SITUATING "EVIDENCE" AND CONSTRUCTING USERS: COMMUNICATIVE AUTHORITY AND THE PRODUCTION OF KNOWLEDGE IN HARM REDUCTION EVALUATION

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Abstract

Despite thirty published evaluation reports citing the effectiveness of Vancouver’s safe injection site (Small 2008), the Canadian federal government refuses to endorse safe injection sites as a health service option available to injection drug users (IDUs). Insite’s evaluation results are undergoing debate, because two communicative spheres of knowledge, each with a unique authoritative language, are conflicting as each is attempting to gain moral authority over the right to recontextualize drug users. Drawing on a literature review of two harm reduction programs in Vancouver, Insite and Sheway, and expert interviews with evaluators, I show that what constitutes “evidence” is in fact subjective, determined by spheres of communicability that are built upon social, professional and political contexts. To confront the problematic nature of this issue, I suggest that evaluators and overseers need to treat program evaluation as a process of negotiation, best approached in a fluid manner. By obscuring multiple user experiences in the evaluation of harm reduction programs, evaluators and overseers risk imposing their communicative ideologies on what it means to be a drug user.
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Introduction

Vancouver, British Columbia, is one of North America’s leading cities in designing innovative health programs based on a harm reduction philosophy. Most discussed of these programs is Insite, a program that allows drug users to inject illicit substances under the supervision of nursing staff. Despite thirty published evaluation reports citing the effectiveness of Insite (Small 2008), the Canadian federal government refuses to endorse the use of safe injection sites (SISs), as a health service option available to IDUs. At the root of this divide, are two opposing ideological positions, each differing in how they view drug users. The supporters of Insite claim that injection drug users (IDUs) are deserving of non-judgemental healthcare support. Meanwhile, the view that the federal government adheres to is that drug users are weak individuals, best dealt with using punitive measures. In regards to the evaluation of Insite, this debate over who a “drug user” is, has produced a lack of consensus on what should constitute “evidence”, and further suggests that what is required as evidence may be politically determined (Gordon 2006; Small 2007). Intrinsically, this renders evaluations of harm reduction programs as problematic.

In what follows, I will show how the evaluations of harm reduction programs are open to debate because of competing ideologies that influence the situating of “evidence”, pieces of information used to draw conclusions about the program’s effectiveness. I will also demonstrate the value of using anthropological theory and methods in program evaluation. Specifically, I will apply Charles Brigg’s framework of communicability to the realm of addiction research and program evaluation. Communicability, as defined by Briggs (2005:270) is the productive capacity of “ideologies of communication in producing subjectivities, organizing them hierarchically, and recruiting people to occupy them.” Using
these theories, I argue that program evaluators work with specific communicative ideologies that create subjectivities, which are not necessarily the same as the overseers or users. Because of these inherent subjectivities, I suggest that program evaluation is essentially a process of negotiation, which evaluators should approach in a fluid manner. By denying this and by ignoring user involvement in the evaluation of harm reduction programs, evaluators risk imposing their subjectivities on what it means to be a drug user.

The first section provides a brief background to harm reduction and it outlines the debate over the evaluation of Insite. It will also describe the role that anthropology has played in the practice and study of program evaluation.

The second section is devoted to outlining Brigg’s theoretical framework of communicability. I will then apply Brigg’s framework to the debate over Insite. Specifically, I will describe the two dominant communicative ideologies in the debate in terms of how each constructs who a drug user is. I will take the position, that in a society defined by institutional accountability, evaluators play a vital role in translating and de/recontextualizing user experiences. Therefore, intrinsically, evaluators are producing new knowledge about what it means to deal with various disorders, such as substance addiction.

The third section will exemplify how communicative ideologies further create subjectivities, which influence how each ideology decides what should count as “evidence”. To accomplish this, I will explore the nature of evidence-based medicine and the evaluation efforts of Insite. Additionally, I will describe how Insite’s evaluators and their opponents have different ideas of what should indicate program “success/failure”.

The fourth section describes the evaluation of another harm reduction program in Vancouver, The Sheway Project, which provides services to women dealing with substance
abuse and other related problems and their families. Here, I will describe Nancy Poole’s (2000) evaluation of Sheway and her use of a methodology that privileges user narratives and empowerment. With this philosophy, I suggest that by incorporating multiple perspectives, especially those of the users, Poole uses a fluid evaluation process.

The paper’s conclusion serves to draw out some of the major implications that communicability and discursive authority have in program evaluation. For Insite, I will argue that two competing ideologies are re/decontextualizing what it means to be a drug user, which may be obscuring the realities of those who use the program. To address this concern, I will examine the role that evaluators, as audience, play in constructing the reality of program users and the potential benefit that user involvement can have in evaluation.

**Harm Reduction and Vancouver’s Safe Injection Site**

Designed as a response to the problem of HIV/AIDS among injection drug users, harm reduction (also called risk reduction or harm minimization) has become an important approach to drug policy research over the last twenty-five years (Moore and Fraser 2006; Roe 2005). Harm reduction evolved due to the idea that IDUs are vulnerable to an array of health concerns, not only infectious diseases such as HIV and hepatitis C, but also; endocarditis (inflammation of heart valves), osteomyelitis (bone inflammation), abscesses and high rates of overdose mortality (Stoltz et al. 2007). In addition to lowering the physical risk faced by IDUs, harm reduction researchers also noted that:

[H]arm reduction did not simply entail the introduction of practices which promised to reduce the risk of HIV transmission, but ...also — at least implicitly — reflected a view of drug users which no longer was based solely on notions of pathology and deviance. (Butler 2002:190)
With this “new” conceptualization of the drug user, public health workers placed the values of harm reduction on pragmatic and humanistic solutions to drug abuse, with the goal of reducing harm, rather than reducing drug use per se (Ritter and Cameron 2006).

Building on an image of a drug user who is more than a social deviant, the Insite program opened in 2003, thus becoming the first medically supervised safer injection facility in North America. Insite provides IDUs the ability to inject pre-obtained illicit drugs under the supervision of a nurse, receive addiction counselling, access guidance regarding safer injection practices and receive clean injecting equipment (Stoltz et al. 2007). In order to ensure Canada’s compliance with international drug treaties, the federal government, at this time led by the Liberal Party of Canada, granted Insite a temporary legal exemption, with the condition that the program be rigorously evaluated. The operators of Insite gave this task to a team of researchers from British Columbia’s Center for Excellence in HIV/AIDS. Because Insite is an innovative project, one of the main deliverables that the operators are receiving from the evaluation is justification of its existence and the resources spent on it.¹ According to Insite’s evaluators, the program’s ability to promote less injection in public spaces and a variety of safer injecting practices proves its effectiveness (Wood et al. 2006; Stoltz et al. 2007). In addition, the evaluators of Insite have noticed that Switzerland, Germany, Spain and the Netherlands have produced a body of work that further supports the medical use of heroin treatment for the most difficult patients addicted to opiates (Small and Drucker 2006).

Despite all this available “evidence”, the Canadian government, led by Stephen Harper’s Conservative Party, continue to oppose the conclusions of Insite’s evaluation and the idea of safe injection sites altogether. Furthermore, they plan to contest a recent Supreme Court of

¹ In most cases where a program is free from controversy, program evaluations provide operators with a positive critique that may be used to make improvements to the program or appropriate use of available resources.
British Columbia decision, which provides Insite a permanent constitutional exemption from prosecution under federal drug laws.

Due to the federal government's strong opposition to safe injection sites, the evaluators and supporters of Insite have become concerned about the political interference of scientific reviews. For instance, the protocol for the Scientific Evaluation of Supervised Injecting (SEOSI) cohort,² which is a group of users set up to provide key data in Insite's evaluation, was denied continuation by the federal government in October of 2007, with no explanation given. This occurred even though the Health Canada's comments on the protocol were very positive. To illustrate, those on the Health Canada's review board had comments such as:

I consider this proposal to be superb and of extremely high importance... The research team has, to date, produced extremely valuable research results... They propose to continue data collection and evaluation, and I have confidence they can do so successfully. (SEOSI reviewers quoted in Wood et al. 2008:222)

Coinciding with their rejection of the SEOSI, the federal government also imposed a moratorium on new SIS research for the rest of Canada. The cities of Victoria and Toronto had to halt plans to set up similar programs. In addition, the government opened up a new competition for SIS research. However, Health Canada made contracts available only to researchers who agreed not to disseminate their findings in any manner, until six months after the current legal exemption has expired, which is extremely uncommon for research grants in Canada. Seeing this move as offering up federal "gag order" money, the Insite evaluation team refused to apply for a grant, as their legal and ethical consultants, at the University of British Columbia, deemed the requirements unethical (Howell 2007; Wood et

² The Scientific Evaluation of Supervised Injecting (SEOSI) cohort, consisting of over 900 individuals, was randomly recruited to provide a representative sample of Insite users.
al. 2008). Thomas Kerr, one of Insite’s main evaluators along with Evan Wood and Mark Tyndall, stated in the media:

> We could produce an analysis showing that there’s been a huge reduction in some type of health outcome and then have the minister stand up and say once again the research has shown nothing—and we’re supposed to sit there and not say anything...It was a very politically motivated contract, and we just couldn’t do it. We just don’t work that way. (Howell 2007:14)

The Insite evaluators have acquired funding from other sources. However, they see this as further proof of a gap between best evidence and actual policy, arguing that policy needs to follow the principles of evidence-based medicine (Wood et al. 2008).³

**Anthropology and Program Evaluation**

One of the most important applications of anthropological knowledge is in the field of program evaluation. Applied anthropologists have worked with, or served as, evaluators for several decades (Erwin 1997; Van Willigen 1993). Even though these anthropologists are still attempting to legitimize their involvement in the evaluation process (Camino 1997), they have shown the importance of treating values as social facts, rather than noise to be eliminated (Butler 2005), using qualitative methods to capture a “programs culture” (Patton 2005), and engaging participants in the evaluation process (Agar 1996). In addition, these anthropologists have drawn attention to the role of power in evaluations. For instance, they have questioned whose values inform the priority issues and which are used to draw conclusions (Harklau and Norwood 2005; Patton 2005). The recognition of anthropology’s importance to evaluation, has led a small group of anthropologists in the United States to

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³ Cartesian dualistic thinking as a guiding premise in clinical medicine is evident here. This suggests a fundamental opposition between mind and body or real and unreal. The supporters of Insite commonly argue that the federal government’s view of SIS is based on ideology, where theirs is on science, as if it represents an ultimate truth and thus is beyond questioning.
coin the term “evaluation anthropology” (Copeland-Carson and Butler 2005a; 2005b). To date, they have worked to promote the use of anthropological methods in the evaluation process, and they have argued the importance of maintaining a theoretical perspective, to allow contributions to social theory.

Recently, another small group of anthropologists has examined the workings of a conceived ‘audit culture’, a topic that is intrinsically related to program evaluation. Building on earlier discussions on accountability as being the general fabric of human interchange (see Douglas 1992), anthropologists such as Strathern (2000a) have examined how institutions create an audit culture that determines the allocation of resources, in a space where moral and financial interests meet to render accountability. Strathern (2000a:1) notes that only certain practices take the form that will convince and persuade those to whom accountability is being rendered. Although much discussion concerning audit cultures is directed towards anthropology as a discipline, thus invoking self-reflexivity, it is relevant in numerous contexts, such as in medical and legal institutions. If we accept Strathern’s notion of an “audit culture”, then it becomes appropriate to relate key discussions on government surveillance, policy (Shore and Wright 1997) and power,4 to program evaluation. For instance, Strathern (2000a:4) notes that some governments have explicitly defined the practices whereby people check themselves and then they withdraw to a position where they can just simply review the resultant indicators.5 Ultimately, the literature on audit cultures looks at the ways that audits and ethics are restructuring social expectations in a manner that creates new principles of organization (Strathern 2000b). Power (1994) argues that this

\[4\] Within anthropology, power is typically defined as the exercise of force or control over individuals or particular social groups by other individual or groups. The writings of Michel Foucault (1973; 1977) have been particularly influential in anthropology, especially his interest in power as enacted through knowledge and discourse.

\[5\] Related to this observation, is Hertzfeld’s (1992) concept of “bureaucratic indifference” and evasion.
social reorganization includes a major shift in power, from the public, teachers and managers, to the professionals and overseers.\(^6\)

**Research Methods**

From September 2007 to June 2008, I critically reviewed program evaluations and subsequent reports on the Insite program and the Sheway project. For Insite, this included approximately thirty sources of peer-reviewed articles based on its ongoing evaluation efforts. For Sheway, I examined evaluations reports by Nancy Poole (2000) and Marshall et al. (2003; 2005). In each report, I analysed how the evaluators view the users of the program, how they determined “evidence”, how they utilized methodology, how they dealt with values and finally, how they responded to overseers. Living in close proximity to Insite and Sheway provided me an opportunity to observe public and professional discourse surrounding these programs. I was able to observe the debate over the “worth” of harm reduction programming as discussed in related conferences, newspaper articles, journal editorials\(^7\) and governmental reports.

In addition to examining evaluation reports and related literature, I interviewed one individual who is involved in the Insite evaluation and one individual who has previously evaluated the Sheway Project.\(^8\) Both interview participants had substantial experience in program evaluation and in the field of public health.

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\(^6\) In regards to the individuals living in poverty in Vancouver, I see their needs and “lived experience” as being removed from the government’s assessment of Insite.

\(^7\) The evaluators of Insite have been very active in advocating the worth of the program beyond the usual activity of just disseminating the results. They have written numerous commentaries and editorials responding to critics of safe injection sites and the government’s treatment of the scientific process.

\(^8\) I received ethical approval from the University of British Columbia’s BREB; both participants signed a consent form and agreed to be audio-recorded.
To scrutinize the evaluation documents, surrounding rhetoric in media/literature and interview transcripts, I made use of discourse analysis techniques as described by Quinn (2005) and Hill (2005). To clarify, I consider discourse to be language in use, either spoken or written, and a place where culture is both enacted and produced (Hill 2005; Quinn 2005; Briggs 1986). Therefore, discourse is an appropriate place where cultural knowledge can be reconstructed (Quinn 2005).  

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9 It was my goal to capture glimpses of a culture of evaluation. To date, I am aware of no comprehensive ethnographic data that captures user-level opinions of the assumptions of harm reduction, evidence-based medicine, or evaluation. This paper points to a need for further research in this area.
The Evaluation of Insite: Looking at Communicability and Discursive Authority

Insite's evaluation results are undergoing debate because the evaluators and the federal government, each utilizing a distinct system of knowledge, are conflicting as they attempt to gain moral authority over substance addiction. In doing so, each side is privileging a distinct image of a drug user and are projecting this image in various communicative outlets, including newspaper stories, editorials and evaluation reports. To understand issues of authority and values in program evaluation, Charles Briggs (2005; 2007) idea of communicability is a useful theoretical tool.

Briggs, a linguistic/medical anthropologist, recently proposed the idea of communicability, as a theoretical model to explore how knowledge is disseminated in society. Noting that the dissemination of medical knowledge involves not just discourse but their ideological constructions as well, Briggs proposed a "model for analyzing the power of ideologies of communication in producing subjectivities, organizing them hierarchically, and recruiting people to occupy them (Briggs 2005:269). More concisely defined as the productive capacity of discourses to map themselves, circulate, and be received by individuals in society, Briggs (2007:332) claims that:

Communicability suggests volubility, the ability to communicate readily and be understood transparently, and microbes' capacity to spread. I add the sense of infectiousness — the ability of communicative ideologies to find audiences and locate them socially and politically. In invoking the notion of "communicability," I am not suggesting that such ideological constructions universally project transparency, volubility, and infectiousness, as the usual sense of the term would suggest. The term rather points to the way that texts project specific, unique cartographies of their own locations in the movement of discourse.

This conception of how ideologies spread can be useful in studying what Briggs refers to as spheres of communicability. Put simply, I see these as systems of knowledge, which guide
how actors understand and act within their social world. Within biomedicine, some of the most powerful spheres of communicability include HIV/AIDS, genetics and SARS. Communicative spheres, such as these, are necessary “for the creation and maintenance of boundaries, and for the regulation of membership... [and] like publics, are multiple, competing, overlapping, and shifting” (Briggs 2005:274).

From Brigg’s definition, we can relate communicability to evaluation. In program evaluations, evaluators, users, and overseers each have ideological constructions, or what Briggs calls communicative cartographies, which are not necessarily identical to one another, or equally authoritative. Therefore, Brigg’s framework is an effective means to identify and study how individuals in program evaluation use certain cartographies, based on overlapping communicative spheres, to produce values, struggle for discursive authority and attempt to align audiences to believe in their position.

Who makes up the audience for program evaluations? Donald Brenneis’s (1986) work on audience, indirection and meaning helps clarify this question. In this work, Brenneis makes a distinction between primary and secondary audiences. Brenneis defines a primary audience as an individual or group to whom a performance is chiefly directed. In the evaluation of Insite, the primary audiences are the local policy makers, the federal government and Insite’s operators. Similarly, Brenneis describes a secondary audience as those who are present or likely to hear about things later, which for Insite’s evaluation, includes the public and the facility’s users. Brenneis (1986) claims that indirectly, “audiences not only shape talk but are actively involved in defining how it is to be understood” (Brenneis 1986:339). However, when powerful communicative ideologies are active, the ability of audiences to participate in the creation of new meanings varies. As I
will elaborate, in many evaluations, primary audiences, especially when they are the sponsor, influence how evaluators carry out their evaluations, by imposing interpretive frameworks, guidelines or restrictions. Whereas, those individuals/groups that make up secondary audiences, even when they have a stake in the results, often lack the authority to influence how evaluations proceed.

Drawing on the work of Bourdieu, Briggs points out that communicability is intrinsically productive. Similar to medicalization and racialization, communicability involves control over the production, circulation and reception of discourses, which are structured by inequalities of power and resources (Briggs 2005). Such inequalities can be as simple as differential access to communicative technologies such as phones, or more complex, such as symbolic capital granted in schools of medicine. However, the ability of a communicative ideology, or sphere, to spread, depends on how much discursive or communicative authority that it can claim. To elaborate, Bourdieu (1991) suggests that forms of communicative competence constitute symbolic capital that organizes individuals and populations in social hierarchies. Bourdieu also claims that institutions reproduce this hierarchy by controlling access to sites for acquiring competence. In a biomedical setting, special institutional training provides health professionals with discursive capital and the right to use biomedical language. Since the majority of drug users and homeless in society lack the symbolic capital to have their voices heard, they rely on health professionals to listen and at times, speak for them. In these cases, program evaluations provide an opportunity for these individuals to communicate whether a certain program meets their needs. In turn, health professionals can use this user knowledge to introduce new ideas about which interventions work and which do not.
This idea that evaluations are important in the production of knowledge was a common theme in my interviews with professional evaluators. Both participants commented that addressing social suffering was a source of motivation for them, rather than simple accountability to their employers. To exemplify, the Sheway participant claimed that they “very much hoped for being able to bring about some social change agenda and rethinking policy and practice” [RL 06/06/08]. The Insite evaluator commented on a similar goal, but also acknowledged their privileged position to do so employing the authority of science to provide credibility to this endeavour:

I value the scientific system...[and] we have evidence of things that work and they remain poorly supported...and it is frustrating as a scientist, because [of] again being someone who really values the role that science should play in directing policy. [BM 05/22/08]

Comments such as these suggest that the evaluators acknowledge their role as being beyond just determining the worth of the particular programs, but also to reconceptualise what it means to suffer from addiction. To accomplish this task, they rely on the communicative authority, which their public health training provides them. However, we must notice that in such evaluations, evaluators/reviewers often translate user-derived information into a scientific language to give it “communicative weight”. In this translation, the evaluator’s communicative cartography becomes visible, as it is producing a new construction of the drug user in its own image. In the case of Insite, the evaluators are using biomedical knowledge to ‘medicalize’ IDUs, thus creating new definitions about the body and drug use – also changing social and political forces along with them (Conrad 1992).

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10 In many cases, it seems like the evaluator simply hands over the results to the overseer and hopes they will do something appropriate with it.
Communicative Ideologies, Constructed users

Program evaluation is an important site where people produce and receive discourse (see Briggs 1998). In the context of contending language ideologies, this productive capacity becomes especially visible. In the case of Insite, where contending narratives have come into conflict, we can observe how they provide a fundamental basis for the creation of social community and the social construction of reality (Comaroff and Roberts 1981; Briggs 1992). In addition, we can observe how authority and the right to speak are under active negotiation (Brenneis 1996) as each side attempts to delegitimize competing ideologies (Briggs 1998).

This productive nature of competing ideologies influences how evaluators and overseers interpret results and how they construct program users. The analysis of media stories, editorials and evaluation reports on Insite, reveals two separate communicative cartographies, each conveying different images of the injection drug user. The Insite evaluators, using clinical and harm reduction communicative spheres, are creating a “new” image of the addict. They argue for a view of drug users who are not responsible for their addictions and who are deserving of social support. Whereas, the well-established ideology of the federal government/RCMP, view drug users as weak individuals, who need heavy-handed approaches to curb their addictions.

To understand how the current federal government views the users of Insite, requires the examination of media stories, as this is where the government has been most vocal on the subject. Harper and his Minister of Health, Tony Clement, have stood against the principles
inherent in harm reduction, arguing that abstinence needs to be the first step.\textsuperscript{11} To illustrate, the Globe and Mail (2007a) has quoted Stephen Harper as saying:

I remain a skeptic that you can tell people that we won’t stop the drug trade, we won’t get you off drugs, we won’t even send messages to discourage drug use but somehow we will keep you addicted but reduce the harm just the same...if you remain an addict, I don’t care how much harm you reduce, you’re going to have a short and miserable life.

Furthermore, Harper’s federal government has claimed publicly, that “what we’re up against” is a perceived culture that since the 1960’s has glorified drug use, which has romanticized drugs, making them cool and acceptable (Galloway 2007:4). Similarly, the media has quoted federal Health Minister Tony Clement saying “the party’s over” when talking about drug users (Globe and Mail 2007b).

Insite’s evaluators attribute the remarks made by the Harper governments on drug users, to the influence from the United States “War on Drugs” (Wood, Kerr, and Montaner 2004). Addiction researchers point out that Richard Nixon created the “war” to respond to the shift of drug use from the social margins to actors and musicians, who are in a position to influence the mainstream population. The message that the U.S. government spread, was that this shift created a romanticised drug culture that is attracting weak individuals. In fact, last October, the federal government announced a sixty-four million dollar anti-drug strategy that reflects this position (Globe and Mail 2007b). The money will go to already existing treatment programs, reinforced border patrols, further criminal sanctions against illegal drug use and an anti-drug messaging campaign focused at teenagers. When it comes to safe injection sites, the federal government believes that by allowing people to inject illegal

\textsuperscript{11} Harm reduction is officially recognized as one of the pillars in Vancouver’s Four-Pillars Drug Strategy. The other strategies are prevention, treatment and enforcement. Insite as a harm reduction strategy is designed to work in conjunction with these efforts and thus is part of a much larger drug intervention effort.
substances under supervision, that we are sending a message that drug use is acceptable, thus, leading to more "weak" individuals joining this perceived 'drug culture'.

Despite the powerful messages contained in a "War on Drugs" sphere, social scientists and public health researchers have criticised it, partly because it masks the realities of homelessness, social stigma and mental illness. Insite's supporters follow arguments made by Merrill Singer (2004; 2006; 2008), who has studied the American war on drugs for the last several years. Singer (2004; 2006) argues that the "war" was, and still is, a social war on those who use drugs, not drug use per se. This ideology has conceptualized the drug user as a deviant and the reason why the streets are unsafe. Singer further asserts that the drug user serves as a scapegoat for urban social suffering and decay, therefore suggesting that the solution lies in removing these individuals with the criminal system. Similarly, Bourgois (2004:310) claims the "war" views drug users with "racialized moral judgements that frames street addicts as flawed individuals who make bad decisions and have week willpower." The positions of Singer and Bourgois reflect what Bourdieu (1992; 2001) calls "symbolic violence", where those in power make socially vulnerable populations blame themselves for their subordination.12

In addition to bringing further harm to drug users, researchers, including those evaluating Insite, have noted that the "war" simply does not work. For instance, Insite's evaluators Thomas Kerr and Evan Wood (2005:148-149) argue that:

Drug law enforcement remains the dominant approach to drug policy despite a lack of sound scientific confirmation of its benefit in terms of supply reduction, and increasing evidence of its harmful impacts. The continued

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12 This act of blaming also reflects attitudes a neoliberal attitude, which suggests that the solution to drug use lies with individual responsibility. As a result, critical medical anthropologists and health researchers have looked at a neoliberal influence on social health interventions, or a lack of (see Farmer 2005; Ritter and Cameron 2006; Moore and Fraser 2006).
The investigation of the health consequences of drug law enforcement is therefore of great importance.

The ineffectiveness of the "war", and the fact that it allows governments to blame drug users for their own situation, has influenced public health providers to design a value-neutral approach, one that avoids setting unrealistic goals for substance abusers.

Standing in contrast to the federal government, the evaluators of Insite are contesting the dominate ideology applied to addiction and are creating a "new" image of the drug user. This image is that of a drug user who is at risk of a host of medical ailments. Of most concern is "high rates of HIV and hepatitis C transmission, fatal drug overdoses and poor health outcomes among injections drug users" (Tyndall, Wood, Zhang, Lai, Montaner and Kerr 2006: 1). The Insite evaluators further acknowledge that "these complications result from, non-sterile injection practices and sharing of syringes, and that they account for a large proportion of emergency room visits and hospitalizations among IDUs" (Stoltz et al. 2007:35). Evaluation reports by W. Small et al. (2006; 2007) and Kerr, Small, Moore and Wood (2007), provide a unique opportunity to explore further how the Insite evaluation team perceives the risk that Vancouver drug users face. For instance, in the report by W. Small et al. (2007),13 the evaluators explore the physical locations and social contexts of public injection, and how such factors influence injection related health risks. In this report, the evaluators describe the environment that drug users typically inject in as being unsanitary and say that they constrain efforts to inject in a hygienic manner. In this setting, they argue that IDUs are at increased risk of drug related harm, due to fears of encountering police, being physically assaulted, or being robbed by street predators. Overall, the evaluators

13 Qualitative research on the Insite evaluation is typically less common than quantitative studies. As discussed in the interview with the Insite evaluator, qualitative research was used because it was the only way to answer some questions in a timely manner. However, the gold standard is still the randomized controlled trial.
describe the injectors as being preoccupied with “hurrying and worrying”, which often leads to “rushing” the injection process, thus putting them at increased risk of puncturing veins or overdosing because they do not have time to check for drug purity or strength (Small et al. 2006; 2007). They further claim that these “micro-environmental factors that shape drug injecting practices and compromise the individual ability to reduce the risks associated with drug related overdose” (Kerr, Small, Moore and Wood 2007:37).

Tim Rhodes (1997; 2002) framework of risk environments has strongly influenced the Insite evaluator’s conceptualization of drug users as vulnerable people. In a response to the over reliance on individual modes of behavioural change, Rhodes claims that a risk environment framework works:

[T]o shift the focus of change from issues of drug use specifically to wider issues of vulnerability, and in turn, human rights. Vulnerability to drug-related harm is closely associated with social, material and health inequalities more generally. Since an enabling environment approach seeks to alleviate the situational and structural conditions of risk and vulnerability it is essentially at once a human rights approach to the alleviation of harm. It actively seeks to make visible the connections between inequalities in general and drug-related harms in particular since this is a necessary step in fostering structural and environmental change. This, in turn, offers a broader vision for intervention than that conventionally constituted ‘harm reduction. (Rhodes 2002:91-92)

From this quote, we can indentify the communicative sphere shared between Rhodes and the Insite evaluators, which communicates that drug users are vulnerable to a variety of risks. This also explains why these researchers see a safe injection site as an important intervention that addresses their belief that public injection settings impede individual’s capacity to adopt safer injection techniques (Small et al. 2007). While viewing drug users as vulnerable peoples, thus placing them in risk categories, the evaluators avoid engaging in the blaming tactics commonly used in a “war on drugs” strategy.
The evaluators whom I interviewed also conveyed the conceptualization of IDUs as vulnerable to a variety of biomedical health risks. However, I did uncover something further, which was that the evaluators were sympathetic to IDUs, partly, because of a psychological communicative sphere, which attempts to understand the social world of the drug user, both past and present. For instance, both participants indicated that drug users need value-neutral healthcare support in order to deal with the various factors that cause individuals to seek drug abuse as a coping mechanism. One participant responded that “substance use is not about substance use as much as it is the context of peoples lives and the various disconnections and impressions, [as well as the] challenges that are facing them” [RL 06/06/08]. Similarly, another participant commented that:

I do think people’s historical, social, and situation really has put them in a pretty rough place. Unfortunately we live in this world where we have this highly criminalised approach to drug use...you know it just doesn’t seem to work at all and certainly putting people in jails increases risk of all kinds of adverse social outcomes as well as risk from infectious disease [BM 05/22/08].

These narratives further suggest that evaluators, working in the field of public health, often have a sympathetic view of those suffering with substance addictions and see them as needing social support to mitigate the risks associated with substance abuse. Therefore, it is safe to assume that evaluators, influenced by discourse on HIV/AIDS and harm reduction, make evaluation decisions based on these understandings.

Applying Briggs’s concept of communicability to program evaluation provides a means to understand the role that evaluators have in constructing what it means to be a user of a given program. This process is ongoing, regardless of the evaluator’s original intentions. Using the productive nature of communicability, as enacted through program evaluation, the evaluators of Insite and Sheway are attempting to legitimize their positions and promote a
more “humanized” image of a drug user. This “new” image reflects clinical and harm reduction communicative spheres; however, they are still in conflict with a “war on drugs” sphere, which the Canadian federal government continues to spread and maintain.
Situating the Evidence in Evidence-Based Medicine

When discussing the “evidence” that Insite is an effective health intervention, I am referring to pieces of information that social actors use to draw conclusions regarding the facility’s perceived benefits or drawbacks. In the field of medicine, health officials and policy makers use lines of “evidence” to answer carefully defined clinical questions, which are subject to critical appraisal of their validity and usefulness (Rosenberg and Donald 1995). However, the problem with evidence is that it varies based on individual perceptions of the nature of the world and rationality, determined by various communicative cartographies.

Evidence-based medicine (EBM) argues that policy makers should use non-biased scientific appraisal of the “best available practice” to inform policy. Through the spread of this communicative ideal, increasing numbers of health officials, including Insite’s evaluators, regard EBM as the “symbolic authority in clinical decision-making” (Lambert et al. 2006:2613). EBM is the process of systematically finding, appraising and using medical research findings as the basis for clinical decisions (Rosenberg and Donald 1995). Founded by a group of researchers at McMaster University in the mid-nineteen eighties (see Sackett et al. 1985), this new approach demonstrated that epidemiology could be applied to individual patient care (Evidence-based Medicine Working Group 1992). EBM is a response to a concern that the physician’s expert opinion exerts too much control over the diagnosis and treatment of his/her patient. As an alternative, EBM claims that physicians, or policy makers, should not base clinical decisions solely on their clinical expertise or hunches, but also include patient preference and most of all, the “best” available research evidence (Haynes et al. 2003).
From an EBM perspective, researchers consider the double-blind random controlled trial as yielding the highest quality of evidence. However, in many medical interventions, such as SISs, a controlled trial is often unfeasible and unethical. Cohort studies, such as those utilized in the evaluation of Insite, even though considered more vulnerable to error than double-blind studies, provide the bulk of the data for Insite’s evaluation and on SISs in other countries. Due to the symbolic authority of EBM, well-designed cohort or case studies along with controlled trials, give the impression that they are scientific, objective and apolitical. However, since anthropologists would argue that there is no such thing as pure objectivity, there is reason to look closer at EBM and the use of “evidence” in Insite’s evaluation.

To date, there have been relatively few anthropological analyses on the assumptions of EBM, however, Social Science and Medicine has recently dedicated a special issue to the subject (see Lambert et al. 2006). Within this publication, various authors examine how EBM operates within different scenarios, and in doing so, question its perceived unbiased nature. The key “evidence” that EBM relies on is typically epidemiological and it is generally comes from systematic reviews and efforts in meta-analysis. Lambert, Gordon and Bogdan-Lovis (2006:2614) further point out that:

A key reason for the attractiveness of EBM to policy makers and practitioners is that the evaluative process outlined by an evidence-based approach permits a certain measure of transparency, allowing others to critically examine the steps employed and thereby lending itself to accountability. Further, it holds the promise of providing a reliable, objective means of informing decision-

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14 A cohort study is a type of a longitudinal/correlational study used in medical research. It typically makes use of ongoing observations of individuals, in a particular subject group, over long periods. Because of the observational nature of cohort studies, it is argued that they are less likely to detect causal relationships that would be otherwise discovered by double-blind random controlled trials.

15 The Cochrane Collaboration is an example of a not for profit attempt to catalogue the results of biomedical controlled trials. Their goal is to help people make well informed decisions about healthcare by preparing, maintaining and ensuring the accessibility of systematic reviews of the effects of healthcare interventions. Recently, there has been an increase in their use of non-randomized observation studies.
making about resource allocation, by determining which therapeutic interventions have been shown to be most effective. Given such promise, most healthcare providers understandably tend to see EBM as a 'gift horse' that offers obvious benefits and should not be too closely or critically examined before being accepted and put to work.

Privileging the well-designed medical studies to guide clinical judgments, EBM is appealing because it represents a value free fact, rather than a product of complex interpretation. However, Goldenberg (2006) points out that we should avoid taking this assumption for granted. Even though health officials view EBM as a positivist approach, Goldenberg argues that it is far from objective and it simply obscures always-present subjective elements. She further points out that there is an assumption that EBM rests on the unquestioned authority of science. In citing Nelson (1993) and Haraway (1988), Goldenberg argues that calls for evidence rely on a specific conception of “evidence”, which is ultimately based on “situated knowledges”. De Vries and Lemmens (2006) take Goldenberg’s position further and suggest that the putative objectivity of EBM masks social and political influence and Barry (2006) argues that judgments of what evidence is ‘good enough’ vary according to the political and economic positions of decision makers.

In addition, these authors recognize that value judgements are embedded in the policy-making process with the result that “EBM is variably used as a standard for decision making depending on perceived risks by policymakers” (Gordon 2006:2708).

Overall, this literature from Social Science and Medicine suggests a structural bias in the way evidence-based research is employed in policy-making. To add to this discussion, I suggest that communicative cartographies work to create these subjectivities, which

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16 The Insite evaluators deemed that it would unethical to use this level of control. Also, since there was evidence from other settings, it was already expected that it would reduce harms in the community.
17 Baer (2004) suggests that many scientists do not recognise that their own way of thinking is not a value-free endeavour, and that it is culturally constructed and deeply embedded in larger political-economic structures.
18 Barry (2006) also argues that social scientists can contribute to raising consciousness of these issues and offer alternative models of evidence.
ultimately inform what evaluators, and their audiences, consider appropriate “evidence”. To illustrate, I will now turn to the evaluation of Insite. Specifically, I will examine how specific communicative ideologies work to conceptualize what is “good evidence”.

With an expectation that the authoritative weight of EBM would turn their results directly into policy, Insite’s evaluation team chose a wide variety of “evidence” to prove the effectiveness of the program and to overcome the lack of SIS research worldwide. To begin, the evaluators claim that Insite is successful because it improves public order. More specifically, that Insite promotes less public drug use and that it reduces publicly discarded syringes and injection related litter (Wood, Kerr, Small, Li, Marsh, Montaner and Tyndall 2004). A second line of evidence that the evaluators examine is overdose at Insite. Because no overdose fatality has occurred at the facility, the evaluators suggest that Insite addresses the risks associated with overdose (Kerr et al. 2006; Kerr, Small, Moore and Wood 2007). A third line of evidence that the evaluators use is changes in injection practices. In this line, they discovered that more-consistent use of Insite was associated with less reuse of syringes or increased use of sterile water (Stoltz et al. 2007). A fourth line of evidence that the evaluators used to prove success, was the fact that Insite attracts IDUs at higher risk of blood-borne diseases and overdose (Wood, Tyndall, Li, Lloyd-Smith, Small, Montaner and Kerr 2005; Wood, Kerr, Stoltz, Qui, Zhang, Montaner and Tyndall 2005). A fifth, and obvious, line of evidence that the evaluators use is the attendance of Insite. As a result, they report that Insite is in very high demand and that users are generally satisfied (Petrar et al. 2007). A sixth line of evidence chosen by the evaluators is the effect of Insite on infectious diseases such as HIV and HCV. While they have yet to come to any conclusions on this.

19 While I have listed various “lines of evidence” used in the evaluation numerically, I do not suggest that there is any order in the way I have listed them. Give the large set of evidence used by the evaluators, the list is also not exhaustive, but simply gives an indication of what types of “evidence” they are looking at.
issue, the evaluators have presented baseline data on HIV seroprevalence (Tyndall, Kerr, Zhang, King, Montaner and Wood 2006) and HCV infections (Wood, Kerr, Stoltz, Qui, Zhang, Montaner and Tyndall 2005). In addition, the evaluators are looking at how receiving safer injection education at Insite is affecting injecting behaviour, thus indicating possible success in the management of blood-borne diseases (Wood, Tyndall, Stoltz, Small, Zhang, O’Connell, Montaner and Kerr 2005).

The main “lines of evidence” that the Insite evaluators have chosen are reflective of the view of drug users at risk and vulnerable to a host of health concerns. Therefore, it is no surprise that the incidence of overdose and the prevalence of certain infectious diseases are key “evidence” in the evaluation. However, while these lines of evidence make sense from a harm reduction philosophy, the federal government’s view of drug users leads them to consider different measures — crime and abstinence being key indicators.20 Tony Clement has publicly commented that Insite needs additional studies into how it influences crime prevention and drug treatment, despite the fact that:

Insite’s primary purpose was never to get people off drugs. Rather it was designed to reduce the harms from injection drug use by reducing public disorder, overdoses, deaths, emergency room visits and needle sharing.21 (Garmaise 2006:22)

This example of differing conceptions of what counts as “evidence” is analogous to what Briggs calls “preferred readings” of texts, which “encode not only meanings but communicable cartographies that project subject positions” (Briggs 2007:333).22 Analysing

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20 Furthermore, by requiring Insite to follow these “lines of evidence”, the evaluators of Insite believe that the government is setting them up to fail [BM 05/22/08].
21 Also see Small (2007) where he presents a similar argument in further detail.
22 Briggs is using the term to refer to media texts, however, I believe this can easily be applied to how evaluation results are read.
how the two opposing sides respond to the final report presented by Health Canada’s Expert Advisory Committee (EAC), further illustrates the “preferred reading” of Insite’s evaluation.

Health Canada formed the EAC in 2006 “to distil and synthesize existing research on Insite and other SISs around the world for the Minister of Health” (Health Canada 2008). The Expert Committee reported several facts about Insite. For instance, they concluded that Insite saves one death by drug overdose per year, that it has a very high rate of service with high user satisfaction, that it has reduced public injecting, and that there have been no adverse effects such as increased drug use/relapse, loitering, petty crime, or drug dealing.

Given this seemingly positive report, Dr. Thomas Kerr, one of the main evaluators of Insite stated that it:

Confirms our research that the site is doing what it’s supposed to do – provide health benefits without increasing harm...now it’s time for the federal government to honour the findings and stop asking if this program should remain open (Bula 2008).

However, the Canadian Police Association (CPA), influenced by the “war on drugs” communicative sphere, had a completely different interpretation of the EAC report. Pointing out that the report claims Insite costs 3 million dollars a year to operate, and that it found no indication of Insite’s impact on the rate of drug addictions, the CPA claims the facility is a failure and it does not justify the money spent on it (Canada NewsWire 2008). Again, following the federal government, the CPA maintains that we need to fight addictions through abstinence and strong criminal measures. Totally ignored by the CPA was the fact that the EAC reported a positive cost/benefit ratio (with some cautions as to the validity of the mathematical model used).23 Furthermore, the CPA excludes from consideration the evaluator’s report showing an increase rate of entry into detox programs, which could

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23 Boyd and Anderson (2008), recipient of one of the research grants handed out by the federal government, also conducted a cost-benefit analysis of Insite and concluded that it creates significant savings for taxpayers.
eventually promote abstinence (Tyndall, Kerr, Zhang, King, Montaner and Wood 2006). Overall, the EAC example shows how “evidence” in evaluations is subject to preferred readings, with the reader/group using their particular communicative cartography.

Similar to the public comments made by the CPA, a few researchers have interpreted Insite’s evaluation findings differently than the evaluation team. Mangham (2007) claimed that the evaluators give an impression that the facility is successful in its goals, but he argued, the findings clearly show a lack of program impact and success. To support this argument, Mangham did not present any new “evidence”, but rather he questioned the validity of the “evidence” that the Insite evaluation team has used. For instance, Mangham argues that the improvement in public order was a result of increased police presence, not because of the SIS. Furthermore, he claims that the Insite evaluators cannot prove that the overdoses that have occurred within the facility would have resulted in death outside of the site.

The evaluators of Insite are quick to dismiss Mangham’s findings, because they clearly represent political interests. Mangham’s review of the evaluation of Insite was published by an online journal called Global Drug Policy and Practice, which to the untrained eye could easily be mistaken for a scientific journal” (Wood et al. 2008). However, the evaluators point out that it lacks credibility since it is not an official scientific journal, which means it is not peer-reviewed.24 In fact, the lobby group Drug Free America Foundation, which is dedicated to “hold drug users and dealers criminally accountable for their actions”, funds the journal (www.dfaf.org/globaldrugpolicy.php quoted from Wood et al. 2008:4). While it is easy for those sympathetic to harm reduction to ignore Mangham’s findings, those who believe in a similar philosophy as Mangham and employ the “war on drugs” communicative sphere, tend to take his work as fact. Mangham’s paper fits the

24 Peer-review involves subjecting an author’s work to the scrutiny of others who are experts in the same field.
ideology of Canadian federal government, which holds that abstinence and criminal sanctions are necessary to control illicit drug use. Therefore, Insite supporters fear that the government will use Mangham’s review, instead of the evaluation findings, to inform policy. This seems to be the case, since Tony Clement has declared that there is a growing academic debate over the effectiveness of SISs, where in reality, beyond the publications in Global Drug Policy and Practice, there is little.

Despite the fact that the federal government is operating with an opposing communicative landscape than that of Insite’s evaluators, as audience, they are influencing how the evaluators choose “evidence”, thus, how they create meaning (Brenneis 1986). For instance, the evaluation team have attempted to choose and discuss indicators that respond ‘indirectly’ to the federal government’s criticism of their work. In addition to the wide range of “evidence” that I have already mentioned, the evaluation team also claimed that Insite has not promoted a rise in drug use initiation or a relapse of prior users (Kerr, Tyndall, Zhang, Lai, Montaner and Wood 2007, Kerr et al. 2006). In addition, the evaluators also reported that Insite has not influenced crime rates or drug dealing in the immediate area (Wood et al. 2006). What is interesting with these lines of inquiry is that they reflect aspects of drug use, which Insite does not specifically address. In my interview with the Insite evaluator, they mentioned this as well. To elaborate, they commented:

I think there has been some things right, like our recent paper that has come out showing that there is a large number of police referrals to the site, which is really partly in response to the rather absurd comments by members of the RCMP and the Canadian Police association suggesting that the police actually don't like this thing, and we kind of always thought all along that you know, there is a lot of officers who think that throwing people into the judicial system for injecting outdoors is really a stupid waste of time. [BM 05/22/08]

The Insite participant also commented about the problem of “evidence” in evaluating a program based on a harm reduction model. For instance, they responded that “there is a
greater onus to rule out potential negative effects” and that you need to look at seemingly unrelated impacts because drug use is so political [BM 05/22/08]. Similarly, the Sheway participant commented that there exists a “challenge in evaluating harm reduction, you know the goals are so fluid...it’s very hard to capture that in a systemic way, you know, of what might happen to this person” if they did not utilize this program [RL 06/06/08].

Overall, this section has highlighted several challenges that evaluators face when evaluating harm reduction programs from an EBM perspective. I have demonstrated that the evaluator’s communicative cartography, determines what they consider “good evidence” and that this conception can conflict with others with a different cartography. In the case of Insite, the two opposing communicative spheres each contain guidelines that determine values, “evidence”, how to view IDUs, and it provides a guide on how to identify and critique subjective positions that originate from the opposing sphere(s). Thus, it shows that “evidence”, which may appear objective within the logic of a communicative sphere, is in fact subjective to the extent that the selection of a sphere reflects contention among social, professional and political contexts.

25 For instance, in the media, the supporters of Insite repeatedly mirror the evaluators claim that policy cannot be guided by what they call “ideology”. Similarly, those opposed to Insite, spread the message that the evidence is flawed and that abstinence is the only moral way to proceed.
The Evaluation of the Sheway Project: Incorporating User Empowerment

Vancouver established the Sheway project in 1993 after calls from various health and social service providers, for a community-based integrated service designed to meet the complex needs of local women and children. Akin to the Insite Program, Sheway utilizes a harm reduction model to respond to the risks that alcohol and illicit drugs has on Vancouver women and their families. These risks include poor outcomes for infants, such as fetal alcohol syndrome, neonatal abstinence syndrome, or low birth weight; and risks to mothers, such as nutritional deficiencies and a host of health concerns that accompany substance abuse. To mediate these risks, Sheway offers a variety of services to families that address the range of difficulties that women face in their daily lives. They provide perinatal and medical care, early childhood and parenting support, access to safe housing, legal and financial advocacy, alcohol and drug counselling, nutritional counselling and emotional support (Garm 1999). Sheway also provides practical day-to-day services. For instance, women and their children are able to drop into Sheway during the daytime for hot lunches/snacks or simply for the basic need of a safe and supportive environment. Sheway also provides dietary supplements and they offer transportation to related health appointments. By making these services available, Sheway’s strives to meet its goal of engaging women with the healthcare system, to provide alcohol and drug education and support, to support women as parents and caregivers and to promote the health, nutrition and development of their children for a period of 18 months following birth (Poole 2000:3).

Despite Sheway’s innovative approach and good intentions, the project is not without controversy. This is something that it shares in common with the Insite program. Greaves and Poole (2004:84) argue that pregnant “women who use substances come under

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considerable scrutiny in Canadian Society.” Also, that pregnant women using alcohol, drugs or tobacco face the unsympathetic brunt of judgements, used to blame women for their addictions. As an explanation for this blame, they assert that women are seen as “vessels” for producing children and that the “focus of legal, media, and public concern is usually on the health and welfare of the fetus and rarely on the health and welfare of the women herself” (Greaves and Poole 2004:87). The underlying message is that unborn children need protection from their abusive mothers. The authors go on to argue that this type of approach can become a barrier to women seeking treatment, as they will be afraid of prejudicial practitioners or even child apprehension. Perhaps to Sheway’s benefit and the women who use it, the program has received very little attention from the media and federal government. However, as the Sheway interview participant commented, “I think that the public can’t even imaging a women using substances during pregnancy…and I think if they knew it would be just as contested [as Insite]” [RL 06/06/08].

Since opening in 1993, Sheway has been subject to several evaluation efforts.2627 Most noteworthy are an evaluation of Sheway’s Infant services by Sheila Marshall and colleagues (2003: 2005) and a comprehensive evaluation completed by Nancy Poole (2000).28 Because of its high regard by the operators of Sheway, I will focus most of my attention to Poole’s evaluation. In contrast to Insite’s evaluation efforts,29 Poole’s evaluation

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26 Due to methodological concerns, not all of Sheway’s evaluations are available to the public. The evaluation reports and reviews that I examined, were those that were publicly available, either distributed by Sheway, available in journals or online.
27 Through the course of my research, I contacted several addiction treatment centers in Canada. I was surprised to find out that very few were formally evaluated. While this may be due to issues of accountability and economics, it could also reflect a “we know best” attitude by professionals, which would nullify any perceived need for an evaluation.
28 Poole worked on the evaluation on behalf of British Columbia’s Center for Excellence in Women’s Health.
29 Poole presented her evaluation report on Sheway in the more traditional method, a larger, more comprehensive document, whereas the Insite evaluation team presented their results in medical journals.
of Sheway has two key features: the negotiated manner used to determine the "lines of evidence" and her use of multiple voices, especially those of the users.

The lines of evidence for Insite's evaluation were determined by "obvious questions" [BM 05/22/08] based on what the program was designed to accomplish and how risk was conceptualized by the evaluators. While this is true of Poole's evaluation, her "evidence" seemed to benefit from the inclusion of multiple voices, representing various spheres of communication. Initially, to identify her lines of evidence in the Sheway evaluation, Poole formed an advisory committee, which guided the process over a ten-month period. The committee was comprised of representatives from a wide range of constituencies, each with a stake in the evaluation. It consisted of Sheway staff and council members (past and present), and experts in women's health research and policy development. The committee also included an Aboriginal health planner and two former users of Sheway's services. Instead of determining the main indicators based on her own experience and background, Poole worked with the advisory committee to negotiate this "evidence". Working with the committee, Poole discovered that the challenge of "defining success" was a common problem, because of different ideas of what constitutes "success" among the participants (Poole 2000:18, 39).

To illustrate how this process worked, in her evaluation, Poole (2000:19) commented that:

[W]hen looking for an indicator of possible later disability in children, low need for specialized care nursery at birth and use of Sunny Hill Hospital was put forth as an indicator. Later concern surfaced about this indicator as most use of specialized nursery care is planned in advance, for children of women who were stabilized on methadone. It was felt that even these uses of specialized nursery care could be avoided if care for these children was provided in the mother's room.

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30 The data that Sheway collected from the women at intake also influenced how the advisory committee chose their "evidence". For instance, data on housing, food security, access to prenatal care, exposure to violence and substance use, became important starting points for investigation.
This gives an example of how an evaluator can allow the “evidence” to remain fluid and at the same time account for the various ideologies to have a say in the evaluation.

With the availability of Sheway’s intake data and the support of the advisory committee, Poole reported on a wide range of indicators in her evaluation, which she used to show program success. Among these indicators, is data showing that Sheway helped women access pre/postnatal care; that it effectively assisted women and their families in receiving important nutrition and finding stable housing; and that Sheway provided support to mothers and families in their capacity as caregivers and parents (including retaining custody of their children). Poole also compiled data showing a decrease of substance misuse and an increase in positive infant outcomes (healthy birth weight, reduction in babies needing specialized care and an increase in babies with up-to-date immunizations).

Not only did the advisory committee decide what the evidence would be, they also determined the appropriate methodology for Poole to use. The committee agreed on a file review for women enrolled in the program, tracking of 12 clients who assessed the services, surveys with staff and council members, a literature review on comparable programming and a focus group with Sheway users. While these methods are routine, the committee uniquely approved interviews with allied professionals working in the area, and several “art expression” sessions that Poole used to gather user needs and gains (Poole 2000). These methods worked to bring the different voices into Poole’s evaluation that might not otherwise have been recorded. To illustrate, Poole interviewed staff members and allied service providers to identify what Sheway’s philosophy actually means to these providers. From these interviews, Poole indentified four main themes. She discovered it means: first, working from a respectful, empowering service philosophy; second; providing comprehensive care
and addressing practical needs; third, undertaking interagency collaboration and coordination and; fourth, providing a broad and flexible continuum of alcohol and drug services.

In addition to a multi-voiced methodology, what is further distinctive about Poole’s evaluation is her commitment to user empowerment, which reflects the design of the program itself. For instance, Sheway allows women to determine the type and extent of change that they wish to make (Poole 2000). Sheway’s mission statement elaborates on this philosophy. It says that:

Sheway recognizes that the health of women is linked to the conditions of their lives and to their ability to influence these conditions...The staff works with women to help them develop the information, skills and confidence that they will need to care for themselves and their children. Sheway affirms the right of all women to self-determination within their own cultural, spiritual and social context. (Sheway planning document, Cited from Poole 2000:2)

Acknowledging the importance of including users in the evaluation process, Poole privileged another “line of evidence”, the consumer view of personal growth and change. Not only did Poole use client narratives in her assessment of how user needs were met, or not, and what gains they made for themselves at Sheway, she encouraged women to voice their assessment through art. This innovative method of multimodal interaction for program evaluation provided an opportunity for users to participate in the evaluation, even if they were uncomfortable or unable to express these issues verbally. For example, one type of art that users produced was outlines of hands, each describing what Sheway provides for them. In addition to care and support, the client’s artwork overwhelming showed that the program gave them respect. Poole discovered similar messages in the focus group as well. Various clients, when asked by Poole, about the most important changes made while getting help at Sheway, responded:

Sheway’s there to support you and you start getting some of your self-esteem back...to respect yourself...Finding your real beliefs...being able to talk and
be open...don’t listen to anyone who says you can’t do it...I learned to value myself as a person other than just as an object.  

(User responses, Cited from Poole 2000:25)

These narratives provide an example of how Poole incorporated multiple user expression and voices in her evaluation. Since users were also involved in the evaluation’s advisory committee, they had a pronounced influence in determining the course of the evaluation, and consequently, how they are recontextualized.

The philosophy of empowerment in the Sheway project as reflected in Poole’s evaluation, describes a third major communicative sphere that I have now discussed in this paper. Similar to the Insite evaluator’s strategy of establishing their integrity through the peer-review process, Poole protects her position by incorporating multiple-voices and viewpoints over her own. While this method better addresses the fluid nature of harm reduction and EBM, it also provides a certain level of communicative authority to program users.

31 From Poole’s evaluation report and my interview with a prior evaluator of Sheway, it is clear that all users viewed the program positively. The only area where there is any indication of unmet need is that many women wish to stay with the program past eighteen months.

32 While Poole’s communicative ideology is similar to those of the Insite evaluators, such as harm reduction, EBM and sympathy to program clients, her choice to privilege qualitative and multimodal interaction methods, rather than statistical quantitative data, sets her working ideology apart from more “scientific” evaluations. The issue of gender in Poole’s evaluation should also be considered, however, it is beyond the scope of this paper.
Discussion

Applying Brigg’s framework of communicability to the study of program evaluation highlights issues of authority, values, “evidence” and how evaluators de/recontextualize users. In the evaluation of Insite, Brigg’s theory suggests that the conflict is a result of two communicative ideologies, each with a unique authoritative language, competing for the right to re/decontextualize who a drug user is. The Insite evaluators, using a biomedical communicative cartography, are medicalizing addiction - bringing addiction into the realm of healthcare and making tremendous gains in humanizing IDUs, thus justifying the need for harm reduction approaches. This is not an easy task, as the current federal government continues to spread the message that we should deal with IDUs using punitive measures, consequently suggesting that biomedicine has no authority in the matter. In these two communicative cartographies, each produces subjectivities, thus creating multiple ideas of what, and what does not, constitute evidence in the evaluation of Insite. Furthermore, both cartographies are represented in the media, as they attempt to convince the public that their particular communicative sphere is the appropriate one to deal with substance addiction. While doing so, they present a guideline that the convinced public can use to critique the opposing spheres.

While Brigg’s framework provides a deeper understanding of the evaluation process of harm reduction programs, it also poses further questions. For instance, while framing addiction in terms of public health, what are the implications of allowing biomedicine to dominate how these programs are evaluated? Additionally, in evaluation, given the authority

32 This explains why the Canadian federal government allows EBM to dictate policy in other areas, such as cancer or heart and stroke, but not in substance addiction. Harper’s government sees policing, not healthcare, as having authoritative say over how we should deal with addiction, evident in their statement “supervised injection is not medicine” (Globe and Mail 2008).
of biomedical language, what is the evaluator’s role in the recontextualization of program users? Finally, because of the positional nature of evaluation, what is the best way for an evaluator to proceed?

As this paper has demonstrated, program evaluations are productive. Evaluators of harm reduction programs are putting this productive capacity to work, often under the authority of biomedicine or EBM, to validate the lives of substance abusers. However, how does biomedicine influence how we view the drug user? Medical anthropologists, for the last several decades, have suggested that medicalization is dominating the representations and our understanding of individual behaviour.34 Kleinman (2006:9) claims that “general reality” is being increasingly clouded by professionals whose technical models introduce a superficial reproduction of the person, thus denying moral significance. Similarly, he argues that medical models are homogenizing the deeply rich diversity of human experience and thus, working to diminish the person. Arguments such as Kleinman’s, reflects Foucault’s (1973) notion of biopower, which states that society uses various techniques to achieve the subjugations of bodies and the control of populations. Through emphasis on the protection of life, rather than threat of death, Foucault claims that the state regulates aspects of human life such as customs, health, behaviour, habits, reproductive practices and family.

The main apprehension among social scientists following Foucault is that the inherent quantitative nature of biomedicine will render patient narratives as unimportant, or simply “noise” to be eliminated (Butler 2005). For instance, Philippe Bourgois (2002), an anthropologist working in the field of street level addictions, claims that epidemiologists, who commonly work on public health evaluations, know nothing about qualitative analysis. While this may be true, when applying this argument to Insite’s evaluators, which employs

34 Briggs (2005; 2007) has illustrated communicability’s role in this process as well.
members knowledgeable of qualitative analysis, it seems a little overstated. Nevertheless, for
Insite’s evaluation, it is safe to argue that qualitative data, though now acceptable, fails to
achieve parallel respectability (Patton 2005; Good 1994). Only a fraction of the Insite’s
thirty evaluation reports, actually incorporate user narratives, which the evaluators obtained
from semi-structured interviews.\(^3\) Given that, it is not surprising that the evaluation team
published their results in prestigious medical journals such as The New England Journal of
Medicine and The Lancet, which privilege numeric data. Indeed, this backs up Arthur
Kleinman’s (1995:2) claim that outside of psychiatry, narrative is “regarded as marginal by
the rest of biomedicine.”

Should biomedicine have complete authority over the evaluation of Insite? On the
one hand, if biomedicine does not have this authority, the federal government will control the
communicative spheres (for their own political ends) that define the lives of IDUs and force
Insite to close. Alternatively, if a biomedical cartography does gain the right to deal with
addiction, IDUs would benefit on multiple levels, most importantly, from a message that they
are deserving of non-judgmental support. However, there is a potential risk that biomedicine
will dictate what it means to be a drug-user, thus obscuring alternative, street based
conceptions.

In the two harm reduction programs that this paper discusses, HIV/AIDS becomes a
powerful sphere of communicability used by the evaluators. This sphere includes theories of
causation that describe how society should think about drug users and what it means to be at
risk. With the dissemination of this type of understanding of HIV and risk, drug users
coming in contact with HIV intervention programs align themselves in relation to the

\(^3\) The use of semi-structured interviews may be questioned in terms of communicability as well. For instance,
if the evaluators already know exactly what responses they are looking for, there is a risk that their
communicative cartography will unknowingly direct user understandings of the program.
dominate discourse of the program, as part of constructed “risk groups”. This idea is best
described through Foucault’s (1973; 1977) work on medicalization and how it produces the
idea of pleasure, desire and self. Foucault’s uses the concept of governmentality, the rational
and calculated ways that conduct becomes self-regulated, as individuals shape themselves to
the discourses learned through forces such as medicalization. However, those who refuse or
who are incapable of adopting this new relationship with biomedicine can become what Ong
(1995) refers to as “biomedical citizens”; or what Briggs and Martini-Briggs (2003) have
more recently termed, “unsanitary subjects”. The medical establishment will therefore
exclude these individuals from receiving care. This warrants concern for the users of
programs such as Insite. For instance, Fischer et al. (2004) have analysed supervised
injection sites, including Insite, through Foucault’s lens of governmentality. They argue that
we can best understand the emergence of SISs in the context of spatial reordering. For
instance, Fischer and colleagues see the intrinsic order of SISs as concealing drugs users
rather than eliminating them and at the same time, they are giving the drug user a new
identity as a ‘disciplined citizen’. However, following similar arguments made by Briggs
and Mantini-Briggs, they warn that SISs may “enable and legitimise the maintenance or even
amplification of repressive measures directed at those drug users (still considerable in
numbers) who are unwilling or unable to partake of the new opportunities for ‘healthy self-
transformation’” (Fisher et al. 2004:363).

One of the main concerns presented in the discourse on medicalization, is that health
officials may exert too much control over subject populations. Michael Clatts (1994) has
also highlighted the potential problems that biomedicine may have in constructing those it
considers: “at risk”. In reflecting on his many years of HIV/AIDS intervention efforts, Clatts
warns that HIV prevention based on behaviour modification can quickly become more about social control than prevention of HIV/AIDS. Researchers can easily direct such concerns towards Insite, especially since the evaluators are focusing on how the facility influences behaviour such as injection habits and needle sharing. Additionally, it is still not clear what happens to those individuals who do not have a biomedical understanding of addiction, or those who choose not to use or follow the rules of the Insite. For instance, when a user compares the evaluator’s/researchers assessment of risk to their own cultural and personal factors, what happens to those who do not see themselves as equally vulnerable to HIV and overdose? These concerns have an impact on program evaluation, because clinical definitions of drug abuse can exclude certain individuals from the evaluation. Therefore, the evaluation will capture a homogenized view of the program, most likely from a biomedical understanding. In addition, since evaluations have a function in knowledge creation, they will not be involved in any recontextualization of what it means to be a drug user.

A strategy that evaluators utilize to avoid over-homogenizing user knowledge, is including multiple voices in their evaluation. To begin though, evaluators need to understand what their role is in translating user responses and they need to consider just how closely they represent user reality. This is especially important, since the communicative spheres inherent in biomedicine, often do the re/contextualizing. In addition to social theory, how interlocutors translate knowledge into text is an area that anthropology has a lot to offer program evaluation. To illustrate, Saris (1995) has proposed a model that explains what happens to individual experience when it is translated into text. He argues that experience is translated into narrative and later into text, through a thick bedding of various institutional
structures,\textsuperscript{36} such as technologies, narrative styles, modes of discourse, and silences. In the realm of program evaluation, these institutional structures can translate user narratives in a way that no longer represents the reality of the user.

Because of the importance that a program user’s narrative can play in their own recontextualization, we should also consider how evaluators, as audience, influence how users fashion their stories.\textsuperscript{37} Anthropologists claim that telling is an interaction in which the audience actively shapes the telling and the teller. Since efficacy is determined through a negotiation between patient and healer (Waldram 2000), we should acknowledge that narrative realities are vulnerable to social influence, and in clinical settings, the authoritative weight of medical interpretations gives them shape (Kirmayer 2000). This reflects Wikan’s (2000) observation that authors construct stories with particular audiences in mind. For instance, the interviewer, serving as audience, gives interactive clues that influence how a story is developed. When this interview is for a clinical program evaluation, the evaluator may be directing users in to a medical language. Through this evaluator/user dynamic, the main message of the user’s story may be lost.

What exactly can be lost when a researcher translates or directs human experiences in a manner that no longer reflects that person’s reality, or ignores them altogether? Rosaldo (1986:98) claims that telling stories allows narrators to communicate what is significant in their lives, and what matters most to them. He claims that this will “often reveal more about what can make life worth living than about how it is routinely lived.” In addition, anthropologists have argued that narrative orders experience (Bruner 1986) and gives a

\textsuperscript{36} Saris is closely following Lyotard’s (1984:17) definition of institutions. He claims that they “always requires constraints for statements to be declared admissible within its bounds…they also privilege certain classes of statements… [and that] Bureaucratization is the outer limit of this tendency”.

\textsuperscript{37} Similarly, Garro and Mattingly (2000) argue that the audience can shape a narrative performance even to the point that text, context, and audience become blurred.
socially positioned version of reality that is culturally grounded (Good and Good 2000). To get an accurate representation of this “reality”, Wiken (2000) suggests, that we should as researchers, attempt to get as close to lived experience as we can get. He proposes that we fill in the representation by observing real life behaviour, to get a clearer picture of a person’s experience. The underlying message of Wiken is that researchers cannot take stories at face value as authentic. In program evaluation, this suggests the importance of allowing clients to talk about what it means to use a specific program and how to improve on it, and then incorporate this with a variety of other data. In addition, in accordance with the systems approach, talking to those who do not use a program, but are familiar of it, can also assist in providing further insights into the nature of the program.

I propose that Poole’s Sheway evaluation model provides an excellent example of how evaluators can allow the process to be fluid, which involves allowing a certain amount of communicative authority to program users. In her evaluation, Poole made use of a communicative sphere that values user involvement and allows user experiences to shape the direction of the evaluation. Poole’s emphasis on user involvement strongly reflects Sheway’s commitment to empowerment. We can trace the origins of this communicative sphere to years of research with marginal groups, such as Canadian First Nations, which has led to increased use of community-based methodology. The use of self-determination and community-based models, developed from a response to the Eurocentric manner that researchers studied First Nation communities (Kew 1994). Therefore, collaborative research

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38 Systems evaluation involves examining how programs or organizations operate within larger contexts, such as the community. Within applied anthropology it is considered to yield the best results.

39 In my analysis, I have observed that the lines between evaluators and program operators become blurred, where they share similar values. As a result, there is a need to examine to what extent operators pass on spheres of thinking to their evaluators, or vice-versa.

40 It is not surprising that Sheway serves a large portion of Aboriginal clients, as does Insite.
approaches that respect cultural values and promotes community interests, have become commonplace, especially after First Nation communities gained further control over the research process. This methodological development has helped ensure that research would meet First Nation needs, reflect cultural values and outsiders would not view them as passive victims (Kew 1994; Harris 1997/8). For outside researchers, this now often means allowing community interests to guide the direction of potential research.

In program evaluation, user involvement can have a significant impact on the lives of those who use the program. Such a commitment has led to the creation of a method called empowerment evaluation, which focuses on self-determination and giving program clients an opportunity to help themselves. First coined by anthropologist David Fetterman (see Fetterman 1994), one of the most remarkable aspects of this model is its potential to foster user improvement, thus increasing the probability of success. For instance, when applying the model in an educational setting, Fetterman (2005) witnessed a rise in student test scores. In addition to education, another area where empowerment evaluation may have a positive impact is in the field of addiction programming. Not only can it help evaluators gain a better understanding of lived experience, but it can also provide users with positive roles and improve social networks. Thus, it may assist individuals in their healing process, through the promotion of self-worth. There have been indications from literature that support this potential, albeit very few. Anderson (2002), in her analysis of a residential drug and alcohol treatment center, reported that those who had the most success in long-term recovery went back to their home communities and set up treatment support groups of their own. In the Sheway evaluation, Poole highlighted the importance of having individuals connect with other parents and the strong desire by “graduates”, to volunteer their services after
completing the program. This suggests that part of the success of Sheway, is its ability to encourage users to view the program as a place that promotes their self-worth. Similarly, in unpublished research, I argued that the reason that a local Aboriginal treatment program had a much higher rate of success than an out-community program was because of its ability to reconnect participants with their family members and community. Therefore, a lasting self-worth and connection to the community was produced, which is usually lost if the social ties were made elsewhere, as in residential treatment programs. Finally, more specifically related to Insite, individuals who became involved in the drug-user run organization VANDU, Vancouver Area Network of Drug Users, reported positive change in their self worth.41 Osborn and Small (2006:71) reported that:

People began to change as they became members of VANDU and saw that organized actions could have real impact. Their voices were finally heard and that made a great difference. It gave users a positive sense of themselves. That’s the result of social activism, realizing that you can be of help and achieve change.

Again, not only does this point to the potential authority that user-level organizations can have in the representation of drug users, it also shows the benefit that active involvement can have on the lives of substance abusers. Clearly, there is a need for future research in this area.

In closing, I would argue that the best way evaluators can adequately recontextualize what it means to be a program user and factor in their own subjectivities and values, is by allowing evaluations to be as fluid as possible and open to negotiation between all parties interested in the results. Evaluators and overseers need to privilege the user level in this negotiation. They are after all, those with most at stake. This is especially true among those

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41 VANDU, influenced by ideas and methods of Liberation Theology formed in the late 1990’s, by holding large public discussion meetings to identify the main issues facing drug users and asking. The organization quickly strengthened in to a peer-to-peer social movement consisting of advocacy groups.
who struggle with substance addictions. This follows medical anthropologist James Waldram’s (2000:607) argument that:

The view of the patient is not necessarily distinct or neatly separable from the view of the practitioner in any treatment encounter. These views often interact and affect each other...Practitioner and patient may or may not agree on the issue of the efficacy of the specific action taken. Efficacy, then, must be viewed as something that is essentially negotiated, in part, in each encounter of a patient and a practitioner in both biomedical and medical systems.

Poole’s evaluation of Sheway, with the use of an advisory committee, strong use of narratives and multimodal interaction, provides a glimpse of how an evaluator can accomplish this task. For Insite, with the federal government far removed from the evaluation process, it remains uncertain whether a process of open-negotiation between the evaluators and government would be possible. To date, the negotiation has been on negative terms through the media.42 It is also unclear, whether the evaluators of Insite are comfortable in allowing user experience to play a larger role in their language of “science”.

Regardless of how objective the evaluators and overseers attempt to be, they should realize that “healthcare does not exist in a social vacuum” (Small 2007:18). Negotiating with all parties involved, inclusive of their subjective positions, does not mean abandoning quantitative data, or a well-designed scientific evaluation (Butler 2005). Rather, it means strengthening evaluations by allowing multiple experiences and possibilities to surface, thus avoiding oversimplification and communicative dominance. Further, this method makes it is possible to take values and treat them as social facts, rather than pretend that they do not exist.

42 The Insite participant spent considerable time commenting on the challenges they have faced in the Insite evaluation. They claimed to be fatigued from constantly trying to defend the results and from being publically slandered. Open negotiation with representatives from the Insite's critics, although sure to be a challenging process, may still be easier on Insite’s evaluators than what they have experienced thus far.
References


Bula, Frances. 2008, April 12. "Health Canada panel gives injection site favourable review: Group of experts finds Insite is having a positive impact and even saving lives." in *The Vancouver Sun*. Vancouver, BC.


Appendix 1 UBC Ethics Board Certificate of Approval

The University of British Columbia
Office of Research Services
Behavioural Research Ethics Board
Suite 102, 6190 Agronomy Road,
Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - MINIMAL RISK

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<td>William H. McKellin</td>
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INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

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Other locations where the research will be conducted:
UBC Offices of researcher/evaluators

CO-INVESTIGATOR(S):
Stephen D. Robbins

SPONSORING AGENCIES:
N/A

PROJECT TITLE:
Harm Reduction Approaches in Health Care: Program Evaluation within a Moral Borderland

CERTIFICATE EXPIRY DATE: March 11, 2009

DOCUMENTS INCLUDED IN THIS APPROVAL: DATE APPROVED:

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The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

Dr. M. Judith Lynam, Chair
Dr. Ken Craig, Chair
Dr. Jim Rupert, Associate Chair
Dr. Laurie Ford, Associate Chair
Dr. Daniel Salhani, Associate Chair
Dr. Anita Ho, Associate Chair