Exploring Subjectivity Through Safer Supply

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Abstract

In 2019, the Canadian government approved the prescription of medical heroin to people with severe opioid use disorder, not as a treatment for addiction, but as a harm reduction tactic to prevent overdose in the face of an increasingly toxic street drug supply (Health Canada 2019). This harm reduction tactic is known as safer supply. Since 2019, the Canadian government has broadened the scope of safer supply to allow physicians to prescribe opioids and other drugs that they deem necessary for their patients (Health Canada 2023). In this thesis, I argue that the regulatory flexibility of safer supply allows physicians to meet their patients where they are, instead of asking them to ascribe to social norms to access care. Safer supply does not seek to end drug use; it only seeks to prevent overdose. Within the clinic, people who use drugs find they are able to understand their drug use through a positive medical/functional model instead of the criminalized model of addiction; many no longer understand their use of opioids to be categorized as addiction at all. Through focusing on personal narratives of addiction and drug use, I argue that many of the harms considered inherent to opioid use within liberal frameworks are caused by the structural violence inherent in the punitive criminalization of drug use. Safer supply allows people to form less pathologized and stigmatized subjectivities of drug use because it does not presume all drug use to be inherently problematic and removes many of the aspects of drug use that people who use drugs find harmful. Accessing safer supply is an act of care of the self and it allows people the space in their lives to begin ethical work. It is critical that as governments develop policy solutions, they consider the voices of people who will use those solutions.

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Introduction

It is late August 2021, and the third day I have spent sitting in the waiting room of a safer supply clinic with people waiting to receive prescriptions for morphine, medical heroin, and other opioids. The people waiting with me have all been deemed by the doctor who runs the clinic as "high risk" for opioid toxicity overdose, and thus eligible to participate in a novel harm reduction tactic known as "safer supply." The name safer supply indicates that in the face of an ever-increasingly toxic street drug supply, this clinic endeavours to prescribe pharmaceutical grade opioids to people as an alternative to that supply. The goal is to prevent death from using the unknown concentrations of fentanyl found in drugs on the street.

At about 2:00 p.m., I am one of only three people in the waiting room, and the majority of the safer supply patients have already been in to see the doctor first thing in the morning, so the room is relatively quiet. Suddenly, there is a loud hammering on the door of the clinic. The door is not locked, so the secretary and I exchange a surprised look, then a man's voice calls from the other side of the door, "Hello? Anyone there?" I jump up to grab the door and am faced with the panicked expression of a man in his mid-forties. He is wearing a basketball jersey and shorts, a sheen of sweat marks his forehead, and his bright red hair serves to add to the overall look of alarm on his face. "I don't have a mask on me, is it okay to come in?" he asks in a rush. The public health policy in August 2021 required all people in an indoor public space to wear a mask; however, safer supply patients who lived out on the streets frequently arrived without one. I quickly grabbed him a disposable mask from the box kept in the waiting room and then stepped aside to allow him into the clinic. As soon as I moved aside, he rushed into the room and began pleading with the secretary, "I need to get on this program, please, please! I need to get on this program or I am going to die. I know it, I am going to die." Before the secretary could calm him

down, he began pacing around the small waiting room and launched into a monologue: “I’m HIV positive and I can’t keep up with my medication because I use too much fentanyl and it has completely fucked with my life. It’s going to kill me, I don’t want to do it anymore please.” Finally, the secretary is able to get a word in and asks for his name. He tells her his name is Jeff, and it turns out the secretary was expecting him. Jeff had overdosed just last week and the paramedic who resuscitated him had told Jeff about the program at this clinic. The paramedic called ahead to the clinic and updated them on Jeff’s history with frequent overdose. The secretary reassured Jeff that Dr. Murphy would be able to see him soon and she directed him to take a seat in the waiting room.

Jeff did indeed enrol in the program and to my knowledge he did not have another overdose event during my time at the clinic. Jeff had initially been excited about talking to me for my project, but in the end, never found the time to sit down for a formal interview. My initial meeting with Jeff nonetheless serves to illustrate the urgency with which many people seek out safer supply.

I choose to open this work with this experience of urgency because the current state of the opioid overdose epidemic in Canada has shown no signs of stopping and has only become worse since it was declared a federal public health emergency in 2016. The vast majority of deaths from opioid toxicity in Canada since 2016 have involved fentanyl (Health Canada 2019). Fentanyl is a synthetic opioid that is more potent than morphine or heroin. Due to its synthetic quality, fentanyl is cheap to produce, and this has led to it being widely available on the streets. Increasingly, fentanyl is mixed with other opioids in the illicit market, often without the knowledge of people purchasing them. This mixing has made illicit opioids even more lethal. In response to this accelerating public health crisis, in 2019 the government of Canada approved

injectable diacetylmorphine (otherwise known as medical heroin) as a treatment for people with the highest risk of overdose (Health Canada 2019). The provision of medical heroin to people who use drugs and are at a high risk of overdose has been called safer supply.

Since 2019, the scope of safer supply has expanded to allow physicians to prescribe any opioids, and sometimes other drugs such as stimulants and benzodiazepines, that they deem necessary for their patients (Health Canada 2023). At this point, the federal policy for safer supply is defined more by what it does not regulate than what it does. This regulatory flexibility is what allows a prescriber to approach each individual within safer supply at the level they are at instead of asking them to change their behaviour in order to join. In a concept document written by the Canadian Association of People who Use Drugs (CAPUD), an organization made up entirely of people who are currently or who have used drugs, safer supply is defined as: "a legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market" (CAPUD 2019, 4). The CAPUD document goes on to clarify the difference between safer supply and traditional forms of harm reduction, such as safe injection sites. For CAPUD, both safer supply and harm reduction function under the logic that people who choose to use drugs, "should not be treated as morally deficient, be criminalized or deemed mentally ill for their drug use" (6). Harm reduction is a response to the harms associated with drug use in a criminalized context, but safer supply is an attempt at decriminalizing drug use (6-7). Importantly, CAPUD is explicit about what safer supply is not. It is not drugs that are used for opioid maintenance, such as methadone, buprenorphine/Suboxone, or slow-release oral morphine. To be considered safer supply, the drugs offered must contain the mind/body altering effects that people seek in recreational drug use (12). This is not a critique of opioid maintenance, also known as opioid agonist treatment (OAT). CAPUD believes that the

combination of safer supply with OAT would be a successful program for many people. The Canadian Government's own definition of safer supply is markedly different from CAPUD's in that the concern for the mind/body altering effects and the language of choice is missing. Health Canada's (2023) website defines safer supply as "the prescription of medication as an alternative to the toxic street supply of drugs to people who are at a high risk of overdose." Health Canada (2023) is also clear that safer supply is different from OAT in that the point of safer supply is not to stop drug use, but to simply prevent overdose. Safer supply conceptually straddles the line between harm reduction and OAT, but cannot be fully understood through the logic of either. When I first encountered these two differing conceptions of safer supply, one that centres the experience and choice to use drugs, and one that does not, I wanted to know which conception more closely aligns with the experience of people using safer supply in Ontario.

In this thesis, I argue that because safer supply does not seek to treat drug use in itself as problematic, it allows safer supply patients the ability to form new less pathologized and stigmatized subjectivities in relation to their drug use. The flexibility in safer supply prescription allows for a greater diversity of available subject positions than traditional opioid agonist therapies.

The Historical and Legal Context of Opioid Addiction and Treatment in Canada

While opioid addiction is not unique to North America, the opioid overdose epidemic is recognized as a largely North American phenomenon (DeWeerdt 2019). The root of this epidemic is often traced to the over-prescription of medical opioids (DeWeerdt 2019). North America is the largest consumer of opioids in the world; in Canada, opioid prescription rates tripled between 2001 and 2014 (Donroe, Socias, and Marshall 2018). In the 1990s,

pharmaceutical companies, such as Purdue, aggressively marketed opioids for non-cancer chronic pain (Donroe, Socias, Marshall 2018; Deweerdt 2019). Significantly, Purdue Pharma introduced OxyContin in 1995 as a synthetic, "safe," and "non-addictive" opioid (Donroe, Socias, and Marshall 2018, 455). North American doctors were poorly educated in treating chronic pain because the use of pharmaceuticals for non-palliative pain management was previously discouraged (Deweerdt 2019, 11). Between the heavy (and at times illegal) marketing of opioids and doctors' lack of experience treating chronic pain, prescription rates for opioids soared. Specifically, opioid addiction increased the most in rural and suburban white populations. A specific, racialized history previously framed opioid addiction as an issue primarily among urban and non-white populations in North America. Pharmaceutical companies took advantage of this history to target rural and suburban white populations when marketing prescription opioids (Hansen and Netherland 2016). A history that once imagined white rural and suburban populations as immune to addiction became the tool that brought highly addictive opioids into their communities.

Canada was one of the first countries to ban the import of opium for personal non-medicinal use with the Opium Act of 1908 (Niccolussi 2018). This legislation was passed in response to the public campaign that imagined opium-smoking, immigrant Chinese men as dangerous for white women (Niccolussi 2018). Racism against Chinese immigrants was partly spurred by the perception that opium smoking was widespread in various Chinatowns (MacKay 2018, 532). Due to the head tax imposed on Chinese immigrants between 1886 and 1923, Chinese immigrants were mainly single men who sent their wages back home to families in China and lived in crowded and unsanitary conditions (Roy 2014, 5). The grim reality of living and working in poor conditions while separated from family drove many of these men to seek

comfort in opium (Roy 2014, 5). White Canadians often assumed this habit was imported with these men, because it was understood that opium was produced in China (a reality that was forced upon China by British imperialism), but that was not always the case (Roy 2014, 5). Chinese immigrants were not the only people in Canada in the 19th and 20th centuries using opiates. For all the moral outrage of white Canadians over Chinese "opium eaters," the use of laudanum and other drugs was widespread in white Canadian society (Mackay 2018, 534). Eventually, the Opium and Narcotic Drug act of 1929 set harsh restrictions for the use of opioids even in medicinal settings (Niccolussi 2018). Heroin and morphine maintenance therapies were first proposed in Canada in 1947. Unfortunately, this proposal was met with moral outrage from conservative politicians and law enforcement alike (Fischer 2000, 188). The moral stigma of drug use continued to exert influence over Canadian politics, even though it was becoming apparent that the complete restriction and criminalization of opioids did not prevent opioid addiction. A minority of Canadian physicians advocated the use of opiate maintenance as a last resort for addicts satisfied with their way of life who did not wish to be cured (189). Nevertheless, the Canadian government claimed that the British and American maintenance experiments had failed and instead emphasized the need for mandatory withdrawal treatment for addicted criminals (189).

Canadian addiction treatment remained unchanged until 1959 when the Department of Health approved a small, controlled experiment by Vancouver addictions treatment specialist Dr. Robert Halliday (Fischer 2000, 190). Halliday wanted to try replacing heroin and morphine maintenance treatments with the new synthetic oral opioid methadone. Halliday was the first to compare methadone maintenance for addicts to insulin treatment for diabetics (191). This comparison framed addiction as a lifelong chronic illness to be managed instead of cured. His

experiment was successful and methadone maintenance treatment (MMT) became the norm for addiction therapies in Canada by the mid-1960s (192). Nevertheless, MMT was and remains extremely restrictive, only available in specialized clinics with patients closely monitored (192).

In 2007, the Canadian government approved the use of suboxone (buprenorphine and naloxone) as a substitution treatment to be administered through private doctors' offices. This approval came out of the belief that MMT was not suitable for suburban white populations because they were more often employed and so unable to submit to the constant supervision of the methadone clinic (Hansen and Netherland 2016). The high rates of opioid addiction amongst rural and suburban white populations allowed for a less restrictive mode of treatment. Yet, office-based therapy is not equally available to all people who use drugs. In Ontario, methadone treatment is covered for anyone, while buprenorphine office-based treatment is only covered for those who are covered under the Ontario Drug Benefit. The Ontario Drug Benefit is only available to people over 65, people under 24 who do not have insurance, and people on the Ontario Disability Support Program (ODSP). The price of suboxone prevents many people from accessing it., resulting in a system of treatment in which populations most at risk for overdose have the most restricted access to treatment. Free heroin-assisted treatment, such as safer supply, is a very new practice in Canada and access to this treatment is severely limited and hotly contested.

After the implementation of the Narcotics Monitoring System in 2012, which required all pharmacies in Ontario to submit opioid prescriptions to a centralized database, the Ontario Government implemented legislation that sought to deter legal opioid prescription by delisting Oxycontin from the Ontario Drug Benefit, implementing prescription monitoring programs, and releasing new opioid prescribing guidelines in 2017 (Antoniou et al. 2019). These legislative

changes reduced legal opioid prescriptions in Ontario but did not affect the rates of overdose (Gomes et al. 2017). Ontario medical regulators have adopted new restrictive opioid prescription guidelines as the standard to which opioid prescribing practices are judged, which has left Ontario doctors prescribing in "a climate of fear" (Clarke et al. 2019, 612). Many Ontario physicians dropped patients with high dose opioid prescriptions or stopped prescribing opioids altogether (Clarke et al. 2019, 612). People who were previously prescribed opioids have been abruptly cut off and forced to seek alternatives in illicit street drugs (Antoniou et al. 2019, 19).

The clinic where I conducted my research is located in a small city in southwestern Ontario. It is the only clinic with a safer supply program in this city and one of very few clinics in the region prescribing opioids at all. The integrated health networks in southwestern Ontario (Erie St Clair, South West, and Hamilton-Niagara-Haldiman-Brant) all had higher rates of opioid mortality in 2022 than the provincial average of 16.8 deaths per 100,000 population (26.7, 18.6 and 23.6 respectively) (ODPRN 2024). Southern Ontario was once a hub of manufacturing and industrial activity and the manufacturing sector is still a dominant employer. Yet, along with the rest of the Rust Belt, it has been in a steady state of deindustrialization since the 1970s (Mah 2012, 40). The loss of the manufacturing sector has meant the loss of good union jobs, replaced with non-unionized and poorly paid service jobs in the tourist sector (Helleiner 2009, 227). In their book, *Deaths of Despair and the Future of Capitalism (2020),* Anne Case and Angus Deaton have discussed opioid overdose as a "death of despair." Case and Deaton point to deindustrialization and the devaluation of the working class as drivers of both suicide and addiction amongst middle-aged men in America. Economically disadvantaged middle-aged men are the most at risk for overdose in Canada as well (Belzak and Halverson 2018). This social and economic context creates a sense of place for this thesis, and also underlines how the

economically vulnerable, deindustrializing southwestern Ontario region has, not coincidentally, seen some of the highest overdose mortality rates in Ontario.

The Anthropology of Addiction

Many scholars in the anthropological field of addiction, which has grown immensely over the last few decades, have sought to problematize the "addiction concept" (Garriott and Raikhel 2015). This notion refers to the larger understanding of addiction in science, therapy, and policy as habitual consumption that is motivated by internal forces out of the individual's control (479). My own research is situated within this project. By listening to individual narratives of people using the emerging treatment of safer supply, I complicate the addiction concept by revealing how addiction changes in different contexts. Safer supply is the legal prescription of the same drugs that in the context of the street are lethal poisons. Within the clinic, these drugs become medications and the people who use them become patients. In this thesis, I argue that safer supply offers people who use drugs a new mode of subjectivation that does not presume all opioid use to be inherently harmful, and this opens up the possibility for people to understand their drug use in less pathologized ways.

Eugene Raikhel and William Garriott's *Addiction Trajectories* (2013) calls for attention to subjectivity in addiction studies through the lens of addiction trajectories:

> Addiction cannot be reduced simply to a biological condition, a social affliction or the symptom of some deeper malaise. Rather, it must be seen as a trajectory of experience that traverses the biological and the social, the medical and the legal, the cultural and the political (Raikhel and Garriott 2013, 8).

Raikhel and Garriott break down addiction trajectories into three separate categories: first, epistemic trajectories are "categories and concepts of addiction as they have transformed over time and moved across domains" (11); second, therapeutic trajectories are "various treatments and related assemblages as they move between cultural and institutional settings" (11); and third, experiential and experimental trajectories are "lives constituted through the terrains of experience and subjectivity" (11). Anthropological focus on the trajectories of addiction reveals that norms, role expectations, and understandings of pathology change in different local settings. The analysis of trajectory highlights the importance of individual experiences and lives, which is largely ignored by the mainstream addiction concept.

Angela Garcia's *The Pastoral Clinic* (2010) is an ethnography of heroin addiction in northern New Mexico that explores subjectivity in addiction. Garcia emphasizes how intergenerational heroin use amongst Hispanos is shaped by the histories of colonial exploitation and transformation in New Mexico (10). Through careful attention to the lives and stories of people she meets at a small rural rehabilitation clinic, Garcia shows how "specific geographies of addiction intersect with institutional and historical formations to shape the lives of addicts" (9). This connection of the addict to the broader social and historical world is an attempt to problematize the popular representation of the addict as isolated from community and family ties (9). The biomedical conception of addiction within the clinic as relapsing brain disease shapes addiction treatment as long-term and partially effective (13). Garcia explores how this biomedical construction of addiction shapes local experiences and understandings of addiction.

In any discussion of how institutional forces shape subjectivity, the concepts of governmentality and biopower are indispensable. Michel Foucault discusses the concept of governmentality as a process of dislocating government from a central authority and using tools

of surveillance to regulate and govern "from a distance" (Harris 2015). Foucault introduces the term biopower in *The History of Sexuality vol 1* (1990b, 140). Biopower, as he defines it, is the result of the development of disciplines, such as public health and demography, interested in quantifying and controlling life in the nineteenth century (140). Biopower works to both subjugate the individual body and regulate the population, and thus can be understood as a tool of governmentality. Foucault credits biopower with the rise of capitalism as the techniques of biopower allowed for the increase in population and the docility of those populations (141). While Foucault's use of the term biopower was historically situated, it remains a useful concept that many scholars apply to the intersection of life and politics today. Among them, some anthropologists have more specifically used the concepts of biopower and governmentality to critique different methods of addiction therapy (Bourgois 2000; Hansen 2013; Harris 2015).

Philippe Bourgois argues that methadone maintenance therapy (MMT) "represents the state's attempt to inculcate moral discipline into the hearts, minds, and bodies of deviants who reject sobriety and economic productivity" (2000, 167). Bourgois emphasizes that the state seeks to control pleasure and productivity through arbitrary distinctions between illegal heroin and legal methadone (167). Methadone is specifically designed to release slowly, preventing a high. All things considered, the only real difference between methadone and heroin is that heroin is more pleasurable to use. Methadone is understood in the biomedical model of addiction as a magic-bullet treatment that can intervene in addiction at a molecular level (173). Nonetheless, the methadone clinic is affected by criminalized and moralized models of addiction. Patients are controlled through their newfound physical addictions, monitored and subjugated by the clinic, and forced to return on a weekly or even daily basis for surveillance. The fear of the physical

pain of methadone withdrawal, which is worse than heroin withdrawal for many people, keeps them subjugated (183).

Shana Harris (2015) explores governmentality in buprenorphine treatment. Buprenorphine treatment, when compared to methadone treatment, offers patients and doctors more freedom in care (513). Office-based opioid treatment (OBOT) is free from many of the disciplining regimes of the methadone clinic, yet patients still govern themselves through everyday choices and self-care (525). Buprenorphine can be understood as a "civilizing technology" that produces healthier and more docile individuals (515). Harris uses Nikolas Rose's (1999) conception of liberal governance, which relies on the promotion of freedom and choice to govern. With increased freedom from the regulation of the methadone clinic, OBOT buprenorphine physicians and patients are instead given a responsibility to make correct choices. This increased freedom marks the possibility for 'normal' subject positions that align with neoliberal values (526). These normal subject positions are not available within the methadone clinic, and many buprenorphine patients express gratitude for the sense of normalcy they feel in OBOT: "Buprenorphine patients and providers come to imagine themselves through their experience and desire for freedom and normalcy. This is the precise result and goal of this type of governmentality and quite possibly the true mark of liberal governance" (516). OBOT governs through the very freedom and normalcy it offers.

My thesis is in conversation with this previous anthropological research on subjectivity in addiction treatment. All the people I spoke to at the safer supply clinic compared safer supply to other forms of opioid maintenance they had tried before. Similar to OBOT buprenorphine treatment, safer supply is not as strictly regulated as methadone maintenance. Safer supply, however, is different from OBOT buprenorphine treatment because it does not seek to end opioid

use altogether. In safer supply, care is not conditional on a person's ability to prescribe to categories of social norms; patients are not required to abstain from illicit drugs. My research problematizes the addiction concept by showing how people's understanding of drug use changes within different treatment modalities and questions the assumption that all drug use is necessarily problematic. In following previous anthropological research on addiction, this thesis pays close attention to the individual narratives of addiction I encountered at the safer supply clinic.

Pleasure, Freedom and Ethics

In the CAPUD (2019) document I reference earlier, a distinguishing feature of safer supply is the recognition that people use drugs for pleasure. Traditionally, liberal drug policy has ignored or denied the pleasure of drug use. O'Malley and Valverde (2004) reveal how within liberal governance, pleasure cannot be recognized as a motivation for drug use, because pleasure must be associated with the ends that liberal governments seek and dissociated from ends deemed problematic. "Liberal pleasure appears as intrinsically volitional, for one who has no control over desire could not perform the calculus that makes her free and rational" (O'Malley and Valverde 2004, 37). An ability to enjoy pleasure in moderation is at the heart of the liberal conception of the rational free subject. Therefore, the figure of the "addict" stands as a problem for the conception of the liberal subject: "The concept of the addict confounds the possibility of being a particular kind of person, the possibility of being an individual who is owner of himself and his capacities and independent of his surrounding social context" (Martin 2013, 284). In liberal drug policy, then, the pleasure of drug use is ignored or silenced and instead drug use is only framed through conceptions of craving and pain. "The dilemma of the modern understanding of addiction is that choice leads to a lack of choice, increasingly leading to a

search for new compounds to repair the machinery of choice" (Saris 2013, 274). Harm reduction programs, such as safer supply, do not seek to end drug use itself, only to lessen the harms of drug use. Even within harm reduction policy though, pleasure as a motivating factor for drug use is often ignored (Race 2008; O'Malley and Valverde 2004). The CAPUD document describes a conceptual dilemma in the logic of harm reduction; harm reduction aims to offer a morally neutral approach to care within the context of the moralized criminalization of drug use, yet this approach would not be necessary if drug use were decriminalized. For CAPUD, safer supply is not just an attempt to reduce the harms of drug use within the context of criminalization, it is a step towards decriminalizing drug use (2019, 6).

Kane Race (2008) discusses the potential that a recognition of pleasure within harm reduction could have for creating de-pathologizing modes of care. A focus on pleasure could reframe the question of whether a person engages in a "risk" to *how* do they engage in it and what techniques do they use? Race argues that the later work of Michel Foucault "helps to navigate the complex terrain of pleasure and care in such a way that care is not conflated with the unthinking imposition of norms" (2008, 422). In the three volumes of *The History of Sexuality,* Foucault (1990b; 1990a; 1988) explores alternative ways to link pleasure, knowledge, and subjectivity that do not pathologize and oppress. Within the final chapter of *History of Sexuality vol 1,* Foucault proposes a "different economy of bodies and pleasures" (1990b, 159) as an alternative to the current oppressive subjectivation of sex and desire. For Foucault, expert discourse that is focused on desire, such as Freudian psychoanalysis, has the power to deem certain forms of desire as deviant. The relationship between expert discourse and pleasure is less theorized, and Foucault understood a pivot to pleasure as a way to escape "the whole apparatus that extracts a truth value from erotic experience" (Race 2008, 419). While Foucault's project

was the historical construction of sexuality, it is not a stretch to see the same pathologizing of desire in categories of addiction. Desire is certainly the object of many treatments for addiction, both those that use pharmaceutical prescriptions (methadone, buprenorphine) and those that do not (12 step programs). While safer supply is a pharmaceutical grade prescription, it is strictly a harm reduction tactic that seeks to reduce overdose; it does not seek to end drug use or its pleasure.

In the second volume of his history of sexuality, Foucault remarks that while the ancient Greeks may have appeared less concerned with the sexual acts than our current moment, they were not unconcerned (Foucault 1990b, 36). It was not whether a sexual act in itself was problematic, or whether it was acceptable to have that desire, but instead it was the techniques used to achieve pleasure that were the object of ethical concern. There have been many interpretations of the ethical project laid out in the three volumes of Foucault's *The History of Sexuality.* In this thesis, I work specifically with both James Laidlaw's (2014) and James Faubion's (2011) complementary conceptions of Foucault's ethics. Faubion defines Foucault's ethical subject as an actor seeking to occupy a particular subject position (4). People are never born ethical subjects; they must work to become ethical subjects throughout their life (4). Importantly, the work in choosing which ethical subject position a person strives to occupy must be taken on freely and self-reflexively (Laidlaw 2014, 102; Faubion 2011, 37). Nevertheless, the ethical subject positions are influenced by culture and society (Laidlaw 2014, 102) and people must adapt themselves to fit the positions available to them (Faubion 2011, 4). The particular telos or subject position a person strives for may be the same position that many other people strive for (to be a good parent, for example), but there are many variations on how an ethical subject position is understood. People are not confined within their subject position; subject

positions are malleable (Faubion 2011, 4). The subject positions available in one place and time will not be the same in another place and time, and the same can be said for different addiction treatments.

While the concept of safer supply presented in the CAPUD document centres the pleasure of drug use, this was not what I found in the clinic. In the narratives of the people who spoke to me, pleasure was largely absent. Pleasure as a motivation to begin drug use, or as a motivation to use safer supply, was missing. It is possible that the pleasure of using drugs was simply not something people wished to speak about with a non-drug user such as myself. Perhaps pleasure in drug use is beyond description to an outsider. Nevertheless, I found instead that people understood drug use within safer supply through a medicalized frame. For many of the people I spoke to, safer supply is a necessary medication required to stay healthy. They made very clear distinctions between drugs on the street and safer supply prescriptions. Many people emphasized that joining safer supply allowed them to be "clean" and free of addiction, even though they use opioids daily. For some people, there are functional benefits they receive from safer supply, such as treating chronic pain or controlling anxiety and depression. While the medicalized model of safer supply I encountered in the clinic did not recognize pleasure in drug use, it also did not assume all drug use to be inherently problematic. In safer supply, there is no ideal or prescribed outcome other than avoiding the harms of using an unknown concentration of drugs. This allows each individual within safer supply to create their own goals and understandings of the program. I argue that because pleasure is absent from the clinical application of safer supply, the main mode of subjectivation available within the program is that of a functional/medical normalization of drug use. Nevertheless, this medicalized model is not necessarily incompatible with ethical subject formation and it did open up the possibility for less

pathologized subjectivities of addiction. Safer supply may be the legal prescription of the same drugs found on the street, but for the people who spoke to me, the reality of the medications within safer supply could not be further from that of the drugs on the street.

Paying Attention to Narrative

Arthur Kleinman's (2020) classic concept of the illness narrative is a useful tool for making sense of the individual narratives of addiction I encountered. I aim to avoid pathologizing addiction, so it seems antithetical to use the concept of illness narratives in my project; however, within the reality of the clinic, addiction is treated as a chronic illness. An illness narrative is simply the story a person tells to make sense of suffering they have experienced. Kleinman carefully differentiates between illness and disease models of chronic suffering; the illness model pays attention to a patient's story and treats the patient as an expert in their own suffering, while the disease model seeks to semiotically translate physical symptoms to an underlying disease with little to no consideration for the patient's life world (136-137). In following Kleinman's distinction, I avoid an illness model of addiction that pathologizes addiction as a moralized, criminal model. Particularly, the personal meaning of addiction helps to better understand the form of subjectivation that patients constitute through their treatment. The specific life experience and social relationships of a patient heavily affect their experience of addiction (30). In his book, Kleinman also emphasizes the importance of personal meaning: "In the context of a chronic disorder, the illness becomes embodied in a particular life trajectory, environed in a concrete life world" (29). Within the criminalized model of addiction, personal experience is devalued. A better understanding of how addiction is shaped through a particular

life world can reveal the barriers to healing and treatment that are invisible in a criminalized model.

To provide particular direction and conceptual meaning to the illness narratives I record in my fieldwork, I draw on the conceptual work of Raikhel and Garriott's *Addiction Trajectories* (2013). An illness narrative pays particular attention to the experience of addiction, but to understand how the subjectivity of a safer supply patient is formed, I need to follow their experiential trajectory as well. Paying attention to experiential trajectories "forces us to look at this experience in terms of the wider systems of knowledge and practice from which the category of addiction derives its meaning and force" (Raikhel and Garriott 2013, 26). The experiential trajectories of addiction are not only affected by the people around them, but also the definitions of addiction imposed by doctors, social workers, and other users, the competing logics of different forms of treatment, and the stigmas of addiction. The experiential trajectories of addiction reveal the importance of subjectivation in the experience of addiction.

At the clinic where I conducted my fieldwork, the majority of safer supply patients are homeless or economically insecure. The media narratives of the opioid epidemic within Canada have been dominated by the deaths of middle-class, suburban, white youth (Johnston 2020). When white, middle-class youth die of overdose, they are given sympathetic illness narratives in media coverage, there are statements from grieving family and friends, and their deaths are destigmatized by emphasizing that they "do not fit the profile of hardcore drug addicts" (Johnston 2020). However, this de-stigmatization of some deaths comes at the expense of others. For people who use drugs who are economically disadvantaged, mentally ill, or homeless and who fit the profile of "hardcore drug users" in the public imagination, the media does not extend the same complex illness narratives (Johnston 2020). In this thesis, I present the narratives of

individual drug users as they were told to me. My goal in centring narrative within my thesis is to highlight the individual experiences of drug users and their understandings of safer supply.

Doing Fieldwork at Home

My research took the form of ethnographic fieldwork in a clinic that started safer supply in August, 2020. This clinic is located within a downtown, low-income area of a small city in southern Ontario. Importantly, this is also where I grew up. My family moved cities a few times in my childhood, but we always lived within Southern Ontario. When I began my fieldwork in August 2021, I moved back home to live with my mother. Returning home to do fieldwork is innately a different experience than travelling to a new place, and my positionality as a researcher was intimately informed by being a member of the community. I have never struggled with addiction, but I have had and lost a close family member who did. I often found myself seeing them in the narratives of the people who spoke to me. The family member I lost faced criminalization and prison for drug use which negatively affected the rest of his life. My motivation to pursue safer supply as a topic for this thesis came out of my own personal belief that the criminalization of drug use only serves to put lives in further danger.

At the time I was deciding what the focus of my research would be, the COVID-19 pandemic had taken hold of the world. In-person fieldwork options were limited for my master's cohort and I am, therefore, deeply grateful that Dr. Murphy, the doctor who runs the safer supply clinic, allowed me access to his clinic. Dr. Murphy is a close family friend, and the clinic secretary is a family member of mine. When I asked Dr. Murphy if I could conduct research at his clinic, he enthusiastically agreed that safer supply would make an excellent research focus, but also emphasized that the safety of his patients was his top priority. For the protection of the

patients enrolled in safer supply, the name of the city as well as the names of the staff and patients within the clinic have all been anonymised. All the names within this work are pseudonyms.

Dr. Murphy is a tall white man in his late fifties with a head of bouncy grey curls. He has a warm and welcoming demeanour that is hard not to love. Throughout my conversations with the patients at the clinic, they continually told me that Dr. Murphy was an exceptional doctor and for some, he was the first medical doctor they trusted. Dr. Murphy's clinical practice is quite small compared to most primary care physicians in urban areas. He keeps his practice small so that he can spend more time with each individual patient, which makes Dr. Murphy's clinic a unique situation even amongst safer supply clinics. At the time I conducted my research Dr. Murphy had about 1000 patients on his roster, but only around 65 safer supply patients. Thus, my research is not representative of all safer supply clinics. Not all clinics have the ability to give individual patients such time and care. During my time at the clinic, Dr. Murphy stayed late working and seeing patients who arrived past closing hours more often than not. He has been an advocate for marginalized groups for the majority of his career. In the early days of his career, he worked with HIV positive patients, many of whom were intravenous drug users. Before he opened his own clinic, Dr. Murphy had worked out of a community health centre focused on serving marginalized groups in the same city. The safer supply clinic shares a building with a safe injection site and there is a methadone clinic across the street. The positioning of this clinic was intentional to make it accessible to those who need it most. I had intended to sit down with Dr. Murphy for an interview, but he is a busy man and we never found the time. The Dr. Murphy present in my thesis is the Dr. Murphy my interlocutors saw in their interactions with him. To his patients, Dr. Murphy is a caring and confident doctor who is certain in his path. Dr. Murphy

certainly cares deeply about his patients, but he is not without doubt. In our interactions within the waiting room and casual conversations I know that Dr. Murphy was confident that safer supply has a positive impact on his patients' lives, but he did worry that at any day the regulations could change and take safer supply away. The current regulatory position of safer supply is tenuous to say the least.

Over the course of five months, from late August 2021 to early January 2022, I observed and took fieldnotes on the interactions between patients and clinicians in the waiting room and engaged in unstructured interviewing. During this time, I was fortunate enough to sit down with seven safer supply patients for a total of twelve semi-structured, qualitative interviews, each lasting about thirty minutes to an hour. Some patients, particularly Trent, agreed to sit with me multiple times. I had a list of guiding questions that I had prepared as part of my research ethics board review, but I allowed the interviews to take the form of casual conversations. The topics covered in these interviews often encompassed much more than what I had outlined in my guiding questions. The interviews took place within the back storage room of the clinic. This allowed for a private place away from the conversations in the waiting room. I used my phone to record each interview and then later transcribed them in full. My main interlocutors were: Trent, Benjamin, Sasha, Paula, Joe, Sarah, and Harry. There were also other people, such as Jeff from the opening vignette and Matt who makes an appearance in chapter one, who did not find the time to sit down for an interview but did give me permission to discuss their stories as they were shared within the waiting room of the clinic.

When I was not interviewing patients, I would sit in the waiting room of the clinic and introduce myself to people as they arrived. One of the complications in my fieldwork was that Dr. Murphy only saw safer supply patients on Tuesdays, which meant that my field site was

limited to one day a week. To make up for this limitation, I opted to conduct my fieldwork over five months instead of four, which is the typical timeframe for master's level fieldwork. I did not accompany people into their appointments with Dr. Murphy, as he wished those appointments to remain a safe and confidential space. Initially, I was anxious that the waiting room of a clinic would not be a fruitful space for ethnographic observations, and I found it rather awkward to start conversations with people in the waiting room of a clinic. However, as people grew to know me and why I was there, the waiting room turned out to be much more of an informal meeting place than I expected. As people waited, they often chatted with each other and with the secretary and eventually with me as well. I owe a lot of my success in finding people who were willing to share their stories with me to the trust Dr. Murphy and his staff inspire in their patients.

Even though the COVID-19 pandemic was present over the course of my research, it is absent from my analysis. In the early days of the pandemic, deaths from overdose skyrocketed as safe injection sites and shelters were forced to close their doors to the public. People who are unstably housed, which many of my interlocutors were at the time, were identified as a group at a greater risk of serious illness and death from COVID-19. At the time I began my research in 2021, the public health measures had relaxed from prohibiting these services from operating to simply requiring people to wear masks while indoors. While in the clinic myself and my interlocutors were expected to be masked and this meant that I conducted most of my research through that filter. While many of my interlocutors were not the most stringent mask users, it did make the job of connecting with people more difficult.

COVID-19 is largely missing from my thesis because COVID-19 was largely missing from the narratives of the people who spoke to me. During our interviews, people generally did not wish to discuss the pandemic. The people I spoke to were certainly affected by the pandemic,

but they were also largely ignored in public discourse about the pandemic. Social distancing and stay at home public health messaging is difficult to follow while living on the streets. If I asked people directly about their experience with the COVID public health measures the most frequent response I would get was an acknowledgement that the disruption of supply chains was bad for the toxicity of the drugs available on the street, and that public health measures did little to protect people without access to stable housing. The chaos of living on the street posed more immediate day to day problems of survival. When you are already living in a state of survival everyday, it is hard to quantify a change in instability.

Organization of the Thesis

In policy, safer supply is strictly a harm reduction tactic meant to keep people alive by allowing access to a known and tested supply of desirable drugs. I had entered my fieldwork expecting to find pleasure at the centre of the experience of safer supply. Instead, the people who spoke to me said that pleasure has nothing to do with it. In my fieldwork, I found safer supply had a complicated meaning for the people I spoke to; because safer supply does not require one particular form of drug use, it allowed each person to set their own goals and expectations within the program. In this thesis, I argue that because safer supply does not seek to treat the use of opioids as inherently problematic, it opens up the possibility for new subjectivities of drug use. The subject positions available for people who use drugs are often limited by the structural violence inherent in the punitive criminalization of drug use. Safer supply can serve to reduce the experience of structural violence for some.

In chapter one, I introduce Trent, Benjamin, and Matt and explore the structural forces that shape the lives of people who use drugs and the ways that the choice to use or not use drugs

is limited by violence. In chapter two, I introduce Sasha, Paula, and Joe and explore the functional benefits that many people seek from drug use. I also emphasize how this understanding of drug use complicates the biomedical understanding of addiction as a chronic relapsing brain disease. In chapter three, I introduce Sarah and Harry and return to Trent to ask if safer supply can make drug use congruent with ethical subject formation. I argue that the regulatory flexibility around safer supply is what allows for a greater diversity of available subject positions.

This thesis considers the experiences of people accessing safer supply seriously. Through the narratives that were told to me, I highlight which aspects of this novel program are important to the people who use it. I cannot make any evaluative claims about the entire project of safer supply in Canada or even Ontario, particularly because the clinic that I conducted my research within was run by a unique doctor. However, I can relate the experiences of the people I spoke to and their understanding of safer supply.

Chapter One
Drug Use as a Coping Mechanism Against Violence

During my fieldwork in the fall of 2021, I often walked to the clinic from the house I was staying in. During this walk, I was able to take in the surroundings of the downtown neighbourhood where the safer supply clinic was located. Like many small cities in North America, the downtown in this city has been falling into disuse. There used to be a large car factory just outside the downtown core of the city, which employed a large portion of the population. When people worked at the factory, they were more likely to live, shop, and eat downtown, but once the factory closed, many people migrated out to the suburbs surrounding the city. The loss of well-paid, unionized factory jobs was devastating for the neighbourhood. People who could afford to leave opted to move to the suburbs and other larger cities where there were new jobs. As people left for the suburbs, so too did resources like grocery stores, schools, and even the hospital. The old downtown hospital was shut down several years before I began fieldwork and replaced by a new larger hospital on the outskirts of the city. The new hospital is difficult to get to from downtown without access to a personal vehicle. The eyesore of the old hospital site, which had been torn down a few years before I began my fieldwork and is now an empty lot surrounded by a chain-link fence, took up an entire block on my walk to the clinic. Many of the buildings in the downtown were historic three-story brick walk-ups, relics of the economic boom in the late 19th and early 20th century that established the city as an industrial powerhouse. Now, broken storefront windows boarded up with plywood and tagged with graffiti are sprinkled along the street in between the remaining businesses. There are a few old barber shops, a salon, a laundromat, some banks, and a Pizza Pizza. A few daring entrepreneurs run

sleek, hip restaurants and cafes along the street, however these businesses are primarily frequented by people from outside the neighbourhood.

In the nooks and crevices of shuttered buildings, people stake out space for themselves in the neighbourhood. An informal tent city is located just down the street from the clinic in a city park. Across the street from the clinic is one of the busiest businesses downtown, a pharmacy. This pharmacy services both the people from the safer supply program and the methadone clinic, with which it shares a building. The safer supply clinic's location across the street from the methadone clinic and within the same building as a safe injection site allows Dr. Murphy to easily make connections with people who use drugs. Both the methadone clinic and the safer injection site will recommend patients to Dr. Murphy's clinic when they are looking for a new primary doctor. This relationship was established before Dr. Murphy started prescribing safer supply. When he initially opened the clinic, he intended to fill a gap in primary care for vulnerable people in this community, but he did not initially set out to prescribe safer supply. He did have experience prescribing narcotics, becoming one of very few doctors in his health care network who would prescribe narcotics for long-term chronic pain patients as well as buprenorphine for opioid replacement therapy. When the federal government officially sanctioned safer supply in August 2019, it was not a huge leap for Dr. Murphy to add safer supply to his practice, especially when one of his most vulnerable patients requested it.

In this chapter, I present the narratives of two people who use safer supply as told to me by them. I also highlight not a complete narrative but a brief moment from a third person's life. Through their individual narratives of drug use and treatment, I explore the structural forces that shape the lives of safer supply patients, as well as the ways that addiction is formed not just by a chemical dependence but also a continuum of violence. This continuum of violence is

experienced as stigmatizing and oppressive and serves to limit the subject positions available to people who use drugs.

Trent

I am sitting in the back storage room of a small medical clinic interviewing Trent, a 44-year-old man who has used injection drugs almost his entire life. The very first day I met Trent, he was having a bad day. Trent is normally one of the more talkative people in the waiting room, but on that day, he was withdrawn and sitting very quietly. I introduce myself to Trent and explain that I am a student studying safer supply, and he immediately perks up. *"Oh! That's very interesting!"* he says. I ask Trent if he is part of the safer supply program, and he informs me that he was actually the first person enrolled in safer supply at this clinic. I ask him if he would be interested in telling me about his experience with safer supply and he enthusiastically replies that he would love to because he feels safer supply has changed his life and he wants to help spread the word about the program. Trent then tells me that he was feeling down when he came into the clinic today, because he was starting to become bored with life. Since he began safer supply, Trent has been able to enroll in ODSP which has helped him find stable housing and greatly reduce his use of fentanyl, but this new stability in his life has left him feeling that life is boring. For years, Trent was accustomed to putting all his available energy into surviving. But now that he wakes up in his own apartment, with just enough ODSP income to feed himself, and a safer supply prescription to stave off dope sickness, he isn't so sure what to do with himself. Trent tells me he wants to get back to working as a drywaller eventually, but that he doesn't feel stable enough yet to hold a job: "*If I was able to use my life experience to help inform research that would be a great source of motivation for me*!" Trent would enthusiastically sit down for an hour

or more with me almost every time he came into the clinic over the four months I spent there. I am very fortunate to have found someone so willing to share their story with me.

During our first interview, Trent tells me that he is not ashamed of being addicted to drugs because, "*I was accustomed to being an addict before I ever really used a drug*." I am caught off guard by this statement and ask Trent to elaborate on what he means by it. Trent explains to me that from a young age, he was very interested in the idea of drugs and would constantly seek out information about them, from peers and sometimes from books. Trent grew up in a very large religious family, the youngest of six children and his father was a pastor. Trent's interest in mind-altering substances grew out of his father teaching him about heaven and enlightenment. Trent read about ayahuasca and other hallucinogenic drugs used in religious rituals in South America and felt drawn to it:

> *Down in South America the way they practice religion, I read a little about that, I realized oh wow there is a way to have a spiritual experience as a human being. It's easy! All you have to do is take this mushroom or this soup. I thought that was wonderful and I was very excited when I learned that these things were possible to have. My dad didn't drink and drugs weren't part of his experience, so he didn't want to do anything that could jeopardize his mind or his ethics. He didn't want anything to do with that.*

Seeking out-of-body experiences through drugs instead of prayer was both an homage to his father's religious teaching and also a rebellion against it.

In elementary school, Trent would sometimes pretend to be high, acting sleepy and out of it in class. His impersonation of being high was so convincing that his teachers contacted his parents out of concern that he was using marijuana. Trent says that this led to both his parents and teachers treating him as a troubled drug addict long before he ever actually consumed a drug. Trent admits that his drug-user act was partially a defence mechanism for his troubles in school. Trent was never formally diagnosed with a learning disability as a child but recognizes now that despite a desire to learn in school, he struggled to read and write as well as the other kids in his

grade. It was easier to take on a persona of an intentional “drugged-out failure” than it was to receive support for his disability. It was not long before Trent managed to actually get a hold of some drugs, mostly just marijuana but also LSD; he was 12 at this time. Trent told me his mother knew he had used LSD because she had read about it in his journal, which she admitted to him many years later, but instead of confronting her son or attempting to prevent him from using it again, she simply accepted that he was going to become a drug user. In high school, Trent received a reputation for being a stoner and people would pay him to guide them through LSD trips. Trent did not end up finishing high school and instead dropped out, although he is adamant that it was not drug use that caused him to drop out so much as the way he was treated as a drug user. Trent believes that using drugs was an inevitable path for his life, and will continue to be so, but that in the last decade of his life, he has come to realize that not all drugs are equal.

Trent’s relationship with drug use was not problematic for him until he first tried opioids in his early twenties. Trent first tried opioids during the height of North America’s oxycontin over-prescription in the late 90s and early 2000s. Trent’s initial drug of choice was prescription painkillers, such as oxycontin, resold on the street. These drugs are relatively expensive and Trent soon found himself seeking out solely injection heroin, which was both less expensive and more available. Drug use then became a daily habit and the craving to use more every day was brought on from fear of withdrawal more than a desire to be high. The fear of withdrawal and the need to seek out drugs on a daily basis took away the specialness of mind-altering drugs. Eventually the energy needed to seek out drugs overtook his life so much that he lost touch with most of his friends and family, and he couldn’t keep a job. In order to have enough money to buy heroin, Trent began cooking and selling meth. Meth was never a particular drug of choice for Trent, but he had known people who had cooked it before and he knew the basics of the process.

Trent's drug dealing never reached the kind of scale that would bring true monetary gain, only ever just enough to fund his own drug habit and keep himself alive.

Fearful of the way opioids had changed his relationship with drugs, Trent first sought help in the form of methadone. Initially, methadone worked very well for him and it even "straightened him out" for two whole years from ages twenty-eight to thirty. During that time, he reconnected with his parents and was able to hold a job as a drywaller with a construction company. Trent would go on and off methadone repeatedly for many years. For a long time, methadone would be a tool to "level out" after a particularly bad binge. Most of the time it would work and reduce his craving for opioids, until suddenly he returned to the clinic to find that methadone was not reducing his craving anymore. Trent tells me there are two reasons methadone stopped working for him: the first is that the formulation of methadone in Canada changed in 2014, and the second is that fentanyl became regularly available on the streets.

In 2014, provincial regulatory bodies across Canada compelled pharmacists and physicians dispensing and prescribing methadone to switch patients to the ready-made formula methadose. Chemically, methadose is the same drug as methadone, but methadone doses are mixed by pharmacists onsite as a solution of methadone and tang orange juice, whereas methadose is a ready-made solution (Denning 2021). Importantly, the pre-diluted methadose is a hypertonic solution making it more painful to inject than methadone (Greer et al. 2016). This change was made with no community consultation, and many people who had found stability with methadone for years found the sudden change to methadose destabilizing. In a survey of people who reported being enrolled in methadone maintenance therapy during the 2014 switch to methadose, most people reported disliking the new cherry flavour, and over half shared

experiencing worse pain, more dope sickness, and a greater need to supplement with other opioids as compared to methadone (Greer et al. 2016).

Trent was an early adopter of fentanyl. About a year before it was even regularly available on the streets in Canada, he was able to order it directly from China through contacts he had made cooking meth as an income. Trent recalls fentanyl use as a true tipping point for him, as the moment that drug use began to pull him out of reality. In the six years before starting safer supply, Trent was living under an overpass bridge in a tent with his girlfriend, consuming fentanyl daily. There were many close calls with fentanyl, and as it became readily available on the streets in Canada, Trent began to see fentanyl as more dangerous than other drugs, more dangerous even than heroin. Even though Trent felt he was able to dose himself properly with fentanyl, the morality of selling or giving it to others began to weigh on him and was a large factor in his desire to stop using it. In other words, Trent was beginning to see the danger fentanyl posed to people around him, but still believed he had the control to keep himself safe while using it daily.

It was not until Trent himself had overdosed on multiple occasions that he began to admit to himself that he needed to stop using fentanyl if he wanted to stay alive. Recalling one particularly bad overdose he had survived before enrolling in safer supply, Trent told me that he had woken up in the detox clinic at the hospital initially unable to even remember how he got there. He was told by the staff at the clinic that someone had found him on the street and had called 911 and paramedics had brought him to the emergency room. He was extremely dehydrated and sore but was too nauseous to do anything but lay in the hospital bed for hours. Eventually, once he had been rehydrated by IV and given anti-nauseant drugs, he was able to get up and take a shower. In the shower, Trent noticed that his body was bruised all over and

memories of the night before came flooding back to him. Someone had mugged him for his drugs and left him badly injured; however, after years of experience on the street, he knew not to keep all his drugs in one place and had an extra stash of fentanyl that they did not get. Anxious, upset, and in pain, Trent injected the fentanyl, but in his heightened emotional state he wasn't as careful as he normally is, took too much and overdosed. This would not be the last overdose Trent experienced before enrolling in safer supply, but it was the first time he came to realize that he didn't have as much control over fentanyl as he thought he did.

Trent was the very first patient who enrolled in safer supply at Dr. Murphy's clinic and it was Trent who suggested safer supply as a possible lifeline for himself. Trent had not been a patient long at the clinic before Dr. Murphy became concerned for his well-being. Shortly after enrolling as a primary care patient, Trent was hospitalized due to overdose two times in one week. Each time, the hospital informed Dr. Murphy because he was now officially registered as his primary care physician. At this time, Trent was homeless and not easily reached, but Dr. Murphy left messages for Trent at the safer injection site. The attendants at the safer injection site passed these messages along to Trent, encouraging him to go into the clinic to see his doctor. Trent did not immediately go in to see Dr. Murphy, because he did not believe there was anything Dr. Murphy could do for him as he had already tried opioid replacement therapy. However, Dr. Murphy was persistent and eventually Trent came into the clinic to see him:

> *I finally came in here and he was like, "You know, Trent, you've had two hospitalized drug overdoses in one week. Now many of my former patients who had this experience were dead within a year's time". So he was like, "What can I do to keep you alive? Two times in one week Trent doesn't look good". He was very concerned. I brought my girlfriend in with me too and I remember she was like sitting in the waiting room and she was on the nod, sleeping, and I was stoned out of my mind when I was talking to him and I was like, "Oh I think I'm gonna be okay! I'm doing alright right now, yeah it's alright". And he was looking over at her nodding out and I was like so high when I talked to him, he knew obviously what was going on and he was deeply concerned.*

Although Trent did not initially take Dr. Murphy's concerns seriously and refused his help, the concern he had shown for him during that initial appointment left an impression on Trent. He told me he felt touched by both Dr. Murphy's persistence in getting Trent into the clinic, and the time he was willing to sit and talk to him during the appointment. Trent had not experienced this much care from a doctor before, as he was used to being written off as a lost cause due to his addiction. Dr. Murphy had made enough of an impression on Trent that a few days later the latter returned to the clinic to speak with him again. Trent knew that his opioid use had reached dangerous levels, but he did not expect a professional to be willing to work with him on a solution. When Trent returned to see Dr. Murphy, he was no longer able to deny he was struggling and he broke down in front of Dr. Murphy and "let loose" all of his struggles. Dr. Murphy listened patiently while Trent spoke and made Trent feel safe enough to try asking Dr. Murphy about safer supply. Trent had heard about the safer supply programs in British Columbia and had previously tried to discuss safer supply with methadone doctors in the area but had been rejected by them. Dr. Murphy had also heard about the success of safer supply programs in British Columbia and he told Trent that if he believed safer supply would be something that could help him, then he would look into it. He reassured Trent that they would work together to make sure he was safer and healthy:

> *I was so touched that he'd heard about it (safer supply) because I had talked to several doctors about it already and they didn't know anything about it, weren't interested, they were methadone doctors so they didn't want anything to know about it, (mimicking a disgruntled voice) "Oh what ah ugh, just shut up! Quiet down!" (laughing) Like that, like that, you know? I'm not pointing fingers, it was just so different when he (Dr. Murphy) was receptive to it (safer supply) like that.*

Trent was not immediately enrolled in safer supply, as it took some time for Dr. Murphy to research the legality of safer supply in Ontario and to connect with a community of practice

made up of pharmacists, doctors, and nurses prescribing safer supply across Canada. In October 2020, however, Trent became the first person enrolled in safer supply at Dr. Murphy's clinic.

Once Trent was coming in regularly to see Dr. Murphy and collect his prescription for safer supply, it became evident that Trent's housing instability was a major hurdle for Trent's ability to stabilize himself and avoid fentanyl and overdose. Trent had been living on the streets for the past six years. The prescription Trent received through safer supply was enough to prevent dope sickness and had the pleasurable effects he sought from drug use, but there were times when he needed a stronger dose to make it through an uncomfortable night. On the streets he also ran the risk of being targeted for theft, because as a patient known to be receiving safer supply, his prescription was often sought after by other people. Trent was not on the Ontario Disability Support Program (ODSP) at the time, but Dr. Murphy believed that Trent could qualify for it and he offered to help Trent fill out the necessary paperwork. Dr. Murphy provided Trent with the paperwork, but Trent did not immediately fill it out and he lost parts of the paperwork a few times. It took a few months before it was completed, but with some assistance from the clinic administrator, Trent eventually filled out all the required paperwork and the clinic secretary mailed it for him. Trent was approved for ODSP very quickly. He even got a call from a housing worker who informed him that he was approved for ODSP and housing, and within a few hours of that phone call, Trent was looking at an apartment with his new housing worker. Trent was still living in this apartment almost a year later when I spoke to him. Safer supply did not directly fund Trent's new apartment, but it did introduce enough stability into his life so that he could focus on priorities other than staving off dope sickness.

Matt

On a quiet night early in my fieldwork, it was 7:30 p.m., a half hour past the clinic's closing hours. Yet, Dr. Murphy was still seeing a few stragglers who hadn't made it to the clinic until the end of the day. I was sitting in the waiting room with two other people waiting to be seen, going over my fieldnotes from the day. Suddenly, the door to the clinic burst open and an extremely panicked man hurried into the waiting room. He ran up to the receptionist's desk and in one breath exclaimed, "Please you have to help me, I need to hide from the cops, I think they are after me." Without question, the receptionist nodded and replied, "Okay Matt, no worries come with me" and walked him to one of the back exam rooms at the clinic. As she walked him to the room, I heard her ask him if anyone was hurt outside; he told her no, but that a fight had broken out at the methadone clinic across the street and the cops had been called. At this point, we could see the blue and red flashing lights of police cars parked across the street. Matt waited in the backroom for several minutes and when Dr. Murphy was finished with the patient he had been seeing at the time, he went to the back room to ask Matt what had happened.

Matt is a safer supply patient at the clinic and Dr. Murphy knew him well. Dr. Murphy returned to the waiting room to thank his receptionist and they nervously discussed what would be in their legal right to do if a police officer did come knocking for Matt. "I believe we are in our legal rights to neither confirm nor deny if a patient of ours is within the clinic," said Dr. Murphy. Fortunately, no police came to the clinic and the flashing lights across the street turned off and the police cars drove away about ten minutes later. When Matt saw the police cars had left, he timidly returned to the waiting room. Still full of adrenalin, Matt began to recount to everyone in the waiting room what had happened:

> "*Two guys got into a bit of a fight outside of the methadone clinic and I guess someone called the cops. I wasn't involved in the fight but as soon as I saw those lights man, I just*

ran. I can't go back to jail right now, I can't. I just know I wouldn't be able to get my medicine in there, I'm clean now, I don't wanna go back."

Matt was not even directly involved in the fight that occurred outside the methadone clinic, but his experience with law enforcement had proven to him that sometimes just being in the wrong place at the wrong time as a person who uses drugs could lead to incarceration. People who use drugs make up a majority of the population in Canadian federal prisons (Bozinoff et al. 2018). Although in theory people in the prison system in Canada are supposed to have access to prescription medications and health care, including opioid agonist therapies like methadone and buprenorphine, the reality is that a lot of people are denied these medications within Canadian prisons (Bozinoff et al. 2018). Safer supply, which is a much newer and less accepted treatment than the well-established methadone and buprenorphine, has even less chance of being administered to an incarcerated patient. For people who have found success with safer supply, the threat of being incarcerated carries high stakes. The presence of an illicit market of drugs within Canadian prisons is well-known and for some people, becoming incarcerated can even serve as an initial introduction to drug use (Bozinoff et al. 2018). I will now turn to Benjamin, a safer supply patient who is well acquainted with drug use behind bars.

Benjamin

Benjamin is one of the few patients at the safer supply clinic that can always be counted upon to show up at the same time every week, always within the first two hours. Tall, slim, with shoulder length dark hair and usually dressed in fitted black jeans, a black t-shirt and hoodie, it was easy to picture Benjamin as a young teenager. Although I met him in his early forties, I often felt like I was speaking to a peer, his cadence and choice of words reminiscent of the conversations I have with people my own age (late 20s). Benjamin tells me with a nervous laugh

that when he was young, he and his friends "*were doing lots of crime and stuff so I was in and out of jail all the time.*" He was never part of any gang related activity but, when he was young, he became friends with people who were making money by selling stolen property. Benjamin did not come from money, so the allure of making his own money, paired with the excitement of breaking rules, got him "mixed up" with the legal system a number of times before he was 30. Benjamin did not wish to discuss his experiences in jail in detail, but suffice to say that he regards his time in jail as being some of the most unpleasant times in his life, even after living on the street.

Benjamin tried injection heroin for the first time in jail when he was just eighteen. Opioid use became a habit for him while in jail, as a way to help pass the time and counter the monotony of life in prison. From Benjamin's perspective, heroin was almost easier to find in jail than it was on the street. Benjamin did not use heroin outside of prison, and in between his many short stints in prison throughout his twenties, he found his heroin habit easy enough to kick with methadone once out of prison:

> *I never really had a chance to get all that buried in it, you know what I mean? Back then, I would just get on methadone, I would go to a methadone clinic, get it for a few days and then not go back. I would just do it because I had no dope, you know? And then I wouldn't even go back (to the methadone clinic) because it would kind of work, I just didn't want to be sick.*

Benjamin was using methadone in a way that it was not intended to be used, but that fit his need to control his craving for heroin at the time. Benjamin was weening himself off heroin, using methadone to ease the symptoms of withdrawal just to return to heroin use once he found himself back in jail. As long as Benjamin was able to resist using daily outside of jail, he felt that his drug use was under control.

When Benjamin first had kids, he was able to stay clean for five years straight, until the height of oxycontin prescriptions in the 2000s. The availability of prescription painkillers turned opioid use into a regular habit for Benjamin instead of isolated binges. However, the true tipping point for Benjamin, just like Trent, was when powdered fentanyl became the dominant opioid both on the streets and in jail. After using fentanyl, Benjamin was no longer able to ween himself off opioids by doing a short stint at the methadone clinic. Between his drug habit now taking up a considerable amount of his time and his history as a convict, Benjamin struggled to keep a regular job. Eventually, he ended up living on the streets and using fentanyl daily. Benjamin was able to get fentanyl regularly by selling it for a larger drug dealer, who allowed him to keep some of the leftover product he did not sell. Benjamin did not like to discuss what happened with his children, but when I met him, he had just found himself a new place through ODSP after living on the streets for a few years and he did not currently have his children with him.

When I asked Benjamin why methadone stopped working for him, he gave me a similar answer to Trent:

> *I found when it was methadone and not methadose and before powdered fentanyl was on the streets, like when it was just pills and stuff, before all that I thought it (MMT) had some effect. But once the fentanyl came, the methadone couldn't touch it, and once they switched to methadose, there was just no chance, it was a waste of time.*

Both Trent and Benjamin identified a change in the formulation of methadone and the introduction of fentanyl to Canada as tipping points for the effectiveness of MMT on their craving for opioids. It would be easy to see fentanyl as the sole problem, especially because the introduction of fentanyl and the formulation change happened at the same time, but it is important not to forget the psychological aspect of drug use. For many people, the abrupt change from methadone to methadose signified the absolute lack of control they had over their own treatment. Even if the two drugs are chemically similar, the experience of taking them is not. The

volume, texture, smell, and taste of methadone and methadose are significantly different. Methadone is a cup of orange tang juice and methadose is a teaspoon of cherry syrup. Benjamin recalls that methadose was never able to prevent dope sickness and even after he had increased his methadose dosage well above his previous methadone dose, he was still feeling sick: "*I was all the way up to 160mL of methadose and I was still sick. Unless you wanna do a jug of it, you'll feel sick*." Benjamin's high dose was not preventing dope sickness while at the same time causing him unwanted side effects. At that dose level, he found it hard to function daily without dozing off or being 'out of it.' Benjamin's goal in MMT was to be able to one day go off methadone completely, already a tall order; then, because he found the methadose formulation to be less effective, this goal was further complicated by his doctor's hesitance to ever reduce his dose, as he explained:

> *[T]hat was one of my problems with methadone is they just want you to go up (in dose) all the time. They never talk about going down, you can't even mention going off it (laughs). Which I don't get…. Like man they honestly will fight you even about going down 10mils. It's ridiculous.*

I asked Benjamin if he was ever given a reason for not being able to adjust his dose and he tells me that he wasn't. It is likely that Benjamin was refused a change in dose because he was still using illicit drugs. Methadone prescription guidelines call for dose increases when patients are using street drugs and dose decreases when patients experience negative side effects like intoxication (Sanders et al. 2013). Unfortunately, Benjamin did not find that methadose was able to treat his dope sickness no matter how high the dose, and because he was not given the option of returning to the original formulation or a new formulation, he felt stuck. This lack of control was a major reason that Benjamin found methadone to be an ineffective treatment for his opioid cravings.

When Benjamin and I spoke, he had been enrolled in safer supply for four months. He told me that when he had first heard about safer supply, he thought the person who told him was trying to play a joke on him, as it sounded too good to be real. At the time, Benjamin was enrolled at the methadone clinic across the street and he was picking up his methadone from the same pharmacy where people from Dr. Murphy's clinic pick up their prescriptions. Benjamin says he would have joined safer supply earlier, but he really did not believe it was real. Once he finally did come in to see Dr. Murphy, he was immediately interested in the program. After an initial appointment where Benjamin discussed his history of drug use and overdose with Dr. Murphy, Benjamin was able to officially enrol in safer supply in less than a month.

Benjamin has found safer supply to be the most effective method of replacing fentanyl. When Benjamin was on methadone, he often found that the dose of methadone was unable to prevent dope sickness, but he also did not want to be continually upping his methadone dose. Now on safer supply, Benjamin hardly ever feels dope sick, but when he does feel dope sick there are options for addressing it. On the day that I interviewed Benjamin, he explained to me that he had just made a switch in his medication because he was starting to feel dope sick in the mornings before he could go to the pharmacy to pick up his dose for that day. The same thing happened all the time with methadone, but instead of upping the dose, Dr. Murphy suggested they try splitting part of the dose to Dilaudid.

> *That way it's pretty much the same dose, it's just distributed differently. I was starting to feel sick in the morning, I can't speak for everyone but for me my tolerance goes up fast, so I don't want to just keep getting more pills because I'm going to get sick no matter what because my tolerance goes up fast… the morphine is supposed to last 24 hours, it's the long acting one, the Dilaudids are short acting. So, when you get the morphine in the morning it's supposed to last to the next morning, but it wasn't for me. So, I take the Dilaudids later so I don't feel sick in between the morphines.*

Benjamin is able to inject morphine in the morning at the safer injection site and then supplement later with Dilaudid pills at home to prevent feeling dope sick by the next morning. Dr. Murphy understood that Benjamin did not want to up his dose but also wanted to stop feeling sick in the morning, so he worked with Benjamin to find a solution. Having these options allows Benjamin to feel like an active participant in his treatment. In the long term, Benjamin would like to stop using all opioids including safer supply. In safer supply, Benjamin has found stability, but more importantly, a path forward to decreasing his dose and ending the cycle of relapse.

Drug Use in the Face of Violence

While using drugs can be a method of relieving pain enacted by violence, the choice to use or not use drugs is also limited by violence. Both Trent and Benjamin's narratives give insight into the ways that violence, be it structural, interpersonal, or everyday shape the experience of drug use. Structural violence as defined by Paul Farmer (2006) refers to the ways that people are harmed by the economic, political, and social structures of the world. Within medicine, structural violence decides who is allowed access to care and who is at a higher risk of falling ill. Within the narratives in this chapter, structural violence is seen in the process of applying for ODSP, the judicial system, and the restrictive regulation of methadone. Bourgois and Schonberg extend Nancy Scheper-Hughes' term everyday violence to the interpersonal and routine experience of violence by the people living on the streets of San Francisco (2009, 17). The everyday violence of living amongst the dangers of the street become vivid in Trent's account of a bad overdose experience after being mugged on the street. The brief moment from Matt highlights for its part the ways interpersonal and structural violence interact as everyday violence.

Trent told me that most of his dangerous experiences with drugs occurred in the later part of his life and it was often a consequence of trying to numb the pain of living on the street. The overdose experience he recounted to me in which he was mugged on the streets is just one example. He found himself in a vicious cycle of living in instability because he needed all his resources to find drugs, and he needed drugs to calm the instability of his life. People who use drugs are much more likely to experience homelessness than those who do not, and homelessness itself is considered a risk factor for a substance use disorder (Schütz 2016). Trent may have begun using party drugs like marijuana and LSD from a very young age, and he is adamant that he alone is responsible for overusing heroin, losing contact with his family, and ending up on the streets, but Trent was clearly a child struggling from a young age left behind by a school system with very few supports. As an adult, Trent easily qualified for ODSP not only on the grounds of having a substance use disorder but also because he showed signs of a learning disability severe enough to prevent him from accessing many forms of employment. Ironically, this same learning disability made filing the paperwork to apply for ODSP such a challenge for Trent. He believes that were it not for the persistence of Dr. Murphy and the clinic staff in helping him fill out the paperwork, he would never have applied for ODSP.

While the embodied experience of dope sickness can be prevented with the material prescription of medical heroin, the reality of Trent's experience of addiction could not be disentangled from his environment. For Trent, being able to check out of his reality using fentanyl was a necessary coping mechanism when he was living on the streets. In the moments when the physical and mental distress of living on the streets was too much to bear, Trent would initiate his heaviest and riskiest drug use. Trent was a skilled user of fentanyl, having dosed himself with it daily for years, but the times he found himself most vulnerable to overdose were

moments of physical or mental distress that were a direct consequence of experiencing homelessness. Trent has found success in safer supply not only because the prescription mitigates the physical pain of withdrawal, but also because it brought him into contact with other material supports that he otherwise would not have accessed.

Another important moment in Trent's story was his initial hesitation to accept help from Dr. Murphy. Having lived as an addict for most of his life, Trent had had many bad experiences with the medical system before safer supply. His initial reaction was to downplay the severity of his drug use to Dr. Murphy and to turn down his offer of care instead of opening himself up to being disappointed in the same way his attempts to influence his treatment had been frustrated by methadone doctors. The structural forces influencing methadone regulation work to make accessing methadone as a treatment untenable for some people. Benjamin's experience with methadone, being told his drug use was too severe to ever lower his dose, made Benjamin feel stuck within addiction. Both Benjamin and Trent told me how the sudden change in formula from methadone to methadose greatly affected their ability to use MMT. The regulatory bodies that made the decision to change the formulation did not take the subjective experience of drug users into consideration. On paper, methadone regulations seek to keep the people using methadone safe. There are tight restrictions around lowering a methadone dose too quickly both out of fear that a person's tolerance for opioids could dip, leaving them at a higher risk for overdose if they return to street drugs, and in the belief that evidence of street drug use always indicates a need for a higher dose of methadone. This logic seeks to control the lives of people who use drugs with little consideration for individual experience.

Benjamin began using heroin in jail, and for a time, jail was the only place he ever used opioids. When Benjamin was young, he got caught up in petty crime and the judicial system that

claimed to serve the purpose of rehabilitation; instead, served to further enmesh Benjamin's life with illicit activity. The term hyper-incarceration has been used to demonstrate how the poor and particular racial and ethnic minorities are punished by the judicial system at disproportionately higher rates (Karandinos and Bourgois 2019). People who use drugs also face a disproportionally higher rate of incarceration, and many people who use drugs live at an intersection of multiple identities subjected to the structural violence of hyper-incarceration. Benjamin did not wish to relive his time in prison in detail with me, except to say that he used drugs in prison to distract from the experience of prison. The experiences of people who use drugs within the prison system has been documented by many anthropologists (Karandinos and Bourgois 2019; Bourgois and Schonberg 2009; Sue 2019). People who use drugs often face violence, abuse, and neglect while incarcerated. In the brief moment I shared with Matt, we can see how deeply the fear of returning to prison affects his day to day experience. After witnessing a fight in front of the methadone clinic, he immediately ran for refuge in Dr. Murphy's clinic, fearing he would be wrongly accused by police of involvement in the fight. Matt does not wish to lose access to his safer supply prescription, as his previous experience with incarceration has taught him that his health, particularly as it relates to his drug use, will not be prioritized behind bars. The everyday violence of living on the street, such as witnessing a fight, is made all the worse by the threat of the structural violence of being accused of wrongdoing simply for being a drug user and in the wrong place at the wrong time.

Trent, Benjamin, and Matt's stories highlight the importance of wrap-around care offered as part of safer supply. Wrap-around care refers to offering social, legal, and occupational supports to people who use drugs accessing health care (Mumba and Mugoya 2022). At Dr. Murphy's clinic, the administrator was hired specifically for this role. Mark, the administrator,

helps patients fill out paperwork, navigate the legal system, and access social supports they may ``not have been aware of; however, this care can only help as much as larger political systems allow. Not everyone qualifies for ODSP or housing support, and assisting someone in navigating the legal system does not change the structural inequalities inherent in that system.

Conclusion

In the narratives of both Trent and Benjamin, the lack of social and economic supports in their lives becomes a significant barrier to stopping drug use. Trent and Benjamin both knew that their drug use was problematic, and wished to stop using drugs for a long time before they were able to successfully stop using fentanyl. For Trent, the pain of living on the street required at times a dose of opioids that was objectively not safe. Changing Trent's daily reality, by allowing him access to housing support and ODSP to leave the streets, had just as much of an impact on his ability to stop using high doses of fentanyl as did the prescription of medical heroin. For Benjamin, the grim reality of life within prison is what first brought him to drug use. The terrible conditions behind bars and the dangers people are exposed to is one of the many ways that the legal system enacts violence on the most vulnerable members of society. The brief glimpse into Matt's life also shows for its part how the efforts to stop using street drugs can be derailed by the prison system.

Addiction cannot be understood as a purely biological or moral phenomenon. For many people who use drugs, the experience of structural and everyday violence shapes the way they use drugs. Paying attention to individual narratives reveals the functional uses that drugs can serve for individual people and how the "choice" to use or not use drugs can be an illusion when people are faced with violence. Liberal conceptions of the free subject obscure the social,

political, and economic factors that shape addiction. If drugs are required to find solace and comfort while living on the streets or in prison amongst the constant threat of violence, how does that factor into a liberal conception of autonomy? This first chapter serves to illustrate how addiction cannot be framed through the individual choice to use drugs, but must be understood within the wider social, political, and economic context of liberal governance. In the following chapter, I introduce more ways that drugs can serve a functional purpose for people.

Chapter Two
"I Don't Wanna Get High, I Just Wanna Get By": Looping from Addict to Patient

Near the end of my time at the clinic, I was returning to the waiting room after a break for lunch when I stumbled into a spirited conversation about naloxone. The debate appeared to be between Sasha, Joe, and Sarah. Joe had just returned from the park near the clinic where a small tent city was established. He was telling the group that he tries to occasionally check on people and make sure they are doing okay. Joe used to live in the park and has friends that still do. He was frustrated because he had administered naloxone to a person in the park he believed was overdosing. The person he administered naloxone to did not thank him when he woke up. This is an expected outcome because naloxone sends a person directly into withdrawal. Joe was therefore not frustrated with the person's reaction, so much as how often he has had to save someone's life in this way. Joe tells the waiting room he believes that since naloxone has become widely available, people in the neighborhood have started using more recklessly than before. Sasha tells him it is silly to blame naloxone and that overdoses occurred often in the neighborhood long before it was available. Sarah chimes in to tell Joe that naloxone has saved her life multiple times and is a necessary tool for preventing death. At this, Joe exclaims that as long as people are using the street drugs, there is no way to prevent death. He expresses his frustration in seeing people he loves continue to use when he has made it out. Sarah and Sasha are sympathetic and agree that it is hard to see people living that way after having "clawed out of it" themselves, but all you can do is keep yourself "clean." Sarah, Joe, and Sasha all use safer supply on a daily basis, but from this conversation it is clear that for them, safer supply is more than a known concentration of opioids. The drugs prescribed through safer supply are distinct from the drugs found on the street. The harm inherent in street drugs is removed and using safer

supply is thus synonymous with being "clean." I argue that this distinction between drugs on the street and in the clinic is due to the medicalization of drug use in safer supply. This particular form of medicalization though does not seek to pathologize drug use in itself, but instead looks to drug use within the clinic as a form of healthcare.

Addiction as a Chronic Relapsing Brain Disease

The National Institute for Drug Abuse (NIDA) is a US federal research institute and the world's largest funder of research into drug addiction. NIDA defines addiction as a chronic relapsing brain disease that requires lifelong treatment (NIDA 2018). The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health teaching hospital and a leader in addiction research within Canada. CAMH also recognizes the chronic relapsing brain disease as the most accepted model of addiction (Herie et al. 2007). Within clinical practice, addiction or a substance use disorder is never diagnosed through brain imaging or neurochemical tests, but through the subjective experience of the person using drugs. In the same information guide from CAMH that posits addiction as primarily an issue of neurology, the four Cs of recognizing addiction are also presented: Craving, loss of Control of amount or frequency of use, Compulsion to use, and use despite Consequences (Herie et al. 2007). For a physician to find answers to the four Cs, they must interview their patients about their experiences, as there are no objective medical tests to be performed.

Addiction as a brain disease is a relatively new concept. It was only after US President Nixon's War on Drugs that funding for neurological research in addiction became widely available, which led in 1973 to the isolation of opiate receptors in nerve tissue (Vrecko 2010). Later in the 1990s, with the advancement of positron-emission tomography scanning, those

opiate receptors could be visually mapped in the human brain (Campbell 2007). By locating addiction within the brain's neurotransmitters, addiction researchers understood themselves to be bringing addiction out of the shadows of moral disorder and into the rational light of science and medicine (Campbell 2011). The hope is that by framing addiction as a biological disease, the social stigma of addiction is lessened. Nancy Campbell has argued that the medicalization of addiction should not be understood through a theory of "social control", but instead as "useful to professional enclaves seeking to displace the prerogative powers of state and police in order to make space for humane, compassionate addiction treatment" (2012, 6). Safer supply is not a treatment for addiction, but I argue that it creates a positive medicalization of drug use. In safer supply, addiction or drug use are not the object of treatment; instead, drug use itself is a medical treatment. In this chapter, I focus on the narratives of three people I met at the safer supply clinic whose understanding of their own opioid use fits within this positive medicalization.

Sasha

I first connected with Sasha over a shared love of dogs. While in the waiting room at the clinic, she showed me pictures of her two dogs on her phone: an adorable husky puppy and a boxer mix. I showed her some pictures of the dog I grew up with and told her I hoped to get a dog myself as soon as I was finished being a student. Sasha is in her mid-forties and has dark brown hair that is always expertly styled. She frequently sports a bold lipstick and loves a bold animal print pattern. The overall effect is never too overwhelming, though; her sense of style is bold yet refined, and she always looks well put together. Sasha, like Trent, was one of the first people to enroll in safer supply at the clinic. Since starting the program, she has been able to level out her life significantly and was one of the fiercest advocates for the program. When Sasha

learned about my project, she was very enthusiastic about sitting down with me for an interview. During our interview, however, I opened with what was accidentally a very confusing question:

> *Claire: So first let's start with how long have you been part of safer supply?*
> *Sasha: Part of safer supply? Okay… do you mean the safe injection sites? Like how long I've been using them?*
> *Claire: Oh no I mean like with Dr. Murphy, the harm reduction program you are doing with him.*
> *Sasha: Oh you mean my medication?*

The term "safer supply" was not familiar to Sasha, because she did not understand the medication she is prescribed by Dr. Murphy as an alternative supply to street drugs. Of course, Sasha understands that the medication she receives is an opioid and that she can get it because the government recently relaxed regulations around prescribing opioids to people with a history of substance use disorder. Yet, for Sasha, safer supply is not just a means to stopping street drug use. It is also a necessary medication. Sasha's path to drug use began out of a need to treat psychic pain from childhood trauma. When Sasha was very young, she was sexually abused by someone she trusted, and the abuse left her with debilitating post-traumatic stress disorder. She did not speak at length about her abuse to me, but she told me that her entire life has since revolved around treating both the physical and mental pain from the abuse. For Sasha, opioids are one of the few things in this world that offer her the ability to manage her chronic pains. Before safer supply, many doctors and other professionals had tried to help Sasha seek therapy or counselling, but she does not believe they would help her, as she explained:

> *My mental state of mind greatly effects my physical state. So, if I'm not in a good place mentally, I'm in terrible pain, and I'm not able to cope with anything. If my emotional state is too high, I can't deal with regular everyday things. For the most part, I'm stable these days, I try not to let it get to a point where I can't get myself back up. I've never been to counselling or anything like that, because I know if I opened everything up at once, it would be too much, I wouldn't be able to handle it, and I wouldn't be able to come back.*

Unlike most of the other people I spoke to, Sasha was adamant that both methadone and suboxone could be effective treatments for opioid addiction. The first time she tried to stop using street drugs, methadone helped her stay clean for two years. Sasha, however, did also tell me that methadone could sometimes exacerbate a bad mood and cause her to "*not think proper and act weird.*" She returned to using street drugs to cope with the emotional pain of losing a close friend to overdose. When she decided to try to get clean again a few years later, she was able to get suboxone through ODSP. Once again, Sasha was able to stay clean from street drugs for two years, but then she lost another close friend to overdose, and it drove her to using heavily again. This time around, fentanyl was the most available drug on the street, and Sasha told me that using fentanyl was an entirely different experience from any other opiate. Methadone and Suboxone were both able to treat the physical cravings for opioids and prevent withdrawal while Sasha was emotionally stable. However, traumatic events, like the loss of a loved one, would cause Sasha to return to street drugs because she required the pleasurable numbing effects that both methadone and suboxone were designed to prevent. Sasha recounts how the potency of fentanyl drove her to use more frequently than she ever had before:

> *I didn't know at the time that I was going to return to opiates, I was still in the mindset that I could get clean, but eventually my opiate problem returned. I found myself abusing even worse than the opiates. I was using on a level that I don't want to see anybody at. Like fentanyl, I'm dead set against it. Now I have no fentanyl in my system whatsoever. I'm clean on fentanyl right now. I wouldn't be able to do that without this program. So now it's a life worth living, because I've seen so many people die from fentanyl, and known so many that have died.*

Sasha joined the safer supply program shortly after Trent. When I met her, she had been on the program for one year. She first met Dr. Murphy when he worked at the community health center and when he started his own practice, she followed him there. Sasha had heard about the new program Dr. Murphy had started with a few patients and expressed interest in trying it for

herself. Dr. Murphy was already very familiar with Sasha's history with drugs, as he had been her primary doctor for a while, and she was thus able to join the safer supply program right away. Sasha trusted Dr. Murphy deeply so she was excited to try safer supply with him. She told me that if another doctor in the community who she had not built trust with had been offering safer supply, she would have been wary about trying out a new program for fear of being cut off unexpectedly. Sasha's fear turned out to be very real. During the time I spent at the clinic, another doctor opened a safer supply clinic in the same neighborhood but ended up closing the clinic and leaving the city just a few short months after opening it. Sasha says that Dr. Murphy is very good at making everyone feel comfortable and safe. At the time that Sasha started safer supply, her drug use was the heaviest she had ever experienced in her life. She thus knew that transitioning to methadone or suboxone would be extremely difficult because the regulated limits on the dose of opioids you are allowed to start on in those programs would be too low to effectively transition her off of fentanyl.

For Sasha, safer supply is not only a method for preventing fentanyl use, but it is also a crucial medication that allows her to live her life the way she wants to. Sasha self-medicated for years with prescription opioids she purchased on the street and then more recently fentanyl, but she could never find a "legitimate" form of treatment that worked for her. Due to her history of drug use, Sasha had a lot of trouble accessing prescription medication and often found herself turned away from clinics. Sasha was frequently advised to seek counselling for her PTSD from childhood sexual assault, but she did not find the forms of counselling made available to her to be very useful. Sasha compares her safer supply prescription to SSRIs prescribed to people with depression and anxiety and the opioids prescribed to people with chronic pain. For Sasha, safer supply is the first time in her life she has been able to find care within the medical system for her

chronic pains. Sasha admits that the lines between treating an opioid addiction and treating her mental and physical pain are blurred, but all that matters to her is that safer supply is helping her to mitigate her pains in a way that allows her to live without fear of overdose: *"Yeah, I can't stress enough how much this program saved my life. It truly is saving lives. I wouldn't be where I am today if it weren't for this program."* Since joining safer supply, Sasha has been able to find stability in her life. Her housing situation is more stable than it used to be, and she is even beginning to work regularly as a cleaner. Sasha explains how she would not be able to work as a cleaner, a physically demanding job, without the safer supply prescription:

> *I'm able to do that because I'm mobile, like I don't have mobility issues when I'm on the medication, so without that I wouldn't be able to do anything. I mean, it treats my depression, it treats my anxiety, it treats my pain.*

Sasha is happy to report that safer supply helped her to stop using fentanyl completely:

> *I didn't feel pressured to go off fentanyl. I didn't feel like if I didn't stop using fentanyl the treatment wouldn't be available to me anymore. I felt encouraged and supported to go off fentanyl though. So, then I did end up going off of it when it was my time, when I was ready. Everyone is going to be very individual in terms of when they can go off. I'm happy to be able to say now that I'm fentanyl free, but I didn't feel pressured at all. You're not gonna fail because you have what you need, you know?*

Sasha does not see a future where she will not need some sort of opioid to treat her chronic pain. For her, safer supply is her success story and she does not feel addicted to fentanyl anymore. The prescription she receives from safer supply is a medication that allows her to move forward with her life, not a temporary treatment on a path to never using opioids again. She is not opposed to changes in dose or the specific form of opioid in the future, but she is opposed to the idea that eventually ending opioid use should be a goal for her.

Paula

Paula is the sort of person who can raise the energy levels in a room just by entering it. Always in a rush, she enters quickly, catches up with you at a mile a minute, and leaves as quickly as she came. The first time I met Paula, she was the last patient to arrive at the clinic for the day. It was nearly 7:00 p.m. and I was sitting in the waiting room of the clinic finishing up my fieldnotes. A loud bang at the door made me jump, and I turned to see a woman in her early fifties struggling through the clinic door with a bulky electric scooter. She was dressed in a graphic band t-shirt and khaki board shorts with a skateboarding helmet unbuckled sitting crooked on top of her head. The clinic secretary exclaimed, *"Oh thank goodness! I was worried we were going to miss you today, and you'd have to come in tomorrow."* Paula laughed and said, *"Me too!"* After hastily stowing her scooter in the back corner of the waiting room, Paula rushed up to the front desk to receive a urine sample cup and Dr. Murphy saw her right away as it was nearly closing time and there were no other patients. Paula does not often stay to chat very long: after a short conversation, she had her prescription renewed and was off to the pharmacy to get it filled before they closed.

It was some time before I was able to sit with Paula for an interview because she was so often in a rush, but one lucky afternoon she arrived at the clinic with plenty of time and told me she wanted to talk. Paula grew up on a farm caring for horses and in her teens and twenties she barrel raced horses in rodeos. Barrel racing is a sport in which a rider and their horse attempt to complete a circuit with sharp turns around barrels as fast as possible. While barrel racing is generally considered a safer rodeo event than, for example, bull riding, the speed that the horse travels around the barrels can spell disaster for the rider if they fall off. The type of training involved in preparing for a barrel race can also be very hard on the body. Paula did not use drugs

heavily when she was young, but drinking and party drugs were a constant presence in the rodeo scene. It was not until her mid-forties, however, when some old rodeo injuries started to catch up with her and she began to experience arthritis that Paula sought opioids: "*I abused my body so much when I was younger; I'm always in pain now, constant pain. Yup, I'm a farmer."* Paula began with actual prescriptions for pain medicine, but when she was cut off, she turned to prescription pills on the streets. I asked Paula why she was cut off so abruptly, and she told me that she had never been given a satisfactory reason. She believed, however, that her doctor at the time had stopped prescribing opioids to any patients and not just her. In the initial response to the opioid overdose crisis, changes were made to Canadian opioid guidelines and many doctors who had chronic pain patients on high doses of opioids were brought under scrutiny by provincial medical regulators. Many doctors simply stopped prescribing opioids at all for chronic pain in fear of losing their license.

At many points in her life, Paula realized that her use of opioids to treat her pain was problematic and made it difficult to lead the kind of stable life she wanted to, but leaving opioids altogether was not an option. Most of her friends and her partner were also heavy drug users, so the temptation to use was ever-present:

> *I moved here a couple years ago with somebody I was in a relationship with, and after 13 years, I just left because she won't get off the pipe you know what I mean? And I'm done with that, don't bring it around me. I wanna work. It's awfully hard when you're all fucked up. Going to bed at 5 in the morning and you work at 7, it's not happening you know? It's not happening.*

Even though Paula's first experience with opioids happened later in her life relative to other patients I interviewed, she had also tried both methadone and suboxone as a method of replacing street drugs before turning to safer supply. Paula did not use either treatment for very long, staying less than a year with each. She tried methadone first, but she did not stick with it

long enough to reach a dose level that was effective for her. Paula was worried about the side effects of long-term methadone use that she saw in other people at the methadone clinic: "*I have a real bad paranoia with my teeth, and everyone I knew on methadone, their teeth fall out!*" After Paula expressed to her general practitioner (who at this time was not Dr. Murphy) that she did not want to use methadone but wanted to stop using street drugs, she was prescribed suboxone. Unfortunately, Paula did not find suboxone effective and she was still using a lot of street drugs while on suboxone. Her doctor at the time was very hesitant to make any changes to Paula's suboxone dose, despite indications that it was not working for her at all.

Fentanyl terrifies Paula more than any other drug she has used before. It is less expensive and more readily available on the streets than most other opioid-based drugs, and certainly much cheaper than the pain pills that Paula had been using to treat her chronic pain. Before using fentanyl, Paula did not believe she had a problem with drugs, but after a few experiences overdosing on it, she began to fear the drug:

> *The fentanyl is so bad, eh? I don't know why I do it, I know it's gonna kill me, but it's just like, "Oh well, does it make a difference if I'm dead?" Terrible thing to think, but it's true. Even when I've ODed, I remember coming out of the hospital and going to get more right away, is that stupid or what? I'm like "I'm not gonna inject it, I'm just gonna smoke it", what the fuck's the difference, right? It's still getting in you. I didn't think you could OD from just smoking it, but apparently you can. It's horrible.*

The realization that she was so dependent on fentanyl that she needed to seek a hit right after being discharged from the hospital after an overdose led Paula to seek out safer supply, even though she had not been using fentanyl for very long.

Paula had been on safer supply for four months at the time of our interview. She was not a regular patient of Dr. Murphy's before safer supply; she had initially heard about the program through a friend who was already enrolled. The doctor Paula had before joining safer supply had

made her feel ashamed of her drug use, as well as small and powerless concerning decisions around her own health. Paula had not used fentanyl for as long as most of the other people on safer supply, so when she first came to Dr. Murphy to inquire about the safer supply program, he was initially unsure whether it was the best fit for her. Yet, after hearing that Paula had overdosed multiple times already, and that she desperately wanted to stop using fentanyl, he agreed to enroll her in the program. Paula recounts her motivation:

> *I was like, "Please! I don't wanna do it anymore". I was at my last wit's end. You know, when you feel like there's nothing that can help you? I mean, I'm still doing the Dilaudids, which is a substitute basically, but it's not going to kill me. I'm not doing outrageous amounts of it. I guess I don't wanna get high, I just want to get by. I don't wanna be like that drooling and pissing myself, no. I just want to be able to go out, and get back to work and stuff you know?*

Since beginning safer supply, Paula has been able to stop almost all fentanyl use. There have only been two times that she has used fentanyl since joining the program, and both times occurred in a social setting where other people were using it. One of the unintended consequences of joining safer supply is that she feels a bit isolated, because a lot of her friends are drug users and to avoid fentanyl, she has to avoid them. When she is on her own, she no longer feels the craving to go out looking for fentanyl. Paula has also known many people who have died from overdose, and that has motivated her to make radical changes in her life:

> *I have no urges to go out looking for it. If it's there, like that's why I messed up because it was there, so I try to avoid people who use. I lead a sheltered life now. I have to, you know what I mean? Everybody I know from before, they're all doing the same shit now. It's like, "Oh god, I'm 51 years old, I gotta move on, everyone's dying, I don't want to do that." They're all doing the same shit, and I'm done with it. Done!*

Paula emphasizes a desire to "move on" from fentanyl. She wants to regain control of her life and she feels that safer supply is a method to do just that.

Paula is in a similar position to Sasha. Paula is no longer using fentanyl, but still needs to use opioids to treat her chronic pain and arthritis. Paula was not yet employed, but out looking for work at the time of our interview. Safer supply has helped stabilize her life substantially, but she does fear that the stigma attached to being in a program for drug users could reduce her ability to find work. Paula was fairly new to the program at the time I spoke to her, and so she was still expected to pick up her prescription daily from the pharmacy. She worries that needing to make a daily trip to the pharmacy could prevent her from holding a job, but also recognizes that safer supply has more flexibility around prescriptions than methadone. When Paula's mother broke her hip earlier in the year, Dr. Murphy allowed her to take home a week's worth of her prescription at once, so that she could travel to visit her mother. Paula's current goal in the program is to continue to stabilize her life, and to prove herself responsible enough to not need to pick up her medications daily. She has no intention of weening off from safer supply.

Joe

Joe is in his late fifties, and he has spent a good portion of his life living on the street. Joe loves to strike up conversation with whoever is in the waiting room, and he often seems to know everyone by their first name. He is a well-known member of this community and a few people remarked to me that Joe's story is a source of motivation for them: he went from living in the tent city in the park using fentanyl everyday, to clean (except for safer supply) and stably housed with his father's help. Joe told me that his first encounter with opioids occurred due to a workplace injury:

> *I was working. I was roofing and I fell. It wasn't on the books, though, it was for my niece. I hurt my back, vertebrae L2, L3, and L4 are now fused together into one and I took a chunk out of one of my discs. So, I screwed my back up pretty bad, and my doctor prescribed me hydromorphone and I was on that for a number of years, then one day I*

went in to his office and he said "I can't give you anymore pills." I was like, "What!? How am I supposed to go to work, you know how bad my pain is, it's bad." He says, "Sorry there's nothing I can do about it, I can't give you no more pills, blah, blah, blah." He gives me this big spiel about going on methadone. I ended up going on methadone, I don't know what happened, maybe he got red flagged. I heard he did this to a couple people. Anyways, that (methadone) wasn't working so good for me, so I started buying them on the street. Off I went, I got them from a friend of mine, and I had as many pills as I could need.

Joe also had negative experiences with both methadone and suboxone. He first tried methadone and had used it for a few years before he decided to quit because he found the side effects intolerable: "*Methadone, I got the feeling that it gave my body, I kinda felt out of control of myself. I would start nodding off when I was watching TV, I'd start falling asleep in class at school and things like that. I didn't like that feeling, so I quit."* Methadone worked to prevent his cravings for street drugs, but it made living a full life impossible. At the time, Joe was trying to go back to school to get a trade certification, and the side effects of methadone were hampering his performance. After quitting methadone, he turned to suboxone, but he found it to be unpredictable. Sometimes a dose would prevent his cravings, and sometimes it would throw him into withdrawal and force him to seek drugs on the street to stave off dope sickness. Joe did not like the unpredictable nature of suboxone, and so he chose to return to the street drugs he knew. At this point, Joe had been using opioids from the street for many years, and he felt that he had more control over his dose on the street than he did in the clinic. When he was using both methadone and suboxone, Joe found himself often leaving appointments without fully understanding what he was being prescribed, or why a dose was modified: "*They [doctors] use medical jargon words, leaving you walking out the door not understanding what just happened.*" By returning to the street supply, he felt he was able to regain autonomy that was lost in the clinic.

Like Paula, Joe had mainly been buying pain pills from the streets to deal with chronic pain from injuries, but he had begun to develop enough resistance to them that the dose he required to deal with his pain was too large to be affordable. Powdered fentanyl was much stronger and cheaper, and so he began to use it instead:

> *That was just such a huge change from pain pills to fentanyl. The addiction is insane with fentanyl. I did it, I'm not gonna blame anyone but me. Fentanyl is easy to find, easy to get a hold of, it's cheaper than pain pills, so I started using it. I saw too many people die from it, so that's when I said, "That's it, I'm done."*

When I spoke to Joe, he had been enrolled in safer supply for three-and-a-half months. Joe was not a patient of Dr. Murphy's before safer supply, but he did know him from the time Dr. Murphy worked at the community health center. Joe reconnected with the physician by chance at a separate walk-in clinic when they both went there on the same day to get a flu shot. While in the waiting room, Dr. Murphy chatted with Joe and as he got a sense that the latter was struggling with his addiction, the physician began to explain safer supply to him. Joe was intrigued by the concept and agreed to come into the clinic for a formal appointment with Dr. Murphy the next week. After that appointment, both Joe and Dr. Murphy agreed that safer supply could be useful for Joe, and he enrolled in the program.

Joe sees safer supply as the "goldilocks" of opioid replacement therapy. Methadone was too much for Joe, as the dose was higher than he wanted, putting him to sleep and preventing him from fully experiencing life. Suboxone was not enough, as Joe felt constantly dope sick and on the edge of withdrawal. Safer supply "gives Joe energy" by fully managing his physical pain and preventing dope sickness without making him feel groggy or "out of it." This fine balancing act is easier to achieve with safer supply than with methadone or suboxone because the prescription of safer supply is less heavily regulated. A doctor can be more flexible when prescribing safer supply than any other comparable treatment.

Joe is careful to emphasize that it is not just the drugs themselves that he finds so useful, but also how easy it is to talk with Dr. Murphy about his prescriptions. Joe feels it is important that he understands what he is being prescribed and why, and Dr Murphy explains every change in his prescription in clear and concise terms. Feeling like an active participant in his care is important for Joe, but it also makes safer supply a more effective replacement for street drugs. Safer supply has been so effective in replacing street drugs for Joe that in the time he has been on the program, he has only used street drugs twice, a much higher success rate than he had on methadone or suboxone. The first time Joe sought out street drugs, he had lost his daily take home prescription and needed to replace it. He bought fentanyl on the street but made sure to use what he knew was a very small dose for himself and then he flushed the rest of it down the toilet. Joe says that before safer supply, he never would have had the control to do that. The second time Joe used fentanyl after joining safer supply was after an emotionally traumatic event. Joe had an aunt who was important to him and who helped him to stay clean from fentanyl. When she passed away, it was very difficult for him. For a day or so after he buried her, Joe "let his addiction have at it." He bought and used a hit of fentanyl and drank a lot, but it was just a onetime bender. Safer supply can meet Joe's needs outside of a few exceptional moments, and that allows Joe to manage his pain without spending all of his money:

> *I have money in my pocket all the time now. There's not a day that goes by that I don't have money in my pocket. Whereas before, I was waking up in the morning and my first thought, my actual first thought, was "Where am I gonna go get some money now? Where am I gonna go get some money so I can get a point so I'm not sick?"*

Before he had access to safer supply, Joe rarely had enough headspace to think about anything besides survival.

Joe's intentions in starting safer supply and his current goals have changed drastically. When Dr. Murphy first explained to Joe what safer supply was, all Joe saw in the program was

free drugs. Joe reflects now that the program has become a tool to help him stop using fentanyl, and he feels he was misguided or taking advantage of the program initially. The stated purpose of safer supply is to provide people with a safer alternative to street drugs. It does not set out to be a treatment for addiction, so it is interesting that after being on the program for a while, that is how Joe interprets it.

> *When people started using this, they started using it for the wrong reasons. It took a while to catch on, and now I see more and more people using it for the right reasons. They're actually doing it to save their lives. They're not doing it to go out there, and sell some pills, and make some money. They're not doing it to get high. They're using the medication properly, as prescribed, and I can see the changes in their lives. It's not too hard to notice. It all depends how that person perceives it, and what they want out of it. You're only going to get out of it what you want. If you're not doing it for the right reasons, if you don't want to get clean, you're not gonna. That's just my perception.*

Joe points here to the diversion of safer supply drugs to the community. The idea that safer supply patients could be taking their prescriptions and selling them on the street has been a major point of contention among the public and politicians against safer supply. Researchers working with safer supply groups point out that diversion of safer drugs to the street is still a safer supply for someone, if not the intended person (Bardwell et al. 2021). People who sell or trade their safer supply prescriptions report doing so for a wide variety of reasons, and sometimes it is understood as an act of care to keep family or friends safe from fentanyl (Bardwell et al. 2021). Given the limited resources of most safer supply programs in Canada, and the long waitlist to join, it is easy to see how sharing safer supply prescriptions with a friend can be a way to share access to the program with those who are not enrolled. No one I spoke to told me they had sold or traded their safer supply prescription, but many of them admitted they knew people on the program who did. Although I made it clear to participants that their names would be anonymous and that anything they told me would not be passed on to Dr. Murphy, it is entirely

understandable that they would not want to divulge such information. It is also possible that the people who were diverting their prescriptions would be less likely to want to speak with me about their experience in the program.

In any case, Joe was adamant that after spending enough time on the program, his goals changed. Being able to access hydromorphone without having to pay for it meant that even when Joe was still using fentanyl, he had more money available to him. The extra money stabilized his living situation and met his basic needs. This allowed Joe to remove himself from the "craziness" he had been living in previously:

> *Cause, let's face it, half of this addiction is living in that chaos. I lived down there, in that park, in a tent for 2 years. It was absolutely crazy. I don't know what I was thinking. You know, I did what I had to do to survive, when in reality all I had to do was pick up a phone and call my dad. I just didn't want to swallow my pride, I wasn't ready. And now I am, that's it.*

Joe initially started using opioids to treat chronic pain from a back injury, and he thinks he will always need some level of pain medication in order to function. His goal in the safer supply program now is to greatly reduce the dose of medication required to treat his chronic pain:

> *I will have to take some kind of pain medication for the rest of my life. It's just finding the right one that I can function with properly, and you know be able to not have them worrying, "Oh, Joe looks a little too high to drive today," or whatever, and end up losing a job over that. I don't want that to happen, so I gotta find that happy medium. Next year, I'd like to try cutting back, maybe removing one pill at a time, see how it goes.*

Complicating the Addiction Category: Looping Effects

When I first asked Sasha about safer supply, she did not immediately understand what I was asking her about. This confusion occurred a few times in my interviews, because the term safer supply was not often used within the clinic. Many people simply called it the harm reduction program. Dr. Murphy's prescription of opioids to people who were diagnosed with an

opioid substance use disorder was understood less as a uniform method of addiction treatment, and more as a one-on-one consultation with the doctor. The logic was not that the clinic offered a certain program of treatment, but that the doctor who ran the clinic was open to prescribing opioids to people who wanted to cut back on fentanyl. This understanding reflects in the way everyone I spoke to emphasized Dr. Murphy's role in their success within safer supply. The relaxed regulations around safer supply, compared to other pharmaceutical opioid treatments, allows Dr. Murphy to be flexible in the type of drug and dose for each patient. Fundamentally, this is because safer supply is understood by the regulatory bodies as a last resort harm reduction tactic, and not an actual treatment. There is no dosing schedule to meet, because there is no end goal except to keep people alive. With no prescribed path, safer supply allows people to form their own goals within the program, and this conceptual freedom, I argue, ends up complicating the definition of addiction.

Many people who seek treatment for addiction voice a wish to establish a sense of 'normality' in their lives or at least to 'feel more normal' (Nettleton et al 2012; Schlosser and Hoffer 2012; Harris 2015). This perceived lack of normality associated with opioid use can be problematized when we consider the forms of psychotropic drug maintenance that are medically normalized. The use of psychiatric medication for the treatment of mental illness and pharmaceutical opioids for the treatment of chronic pain are regular practices within biomedicine. While there is certainly stigma associated with these medicines, their regular use is not considered an addiction, whereas it is with illicit street drugs. To further complicate matters, many people who use drugs cite mental health and chronic pain issues as reasons for beginning and maintaining illicit drug use (Schlosser and Hoffer 2012). Distinctions between the pharmaceuticals used to treat opioid addiction (methadone and buprenorphine) and the illicit

opioids themselves have been blurred by academic discourse (Bourgois and Schonberg 2009; Campbell 2007). I argue that safer supply contributes to the further blurring of these distinctions by the legal prescription of illicit drugs.

I aim to problematize the concept of opioid addiction as an inherently problematic form of drug use. For many people who use drugs, there are specific functional benefits to using illicit drugs that they cannot achieve elsewhere (Duff 2015). In the context of Ontario, many of the people now considered addicted to opioids were previously prescribed opioids by a medical professional who subsequently lost their license. The great irony for people like Paula and Joe is that their use of opioids was at first legally sanctioned, then suddenly deemed problematic addiction, and now re-medicalized through safer supply. Scholarly discussions about how to define and treat addiction have tangible consequences for those struggling with addiction. Ian Hacking's (2006) "looping effect" describes the way that classifications of people and those who are classified interact with and influence each other. Hacking argues that science does not discover classifications of people, but the act of classifying brings those people into existence. Or rather, the creation of a category allows for people to live within that category. Categories of people are created by experts and professionals in social sciences and medicine; these categories are then applied to therapeutic practice. Hacking (2006) points to categories such as autism. A person could not experience themselves or interact with family, friends, or doctors as an autistic person before the category existed in psychological practice. These categories are "moving targets" for the human sciences, which means the categories themselves are continually changing (Hacking 2006). The mechanism with which these categories change is what Hacking (2006) refers to as the looping effect. People adapt to new categories, but they also adapt categories to

fit themselves. Future investigations into the lives of people within these categories then continually "discover" new ways to understand that category.

The looping effect is useful to understand the ways that safer supply can open new kinds of opioid users. Hacking's looping effect explains the process through which expert knowledge categorizes people into certain human kinds, and then the people categorized behave in ways that subtly change their categorization. A human kind is Hacking's (1996) term for the mostly deviant behaviours that experts who study people want to gain knowledge about. Experts studying human kinds often seek to gain knowledge out of a desire to help people, or prevent others from becoming that human kind (Hacking 1996). The addiction scientists who sought to understand addiction not as a moral failure but instead as a brain disease had the goal of helping people who use drugs and also preventing other people from becoming drug users (Campbell 2011). Categorizing addiction as chronic relapsing brain disease created a new way to be a drug user, a new human kind. People who use drugs could now understand themselves not as damaged, weak-willed individuals but instead as damaged brains that require constant maintenance with drugs. Within the logic of brain disease, pharmacotherapy like methadone and buprenorphine would be the ideal treatment for addiction. However, for Paula, Joe, and Sasha, the moments when methadone and buprenorphine stopped working for them were not related to the drug's ability or inability to properly bind with neurological receptors. These failures rather were reflections of regulatory limitations, their environment, and most importantly, their subjective experience.

Sasha and Joe left treatment in moments of emotional distress. For Sasha, the deaths of two people close to her were the triggers for returning to street drugs after she had found long-term success from methadone and then buprenorphine. One of the two times when Joe used

fentanyl after joining safer supply was after the death of a close aunt. Through the brain disease model of addiction, these moments of emotional distress are understood to trigger neurochemicals that increase a craving for the drug. The brain disease model does not blame the individuals for the return to street drugs, instead it is their neurochemistry at fault. While this neurochemical understanding medicalizes relapse, it does so within the context of criminalization and an understanding that abstinence from street drugs should be the only goal. Safer supply does not refute the brain disease model, but it does refute the idea that abstinence is the only or essential goal in helping people who use drugs. When people experience a relapse within a methadone program, this often leads to a required change in dose. Many of the people I spoke to said that these forced dose changes served to make methadone inaccessible to them. Within safer supply, doctors do not have strict dosing regulations to follow. In moments when a patient relapses, there can be a discussion between the provider and patient in terms of what or even if anything needs to change to return to stability. Safer supply does not assume drug use itself is the problem, which allows for the recognition of the functional benefits that can come from drug use.

Both Paula and Joe first started using opioids under the direction of a doctor, and at this time, they did not perceive their opioid use to be problematic even though their neurochemical receptors were most likely already reshaped by opioids. Paula and Joe needed to use opioids to manage their chronic pain. Sasha did not start with a doctor but she also began using opioids to manage chronic pain. Making prescription opioids unavailable for people who want to use them for a functional purpose only serves to push people towards illicit opioids. The government's regulatory changes that probably influenced both Paula and Joe's doctors to stop prescribing them opioids also led to a decrease in the availability of pain pills on the illicit market. This

process is how fentanyl, an extremely potent and cheaply made opiate, has become ubiquitous on the streets.

Framing the addiction trajectories of Paula and Joe through Hacking's looping effect, we can see how categorization and the actions of those categorized influence each other. Before addiction was recategorized as a relapsing brain disease, Paula and Joe's opioid use could not be understood as addiction. They were simply pain patients. When regulations influenced by the recategorization of addiction as a brain disease took their prescriptions away from them, Paula and Joe's pain did not disappear. Suddenly finding themselves categorized as having a substance use disorder, Paula and Joe did not find that the logic of methadone and buprenorphine treatment worked for them. Turning to the opioids available on the street, without ODSP to cover the cost of pain pills, fentanyl became the most accessible source of pain management. The experience of using fentanyl, a much more potent opioid than pain pills, upended their lives and left them living in "chaos."

Safer supply was in part created as a resource for people who tried and failed out of methadone and buprenorphine. While safer supply does not refute the brain disease model of addiction, it does recognize that the experience of using opioids is subjective and does not seek to prescribe a one-size-fits-all regime. Sasha, Joe, and Paula are all able to use opioids to treat their chronic pain without the assumption that their use is problematic. People like Paula, Joe, and Sasha complicate the categorization of addiction as brain disease. Now that they have access to prescription opioids through safer supply, Paula, Joe, and Sasha no longer understand themselves as addicted. They behave in ways that defy the category of addiction and, consequently, they are bringing a new category into being.

Conclusion

In the opening vignette of this chapter, I shared a moment from the clinic waiting room where Sarah (who I will introduce in chapter three), Joe, and Sasha drew clear distinctions between the opioids found on the street, specifically fentanyl, and those prescribed in the clinic. Sasha, Paula, and Joe all began using opioids to treat chronic pain. Joe and Paula first used opioids under the prescription of a doctor, and it was not until those prescriptions were taken from them that they began to understand their relationship to opioids as addiction. Finding prescription opioids on the street is an expensive endeavor, and so each of them eventually turned to fentanyl, which is cheaper than prescription opioids and generally more available, too. The material reality of using fentanyl is vastly different than prescription opioids. Each person I spoke to agreed that the experience of using fentanyl was incomparable to any other opioid, and the ensuing withdrawal more terrible than any other. Within each person's narrative, fentanyl is a kind of life-sapping force, even for people who have a specific goal in using opioids, such as treating pain. For each person I spoke to, the experience of addiction is thus defined not just by a neurochemical craving for opioids but also by the material reality of particular drugs, their social world, and the environment.

Regarding the power of fentanyl, there is certainly a biochemical material reality. Fentanyl is a completely synthetic opioid, not extracted from poppy seeds like heroin, morphine, and methadone. It binds to the brain's neuroreceptors more completely than natural opioids and other synthetic opioids like buprenorphine (Ciccarone, Ondocsin, and Mars 2017). Raikhel (2015, 377) calls for social scientists to engage with "ecologies of addiction" to make sense of the epistemic chaos of addiction studies. Raikhel appeals not for a unified model of addiction but instead a greater engagement between disciplines that approach the question of addiction in very

different ways (392). The solution is not to solve the epistemic chaos, but instead embrace it. I argue that safer supply can meet this demand because it approaches care for people who use drugs without an agenda. The point of safer supply is simply to allow access to care and support in the way that each individual requires. Paula, Joe, and Sasha understand themselves as "clean" when only using safer supply and "addicted" when using fentanyl or heroin. Care that embraces the material, social, and economic realities of drug use can be a path to allow people to use opioids and live a life they want. In the next chapter, I further explore this potential for drug use to become compatible with "a good life."

Chapter Three
Safer Supply and the Beginning of Ethical Work

It is a rainy Tuesday morning, a safer supply day, and the waiting room is full. The damp sky and chilly weather makes dealing with morning dope sickness especially unpleasant for most people and the waiting room is silent except for the quiet hum of the fridge behind the front desk that contains urine samples. Sarah, a woman in her late twenties and one of the younger patients at the clinic, has been waiting quietly in a corner of the waiting room. She greeted me when she arrived, but after a brief chat, sat across the room. The silence of the waiting room is interrupted suddenly with a bang, and the clinic door opens to Joe, smiling ear to ear. He greets the entire room with a warm *"Good morning, everyone."* Not everybody in the room is receptive, but a few people nod politely in his direction. Someone comments that Joe is far too chipper for the morning and Joe replies, *"Every morning I wake up and don't feel sick is a great morning for me!"* The room enthusiastically agrees with this point. Joe sees Sarah and greets her, and after some small chit chat, the conversation turns to how they are progressing in the program. Sarah enthusiastically reports that she is clean from fentanyl at the moment because she has found a stable place to live, but that some days are more difficult than others. Everyone in the waiting room agrees that it is much easier to stay clean while housed. Joe slightly unsympathetically tells the group, *"It's not hard to stop beating yourself up every day. You just have to realize that you are hurting yourself and that you don't deserve it."* Sarah replies to Joe with, *"Yeah I know, I know, but it's just that when I was on the streets, I'd wake up and have to get going right away to stay safe and to try to get high. Now I find it hard to wake up and do nothing."* Joe shakes his head and then in a softer voice replies, *"Doing nothing is still something, it's not getting high."*

The waiting room at the safer supply clinic can double as an informal peer counselling room. Dr. Murphy does not only treat safer supply patients, as he is still a general practitioner who sees a wide variety of patients, but on Tuesdays, he only schedules safer supply. Barring some urgent need from one of his other patients, Dr. Murphy blocks out the entire day for safer supply. Dr. Murphy and the staff at the clinic have found that booking in safer supply patients for a particular time ends up being unproductive for everyone involved. If a person is feeling unwell in the morning, they will not want to wait for their afternoon appointment to feel better, and alternatively, if they are feeling fine, then there may be other more pressing matters they need to attend to for survival for that day. Especially for safer supply patients still living on the street, keeping to a precise time schedule can be nearly impossible. This is why Dr. Murphy decided to block out his entire Tuesday and work in a first-come, first-served model for safer supply. Many Tuesday mornings, several people show up at the same time and must wait to see the doctor; for some of the safer supply patients, the waiting room becomes a social setting that allows them to check in on friends and acquaintances on the program. People would often announce their fentanyl sobriety milestones or commiserate with each other over a rough week. Scenes like the one between Joe and Sarah were commonplace during fieldwork. The sentiment that joining safer supply gives people extra time that they did not know how to use came up a few times in the waiting room and also in my interviews. As outlined in the previous chapter, on the very first day I met Trent, he expressed this exact concern to me. For people who have had to work extremely hard just to stay alive for a large portion of their lives, suddenly finding your most basic needs met on the day to day can be jarring, but for those willing to take advantage, it can also be freeing.

In this chapter, I argue that safer supply removes the criminalized aspects of opioid use that many drug users find de-subjectifying. This then opens up space in their lives to begin to imagine positive futures. While the centering of pleasure I expected to find within safer supply ended up being a functional medicalized model, I find that framing this absence of pleasure through Foucauldian ethics to be useful. While the subject positions available within safer supply are still limited, they are much more diverse than those available while actively using street drugs. Safer supply is useful to the people who spoke to me because it allows them more freedom in understanding themselves in relation to their drug use. In this chapter, I focus on the narratives of people within safer supply who expressed a desire to begin the ethical work of reaching a desired subject position. Some of the subject positions my interlocutors expressed a desire in reaching were: community leader, supportive partner, and independent person.

Sarah

Sarah, a woman in her late twenties, is one of the few young patients at the clinic and the only young person who wanted to take part in my project. She did not feel comfortable sharing the origins of her drug use with me, but she was happy to discuss her experience in seeking treatment both in safer supply and methadone. The first time I met Sarah, she had arrived at the clinic with her boyfriend Jack, who is also enrolled in safer supply. Too high to be able to sit in a chair, she sat slumped against the wall on the floor. Sarah and Jack were living on the streets at the time and injecting fentanyl nearly daily. I had noticed Sarah fumbling with a plastic water bottle she had most likely received from the safe injection site across the hall. I offered to help her open the bottle and she lit up saying, *"Thank you!"* as she passed me the bottle. I broke the seal on the cap for her and handed it back. She explained that her hands were weak because she

had a lot of pain in them from the recent cold nights. She waited quietly to see the doctor, sitting on the floor of the waiting room with her head propped up against the wall, nodding off a few times during the wait. This was the only time I would see Sarah come into the clinic so high. During our formal interview a few months later, I learned that the day we met was one of her first days enrolled in safer supply.

Before Sarah joined the safer supply program, she had struggled with drug use for years. She did not want to talk much about why and when she began using drugs, but she did tell me that at the time she was enrolled in the safer supply program, she had already tried and dropped out of several other treatment programs, including methadone maintenance. Sarah found methadone to be ineffective, but she did not mention the formulation change like Trent and Benjamin had. Sarah first tried methadone because she was trying to stop using crystal meth. There were many people in her social circles who had found success in controlling or at least reducing cravings with methadone, so she was optimistic that it would work for her. Unfortunately, after a few months on methadone, she found that it made her violently ill: "*I tried methadone and a few months into it, it started making me puke. It started making me nauseous. One day I wound up puking like a blackish greenish yellowish fluid and was rushed to the hospital.*" Sarah's complaints that methadone caused her illness were not taken seriously by her doctor at the clinic, and so she decided to just stop going there.

Sarah was new to the program when I first spoke to her, having been enrolled for only two months. She first heard about the safer supply program through her boyfriend, Jack, who had been a patient of Dr. Murphy's from before he started prescribing safer supply. Jack had been enrolled in the safer supply program with Dr. Murphy for just a few weeks before Sarah decided she wanted to try it. She is usually wary of most medical spaces and told me she had had some

unpleasant interactions at the emergency room in the past but did not wish to elaborate on them. Sarah shared that having a history of overdose on your medical record can make every interaction with the health care system feel infantilizing, even when seeking help for something unrelated to drug use: "*I'm generally treated with respect to my face, but I get the feeling that hospital staff just don't even care what I say. They don't like to listen to me*." Part of the reason Sarah was so eager to try out safer supply, even though methadone had been such a disappointment, was because her boyfriend had a high opinion of Dr. Murphy. Jack told Sarah that her concerns would be taken seriously in this program and so she decided to tag along on one of his safer supply appointments. Dr. Murphy agreed to sit down with her that day and she discussed her history of drug use and overdose with him as well as her interest in lowering or stopping her use of fentanyl. After their initial appointment, Dr. Murphy decided Sarah was a good candidate for the program and had her enrolled the next week. Sarah told me that she did not feel like she was being pressured to stop all drug use, but that she felt like wanting to reduce fentanyl use was an important part of getting into the safer supply program.

Since joining the program, Sarah has been able to stop using fentanyl and she has found that the pills prescribed through the program satiate her cravings and prevent any withdrawal. Sarah has also been able to find herself a place at a local women's shelter and is in contact with a housing worker who is working on finding her a more permanent apartment. Sarah reflects that before safer supply, finding a spot at the women's shelter was difficult because they have very strict rules at the shelter around drug use and curfew. When Sarah was using fentanyl daily, she had to spend a lot of time working on the street to collect money for fentanyl and often by the time she had earned enough to get her drugs, it would be too late to go to the shelter. If she did manage to get them in time, showing up too high at the shelter could get you kicked out, too.

Now that Sarah can get her pills through the safer supply program, she has been able to keep a spot at the shelter on a temporary basis until her housing worker finds an apartment. The women's shelter is run by a local church. Sarah has been attending a women's coffee group there, although it is not a mandatory part of staying at the shelter. Sarah tells me that the group offers a free breakfast in exchange for attending a bible study and an informal group therapy session. The coffee group offers a dual purpose for Sarah: it serves both as a distraction early in the morning when her cravings are the strongest, and it gives her a daily morning routine. Checking in with the other women each morning helps her set goals for herself, and knowing that she will check in again the next morning helps her stick to those goals over the course of the day. At the time Sarah and I sat down for an interview, her boyfriend Jack was currently an inpatient at the hospital. Sarah did not tell me what was wrong with Jack, just that he had been quite ill and would continue to be in the hospital for a while longer. Staying clean from street drugs was especially important for Sarah while Jack was hospitalized, so that she could properly advocate for his care.

In the long term, Sarah would like to eventually stop using all opioids, including safer supply. She thinks it is a goal that could be achievable one day, but probably not in the immediate future. At the time I spoke to Sarah, she had only just begun using safer supply and was just starting to see changes in her life. One thing Sarah is certain of is that safer supply has saved her life. Even though she did not wish to speak with me in depth about her experiences using fentanyl, she did tell me that she had had more than one serious overdose experience and that if safer supply had not been available, fentanyl would have eventually killed her. Now that she is on safer supply though, Sarah looks ahead at her future hopefully.

Harry

Harry, a shy man in his late forties, always has his guitar on him. The first time I met him, he was humming quietly to himself while strumming on his guitar in the waiting room of the clinic. He is a tall, slender man with long black hair that he kept out of his face with a bandana. Harry would often be sporting black eyeliner and black painted nails along with an outfit that would fit in comfortably at a rock concert. His outer appearance did not match his reserved, quiet manner. Harry agreed to sit down with me for an interview about his experience with safer supply and other methods of opioid addiction treatment, but when I asked him about his experience beginning drug use, he simply told me,

> *Pretty much my whole life, I've done pretty much everything. That's always how it's been. I've always done anything and tried anything. Tried to get as much of everything as I could get. That's how it's been my whole life. But now I basically just drink a little bit and smoke pot, and I'm on the program.*

He did not wish to elaborate on his first experiences with drug use any further except to tell me that he first started using opioids while in prison.

Before joining safer supply, Harry had tried for many years to make methadone work for him but was never successful. The main problem that Harry had with methadone was the unforgiving regulations around missed doses. When a person first enrolls in methadone maintenance, they are given the smallest dose and eventually, over a few weeks, the dose is brought up, until they do not feel withdrawal symptoms anymore. Unfortunately for Harry, to bring up a methadone dose, you cannot miss appointments or doses. Due to the chaos of life on the streets, Harry would miss the occasional dose and be forced to start over again, losing weeks of progress. Harry tells me that even when he was able to make his doses regularly, methadone still could not prevent cravings and withdrawal and that he and everyone he knew on the

program had to supplement methadone with street drugs in order to not feel sick: "*With methadone, people are still using like all the drugs you can think of, you know?"*

Harry had been a patient at Dr. Murphy's clinic before the doctor started prescribing safer supply. He had a bad abscess from an infected point of injection on his arm and was a regular user of the safe injection site across the hall from Dr. Murphy's clinic. The staff at the safe injection site noticed that Harry's abscess was not healing and was becoming quite dangerous, so they recommended he go across the hall to see Dr. Murphy. The physician made time for Harry right away after he saw the state of his arm. He gave him an antibiotic prescription and supplies to bandage and keep the abscess clean. The abscess then healed quickly and Harry's experience at the clinic was so positive that he began to return to see Dr. Murphy whenever he had a problem.

Forgetting to return to the methadone clinic across the street for doses, and then being forced to start the whole program all over again, became a dangerous loop for Harry that frequently left him at risk of overdose. Harry was discouraged and expressed these concerns to Dr. Murphy, who then decided to try Harry on safer supply. After that conversation, the next time Harry went into the pharmacy to pick up his prescription, he was picking up a safer supply one instead of methadone. Initially, it "threw Harry off" that he was so easily able to enroll in the program, but he trusted Dr. Murphy and decided to try the new prescription. At the time of our interview, Harry had been enrolled in safer supply for five months.

Earlier in the year, Harry had been jumped by a group of people and severely beaten. This experience left Harry with a lot of fear and anxiety, and he found it very hard to leave his apartment on many days. During this time, Dr. Murphy allowed Harry to switch his appointments to over the phone and the pharmacy organized delivery of his prescriptions to his

apartment. Had Harry been on methadone at the time, he thinks he would have been forced to leave the program if he could not attend appointments in person at the clinic and that he would have had to start over at a low dose again when he returned. Harry sees the flexibility of safer supply as a rare occurrence in the field of medicine. He says that before meeting Dr. Murphy, he had never trusted a doctor. Harry has even begun to rely on the clinic for help with non-medical issues. He has struggled in the past with keeping important dates, and navigating the legal system, but now the clinic staff help him keep organized:

> *Yeah, I have a court case coming up, and every time I think I've missed court, I panic, and I don't know what to do I come here, and they make phone calls for me and help me out that way. I mean anything I go through really, I come here for help, and they always help.*

When I asked Harry if he felt safer supply was working for him, he was adamant that it was and for other people he knows, too. When Harry began using safer supply, he had been using seven points (0.7 grams) of fentanyl a day, and over the course of a month, he suddenly realized one day that he had not used fentanyl at all in that week. The transition had been painless for him. Harry expressed to me that he has seen a great amount of improvement in the lives of the people he knows enrolled in safer supply at the clinic. The improvement in people's lives comes not just from stopping fentanyl use, but also from removing themselves from the criminal element involved in buying fentanyl:

> *It's kept me out of a lot of environments where I could be in a lot of danger. I'm not out looking for drugs, you know? Trying to find drugs, there's just a lot of bad things happening out there. Where you find drugs, there's a lot of bad things happening.*

Harry sees safer supply as more than just a medical treatment. While Harry agrees with the other people I spoke to that the medication he is prescribed through safer supply is more effective at treating withdrawal and satiating cravings than other methods he has tried before, he also thinks it is actually Dr Murphy and his staff who make the program work as well as it does:

> *I think he just… whatever you have he just wants to make it better. He's just got this permanent smile, he makes you feel like everything's going to be okay, you know? The people at this clinic, they've helped me a lot, incredibly.*

For Harry, it is the care and respect he has received at the clinic that has made safer supply so successful for him. Being on the program has allowed him to safely transition away from fentanyl at a pace that fits his own needs.

Trent

Trent, introduced in the first chapter, was the very first person enrolled into safer supply at Dr. Murpy's clinic and thus had used safer supply the longest. In the year Trent had spent on the program, he had gone from living in a tent under a highway overpass, using fentanyl daily and with multiple recent overdose events, to stably housed and not using fentanyl at all. In this chapter, I focus on the ways that joining safer supply has changed Trent's relationship to drug use.

A particularly interesting part of Trent's story is the way he understands drug use as an inevitable path for his life:

> *I think that you know[that] being a drug addict was always going to be part of my experience in life and I knew that before I ever even did any drugs. I feel like this (talking about his experience with drug use) is a way [that] as a human being I can contribute to the world, and you know, do something for society, for the future, so that people can have different choices than I have had to make over drug use.*

Trent had started using party drugs when he was very young, building an identity around drugs in his teenage years. Trent is adamant that he loves his family but will also admit that he was kind of a lonely child. The youngest of six with parents who loved him, but were very busy, Trent spent a lot of his childhood alone in his own imagination. Later in his teens and twenties, mind-altering drugs like LSD were another way for Trent to escape from life into his own mind again.

Trent struggled in high school, particularly with reading and writing, and at the time he was going to school there were almost no educational supports. Trent became known as a person who could get drugs for people, and he even started a business leading them through LSD trips. School made Trent feel like he was not good at anything, but guiding people through LSD trips and his knowledge of drug use allowed him to assume the role of expert. Being a drug user, and more importantly an expert drug user, is a large part of Trent's identity and he does not see a future for himself where he never uses drugs.

Even though Trent does not wish to stop using all drugs, he does want to stop using fentanyl. There were times when Trent was able to keep himself housed and employed while also using drugs, but the illicit supply of street drugs is just too unstable. Dealers come and go, drugs change because certain supplies get cut off, and one can never really trust what is in a specific drug on the street. Trent believes it is not the effect of drugs themselves, but their criminalization that caused so much instability and uprooted his life. Having reliable access to a known supply of opioids has made drug use compatible with the kind of life Trent wants to live:

> Claire: *You have a good relationship with Dr. Murphy and the pharmacist?*
>
> Trent: *Oh yeah for sure. You see the same people pretty much every day, so there's a lot of routine there. You know there's a leash with street drugs, and there's a leash with safer supply, but at least this leash is one that's around good people.*

Here, Trent reflects that while he is still dependent on safer supply, specifically how he must visit Dr. Murphy every two weeks and go to the pharmacy to pick up his prescription daily, this "leash" is working to help keep his life stable, while the "leash" involved in using street drugs actively invites danger and instability into his life.

Safer supply has also changed the way that Trent physically uses drugs. When he was using fentanyl, Trent would primarily inject it straight into his veins, but after years of vein

injections, the veins in his arms have become damaged and harder to inject into. Trent tells me that hydromorphone is easier to "muscle" than fentanyl and so he has taken to muscling his safer supply prescription instead of injecting into a vein. Muscling refers to injecting a drug directly into muscle tissue instead of locating a vein to inject into. The effects of a drug come on more slowly than through intravenous injection and there is less risk of bleeding involved. Hydromorphone from safer supply is safer to muscle because it is a pure and particle free drug, whereas muscling street drugs can put a person at a high risk for an abscess if they are contaminated by undissolved particles. Trent speculated to me that if he had not joined safer supply, he thinks he would have continued to inject into his veins until they were completely destroyed.

> *I've used needles for 20 years, 10s of thousands of them. It's really wrecked a lot of my superficial vein structure. I've realized it puts strain on everybody, I'm a little bit older now and I can see, "Okay you've used drugs for 20 years Trent, now it's under control, I can see a little better, and the repercussive effects of this are much more apparent to me.*"

By the third interview I did with Trent near the end of my fieldwork, he had even begun to stop muscling and rely mostly on taking hydromorphone pills orally: "*The needles have become a bit vulgar to me to some extent. I don't mean to say that I'm disgusted by them, but I can't handle fishing around on my own body anymore at all, I have no tolerance for that*."

Another side effect of Trent beginning safer supply was ending his reliance on cooking meth as a source of income. Getting enough fentanyl to prevent withdrawal every day was an expensive endeavor for Trent, so he cooked and sold his own meth to afford it. Cooking meth was a necessary evil for Trent, and he still carries a lot of guilt about it:

> *I started to worry about my influence on people around me and my friends, you know, I didn't want to be the person who brings the damaged stuff into the party, I wanted to be the person who brings the good things. So, I realized, "Trent, you need to stop devoting your life to being a professional cook. This is not a good way to make a living. You want*

to be able to look people in the eye and say I'm a good person! A person who doesn't bring horrible things into the world!"

Trent's guilt around previously cooking and selling meth came up in our interviews multiple times. He expressed to me that he now feels he has a karmic debt to repay for any damage he may have caused to the lives of other people by introducing them to drug use. He has a particular concern now for making sure that young people he meets understand that his life with drugs has been difficult. Part of Trent's motivation for speaking with me so frequently was because he felt my research would be a good avenue for him to tell people his story and make it clear that an illicit drug market is dangerous.

One of Trent's future goals for his life was to feel stable enough to rekindle relationships with his family. He is particularly interested in seeing his nieces and nephews again. Trent told me that he has isolated himself from his family and especially their younger members, because he worried he would have a bad influence on them, but if he could continue to stabilize his life with safer supply, maybe he would not feel that way anymore:

Trent: *I feel like since I've made it this far, people are looking at me. I would like to be around my nieces and nephews, but I'm concerned what they see in me. Like maybe if I do it, then they'll think they can. So maybe it's better if they just don't even see me.*

Claire: *Well, think about the progress you've made this year, who knows about next year.*

Trent: *Yeah that's what I'm sort of seeing. You know, if I can keep going this way, then maybe I can be around my nieces and nephews. Family is a good thing to live for*.

Trent's relationship with his family, and particularly his father, was a complicated subject for Trent. His father was a pastor and a relatively conservative man; he did not understand Trent's fascination with drugs, and it was a source of conflict between them. Trent's father passed away six years ago, around the time that Trent's last stable period on methadone finished, and he ended up living under the highway overpass with his girlfriend. Trent tells me that he has only started to

process his father's death since beginning safer supply, and that he regrets not being able to fully heal their relationship before he passed. While he had a complicated relationship with his father, Trent respected his dedication to his job as a pastor and his ability to lead people through their lives. Trent is not a religious person, and so the teachings of his father never fully worked in his own life, but he would like to work on his own philosophy of life and find a path to becoming a leader in his own right. During one interview, Trent told me about how his father came to him in a dream during the first month he was on safer supply:

> *My father came to me the day before I got my new place. The night before I got the place, I hadn't seen him since he died, he came to me and said, "Trent, I love you, but you have led people in your life down a bad path. I don't wanna say it to ya Trent, but I think you aren't good for them. You need to get it right." He kind of let me know there's consequences for leading people down places that are unhealthy. And I know that. Of course, when you bring negativity into the world, you have to pay for it. We're all responsible to uplift ourselves and each other as human beings. I wanna get that shit right. Anything I can do to hopefully steer myself and lead others the right way, yeah let's try it out. That's the way I feel. I think safer supply, it's gotta be a step in the right direction….*

Near the end of my fieldwork, during our final interview, Trent expressed to me that he might one day want to work in peer support for other people looking to lessen or stop drug use. Trent knows he has come a long way over the year he has been enrolled in safer supply, but he believes he still has a long way to go. Safer supply has not been the solution to every problem in his life, but it has given him the crucial stability he needed to begin to reflect on what kind of existence he even wants:

> *I'm just kinda getting some things right now that my brothers and sisters have had right as long as they were alive, and here, I am figuring it out at 44. But it's okay, so far, I've managed to catch on enough that I think I can do something good before I'm gone. That will make some difference, leave some contribution. I think safer supply gives me freedom to think about things. When drugs get ahold of ya, there's so much power there, that you'll think about the drug before your own housing. Sacrifice your own home to get high because it's got that much control over you. It's a really scary thing to have that kind of vice. Something like safer supply, I could just really see it was going to put the brakes on things and get me under control.*

During the six years he was living under the highway and using fentanyl daily, it took his every physical and mental resource just to survive. The day that I met Trent, he told me that he was starting to feel depressed because he had nothing to do all day now that he had a legal supply of opioids, an apartment, and a small income from ODSP. Over the course of our interviews, Trent began to make plans for his future and ask himself important questions, such as what kind of job does he want, what kind of work needs to be done to mend familial bonds, how will he find meaning in his new life? This kind of reflection, I contend, is the beginning of ethical work.

Moving Beyond Stability: Beginning Ethical Work

Meg Stalcup and Yvonne Wallace (2021) argue that harm reduction can at times be at odds with ethical subject formation (9). In their research with Overdose Prevention Ottawa, they found that the careful practices people use to reduce the risks of using drugs are anethical (11). Reducing the risks of using drugs, while keeping people safe, does not in itself help them work towards any ethical subject positions because working towards an ethical subject position would require them to not use drugs. Stalcup and Wallace explain that, "The careful practices of harm reduction are ways that drug users choose to use more safely, when they cannot choose not to use" (12). Nevertheless, these careful practices do allow people to maintain the potential for ethical work. Stalcup and Wallace found that drug use was antithetical to desired subject positions, and so even using drugs carefully was de-subjectifying. Careful practices such as using clean needles, carrying Naloxone, and using safe injection sites, are not care of the self, but they do leave open the possibility for a person to do ethical work in the future.

Safer supply, I argue, allows for a greater diversity of subject positions than traditional forms of harm reduction, specifically because many of the aspects that people find de-

subjectifying about drug use are removed in safer supply. Drug use is de-subjectifying when it prevents people from working towards a desired ethical subject position. In Stalcup and Wallace's paper, one woman, Dina, explained how using drugs with friends is safer because there is someone else present to help in case something goes wrong, but it is de-subjectifying because she believes a good friend would not sit by and watch a friend use drugs (2021, 418). Being a good friend is a desired subject position for Dina and using drugs alone is life-threatening, so as long as she is using drugs, the ethical subject position of "good friend" is difficult to achieve.

While Trent was cooking and selling meth, he could not work toward an ethical subject position. While he understood drug dealing as harmful both to himself and others, he needed the money to prevent his own sickness, and thus did not have the space to reflect on his own actions. Trent was not actively choosing to be a drug dealer so much as he was using his expertise in drugs to survive. For Trent, there is no way to be a good drug dealer, but there is a path towards being a good ex-dealer by telling his life story to others to prevent them from making the same mistakes that he did. Now that he no longer needs to deal to survive, Trent wants to work towards being a responsible member of his community by leading others through example. Safer supply has opened a path to an ethical subject position for Trent.

Harry makes it clear that while the hydromorphone he receives through safer supply works better than methadone at satiating cravings and preventing withdrawal, the most important part of safer supply for him is its flexibility. Methadone did not work because he could not "discipline" himself enough to fit within the role of an ideal patient. In safer supply, Harry is met on the level he is at, instead. Methadone was de-subjectifying in the way it required Harry to fit within the role of idealized patient, but safer supply allows Harry the space to form his own goals around drug use and possibly the potential for an ethical subject position.

Sarah was new to the program when I met her and was just beginning to wonder what she would do with her newfound time, now that she did not have to devote every waking moment to finding drugs. She was very proud of the fact that she had not used fentanyl while on safer supply and that she was now able to attend to important things in her life with the attention they deserved. Being able to regularly attend the women's coffee club, and advocate for her boyfriend while he was in the hospital, were both positive outcomes in Sarah's life due to abstaining from fentanyl. Wanting to be a supportive partner to Jack is the kind of ethical subject position that using street drugs made impossible for Sarah, but that safer supply now makes possible to work towards.

For the people I spoke to, safer supply is an act of intentional self-aware work on or care for the self. Following James Faubion and James Laidlaw's (2011; 2014) conceptions of Foucauldian ethics, my interlocutors are practicing care of the self within safer supply. The choice to pursue these ethical subject positions is taken on freely and self-reflexively. While the subject positions available to people within safer supply are still limited by the medicalization of opioid use, it is significantly less limiting than the reality of using street drugs in a criminalized context. Safer supply gives people the space to reflect on what kind of life they want to live and it allows them to make using opioids congruent with ethical subject formation.

Conclusion

Throughout this chapter, we have seen that people understand safer supply to be a major stabilizing force in their lives. Safer supply allows them to treat their pain and withdrawal without fear of overdose. Safer supply allows them to focus their time and money on other aspects of their lives, because the financial pressure of finding enough money to get enough

drugs to stay well is removed. In the opening vignette of this chapter, I relayed Joe's thoughts on the newfound time people in the program are discovering now that they no longer had to hustle to survive every day. Joe said to Sarah that, *"Doing nothing is something, doing nothing is not getting high."* It takes active work to not return to using street drugs, and safer supply facilitates this work. Safer supply affects the way a person uses drugs to a much greater extent than other forms of harm reduction like safe injection sites.

Other forms of opioid replacement like methadone were unsuccessful for most of the people who spoke to me because they found them de-subjectifying in various ways. Foucault's concept of biopower, in which power is exercised at the level of life and incites people to govern themselves through subjectivation, is often employed in discussions of subjectivity and opioid addiction treatments. These anthropologists note how different forms of addiction treatment shape which subject positions are available to those that use them. Bourgois (2000) outlines the disciplining power of the strictly regulated methadone clinic, and how it produces a criminalized and medicalized subject. Harris (2015) explores how buprenorphine prescribed in private practice offers freedom from many of the oppressive aspects of the methadone clinic, and how those freedoms allow buprenorphine to be a normalizing technology (526). Harris points to the looser regulation of buprenorphine prescription compared to methadone as the driving force to buprenorphine's ability to normalize the treatment of addiction (526).

Safer supply is even less regulated than buprenorphine, and similarly to Harris, I found patients comparing the way safer supply works for them to the ways that methadone and even buprenorphine did not. I argue that safer supply offers a less pathologized subjectivity of addiction because it does not assume those who use it to be treating addiction, and therefore avoids locating opioid use in and of itself as problematic. In safer supply, the problem is instead

located in the substance itself, particularly fentanyl. It is fentanyl that is dangerous, and it is fentanyl that kills people. The people who spoke to me all considered themselves to be "clean" when they were taking only their prescription, and they described a "relapse" as solely returning to fentanyl. Safer supply was born out of a desire to keep people alive in the face of an increasingly toxic street drug supply. As a harm reduction tactic, the barrier to entry for safer supply was set not just for those who wished to stop using opioids, as is the explicit purpose of both methadone and buprenorphine, but for anyone who wishes to avoid using unregulated and unknown concentrations of fentanyl. Even within that frame, safer supply allows for people to continue to use those street drugs without removal from the program. This freedom from regulation within safer supply is what allows each person to make it their own. The people who spoke to me at the clinic told me that using street drugs like fentanyl prevented them from living the lives they want to live. Indeed, by enrolling in safer supply, people are able to remove the aspects of street drug use that prevent them from doing ethical work.

Conclusion

This thesis began with the question: What does it mean to allow for pleasure in the prescription of opioids within the clinic? I was interested in how such a seemingly radical harm reduction program would work within a clinical setting. Opioid replacement therapy is not a new concept, as discussed in the introduction. Methadone maintenance therapy has been available in Canada since the 1960s, but safer supply is conceptually different from opioid replacement therapy because it does not purport to be treating addiction at all. Safer supply is instead a harm reduction program modeled after similar unsanctioned programs run by grassroots activists like the Drug Users Liberation Front in the downtown East Side of Vancouver (Kalicum et al. 2024). How would a radical program that allows people to use drugs to get high work within the controlled environment of a clinic? I entered fieldwork hoping to talk to people using safer supply about the ways they use their prescription for a pleasurable high. To my surprise, everyone who spoke to me told me that they do not use their safer supply prescription to get high, and some even went as far as to say it would be impossible to get high using their prescription. Joe told me that people trying to get high with safer supply were using the program for the wrong reasons, but he also told me that his prescription makes him feel good and that it *"gives him energy."* Benjamin told me, "*You don't really get high off it, you couldn't get enough pills into a needle to get high off it. You know what I mean?"* But he also told me that he felt a calming sensation in the morning when taking safer supply. Paula was explicit about what being high meant to her: dozing off, drooling, and peeing on herself. This kind of drug use is exactly what she wanted to avoid because she wanted to be able to return to work. Trent told me that he only feels high taking safer supply if he is under *"a prior inspiration;"* he clarified for me that a prior inspiration was just a certain frame of mind that would allow him to fully relax into the

physical sensation of using safer supply. Therefore, my question became: Why did the recognition of pleasure in drug use not translate to the user's experience of safer supply?

Throughout this thesis, I have sought to explore how the criminalization of drug use creates an oppressive and pathologized subjectivity of addiction, and the ways that safer supply can offer new subjectivities of drug use. I believe that the medical model of safer supply is unable to recognize the pleasure of drug use because it is informed by liberal policy. Liberal governments must avoid associating ends deemed problematic with pleasure because liberal governments use pleasure as a tool for governing from a distance (O'Malley and Valverde 2004). While safer supply does not recognize pleasure in drug use, it does offer a positive mode of medicalized subjectivation. Safer supply offers this potential effect because it is able to remove some of the aspects of drug use that limit the subject positions available to drug users in a criminalized context. Chapter One focuses on how the narratives of Trent, Benjamin, and Matt reveal the structural forces that shape the experience of addiction. Drug use in the face of structural violence can be a method of survival. On the streets or in jail, using drugs to excess brings a separation from reality that is required to survive. The everyday violence experienced by people who use drugs is both a reason to use drugs and also a barrier to stopping drug use. The choice to use drugs for pleasure is hampered through structural violence. Chapter Two focuses on the functional benefits that Paula, Sasha, and Joe seek in opioids. Within the context of criminalization of drug use, people who want to use opioids to relieve physical and mental pain are told that their drug use is deviant, illegal, and should be stopped. Safer supply, because it does not locate drug use as inherently problematic, allows Paula, Sasha, and Joe to reclaim their drug use outside the categorization of addiction. Chapter Three introduces Harry and Sarah and returns to Trent. In this final chapter, I engage with Foucaultian ethics to ask whether safer

supply could allow drug use to become compatible with ethical subject formation. Because safer supply does not demand a person using drugs become one specific form of drug user, the conceptual freedom of safer supply allows people to develop their own goals within the program. Safer supply removes the elements of street drug use that de-subjectify and opens a future for people who use drugs to move on from "survival" to care of the self.

Safer supply is not a perfect solution to the opioid crisis. There are still far too few programs available and the waitlists for safer supply programs are always long. In a recent knowledge exchange series hosted by the federal government of Canada between researchers, prescribers, and users of safer supply, users and prescribers argued that the current framework for evaluating the effectiveness of safer supply programs, whether it prevents death, is too limited (Health Canada 2023). To make sure safer supply programs are meeting the needs of those who wish to use it, they suggest that evaluating effectiveness should begin by asking people using safer supply what they want out of it (5). One of the most important recurring themes among the people who spoke to me was their clear distinction between the opioids within the clinic and the opioids used on the street. Most of the people who spoke to me understood themselves as "clean" when they did not use drugs from the street. Safer supply does offer a lower barrier to entry than other opioid agonist therapies, as ending drug use or even street drug use does not have to be a goal, but stopping street drug use turned out to be a desired outcome for everyone who spoke to me. For some, ending street drug use was a goal for them before entering safer supply, but for many, this was a goal that developed after starting safer supply. This clear distinction between opioids in the clinic and opioids on the street is partially due to the lower risk of overdose from safer supply drugs, but it is also bound up in the context of the clinic. For many people, this clinic is one of the first positive experiences they have had with the medical system. People told

me they felt listened to by Dr. Murphy. They felt he took their pains and worries seriously and that his care was a pivotal part of their success in the program. The safer supply clinic also brought some people into contact with social services that they otherwise would not have accessed. The wrap-around care of the clinic is just as important to the patients as their prescriptions. I argue that this positive medicalization of drug use allows people to adopt new subjectivities that are less oppressive and pathologizing than those available through a criminalization of drug use.

Undeniably, the presence of fentanyl on the streets is one of the main drivers of the current opioid overdose epidemic. In the narratives of people using safer supply, this risk was confirmed in the way they all pointed to fentanyl as an especially ruining drug. Fentanyl is so ubiquitous on the streets because it can be produced cheaply in a lab, without need to grow or harvest poppies, and it is extremely potent. The age-old consequence of restrictive prohibitions on substances, creating a market for more dangerous illicit versions of those substances, persists. How to manage the decriminalization of opioids is a topic too complicated for the scope of this thesis, but my research makes it clear that seriously considering the experiences and goals of people who use drugs is a crucial step in making any policy changes successful. In the conclusion of their book, *Righteous Dopefiend* (2009), Philippe Bourgois and Jeff Schonberg call for anthropologists working with people living under structurally imposed suffering to engage with "good enough critically applied anthropology" (298). They use the term *good enough* to reflect the tension between applying rigorous academic theory to urgent public debates. A researcher's self-reflection on the limitations of linking theory and practice within an urgent crisis like the opioid overdose epidemic is necessary. The current state of safer supply in Canada is precarious, as many programs are in danger of losing federal funding due to a moralized public

debate around the prescription of drugs to people deemed “deviant” (Health Canada 2023) and there is plenty of political opposition (Taylor 2024). While my project cannot make any evaluative claims about the ability of safer supply to affect the current trajectory of the drug toxicity crisis, it highlights the importance of paying close attention to the experience of individuals. In the narratives I collected, a positive medicalization program clearly removes many of the aspects of drug use that people who use drugs find harmful. Whichever policy solutions governments bring to the table, it will be critical that the voices of people who will use those solutions be considered in their development.

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