards specific iterations of the issue (Walters, 2022).

This interplay of visibility and invisibility is predicated on the draw of attention. Inherent to managing and directing attentions is the presence of those attending to the issue. As OPO’s scene drew attention to the issue of injection drug use, practices within it articulate the production of novel publics (Walters, 2022).
Publics may be understood as contingent collections of disparate individuals coalesced through a practice, tactic, or objects (Marres, & Lezaun, 2011). A clear example is an opinion poll, the technique of polling creates a collected group of distinct individuals united on a certain issue and brought together through the practice of polling (Osborne, & Rose, 2003). Critically, these are not pre-existing groups or categories, but contingent upon the practices which construct them (Marres, & Lezaun, 2011). Publics are constituted non-permanently through practices, tactics, and objects, and called into being by the presence of an issue (Marres, & Lezaun, 2011; Walters & D’Aoust, 2015). The creation of the scene calls upon disparate peoples to attend to a specific issue through a specific lens and might undertake practices which create multiple publics (Walters, 2022).

In response to OPO’s scene, various publics arose both in support of and resistance to the unsanctioned site. OPO’s digital presence called together a following of disparate parties under a contingent and time-limited collection, spurring the formation of publics, which in turn were mobilized and their actions become an expansion of the scene itself. One example is the practice of call outs. Call outs refer to requests or comments by a group or individual intended to produce some form of action in support of the individual or group that initiated the call out. These are often seen through social media posts. One example of discursive support is activists calling out politicians and spurring on many followers to rally behind their comments. A more material example can be seen when organizations put out requests for specific donations via social media. Though distinct forms of support, both are initiated by a group or individual, dispersed to a wide audience, and seek the support of disparate individuals through material, financial, or discursive contributions. The initiator calls out, and the audience responses.
Through the practice of call outs, publics were mobilized to undertake actions in support of the unsanctioned site which expanded the occupied spaces of action, altered the relations of visibility, and induced specific affective responses. The jarring contestation of normative practices surrounding drug consumption also called into being publics resisting the counter-conduct. This was notable in the emergence of a community safety group and the dispersal of sterile needles throughout the surrounding neighbourhood. This group comes into being in resistance to the unsanctioned site and mobilizes to protect a perceived risk to the safety of an alternate public. In response to OPO’s counter-conduct, a counter-resistance emerged in which actors produced another scene altogether.

**The Digital Scene**

OPO’s site drew and held attention through a variety of means. Social media – Twitter and Facebook, were used to maintain a digital presence and develop a following. In the most direct sense, a dispersed and contingent conglomerate of persons unified through “following” OPO online, and attending to it’s curated digital visibility. At the time of writing, their Twitter following rests at 2046 accounts and Facebook at 1885 (OPO, n.d.; Overdose Prevention Ottawa, n.d. a). OPO organizers report using Twitter call outs to mobilize their online following towards actions in support of the organization. These disparate individuals drawn together through the technologies of social media and a collective interest in the scene and counter-conduct of OPO’s site and mobilized to action through the call out. As a public, not an audience, the individuals are not simply absorbing provided information but the relationship between the speaker and the public is participatory and bi-directional (Walters, & D’Aoust, 2015).

While Twitter and Facebook themselves offer a means of engaging with the narratives and logics of OPO, the practice of the call out propelled these publics toward action. At times,
call outs are seen in the request for specific supplies. Responses to these requests were near-immediate. While these support and bolster the capacity to maintain the scene, other call outs drew publics into the scene and actively expand it. These call outs are less explicit, they express a request for publics to engage with the scene itself through sharing of information and direct contestation of political figures in a digital space. OPO organizers expressed that their Twitter following mobilized to confront and challenge Mayor Jim Watson and Councillor Mathieu Fleury following OPO’s online call outs. By drawing attention to the conflict with these figures, their tweets mobilized a public of supporters to act. As members of this public drew attention to the comments and contestations of Watson and Fleury, the followers too became enmeshed with the scene.

The visibility of Twitter comments, re-tweeting, hashtags, the tweets tagging public figures dramatized the political resistances to the counter-conduct and made visible the policy positions, actions and inactions, and biopolitical outcomes of politicians’ stances on monitored injection. Twitter became a space of action, making visible politicians who were perceived as resistant or ambivalent towards PWUD and supervised consumption, while leaving nuanced articulation of drug policy invisible in the space of 240 characters.

While drawn together by the presence of the physical and digital scene, external actors coalesced into a public and mobilized through practices of Twitter call outs. These publics became an expansion of the scene itself as much as a reaction to it. By posting about OPO, reposting OPO’s tweets, incorporating identifying hashtags, and tagging politicians in tweets, the scene expands from solely the followers of the OPO Twitter page to include the pages of all those retweeting, and their followers’ feeds. By tagging politicians it directly associates them
with the scene and the issue, and the bombardment of tagged tweets makes visible the issue to politicians through a digital space.

Twitter posts associated with OPO were often steeped in emotion. Expressing rage, grief, and tragedy, at times they referenced politicians’ dangerous abdication of responsibility which lets die PWUD. At other times, tweets called attention to the immediacy of the opioid crisis, and need for novel governances through safe injection sites. By positioning municipal governments unwilling to act, emphasising alternative governances, and focusing attentions on untimely loss, OPO organizers attempted to elicit affective responses in observing publics. Mobilizing publics to expand the scope of the scene, occupy greater digital territory, and convey affect-laden messaging creates a context in which a public initially engaged through the scene and mobilized through call outs, undertakes actions which bring them into the creation and expansion of the scene itself. The response to the scene becomes a part of it.

This can be noted in a post on the OPO Twitter page which tagged Mayor Jim Watson directly, rendering it visible to his account. It was shared 39 times, making it visible across numerous accounts and to all those following these accounts, occupying space on the pages and twitter feeds of many. The tweet reads “See @JimWatsonOtt this weekend ask him what an accessible safer consumption space is. Ask him how to prevent an overdose. Ask him what he knows about isolation and shame. Ask him what he knows about the impacts of drug use stigma. #hetakswedie #nothingaboutuswithoutus” (OPO, 2017).

The tweet directly targets the city’s mayor and suggests that he is inappropriately positioned to govern over consumption, the practices necessary to intervene on life-threatening overdoses, and by extension the policies which restrict these interventions. These speak to an outrage with his response to the OPO site. The writer directly tied in elements of tragedy through
the imagery of isolation and shame associated with unhoused persons using substances. The sadness and fear of death are ever present in the use of the hashtag he talks we die.

The hashtags nothing about us without us, he talks we die, and OPO saves lives are used repeatedly on OPO’s twitter account (OPO, n.d.). Nothing about us without us appeals directly to the expertise and knowledges utilised in drug policy creation and the governance of drug consumption. Actively constructing the Twitter page as a site of contestation of knowledges and logics of care. OPO saves lives references the alternative practices proposed within the heterotopic site. Finally, he talks we die serves to dramatize and integrate affective responses into the expansion of the scene. This phrase draws attention to the temporality of decision-making and the burgeoning opioid crisis. Implied in this is while political figures have the space and time to deliberate policy, the effects of inaction or inexpedient action lead directly to the deaths of people who use drugs. The language used crafts a sense of urgency and crisis, implying this issue might require responses beyond the slow, deliberative, and bureaucratic measures of democratic decision-making.

Through the use of Twitter, OPO was able to perform call outs, mobilizing their followers towards action. The use of Twitter in the condemnation of political actors allowed followers to expand the scope of the scene, influence the visibility of the contestation, and contribute to the visibility of affect-inducing discourse. In essence, the OPO site itself was a scene which organizers expanded into technological and discursive spaces through social media. This created a following, a public, which was then embedded in a multi-directional relationship with the information shared by OPO. Followers were able to grow the scene through engagement of wider audience and visibility of messaging.
Changing Shape

“… [an organizer] set up an appointment… so we knew he would be there, and we all stormed city hall. We brought the 600 letters, we brought signs, we brought naloxone kits. We had speeches outside before. And so long story short, we stormed the place and demand you talk with us because you’re threatening us and you’re not supporting us, and he never came out!”

Here, an OPO organizer highlights the protest actions taken by OPO and supporters, attempting to confront Mathieu Fleury outside of his office at Ottawa’s city hall. An appointment with the councillor was booked under false pretenses to ensure his presence during the protest. Organizers, volunteers, and supporters marched from the unsanctioned site to city hall carrying empty naloxone kits, placards, and 600 signed letters to in support of the unsanctioned site. This act reflects the mobilization of a public towards actions which expands the physical borders of the scene. The use of the empty naloxone kits performs a dramatizes the issue of overdose deaths and invokes related affective responses. The march itself rearticulates the relationship between shame and use, and appeals to a sense of democratic obligation. Finally, it articulates various publics through the use of protest and petitions, which at times conflicts with other publics in support of surveilled consumption.

Again, bringing together a public through social media, OPO was able to use a call out to request participation of followers in their march. The march was intended to confront councillor Fleury and present him with a petition containing 600 signatures, voicing support for OPO in the face of his public resistance to the site. The petition itself articulates a public, providing a means through which disparate residents of Ottawa may come together in response to OPO’s scene and unite as a collective through the mechanism of the petition.
Mobilizing these publics, OPO initiated a Twitter call out requesting supporters join the march. By coming together through the practice of the protest march segments of this digitally constructed public mobilized and became integral to an expansion of the scene itself. Through the act of the march on city hall, the scene expanded from the territorialized borders of Raphael Brunet Park, to encompass a wider and transient occupation of space as a site of visible contestation of governmentalities. The heterotopic site had breached its borders.

The integration of affect and dramatization of the issue of drug consumption and SIS are evident in the inclusion of empty naloxone kits, as well as in the tactic of the march itself. Naloxone is an extremely effective reversal agent for an opioid overdose and prior to 2016 required a prescription to acquire (Canada, 2016). At the time of the protest naloxone was available through some pharmacies and community organizations, however participants report that it was somewhat difficult to acquire and that pharmacies would “ask lots of questions.”

The empty naloxone kits drew attention to the recent rise of overdose deaths. They forced a centrality to the issue of untimely and preventable deaths associated with the growing opioid epidemic. The inclusion of these objects appealed directly to tragedy, the emotional devastation of continuous bereavement, and a mournful grief associated with deaths that might have been prevented through alternate practices and policies surrounding substance use. The use of the empty kits conveys to onlookers a substantial affective response by centering death and loss, and by extension dramatizes the relatively routine act of a protest march.

The march itself, while commonplace, is an act of dramatization and visibility. The language used in the above quote ties in an affective experience associated with a democratic duty. The unsanctioned site had spilled over into public demonstrations of resistance and moved from centering the focus and attention on care practices, and towards centering on politics. The
crowd chanted “shame” outside city hall, drawing media attention, creating a scene for observing publics, and city officials within the building. This expressed an inversion of the relations of (in)visibility and shame observed within the borders of Raphael Brunet Park.

The original scene actively strived to disconnect shame from the practice of consumption through (in)visibility – here the expansion of the scene displaces the shame from the act of consumption and PWUD, onto those opposing practices of surveilled consumption and directly onto municipal leaders. The practices of use were presented to observing publics as disconnected from the affect of shame, while the structural abdication of responsibility and the active resistance to monitored consumption was portrayed as shameful.

Beyond the reallocation of shame surrounding use, the language used by organizers conveys a sense of duty or moral obligation to the will of the public, a public configured through these acts of protest and petition which were presented as representative of larger silent majorities (Rodgers, 2018). The language of storming city hall conveys a revolutionary endeavour, a storming of the Bastille to seize control for the peoples and forcing disconnected political leaders to confront the governed. The march makes visible the perceived incongruence between the actions and governances by political apparatuses and the will of ‘the people’. While it does bring visibility to Ottawans’ previously unaffiliated with the site, united as a public through petitions and marches in resistance to the ongoing governing substance use, what is not visible in the ‘storming’ is the discrepancies between support for OPO and support for sanctioned surveilled consumption amongst residents of Ottawa. Previous surveys document a slim majority support for safer consumption sites in Ottawa (ForumResearch, 2016; Duggan, 2017), however a small survey by the Lowertown Community Association suggested that 62 % of respondents were opposed to OPO’s unsanctioned site, and 62 – 75 % supported the various
proposed sanctioned sites. Curiously 90% of Ottawa respondents outside of Lowertown expressed support for the site (Lowertown Community Association, 2017). It is noteworthy that some of these surveys had a relatively low number of respondents. These opinion polls may reflect deliberate actions to mobilize responses of publics and craft an image of a silent majority whose opinions go unheard, without necessarily reflecting the actual positions of Ottawa residents writ large. These polls might be best understood as technologies of politics, rather than honest reflections of political opinions.

Regardless of the whether or not the march reflected popular opinions within the region, it did create an affective response to the imagery of politicians unresponsive to their electorate, unwilling to address ‘the people’, and by extension conjures up notions of democratic duty and revolutionary fervor. The empty naloxone kits create a salient affect associated with tragedy and loss. These acts and objects expanded the scene beyond the site of care into the realm of the political and incorporated markedly different affective experiences.

These tactics made visible to media, residents of Ottawa, and politicians a public unified in support of OPO. The visibility of a public in support suggests to politicians they would be wise to heed the voices of their electors, and to the media that OPO’s counter-conduct does not stand alone but has a loud endorsement from those outside of the site. This scene does not render visible a more nuanced exploration of public opinions on OPO and the intermediaries and alternatives to an unsanctioned site.

Both the march and the social media engagements represent an expansion of the scene through the mobilization of publics towards actions supportive of the unsanctioned site. Through the expansion of the space of ongoing action, the integration of affect, and the navigation of
(in)visibility, the march and Twitter feed are clear expansions of OPO’s scene. The publics which responded to the initial scene played an active role in the expansion of the scene.

**Publics of Safety**

While the scene of the unsanctioned site called into being publics in its support, publics certainly formed in resistance to the counter-conduct. These resistant publics also produced scenes. A small number of concerned neighbours came together to form a community safety group. Most of their actions and tactics of resistance directly pertain to the disruption of OPO’s ability to maintain their occupation of Raphael Brunet Park. These tactics include covering the park in manure, illuminating the site with flood lights, and the use of airhorns. A notable divergence from these tactics of disruption was the dispersal of paraphernalia throughout the neighbourhood. Here, the safety group departed from the attempts to complicate OPO’s capacity create an ongoing space of action and branched into the creation of a novel scene.

“Somebody was planting supplies all over… and saying that we were contributing to this litter, these used supplies and they were so dangerous because they were used… none of them were used. Like the cookers were clean, they just opened up everything and dumped it. So, we’re pretty sure it was just sabotage by that group.”

During the operation of OPO’s site a person or group of persons obtained sterile injection supplies and placed them throughout the Lowertown neighbourhood. Some organizers allege this was an intentional sabotage by the community safety group. Others clarify that these were not the fault of the site itself, aware of the perception of used paraphernalia organizers thoroughly cleaned the park each night. This tactic of dispersing paraphernalia created an alternate scene, one in resistance to the heterotopic site. Here the occupied space of action takes on a wider
breadth than the boundaries of the park. By placing affect-laden paraphernalia throughout Lowertown, the alleged saboteurs created a novel scene encompassing the entire neighbourhood.

The affective dimension of dispersing needles in public spaces is apparent. This capitalizes on the same premises that OPO’s de-dramatization sought to avoid - the shock of finding seemingly dangerous paraphernalia, the fear associated with needles, and a deep concern for the safety of children. The complication exists within the ability to recognize hazardous injection supplies. As with any scene, not all narratives are within the control of the actors. The needles found were often capped, and a plastic cover intended to prevent depressing the plunger remained on – while it is possible to recap a needle, the plastic protector indicates that the needle was unused. Cookers – the “spoon” in which injectable drugs are prepared are easily identifiable when used. The handle would be attached, a coloured residue would be present, and the underside would be charred. These markings would have been familiar to OPO organizers and guests, making it clear to them that these items were not used. However, this would have been unknowable to persons unfamiliar with injection drug use. The sterility would have been invisible, reifying the fear and danger associated with the items

The question of visibility goes beyond the needles themselves. While this tactic renders visible the needles which OPO’s consumption tents worked to conceal and de-dramatize, it also maps out dystopic future imaginaries. It reifies fears surrounding the outcomes of integrating injection spaces into the community. By associating the outcome of needles scattered around the neighbourhood with OPO’s articulation of public consumption, these actors render unseen and unspoken the long history of public drug consumption within the neighbourhood. The practice of injection drug use occurred in this region well before the unsanctioned site. One might expect a site with appropriate receptacles and the ability to contain injection drug use would result in
fewer needles on the surrounding streets, not more (Wood, Tyndall, Lai, Montaner, & Kerr, 2006; Wood, Kerr, Small, Li, Marsh, Montaner, & Tyndall, 2004).

By placing needles throughout Lowertown, the actors brought out several new publics. The implicit association with the presence of these needles is a risk of exposure. This risk is commonly associated with children, and a fear of children encountering unsterile needles. These imagined children became the public in need of protection from needle exposure, and by extension from OPO’s site. The ‘public’ needed to be shielded from the impacts of the site.

Regardless of culpability or innocence in this alleged sabotage, the community safety group itself brought forward alternative publics. As a community safety group materialized and mobilized in response to OPO, they implicitly defined a distinct public that is the “community” of Lowertown. By positioning themselves as the protectors of this public, they necessarily create malefactors against which they protect. As this group is an explicit response to OPO, this cast guests of the site as alterior subjects. PWUD are not a part of the community, but a force enacting harms against said community. They are interlopers in Lowertown, from which the community must be protected. This renders invisible the longstanding residency of many street-involved PWUD within Lowertown. Unhoused and shelter-housed individuals in Lowertown are rendered non-members of the community by virtue of their housing status and drug consumption. The community safety group explicitly aims to protect the safety of members of the community. This positioning of exteriority renders guests as threats to safety, and makes invisible their needs for protection and safety.

The community safety group was produced in response to the site and scene of OPO. The group allegedly created a scene of resistance to the counter-conduct by dispersing of needles throughout Lowertown. These actions capitalized on the strength of emotion associated with
needles and the fear of exposing children. This countered efforts of de-dramatization by rendering visible the affect-laden objects. Novel publics, or a community, was conceptualized through these tactics and objects. Inherent in this was the vilification and othering of persons who use drugs. The complexity of the (in)visibility of the objects as sabotage was predicated on a highly specific knowledge, the inaccessibility of this knowledge made true the risk and danger associated with these apparently used injection materials. The counter-scene was a resistance to the scene of OPO’s counter-conduct, which in turn was resisting ongoing governances of drug consumption. Further complicating this, all actors and scenes are apparently done in the name of “public” health and safety – articulating diverse concepts of public and how to render these peoples safe.

Conclusion

The complexity of seeing and unseeing drug consumption was ever-present at the unsanctioned site. The overt publicity of illicit drug use brought forth the truth of ongoing public drug consumption, while normalizing and destigmatizing the practice to some degree. In contrast, individual acts of consumption were concealed within vinyl walls, mitigating affective responses through inexposure and de-dramatizing the narrative surrounding the site. Though contested by the practices of external actors, this management of visibility and minimization of fear worked to centre attention on governances of use and the practice of surveilled consumption.

The creation of OPO’s scene is predicated on the discussed practices of (in)visibility within their site. As a byproduct of this scene, various publics were produced. The utilization of Twitter brought into being a digital public. Segments of this public were catalysed to act through call outs. By retweeting, tagging, and posting this contingent public expanded visibility and scale of OPO’s digital scene. Similarly, supporters joined in a protest march, expanding the size and
nature of occupied spaces of action, incorporated novel affects of democratic duty and tragedy, rendered visible distinct publics, and dramatized the march through the inclusion of empty naloxone kits. In both such cases, the publics which were created by an initial scene, and undertook practices which led to their integration into the scene and expansion upon it.

Unsurprisingly, OPO’s counter-conduct was met with some resistances. One remarkable resistance crafted a distinct counter-scene characterized by fear and concern for the well-being of children and “the community”. Through the distribution of needles and cookers in public spaces, these actors dramatized the act of consumption in direct opposition to OPO’s practices of de-dramatization. This scene created an alternative public, a community of Lowertown residents excluding those utilizing OPO’s services.

The interplay of visibility and invisibility were paramount to the heterotopic site. This space of counter-conduct, and narratives presented through it were forged through dynamic relations of seeing, unseeing, and selectively attending. By making seen and making a scene, the work of OPO organizers brought to the fore distinct logics and practices, and actively challenged external governmentalities of drug use.
“Your medicalized model will not work”: Autonomy, self-determination, and medical regimes in the management of safer drug supplies

“…the dealing, that was totally on the downlow. Not very many people know about that, like still to this day not very many people know.” A largely unseen and unknown practice within the unsanctioned safer consumption site was the provision of safer drugs. The management of available drug supplies provides a point of analysis for autonomy, expertise and authority in decision-making, and relationship to medical regimes embedded within practices at the heterotopic site. The managed supply program exemplifies how the de-prioritization of medical regimes unfolded within the site, positioning these resistances at the fringes of medical regimes. Participants overtly reject of the ‘medicalized model’, or medicalization of care, in turn practices articulated a de-medicalized managed drug supply program.

Introduction

Overdose Prevention Ottawa organizers directly asserted that their services were a form of healthcare. The caveat to this claim of healthcare status was an exteriority to what organizers termed the “medicalized model” – that is, their capacity to operate outside of medical regimes and center guests’ autonomy and capacity to determine their own care needs. This represented a complex de-medicalized articulation of health care. OPO overtly placed the governances of the behaviours and practices of substance use within the realm of health and social services, their practices articulate care external to the medicalized model, and at the borders of medical regimes through the de-medicalization of care. In navigating these overt rejections of the medicalized model and the dominance of medical expertise in the governances of substance use, OPO’s
practices and logics articulated a distinct positioning of knowledge-holders and expertise. Attempts to centre guests’ autonomy in decision-making and self-determination of care needs were evident in the practices surrounding OPO’s managed drug supply program (MS).

Medicalization refers to the process through which elements of everyday life and typical behaviours transition from ‘normal’ to pathological and are then governed by medical knowledges and expertise (Hancock, 2018; ten Have, 2022; Ballard, & Elston, 2005). In essence, the process of medicalization implants a practice or behaviour within the domains of medical governances and within medical regimes. When organizers discuss the medicalized model, there were repeated references to prioritization of medical knowledges, positioning of medical practitioners as experts, and reliance on medically-determined interventions. In contrast, this posits the existence of an alternative process of de-medicalization – which will be defined as the removal of the behaviour or practice from medical regimes, medical knowledges, medical decision-making, and professionalized expertise. It is noteworthy that OPO still deems these behaviours and practices as an appropriate site of intervention predicated on risk to health, making this de-medicalization partial.

Capacity to determine need and autonomy in decision-making were central to the practices of de-medicalization. Over the last few decades, patient-centred care has come to the fore. Patient-centred approaches are considered a metric of the quality of patient care (O’Shea, Boaz, & Chambers, 2019). This is reflected in the positioning of the clinician as the sole decision-maker in healthcare slowly transitioning to a model of shared decision-making and power (De Haes, 2006; Taylor, 2009; O’Shea, Boaz, & Chambers, 2019). Health institutions verbalizing these intentions of power-sharing and shared decision-making do not necessarily reflect the actualities of care and practices within clinics (Nimmon, & Stenfors-Hayes, 2016;
Joseph-Williams, Elwyn, & Edwards, 2014). As explored below, sanctioned managed drug supply programs are deeply entrenched within medical regimes, and decision-making is predominantly in the hands of professionalized carers.

Within medical apparatuses, patients are positioned as holding ‘care preferences’ while medical providers are positioned as holding the expertise and evidence needed for ‘evidence-based practice.’ This discrepancy is noted in medical care more broadly, as well as in the treatment of substance use disorders (Bailo, Vergani, & Pravettoni, 2019; Friedrichs, Spies, Harter, & Buchholz, 2016). The positioning of expertise and knowledge-holding place the medical professional and patient in an asymmetrical power dynamic, whereby the practitioner holds the specialized knowledges and the capacity to execute care (Nimmon, & Stenfors-Hayes, 2016). Critical to the concept of evidence-based practice is the formation of truths, and acceptable means of acquiring evidence. One core organizer highlights this dilemma while considering the adoption of surveilled consumption into sanctioned care services, “… and evidence needs to be academically validated. Those institutions [care facilities] accepting it as valid, rather than information sourced from people on a front-line position.” This individual directly critiques the formulations of truth and knowledge as exclusively within the domain of professionalized skillsets and medical apparatuses, calling attention to the dismissal of experiential knowledges within the medicalized model of care.

Collectively, these call to attention the autonomy of the guest and capacity for self-determination of care needs, as well as the formulation of truths and localization of knowledges. Within the process of medicalization, medical practitioners and medical knowledges pathologize behaviours and states, and govern interventions on such pathologies (Hancock, 2018). In the case of OPO, the process of de-medicalization of care may be observed in various Managed Supply
practices that reflect prioritization of non-professionalized knowledges, autonomy in decision-making, and the capacity to determine ones’ own needs and interventions.

The ‘Medicalized Model’

The medicalization of substance use and the construction of use within a medical regime provide an analytic lens which closely reflects the more colloquial positioning of “the medicalized model” as explained by participants. The medicalized model refers to practices of care articulated through professionalized expertise, with limited capacity for individual autonomy and self-determination of care. Participants repeatedly explored this concept referencing the prioritization of medical knowledge over clients’ sense of wellbeing. They further emphasised that external medical decision-making processes often did not reflect clients’ expressed needs. One respondent highlighted this by contrasting OPO’s site with a sanctioned site. “Its sterile, its rule laden. Its hours are very banker driven… its not trauma informed. I don’t know. We had something beautiful, we had something that worked.”

Another participant elaborated on the relative positioning of knowledges through a comparison of OPO and sites which endorse a more medicalized model of care. This participant draws attention to the medicalized model’s emphasis on highly professionalized skillsets, and prioritization of medical knowledges over experiential knowledges and lived-expertise. “… [At sanctioned sites] still the nurses are at the top. At OPO there was one nurse, and the rest was peers… we don’t need an overlord to tell us when to jump and how high. We’re sick of that. Especially when it comes to this, we’re the experts in this."

Further, an OPO core organizer elaborated on this distinction in authority and decision-making within care sites. “There was no sign that somebody was in charge there, there was
nobody in charge ever. If there was anybody in charge, it would be you, you know? That's how
we worked. There was no nurse telling me what we should do or me telling a nurse what to do.
Everybody was working together.” A third organizer highlighted the role of autonomy, and
guests’ ability to determine their own needs and desires as they pertained to substance use and
relevant interventions. “I think the medical model is very much, as you know, something is
wrong with you, you need to change. And obviously we are not, in any way shape or form, like
that. We never felt like anyone needed to change anything or that any kind of specific
intervention should be happening while we were providing service.”

While articulating the managed supply program largely outside of the medicalized model
and medical regimes, and integrating experiential knowledges and guest autonomy, OPO’s
practices of formulating a replacement opioid program de-medicalized care, while
simultaneously continuing to articulate these practices and behaviours as site requiring
intervention on associated health risks. In essence, the construction of the MS program outside of
the medicalization of use achieves a de-medicalization through positioning of expertise,
knowledges, and autonomy. There was an interesting juxtaposition of medicalization and de-
medicalization within the site and the managed supply program. OPO’s practices are
simultaneously medicalizing surveilled injections through something comparable to patient
advocacy and the overt demand for inclusion in healthcare, and medicalizing managed supply by
positioning it as a site of intervention on health risks, while implementing this care through a de-
medicalized lens and actively resisting adoption into medical regimes.

Several models of opioid replacement programs exist within medical apparatuses. Opioid
agonist therapies (OATs) were available in Ottawa during OPO’s operation. A comparable
program to MS began in Ottawa in 2020, this program is known as safe supply (SS) (Deachman,
Processes of acquisition, dosing and titration, acceptable routes of administration, and practices of surveilling consumption are used to compare and contrast the relative positioning of OAT, SS, and MS on autonomy and self-determination, and proximity to the medicalized model.

**Managed Supply**

OPO’s managed supply program was an open secret – knowledge held only by those directly involved in the program. OPO’s practices of providing a managed supply were not given a title by organizers – however this researcher refers to the program as managed supply (MS) to effectively differentiate from the existing sanctioned replacement programs, opioid agonist therapy (OAT) and safe supply (SS). This is not reflective of terminology used by the organization, but research-imposed language to facilitate ease of communication throughout this comparative analyses.

Managed supply consisted of core organizers soliciting the services of illicit substance suppliers, or more colloquially drug dealers, to sell substances at the unsanctioned site. These vendors were suggested to have supplied opioids which were less contaminated with fentanyl. The explicit intention of this practice was to decrease the risk of overdose for guests of the site. One organizer explains that as fentanyl was relatively new to Ottawa and organizers strived to provide a safer alternative. “We didn’t know what it was, and so we had - we knew a few dealers and we knew their supply, so we had people deal drugs that were not cut with shitty stuff, and we had them around.”

These approved vendors were available on site should a guest wish to purchase substances from a provider quietly endorsed by the organization. It is critical to note that should organizers elect to invite a vendor into their site, that the organizers themselves have self-
appointed the authority to determine which substances should be managed and which should not – namely the illicit opioid supply. As well, the organizers were then choosing which dealers, and by extension which substances were immediately accessible to guests. The intention was the creation of a safer drug supply and minimization of overdose risk for guests, however this was a notable departure from the existing relations of substance acquisition and reflects external determinations of care needs.

The knowledges embedded in managed supply are multiple. The most direct knowledges associated with the development of the program are the self-determined expertise, and self-appointed authority of organizers to determine care needs. The practices within the program reflect the experiential knowledges and expertise of guests, allowing for autonomy in decision making and the self-determination of need.

One of the two main positions of expertise in MS is a self-appointed authority to determine community need. The authority and capacity to construct programs, and determine need was fundamentally self-determined and self-appointed through organizers positioning themselves as carers. This role was largely predicated on organizers being in and of the community of PWUD – as persons with lived-experience themselves, they were positioned as able to articulate and act upon the community’s needs. However, this is complicated by the fact that many core organizers did possess professionalized skillsets, licensure, and educations pertaining to social and health care. While not all core organizers laid claim to the title of peer, multiple respondents positioned OPO’s service as peer-run and peer-led. Not all organizers had formal training or specialized education, however it is important to acknowledge these clinical skillsets in the positioning of the self-appointed authority to determine need and adequate recourse.
Beyond organizers’ capacity to determine community need and articulate the scope of response, a substantial component of MS was guests’ capacity to determine their own needs and the autonomy in decision-making surrounding personal practices of use. The practices of MS, to varying degrees, reflect individuals’ knowledges gained through lived-experience and an expertise over one’s own use. Guests were largely able to determine their own needs and patterns of consumption in accordance with their knowledges. Guests were able to determine how much, how often, and through which routes of ingestion they used the alternate opioids. They were able to consume wherever they choose – surveilled or otherwise, and whether they would share or sell the acquired substance.

**Opioid Agonist Therapies**

Managed supply possesses some parallels to the sanctioned opioid replacement program known as OAT. Opioid agonist therapies provide medically-prescribed opioids to persons with opioid use disorders in maintenance doses or detoxification doses (CAMH, 2021). Maintenance refers to the practice of providing an ongoing stable dose to mitigate withdrawal symptoms from an illicit opioid, and detoxification refers to a slow decrease in dosing towards a goal of eventual abstinence (CAMH, 2021). Methadone and Suboxone OAT programs are deeply enmeshed within medical regimes, derived from professionalized sources of knowledge and expertise. These distinctions are notable in the processes of acquisition, as well as dosing and titration. The act of surveilling consumption under the gaze of a medical practitioner is common to both OAT and managed supply, but differentiated in function and relative autonomy.

Methadone is a long-acting opioid medication, prescribed primarily for opioid use disorders (Anderson, & Kearney, 2000). It is intended as a replacement for illicit opioids. The explicit purpose of methadone is to replace illicit consumption while eliciting minimal
withdrawal symptoms – this is known as methadone maintenance (CAMH, 2021; Anderson, & Kearney, 2000). This is often followed by methadone detoxification, a gradual downward titration of dosing, with an end-goal of complete abstinence (Anderson, & Kearney, 2000). Methadone has a known overdose risk associated with its use outside of prescribed dosing, or in conjunction with other opioids, alcohol, or benzodiazepines (CAMH; 2021). It is often administered as a daily dispensed liquid, and consumption is witnessed by a clinician or pharmacist (Anderson, & Kearney, 2000).

Similarly, Suboxone contains a long-acting opioid called buprenorphine and is used to minimize opioid withdrawal symptoms. However, it also contains naloxone (CPNP, 2021; CAMH, 2021). Suboxone is taken as a sublingual tablet, and when ingested through this route the naloxone is inactive. Should an individual consume the tablet intravenously or intranasally, the naloxone will precipitate opioid withdrawal (CPNP, 2021). As with methadone, this is consumed once daily as prescribed by a medical practitioner, and doses are gradually titrated up to a maintenance dose (Velander, 2018). Suboxone presents with a lower overdose risk profile than methadone and is considered the gold standard treatment for withdrawal management (CPNP, 2021).

Both OAT medications, Methadone and Suboxone, are prescribed by licensed medical providers and practices are determined by specialized medical knowledges. These practices substantially diverge from the positioning of expertise and knowledge within the managed supply program. These distinctions are observed through the practices of acquisition, the determinations of dosing and titrations, and the practices of surveilling consumption.
**Practices of Acquisition**

Distinctions between the OAT and MS programs are noted in the means of acquisition. OAT and MS have radically different practices of knowledge-holding and of determining need as gate-keeping factors to acquisition of replacement opioids. These are reflected in the role of the care provider, as well as the autonomy of the client.

For Methadone & Suboxone, the processes of acquisition situate the care provider as the knowledge-holder and entrust providers with the capacity to determine need in accordance with a specialized medical knowledges. The client has relatively little ability to arbitrate or contest the practices of acquisition. Access to Methadone and Suboxone are at the discretion of a designated medical prescriber. This prescriber will have obtained a specialized education in, and practicing as, a medical doctor or nurse practitioner and licensed by the appropriate governing bodies (College of Physicians and Surgeons of Ontario, n.d.; Ontario Ministry of Health, 2018b). The prescriber must further possess the appropriate legal exemptions to the Controlled Drugs and Substances Act, as regulated by Health Canada (Ontario College of Pharmacists, 2018). The knowledges valued here are highly professionalized and emerge from medical apparatuses. This prescriber will assess the client’s request for OAT and determine eligibility for this program utilizing treatment protocols and clinical guidelines developed by medical bodies (CAMH, 2021). This places the capacity to determine needs and knowledge necessary for such assessments, squarely within the medical field. Here the knowledges, capacity to render care decisions, and expertise are reflective of medical regimes.

Once the practitioner has determined the client is eligible and is willing to prescribe the replacement opioid, an approved clinic or pharmacy may dispense the medication in accordance with the Ontario College of Pharmacists – Opioid Policy (Ontario College of Pharmacists, 2021).
This further requires oversight mechanisms through the monitoring and mandatory reporting of prescribing and dispensing to professional regulatory bodies (CAMH, 2021; Ontario College of Pharmacists, 2021). The practices of determining capacity to dispense medication are predicated on specialized medical knowledges and professionalized skillsets. Compliance with medical practices in ensured through the oversight of various medical apparatuses. Here too, knowledges, knowledge-holders, and capacity to determine appropriate practices are firmly established within medical regimes.

The knowledge and capacity to determine need and access to OAT is placed in the hands of the licensed medical prescriber. They are granted this privilege through extensive education, licensing, and legal exemptions, all administered through medical apparatuses. The autonomy in decision-making and self-determination of need exercised by the client, in regard to OAT acquisition, is limited to the choice to request access. The dispensing of these substances is further restricted to those with professionalized and accredited skillsets and is overseen to ensure compliance with medical knowledges and established appropriate practices. The placing of knowledges, determinations of need, articulation of appropriate practices, and role of the care giver in the process of OAT acquisition all firmly root the OAT programs within medical regimes.

OPO’s managed supply program placed knowledge-holding, determination of need, the role of the care giver, and client autonomy in starkly different positions. Knowledge-holding and determination of need were in the hands of both the care provider and the guest, and reflect positioning outside of medical regimes – suggesting that practices promoted de-medicalization of care.
The care providers, OPO’s core organizers, granted themselves the authority to determine community need through the facilitation of the managed supply program. By deciding this program was necessary, determining the boundaries of it, and initiating the program, they were in fact positioning themselves as holding knowledge about community needs and granting themselves the authority to act upon these perceived needs. The positioning of the care provider and the program initiation reflect an expertise and positioning the unsanctioned care providers as holders of unique knowledges. This positioning as experts or knowledge-holders was self-appointed and predicated on an integration into the community of PWUD. Several participants placed emphasis on lived and/or living-experience with substance use as the basis of their knowledges on community need. From this position as within the community, they grant themselves permission and authority to intervene on behalf of said community. The knowledge and expertise to determine need were experiential, not professionalized, and the authority was self-appointed not through medical apparatuses and licensure. Fundamentally, these positionings represent a departure from the medicalized model – these practices do not reflect medical regimes.

It is from this position of experiential expertise and self-appointed authority that care providers determined the need for MS, whose drugs were safe, and which drugs would be intervened upon. It is critical to note, while operating outside of legal and sanctioned services, many organizers possessed professionalized skillsets and were already employed as sanctioned care providers for the community of PWUD. One organizer explained, “at any given night, chances are there was one, two, three social workers there. There was [personal support workers] there. Chances are there was at least two nurses there, lots of peers…” Some participants drew attention to the fact most core organizers were not actively unhoused or using substances at the
time of OPO’s operation. While these skillsets and life circumstances do not negate knowledge and expertise acquired through lived-experience, it does complicate the narrative of expert positioning as from the community of PWUD. The practices rearticulate elements of medical regimes while openly resisting others, positioning this de-medicalization as a non-totalizing process. Even with the inclusion of professionalized carers, the MS program was operating outside of the bounds of legal, licensing, and professional oversight mechanisms. The operation of this program was based on a self-appointed authority, granting themselves permission to dispense narcotics outside of medical regimes. Here, the practices do not necessarily endorse a full de-medicalization and are complicated through the inclusion of a plethora of clinical skillsets. Elements of the unsanctioned program reflect dominant governmentalities while others resist these governmentalities. Through the rearticulation of certain elements of dominant medical regimes, and the integration of practices, logics, and knowledges counter to dominant governances – OPO articulated care from the borders of medical regimes.

Guests possessed a great deal of autonomy in the process of MS acquisition. While the range of available substances was externally determined, the ability to acquire these substances was at the discretion of the individual. The individual’s knowledge of self and capacity to determination of their own need was sufficient to qualify for such a program. No assessment or eligibility criteria were enforced. The guests were simply required to decide to access the service, attend the site and seek out the appropriate vendor, and purchase the substances. This represents a substantial departure from the highly professionalized knowledges, endorsing self-knowledge and experiential expertise. Further, it reflects an autonomy in decision-making and capacity to self-assess and determine need. These positionings of knowledge and expertise, and autonomy in decision-making are significantly distinct from that of medical regimes, and of OAT specifically.
OAT and managed supply highlight differential positionings of medical and experiential knowledges, expertise, determinations of authority, and individual autonomy and self-determination of the service users. Acquisition of OAT is gatekept through specialized knowledges and expertise, acquired through extensive education and a licensing process. It is regulated and monitored by various discipline specific governing bodies, as well as Health Canada. Patients of these prescribers have minimal autonomy and self-direction in the process of acquisition. Medical knowledges are centered and prioritized over experiential self-knowledge. It is firmly situated within medical regimes. In contrast, managed supply reflects de-medicalized practices of accessing replacement opioids.

The development of managed supply centred the knowledges and expertise of self-authorized carers in determining the needs of the community of PWUD. This is predicated on a self-determined status as representing the community rooted in lived- and living-experience. This narrative is complicated by the inclusion of professionalized and licensed care providers within the core group of organizers. This reflects a non-totalizing process of de-medicalization, whereby elements of dominant governances are present within the counter-conduct. It articulates care practices at the fringes of medical regimes. Guests maintain substantial autonomy and self-determination of personal need in the process of acquisition, with few external constraints to accessing the managed supply. The contrast in locality of expertise, authority, and capacity to determine practices of acquisition highlight the distinction between medicalizing practices of OAT and the de-medicalizing practices of managed supply.

**Dosing and Titration**

Determinations of dose and titration further highlight these distinctions between OAT and MS. Amounts of replacement opioids consumed by service users reflect patterns of
knowledge-holding and expertise, capacity to determine need, and the autonomy and self-determination observed within medical regimes or de-medicalization, respectively.

OAT dosing and titration are regulated by clinical guidelines, clinical judgement, and enforced through reporting structures. These cumulatively reflect the knowledge produced and disseminated through medical apparatuses, expertise of medical professionals, determination of practices in accordance with these. Practices of dosing and titration emblemize the ways in which OAT is entrenched in medical regimes.

The starting doses of OAT is generally well below the maintenance dose of methadone or suboxone. These doses are prescribed in accordance with an appropriate range determined by clinical guidelines and treatment protocols (CAMH, 2021). The determination of amounts of replacement opioids required is reflective of various medical knowledges. The doctor might articulate where within the appropriate dose range an individual may start, and guidelines created by governing bodies and health institutions articulate the boundaries of these ranges, in turn reliant on clinical research (CAMH, 2021). While the client may be aware of their tolerances or have previous experience with the OAT drugs, dosing is not at the discretion of the client. This reflects a production and dissemination of knowledge through medical apparatuses, clinical judgement allotted to a professionalized expert, and determination of need articulated in ways that reflect medical regimes.

The titration of doses is governed similarly. The amount of a substance consumed per day, and rate of alterations of dosing are decided in accordance with dosing standards and patients’ tolerance (Isaac, Janecek, Kalvik, & Zhang, 2015; CAMH, 2021). There are minimum timeframes between the incremental increases or decreases of doses, and maximum size of changes to doses are predetermined (Isaac, Janecek, Kalvik, & Zhang, 2015). This suggests that
the medical knowledges and experts are more apt to determine the amount of an opioid that an individual can tolerate safely than the individual themselves, regardless of histories of use. It places the expertise in medical prescribers, and the production and dissemination of knowledge within clinical research apparatuses and medical governing bodies. The practices of dosing and titration are articulated through medical regimes

The client possesses the autonomy to petition for dosage increases, however these changes to prescriptions are ultimately at the discretion of the prescriber and informed by standard treatment protocols and obligatory reporting to oversight bodies (Ontario College of Pharmacists, 2021). This reporting structure ensures compliance with approved practices of care. It positions the research and evidence upon which best-practices are determined as the bearer of truth for the client – these knowledges as more capable of determining the quantity of prescribed opioid required than the individual using said opioid. Cumulatively the practices of dosing and titration place the OAT programs within medical regimes through positioning of knowledge-holding and expertise, determination of needs, and localizing knowledge production and dissemination within medical apparatuses.

In contrast to OAT, the MS program had no externally imposed stipulations or requirements on dosing or titration. Guests were able to exercise full autonomy in decision-making by electing the dose, rate of increase or decrease in use, and frequency of consumption as per their own determination of their needs. Knowledges of self and autonomy in decision-making are centered through these practices, reflecting the articulation of a replacement opioid program outside of medical regimes, and ultimately de-medicalizing care.

It is important to highlight that illicit opioid use does not always pertain to seeking a state of substantial intoxication, but at times is used to counteract withdrawal symptoms. This type of
use reflects practices of maintenance OAT, while allowing the individual the ability to determine what dose is required and when changes to patterns of consumption are necessary. This is not to argue relative efficacy of autonomous versus medical maintenance, but to draw attention to the articulation of such a practice outside of medical regimes and constructed with space for greater autonomy in decision-making and self-determination of care.

**Surveilling Consumption**

Surveilling consumption presents an interesting insight into the integration of medical knowledges and individual autonomy for both OAT and MS. The above discussed examples emphasize distinctions between the positioning of expertise and decision-making in these programs and how they were reflective of medical regimes and processes of de-medicalization of care. Through this analytic exploration of practices of surveilled consumption, the articulation of medical expertise and knowledges are drawn into the de-medicalized program – emphasizing the non-totalizing nature of the process. Both medical knowledges and experiential knowledges intertwine to facilitate distinct practices of care.

Surveillance practices within OAT programs differ between Methadone and Suboxone. Methadone is often administered as a daily dispensed witnessed dose (College of Pharmacists of British Columbia, 2013; Ontario College of Pharmacists, 2018). This refers to the practice of dispensing a single dose of the medication each day by a clinician or pharmacist, who will then immediately observe the act of consumption (BC Centre on Substance Use, n.d.). This practice of surveilled consumption ensures compliance with the treatment regimen set forth by the prescriber, in accordance with treatment protocols (BC Centre on Substance Use, n.d.). The client may advocate for unwitnessed doses and carries (multiple doses to take home), however this is ultimately at the discretion of the prescriber. The capacity for decision-making
surrounding the surveillance of consumption is placed with the licensed prescriber, the recommendations of surveillance practices are made by medical bodies in accordance with treatment protocols which ultimately reflect production and dissemination of medical knowledges. The act of consumption itself is surveilled by professional care provider. The positioning of expertise, knowledge-holding, production and dissemination, and the capacity to determine practices are firmly planted within medical regimes, and reflect the ‘medicalized model’ of care.

Additionally, the prescribers themselves are surveilled through medical apparatuses which ensure compliance to approved practices. Practitioners must report methadone prescribing to the College of Physicians and Surgeons of Ontario (Ontario Ministry of Health, 2016). The surveillance of consumption and allowance of consumption are embedded in medical apparatuses and determined by medical regulatory bodies. The oversight pertains directly to compliance with medical knowledges derived from appropriate clinical research.

Suboxone presents as an intriguing rearticulation of surveillance. While the consumption of the medication is often not directly observed, the composition of medication itself serves a similar end to witnessed dosing. Compliance with prescriber-determined routes of consumption and treatment regimen are pharmacologically enforced. The inclusion of naloxone in the Suboxone tablet provides a direct punitive outcome for consumption through alternative means. When consumed as prescribed, sublingually, the naloxone is inactive. If taken intravenously or intranasally, the naloxone will initiate a state of precipitated withdrawal (Velander, 2018). Further, the buprenorphine in Suboxone has a ceiling effect whereby further increases in dose will not elicit further intoxication (Velander, 2018). For Suboxone, compliance with medically-determined treatment regimens are not enforced through visually surveilled consumption but
through pharmacology. The client retains the autonomy to determine whether to allow visual surveillance of consumption by any other individuals. With Methadone, the intended purpose of witnessed dosing is to ensure medications are not diverted – with Suboxone, this end is accomplished through the inclusion of buprenorphine. The punitive structures built into the medication reflect the prioritization of medical practices and treatment regimens, of medical expertise, and the prioritization of medical knowledges. While not physically surveilled, the comparable mechanisms continue to situate Suboxone OAT within medical regimes.

With managed supply, there was an implicit encouragement towards surveilled consumption. The unsanctioned site’s explicit purpose was to surveil consumption. By accessing a managed drug supply at a supervised consumption site, guests are aptly positioned to consume under surveillance with minimal intermediary tasks or barriers. Guests utilizing MS ultimately possessed the autonomy and self-determination regarding the practice of surveilled consumption. Using on site was not obligatory and the individual had the autonomy to determine whether to engage in surveilled consumption. However, the practice of dispensing on site would likely influence this decision-making.

The structure of managed supply, while not obligating witnessed consumption by a medical professional, certainly encouraging this practice. Within the injection tent there was one nurse and one peer surveilling consumption. The logics underpinning OPO’s articulation of surveilled consumption were distinct from those of OAT, emphasizing not treatment compliance but rather overdose intervention. However, through the mandatory inclusion of nurses in surveilling consumption, OPO’s MS marks a clear departure from its previous disentanglements with medical regimes and medical authorities over knowledge, integrating elements of dominant external governances.
The nurse, a licensed medical professional with a highly specialized skillset, though operating outside of legal and licensing structures was surveilling the act of consumption. The mandatory inclusion of this professionalized carer places a strong emphasis on medical knowledges and skillsets. While the mandatory inclusion of a peer complicates this narrative by undermining the prioritization of medical knowledges on health. One core organizer noted that they had likely intervened on more overdoses through lived experience than the nurses had through their medical training. “I probably reversed more overdoses at that point than she had ever reversed. Yeah, but because she's a nurse and she's there, it gave me credibility. And because I was there, it gave her credibility. So, I think that's the piece that was really important.” This OPO organizer offered the suggestion that the medical and experiential skillsets and expertise were collaborative and integrative, providing each role with legitimacy and credibility within the street-world and external to it. These roles were intended as non-hierarchical and equivalent in value, however practices and expressions of non-hierarchical positioning of roles and knowledges were at times imperfect and reflected external logics and practices. This articulates a space in which medical regimes enter into the practices of surveilling consumption but do not totalize them. There is an integration of experiential practices, knowledges, and expertise which suggests a simultaneous medicalization and de-medicalization of care.

Cumulatively, the practices of acquisition, dosing and titration, and surveillance observed within the OAT and MS programs reflect distinct positioning of expertise, of service users’ autonomy, and prioritize distinct knowledges. The MS program can be understood as a refusal of medical expertise and highly professionalized knowledges, centering instead autonomy and self-determination of guests. These practices and logics formulate medical dissent through refusals of medical regimes. OAT Methadone and Suboxone maintenance programs are situated within
medical regimes and reflected the ‘medicalized model’ of care. MS engages with a self-appointed authority to administer care, predicated on the assumption of lived-expertise, however this narrative is complicated by co-existing professionalized skillsets. Overall, guests’ autonomy in decision-making and self-determination of care needs are centred within the MS model, while OAT predominantly places decision-making and assessments of need to licensed care providers. The practices of surveillance complicate this dynamic through the integration of medical practitioners into the unsanctioned site, while maintaining space for experiential knowledges. While OAT directly reflects medical regimes in each of these practices, MS reflects a complicated positioning of simultaneous de-medicalization and medicalization, largely yet incompletely formulating care outside of medical regimes. This incomplete rejection of medical regimes articulates care at the borders of these regimes, rearticulating elements of the dominant governmentality within the counter-conduct.

Safe Supply

Safe supply programs became available in Ottawa during 2020 (Deachman, 2020), well after the November 2017 closure of Overdose Prevention Ottawa’s safer consumption site. However, the relevance of safe supply programs to the managed supply program is clear. One organizer drew this comparison directly, framing OPO’s managed supply program as a safe supply program. They explained, “Yeah, I could speak a little bit more to trying to get a safer supply of substances too. This is around the time that purple fentanyl had just came on the scene, and that was really scaring the shit out of us. We didn’t know what it was and so we had, we knew a few dealers and we knew their supply. So, we had people deal drugs that were not cut with shitty stuff, and we had them around so our participants at the site could have our own
regulated supply and our overdose rate went down. We had our own safer supply program going on.”

Considering participants directly associated these programs, it is worthwhile to explore the nature of the relationship between MS and SS, and how practices might figure into medical regimes and alternate positionings of knowledge. To this end, routes of administration and practices of surveilling consumption are explicated. Again, these pertain directly to knowledge-holding and expertise, practices of determining need, and the autonomy and self-determination of the service user.

Safe supply or safer supply (SS) programs are medical treatments in which licensed providers prescribe opioids to be used in replacement of illicit street drugs (Penn, 2019). SS is not intended as a maintenance or detoxification medication, but an outright replacement for illicit opioids to be consumed as the individual sees fit. Doses are dispensed as carries – meaning the individual receives an allotment of tablets per day, or other determined timeframe, and may consume them independent of medical supervision (Penn, 2019). The replacement opioids provided are often the long-acting opioid Kadian, and short-acting opioid Dilaudid (Penn, 2019).

As with the OAT program and MS, the range of substances available for substitution is not determined by the individual accessing the service. In all programs discussed, sanctioned and unsanctioned, the determination of which substances requiring substitution and the opioids rendered as available alternatives are determined by care providers in accordance with their knowledges and expertise.

It is important to note that processes of acquisition, and dosing for safe supply are similar to that of Methadone and Suboxone (Penn, 2019). SS is subject to similar oversights and requires
federal exemptions from the Controlled Drugs and Substances Act (Canada, 2022a). In these capacities, SS is subject to the same positioning of expertise, knowledge, and client autonomy as OAT, rendering these processes well within the bounds of medical regimes.

One participant drew attention to this prioritization of medical knowledges and raised concerns surrounding dosing and titration of safe supply. “…even Safer Supply – it’s not really working. If someone has a super hardy fentanyl addiction and you give them – what is it? Fifteen Dilaudids a day, you’re going to put them into precipitated withdrawal. You may as well tell them to be abstinence-only. We still don’t have nurse practitioners and doctors that really understand addiction.”

The clearest divergences and interplay between medicalization and de-medicalization in SS are present in practices surrounding routes of administration, and the surveillance of consumption. These again are seen in knowledge-holding, expertise, determination of need, and autonomy.

Routes of Administration

Routes of administration are the most clear and direct example of practices centering experiential knowledges, self-determination of need, and autonomy in decision-making. Both SS and MS emphasize client autonomy and self-determined need, through complete allowances of decision-making capacities to the individual regarding routes of consumption. Neither program removes the capacity of independent choice in this realm.

The care provider and the individual dispensing the substance place no restrictions on the means of ingestion and route of administration. Clients are free to determine how they wish to consume the substance – orally, nasally, intravenously, etc. They are also free to inject the
substance with assistance of another individual, or independently as they see fit. There are no external managements of this process. The individual using may autonomously decide when they consume, how they consume, and how much of the given supply they consume at one time, as per their knowledge of self and determination of their own needs. This is an articulation of consumption practices within comparable replacement opioid programs where centering of experiential knowledges, lived-expertise, and guests autonomy in decision-making reflect a de-medicalization of consumption practices for both MS and SS.

This is clear and distinct departure from the regulated practices of OAT, whereby methadone is dispensed as a witnessed dose to ensure compliance with medically determined routes of administration. Suboxone further limits routes of administration through the inclusion of naloxone within the sublingually-administered tablet. In these instances, the practitioner’s knowledge and the protocols and standards of administrative bodies determine the appropriate means of consuming replacement opioids. Safe supply and managed supply stand counter to the centering of medical expertise in the routes of administration and determinations of patterns of use. The prioritization of the client’s knowledge and determinations of their own needs reflects the centring of autonomy and self-determination over professionalized and external expertise. The knowledges and positioning of expertise observed in the practices surrounding routes of administration do not reflect medical regimes.

**Surveilling Consumption**

While routes of administration were largely unconstrained by external expertise, this approach is not reflected in all aspects of SS or MS. Surveilling consumption is explored through direct and indirect means of surveillance and ensured compliance. Care providers were positioned in both programs as determiners of need, with varying levels of autonomy for service
users. This reflects some degree of entrenchment within medical regimes, as well as some practices of de-medicalization.

As discussed above, managed supply was accessible at the supervised consumption site. This served as an incentive to consume within surveilled spaces. Within the injection tent, this included the supervision of individuals by a medically-trained professional and a peer. These represent the integration of both professionalized knowledges and the experiential knowledges in the practices of surveilling consumption, and an entangled logics of simultaneous medicalization and de-medicalization. Guests retained the autonomy to elect to use elsewhere and reject direct surveillance of use.

The surveillance of use in the safe supply program is not direct. The act of consumption is not surveilled by care providers. Clients are simply provided with the substances to consume as they see fit. This is reflective of the individual’s capacity to determine whether they require surveillance, and the autonomy to decide where to consume. The client’s knowledge of self, and determination of need is centred in this capacity. It would appear to de-medicalize the practice of consumption.

There is, however, an indirect surveillance of use. Clinical guidelines direct practitioners to utilize routine urine drug screening with SS clients (Hales, et al., 2019). This allows practitioners to surveil the client’s consumption indirectly, ensuring the provided opioid is being consumed by the client. These guidelines further suggest practitioners monitor consumption of various illicit substances through urinary drug analysis (Hales, et al., 2019). This suggests the surveillance of not only SS drug consumption, but a wider surveillance of substance use. The articulation of these practices of surveillance are informed through medical knowledges, align with medical practices, and are executed by professionalized carers. Interestingly, the medical
Evidence supporting surveillance practices is indirect, and extrapolated from medical research pertaining to other opioid replacement programs (Hales, et al., 2019). Authors of these safe supply treatments guidelines suggest that their clinical expertise in conjunction with inferred evidence, all situated within medical apparatuses, are sufficient to support the adoption of these surveillance practices (Hales, 2019). The relationship between surveillance practices and appropriately produced medical evidence becomes less direct in the acknowledgement of the absence of formal medical research on surveilling SS programs. Prescribers are encouraged to exercise clinical judgement in surveillance (Hales, et al., 2019). This positions indirect surveillance as a practice embedded in expert opinion, determined through medical apparatuses, disseminated through medical governing bodies, yet with a tangential relationship to medical evidence. The practice of urinary drug screening as indirect surveillance falls well within medical regimes, but is complicated in its relationship with the practices of producing knowledge.

While unable to provide the evidence - which underpins the clinical training, knowledges, and expertise of practitioners, it is here suggested that these trained experts are able to articulate these truths and knowledges on the basis of their positioning as expert clinicians. The guidelines’ recommendations of indirect surveillance are predicated on the positioning of the expert, not on the body of evidence.

Clients’ capacity for autonomy and self-determination in this indirect surveillance is limited. The practitioner controls accessibility of the replacement opioid. The client might exercise autonomy in the choice to consume in alternate spaces – directly surveilled or in private. However, the capacity to determine whether to engage with indirect surveillance through urine
screening is beyond the control of the client. The positioning of decision-making capabilities, and expertise in monitoring practices are rooted in medical regimes.

**Conclusion**

Elements of surveillance of consumption are present in OAT, SS, and managed supply. With methadone, this often takes the form of a prescriber-mandated witnessed dosing, whereby approved clinical practitioners may visually observe and document consumption to ensure compliance with medically-determined treatment protocols. Suboxone offers an alternative means of ensuring this adherence without direct surveillance; the inclusion of naloxone in the drug formulation offers a punitive assurance of adherence. Clients may petition for unwitnessed dosing, however the decision-making ultimately lies in the hands of the prescriber. Managed supply, while not mandating surveillance does encourage the use of substances under the direct surveillance of self-appointed and/or medically-trained care providers, here integrating the prioritization of medical expertise and knowledges through the mandatory inclusion of nursing staff within the injection tent. This interweaves of practices which medicalize and de-medicalize, constructing care at the border of medical regimes, contesting many practices and logics while rearticulating and incorporating others. With MS the ultimate determination of need for surveilled consumption is at the discretion of the guest. They may exercise their autonomy in deciding to access the managed supply without engaging in surveilled consumption. Lastly, SS does not require direct surveillance of consumption, nor does the structure of the program encourage directly surveilled consumption. It renders the client autonomous in decision-making regarding direct surveillance, however it does indirectly surveil consumption through routine urine drug screening. This drug screening is not within the discretion of the client, but governed through medical apparatuses. Across these three programs, positioning of decision-making
capacities, localization of knowledge and knowledge production, expert positioning, and autonomy are expressed through various practices, articulating distinct interweaving of medical regimes and de-medicalization.

OPO organizers directly asserted that their care services were in fact healthcare, however positioned themselves as in exteriority to medical regimes. They are at times articulating a process of de-medicalization, and at others are reflective of elements of medical regimes. Understood in conversation with opioid agonist therapies and safer supply programs, the managed supply program articulates a central focus on experiential knowledges, self-appointed authorities, guests’ autonomy in decision-making, and a capacity to self-determine care needs. This navigation of the health care external to formal medical structures is reflective of an incomplete de-medicalization of care.
Chapter 7: Conclusion

Overdose Prevention Ottawa presents a unique opportunity to explore the unsanctioned histories of harm reduction. Borrowing from Foucauldian concepts, OPO may be understood as a heterotopic space and a counter conduct. It was a site of contestation of visibilities, knowledges, and practices governing substance use. The borders of the site were both rigid and permeable, navigating the resistance to medical regimes while simultaneously articulating medical logics within specific practices.

OPO contested specific governances of substance use and structures of health care for PWUD. It represented both resistance to political governmentalities and medical dissent, rearticulating care from the borders of medical regimes. Contestations were notable in practices of making visible and knowable the prevalence of substance use and making visible elements of care while rendering invisible and dedramatizing others. Practices and objects were mobilized in the creation of scenes – call outs, marches, petitions, and naloxone kits call into being unique publics and mobilized said publics towards the expansion of the scene. While the first analytic chapter addresses contestations and resistances visible from a position of exteriority to the site, the second analytic chapter turned towards internal practices of resistance - focusing on practices of de-medicalization.

This concept of de-medicalized care is apparent in the contrasts between of replacement opioid programs. Comparisons of OAT and MS programs emphasize the distinctions in autonomy in decision-making, self-determination of care needs, and localization of expertise. While safe supply programs introduces a larger degree of autonomy and self-determination than OAT, both programs are firmly rooted in medical knowledge, practice, and expertise. Overdose Prevention Ottawa’s managed supply program was for all intents and purposes a sanctioned drug
dealer on location, purported to provide a less contaminated product. This practice did impart some decision-making and expertise into the hands of organizers, while practices of consumption were largely dictated by the guest – prioritizing autonomy in decision-making and self-determination of care needs.

Cumulatively, these practices and logics of (in)visibility and the articulation of health care on the fringes of medical regimes – or the medicalized model, position the unsanctioned site as both a scene and a heterotopic space of counter-conduct. The resistances and alternative knowledges, logics, and practices noted within the space represent a node within a larger network and history of unsanctioned peer-based care. The actions undertaken by OPO organizers can be situated in a broader network harm reduction services. OPO’s practices and logics are largely shared by other organizations such as Toronto’s Moss Park unsanctioned site and previous unsanctioned injection sites in Canada (Kerr, et al., 2017). OPO may be situated in a loosely affiliated collective of harm reduction efforts and organizations spanning at least six decades (Blok, 2011). As with counter-conducts, resistances are not solitary isolated refusals of dominant practice, but are situated within a dispersed network and loosely united through practices, knowledges, subjectivities, and logics. OPO’s site integrated elements of dominant governances and medical authorities within their practices of care, articulating a non-totalizing process of de-medicalization and positioning their practices at the borders of medical regimes. The rearticulation of elements of OPO’s practices, namely surveilling injections, into dominant governances of substance use within Ottawa further emphasizes the positioning of OPO as a counter-conduct.

The current work contributes to the minimal publications exploring harm reduction through Foucauldian analytics (McLean, 2011; Scher, 2019). This research serves to deepen
understanding of the practices and logics within both sanctioned and unsanctioned services through an in-depth exploration of unsanctioned care. This provides a counter-balance to understandings and practices of harm reduction within medical regimes, and makes visible alternative governmentalities of use. Further, these analyses provide a window into the largely concealed internal practices of Overdose Prevention Ottawa, which is valuable in contextualizing current practices within sanctioned services. Finally, it contributes to a largely under-researched domain of unsanctioned care services for PWUD. While extensive research exists on sanctioned safer consumption services, minimal academic works address unsanctioned services (Kerr, et al., 2017; McLean, 2011; McNeil, et al., 2014; Blok, 2011; Foreman-Mackey, et al., 2019). By documenting the unsanctioned efforts and practices of Overdose Prevention Ottawa, this research contributes to a fuller understanding of harm reduction and its complex and often under-reported histories of resistance.

**Limitations and Future Works**

The limitations of this work are multiple. While some reflect logistical challenges, others present opportunities and avenues for future research. Logistical considerations include technological considerations, issues of compensation, and the inability to interview a wider breadth of participants. Future works may examine the perspectives and knowledges of those external to these sites, as well as service users themselves. Further, comparative analyses of the distinct governmentalities of use present within various sanctioned sites presents an interesting avenue for future works.

The practice of online interviewing allowed participants to turn off their cameras. In future endeavors it would be advantageous to perform in-person interviews. Non-verbal communications were largely lost through the use of Zoom.
As per the advice of one organizer, compensation could have more adequately reflected the expertise held by participants. While the honorarium was reflective of that offered through similar research projects, peer work is precarious, underpaid, and undervalued (Kennedy, et al., 2019; Greer, Bungay, Pauly, & Buxton, 2020). This researcher does not wish to contribute to the continuation of such valuations. Future compensations may reflect the positioning of expertise and knowledge more appropriately.

Perspectives of neighbours, municipal politicians, and services users would have provided a much more comprehensive understanding of the practices, perspectives, knowledges, and identities within the unsanctioned space. Interviews were not conducted with service users. The perspectives and experiences of guests of the unsanctioned site and clients of sanctioned services would provide a wealth of information and insight into experiences within sanctioned and unsanctioned spaces. They might also speak to the efficacy of attempts to articulate logics and practices of de-stigmatization, empathy, and normalization. Unfortunately, amid a global pandemic it seemed imprudent and infeasible to interview persons who are often substantially immunocompromised and do not have consistent access to technologies such as Zoom. However, these subaltern voices may make visible the impacts of care practices on service users and highlight how experiences differ in varying spaces and under differing governances. The inability to articulate knowledges beyond those of care providers is a significant limitation of this work and these findings.

The current work was not able to explore the relationships between practices in sanctioned and unsanctioned sites in great depth, and the myriad of logics present within sanctioned sites. Additionally, this work was not able to interrogate the nature of unsanctioned practices within sanctioned sites. These areas of investigation add complexity and nuance to the
clandestine histories of harm reduction, while emphasizing ways that sanctioned and regulated services often operate outside of legal and medical apparatuses to support the well-being of service users. These are excellent avenues for future investigations.

Finally, though it would present with substantial logistical challenges, it is necessary to investigate and understand ongoing unsanctioned services. These might provide insight into future directions of sanctioned harm reduction policies and services, as well as demonstrate distinct logics and practices of care. Examination of such practices prior to sanctioned implementation may provide a more thoroughly informed framework of practices and logics, shaping forthcoming sanctioned programs.

**Closing Remarks**

While these analyses centered on counter-conducts within and exterior to the heterotopic space, it is not to detract from the overt purpose of the service. Understanding practices of care and positioning of expertise allow for an exploration of alternate governances of use and surveilled consumption, drawing attention to distinctions between medical and grassroots harm reduction structures. The services themselves however, both sanctioned and unsanctioned, are explicitly an intervention on overdose death – SIS do not prevent overdose, they prevent death. While this work left topics of overdose and death largely aside, focusing instead on counter-conducts of the ongoing governmentalities of use, this is a core facet of the site. It should not be overlooked through distanced discussions on the minutia of care practices.

With gratitude to the core organizers and managers of sanctioned sites who participated in and contributed to this work, I wish to conclude with the words of a participant on their works in this field of care. The comments reflect logics of community care and mutual aid which are
deeply intertwined with histories and practices of harm reduction. They reflect why individuals enter into this field of care, and the reasoning behind how OPO came to be.

“They come up to me and they’re like, ‘you saved my life.’ I remember the first time someone said that to me, and I looked at them and said, ‘I would like to think you would have done the same thing for me.’ I think I’ll finish with that, that’s my motto in this whole big thing. I’d like to think that everyone would have done the same for me.”
References


Canada (2021b, March) *Opioid- and stimulant- related harms in Canada: Number and rates (per 100,000 population) of total apparent opioid toxicity deaths by province or territory in 2020 (Jan to Sep).* Government of Canada. Retrieved from: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/maps


Ottawa Board of Health (2016a) Ottawa Board of Health: Minutes # 9. City of Ottawa. Board of Health [Meeting – April 18 2016]


Interview Guide – Sanctioned SIS Management

Opening:
Can you state who you are, your organization, and your role within your organization’s safer injection site?

Actions and Interventions & Practices of Care:
Did the actions of OPO differ significantly from the available care at the time?
What did practices of caring for people who inject drugs look like before OPO? After?
- What services were available?
- What limitations did you have on types of care you could provide?
Was your organization in communication with OPO while establishing your safer injection site?

Knowledges and Expertise:
Was peer-knowledge a guiding component of care at that time?
- Do you think it is now?
Has the role of the healthcare expert in shaping programs shifted at all?
- Who were the experts? Who are the experts?
- Were peer roles available in your organization at the time? Are they now available?
  Do peers hold management positions or consult on programs?

Advocacy and communications:
Did Overdose Prevention Ottawa’s work impact your organization in any way?
Did any language, or ideas around what constitutes acceptable care within your field shift around the time of Overdose Prevention Ottawa?

Legitimacy:
In what ways did the actions of Overdose Prevention Ottawa contributed to the change in policies and practices in Ottawa?
In your experience, how did it impact healthcare work and workers?

Do you think we would have safe injection sites in Ottawa if OPO did not open its site?
Interview Guide B

Interview Guide – Overdose Prevention Ottawa

Opening:
Can you tell me who you are and your relationship to Overdose Prevention Ottawa?

Actions and Interventions:
Can you give me a brief history of Overdose Prevention Ottawa’s safer injection tents?
What support and resistance did you receive from municipal and provincial politicians?
  - Local community?
  - Police?
  - Media?

Practices of Care:
Can you walk me through what a visit was like in the Overdose Prevention Ottawa tents?
What services did Overdose Prevention Ottawa offer and how did they differ from what was available at the time?
  - How do they differ from what is currently available?

Knowledges and Expertise:
What are the central ideas or philosophies that guided the work you were doing with Overdose Prevention Ottawa?
How do these differ from the dominant ideas in healthcare at the time? Or now?
Where do these ideas come from?
  - Peer knowledge, health research, models in other locations

Advocacy and communications:
Were you trying to change the public discussion around injection drug use?
Was there a strategy for communicating with media? Politicians? The general public?
  - What was it?
  - Do you feel it was successful in meeting its ends?
Were organizers in communication with municipal or provincial politicians?
    - Petitions? Letter-writing campaigns? Consultations?

Did OPO take any steps to challenge the legal status of safer injections?

Legitimacy:
What impacts do you think your work had on policy surrounding substance use in Ottawa?
What impacts do you think your work had on healthcare providers?
What impacts do you think your work had on municipal and provincial politicians?
What impacts do you think your work had on the street-involved community?