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Negotiating sex work and client interactions in the context of a fentanyl-related overdose epidemic

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ABSTRACT

Despite awareness of the role of drug use in shaping sex worker/client interactions, these dynamics remain poorly understood in the context of illicit fentanyl-driven overdose epidemics. This study examined sex workers' experiences negotiating client interactions amidst a toxic drug supply in Vancouver, Canada. Findings draw from two ethnographic studies. The first, conducted between December 2016 and May 2017, examined the rapid implementation of several low-threshold supervised consumption sites. The second investigated experiences of women accessing a women-only site from May 2017 to June 2018. Data included 200 hours of fieldwork and in-depth semi-structured interviews with 34 street-based sex workers who use illicit drugs. Data were analysed thematically with attention to the risk environment. Participants described providing harm reduction services to clients as a means to reduce overdose-related risks, thus increasing sex workers' hidden labour. Participants, comments regarding criminalisation and stigma surrounding drug use and sex work indicated a reticence to report overdoses, thereby potentially increasing the risks of overdose-related harms, including death. There is an urgent need for sex worker-led overdose prevention strategies that prioritise health and safety of sex workers and their clients with specific attention to how the criminalisation of particular drugs, practices and people contributes to overdose-related risks.

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Introduction

Street-based sex workers experience a high burden of work-related violence globally, including sexual and physical violence and homicide (Deering et al. 2014; Decker et al. 2015). The vulnerability of sex workers to violence is driven by structural vulnerabilities, including poverty and lack of access to health and social services, that compound

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their risk of health and social harms such as sexually transmitted infections (Rekart 2005; Malta et al. 2008; Shannon and Csete 2010; Shannon et al. 2015; Socias et al. 2016; Rhodes et al. 2012). Such harms are driven in part by sex work criminalisation and social and occupational stigma, which often result in precarious working conditions and displacement to isolated areas that constrain the ability to negotiate safer sex practices (e.g. condom use) (Malta et al. 2008; Deering et al. 2014; Shannon et al. 2009). These social and spatial dynamics can result in increased risks for violence when initiating sex worker/client transactions (Malta et al. 2008; Deering et al. 2014; Shannon et al. 2009).

In settings where street-based sex work and drug markets overlap, sex workers can experience an increased risk of harm of interpersonal violence due to the criminalisation of both sex work and illicit drug use (McNeil et al. 2014; Wood et al. 2003; O'Connell et al. 2005). This is particularly relevant when drug use is part of sex worker/client interactions (Shannon et al. 2009; Deering et al. 2013; Shannon et al. 2008; Bungay et al. 2010; Krüsi et al. 2014; Goldenberg et al. 2013; Sherman, Lilleston, and Reuben 2011). Previous research has drawn attention to how fear of policing can lead to the rushed screening of clients (a vetting practice to better support the well-being of sex workers), which can exacerbate violence for sex workers (Rhodes et al. 2012).

While it is recognised that the contexts in which sex work and drug use overlap and shape sex worker/client interactions (Rhodes et al. 2012; Deering et al. 2013, 2011; Goldenberg et al. 2013; Sherman, Lilleston, and Reuben 2011), less is known about the impact of overdose epidemics on these relationships. We draw on two ethnographic studies examining interventional responses to the overdose epidemic in Vancouver to investigate how the navigation of stigmatised, criminalised and political environments shapes experiences and vulnerability to overdose among a population of predominantly precariously housed, street-based sex workers with a history of illicit substance use.

Background

In Canada, sex work remains criminalised as specific activities, such as advertising and profiting from sex work and the purchasing of sex, remain illegal. In 2013, the Supreme Court of Canada struck down three provisions of federal sex work laws (i.e. prohibition of brothels, restricting the ability to live off the avails of prostitution, communicating in public about sex work) as unconstitutional because they interfered with sex workers' right to security of the person (Krüsi et al. 2014; Department of Justice Canada 2014a). In a subsequent policy shift, Canada pursued a model of asymmetrical criminalisation focused primarily on criminalising clients (i.e. purchase of sexual services), but which also continued to prohibit other activities (e.g. advertising, working in proximity to select locations) that *de facto* criminalised sex workers (Department of Justice Canada 2014b).

The need to understand sex worker/client interactions and negotiations within the context of an overdose crisis is particularly relevant in the province of British Columbia (BC), Canada. In 2016, a public health emergency was declared in BC due to a

dramatic increase in overdose-related deaths from the contaminated illicit drug supply (BC Coroners Service 2018). BC has experienced more overdose-related deaths than anywhere else in Canada, with 90% of the 975 provincial overdose deaths in 2019 linked to illicit fentanyl, detected in adulterated opioids and stimulants (e.g. heroin and cocaine) (BC Coroners Service 2018; 2020). In response to the growing number of overdose deaths, unsanctioned low-barrier supervised consumption sites were first implemented in BC as community-led initiatives. They were approved provincially by 2017 as a temporary emergency response (Wallace, Pagan, and Pauly 2019), along with increased take-home naloxone distribution, an opioid agonist (BC Centre for Disease Control 2020). Low-barrier supervised consumption sites were meant to facilitate access for vulnerable populations, often leverage existing community infrastructure, and are less clinical than federally-authorised supervised consumption sites (Collins et al. 2018).

Despite the importance of drug use in influencing the contexts in which sex workers negotiate safer sex practices, how sex work and drug use intersect – particularly in relation to the fentanyl-related overdose epidemic – has received little attention. Exploring these intersections is especially important within Vancouver's Downtown Eastside–a low-income neighbourhood located on unceded Coast Salish territory with visible street-based sex work and drug markets, and one of the epicentres of North America's overdose crisis. The Downtown Eastside has also been the site of a long-standing history of heightened violence against women, particularly Indigenous women and sex workers (Krüsi et al. 2012; Culhane 2003). While sex workers are heterogeneous, those living in the neighbourhood with a history of illicit substance use and who also live in poverty are disproportionately impacted by the toxic drug supply.

Approach

An intersectional risk environment framework (Boyd, Collins, et al. 2018; Collins et al. 2019) provides a useful approach to investigating the complex ways in which sex workers experience worker/client interactions during an overdose crisis. Intersecting physical, social, economic, and political factors create 'risk environments' (Rhodes 2009, 2002) that converge with social locations (Collins et al. 2019), shaping risk and harm among sex workers and their clients. In this context, attention to risk environments, including physical (e.g. injecting and sex work locations), economic (e.g. informal and illegal income generation/poverty), social (e.g. occupational stigma), and political (e.g. punitive laws governing drug use and sex work) factors, can provide a useful lens for identifying the social and structural constraints shaping sex workers' lives during an overdose crisis.

Analyses that draw upon this intersectional risk environment framework are useful in examining heterogeneous experiences of health-outcomes in order to better assess social and health inequities that render some populations more susceptible to harm (Collins et al. 2019). For example, this framework has been used to draw particular attention to how neighbourhood factors such as targeted police surveillance, socio-economic spatial distribution and closeness to harm reduction services result in intra-group differences, with increased health harms for racialised people who inject drugs

(Cooper, Arriola, et al. 2016; Cooper, Linton et al. 2016). Analyses using this framework have further highlighted how low-income individuals who turn to informal and illegal forms of work (e.g. sex work, recycling, drug dealing) experience increased risk of violence (including arrest) that is heightened for those already negatively impacted by interlocking systems of oppression (e.g. racism, colonialism, transphobia, patriarchy). So, for example, Indigenous women, Black women and women of colour are disproportionately impacted (Boyd, Richardson, et al. 2018; Strathdee et al. 2015). Attention to the potential role of the intersectional risk environment operating within criminalised spaces (sex work and drug use) in shaping sex worker/client interactions addresses a significant gap in existing research.

Methods

This study draws on findings from two complementary, ethnographic studies undertaken in Vancouver's Downtown Eastside neighbourhood: (1) one rapid study focusing on the implementation of low-barrier supervised consumption sites as part of the initial emergency public health response (Study 1, December 2016 to May 2017); and (2) another study focusing on the subsequent implementation of a women-only (transgender and non-binary inclusive) low-barrier supervised consumption site (Study 2, May 2017 to June 2018). We sought to understand engagement with these sites and to characterise the unfolding overdose crisis in Vancouver's Downtown Eastside as experienced by different drug-using populations (including sex workers).

Data collection for both studies involved semi-structured interviews with people who use drugs (including sex workers) recruited directly from low-barrier supervised consumption sites, along with written field notes that documented observations, conversations and interactions in and directly outside the sites. Participants were recruited by peer researchers (members of the Downtown Eastside community trained in research activities with lived expertise of drug use) and interviewed onsite or at our field office. Fieldwork involved observation in 4–6 h sessions and unstructured conversations with people who use drugs accessing sites. Interviews averaged 30–60 min, were audio-recorded and transcribed verbatim. Identifying information was removed from transcripts to ensure confidentiality, and each interviewee was assigned a pseudonym using an online name generator. Participants received $30 CAD honoraria for their time.

Ethnographic research involves ongoing engagement with participants in their everyday lives (Maher 2002), and considers social, structural, cultural and political-economic contexts (Rhodes et al. 2012). This method enables the researcher to be particularly attentive to the everyday realities and activities of people who use drugs (Hammersley 2008). Rapid ethnography, which employs similar principles, further harnesses researchers' existing familiarity with contexts to rapidly gather data and has proven important during health emergencies (Handwerker 2001; Johnson and Vindrola-Padros 2017). Because both studies were undertaken consecutively, involved the same researchers and included harmonised sections of interview guides, ethnographic observation procedures, and recruitment methods, this facilitated the merger of data involving sex workers from across studies. Observation of sex worker/client

interactions was not a focus of either study; rather, fieldwork data emerged only from observation within overdose prevention sites and informal accounts and conversations regarding sex worker/client interactions that took place in those spaces.

Study one

Data included over 200 hours of observational ethnographic fieldwork at three mixed-gender and one women-only supervised consumption site, as well as semi-structured interviews with 72 socio-economically marginalised people who use drugs. An interview guide was used to facilitate discussion on experiences and perspectives related to use of low-barrier supervised consumption sites in the context of an overdose crisis. For example, we asked how sites differed from consuming drugs in other settings. However, the guide also included population-specific questions related to employment, including sex work. For example, we asked how the service impacted participants' means of income generation, and when relevant, if it had impacted relationships with sex work clients.

Study two

Based on preliminary findings from the first study and a research opportunity following the further scale-up of a low-barrier women-only (transgender and non-binary inclusive) supervised consumption site, a second ethnographic study was developed. Data collection included approximately 100 hours of ethnographic fieldwork and semi-structured interviews with 45 women accessing the site. An interview guide was used to elicit insight on experiences using the site, negotiating sex work, gender-based violence, and overdose prevention.

Relational data analysis

Data from both studies were imported into NVivo, a qualitative data analysis software programme, and were initially coded separately, yet relationally (coded with similar themes in mind), by the authors. Data pertaining to sex work were then extracted from both studies, combined, and analysed thematically, with attention to the impact of an overdose crisis on sex worker/client interactions. This analysis focused only on data from sex workers, the majority of whom identified as women, across both studies ($n = 34$), and included 20 participants from the first study and 14 participants from the second study. Fieldnotes from both studies were utilised to further augment analysis of sex workers' discussions of their experiences. Codes based on initial themes (e.g. experiences of overdose response) and emergent themes (e.g. supervised consumption, increased labour and caregiving, distrust of law enforcement) were developed iteratively throughout the analysis and were informed by the intersectional risk environment (Boyd, Collins, et al. 2018; Collins et al. 2019), and theories of structural and everyday violence (Rhodes et al. 2012; Bungay et al. 2010; Bourgois, Prince, and Moss 2004). These studies were approved by the Providence Healthcare/University of British

Table 1. Participant demographics.

	Total	Low-barrier SCS[a] Study	Women-only SCS[a] Study
Participant Characteristics (employed in sex work)	n (%) N = 34	n (%) N = 20/72	n (%) N = 14/45
Age			
Median	38.5 years	38.5 years	42 years
Range	23 – 55 years	23 – 55 years	24 – 60 years
Gender[b]			
Man	1 (2.9%)	1 (5%)	0 (0%)
Woman	31 (91.2%)	19 (95%)	12 (85.7%)
Two-spirited	1 (2.9%)	1 (5%)	0 (0%)
Trans	4 (11.8%)	2 (10%)	2 (14.3%)
Race/Ethnicity[b]			
White	17 (50%)	8 (40%)	9 (64.3%)
Indigenous	14 (41.2 %)	9 (45%)	5 (35.7%)
Black/African Canadian	2 (5.9%)	2 (10%)	0 (0%)
Latin American	1 (2.9%)	0 (0%)	1 (7.1%)
Chinese	1 (2.9%)	0 (0%)	1 (7.1%)
Other	2 (5.9%)	1 (5%)	1 (7.1%)
Homeless in past year			
Yes	24 (70.6%)	14 (70%)	10 (71.4%)
No	10 (29.4%)	6 (30%)	4 (28.6%)
Overdose in last year (Prior to interview)			
One	4 (11.8%)	3 (15%)	1 (7.1%)
Two	4 (11.8%)	3 (15%)	1 (7.1%)
Three or more	8 (23.5%)	6 (30%)	2 (14.3%)

[a]Supervised consumption site.
[b]Participants could select more than one.

Columbia Research Ethics Board as part of the same research protocol for a larger US National Institutes of Health-funded study.

Findings

The majority of participants were cisgender women, predominantly white and Indigenous. All participants engaged in sex work as a means of income generation and reported regular illicit substance use (including opiates and stimulants). Most participants had been homeless in the past year, and just under half had experienced at least one opioid-related overdose in the year prior to the interview (see Table 1).

Sex worker interactions and the mediation of overdose-related risks

The narratives of street-based sex workers in this study working during the overdose crisis pointed towards a shift in sex worker/client interactions (described as "dates" by participants), specifically in relation to strategies to mediate overdose risk. Within these interactions, participants described themselves as performing a broad range of roles, including acting as informal "doctors" (i.e. assisting with client injections), providing clients with safer places to consume drugs, and overall harm reduction support.

A few participants described particular clients as enlisting their services for activities that involved drug use during dates rather than sexual activity. 'Stephanie,' a 30-year-old Indigenous woman, explained:

> He might just want to do drugs and just, you know what I mean, hurry up out of there, right? You never know what you're going to get with a client, right?

Similarly, 'Diane,' a 32-year-old white transgender woman, stated:

> because [sometimes] all they [clients] want to do is smoke crack and that's it and just they'll pay you for your time.

While clients' drug use during dates may or may not be driven by concerns of overdose risk, many participants described engaging in informal peer witnessing of drug consumption, given the toxic drug supply. Client drug use, thus, sometimes inadvertently placed additional expectations on sex workers to provide harm reduction support. For example, participants highlighted how the fentanyl-driven overdose epidemic not only intensified sex workers' roles as peer support workers, but also imposed increased responsibility for clients' lives. 'Alexis,' a 29-year-old woman (ethnicity unknown), characterised the experience of being responsible for clients' overdoses, particularly among those inexperienced in opioid use:

> I had three dates OD [i.e. overdose] on me. They said they did down [i.e. opioids] but they didn't really do down [i.e. potentially had lower opioid tolerance] and I had down on me. […] I had to just call paramedics and do the CPR and training of the shot [i.e. naloxone administration].

In this case, clients with heightened risk of overdose (due to apparent inexperience) were dependent on the participants' training in overdose prevention and first aid.

Participants described further supporting clients' drug use practices by imparting safer injection education and assisting with injections. 'Taylor,' a 24-year-old Indigenous woman, emphasised client demands for her harm reduction skills and explained that she helped with assisted injection if a client asks for it:

> Sometimes they [clients] can ask it [assisted injection]. It just depends on who you are. Do you know what I mean? Like some people do it themselves and some people don't do drugs at all. Some people don't inject it. I don't have no problem doing it [assisted injection]. I'm really good at it.

Taylor expressed confidence in her ability to safely assist her client. However, some participants noted that, though they were "good at it," they "don't like to" assist but sometimes felt obliged to help rather than watch injectors "torturing" themselves by doing it incorrectly.

Participants further shared examples of providing clients with safer environments to consume drugs. For example, 'Lori,' a 49-year-old white woman, detailed offering a client a safe place to use without police interference, while providing peer support:

> Well, this one guy comes from Surrey [a metro Vancouver suburb] and I said, 'Dude, you don't want to get high in that fucking building. Number one, there's, you know, there's narcs [police] running around everywhere. You don't want to be seen down here. Come and get high in my box [secure storage box].' […] He comes back the next weekend, he goes, 'Hey, can I get high in your box again?'

The imposition of responsibility for overdose responses and emotional labour onto sex workers

Within the intersection of sex work, emotional labour, and responsibility of overdose prevention in the context of a fentanyl epidemic, some participants reported feeling

placed in a situation where they were providing more services for less pay. For example, 'Brianna,' a 21-year-old Indigenous woman, expressed frustration at her now overlapping responsibilities when with a client:

> Because you know it [client/sex worker dates that involve drug use] always turns into like this 5-hour long deal and they're not paying me by the hour – like they're not actually giving me like good pay for that. Like I guess there was one time I got like $500 from a guy but I had to sit there and fucking light his crack pipe for him … I don't want to sit there and buddy up to them and listen to their fucking life story just as much as I'm sure they don't want to listen to my life story.

Many participants noted that attending to their clients' emotional needs was a major component of their work. 'Paige,' a 34-year-old white woman, explained that she had autonomy and agency in her work while emphasising the importance of providing her clients with emotional care:

> It doesn't mean I have to do what they want me to do. They are paying for my time. They're not paying for me to have sex with them. If I have sex with them, that's my own choice. I don't lie … It's important to be there for people too. A lot of the job is just being there for people because people need people.

As Paige indicated, sex work also involved a considerable expectation of caretaking, or "being there for people." However, the imposition and expectation of sex workers to provide emotional labour was significantly intensified in the heightened context of an overdose crisis.

'Joshua,' a 32-year old black/Indigenous man, described once having to interrupt a date to attend to an overdose on the street, explaining that dealing with overdoses and the constant replenishing of naloxone kits for this purpose was "overwhelming" and "starting to take a toll on people." Sex workers expressed exhaustion, frustration and concern over the constant onslaught of overdose that impacted their night shifts, often exclaiming, "I'm sick of this shit." Sometimes, they divulged particular client drug use patterns to one another (e.g. experienced with opioids or not) when shared clients were identified, an information-based risk reduction tactic. During one informal site conversation, a few sex workers agreed that older clients were preferable as they made them feel "more dignified" as these clients were less likely to overdose than younger clients perceived as having "riskier" drug use practices.

Some participants, however, noted that they had to hide their drug use from non-drug using clients in ways that exacerbated their own risk of overdose. For instance, 'Michelle,' a 44-year-old white woman, described having to rush injections in public settings (e.g. the alley) before and after client interactions. Michelle explained that while carrying naloxone was "common sense" given the overdose crisis, she was not comfortable carrying it because she feared being "cut off immediately" by certain clients if discovered. When asked if her clients could effectively respond if she did overdose, Michelle explained: "No, probably not. They'd probably think, 'Oh, she's sleeping.' Honestly, that would be funny. [Laughs] Not really funny … it's kind of macabre." The labour of sex work in this context encompassed an unrecognised and unreciprocated responsibility of care that is compounded by substantial overdose risk.

Intersecting barriers to reporting overdoses to law enforcement and medical services

Everyday violence and ongoing fear of police violence, which many participants had experienced, was a consistent theme in interviews. For example, 'Lindsay,' a 33-year-old Indigenous woman, spoke about two incidents where she was mistreated by police:

> When I was living in a tent, they [police] actually handcuffed me and stole everything around me and put it in the back of a garbage truck. Another time they handcuffed me, and they dropped me off at the Skytrain [subway] with my bike and no helmet and no shoes and they let me off there. [….] I've been handcuffed and searched, like strip searched, by five male cops without a female cop present. That was when I was in [Vancouver suburb]. I've just had a lot of bad experiences with the police. I don't really have much good to say about them.

Other participants described 'starlight tours,' referring to the colonial practice by Canadian law enforcement officers of dropping Indigenous people off in isolated areas outside of cities during extremely cold temperatures without proper clothing or shoes, in many cases resulting in death (Razack 2014). Lori described how young women, mainly young sex workers, were being routinely targeted by the police in a similar manner:

> Like I said, I'm not a very good ho [sex worker], but oh man, the hos have a lot of bad experiences too, where they [police] were picking them up and fucking driving the young girls, they drive them out. Drop them off and say, 'Okay, see you later. Try and find your way back home.' That's fucking gross, man. Isn't that awful? And those are young girls. They're like 17, 18 years old.

Participant distrust of law enforcement has potential consequences because police are sometimes the first responders in an overdose event – something potentially contributing to a reluctance to contact emergency services to report client overdoses. 'Nicole,' a 34-year-old Indigenous woman who refused to call the police for support after her client died from an overdose, highlights this tension:

> And I'd never seen a dead person in my life. When I came out of my nod [i.e. high] he [the client] was all blue and stiff and I never told the staff there. I just left the whole building. I was at [a single-room occupancy hotel] so I went to [women-only supervised consumption site]. That was the first place I went to cause I wanted to talk to the lady who works there. I like them you know [the peer staff]. They're the only ones I feel comfortable talking to.

That Nicole sought out the women-only supervised consumption site to provide support during an overdose event, rather than calling emergency services, demonstrates the extent to which some participants distrusted first responders, fearing arrest, harassment, and assault by police. Nicole, further described fear of arrest (compounded by the criminalisation and social stigma of both sex work and illicit drug use) as a potential outcome of reporting her client's overdose:

> … what if it was different, like if I did call the police and they just came and what if they arrested me at that time because they thought I did something to him, which I didn't. Because people might think that you inject somebody with Heroin just to try and kill him, right, and what if they think that I tried to do that or something, which I didn't? I think

about it now, what if it was different? What if they took me to jail and said that I tried to kill him or something?

Some participants also reported distrust of medical first responders due to stigmatising encounters. For example, one participant described observing Emergency Medical Technicians making fun of a woman who had overdosed for being overweight. Another participant explained that, because she was perceived as an "addict" by emergency responders, they discounted her capability in administering first aid to a woman, even after she explained her credentials. Diane stated, "They treated me as if I was an addict or a fuckin' person that lived there [in low-income housing] and I was pretty offended." These accounts served to underscore the ways in which many sex workers avoided seeking medical attention during an overdose epidemic due to adverse interactions with medical professionals and first responding police officers. Criminalisation, stigma and violent police encounters intersected in shaping sex workers' responses to overdose-related harms and risks.

Discussion

Findings from this research offer critical insight into how sex workers managed their risk environments within the context of an overdose epidemic. Participants described their experiences with client interactions during an overdose crisis in diverse ways, noting increased expectations around practising harm reduction and associated overdose-related risks, such as concerns inhibiting the reporting of overdoses. Participants' accounts emphasised how the overlapping criminalisation of sex work and drug use, social stigma and police violence shaped their daily experiences, which were intensified by the overdose epidemic. Their stories underscored how interactions with clients have also been used as additional means to reduce overdose-related risks through supervised consumption. At the same time, findings further demonstrate that while sex workers have always attended to the emotional needs of clients, emotional labour in the context of an overdose crisis involves an unrecognised responsibility of care for this segment of sex workers. Such caregiving is compounded by substantial overdose risk, and in turn, increased risk of interaction with law enforcement and medical professionals.

In the face of social and structural inequities (e.g. economic marginalisation, occupational stigma, criminalisation of sex work and drug use) (Shannon et al. 2008), sex workers' narratives in this study revealed the ways in which they draw upon their individual knowledge-base and skills to provide clients with safer drug use and more secure spatial locations for sex work/drug consumption encounters (i.e. locations with limited risk of police presence). Their specific lived experiences reveal how intersecting economic (e.g. illegal income generation and poverty), physical (e.g. enforced isolation), social (e.g. intersecting stigma), and political (e.g. criminalisation) factors shaping overdose-related risks are informally mediated in sex worker/client encounters through a variety of practices.

Sex workers described providing clients with peer witnessing, which can be critical in preventing overdose-related deaths (Shannon et al. 2009; O'Connell et al. 2005). Some sex workers also described assisting clients with injections. In some

circumstances (e.g. demonstrated need for assistance due to lack of experience or disabilities) assisted injection can help reduce overdose-related risks (McNeil et al. 2014; Gagnon 2017). However, assisted injection is illegal in Canada and can therefore put sex workers at considerable risk for criminal charges as there is no legal protection under Canadian law in the event harms were to occur (McNeil et al. 2014; O'Connell et al. 2005; Gagnon 2017). These results underscore how some sex workers' navigations of overdose risk reduction are both hidden and undermined in the context of criminalisation, at a time when overdose prevention is critical.

Participants in this study were structurally vulnerable (Rhodes et al. 2012) (e.g. experiencing poverty, discrimination, criminalisation), with limited capacity to mediate overdose-related risk while navigating the additional labour of caretaking in the form of overdose prevention and response. Sex workers described how the labour of overdose prevention can result in an unaccounted burden of increased responsibilities of care. Research has documented the struggles of peers working in harm reduction to care for others in ways that extend far beyond the parameters of their roles (Bardwell et al. 2019; Boyd and Boyd 2014; Dechman 2015; Greer et al. 2016), but less often has this been documented in relation to the intersection of sex work and harm reduction.

Consistent with past research (Rekart 2005; Malta et al. 2008; Deering et al. 2013; Shannon et al. 2008; Krüsi et al. 2014; Deering et al. 2011), our findings demonstrate that the dual criminalisation of sex work and drug use renders sex workers and their clients particularly vulnerable to a range of drug and sex work-related harms, including overdose risk, and can further exacerbate marginalisation of Indigenous women in particular (Bingham et al. 2014). The purchasing of sex remains criminalised in Canada, while the criminalisation of activities surrounding sex work, which can result in increased police surveillance, harassment and subjection to punitive enforcement strategies, contributes to a high level of harm among sex workers (Krüsi et al. 2014; Bennett and Larkin 2018; Bingham et al. 2014; Gratl 2012; Oppal 2012; Sherman et al. 2015). Law enforcement strategies, such as the criminalisation of procuring sex work, further displace sex workers into isolated and secluded areas (overdose risk environments), often limiting their ability to have agency over their transactions (Shannon et al. 2008) and to practice harm reduction.

Starlight tours, described by participants, exemplify sex worker narratives of police violence while simultaneously drawing attention to Canada's colonial legacy and the on-going systemic criminalisation of Indigenous people who have been disproportionately impacted (Razack 2014; Million 2013). These narratives of distrust have particular implications during an overdose crisis, as they exist despite initiatives such the Good Samaritan Drug Overdose Act enacted in BC in May of 2017 (Government of Canada 2019), which provides some legal protection for those offering help during an overdose. Though some data suggests that law enforcement are not showing up to reported overdoses (Karamouzian, Kuo, Crabtree, and Buxton 2019), participants continue to express concern about police presence. Our findings suggest that distrust of the police and fear of being criminalised for activities associated with both sex work and drug use, compounded by intersecting socio-structural violence such as systemic racism, can prevent sex workers from enlisting police services during overdose events.

Limitations

This study has several limitations. Participants' accounts reflect predominately the views of street-based, low-income sex workers who use illicit drugs and who attended low-barrier supervised consumption sites and therefore may not be representative of the experiences of sex workers in other settings or of those who did not access these sites. In comparison to the greater Vancouver region, Indigenous people are over-represented in the Downtown Eastside (City of Vancouver 2013). Notably, as is consistent with previous work in this neighbourhood (Socias et al. 2016), the majority of sex workers participating in this study identified as white or Indigenous and their perspectives are unlikely to be representative of other racialised sex workers. Although this study captures some issues related to the ways in which sex workers experienced client relations during the overdose crisis, it does not attend to the more nuanced experiences of sex work interactions, including those who work indoors. As a result, findings are not transferrable to all settings where the intersection of sex work and drug use are present. Findings further suggest research is needed addressing client-specific barriers to overdose prevention initiatives, as well as the necessity of highlighting the unique and intersecting experiences of transgender, non-binary, and two-spirit, Indigenous, and other racialised sex workers.

Conclusion

The dual stigmatisation of sex work and drug use experienced by participants, compounded by the intersections of systemic racism, misogyny and poverty, is accompanied by material impacts, including increased criminalisation, police violence, and overdose risk. These findings illustrate an urgent need to re-account for the increased burden faced by some sex workers practising harm reduction and attending to overdose events. Greater emphasis on community-based, sex worker-led strategies to prioritise their own and their clients' health and safety is required. This includes the development of culturally-attentive overdose-focused strategies directly informed by the varied experiences of diverse sex workers.

Increased naloxone distribution and expanded low-barrier supervised consumption sites are promising strategies to reduce overdose death. However, given that Canada's overdose crisis is primarily caused by a contaminated drug supply, increased low-barrier access to pharmaceutical-grade drugs could help to reduce some overdose-related deaths among our study population (Tyndall 2018). However, efforts to address overdose-related risks and the root causes of harm faced by sex workers also require broader structural and systematic change, towards ending colonisation, gender and race-based violence, drug prohibition and punitive sex work laws.

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