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Research paper

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

C. Strike[a,*], A. Guta[a], K. de Prinse[b], S. Switzer[a,b], S. Chan Carusone[b]

[a] University of Toronto, Dalla Lana School of Public Health, Toronto, Canada
[b] Casey House Hospital, Toronto, Canada

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ABSTRACT

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

Introduction

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

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

* Corresponding author at: 155 College Street, Toronto, ON M5T 3M7, Canada. Tel.: +1 416 978 6292; fax: +1 416 978 2087.
E-mail address: carol.strike@utoronto.ca (C. Strike).

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

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

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

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

Space, place, and health

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

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

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

Governing place and the body

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