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Exploring the Public Health Impacts of Private Security Guards on People Who Use Drugs: a Qualitative Study

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ABSTRACT *Private security guards occupy an increasingly prominent role in the policing of private and public spaces. There are growing concerns regarding security guards' potential to shape violence, discrimination, and adverse health outcomes among vulnerable populations, including people who use drugs (PWUD). This is relevant in Vancouver, Canada, where private security guards have increasingly been employed by private organizations to manage public and private spaces, including those within urban drug scenes. This qualitative study sought to understand interactions between PWUD and private security guards and explore their impacts on health care access, risks, and harms among PWUD. Semi-structured interviews were conducted with 30 PWUD recruited from two ongoing prospective cohort studies. Interviews were transcribed and analyzed using a coding framework comprised of a priori and emergent categories. Study data indicate that participants experience pervasive, discriminatory profiling and surveillance by security guards, which exacerbates existing social marginalization and structural vulnerability, particularly among PWUD of Aboriginal ancestry. Participants reported that security guards restrict PWUD's access to public and private spaces, including pharmacies and hospitals. PWUD also reported that their interactions with security guards often involved interpersonal violence and aggression, experiences that served to increase their vulnerability to subsequent risks and harms. Our findings highlight that private security forces contribute significantly to the everyday violence experienced by PWUD within drug scenes and elsewhere and do so in a manner very similar to that of traditional police forces. These findings point to the urgent need for greater oversight and training of private security guards in order to protect the health and safety of PWUD.*

KEYWORDS *Private security, Security guard, Injection drug use, Structural vulnerability, Policing, Health care access, Health disparities*

INTRODUCTION

It has been well established that policing practices contribute significantly to adverse health and social outcomes among structurally vulnerable populations.[1,2] Structurally vulnerable populations, including people who use drugs, occupy marginal positions in social hierarchies as a result of intersecting social-structural inequities,

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such as drug criminalization, poverty, and housing instability.[3] In turn, the marginalized positions of these populations render them susceptible to a wide range of adverse health and social outcomes.[3–5] As a result of their structural vulnerability, people who use drugs (PWUD) experience increased exposure to police and are therefore disproportionately impacted by policing. Previous epidemiological studies have linked diverse police strategies (e.g., crackdowns, spatial policing interventions) to increases in drug-related risks and harms, including unsafe injecting practices (e.g., syringe sharing),[4] HIV transmission,[6] non-fatal and fatal overdoses,[7] and reductions in access to harm reduction and health care services.[4,8]

Ethnographic and qualitative studies have further illustrated how policing strategies function to increase PWUD's vulnerability to harm by constraining their capacity to enact risk reduction, thereby impacting the day-to-day safety and well-being of PWUD. Specifically, these studies have outlined how the risk of arrest and incarceration, as well as routine violence occurring within the context of police interactions, function to perpetuate harm.[9–12] Notably, policing strategies (e.g., surveillance, crackdowns) have been found to foster syringe sharing[9,10,13–15] and rushed injections,[9–11,13,15] while undermining the willingness of PWUD to carry harm reduction supplies.[9,11,13,15,16] Meanwhile, the displacement of PWUD from drug scenes where harm reduction and health services are located has been shown to interrupt access to care.[13,15,17–19] These studies demonstrate how the normalization of routine and, thus, invisible violence occurring within the context of these encounters—what Scheper-Hughes has termed "everyday violence"[20,21]—produce suffering among PWUD.

Although the impacts of police have been well documented, conventional police forces represent only one form of security personnel regularly encountered by PWUD and other structurally vulnerable populations. Explosive growth in private security has occurred over the past two decades;[22–24] in Canada, there are now more than three security guards for every two police officers.[25] These changing dynamics are due, in large part, to the growth of semi-private spaces, such as malls and stadiums, termed "mass private property".[26] An increase in mass private property has coincided with greater use and reliance on these spaces by the wider public and simultaneous growth in the privately controlled policing of these spaces.[26,27] The securitization of mass private property has increased the extent to which all individuals are subject to surveillance and intervention by security personnel. However, structurally vulnerable populations may be more frequently subjected to these forms of socio-spatial control because they lack access to private space and are therefore more likely to rely on mass private property for everyday activities.

Further, the scope of areas patrolled by security guards has also expanded into public spaces (e.g., sidewalks, alleyways). Various groups, such as business improvement associations, regularly deploy security guards to patrol public spaces, particularly in commercial areas in close proximity to structurally vulnerable populations, including PWUD or homeless persons. This is often done with the explicit intention of promoting "public order" to improve marketability and commercial opportunities, often to the detriment of structurally vulnerable populations, and with little formal governmental oversight.[28–31] Importantly, despite private security guards' increasingly prominent role in the policing of spaces and their resulting increased contact with structurally vulnerable populations (including PWUD), the public health impacts of private security on these populations have not yet, to our knowledge, been examined.

Security guards' potential to harm structurally vulnerable populations has become a matter of growing public concern in Vancouver, British Columbia—Canada's third largest city and home to the country's largest drug scene.[32] While provincial legislation and human rights law prohibit discrimination against a person or class of persons on the basis of age, race, gender, sexual orientation, or disability, as well as the use of excessive force by security guards, several prominent examples of security guard brutality toward street-involved populations have garnered recent media attention and prompted public outcry.[33–35] For example, one security guard was charged with assault after knocking an individual onto the ground from his wheelchair with a blow to the head.[33] In response to mounting complaints by street-involved populations, a Vancouver-based legal advocacy group also authored a report suggesting that inappropriate and discriminatory conduct toward these populations by security guards is commonplace in the city.[36]

The aforementioned report generated important insights into the harmful practices of security guards. However, in order to comprehend the overall public health impacts of policing systems—including both traditional police and private security forces—there remains a need to better understand the health and social impacts of security guards on PWUD. Accordingly, this study aimed to explore interactions between PWUD and security guards in Vancouver, with an emphasis on how these interactions shape health risks and harms among PWUD, including their access to health care services.

METHODS

Qualitative interviews were conducted within an ethno-epidemiological research program examining the impact of social-structural influences on risks and harms among PWUD in Vancouver, Canada.[37] Ethno-epidemiological approaches examine how intersecting social-structural influences shape the distribution of health risks and harms by integrating epidemiological and qualitative methods.[38,39] The qualitative component of this research program operates in connection with three ongoing prospective cohort studies comprised of more than 2500 PWUD: the Vancouver Injection Drug Users Study (VIDUS; HIV-negative), AIDS Care Cohort to Evaluate Exposure to Survival Services (ACCESS; HIV-positive), and the At-Risk Youth Study (ARYS). Cohort participants are recruited through outreach and drop-ins at a storefront research office located in Vancouver's Downtown Eastside and Downtown South neighborhoods. Although eligibility criteria for these cohorts center around drug use, cohort participants also experience high levels of housing instability and poverty. Therefore, study findings reflect experiences of not only PWUD but also those affected by wider socioeconomic disparities. Cohort participants complete baseline and semi-annual follow-up questionnaires covering a range of topics relating to individual and social-structural influences on health and risk behaviors, including interactions with security guards. These cohort studies have been described in detail elsewhere.[40–42]

Cohort participants from the VIDUS and ACCESSS studies were eligible to participate in qualitative interviews undertaken as part of this project if they reported recent interactions (within the past 6 months) with security guards during baseline or follow-up surveys completed between December 2012 and March 2014. The lead author contacted eligible participants to invite them to participate, and cohort study staff also scheduled interviews when eligible participants visited the research office for follow-up surveys. Thirty individuals completed semi-structured

interviews between March and November 2014 (see Table 1 for participant demographics). All interviews were conducted by the lead author and audio recorded. Each interview lasted 45 to 75 minutes. While no one refused to participate, some individuals did not show up for scheduled interviews.

Written informed consent was obtained prior to interviews, and the lead author answered any questions about the study. An interview guide was used to facilitate discussion that covered a range of topics, including: experiences of physical or verbal abuse, positive encounters with security guards, responses to surveillance, and understandings of legal rights. The research team met regularly to identify and discuss emerging themes, which informed lines of inquiry in subsequent interviews.

TABLE 1 Participant characteristics

	n (%)
Participant characteristic	*N*=30
Age	
Mean	48 years
Range	30–60 years
Gender	
Male	19 (63 %)
Female	11 (37 %)
Race	
White	17 (57 %)
Aboriginal ancestry	10 (33 %)
Other	3 (10 %)
Current housing	
SRO hotel	16 (53 %)
Apartment	7 (23 %)
Unsheltered	2 (7 %)
Other	5 (17 %)
Substance use (30 days prior to interview)[a]	
Heroin	18 (60 %)
Crack cocaine	11 (36 %)
Crystal methamphetamine	11 (36 %)
Powdered cocaine	7 (23 %)
Other opiates	6 (20 %)
Interactions with security guards (2 years prior to interview)[a]	
Told to move on	25 (83 %)
Verbally abused	18 (60 %)
Chased	13 (43 %)
Searched	9 (30 %)
Property taken	6 (20 %)
Assaulted	5 (17%)
Income generation (2 years prior to interview)[a]	
Social assistance	28 (93 %)
Full- and/or part-time employment	18 (60 %)
Recycling/binning	16 (53 %)
Reselling goods	16 (53 %)
Drug dealing	10 (33 %)
Panhandling	5 (17 %)

[a]Participants were able to select more than one response

Participants received a $30 CAD honorarium as remuneration for their time. Interviews were transcribed verbatim and checked for accuracy by the lead author.

Data were imported into NVivo, a qualitative analysis software program, and coded using a priori categories derived from the interview guide. The research team met regularly to discuss the analysis, and emergent categories were integrated into the coding framework. Interview transcripts were recoded following the establishment of the final categories to ensure their credibility. During thematic analysis, the concepts of structural vulnerability and everyday violence were employed to understand the relationship between themes and sociostructural disparities and to frame how security guard actions produce vulnerability and harm.[43,44] Ethical approval was obtained from the University of British Columbia/Providence Healthcare Research Ethics Board.

RESULTS

Profiling and Discriminatory Surveillance

Participants described how discriminatory surveillance by security guards was a common feature of their everyday activities. Participants reported experiences of surveillance across all spaces occupied in their daily lives, including, but not limited to malls, stores, pharmacies, hospitals, clinics, government offices, public parks and sidewalks, and public transit systems. Although our initial interview guide included questions regarding surveillance, the degree to which participants experienced surveillance and the discriminatory nature of these interactions emerged as salient themes during the interviews and analysis.

Most participants reported that security guards profiled them based on their appearance. Among participants, characteristics associated with extreme poverty, such as lack of access to washrooms and laundry facilities, led to a "*grubby*," "*dirty*," or "*disheveled*" appearance, which they perceived as increasing their likelihood of being profiled by security guards and subjected to discriminatory surveillance. In the words of one participant:

> *People that are having these interactions with security guards* […] *look a little more gaunt, a little less healthy, a little less taken care of.* […] [Guards] *see a person who's either been in trouble or is going to cause trouble.* [Participant #4, White Man, 39 years old]

Participant accounts illustrated how racism intersected with poverty and drug-related stigma to render people of Aboriginal ancestry disproportionately vulnerable to discriminatory surveillance. The following excerpt demonstrates these racialized dimensions of security guard surveillance:

> *I don't know why they're following me. Just 'cause I'm Aboriginal? What the hell? Maybe I looked a little bit rugged, 'cause I was wearing my work clothes…Of course I look dirty—I'm a landscaper.* [Participant #16, Métis Man, 35 years old]
> '*Cause we were First Nations,* [the guard] *followed. And you know, my mom, and my grandma were very well dressed but he still followed them.* [Participant #8, Aboriginal Woman, 57 years old]

For most participants, profiling and surveillance were routine and expected, particularly in commercial and other regulated spaces including health care settings.

Typical experiences of discriminatory surveillance involved being followed, asked to leave public or private spaces, and having security guards request to inspect personal belongings or bags without cause. Participants expressed that these actions were prejudicial, pointing out that they often "*hadn't done anything*" to warrant negative attention from security guards. While some participants reported that it might be possible to minimize profiling by changing their physical appearance (e.g., wearing different clothing), others were reluctant or unable to make such changes to their physical appearance. These participants chose to avoid locations where surveillance was particularly pronounced (e.g., department stores, malls). For example:

> *I've grown accustomed to it* [i.e., surveillance]*…I get followed around. I don't like that, but I'm not going to change my appearance either…What do you think I should look like to be allowed in your store?* […] *Is there a dress code?…I won't regularly go to* [certain stores] *because of their security guards.* [Participant #28, Métis Man, 42 years old]

The Everyday Violence of Security Guard Encounters

Participants described how interactions with security guards were framed by everyday violence, namely physical violence and verbal abuse unfolding in distinctly gendered patterns. Participants reported how security guards assaulted PWUD in private and public spaces, with nearly all participants having witnessed or experienced violence. Physical violence most commonly occurred due to suspected shoplifting, whether real or perceived due to prejudicial surveillance. Some participants reported that they would not return stolen merchandise unless physically apprehended, with one participant noting, "[if] *I have a chance to get away, I'm taking it*." While many participants expressed that security guards "*were just doing their jobs*" if low levels of force were used to apprehend them and retrieve stolen merchandise, participants often reported that violence was excessive and resulted in personal injury. For example:

> *I boosted* [i.e., shoplifted] *some stuff at* [local department store]…[The security guards] *came up behind me, and pushed me down the stairs, and handcuffed me, brought me back inside and beat the living shit outta me while I was handcuffed. When the police came they took one look at me and drove me to the hospital.* [Participant #21, White Man, 55 years old]

Men also routinely experienced physical violence at the hands of security guards when engaged in daily survival activities in public spaces, such as collecting bottles for recycling or sleeping in public spaces. For example, one participant described how security guards subjected him to violence after he was caught sleeping outside:

> [Security guards] *wake you up by kicking you on the bottom of the feet. But they do it really hard…First thing you feel, you're waking up, you're being kicked, so you think you're being attacked.* […] *It's a really rude awakening…like being assaulted.* [Participant #13, White Man, 37 years old]

All participants reported being routinely subjected to verbal abuse, which reinforced their marginal position within social hierarchies. Participants emphasized how security guards spoke to them like they were "*piece*[s] *of shit.*" One participant

described the verbal abuse he experienced as follows: "[The guard] *screams at me* […] *'Move on you dumb addict' or 'you dumb junkie.'*" Participant accounts also illustrated how women were subjected to sexual harassment as a consequence of gendered power relations that subordinate women within the local drug scene. The following excerpt illustrates how these gendered hierarchies resulted in routine sexual harassment in security guard encounters:

> [The security guards are] *insulting, okay, more times than I'd like to admit…Um,* "*Hey baby, how about a blow job?*" *That's very professional. If he said that to you* [i.e., interviewer], *he could lose his job.* [He] *says that to me, him and his boss joke and laugh about it later.* […] *The worst one… he said if I gave him a blowjob, he'd let me have all the cans on the site.* [Participant #9, White Woman, 36 years old]

Restricted Access to Health Care

The everyday violence of security guard encounters reinforced social-structural barriers to health care access and thereby the structural vulnerability of our participants. Participants reported that security guard activities had adversely impacted their access to health services by preventing entry to or removing them from health care spaces, including public hospitals and clinics. Many participants described how they were prejudicially removed from these settings due to their real or perceived non-compliance with behavioral codes of conduct, resulting in the denial of care:

> *They thought I was drunk. I was slurring my words, but I was having a stroke and they kicked me out…They came right up behind me and they said, 'You yelled at this secretary.' I said, 'She keeps asking me the same question over and over, accusing me of being drunk.' 'You have to leave sir. Leave yourself or we'll do it.' Three great big guys so I figured I'd better leave…I passed out on Granville Street and I wound up in* [a different hospital]. [Participant #12, White Man, 59 years old]
>
> *My sister, one time she had a broken arm…I was taking her to the hospital and she was in a lot of pain…The security guard come over and yanked her outta the chair by her broken arm, and she's screaming, and then they threw us both outta the hospital…Took me all this time to get her to the hospital and now she's dragged by the broken arm and thrown out.* [Participant #21, White Man, 55 years old]

Participant accounts illustrated how the actions of security guards also interfered with access to ongoing care, leading to interruptions in necessary treatment for acute infections and chronic diseases, such as injection-related infections and diabetes. For example, one participant described how the tactics employed by hospital security guards resulted in an interruption in intravenous antibiotic treatment for a severe MRSA infection:

> *I would have to go* [to hospital] *at these certain odd intervals like several times a day* [for treatment]*…I guess I was being kind of belligerent complaining about the how long it was taking the service…*[The guards] *basically carried the chair right outside the emergency room and just threw me right into the street and I get up and there's the police paddy wagon there and then they took me to jail.* […] *I*

> *probably missed like a good day's worth of doses.* [Participant #26, White Man, 52 years old]

Many participants emphasized how their experiences with security guards prompted them to avoid hospitals and clinics, further undermining their access to acute health care. For example, one individual participant described how he "*won't go there unless I absolutely have to*" due to concerns about being "*treated as shit*" in the hospital. In turn, this dynamic routinely led to treatment interruptions and delays, which seriously impacted the health of participants.

Constrained Access to Public and Private Spaces

Participant accounts illustrated how discriminatory surveillance intersected with everyday violence to constrain their access to public and private spaces. Most notably, these spaces included pharmacies situated within grocery stores or pharmacy chain stores, which were critical to ongoing disease management and drug treatment (e.g., methadone maintenance therapy, HIV medication). Nearly all study participants reported that security guards had "*tailed*" or "*harassed*" them in commercial spaces inclusive of pharmacies, often from the time they entered the store until they exited. Other participants articulated how they were "*hustled out*" of stores, "*before I even get in there.*" Routine surveillance and harassment, along with the potential for physical violence, made many participants "*so uncomfortable*" that they would leave or avoid particular spaces. For example:

> *The minute I walk in there I had people tailing me through the store. All the way, everywhere…the guys'd be following me. Right to the register. And then they stand there at the register to see…what I'm buying…That really hurts me. That's why I don't go to that* [store] *anymore.* [Participant #22, Aboriginal Man, 60 years old]

Security guards are legally authorized to ask individuals to leave private spaces as long as actions are warranted and not conducted in a discriminatory manner, however, participant accounts demonstrated how PWUD were removed from space in a prejudicial manner. In many regards, PWUD's marginalized status undermined their ability to negotiate access to private and public spaces despite their awareness that security guard actions contravened the law. As one participant explained:

> "*There was a loss prevention officer at* [the pharmacy]*…I went up to him…I told him, I says, 'Hey man, I used to be a loss prevention officer. You gotta get a basket, put cotton balls, just light stuff.'…He turns to me and goes 'Y'know, I could get you kicked out of here.'…I knew he couldn't…But I let it go 'cause I didn't want to get barred from* [the pharmacy]." [Participant #2, White Woman, 49 years old]

Meanwhile, although security guards have no legal right to remove people from public spaces such as sidewalks and parks, almost all participants reported that security guards had sought to remove them from these spaces. Many incidents occurred within the context of income generating activities (e.g., recycling, reselling goods, panhandling). Participants described how security guards seeking to limit public disorder, particularly in areas surrounding businesses, subjected them to violence and harassment to exclude them from these spaces. Participants emphasized

how these actions constrained their income generation opportunities critical to negotiating survival within the context of extreme poverty. For example, the following excerpt illustrates how one individual was subjected to security guard brutality and harassment while engaged in his income-generating activities in public space:

> *They were really giving this girl a hard time 'cause she was panning* [i.e., panhandling] [...] *She was right on the corner so she wasn't on private property...and one of the security guards kicked her out onto the street...It was a borderline assault.* [Participant #1, White Man, 45 years old]

DISCUSSION

Our findings illustrate how many PWUD are subjected to pervasive and prejudicial surveillance by security guards, with those of Aboriginal ancestry most impacted. We found that interactions between security guards and PWUD occurred within a context of heightened surveillance and were framed by everyday violence, which functioned to normalize physical and verbal violence, including sexual harassment. In consequence, PWUD were directly and indirectly excluded from health care and other spaces (e.g., hospitals, stores), as they often avoided these locations in order to limit their exposure to everyday violence. In turn, experiences of exclusion, violence, and aggression negatively impacted PWUD's access to health care services and essential treatments and thus functioned to increase physical injury and social marginalization. Collectively, these findings illustrate that security guards often operate as potent drivers of health-related harm within the broader risk environment of PWUD. This is of significant public health concern given the growing deployment of security guards within public and private spaces, including the regulation of PWUD and "public order" through security personnel.

Previous research has illustrated how structurally vulnerable populations—including racial minorities and low-income populations—are subjected to prejudicial surveillance, interactions, and penalization by traditional police forces.[45–50] Our study documented similar instances of discriminatory surveillance and harassment of PWUD by security guards. Mirroring findings among traditional police forces, our study identified that prejudicial conduct was often racialized and gendered, findings that are also consistent with community legal research on security guard practices in Vancouver.[36] Notably, prejudicial conduct by security guards stands in violation of provincial regulations, which forbid such behavior.

Among people of Aboriginal ancestry, fears of victimization due to racial profiling by security guards were particularly pronounced and reflect distrust in law enforcement and legal systems stemming from punitive law enforcement practices and the ongoing legacy of colonialism and institutionalized racism against Aboriginal people in Canada.[50–53] Similarly, we found that the differential routine experiences of men and women illustrated the intersection of prejudicial security guard practices and gendered power relations that render women disproportionately vulnerable to sexual assault and harassment, and men to physical assault in the context of daily activities. Prejudicial conduct by security guards on any grounds must be addressed through relevant cultural safety and other training for personnel. In instances where prejudicial conduct does occur, it is also imperative that policies

be enacted and enforced, so as to remove any guards who contravene codes of conduct from practice.

In another parallel with traditional policing, we also found that tactics employed by security guards, such as surveillance and violence, function as forms of everyday violence similar to those observed in studies of police activities.[1,2] Our finding that excessive force is commonly employed by security guards toward PWUD builds upon research from around the globe drawing attention to the use of excessive force by police[11,12,51,54,55] and extends these trends into the domain of privatized policing activities. Consistent with previous work, we found that excessive force sometimes resulted in severe personal injury, underscoring the immediate public health impacts of these tactics. Of grave concern, the use of excessive physical force by security guards—a practice that is definitively forbidden by legislation in many settings (including British Columbia)—also represents a human rights violation that warrants immediate legal and policy action. Possible responses include the provision of urgently needed accessible, third-party complaint systems, as well as stringent penalties for security guard abuses. Legal education and support for PWUD may also prove critical in enabling individuals to assert their rights.

In addition to outcomes of everyday violence, our findings demonstrate how security guard conduct functioned to reduce PWUD's health care access, thereby exacerbating their structural vulnerability to adverse health outcomes. Building upon previous research outlining social-structural forces within health care settings that undermine access to care,[37] our findings illustrate how security guards are features of these environments with the potential to interrupt care access and treatment. For example, we found that security guard actions denied access to hospital care, while negatively impacting the willingness of PWUD to seek necessary care in future. Given the disproportionately high burden of disease experienced by PWUD, including high rates of drug-related complications (e.g., infections, overdoses)[56,57] and infectious diseases (e.g., HIV, hepatitis C),[58,59] it is imperative that health care settings implement changes within their governance structures to ensure that the role of security guards is focused only on the de-escalation and protection of those at risk of personal injury, rather than policing who has access to care. Without such changes, barriers to care have the potential to produce serious adverse health outcomes and undermine broader public health goals.

Finally, our findings demonstrate how actions taken by security guards also served to exclude participants from other health care settings—namely pharmacies—critical to treatment regimens for complex and co-morbid conditions (e.g., anti-retroviral therapy, methadone maintenance therapy). In the context of chronic health conditions such as HIV and hepatitis C infection, as well as methadone maintenance therapy for opioid dependence,[60] regular, uninterrupted access to medication dispensaries is critical for successful treatment regimens. In previous studies of traditional police forces, spatial exclusion stemming from policing practices has been shown to reduce access to health and harm reduction services among PWUD,[4,8,17–19] outcomes likely produced by similar behavior by security guards. Indubitably, spatial restrictions in care settings further demonstrate the public health imperative to reshape security guard conduct in spaces crucial to the health of PWUD.

This study has several limitations. First, this study was undertaken in Vancouver, Canada, and findings might not reflect the experiences of PWUD in other settings. Furthermore, participants selected for this study had all interacted with security guards during the previous 6 months. Their experiences may not be representative of

other PWUD who come into contact with security guards less frequently. Finally, because we did not observe security guard interactions or interview security guards, our findings do not integrate the perspectives of individuals who provide security services and, therefore, may not account for all factors that shape interactions between PWUD and security guards. Further research is required to understand the experiences of security guards and inform effective solutions to security guard brutality.

Despite these limitations, our findings illustrate how security guard tactics reproduce harms similar to those stemming from policing practices among PWUD, including spatial exclusion, violence, and reduced health care access. Improved complaint filing systems and more stringent penalties for misconduct are urgently needed to reduce the potential for security guard violence, as well as to increase accountability. Improvements in training are also needed to ensure that security guards do not prejudicially target PWUD, particularly those of Aboriginal ancestry. Importantly, our findings are unique in demonstrating how such changes are needed not only to limit abuses but also to improve public health.

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REFERENCES

1. Werb D, Rowell G, Guyatt G, Kerr T, Montaner J, Wood E. Effect of drug law enforcement on drug market violence: a systematic review. *Int J Drug Policy*. 2011; 22(2): 87–94.
2. Kerr T, Small W, Wood E. The public health and social impacts of drug market enforcement: a review of the evidence. *Int J Drug Policy*. 2005; 16(4): 210–220.
3. Quesada J, Hart LK, Bourgois P. Structural vulnerability and health: Latino migrant laborers in the United States. *Med Anthropol*. 2011; 30(4): 339–362.
4. Wood E, Spittal PM, Small W, et al. Displacement of Canada's largest public illicit drug market in response to a police crackdown. *Can Med Assoc J*. 2004; 170(10): 1551–1556.
5. McNeil R, Kerr T, Anderson S, Maher L, Keewatin C, Milloy MJ, Wood E, Small W. Negotiating structural vulnerability following regulatory changes to a provincial methadone program in Vancouver, Canada: a qualitative study. *Soc Sci Med*. 2015; 133: 168–176.
6. Friedman SR, Cooper HLF, Tempalski B, Keem M, Friedman R, Flom PL, Des Jarlais DC. Relationships of deterrence and law enforcement to drug-related harms among drug injectors in U.S. metropolitan areas. *AIDS*. 2006; 20: 93–99.
7. Bohnert AS, Nandi A, Tracy M, et al. Policing and risk of overdose mortality in urban neighborhoods. *Drug Alcohol Depend*. 2001; 113(1): 62–68.
8. Beletsky L, Heller D, Jenness SM, Neaigus A, Gelpi-Acosta C, Hagan H. Syringe access, syringe sharing and police encounters among people who inject drugs in New York City: a community-level perspective. *Int J Drug Policy*. 2014; 25(1): 105–111.
9. Maher L, Dixon D. The cost of crackdowns: policing Cabramatta's heroin market. *Current Issues in Criminal Justice*. 2001; 13(1): 5–22.

10. Aitken C, Moore D, Higgs P, Kelsall J, Kerger M. The impact of a police crackdown on a street drug scene: evidence from the street. *Int J Drug Policy*. 2002; 13: 193–202.
11. Sarang A, Rhodes T, Sheon N, Page K. Policing drug users in Russia: risk, fear and structural violence. *Subst Use Misuse*. 2010; 45(6): 813–864.
12. Cooper H, Moore L, Gruskin S, Krieger N. Characterizing perceived police violence: implications for public health. *Am J Public Health*. 2004; 94(7): 1109–1118.
13. Small W, Kerr T, Charette J, Schechter MT, Spittal PM. Impacts of intensified police activity on injection drug users: evidence from an ethnographic investigation. *Int J Drug Policy*. 2006; 17(2): 85–95.
14. Rhodes T, Mikhailova L, Sarang A, et al. Situational factors influencing drug injecting, risk reduction and syringe exchange practices in Togliatti City, Russian Federation. *Soc Sci Med*. 2003; 57: 39–54.
15. Maher L, Dixon D. Policing and public health: law enforcement and harm minimization in a street-level drug market. *Br J Criminol*. 1999; 49: 488–508.
16. Cooper H, Moore L, Gruskin S, Krieger N. The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: a qualitative study. *Soc Sci Med*. 2005; 61(3): 673–684.
17. Davis CS, Burris S, Kraut-Becher J, Lynch KG, Metzger D. Effects of an intensive street-level police intervention on syringe exchange program use in Philadelphia, Pa. *Am J Public Health*. 2005; 95(2): 233–236.
18. Shannon K, Rusch M, Shoveller J, Alexson D, Gibson K, Tyndall MW. Mapping violence and policing as an environmental-structural barrier to health service and syringe availability among substance-using women in street-level sex work. *Int J Drug Policy*. 2008; 19(2): 140–147.
19. McNeil R, Cooper H, Small W, Kerr T. Area restrictions, risk, harm, and health care access: a spatially oriented qualitative study. *Health Place*. 2015; 35: 70–78.
20. Bourgois P, Prince B, Moss A. The everyday violence of hepatitis C among young women who inject drugs in San Francisco. *Hum Organ*. 2004; 63(3): 253–264.
21. Scheper-Hughes N. Small wars and invisible genocides. *Soc Sci Med*. 1996; 43(5): 889–900.
22. Shearing CD, Stenning PC. Modern private security: its growth and implications. *Crime Justice*. 1981; 3: 193–245.
23. Rikagos G. *The new parapolice: risk markets and commodified social control*. Toronto, Ontario: University of Toronto Press; 2002.
24. Button M. *Private Policing*. Portland, Oregon: Willan Publishing; 2002.
25. Li G. Private security and public policing. Juristat – December 2008. http://www.statcan.gc.ca/pub/85-002-x/2008010/article/10730-eng.htm Published December, 2008. Modified March 12, 2009. Accessed May 16, 2015.
26. Button M. Private security and the policing of quasi-public space. *Int J Sociol Law*. 2003; 31(3): 227–237.
27. Mitchell D. *Right to the city: social justice and the fight for public space*. New York, New York: The Guilford Press; 2003.
28. Wakefield A. The public surveillance functions of private security. *Surveill Soc*. 2005; 2(4): 529–545.
29. Amster R. Patterns of exclusion: sanitizing space, criminalizing homelessness. *Soc Just*. 2003; 30(1): 195–221.
30. Cook PJ, MacDonald J. Public safety through private action: an economic assessment of BIDS. *Econ J*. 2001; 121(552): 445–462.
31. MacDonald J, Stokes RJ, Grunwald B, Bluthenthal R. The privatization of public safety in urban neighborhoods: do business improvement districts reduce violent crime among adolescents? *Law & Soc'y Rev*. 2013; 47(3): 621–652.
32. Wood E, Kerr T. What do you do when you hit rock bottom? Responding to drugs in the city of Vancouver. *Int J Drug Policy*. 2006; 17(2): 55–60.

33. B.C. guard seen in wheelchair takedown charged with assault. CBC News. March 28, 2013. http://www.cbc.ca/news/canada/british-columbia/b-c-guard-seen-in-wheelchair-takedown-charged-with-assault-1.1374084. Accessed May 16, 2015.
34. Home Depot security guard Ali Rahnumah charged in shoplifter beating. CBC News. January 12, 2015. http://www.cbc.ca/news/canada/british-columbia/home-depot-security-guard-ali-rahnumah-charged-in-shoplifter-beating-1.2898440. Accessed May 16, 2015.
35. Burgmann T. Downtown Vancouver Ambassadors discriminated against homeless. CBC News. April 11, 2015. http://www.cbc.ca/news/canada/british-columbia/downtown-vancouver-ambassadors-discriminated-against-homeless-1.3029392. Accessed May 16, 2015.
36. Bennet D, Eby D, Richardson J, Tilley K. *Security before justice: a study of the impacts of private security on homeless and under-housed Vancouver residents*. Pivot Legal Society; 2008. Available at http://d3n8a8pro7vhmx.cloudfront.net/pivotlegal/legacy_url/253/securitybeforejustice.pdf?1345765598. Accessed May 16, 2015.
37. McNeil R, Small W, Wood E, Kerr T. Hospitals as a 'risk environment': an ethno-epidemiological study of voluntary and involuntary discharge against medical advice among people who inject drugs. *Soc Sci Med*. 2014; 105C: 59–66.
38. Lopez AM, Bourgois P, Wenger LD, Lorvick J, Martinez AN, Kral AH. Interdisciplinary mixed methods research with structurally vulnerable populations: case studies of injection drug users in San Francisco. *Int J Drug Policy*. 2013; 24(2): 101–109.
39. Wagner KD, Davidson PJ, Pollini RA, Strathdee SA, Washburn R, Palinkas LA. Reconciling incongruous qualitative and quantitative findings in mixed methods research: exemplars from research with drug using populations. *Int J Drug Policy*. 2012; 23(1): 54–61.
40. Strathdee SA, Patrick DM, Currie SL, et al. Needle exchange is not enough: lessons from the Vancouver injecting drug use study. *AIDS*. 1997; 11(8): F59–F65.
41. Wood E, Montaner JS, Yip B, et al. Adherence and plasma HIV RNA responses to highly active antiretroviral therapy among HIV-1 infected injection drug users. *Can Med Assoc J*. 2003; 169(7): 656–661.
42. Wood E, Stoltz J, Montaner JS, Kerr T. Evaluating methamphetamine use and risks of injection initiation among street youth: the ARYS study. *Harm Reduct J*. 2006; 3(1): 18–24.
43. Farmer P. *Pathologies of power: health, human rights, and the new war on the poor*. Berkeley, California: University of California Press; 2003.
44. Scheper-Hughes N. *Death without weeping: the violence of everyday life in Brazil*. Berkeley, California: University of California Press; 1992.
45. Ruddell R, Thomas MO, Patten R. Examining the roles of the police and private security officers in urban social control. *Int J Police Sci Manag*. 2011; 13(1): 54–69.
46. Berti M, Sommers J. "The streets belong to people who pay for them": the spatial regulation of street poverty in Vancouver, British Columbia. In: Crocker D, Johnson VM, eds. *Poverty, regulation, and social justice: readings on the criminalization of poverty*. Canada: Fernwood Publishing; 2010: 60–74.
47. Chesney CT, Bellot C, Sylvestre M. Taming disorderly people one ticket at a time: the penalization of homelessness in Ontario and British Columbia. *Can J Criminol Crim*. 2013; 55(2): 161–185.
48. Fitzpatrick KM, Myrstol B. The jailing of American's homeless: evaluating the rabble management thesis. *Crime Delinq*. 2001; 57(2): 271–297.
49. Brunson RK. "Police don't like black people": African-American young men's accumulated police experiences. *Criminol Public Policy*. 2007; 6(1): 71–101.
50. Wortley S. Hidden intersections: research on race, crime and criminal justice in Canada. *Canadian Ethnic Studies Journal*. 2003; 35(3): 99.
51. Pan SW, Christian WM, Pearce ME, et al. The Cedar Project: impacts of policing among young Aboriginal people who use injection and non-injection drugs in British Columbia. *Int J Drug Policy*. 2013; 24(5): 449–459.

52. Cuneen C. The criminalization of Indigenous people. In: Das Gupta T, James CE, Maaka RC, Galabuzi G, Andersen C, eds. *Race and racialization: essential readings*. Toronto, Ontario: Canadian Scholars' Press Inc; 2007: 266–274.
53. Hylton JH. The justice system and Canada's Aboriginal peoples: the persistence of racial discrimination. In: Chan W, Mirchandani K, eds. *Crimes of colour: racialization and the criminal justice system in Canada*. Ontario, Canada: Broadview Press, 2002: 139–156.
54. Hayashi K, Ti L, Csete J, et al. Reports of police beating and associated harms among people who inject drugs in Bangkok, Thailand: a serial cross-sectional study. *BMC Public Health*. 2013; 13: 733.
55. Ti L, Wood E, Shannon K, Feng C, Kerr T. Police confrontations among street-involved youth in a Canadian setting. *Int J Drug Policy*. 2013; 24: 46–51.
56. Seal KH, Kral AH, Gee L, et al. Predictors and prevention of non-fatal overdose among street-recruited injection heroin users in the San Francisco Bay Area, 1998–1999. *Am J Public Health*. 2001; 91(11): 1842–46.
57. Binswanger IA, Kral AH, Bluthenthal RN, Rybold DJ, Edlin BR. High prevalence of abscesses and cellulitis among community-recruited injection drug users in San Francisco. *Clin Infect Dis*. 2000; 30(3): 579–81.
58. Patrick DM, Tyndall MW, Cornelisse PG, et al. Incidence of hepatitis C virus infection among injection drug users during an outbreak of HIV infection. *Can Med Assoc J*. 2001; 165(7): 889–95.
59. Public Health Agency of Canada. HIV/AIDS Epi Update—Chapter 1: National HIV Prevalence and Incidence Estimates for 2011. http://www.phac-aspc.gc.ca/aids-sida/publication/epi/2010/1-eng.php. Published October 2014. Accessed May 23, 2015.
60. Noysk B, Anglin MD, Brissette S, et al. A call for evidence-based medical treatment of opioid dependence in the United States and Canada. *Health Affair*. 2013; 32(8): 1462–1469.