

## Going Nowhere: Ambivalence about Drug Treatment during an Overdose Public Health Emergency in Vancouver

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*The declaration of an overdose public health emergency in Vancouver has generated an “affective churn” of intervention across youth-focused drug treatment settings, including the expanded provision of opioid agonist therapy. In this article, I track moments when young people became swept up in the momentum of this churn and the future possibilities that treatment seemed to promise. I also track moments when treatment and what happened next engendered a sense of stagnation, arguing that the churn of intervention ensnared many youth in rhythms of starts and stops that generated significant ambivalence toward treatment. The colonial past and present deepened this ambivalence among some Indigenous young people and informed moments of refusal. Youth’s lives unfolded through but also around treatment programs, in zones of the city where drug use could generate a sense of momentum that was hooked not on futures, but on the sensorial possibilities of the now. [North America, overdose, drug treatment interventions, youth, affect]*

Passages,<sup>1</sup> located in a picturesque residential neighborhood, is a double-sided house that has been repurposed into a short-term (typically one- to two-week) detoxification and drug treatment facility for youth ages 13–24. The building has retained its homey feel by design. While young people are designated to a particular side of the house on admission based on gender identity, age, and/or intensity of drug use, the doors remain unlocked. There is a large back yard with an apple tree in the middle of it and some plastic deck furniture. Many of those at Passages are “frequent flyers” who end up there repeatedly. Beyond detoxification and treatment, it’s a place where youth can take a break from the everyday emergencies of homelessness, addiction, and poverty on the streets of Vancouver. The staff at Passages are friendly and laid back; they give out cigarettes, make grilled cheese sandwiches on request, and are there to talk if young people are interested.

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For many youth, Passages is where they first hear about what is available to them in terms of treatment programs, as well as other kinds of community support. The site is visited daily by nurse practitioners who are part of one of the city's new youth intensive case management teams. These providers will discuss a buprenorphine-naloxone (trade name Suboxone) induction with any young person who arrives with the goal of taking even a short-term break from opioid use. Youth are also connected to longer-term residential treatment and recovery programs, day treatment programs, Twelve Step programs, mental health programs, alternative schooling programs, government-subsidized housing programs, outreach programs, and drop-in programs, including a "one-stop shop" service hub called YouthNow that delivers comprehensive mental health and substance use care and also hosts various recreational activities.

Hearing about these different programs and the anticipation of accessing them after leaving Passages can be a mobilizing experience. "I'm going to start going to the YouthNow drop-in once I get out of here," 19-year-old Shane told me in 2017. He was through the worst of his withdrawal from fentanyl and had started Suboxone 72 hours earlier, and was now sitting on the couch in the living room binge watching *Homeland* on low volume. Two other youth were shuffling around sleepily in the adjacent kitchen, contemplating food or a cigarette. Shane described the moment when he got to a dose of Suboxone that adequately mediated his cravings as a "light switch." "It seemed like I was feeling miserable, feeling miserable—and then, bam! I was, like, ready to eat five grilled cheese sandwiches all of a sudden," he laughed. Now Shane was energized, rapidly tapping his foot on the ground as he spoke. "[The YouthNow program] apparently has, like, things going on every day, like art programs and outings and activities and classes and stuff like that, that I'm going to start doing."

Shane eventually added more quietly, "I've had thirteen overdoses in the past year, right? If I O.D. [overdose] another time, I'm sure I won't come back."

A few weeks after my conversation with Shane, I ran into 20-year-old Raymond on the street in downtown Vancouver, only hours after he had left the hospital against medical advice (or A.M.A.). Raymond is Anishinaabe First Nations and moved from Winnipeg to Vancouver when he was 14 to reconnect with an uncle who was living in the Downtown Eastside. That day in 2017, he was wandering around alone, his plastic hospital bracelet still around his wrist. Raymond told me that earlier that morning he suffered an overdose that could not be reversed with six shots of Naloxone (the overdose antidote). As we sat on a park bench, he explained wearily:

In the last year, this is when I started overdosing, right, because I just—things are not going to get any better in my life, right? So, I just started using more and more, you know? I was—I was afraid, you know, of the future, afraid of the past and afraid of the present, right? You know, too scared to kill yourself, but I was close to death each time. I am close to death.

I immediately began trying to talk Raymond into letting me take him somewhere for further medical attention, or where he could at least talk to someone. "What about Elder Neil [from the intensive case management team]?" I suggested, in an attempt to connect Raymond with a more "culturally safe" model of care

(FNHA 2015). The youth I knew, whether Indigenous or not, often told me how much they loved Elder Neil. But Raymond just stared at the ground, slowly kicking at the gravel with his shoe. I then brought up the idea of a stay at Passages.

“Residential treatment places are where a lot of angry Native kids get put,” he told me sharply, pulling the hood of his thin sweatshirt over his head and getting up to go. “Foster care, group homes, jail—it’s all the same,” he muttered. This sentiment was expressed repeatedly by the youth I knew, no matter how tirelessly those on the frontlines worked to make treatment programs “low barrier,” “youth friendly,” and culturally safe. I feebly offered Raymond the food I had in my bag and told him he could call me later if he needed help. He replied more forcefully, “No, no—I’m going to catch the SkyTrain<sup>2</sup> out of here [downtown Vancouver] now. Go get some dope [drugs]. Have some fun. Get into trouble.”

“Where can I find you?” I asked, somewhat desperately. “I just want to check in to make sure you’re okay.”

“You can’t,” he chuckled. “I’m everywhere. I’m everywhere.” And with that, he took off down the street without looking back.

Vancouver, Canada, is an epicenter of North America’s overdose crisis. The declaration of a public health emergency in the province of British Columbia (BC) in 2016 set in motion the rapid development, implementation, and scale up of various drug treatment programs for at-risk populations, including young people who use drugs (Government of BC 2016).<sup>3</sup> Central to these ongoing efforts has been the development of new clinical practice guidelines for the treatment of opioid use disorder (OUD), and the expanded provision of opioid agonist therapy (OAT). In particular, Suboxone is now the recommended first-line therapy for youth who are diagnosed with OUD, and has been made widely available across acute, community, and residential treatment settings via intensive case management and outreach teams staffed by physicians, psychiatrists, nurse practitioners, social workers, outreach workers, drug and alcohol counselors, and Indigenous Elders (BC Centre on Substance Use and BC Ministry of Health 2017; VCH 2017). Addiction medicine consult teams have been created at local hospitals to improve the integration of treatment, including OAT, into hospital settings, and ensure greater continuity of care (PHC 2016). In this context, many urban young people are now experiencing on-demand access to OAT. Suboxone, in particular, has been tasked with promoting abstinence from illicit opioid use and the protection of life (Stevenson 2014) among at-risk youth.<sup>4</sup>

This biomedical hope and an aggressive will to intervene among those whose job it is to address the overdose emergency is a stark contrast to many young people’s ambivalence about treatment, including pharmacotherapies like Suboxone. In this setting, youth’s possibilities increasingly unfold through but also around treatment, as my encounters with Shane and Raymond begin to demonstrate. This article draws on over a decade of fieldwork with young people who use drugs in Greater Vancouver. I argue that the overdose emergency has generated what I characterize as an “affective churn” of intervention across youth-focused treatment settings, or what Andrea López (2020) calls the care assemblage. In what follows, I track moments when youth became swept up in the momentum of this churn and the goal setting and planning exercises that are an increasingly integral part of both in- and out-patient treatment programs. In these moments, treatment, and especially pharmacotherapies like Suboxone (or methadone, or Kadian, or Sublocade),<sup>5</sup> could seem to hold out the promise of a different, better future: a future in which it was possible

to finish school, get a job, find a nicer place to live, enter into healthier relationships, and, for a number of young people, be a good parent. However, this sense of momentum existed alongside other kinds of affective intensities as well, including the sense of stagnation that was generated by plans that regularly “fell through,” “stalled,” or “dead ended.” I suggest that the churn of intervention ensnared many young people in rhythms of starts and stops that generated deep ambivalence toward treatment. This ambivalence led some youth to increasingly evade or refuse these programs. Instead, they carved out zones of the city where the use of fentanyl and crystal methamphetamine (meth) could generate a sense of momentum that was hooked not on futures, but on the sensorial possibilities of the now.

Previous work has signaled the importance of attending to senses of momentum and stagnation using lenses of eventfulness (Cohen 2001) and boredom (Jervis et al. 2003; Mains 2007; Masquelier 2019; O’Neill 2014). Anthropologists have examined how affects like melancholy, uncertainty, and grief shape forms of life in communities marked by drug use, violence, and loss (Garcia 2010; Laurence 2017; Stevenson 2014). Previous work on addiction and treatment has explored affect as one of the materials out of which experiences are made (Garcia 2010; Knight 2015; Meyers 2013; Schüll 2014). However, anthropologists have not yet probed the affective rhythms and intensities that are released by public health emergencies and assemblages, and what these do as they move through and accumulate in bodies, pharmacotherapies, substances like fentanyl and meth, and places that include both treatment settings and the various “elsewheres” (Meyers 2013) through which therapy and addiction travel.

Here, I explore how the “weighted and reeling present” of drug use and treatment during an overdose emergency can be productively explored through what Kathleen Stewart (2007: 1) calls ordinary affects: those visceral, surging forces that animate bodies, things, places, encounters, and atmospheres, and that constitute a “felt knowledge” (Million 2013: 67) of a situation and its possibilities. The rhythms and intensities that this article describes came into view in bodily gestures, such as when young people paced excitedly around the living room in a residential treatment center, talking rapidly about their plans for “when they got out,” or when they slumped down tiredly in that same living room, mumbling that they were “completely worn out.” They surfaced in forms of sociality, such as the frenetic “fun” of intensive drug use, and became legible in strategies and their failures, including the decision to go to treatment again (and again). They circulated in dreams and expectations, such as the feeling that this time, with the help of Suboxone, things were “going to be different,” or the impression that “treatment gets you nowhere.” While affect is often characterized as pre-discursive (Massumi 2002), it seemed to me that youth did attempt to put a palpable sense of stagnation into words when they used the language of boredom and phrases like “going nowhere.” Alternatively, they evoked a sense of momentum when they used the language of business and described feeling like they were “in *something*” rife with potential.

Tanana Athabascan scholar Dian Million (2013: 46) has argued that colonialism itself is a “felt, affective relationship.” It is a “residue of common experience sensed but not [always] spoken” (Berlant 2011: 65), particularly in ways that fit neatly with medicalized imaginaries of disorder and healing. Raymond’s words to me that day in 2017 seemed to reflect a felt knowledge of how the past can weigh on the present and the future to create a sense of stagnation (*Things are not going*

to get any better) that cannot be addressed by culturally safe treatment programs, as we might hope. Instead, Raymond gestured to the imminent possibilities of drug use, “getting into trouble” and geographic mobility (*I’m everywhere*). His refusal of residential treatment as just another in a long line of places where “angry Native kids get put” carries the residue of intergenerational experiences that include the systematic dispossession of land and forced poverty, 100 years of residential schooling, the ’60s and Millennium Scoops (throughout which thousands of First Nations, Métis, and Inuit children have been taken from their families and placed into foster care or put up for adoption), racist policing and high rates of incarceration, and successive waves of pathologization and containment related to public health emergencies such as tuberculosis, HIV, and suicide (Stevenson 2014). Indigenous scholars, activists, and organizations have demonstrated that disproportionate rates of addiction and overdose among Indigenous people in Vancouver and BC are powerfully constituted by this colonial past and present (FNHA 2017; Goodman et al. 2017; Lavalley et al. 2018; Martin et al. 2019; Pearce et al. 2015)—as are their proposed solutions. Residential treatment and OAT echo colonial logics of control, even as providers increasingly work to ensure that programs are culturally safe.<sup>6</sup>

The relationship between past, present, and future deepened ambivalence toward treatment among some of the Indigenous young people I knew, and informed moments of refusal (Simpson 2014): a refusal to wait for the ambulance after an overdose, to stay in the hospital or residential treatment center, to take Suboxone, and, as my interaction with Lula described below shows, to be knowable and countable as “just another Indigenous youth overdose death.” These moments of refusal or “turning away” (Coulthard 2014; Fanon 2008) from the state-sponsored churn of intervention were almost never explicitly politicized in the ways that Audra Simpson (2014) describes in her ethnography of the Kahnawà:ke Mohawks—or at least, those politics were rarely made visible to me in those ways. However, they were generative of other lines of potential, including an impulse to be everywhere and therefore not so easily surveilled, tracked, counted, or contained.

The first part of this article describes how young people are drawn into a churn of intervention in Vancouver, and the alternating senses of momentum and stagnation that this churn can generate, while the second part focuses on the affective intensities that are unfolding around treatment programs. First, I provide a brief further description of my research setting and subjects.

### Public Health Emergency and Intervention in Vancouver

Vancouver has long been the site of intensive intervention, where a plethora of services offer shelter, food, health care, and advocacy to those in need (Murray 2011; Roe 2009). This care assemblage centers on the Downtown Eastside neighborhood, which is often imagined as the proper destination of the visibly homeless, addicted, and mentally ill in Vancouver (Culhane 2003a). The Downtown Eastside is also a racialized space, where over one-third of the neighborhood’s inhabitants are Indigenous. These demographics reflect the continued presence of Indigenous people on land that has been occupied by Coast Salish peoples for at least 10,000 years, the

pull of big city life for those whose opportunities for work and leisure may be limited elsewhere, and the disproportionate burden of social suffering carried by Indigenous people in Canada's poorest postal codes.

The care assemblage in downtown Vancouver expanded rapidly with the declaring of an HIV/AIDS public health emergency in 1997, and has continued to grow to address a "second generation" crisis of street-based homelessness and public disorder that is largely framed through the language of "mental health and addictions" (Boyd and Kerr 2015; VCH 2015). More recently, an unprecedented overdose epidemic, driven by the proliferation of illicitly manufactured fentanyl, related analogs and fentanyl-adulterated stimulants, has claimed the lives of over 6,400 people in BC since 2016, including over 1,200 young people under 30 years of age (BC Coroners Service 2020). As a result, harm reduction services such as the distribution of take-home Naloxone overdose antidote kits and sites such as overdose prevention tents and rooms have increased in recent years. The city is actively creating an expanded and more coordinated system of substance use services for youth, exemplified by the various teams described above. These teams follow youth as they move between hospital wards, community health clinics, street youth drop-in centers, residential treatment and recovery sites, shelters, safe houses, and supportive housing buildings located throughout Greater Vancouver, providing continuity of substance use and mental health care, including OAT.

I take seriously Unanga̓ scholar Eve Tuck's (2009) challenge to move away from damage-centered research that further pathologizes young people, especially Indigenous young people, and toward work that attends closely to their desires for things to be otherwise. The youth I followed are part of an urban population for whom everyday living has been rendered problematic in similar ways by structural forms of oppression. On the streets of Greater Vancouver, they navigated the everyday emergencies of homelessness and entrenched poverty; addictions to fentanyl, meth, and alcohol; blood-borne infections, overdoses, "mental breakdowns," and cycles of voluntary and involuntary institutionalization; and volatile drug deals, sex work transactions, and romantic relationships. In the places of their childhoods, the majority grew up in circumstances marked by poverty, violence, and routinized crises. Ongoing experiences of violence took the form of physical assaults, but also encompassed the everyday violence of perpetual uncertainty and dislocation. Approximately half were apprehended from their birth families by the state, and subsequently grew up cycling between multiple government foster care and group homes before "aging out" of the system at age 19 and then again at age 25. Half have spent time in psychiatric wards, juvenile detention centers, and jail, and less than half have graduated from high school. And yet, while those I followed are in many ways relegated to the social, spatial, and economic margins of Canadian society, they are also at the very center of city life and state projects, including the project of protecting life in the context of the current overdose emergency (Das and Poole 2004). In what follows, I stay close to young people's desires and the "not yet" and "not anymore" moments in their stories-so-far (Tuck 2009: 417), while also drawing out the dynamics that regularly thwart their plans for the future.

## Living on the Edge of Change

“Treatment is incredibly boring,” young people told me over and over again. Indeed, a sense of boredom in residential programs was often palpable during my fieldwork. At Passages, I frequently found myself sitting around with youth, watching episode after episode of TV until we were all bleary eyed. Many of those I met at Passages agreed that the best way to pass the time there was by sleeping. While youth could interact with each other in the house’s common areas, lively conversations that veered into “war stories” about drug use, drug dealing, crime and the dramas of street life were prohibited in all of the residential programs I frequented because of the perception that they could trigger a relapse. Access to mobile phones was also generally prohibited in these places, since contact with those on the outside who were still using drugs was also considered triggering. Some youth commented that this left them bored and alone much of time, with nothing to do beyond sleeping, eating, smoking, and watching TV.

And yet, there were other kinds of affective intensities circulating in these settings as well, including a sense of being on the edge of big life changes rife with potential. While youth may not always have been engaged in much conversation with other residents, they were regularly drawn into discussions with various workers and providers focused on planning and goal setting for the future. One of the primary mandates of Vancouver’s expanding and more coordinated system of youth substance use services is to ensure greater continuity of care and prevent vulnerable youth from “falling through the cracks” (Representative for Children and Youth 2015). Across acute, community, and residential treatment settings, a range of workers and providers are implored to work together with youth on developing actionable plans for how to connect them with a range of community supports that will allow them to keep moving forward with goals that include reducing or eliminating illicit drug and alcohol use (or using more safely), finding housing, reconnecting with school, and gaining employment.

Not all youth entered residential treatment programs with these kinds of plans and goals in mind. However, the churn of planning and goal-setting activity that occurred in these places meant that once there, many did begin to actively imagine what a different kind of future might look like. The lives they began envisioning often involved better mental and physical health, better opportunities for education, work and leisure, better housing, and better relationships. This kind of imagining itself generated a sense of momentum, despite chronic boredom.

“In treatment, *every single day* is the same thing,” 16-year-old Jessica told me as she was nearing the end of her six-month stay at Horizons Treatment Center. Although the program at Horizons was longer and young people’s time there more rigorously scheduled than at Passages, the social and affective landscapes of both facilities were similar. She continued:

You have chores. You have meals. You have group therapy. You go to [Twelve Step] meetings. You have to talk to people about your problems over and over again, but you aren’t allowed to talk to other clients [youth] about pretty much anything real that’s happened to you. But still, I’m just, like, looking forward to the next thing, which is housing, right? Just having



that goal at the end is really helpful to stick it out until I get that call saying, okay, we have [government-subsidized] housing available for you. I can't wait for that.

For young people like Jessica and Shane, going on Suboxone while in residential treatment seemed to energize the planning and goal setting that they were drawn into as their stays progressed. The energizing effects of Suboxone that I observed were undoubtedly shaped by the growing enthusiasm for this pharmacotherapy on the part of many workers and providers during my fieldwork, which overlapped with the 2017 release of the new clinical guidelines. Beginning around that time, young people were increasingly told that Suboxone would not only save but also help to stabilize their lives, allowing other “pieces”—such as finding a job or finishing school—“to fall more easily into place,” as one provider put it to me. Taking Suboxone became a way for youth to actively invest in different kinds of futures across time and place. When I asked 18-year-old Jeff how things were going now that he was on Suboxone and about to leave Passages, he responded seriously:

I've been thinking a lot about my kid. And about my own father. And how I never wanted to be like my father, because he left me at eight months old, and then I pretty much did exactly that to my son because of my addiction. But now I think, with Suboxone, I might have that, like, chance, to be a good father, out there.

Once “out there,” staying on Suboxone was one way of maintaining the sense of momentum that youth had found in residential programs. They frequently explained to me that staying “clean” off drugs and pursuing the futures they wanted for themselves was a matter of “just keeping going” and “filling the hours.” Periods of boredom were feared (see also Mains 2007) because they could feed a troubling sense that one was, despite daily efforts to keep moving forward, somehow “going nowhere” desirable. When this sense of stagnation overwhelmed young people, the end result was almost always relapse. In an effort to avoid this, youth attempted to construct elaborate daily schedules, describing to me in detail how they kept themselves busy each day while at the same time avoiding the people, places, and things that could trigger a relapse. As they navigated the boredom and isolation that often accompanied staying clean, many told me that Suboxone not only mediated cravings, but also gave them a heightened ability to get going each day.

“I've had zero cravings [for opiates],” Jessica said happily when we met for coffee a few weeks after she had finished her six-month stay at Horizons. Freshly made up and wearing a stylish outfit, her appearance, tone, and posture all exuded energy and optimism.

And, like, I feel so, like, *productive* on Suboxone. It just, like, helps with that—with keeping going—I think. I've just, like, been really keeping myself busy, handing out my resume. Just for basic shitty retail jobs, but still. I'm planning on going back to school in the fall, and I think there's just no way that would be possible without the Suboxone.



## Stalls and Dead Ends

Ideally, youth moved directly from short-term residential programs like Passages to longer-term residential programs like Horizons, and then directly into some form of safe and supportive housing (e.g., a family or foster care or group home if they were under 19 years of age, and transitional or recovery housing if they were over 19). However, these kinds of plans often fell through, stalled, or dead ended. Long program wait lists and time lags between placements, and an inability to secure housing often led to periods of street-based homelessness, couch surfing, and shelter stays. Housing unavailability is shaped by a number of factors, not the least of which is Vancouver's exorbitant housing market and rental costs. Government-subsidized supportive and temporary modular housing are limited, and in some cases inappropriate for youth who are attempting to maintain abstinence because of the volume of drug use and dealing in some of these settings. Several treatment program managers commented to me that foster care and group home placements for youth seem to be becoming increasingly scarce, as homeowners make the decision to convert basement suites to much more lucrative market or Airbnb rentals rather than take in a youth in government care. In many cases, young people were adamant that they could not return to chaotic family homes, even when the Ministry of Children and Family Development deemed these settings safe.

Fragmented institutional and housing trajectories meant that the sense of momentum and promise generated by the churn of planning and goal setting in residential treatment programs could quickly dissipate. Youth also continued to endure the quiet ravages of inadequate monthly income assistance payments and entrenched poverty, which frequently left them "sitting around with nothing to do." At 19 years of age and then again at age 25, they aged out of the services and programs they had once been so excited about accessing, a situation that further contributed to isolation, chronic boredom, and a crushing sense of stagnation. Under these kinds of structural pressures, imaginaries of different, better futures and a commitment to staying on Suboxone or another form of OAT often collapsed. In the wake of this loss, some youth became engaged in another kind of seemingly endless cycle of withdrawal and return beyond that which characterizes addiction: they withdrew from the treatment programs that they had engaged with previously and then were drawn back into the system at regular moments of crisis, usually when they required shelter or hospitalization.

While we sat together in a McDonald's restaurant, drinking endless coffee refills over the course of a couple of hours, 17-year-old Rebecca summarized the rhythms of starts and stops that characterized her engagement with treatment, and her growing ambivalence toward it. She was once again homeless and using fentanyl multiple times daily. "I've been to Passages maybe a dozen or more times," she laughed shakily.

Maybe two dozen. I was there all the time. But, like, pretty much ended up homeless every time I left, which tells you something. Eventually I moved to some random guy's place that I met. And then after that I moved back to Yew House Shelter, because he decided not to answer the door anymore. And then after that I went to a longer treatment—Horizons, I think? And I

actually tried really hard in that program that time, and was like, hopeful and stuff, when I came out, that things could be different. But then, somehow, I ended up at Yew House Shelter again after that.

She took a long pause, during which she seemed to be fighting back tears. “And then I think I went to Cedar Treatment Center, but only stayed for a couple days. And then *back* to Yew House Shelter, until I went to Horizons again. So. Am I really willing to try it all again, when it is getting me absolutely nowhere? I just don’t know.”

Many of the youth I followed were enmeshed in what Lauren Berlant (2011) calls “cruel optimism.” As they cycled in and out of residential programs and on and off Suboxone and other forms of OAT, they were increasingly faced with the troubling sense that treatment would not necessarily produce different, better futures. Some youth did seem willing to try again and again to keep moving forward with treatment one way or another, even as they moved in and out of shelters, hospital wards, and residential programs, experienced numerous slips, relapses, and overdoses, and went on and off Suboxone or another form of OAT at a dizzying rate. Others, however, were not able or willing to keep going. In the face of a growing sense of stagnation, some turned instead to the more immediate possibilities of intensive drug use.

### Living with Death in a Broken Promise Land

Even as the geography of overdose prevention sites, patrols, and outreach teams has expanded to cover more and more of the interstitial spaces where drug use takes place in Greater Vancouver, young people have continued to carve out hidden spaces for themselves: bridge underpasses, uninhabited beaches, and semi-forested areas where they camp alone or in small groups to avoid drawing the attention of workers, providers, and police. There are also those who have carved out these spaces right up against those of intensive intervention: along alleyways and in tent cities and single room occupancy hotels (SROs) in downtown Vancouver.

In these places, youth frequently acknowledged that they were “living on the edge of” or “with death,” as those who had overdosed and been brought back multiple times sometimes described it. In these lives lived alongside death (Stevenson 2014), the intensive use of fentanyl and/or meth had its own kind of momentum that was hooked not on futures, but on the sensorial possibilities of the now.<sup>7</sup> The frenzied daily rhythms and geographies of addiction meant that there would always be another all-consuming mission (to track down drugs, or the money for drugs, or the people who had both), interpersonal drama (often connected to the mission of tracking down people, money, and drugs), and high on the horizon. The sense of momentum opened up by intensive drug use was often inextricable from the rich socialities that, as Philippe Bourgois and Jeff Schonberg (2009) have shown, hold together communities of addicted bodies in the margins. Yet, my research equally revealed the forms of isolation that can emerge as youth attempted to evade or refuse treatment programs.

Young people were sometimes captured by the system they were trying to avoid. Consequently, they learned to jump out of ambulances before they left for the hospital or leave the hospital A.M.A., as Raymond did, when they ended up there after

overdosing. They learned to say, in a tired but firm tone, “No, I’m not interested in treatment,” on those occasions when they woke up in the hospital or were forced to access care for blood-borne infections like hepatitis C and endocarditis. Sometimes youth pushed firmly against continued involvement in my research, which they knew was focused on treatment and futurity by design.

“As I see it, it’s basically your job now to witness my death,” 25-year-old Lula said to me almost casually one day in 2017 as she was leaving my office. Lula is Syilx First Nations. She left the place in the Okanagan where she was born when she was only a few days old, following her adoption by a family in Vancouver. I hadn’t seen her in a long time prior to that impromptu visit and was very worried about her. I wanted to know where she was living and when we might see each other next, but on that day, Lula refused to make these kinds of plans with me. “I’m not interested in treatment or any of that,” she replied after telling me about a recent overdose. “Just promise me one thing,” she said, as she gathered up her jacket, backpack and the battered phone she had been charging. “*Promise me* that you’ll look into the circumstances if I do die. I might *not* overdose, right? And I don’t want to be added into those [Indigenous youth overdose] numbers.”

In this encounter, Lula expressed multiple refusals: a refusal to go to/on treatment, to submit to the gaze of research, and to be (mis)recognized as “just another” Indigenous youth overdose death (Coulthard 2014; Simpson 2014). Like the Inuit youth described by Lisa Stevenson (2014) who are contending with the suicide epidemic in Canada’s North, Indigenous young people in Vancouver are being asked to cooperate in their own survival by going to residential treatment, taking lifesaving pharmacotherapies like Suboxone, and submitting to various forms of surveillance. But Lula and some of the other Indigenous young people I knew, such as Raymond, refused to be drawn into this relationship of cooperation with the care assemblage, even as culturally safe youth-focused treatment programs are made increasingly available. Lula and Raymond both had a long history of being drawn into the churn of state-sponsored intervention. Experiences of government care, incarceration, and hospitalization across their own young lives, as well as intergenerational experiences of institutionalization, informed a felt knowledge of the broken promises and forms of stagnation, violence, and loss that this churn can generate. From the Indian Act to Canada’s recent endorsement of the United Nations Declaration on the Rights of Indigenous People, the colonial past and present is rife with promises of a different, better future offered in return for particular kinds of cooperation. These promises are often violently and abruptly broken. In this context, the sense of future promise that can be generated by the churn of intervention may not only ring false but even signal danger. Lula and Raymond were not so much falling through the cracks as following different lines of potential in a broken promise land powerfully shaped by history. Intensive drug use, getting into trouble, and geographic mobility were alternative ways of binding themselves to life beyond the care assemblage, even as they brought them into close proximity with death (Goodfellow 2008).

The broken promise land of treatment was also shaped by the post-welfare neoliberal state, in which opportunities to attain various markers of the good life—housing, employment, leisure, upward mobility—are rapidly dissolving for those at the bottom of socioeconomic hierarchies (Berlant 2011). “I’m on drugs, this is

something I have, this is fun, and what am I giving it up for, anyways? What am I surviving *for*?" 20-year-old Rachel asked me one day. We were in the camp she shared with her on-again-off-again boyfriend, located underneath the SkyTrain in one of Vancouver's suburbs. She was pacing back and forth in front of her tent, obsessively adjusting and readjusting the pink wig she was wearing with one hand and spilling the large double cream-double sugar coffee I had brought her from Tim Horton's with the other. She continued sarcastically, "Oh, you want me to get a crap job? Oh, okay, I'm gonna have to pay this student loan off for the rest of my life and I'm never gonna be able to actually have a *good* job—I'm gonna be one pay cheque away from homelessness my entire life? Oh, *great*."

It should be emphasized that the momentum of fentanyl and meth use was simultaneously a source of fun, terror, and loss for youth in the context of a toxic drug supply and the other forms of everyday violence that marked their lives. Most of those I knew had long ago lost count of the number of friends and family members they had lost to fatal overdoses. And yet for some, continually chasing a high seemed to be preferable to wading through the stops and starts and broken promises that were generated by the churn of intervention.

## Conclusion

Crouching awkwardly in her SRO room, 24-year-old Pearl insisted to me, "I don't wish to ever really participate in [taking OAT] again." Her room was packed with various items recovered from dumpsters and littered with used syringes, which she explained was so that building and outreach workers would be "scared to enter and just leave her alone." She continued:

I don't know, I got really bored on it. It was just a pretty boring life on it after a while, so, um, I kind of missed having fun. I really enjoy the high I get [from fentanyl and meth]. Especially the down [fentanyl], it's *something*, right, that I have in my life, that I am really, really focused on. Everyday I go to my friend's place—the place where he is staying, and we just really, completely focus on our down addictions. How to get drugs, where to get drugs, how to get as much as possible.

She trailed off, before adding frankly, "I've recently decided I don't want anything else in life. At all."

Three years after this encounter, Pearl died of an overdose in her room.

The churn of intervention across youth-focused treatment settings continues to be fueled by a desperate desire to do something to stem the tide of deaths locally. No one whose job it is to address the overdose public health emergency intends to hold out treatment as a sure promise of a bright and shiny future. If, as Bharat Venkat (2016) has argued, treatment constitutes a promise of sorts, it is one that is frequently broken by the near inevitability of relapse. What is less well understood, perhaps, is that among many young people, the broken promises of treatment do not lie in the limitations of particular programs and pharmacotherapies. Rather,

they are located in history and the post-welfare neoliberal state, and registered affectively as a crushing sense of stagnation (*Things are not going to get any better*). This article casts a disturbing light on Indigenous young people's felt knowledge of colonialism (Million 2013), and how it shapes the recurring forms of loss that are operating on the bodies of the Indigenous future (Garcia 2010). It also illuminates a kind of selective biopolitics that is at work in Vancouver, in which treatment can perhaps improve youth's chances of accessing various poverty management services, but nevertheless often still leaves them living in undesirable housing, barely scraping by on a crap job and/or meager monthly welfare payments, and firmly locked out of desired forms of home-making in the city.

"I don't make promises to youth about housing and jobs and stuff like that anymore," one manager at a residential program told me recently with real anguish in her voice.

There have been times in the past when it seemed easier to find them a place [to live], and we could work on those things together. But not now. And it's really heartbreaking not to be able to offer them something, especially when they are doing *everything* we are asking of them, and not putting a single foot wrong in terms of the plan we have developed for them. But at the same time, we need to prepare them for the reality of what's out there.

Or, what's not out there. Without equal investment in housing, employment programs, and addressing structural and historical forms of inequality and oppression, the churn of intervention across youth-focused treatment settings can actually exacerbate harm when youth are repeatedly caught up in a sense of momentum and promise, only to be faced with a rapid descent into a sense of stagnation when their plans for the future fall through, stall, and dead end.

In this context, many young people expressed a commitment to the thing that could be counted on to propel them forward in the present: the frenetic fun of intensive meth and fentanyl use. I am not arguing here for increased attention to pleasure in drug research, although such arguments are important (Moore 2008). Rather, I am pointing to the immediate sense of momentum that can be generated by the rhythms and geographies of addiction, and how it may be a powerful antidote to the stagnation generated by the churn of intervention, historical oppression and marginality (Stewart 2007). As Aaron Goodfellow (2006) reminds us, it is easy to translate youth's drug use beyond the grasp of life saving programs into institutionally authorized forms. Their evasions and refusals of treatment thereby become a reflection of pathology, symptoms of untreated substance use disorders, or of gaps and barriers to access in the youth substance use service system. This framing further fuels the will to intervene. Anthropologists, alternatively, might read youth's evasions and refusals through the lens of resistance. Indeed, affect's political potential has been a focus of much previous work (Garcia 2017; Laurence 2017; Million 2013), and there are many important stories of activism to be told about people who use drugs in Vancouver, as individuals and communities, and in particular Indigenous individuals and communities (Culhane 2003b; Martin and Walia 2019), continue to demand change on terms that exceed medicalizing, pathologizing framings. However, this article is an attempt to tell a different kind of story: one about

affect's potential to engender deep ambivalence toward treatment in the context of an overdose public health emergency, which sometimes crystalizes into moments of withdrawal, evasion, and refusal.

## Notes

1. All names, including the names of programs and services, are pseudonyms.
2. The SkyTrain is a transportation system that connects downtown Vancouver with the city's outlying suburbs. Youth frequently moved between downtown Vancouver and these suburbs as they tracked down and generated income, bought, sold, and used drugs together, and accessed various services and systems.
3. Generally defined by local planners as those between 14 and 24 years of age.
4. When compared to methadone, Suboxone tends to promote greater abstinence from illicit opioids because the buprenorphine component has a high affinity for the  $m\mu$  receptor, which means that it reduces the effects of additional opioid use. Suboxone also causes less respiratory depression than methadone, thereby reducing overdose risk (see Whelan and Remski 2012).
5. While Suboxone has been the recommended first-line therapy for OUD among youth since 2017, multiple medication assisted treatments were available during my fieldwork. Those who did not respond well to Suboxone or methadone were generally next offered morphine sulfate extended-release capsules (brand name Kadian). Injectable opioid agonist therapy (iOAT; titrated daily witnessed injected doses of diacetylmorphine or hydromorphone) was officially available to youth over 18 and unofficially available to younger youth based on a physician's discretion. A long-acting monthly injectable form of Suboxone (brand name Sublocade) became available in 2020.
6. As others have long argued (Bourgois 2000), OAT involves multifarious forms of discipline, including daily trips to the pharmacy for witnessed dosing and regular appointments with prescribers for monitoring. While youth-focused in-patient treatment settings in Greater Vancouver vary widely in terms of institutional "feel," they include and can be virtually indistinguishable from hospital wards.
7. In her ethnography of machine gambling addiction, Natasha Schüll (2012: 19) describes the "world-dissolving state of subjective suspension and affective calm" that her research subjects derived from entering "the zone" of machine play. For Schüll (2012: 223), machine gambling addiction represents an intensification of Freud's death drive, "a set of tendencies whose aim was to extinguish life's excitations and restore stasis." I am documenting something quite different: addiction as a means of amplifying excitement in circumstances frequently marked by boredom and stagnation.

## Notes

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