INJECTION DRUG USERS' EXPERIENCES WITH SUPERVISED
INJECTION SITES

by

Patrick Anthony de Sousa

RN Diploma, George Brown College, Toronto, Ontario, 1993

BScN, Ryerson University, Toronto, Ontario, 1997

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES

THE UNIVERSITY OF BRITISH COLUMBIA

April 21 2006

ABSTRACT

INJECTION DRUG USERS' EXPERIENCES WITH SUPERVISED INJECTION SITES

The injection of illicit drugs, such as heroin and cocaine, is associated with human suffering and high financial costs that harm individuals, families, communities, and society. Canada has approximately 125 000 injection drug users (IDUs), with approximately 5 000 living within 16 square blocks in Vancouver's Downtown Eastside. In this area's streets and alleys, illicit drugs are openly sold, bought and consumed. To address problems related to drug trafficking and consumption, the City of Vancouver adopted in 2001 a "Four Pillar" approach of 1) Prevention; 2) Enforcement; 3) Treatment; and 4) Harm Reduction. One component of the harm reduction pillar was the establishment and operation of two supervised injection sites (SISs) as research pilot projects. Although SISs are operating in Europe and Australia, Vancouver has the only official sites in North America.

The limited research on SISs has focused on operational statistics, client demographics and health, and the effects on the community. Very little is known about the experiences of IDUs. I conducted a qualitative study, using interpretive description as a methodology, to explore IDUs' experiences with SISs. The primary data was collected through audiotaped interviews with seven IDUs residing in single-room occupancy hotels and apartments located near an open drug scene.

Findings revealed that while participants unanimously support SISs, because they believe the sites save lives, most use the sites only rarely or occasionally. Although

SISs are designed as a low-threshold service to meet the needs of high-risk IDUs, five barriers that limit access to the service have been identified: 1) Limited Hours of Operation; 2) Public Entrance – Lack of Anonymity; 3) Waiting Time; 4) Atmosphere; and 5) Prohibition of Assisted Injection. This research revealed some unexpected findings. First, many participants feel unsafe because they perceive that the degree of violence on the streets has increased and they blame this on younger crack smoking addicts. Second, participants expressed a concern for others and they have acted to make positive changes through advocacy, action, and acts of compassion. These findings highlight the importance of including IDUs' perspectives regarding health interventions, such as SISs, that are specifically directed at them.

TABLE OF CONTENTS

ACKNOWLEDGMENT

DEDICATION

To my Dad, who died the year I started the journey to complete the Masters of Science in Nursing. You were with me at my most difficult moment. I know that nothing will ever be harder than that in my life.

CHAPTER ONE: INTRODUCTION

In this qualitative research project, I explore injection drug users' (IDUs) experiences with supervised injection sites (SISs or sites). This is both a timely and important research issue because of the health, social and financial costs related to IDUs. Injection drug users are at risk for contracting serious chronic diseases, and dying from suicide and drug overdose (Single, Robson, Rehm, & Xie, 1999). Human Immunodeficiency Virus positive (HIV+) IDUs have high rates of hospitalizations due to complications related to their drug use (Palepu et al., 2001). IDUs are also at risk of becoming homeless (Vangeest & Johnson, 2002), and many commit property crimes to support their drug use (Pernanen, Cousineau, Brochu, & Sun, 2002). A study looking at the impact of substance abuse in 1992 found that illicit drug use cost Canadians $1.37 billion that year. This represents 0.2% of Canada's GDP, or $48 per capita (Single, Robson, Xie, & Rehm, 1996). The Canadian Centre for Substance Abuse is currently re-examining the impact of substance abuse in Canadian society; the results should be released soon.

Many approaches have been taken to address the problems associated with street drug use, from treating it as a criminal activity to looking at it as a health issue. The City of Vancouver has taken a four-pronged approach of prevention, enforcement, treatment, and harm reduction. One harm reduction strategy implemented by the City of Vancouver is the operation of SISs. SISs are secure places where drug users can bring their pre-obtained drugs and self-administer them in a hygienic environment under the supervision and guidance of specially trained and educated staff, usually nurses (Gold,

2003; Kemmesies, 1999; Kerr, 2000; van Beek, 2003). SISs are often located close to open drug scenes (ODSs). Open drug scenes are areas where the selling, buying, and consumption of illicit drugs take place openly in public. The two SISs are operating in Vancouver on a three-year research trial basis. The goal of the sites is to decrease the harm experienced by IDUs themselves and the communities in which they operate (Kerr, 2000; Wolf, Linssen, & De Graaf, 2003; Zurhold, Degkwitz, Verthein, & Haasen, 2003).

I conducted a literature review and found limited research on SISs. Available information focused on IDUs' demographics, their health, as well as the effects of their substance abuse on the surrounding community (Hedrich, 2004; MSIC Evaluation Committee, 2003). Although IDUs have completed surveys about SISs, I was unable to find any study that specifically enquired about IDUs' experiences with regards to SIS use. As SISs are designed for IDUs, I believe it is essential to talk with those who use them to obtain their perspectives and learn from their experiences. This research is important because people are contracting serious chronic illnesses and dying as a result of substance abuse.

BACKGROUND TO THE PROBLEM

The use of mind-altering substances and psychoactive drugs (see p. 18) is not new; its origins are unknown and shrouded in the mists of antiquity. Archaeological evidence and early-recorded history reveal that the use of psychoactive drugs has been a well-established practice in many cultures (Sullivan & Hagen, 1997). Sullivan and Hagen provide examples from Glover, who presented archaeological evidence that a

stimulant, the betel nut, was chewed in Timor 13 000 years ago, and Plowman, who asserted that coca was domesticated in the western Andes 7 000 years ago.

People start to use drugs for a variety of reasons such as curiosity, pain relief, peer pressure or pleasure, but may continue to use substances for completely different reasons, such as an escape from reality, for example (Health Canada, 2005; Kerr, 2000). There are suggestions that the propensity for substance use is related to evolutionary biology (Darwin, 1871; Sullivan & Hagen, 1997). Humans may have a primordial predilection to the use of substances that alter reality. Darwin, in his book *The Descent of Man* (1871) discussed similarities between humans and other primates. Darwin suggested that there are neural commonalities between human and non-human primates by referring to the voluntary intake of psychoactive drugs.

Whether there is a genetic predisposition for psychoactive substance use or not, the use of drugs has been ever-present in almost all cultures in human history. For example, the pre-Columbian inhabitants of the Americas have used psychoactive plants for millennia (Torres, 1996), and the origins of beer and wine date back at least to the fourth millennium BCE, during the Neolithic period (Rudgley, 1999). For whatever reasons, whether as concrete as relieving pain and stimulating pleasure, or wrapped up in the world of genetics and evolutionary biology, humans have always used and continue to use psychoactive drugs. It is therefore fanciful and simplistic to believe that people should abstain from use by just saying no to drugs. Acknowledging that people use drugs, even though the drugs may be detrimental to individual and community health, and that abstinence is not achievable for all, is necessary in order to fully

appreciate the complexity of the culture of drug use. With this in mind the next step is to discuss the effects of drug use.

The outcomes from drug use can range across a spectrum from beneficial, casual non-problematic, problematic, to chronic dependence (BC Ministry of Health Services, 2004; City of Vancouver, 2005). Beneficial refers to drug use intended for its positive health, social and spiritual effects. Casual non-problematic, also called recreational, use is when there are negligible health or social impacts to the drug use. Drug use becomes problematic when it harms the health of an individual and/or has negative impacts for that person's friends and family. An individual is considered chronically dependant on drugs when drugs are used habitually and with compulsion, despite the negative consequences to their health, social relationships and society.

Although there are many ways in which substances can be taken, in this paper I focus on injection drug use. The injection of drugs began soon after the development of the syringe in the mid-1800s. It was believed that the syringe would reduce morphine addiction because smaller amounts of the drug would be needed for injections compared with oral intake; this turned out to be a false assumption that led to new problems (White & Webber, 2003). Currently there are 136 countries that report injection drug use, with a total of 13 million people injecting worldwide (United Nations Office of Drugs and Crime, 2004).

Users of illicit street drugs often congregate in public places, referred to as open drug scenes, where drugs are sold, purchased and consumed. These people often have unstable housing situations, and are marginalized by society and scorned by the business community. Frequently, they become the focus of intense police attention and,

for numerous reasons, lack access to basic health and social services, thus placing them at great risk for developing severe health problems (Human Rights Watch, 2003; Kerr, Oleson, & Wood, 2004).

Injection drug users are contracting serious chronic illnesses and are dying from overdose and suicide at an unnecessarily high rate (Health Canada, 2001; Kerr, 2000). These health issues also have immense economic impacts. In 2001, the Auditor General of Canada estimated that illicit drug use cost society $5 billion a year in health care, law enforcement, property crime and loss of productivity (Auditor General, 2001). Until recently, the traditional drug policy was one of criminal prohibition (Auditor General, 2001; Riley, 1998). Many have argued that this policy has had little positive effect in dealing with this individual and societal health crisis (Csiernik, 1993; Riley, 1998).

In 2001, the City of Vancouver adopted a four-pillared approach of prevention, enforcement, treatment, and harm reduction to combat the growing drug use problem (MacPherson, 2001). One of these pillars, harm reduction, has been articulated through the development of policies and programs designed to reduce the deleterious effects associated with drug use. One harm reduction strategy, supervised injection sites (hereinafter referred to as SISs or sites), has been used in Europe and Australia. SISs are secure places, usually near open drug scenes, where drug users can bring their pre-obtained drugs and self-administer them in a hygienic environment, using the clean and sterile equipment supplied at the site, under the supervision and guidance of specially trained and educated staff, including nurses. The nurses provide primary care, including client teaching, emergency care in the case of overdoses, and referrals to

addiction treatment, other specialty health professionals and social services. SISs are designed to meet the needs of hard-to-reach, street-entrenched, long-term IDUs who have not met the criteria for other services or who have been unsuccessful with treatment. SISs have four objectives: 1) improve the overall health of injection drug users by decreasing the incidence of drug overdose and the transmission of infectious diseases; 2) reduce public nuisance associated with injection drug use, including crime, discarded drug paraphernalia, especially needles, and the open use of drugs on the street; 3) increase drug users' appropriate access to health and social services; 4) reduce the economic costs of illicit drug use in the areas of health, social services and criminal justice (Kerr, 2000).

The Canadian Controlled Drugs and Substances Act (CDSA) prohibits the possession and trafficking of specific controlled substances such as heroin and cocaine. Controlled substances are defined as "psychoactive substances and their precursors whose distribution is forbidden by law or limited to medical and pharmaceutical channels" (World Health Organization, 2006). Under the original CDSA restrictions, SISs are illegal to operate; however, Section 56 of the CDSA makes provision for a ministerial exemption if she or he deems it necessary for medical or scientific reasons or if it is in the public's interest (Health Canada, 2002). In 2003, the then federal Minister of Health, Anne McLellan, gave approval for Vancouver to run two SIS pilot projects by using the Section 56 exemption.

The origin of the idea of operating SISs in Vancouver has been difficult to identify from literature sources, but it probably came from information about similar sites in Europe. Vancouver has had four SISs although the first, the Back Alley Drop-In, does

not fully meet the definition of an SIS as presented above. The Back Alley Drop-In did not have any staff that were specially trained and educated, such as nurses, and was an unlicensed, peer-driven, peer-run site that operated between 1995 and 1996. Active drug users would watch the doors, answer the phone, supervise the injections, and try to revive people who overdosed. On the busiest nights up to 200 people would come to the site (Drug War Chronicle, 2005). Information regarding the Back Alley Drop-In is limited and no research was conducted. The site was closed, probably due to a lack of finances (City of Vancouver, 1996; Drug War Chronicle, 2005).

It was not until the fall of 2001 that Vancouver's second site was started, located at the Dr. Peter Centre. The Dr. Peter Centre is an HIV/AIDS healthcare centre with a primary mandate of offering a 24-hour assisted-living residence and a daytime health program. Nurses at the Dr. Peter Centre recognized that there were increased complications associated with abscess and cellulitis in their injection drug-using clients. The nurses believed that by offering care while a client is injecting they would be able to educate the clients and help them to improve their technique in order to prevent vein damage and infections (Wood, Zettel, & Stewart, 2003).

The Dr. Peter Centre worked with the BC Centre for Excellence in HIV/AIDS, the Provincial Street Nurse Program, and the Vancouver Area Network of Drug Users to start a pilot SIS in the fall of 2001. The pilot project focused on nursing practice by collecting anecdotal evidence on the site's effectiveness. The documentation of all nursing interactions involving the supervision of safer injection techniques was fastidiously recorded. The site became fully operational in April 2002. The SIS at the Dr.

Peter Centre is still in operation and now has government approval through the Section 56 exemption.

Like the previous two sites, Vancouver's third SIS, "327", as it was/is known, started without government sanctioning. It was a user-driven site that began in protest to their perception that the City of Vancouver and Health Canada were moving too slowly in establishing an official SIS by Vancouver Coastal Health Authority. The catalyst for starting this site occurred after the Vancouver Police Department initiated Operation Torpedo, the redeployment of 42 police officers to the DTES (Lithgow, 2003). The goal was to break the cycle of drugs and crime by disrupting the open drug market (City of Vancouver, 2003). Finally, in September 2003, the government sanctioned the fourth site; a stand-alone site run by Vancouver Coastal Health in partnership with the Portland Hotel Society Community Services Society was opened in the DTES.

Despite the long history of injection drug use in the DTES, and evidence that the population of IDUs is at greater risk for a number of serious health and social issues that SISs are intended to mitigate, research on SISs has rarely included the perspective of IDUs. In this research project, I explore the experiences of IDUs with SISs. In this chapter, I will lay out the foundation for this project by discussing the problem, making clear the purpose of the study and stating the research question. I will then address the definition of terms used throughout the paper and present the assumptions I bring to the research. Finally, I will present the organizational format for this paper.

PROBLEM STATEMENT

Limited research has been done on SISs (Wright & Tompkins, 2004). The studies that have been undertaken have focused on the operational statistics of SISs (number

of clients, number of referrals to treatment, etc.), client demographics (gender, age, ethnicity, etc.), the effects on the community (number of discarded needles, crime rates, etc.) and the health of IDUs (overdoses, prevalence of HIV and hepatitis C, etc.) (Hedrich, 2004). There is a significant gap in the research coming out of cities with SISs in Europe, Australia and Canada, and although SISs have been in existence since the early 1990s, I was unable to find any studies in which IDUs' experiences with SISs were explored. Since SISs are directed towards IDUs, it is important to provide this target population with the opportunity to share their experiences and contribute their ideas for improving SIS impact. The most accurate and complete information about participants' experiences must come directly from those who are experiencing the phenomenon. This study engages IDUs in in-depth interviews concerning their experiences with SISs.

RESEARCH PURPOSE

The purpose of this research is not to evaluate SISs, but rather to elucidate IDUs' experiences with the sites. The information I gathered from this research will be used to shed light on some of the IDUs' experiences, most of whom live somewhat "hidden" lives, thereby better informing health and social service providers about the needs of their clients.

Street nurses have identified building and maintaining the trust of their clients as a key part of their work (Hilton, Thompson, Moore-Dempsey, & Hutchinson, 2000). A more thorough understanding of their clients' thoughts, feelings and experiences will enable nurses to better meet their clients' needs. This research is also intended to benefit healthcare policy makers and program planners. There are a wide variety of healthcare problems associated with injection drug use. Healthcare policymakers

provide direction and guidance so that programs and other healthcare initiatives best meet the health needs of individuals and society. SISs are new and controversial, but still a key component to the policy of harm reduction. This research gives IDUs a voice to express thoughts and opinions regarding their experiences with SISs. This research is designed to bridge the gap between policymakers and the reality of the participants' experience as interpreted by the researcher.

RESEARCH QUESTION

When formulating my research question, I took into account the context surrounding IDUs and SISs, as well as the serious health problems associated with injection drug use. Previous policies and strategies have had moderate success at best. SISs are new initiatives set up on a trial basis. In my literature review I did not find specific studies that enquired about the IDUs' experiences with SISs. Therefore, there is a need to ask "What are injection drug users' experiences with SISs?" Considering that the SISs are operating on a three-year research trial basis, this is both a timely and important question.

DEFINITION OF TERMS

The following is a list of terms used in this paper. All but one of the definitions come from the World Health Organization (WHO, 2006). I purposely chose to use the WHO because it is a well respected international organization, and this thesis may be looked at outside of Canada. The definition for injection drug user states "IDU Injecting drug user or use". This definition was inadequate for this research study so I selected a more appropriate definition after using Google "Web Definitions" search. For words or phrases that are only used once, definitions will be provided at the time they are

employed. Slang street and drug terms used by the participants during their interviews

will be listed in Appendix I.

1. Drug: "A term of varied usage. In medicine, it refers to any substance with the potential to prevent or cure disease or enhance physical or mental welfare, and in pharmacology to any chemical agent that alters the biochemical physiological processes of tissues or organisms. Hence, a drug is a substance that is, or could be, listed in a pharmacopoeia. In common usage, the term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs, of which there is non-medical use in addition to any medical use. Professional formulations (e.g. 'alcohol and other drugs') often seek to make the point that caffeine, tobacco, alcohol, and other substances in common non-medical use are also drugs in the sense of being taken at least in part for their psychoactive effects" (World Health Organization, 2006).

2. Drug Addiction: "Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means. Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted. The life of the addict may be dominated by substance use to the virtual exclusion of all other activities and responsibilities" (World Health Organization, 2006).

3. Harm Reduction: "In the context of alcohol or other drugs, describes policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or drugs. The term is used particularly of policies or programmes that aim to reduce the harm without necessarily affecting the underlying drug use" (World Health Organization, 2006).

4. Illicit drug: "A psychoactive substance, the production, sale, or use of which is prohibited" (World Health Organization, 2006).

5. Injection Drug User: "A person who uses a [non-prescription] drug (e.g., heroin, cocaine) that is administered with a needle and syringe. The term intravenous drug user (IVDU) is also sometimes used. IDU is more general, and refers to injection methods other than intravenous administration" (KC Adherence Project, 2005).

6. Methadone: "A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision" (World Health Organization, 2006).

7. Overdose: "The use of any drug in such an amount that acute adverse physical or mental effects are produced. Deliberate overdose is a common means of suicide and attempted suicide. In absolute numbers, overdoses of licit drugs are usually more common than those of illicit drugs. Overdose may produce transient or lasting effects, or death; the lethal dose of a particular drug varies with the individual and with circumstances" (World Health Organization, 2006).

8. Polydrug Use: "The use of more than one drug or type of drug by an individual, often at the same time or sequentially, and usually with the intention of enhancing, potentiating, or counteracting the effects of another drug. The term is also used more loosely, to include the unconnected use of two or more drugs by the same person. It carries the connotation of illicit use, though alcohol, nicotine, and caffeine are the substances most frequently used in combination with others in industrialized societies" (World Health Organization, 2006).

9. Psychoactive Drug or Substance: "A substance that, when ingested, affects mental processes, e.g. cognition or affect. This term and its equivalent, psychotropic drug, are the most neutral and descriptive terms for the whole class of substances, licit and illicit, of interest to drug policy. 'Psychoactive' does not necessarily imply dependence-producing, and in common parlance, the *term* is often left unstated, as in 'drug use' or 'substance abuse'" (World Health Organization, 2006). This paper will use the terms "drug(s)" and "substance(s)".

10. Substance Abuse: "...a maladaptive pattern of use indicated by...continued use despite knowledge of having a persistent or recurrent social, occupational, psychological or physical problem that is caused or exacerbated by the use [or by] recurrent use in situations in which it is physically hazardous" (World Health Organization, 2006).

11. Withdrawal: "A group of symptoms of variable clustering and degree of severity which occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses. The syndrome may be accompanied by signs of physiological disturbance. A withdrawal syndrome is one of the indicators of a dependence syndrome. It is also the defining characteristic of the narrower psycho-pharmacological meaning of dependence" (World Health Organization, 2006).

RESEARCHER'S ASSUMPTIONS

When setting out to conduct this research I identified my pre-existing beliefs and assumptions. In this section, I will list my assumptions so the reader will have a frame of reference to better understand why I conducted this research and why I chose the

methodology, and to understand the numerous decisions I made throughout this process.

1. Injection drug users' lives are complex and often hidden from the eyes of society. My experiences of working as a street nurse in Toronto provided me a glimpse into IDUs' lives, but I soon realized there was much I didn't know.

2. Injection drug users are capable of discussing their experiences in a competent and thoughtful manner. The IDUs I worked with shared with me many opinions and stories about their life. I realized quickly that they can be the best source of information because they are the authority on their own experiences.

3. Injection drug users will be open and honest about their experiences. I found that the vast majority of IDUs appeared to have spoken openly and honestly with me when I was a street nurse.

4. My nursing education and practice leads me to believe that there is no one truth or reality. Each person has his or her own understanding of reality. Through direct nursing practice, the nurse and the client realities co-exist. In the case of this research, I will be presenting my interpretations of the participants' experiences.

5. Stories can have different meanings when viewed in a variety of contexts. As a nurse researcher, I listened to the stories that participants shared during the interviews and occasionally asked follow-up questions that I felt were important but that may not have been related to the main point of the story.

6. The relationship established between the researcher and the participant is central to the research. The researcher cannot be separated from the participant

and must play an active role in guiding the research process. For this reason, reflexivity, demonstrated by continuous assessment and interpretation of my actions, guided me throughout the research.

7. Since everyone has his or her own perceptions and understandings, no one can be truly objective. Therefore I needed to be aware of my subjective stance and recognize how it influenced the research.

8. Openness to ideas and curiosity to explore are necessary qualities of a qualitative researcher. My openness and curiosity rose and fell repeatedly throughout the research process in direct relation to other life circumstances unrelated to the study issues. Realizing this, I took time off from work to conduct the interviews and analyze the data.

9. People are complex beings and therefore researchers need to take a holistic approach in order to understand participants' experiences.

THESIS ORGANIZATION

There are five chapters and accompanying references and appendices in this thesis. Before providing a brief explanation of each chapter's contents, I will explain how I use the terms "part" and "section". Chapters 2, 3 and 4 have a great deal of information so I have organized the information and divided it into parts. Each part is further divided into sections. For example, Chapter 3 is divided into three parts: 1) Conceptualizing and Designing the Study; 2) Research Process; and 3) Researcher Consideration. Part 2, The Research Process, is broken into four sections: 1) Sampling; 2) Data Collection; 3) Data Analysis; and 4) Rigour.

In Chapter 1, I provide background information necessary to understand the general problem. This is followed by a problem statement which explains why there is a need for this research. The purpose of the research is then explained. The research question is then stated. The next three sections provide background information for the reader to better understand and use this document. Common terms used throughout the thesis will be defined. I clearly state the assumptions I hold that influence my role as the researcher of this study and author of this document. Finally, in this section, I explain the organization of this thesis.

Chapter 2 is the literature review section. Because drug use is an illicit act, the experiences of IDUs are often hidden from public view. Instead of focusing the literature review on SISs, I take a broad approach to bring to light the complexities of the lives of IDUs. The second part of the chapter focuses on literature surrounding SISs.

As stated earlier, there are three parts in Chapter 3. The first part deals with the identification of the research topic, the description of the research approach, including an explanation of its appropriateness, and a description of how participants were accessed and recruited. The middle part of the chapter contains the research process. The final part of the chapter deals with all the researcher considerations. The sections are ethics, inclusion/exclusion criteria, informed consent, participant compensation, and researcher safety.

Chapter 4 is the heart of this paper, where I present the research findings. Therefore, I will describe this chapter in greater depth than the others. Chapter 4 will be divided into five parts: 1) Participant Background; 2) Injection Drug Users' Experiences; 3) Experiences Using SISs; 4) Participants' Opinions and Recommendations; 5) Main

Findings; and 6) Unexpected Findings. There will be an overview of the group in the background section which will include a reference table listing demographic information about the participants, such as gender, age, years of injecting, etc. The strength in this type of research comes from the richness of data derived from the in-depth interviews that have been analyzed and presented as findings.

To enable the reader to better understand the background and context from which the findings were derived I have chosen to provide a brief description of each participant. In the second section, I will relay the participants' descriptions of their lives prior to SISs becoming operational. Although this study was designed to explore the experiences of using SISs, my study of history has taught me that learning about the past is fundamental in understanding the present. The third section will focus on findings regarding SISs. I structured this section so the reader will follow the participants as they travel through the different rooms in the site. The first room is the reception area, followed by the injection room, and then finally the space allocated for relaxing prior to leaving the premises. I have chosen to present the findings in this way so the reader will get a better understanding of the IDUs experiences in a logical manner. In this section I will also cover participants' interactions with other users, registered nurses and peer support workers.

In the next section, participant's opinions and recommendations are presented. The main findings are the major focus of this chapter. Five barriers are identified which restrict access to SISs: 1) Limited Hours of Operation; 2) Public Entrance – Lack of Anonymity; 3) Waiting Time; 4) The Atmosphere; and 5) Prohibition of Assisted Injection. Finally, before summarizing the findings, unexpected findings which are not

directly related to the initial research question are presented. I have chosen to include these findings because they have important implications for nurses and other health or social service providers who work with people addicted to street drugs and for those interested in SISs as a harm reduction strategy. These findings may also be worthy of further exploration in future studies. In Chapter 5, I provide a summary of the research, a discussion of the implications, and a conclusion.

CHAPTER TWO: LITERATURE REVIEW

INTRODUCTION

Rather than focusing the review specifically on the literature related to IDUs' experiences with SISs, I have decided to broaden the scope in order to gain a better understanding of the lives of IDUs and build an analytic framework based on the available existing knowledge. I made this decision for three reasons. First, there is limited research regarding this topic. Second, since the use of street drugs is an illicit act, the daily experiences of IDUs are often hidden from view and not commonly known. Finally, this format is congruent with the interpretive description method I used in this study. Interpretive description requires the researcher to critically analyze existing formal (literature) and informal (clinical interpretations) knowledge (Thorne, Kirkham, & MacDonald-Emes, 1997). Therefore, in the first part of this chapter I will present information that will help provide an understanding of the context in which IDUs live.

To learn from a person's experiences it is necessary to understand the factors that construct the situation. In this section, I will outline the first part of the literature review: 1) the prevalence of drug use; 2) risk factors for drug addiction; 3) commonly used injection street drugs; 4) common health complications; 5) the open drug scene; 6) drug strategies; and 7) Vancouver's Four Pillar approach to drug-related problems. In the second part of this chapter, I will focus on critically analyzing the literature available regarding SISs from Europe and Australia.

PREVALENCE OF DRUG USE

People have a fascination with altering their perceptions of the world by using psychoactive drugs. This is not a new phenomenon. Evidence of psychoactive drug use

has been documented in all ancient civilizations (Csiernik, 1993). The illicit nature of drug use makes it difficult to estimate the magnitude of the problem. Over 15.3 million people in the world are diagnosed with a drug use disorder, and injection drug use has been reported in 136 countries (WHO, 2003). AVERT, an international HIV/AIDS charity that was formerly known as "AIDS Education & Research Trust", estimates that by the end of 2003 there were 13.2 million IDUs, living in 41 countries (AVERT, 2004). It has been reported that Canada has 125 000 to 132 000 IDUs, most of whom inject heroin, cocaine, or steroids (Health Canada, 2001; Riley, 1998). Schechter and O'Shaughnessy (2000) reported that approximately 12 000 IDUs live in the Greater Vancouver Area and almost half of them live in the DTES.

DRUG USE MODELS

Many different models have been proposed to explain addiction and substance abuse. In this section I will briefly present the moral and medical (disease) models because both dominate and shape society's understanding of drug use. The moral model holds that any amount of drug use is harmful, criminal, and will lead to addiction. Drug users are seen as being solely responsible for their actions, and the use of certain substances is viewed as unacceptable, often even sinful (Csiernik, 1993). The model favours punishment for those who produce, distribute or use drugs. It is based on prohibition with a goal of a drug-free society. This model is clearly seen in America's "War on Drugs".

The medical model can be traced back to the morphine epidemics in England during the 1890s, but it only caught on in North America in the 1930s as an alternative

explanation by the Alcoholics Anonymous[1] movement (Alcoholics Anonymous, 2006; Csiernik, 1993). The models are similar in that drug use is seen as harmful and leads to addiction. Proponents of both models seek to reduce the supply, demand and use of drugs with an end goal of eliminating its prevalence. Instead of treating the user as a criminal, advocates of the medical model view substance abusers as being ill and in need of help.

The two signs and symptoms of addiction according to the medical model are: 1) loss of control over drugs, and 2) denial of the severity and consequences of using. It is believed that addiction is incurable and abstinence is only a remission. This is reflected in the expression "once an addict always an addict". The stigma of being a criminal shifted to that of being weak and sick. The two models focus on the individual user rather then societal or environmental causes.

RISK FACTORS FOR ADDICTION AND SUBSTANCE ABUSE

Many factors place people at risk for addiction and substance abuse, including genetics, psychological, psychiatric, peer and family influences, and life events. Before going further, it is important to discuss what "risk" means. The concept of risk has both an objective and a subjective aspect. For a risk to be present there must be a probability of harm and a perception of danger (Health Canada, 1997). Risk is "the likelihood or probability of encountering harm or loss....cause by a specific danger or threat. These are commonly referred to as 'risk factors'" (Health Canada, 1997, p. 4). In this section, I have clustered the risk factors into two categories: constitutional predisposition and environmental factors. Gender differences will then be compared. Since there is an

---

[1] Alcoholics Anonymous, founded in 1935, is an informal society of recovering alcoholics that support and help each other to remain sober. There are 105 294 groups, with a total membership of 2,076,935 located in over 150 countries.

overrepresentation of First Nations with substance abuse problems, a brief discussion of the health and social inequities that have contributed to this problem is provided. The interrelationship between homelessness and substance abuse, including a section on street youth, is then discussed.

Since over 90% of all adult drug addicts started to use psychoactive substances as adolescents (Sheehan, Oppenheimer, & Taylor, 1988), and problematic drug use as a teen is the biggest predictor of substance abuse in adulthood (Deas & Thomas, 2002), the following risk factors focus on adolescence.

Constitutional Predisposition

Constitutional predisposition relates to the genetic makeup, psychological traits, behaviour, and psychopathology of individuals. A link between genetics and substance abuse was made by studying the degree of concordance in monozygotic (identical) and dizygotic (fraternal) twins with similar environmental influences (Hardie, 2002). While mapping the human genome, researchers have found that no single gene, but rather a number of genes, can be attributed to cause substance abuse (Hardie, 2002). Psychological traits refer to personal characteristics (Deas & Thomas, 2002; Hardie, 2002; Hawkins, Catalano, & Miller, 1992; Pumariega, Rodriguez, & Kilgus, 2004). Traits associated as factors for substance abuse include:

1) a high level of novelty seeking – exploring
2) low harm avoidance – reaction to harmful stimuli
3) high reward dependence – conditioned to feeling a relief of punishment or the receiving of a reward
4) poor self control
5) risk taking
6) anger
7) independence
8) negative effect

Aggressive and anti-social behaviour, as well as a tolerance for deviance – going against societal norms – are risk factors for substance abuse (Swadi, 1999). Robins, as cited by Swadi (1999), noted that dropping out of school is a significant risk factor that leads to substance abuse. General psychiatric disorders, but more specifically conduct disorders like Attention Deficit Hyperactivity Disorder and mood disorders such as depression, are also considered to be risk factors for substance abuse (Swadi, 1999). There are many factors, including genetics, psychological characteristics, behaviour, and psychiatric disorders, that can be used to identify risk for substance abuse.

Environmental Risks

Environmental factors are daily experiences and life events that may place a person at risk. Youth are greatly influenced by their family and peers, and children of substance abusing parents are at higher risks of developing drug-related problems (Deas & Thomas, 2002; Swadi, 1999). Swadi (1999) also mentioned family relationships, divorce, poor communication, inconsistent discipline, violence and lack closeness as other risk factors. As adolescents become older, peers play a greater role and have the greatest impact on substance use (Swadi, 1999). Indeed, use of drugs by friends is the strongest indicator of whether a teen will use drugs or not (Deas & Thomas, 2002). Traumatic life events in childhood and adolescence have also been linked to substance abuse (Swadi, 1999). Swadi reported a variety of studies that have shown that adolescent drug users had higher rates of bereavement, illness, unwanted pregnancy, and sexual abuse.

Substance Abuse – Differences in Gender

The causes, effects, and consequences of substance abuse differ between the genders (Hanson, 2002; Whynot, 1998). Slightly over 2% of the Canadian population use illicit substances other than marijuana (Tjepkema, 2004). Canadian men (10%) use illicit substances on a daily basis, slightly more than women (9%) (Tjepkema, 2004). They are also more likely to be dependant on illicit drugs (Tjepkema, 2004). It is important not to automatically think that males are more likely to abuse substances. Boys receive more drug offers and at a younger age than girls, but both genders accept drugs at the same rate (Hanson, 2002; NIDA, 2000). Girls are usually offered drugs, in a private setting, by a female friend or family members who are around the same age, and to a lesser extent boyfriends who are older, who have minimized the risk factors. Boys, on the other hand, are usually approached by other male relatives and acquaintances. They are also approached by strangers in public places such as parks and streets. Those offering drugs to boys tend put a positive spin to drug use (NIDA, 2000).

Drugs can affect women differently to men. Hanson (2002) suggested that for women there may be a difference in how drugs are metabolized. Preliminary research shows that from first use, women become dependant on cocaine and heroin quicker than men, but men are at greater risk for cocaine-induced cognitive impairments and stroke (Hanson, 2002). Of those that inject drugs, women have a 40% higher incidence of HIV than men (Spittal et al., 2002). The literature provides two explanations for this phenomenon. First, injecting drug-using women are more likely to have sexual partners (main, casual, and commercial) who are also IDUs. The second is that women who

inject drugs are more likely to be recipients of injections from someone else (Riehman, Iguchi, Zeller & Morral, 2004; Riehman, Kral, Anderson, Flynn, & Bluthenthal, 2004). This dependency on others for injecting has been linked to greater sharing of needles (Wood et al., 2001) and an increased rate of HIV seroconversion (Spittal et al., 2002). According to Murphy and Waldorf (as cited in Kral, Bluthenthal, Erringer, Lorvick & Edlin, 1999), women IDUs reported that their veins are smaller than men's, making self-injecting more difficult, thus explaining the need for assistance.

Gender power dynamics associated with intimate sexual relationships also have an influence on needle sharing (MacRae & Aalto, 2000; Reihman et al., 2004). MacRae and Aalto (2000) found that 80% of injection drug-using women in heterosexual relationships have been predominately injected by their sexual partners, even though they have previous experience and are still capable of self-administration.

Aboriginal Peoples

Aboriginal peoples[2], the indigenous inhabitants of Canada, continue to face health and social inequalities despite recent improvements to health (British Columbia Provincial Health Officer, 2003; Browne, Smye, & Varcoe, 2005). The inequity is a complex issue that relates to federal and provincial government attitudes of racial and cultural superiority, along with discriminatory policies and programs, suppressed languages and cultures, and outlawed spiritual practices that have led to the suppression of culture and values and have eroded political, economic and social systems (Royal Commission on Aboriginal Peoples, 1996).

---

[2] Aboriginal Peoples refers to First Nations, Inuit and Métis peoples, and it was a term used by the Royal Commission on Aboriginal Peoples (1996). First Nations replaces Indian, Inuit replaces Eskimo, and Métis have a mix of European and Aboriginal ancestry (Browne, 2005).

First Nations account for 2% of the City of Vancouver population but make up at least 25% of all the people that sleep outdoors (Graves, 2004). Another study found that the First Nation people account for 30% of the homeless population of Greater Vancouver, 34% of the street homeless, and 23% of the sheltered homeless (Social Planning and Research Council of BC, 2005). The British Columbia Centre of Excellence in HIV/AIDS found that those identifying themselves as having First Nations' ancestry have a high representation in their random selection of SIS clients for their drug study (Insite, 2004).

Homeless people

Before discussing the relationship between chronic drug use and homelessness, the definitions and meaning of homelessness must be addressed. Vangeest and Johnson (2002) distinguish two types of homelessness: literal and at-risk. They define the literal homeless as "individuals who would be homeless by any conceivable definition of the term" (p. 456). This broad definition covers, but is not exclusive to, people living and sleeping on the streets, in abandoned buildings, in automobiles and in temporary shelters (both indoor and outdoor). "At-risk" homeless people may be living in single room occupancy (SRO) hotels or in accommodation such as apartments and rooming houses where the ability to pay the rent is tenuous and there are no other options for a stable place to stay. The literal homeless population is sometimes further divided between the sheltered homeless population, who have some form of temporary shelter (e.g. emergency shelters, safe houses or transition houses), and the street homeless population, who live and sleep on the street (Social Planning and Research Council of BC, 2005).

A distinction must also be made between what is meant by the terms "housing" and "home". Housing meets the basic human need for space and security. A "home", on the other hand, provides privacy, comfort and convenience as well as something more important. A person has a sense of connection to a home because it provides them with order and it represents part of their identity (Baumann, 1993). For example, an emergency shelter provides housing because it provides shelter and relative security, but it would not constitute a home because it lacks privacy and a connection with the individual.

In a report presented to Vancouver City Council, Graves (2004) states that approximately 500 to 1 200 people without shelter sleep outdoors in the city every night and that two-thirds of these people suffer from severe addictions. The Social Planning and Research Council of BC released Homeless Count 2005. On March 15, 2005, over a 24-hour period, a count of the homeless was undertaken. The search took place in places known to have homeless populations located within the Greater Vancouver Regional District. The count of street and sheltered homeless revealed 2 174 people, which doubles the 2002 count. The number of street homeless has increased 238% since 2002. The 2005 Count also states that 74% of homeless people have at least one serious health condition, the most common of which is addiction.

Although there is clearly a relationship between substance abuse and homelessness, Johnson, Freels, Parsons, and Vangeest (1997) suggest that the relationship is not well understood. Two opposing models attempt to explain this relationship. The social selection model maintains that substance abuse is just one of many paths that drain a person's financial resources, break stable social connections

and, if prolonged, result in homelessness. The social adaptation model looks at the relationship from the other perspective. It holds that a person uses drugs as a way to adapt to life. In regard to homelessness, a person's abuse of drugs is a learned method of coping with street life. Neither the social selection model nor the social adaptation model are sufficient. Although the authors feel both models are necessary, they are correct in suggesting that a multidirectional model would better our understanding of the connection between homelessness and substance abuse.

Street Youth

The abuse of alcohol and drugs by youth is a serious public health concern. There are differing opinions on how to define street youth. Riley (1998) defines street youth as anyone aged 12–25 who is away from his or her home without parental permission for over 24 hours. The McCreary Centre Society's (2001) definition includes only those under the age of 19 who lack parental supervision or shelter because they have run away from home or have been "kicked out" of their home. Regardless of the age differences, homeless preteens, teens and young adults are engaging in high-risk behaviours, such as having unprotected sex and using illicit drugs, which make them more vulnerable for contracting sexually transmitted diseases, HIV and HVC (MacPherson, 2001).

By Riley's definition, there are approximately 150 000 street youth in Canada (Riley, 1998). These youth often come from unstable homes where poverty, substance (especially alcohol) misuse and both physical and sexual abuse were the norm (MacPherson, 2001). Norton, Weinrath, and Bonin (2000) report that 85% of Vancouver's street youth have used cocaine, and of that number, 48% of males and

32% of females say they have injected drugs. The Social Planning and Research Council of BC (2005) found that 56% of all street youth have substance addictions, which is a higher percentage than for any other homeless subgroup. Use of alcohol and other drugs in adolescence is the biggest predictor of adult drug dependence (Swadi, 1999).

DTES – THE DRUG USING ENVIRONMENT

The DTES is one of the oldest neighbourhoods and is considered to be the historic centre in Vancouver. The DTES is a ten square block area to the east of Vancouver's City core. Like many large urban centres, it faces many problems related to drug addiction. It has an open drug scene, property crime and prostitution, inadequate housing, unemployment and disproportionably high rates of health problems such as HIV and hepatitis C. Of the 16 275 residents living in the DTES, approximately 4 700 inject drugs (Schechter & O'Shaughnessy, 2000). Although there are many problems, the DTES community website lists over 160 health and social support agencies that are based or have projects in the DTES (2006). The City of Vancouver realized that even with all of these services the drug problem was getting bigger (Brands & Marsh, 1997; MacPherson, 2001).

Street Drugs

Psychoactive drugs are inhaled, smoked, and injected for the temporary euphoric pleasure they bring through the rise in certain neurotransmitters, particularly in dopamine. People seek this "high" for numerous reasons, including, but not limited to, pain relief, relaxation, boredom, and a reprieve from emotional hurt (MacPherson, 2001). Substance abuse occurs when a person experiences physical, mental,

emotional, legal or social problems associated with the use of psychoactive drugs. Drug misuse not only causes harm to the user, but also to the user's family, friends and community.

In a pilot study of risk behaviours among Canadian IDUs, researchers found that the most commonly injected drugs are cocaine (81.9%), morphine (54.3%), dilaudid (50.2%), heroin (42.8%), and crack cocaine (30.5%) (Public Health Agency of Canada, 2004). Medications like morphine and dilaudid are sometimes diverted to the street drug market. Heroin and cocaine are the most common illicit drugs produced, trafficked and injected.

Diacetylmorphine, commonly called heroin, is a chemically modified version of morphine which is derived from opium, the exudate extracted from seedpods of the opium poppy, papaver somniferum. Heroin, three times stronger than morphine, was developed in 1874 and first marketed by the Bayer company in 1898. Bayer stopped production in 1913 when heroin's addictive properties became well known. Heroin is most often injected or smoked (Askwith, 1998). When injected, it takes 15–30 seconds to reach the brain, and when smoked, about 7 seconds. When heroin is consumed, the user will experience an intense rush of warmth and relaxation. Stress, anxiety, hunger, fear and pain all seem to dissolve away, leaving the user feeling safe and secure. The peak effects are experienced within a few minutes and the feeling of tranquility lasts 3 to 5 hours. Heroin users usually inject 2 to 4 times per day (Centre for Addiction and Mental Health, 2005).

Since 3000 BCE, the leaves from the erythroxylon coca plant, indigenous to South America, were chewed for their effect as a psychoactive stimulant. Pure chemical

cocaine was first synthesized in 1855 from coca leaves. Nowadays, cocaine is most often snorted, smoked or injected. In its white powdery street form, cocaine is snorted. Smoking and injecting provides a quicker "high". A smokeable, freebased form is developed when cocaine is mixed with ammonia and ether and then heated. Since the 1980s cocaine has been concentrated by heating it with baking soda to produce crack. Crack is another smokeable form of cocaine. When smoked, crack can reach the brain within 10 seconds. The user will have a rush of energy and a feeling of being more alert and invincible. There is a sense of increased confidence, motivation and sex drive. The effects of cocaine quickly wear off, leading users to seek more. Cocaine is the most popular drug injected in Vancouver (Strathdee, 1997). Many cocaine users also use other illicit drugs (Norton, Weinrath, & Bonin, 2000). IDUs who use cocaine are more likely to engage in high-risk behaviours like needle sharing and unprotected sex (Compton, Lamb, & Fletcher, 1995).

Polydrug use refers to taking more than one drug. Polydrug use may occur to enhance or counter the effects of another drug, or simply because the user cannot access his or her preferred drug due to expense or lack of availability. Polydrug use is common among IDUs and has been linked to high-risk behaviours and overdose (Darke & Hall, 1995).

Injecting outside is unhygienic and unsafe. IDUs buy their drugs and often go to a nearby alley to inject. The following description is based on Vancouver Coastal Health's SIS video (2003a). The alleys are dirty and often littered with used injection paraphernalia and human excrement. IDUs often inject under a covered doorway for privacy and shelter. Sometimes they sit down on a broken down cardboard box to stay

clean. There is no access to clean water for washing hands, let alone mixing the drug; sometimes IDUs resort to using puddle water. Even if they have clean syringes and containers of sterile water, they can easily contaminate their supplies prior to injecting. Alleys do not have clean flat surfaces on which supplies can be laid out. If clean needles are not available, IDUs may reuse the same needle or even share a needle with friends or acquaintances. Some IDUs are desperate enough to inject themselves using discarded dirty needles they find on the ground. Worried for their safety in the alleys, as well as going through withdrawals, IDUs often rush to inject their drug. This leads to injecting practices that IDUs would not normally use. Miscalculating amounts of the drug can lead to overdoses.

Service Utilization

IDUs have complex health issues which often require hospitalization. With high rates of chronic illnesses like hepatitis and HIV, hospitalization is common. Infections may need to be treated with expensive antibiotics and regular dressing changes. When wounds do not heal, surgery may be needed.

Hospitalized IDUs often leave against medical advice, and have frequent readmissions for the same or related problems. The lengths of stay for the readmissions are significantly longer and therefore use more hospital resources (Anis et al., 2002).

Financial Costs

Injection drug use has negative consequences for society as well as for the individual. Millar (1998) reports that an untreated heroin addict costs society approximately $30 000 per year. Drug use is associated with a wide variety of crime ranging from prostitution, car theft, and breaking and entering to murder. Fifty percent of

all crimes in which the perpetrator gains financially are attributed to drug use (Pernanen et al., 2002). In 1999 there were 400 000 court appearances related to, and 50 000 people charged with, drug offences (Auditor General of Canada, 2001). The combined economic cost of illicit drug use in Canada is estimated to exceed $5 billion a year (Auditor General of Canada, 2001). Until recently, Canada focused most of its effort and finances on drug enforcement. More than 90% of the $454 million spent on dealing with illicit drugs is devoted to reduction of supply (Auditor General of Canada, 2001). Many argue that drug enforcement is not effective (Alexander, 2001; MacPherson, 2001; Wood, Zettel, & Stewart, 2003).

HEALTH PROBLEMS ASSOCIATED WITH INJECTION DRUG USE

IDUs have high mortality and infection rates; the vast majority of these deaths and infections are deemed preventable (Health Canada, 2001; Kerr, 2000; Sporer, 2003). In 2003, British Columbia had 178 illicit drug deaths, of which 155 were classified as accidents, and 11 were suicides (BC Coroner Service, 2004).

Every year, 2% of all injection heroin users die, with overdose being the leading cause of death (Darke & Zador, 1996; Darke & Ross, 2002; Sporer, 2003). According to Darke (2003) of the National Drug and Alcohol Research Centre in Australia, myths surrounding overdose have become so popular that they have impeded scientific inquiry. The statements below have been called into question by studies undertaken by various researchers.

- People who overdose are young, inexperienced users.
- Overdose death occurs almost instantaneously.
- People overdose because of impurities in the drug.
- Overdose occurs when the amount of the drug exceeds the person's tolerance.

Sporer (2003) states that most deaths related to intravenous heroin overdose occur in users who have been injecting for 5 to 10 years and that new users account for only 17% of heroin deaths. In fact, the average heroin addict lives twenty years after first starting to inject, while cocaine addicts survive on average only four (Perry, 1995). In fatal overdose, death usually occurs 1 to 3 hours after injection; it is not common for IDUs to die instantly (Sporer, 2003).

Heroin-related deaths occur at a steady rate and do not fluctuate with sudden changes in purity levels (Sporer, 2003). Furthermore, IDUs do not usually overdose from taking an amount of one drug which exceeds their tolerance. The majority of overdose deaths are related to polydrug use, the taking of two or more psychoactive drugs, and not to the amount or purity level of heroin (Coffin et al., 2003). The combined effects of multiple drugs in the system lead to respiratory depression and overdose. A 12-month Swiss study of opiate overdose cases presenting at the emergency room of a 1 000 bed hospital found that 90.4% were related to polydrug use (Cook, Moeschler, Michaud, & Yersin, 1998).

HIV and Hepatitis C

An epidemiological survey of Vancouver drug use determined that injection drug use was the mode of transmission in 28% of those newly diagnosed with HIV. The survey also states that 62% of those with HVC report having a history of injecting drugs (Buxtom, 2003). McLean (as cited by Kerr, 2000) estimates that number to be much higher at 88%, and the Vancouver Coastal Health Region states it is as high as 90% (VCH, 2003a). Vivianna Zanocco, the spokesperson for the Vancouver Coastal Health Authority, stated that the cost of treating a person with HIV is approximately $150 000

over a lifetime (Brown, 2003). Harm reduction strategies like SISs can decrease the spread of blood borne infection and thereby decrease the health cost to the individual as well as the financial cost to society.

Other Infections

Bacterial wound infections can lead to abscesses on the legs, arms, neck, or anywhere a person injects. With their multiple chronic health issues, inadequate housing conditions and generally poor nutrition, IDUs have weakened immune systems which allow even the smallest infections to spread quickly. This can lead to septicaemia and septic shock. Abscesses may take months or years to heal and sometimes even progress to the point where amputation is necessary. Like contracting HIV or hepatitis C, the personal and societal cost of developing infections are great. Education on safe injecting practices can reduce the incidents of abscesses.

FOUR PILLAR APPROACH

In May 2001, the City of Vancouver adopted a four pillar approach of (1) prevention, (2) treatment, (3) enforcement, and (4) harm reduction, to deal with the problems associated with drug use (MacPherson, 2001). The four pillar approach views drug addiction as a health issue, but the crime associated with it as a legal issue. This four pillar approach has been tried and considered successful in cities in the United States of America, the United Kingdom, and in various countries in continental Europe (MacPherson, 2001). The term pillar may be misleading, as there is an inter-relationship and an overlap of services within the four pillars. Although all four pillars will be mentioned, this study is based on the principles of harm reduction. In the following

section, I will briefly introduce the prevention, treatment and enforcement pillars. I will then explore harm reduction in more detail.

Prevention

The City of Vancouver's draft plan for Preventing Harm from Psychoactive Substance Use is based on population health, community and individual harm reduction, and community-based approaches (City of Vancouver, 2005). Population health recognizes factors such as employment and housing as contributing to health and accessibility of healthcare. Psychoactive substance use runs along a spectrum from beneficial use, to casual non-problematic use, to problematic use, and then to chronic dependence (MacPherson, 2001).

The prevention plan is intended to achieve four main outcomes. First, it hopes to reduce both the incidence and prevalence of drug use. The second goal is to delay the onset of substance use; in other words, to postpone as long as possible a person's first experience using drugs. The prevention plan's third goal is to reduce harm to the individual, family, neighbourhood and community. Finally, it hopes to improve public health, increase safety, and maintain order.

The prevention strategies focus on educating people about the dangers of drug use, the reasons for drug misuse, and strategies to avoid addiction. The four pillar approach divides prevention into primary, secondary, and tertiary. Primary prevention strategies try to prevent, or at the very least delay, the use of substances. Drug awareness programs in schools fall into this category. As it currently stands there is a lack of prevention programs and strategies at early ages (MacPherson, 2001). Secondary prevention focuses on the early stages of drug use prior to addiction and

serious harm. I have not come across programs or strategies that fall into this category.

Tertiary prevention (low threshold) is designed for the street-entrenched addicted

individual. Prevention strategies at a tertiary level fall under the harm reduction section

and will be discussed later in the chapter.

Treatment

Treatment, the second pillar, takes a broad perspective and encompasses a wide

range of programs. Abstinence, methadone maintenance and detoxification programs,

as well as programs providing peer support, assistance with employment and housing,

and the learning of life skills, are all included. Reports have shown that money spent on

treatment has a substantially better return than money spent on law enforcement or on

fighting drug production (MacPherson, 2001). This being said, the government of BC

spends approximately $100 million per year, equal to $24.04 per capita, on prevention

and treatment programs and there are long waiting lists due to the lack of available

treatment programs (Kaiser Youth Foundation, 2001; MacPherson, 2001). Six obstacles

to adequate treatment services were listed in Vancouver's Four Pillar Framework

(MacPherson, 2001):

1) Lack of available treatment leading to long wait lists
2) Inadequate evaluation of current services leading to wasted money on ineffective and/or inefficient treatment services
3) Lack of early intervention (prevention)
4) Lack of coordination between government and private agencies, further complicated by the overlapping services in the ministries of health, education, justice, and social services
5) Current services not treating the addicts that are actively using and involved with the open drug scene street
6) Lack of user involvement

It is the fifth point that is the most relevant to this study. The most street-entrenched

users are still isolated and marginalized by the current services offered. This means that

SISs could potentially be a meeting point between the chronic IDU and the healthcare system.

Methadone maintenance programs are the number one choice of treatment for heroin users. It is liquid medication that is taken orally and prescribed to replace heroin. 20–25% of illicit opiate users are treated with methadone (Fischer, Chin, Kuo, Kirst, & Vlahov, 2002). In 2000, there were 5 563 IDUs in British Columbia being treated, and it was predicted that the program would grow by 150 people per month (MacPherson, 2001). At this point I have not been able to get updated statistics. The cost for methadone maintenance and counselling for one person is $4 000 per year. When compared to a societal cost of $30 000 per year with no treatment, methadone makes financial sense (Millar, 1998). Methadone maintenance programs reduce both fatal and non-fatal overdoses and decrease the risk of death by 75% (Sporer, 2003).

In a Canadian study published in 2002, illicit opiate users' views on methadone maintenance were explored (Fischer et al., 2002). Three distinct reasons limited the acceptance of methadone as a treatment. First, drug users did not like methadone as a drug because of the perception of its side effects, addictive properties, and pharmacological properties that were considered to be "synthetic" and bad for the body and mind (Fischer et al., 2002). Some users do not like methadone because they crave the use of needles almost as much as the drug itself (Fischer et al., 2002). Second, many users believe that the way the methadone maintenance system is structured is disempowering, restrictive and punitive (Fischer et al., 2002). Lastly, opiate users feel that those providing methadone maintenance treatment do not understand the users' feelings and are disinterested, leading to the users feeling alienated (Fischer et al.,

2002). Although methadone maintenance has been show to be effective, not all will use it.

For a variety of reasons, most treatment programs do not reach the most street-entrenched IDUs. As with prevention, there is a wide belief that treatment is underfunded and inadequate (MacPherson, 2001). Although the problem of injection drug use has grown, treatment services have been slow to respond. Many have long waiting lists and often require the IDU to pay some of the costs. Most treatment programs require the person to quit using drugs to qualify for treatment for drug use. For those ready to quit, the wait for help may be too long; for those that cannot quit, there are no treatment options available. Only 20% of drug users attend treatment, leaving 80% with nothing (Denning, Little, & Glickman, 2004). Of the 20% that show up, only 5% to 39% are estimated to be successful. In other words, treatment is only successful in 1% to 8% of the drug-addicted population (Denning, Little, & Glickman, 2004).

Enforcement

The goal of enforcement is to increase public order by decreasing crime. According to Statistics Canada (2004), Vancouver has the highest rate of property crime for a Canadian city of comparable size. Drug enforcement has received more funding than any of the other three pillars, while having only marginal success. The challenges it faces are many. The organized drug trade accounts for US$400 billion or 8% of the world's trade (Riley, 1998). The sheer size and sophistication of the trade makes it almost impossible to control through enforcement. MacPherson (2001) notes that an RCMP Criminal Intelligence Directorate listed that 15 tons of cocaine and one to two tons of heroin are smuggled into Canada every year. The Canadian drug trade has a

street value of $18 billion (PSEPC, 2003). Because drug addiction is viewed as a health issue, the police are put in a difficult position. Although possession is illegal, the justice system has focused on treatment over prosecution. Often a police drug "crackdown" shifts drugs to other geographic regions.

In 2004, the Attorney General of British Columbia formed the Street Crime Working Group (SCWG). This group's one-year mandate was to inquire about the nature and extent of street crime and disorderly conduct in downtown Vancouver, with attention focused on repeat offenders, mentally disordered offenders, and youth, aboriginal people, and substance-addicted people in conflict with the law. The terms "street crime" and "disorderly conduct" refer to crimes and behaviours which directly affect the lives of people in the community, such as breaking and entering, car theft, mugging and harassment. The SCWG was asked to consult with community members in order to develop a community based, multidisciplinary approach to respond to crime and disorderly conduct.

The members of the working group were asked to consider how a triage process could be used to separate criminal cases that need to be processed by the criminal justice system from those that can be handled with minimal or no involvement of the courts. For example, the offender's history, life circumstance, health and social service needs and criminal background should be available to the triage team so an informed decision can be made. They were also asked to consider a "Community Court Model". Community courts aim to address some of the causes of crime and to streamline the process of dealing with street crime and disorderly behaviour by coordinating health and social services with the justice system.

The SCWG came up with five recommendations:

1) Involve the public in the criminal justice system through the creation of a Community Justice Advisory Board and annual Street Crime Plans
2) Apply a triage approach to chronic offenders in the criminal justice system
3) Integrate the justice system with health and social services by creating an Urgent Response Centre to provide "wrap-around services" and a Chronic Offenders Pilot Project
4) Change how courts respond to street crime and chronic offenders by creating a Vancouver Community Court
5) Ensure there is funding and accountability for these recommendations

Harm Reduction

Harm reduction is a pragmatic approach to prevent or reduce individual and community harms associated with drug use through various policies and programs. It can be traced back to the Rolleston committee in Britain during the 1920s. The committee recommended that maintenance on drugs for long-term abusers might be necessary for living useful, productive lives within the rest of the community (Shipman Inquiry, 2005). Since then, injectable opiates have been prescribed in the Merseyside area of Liverpool. Since the 1980s, in response to the AIDS crisis, harm reduction has been gaining greater popularity.

Harm reduction accepts the fact that people use drugs and engage in risky behaviours like needle sharing. Harm reduction takes a realistic approach and does not condemn or criticise users, as the moral and the medical models do. The moral model states that any amount of drug use is wrong and merits punishment. Similarly, the medical model considers any amount of illicit drug use harmful. Often drug users are required to stop using before going into treatment. Harm reduction does not view abstinence as a priority because the problem is not the drug use; it is the harmful effects

of the use on individuals, families, friends, and communities. Harm reduction strategies do not judge or punish the user; they in fact allow the user to reconnect with society.

Harm reduction officially became part of Canada's national drug strategy in 1987 (Riley, 1994). Harm reduction strategies are medium and low threshold services that are easily accessible to users. The term "threshold" refers to the number of preconditions that a person must meet in order to qualify for a service. Thus, more people will be able to access a low threshold service because it will have few restrictions.

Needle Exchange Programs (NEPs) provide sterile syringes to IDUs to help prevent the spread of blood borne pathogens. Sharing used needles is common among IDUs. The provision of clean syringes decreases the risk of HIV and hepatitis C. NEPs can be in a fixed location, portable with vehicles, or on foot with outreach workers. NEPs are access points for health providers to get in contact with IDUs. NEPs can offer risk-reduction education, counselling, and referrals to health and social services. Since IDUs take the syringes and inject away from others, NEPs miss the crucial point at which IDUs are most at risk for overdosing.

SUPERVISED INJECTION SITES

SISs are operating in Australia, Austria, the Netherlands, Switzerland, Germany, Spain and Canada. SISs are secure places where drug users can bring their pre-obtained drugs and self-administer them in a hygienic environment under the supervision and guidance of specially trained and educated staff (Broadhead et al., 2003; Kerr, 2000; MacPherson, 2001; Vancouver Coastal Health, 2003; Wright & Tompkins, 2004). While at a site, IDUs have access to healthcare and counselling. Referrals for health and social services can also be made, depending on the need and

desire of the client. SISs are designed to meet the needs of the hard-to-reach, street-entrenched, long-term IDU who has not met the criteria for other services or has been unsuccessful with treatment.

There are two major goals for SISs (Wolf, Linssen, & de Graaf, 2003):

1. To reduce the harm of injection drug use to the user

2. To minimize the public harm and the nuisance drug use can cause

"Supervised injection site" is just one of many terms used in the literature, some of which are synonymous, while others have slight differences in meaning. Drug consumption facilities (Wolf, Linssen, & de Graaf, 2003; Zobel & Dubois-Arber, 2004), drug consumption rooms (Zurhold et al., 2003) or consumption rooms (Hedrich, 2004) allow clients to come in either to smoke or to inject their drugs. Safer injecting facilities (Anoro, Ilundain, & Santisteban, 2003), medically supervised injection centres (MSIC Evaluation Committee, 2003), and supervised injection facilities (van Beek, 2003) are strictly geared for injection drug use. These terms have been used interchangeably, as seen in the first year summary of Vancouver's site. The title is "Evaluation of the Supervised Injection Site", but in the very first sentence it is called a "supervised injection facility" (VCH, 2004). For this document, a site where inhalation and injection occur will be called a "drug consumption facility" (DCF/DCFs). With sites located in buildings, trailers, tents and vans, the term facility is more appropriate than room. A place where only supervised injections occur with be called a supervised injection site (SIS).

Although the term "shooting gallery" has been used in commentaries and in news media stories to describe these healthcare facilities, there is a distinct difference (BBC

News, 2003; Armstrong, 2003; Potvin, 2004). Frequently controlled by drug dealers, shooting galleries are clandestine places, often unhygienic and sometimes structurally hazardous, where IDUs usually pay money, or barter sex or drugs, to have a protected indoor place away from the police in which to inject their drugs (Klein & Levy, 2003; MSIC Evaluation Committee, 2003; Wright & Tompkins, 2004).

In this section, I review DRF and SIS literature relevant to my study of IDUs' experiences. Since SISs are relatively new, there is minimal research on SISs in Canada. It was necessary to review literature from other countries to provide the needed background. I was unable to access literature from Austria, but research from Germany, the Netherlands, Spain, Switzerland, and Australia, as well as Canada, was reviewed.

Supervised injection sites were first established in Europe during the mid to late 1980s and early 1990s. Many of the reports from the earliest SISs were either unpublished or published in languages other than English. I chose not to explore having these reports translated for time and financial reasons. An overview of these reports, "European report on drug consumption rooms" was produced by Hedrich (2004). In the following paragraphs, I discuss the relevant literature for that document as well as from the other studies regarding SISs. Before proceeding with the specific articles, a clarification should be made. I realized some researchers refer to questionnaires as interviews. For the purpose of this paper, I need to differentiate between these terms. Polit and Hungler, in their book *Nursing Research: Principles and Methods* (1999), define the terms as follows. A questionnaire is a self-administered method of collecting self-reported information from a participant using a paper-and-pencil style format. An

interview is a data collection method in which the interviewer asks questions of the participant. Interviews can range from being completely unstructured to focused. With a less structured interview, the participant is less restricted on the topics he or she can speak about. This is important to know because in most studies participants responded to predetermined survey questions, thus limiting their ability to speak about what they believe to be important.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), in its report on European Consumption Rooms (CR), found that the earliest documentation, from the 1990s, focused on legal issues, policies, and the functioning of DCFs (Hedrich, 2004). The EMCDDA reported that later studies, which analyzed the DCFs and surveyed clients and staff, concluded that DCFs had positive benefits for both the drug user and the community, but stressed that the evidence was limited and that comprehensive studies should take place.

Germany

In 1999, Kemmesies produced an English version of the 1995 final report of a study on the open drug scene and the SISs in Frankfurt. The study had two main goals. First, it attempted to gain a greater understanding of the composition and living conditions of IDUs in the open drug scene. The second part sought to find out how the SISs, initiated in late 1994, had been accepted as a harm reduction initiative by the target group. Interviewers used a questionnaire for their structured standardized interviews. This format enabled the researchers to collect, organize and analyze large amounts of data in a relatively short period. Researchers collected 180 individual pieces of data per participant. These included statistics on age, gender, marital status,

nationality, education, current living conditions, drug use, health, including HIV status

and overdose experience, sources for drugs and finances, and use of drug-aid services.

It was not until the end of the interview that participants were asked to share their

thoughts and provide input into a service. Two questions stand out:

1. Why do you continue to inject on the street when there is an SIS available?
The reasons provided:
- Limited hours of operation
- Long waiting times to inject
- Distance too far to the SIS
- Place of drug purchase is also the place of consumption
- Drug sharing prohibited
- Atmosphere too noisy, crowded and hectic
- No admission for people on the methadone program

2. What suggestions do you have for improving the SISs?
- Establish more sites and extend operating hours
- Improve atmosphere
- Allow methadone users and people who share drugs access

Although the study project was inhibited by time limitations and staff capacity, it

did succeed in providing a general statistical overview of the open drug scene and the

use of SISs. Researchers conceived and conducted the study, analyzed the data and

presented the final report within a 3-month period. The report acknowledges that many

aspects of the research had to be "neglected" or were "unobserved" because of these

constraints. I realized that the IDUs' reasons for injecting publicly and their suggestions

for improving the site might also be mentioned by the participants in my study.

The Netherlands

There are approximately twenty DCFs operating in ten cities (Wolf, Linssen, &

Graaf, 2003). From October 2000 to March 2001, a study was conducted to investigate

DCF operating services, the differences between the sites and what will improve the

facilities (Wolf, Linssen, & Graaf, 2003). The authors identified that some IDUs do not

use DCFs because they do not want to follow the admission rules. This made me aware that participants in this research may also be at odds with the SIS's rules. The DCFs are generally made up of three areas: injection room, inhalation room, and a common room. In the common room, a television, music, games and materials for reading were often supplied for the IDUs' use. No information was given about the IDUs' experiences in each room. The authors said that the DCFs either had furnishings designed to be either more clinical or more social. A clinical, hospital-like décor was chosen if the IDUs were viewed as patients, but furnishing the site to encourage a relaxed social environment was selected if the DCF was designed as a "place for the users". I was curious to find out if the participants in my study would mention the furnishings.

Spain

Spain has two SISs. The Espacio de Venopuncion higenica Asistida (EVA), located in the Can Tunis quarter of Barcelona, and began operating September 12, 2001. The data collected included gender, age, citizenship, housing/homelessness, access to health and social services, health problems related to drug use, and overdose rates (Anoro et al., 2003). Anoro et al. (2003) stated that the staff were frequently asked by the IDUs to inject them, and in certain circumstances, EVA's staff would assist clients by performing injections. The authors did not know what these circumstances were. This is an interesting point because IDUs attending Canada's two official sites are not allowed to be injected by another person.

Switzerland

Most evaluations of Swiss DCFs have not been translated into English; however, an appraisal DCF was conducted by the University Institute of Social and Preventative

Medicine for the Swiss Federal Office of Public Health (Zobel & Dubois-Arber, 2004).

The authors referred to a number of surveys that sought IDUs' opinions regarding

DCFs. These surveys found that having a hygienic place to inject, without disturbance,

away from the police and protected from immediate risks, are the most important factors

for IDUs. The surveys also showed that IDUs want a place to eat, drink, and rest after

injecting. The relationship with staff was identified as being important. IDUs wanted staff

who are non-judgmental, and both available and willing to listen to them. The surveys

also identified that IDUs use the DCF differently. Some IDUs inject and leave, while the

more socially marginalized users tend to utilize the available health and social services.

Australia

The Government of New South Wales (NSW) commissioned a report to evaluate

the 18-month trial of the SIS at Kings Cross in Sydney (MSIC Evaluation Committee,

2003). The mandate given to the researchers was to determine the SIS feasibility at the

Kings Cross area, the impact on IDUs, the attitudes of the local residents and

businesses, and of the general population of NSW, and finally the economic costs and

benefits of the SIS. This was the first comprehensive SIS study conducted in English.

Researchers elicited IDUs' perspectives regarding the operation of the SIS and

their health and requests for referral to other services. Self-administered surveys were

given to IDUs. The surveys focused on IDUs' experiences with local businesses, police

and passers by, injecting behaviours (injection frequency and technique as well as use

of treatment services), and how they rate the SIS service. The researchers found that

IDUs using the SIS are more likely to report injection-related problems such as

abscesses and skin infections, and had less scarring and bruising around their veins.

Almost half of those that participated in the survey reported that their injection technique improved.

Canada

Following the lead of some European countries and Australia, Canada's first SIS opened in April 2002 as one service offered by the Dr. Peter Centre (Wood, Zettel, & Stewart, 2003). The Dr. Peter Centre serves HIV/AIDS-diagnosed clients who are most at risk for their health to deteriorate due to multiple health issues, including mental health conditions, substance use, addiction, lack of social and financial support, unstable housing, and physical disabilities (Dr. Peter Centre, 2004). The SIS was not sanctioned by Health Canada until 2003, although it had received the approval of the Registered Nurses Association of British Columbia (RNABC), now called the College of Registered Nurses of British Columbia (CRNBC).

In November 2002, the new municipal government for the City of Vancouver promised to open an SIS in the DTES. In April 2003, as a protest to a large-scale police drug scene crackdown and governmental inaction or inability to fulfil its promise of starting a SIS, IDUs and their advocates established an unsanctioned SIS at 327 Carroll (Kerr, Oleson, & Wood, 2004). Volunteers and a registered nurse staffed it. It stayed open for 181 days, until 3 weeks after the official government site became operational. In June 2003, Health Canada approved an application for a pilot project by the City of Vancouver for a three-year research evaluation. In September 2003, Insite, a stand-alone SIS, opened in Vancouver.

Vancouver now has two SISs, both functioning under the auspices of the Vancouver Coastal Heath Authority (VCHA): one at the Dr. Peter Centre, an HIV/AIDS

health centre, and Insite, serving IDUs living in the DTES. The DTES, one of the oldest neighbourhoods in Vancouver, has an open drug scene where users buy and consume their drugs in public. The area has high rates of unemployment and crime and a problem with the lack of adequate housing. The three-year research trial will evaluate Insite's impact on health, and its ability to reduce harm, through the collection of data on overdose rates, health of injection drug users, health and social services utilization, and financial costs (VCH, 2003).

The Canadian studies have been left to the last because they are the most recent and most relevant to this project. A formal evaluation of the SIS at the Dr. Peter Centre has not taken place but the nurses have kept anecdotal records of all their interactions with clients using the SIS service since its pilot project started in the fall of 2001. Vancouver Coastal Health Authority[3] and the Portland Hotel Society[4] jointly operate Insite, which is being run as a three-year research trial.

The Dr. Peter Centre

The SIS, part of the harm reduction services at the Dr. Peter Centre, has approximately 25 clients (Wood, Zettel, & Stewart, 2003). Since no formal research evaluation has taken place, the data from this site is sparse. The article "Harm Reduction Nursing" provides background information about how Canada's first official SIS at the Dr. Peter Centre came into being (Wood, Zettel, & Stewart, 2003). The article also includes some general outcome information about client referrals to detox and drug treatment. The authors noted that they have seen a decrease in the incidence of abscesses and cellulitis but did not provide further documentation.

---

[3] Vancouver Coastal Health: one of the government of BC's five regional health governing authorities.
[4] Portland Hotel Society: DTES non-profit organization.

I found the most interesting and most helpful part of the article to be the direct quotes from clients[5]. For me, the words of the clients were more powerful than the statistics from the other research. Even without further analysis by the article's authors, the quotes revealed a lot of information. The quotes reinforce my ideas that the experiences of IDUs are not well known, that harm can be prevented through education, and that the nurse can be a link to people marginalized by society. These three points are reflected in my choice of research method and the questions I asked while conducting the study.

Insite

Insite opened and began operating in September 2003. The BC Centre for Excellence in HIV/AIDS has been commissioned to evaluate Insite as a three-year study. The site researchers are collating a database that includes the number of visits per day, the number of persons using the site, the purpose of each visit, the types of substances used, the referrals made and the number of overdoses. Insite's hours of operation run from 1000h to 0400h the following morning, providing a total of 18 hours of continuous service. The average number of injections occurring in the SIS is approximately 650 per day (VCH, 2004). This shows that the SIS is well attended. On one day, the operation was expanded to 24 hours and a recorded high of 890 injections took place (VCH, 2004). Use of the site varies: 27% of people use it once a month while 40% are there ten or more times (VCH, 2005).

---

[5] Said one participant, "It's so good for you to see me like this, like I really am, suffering. This isn't fun. People think what we are doing is fun. You can see this isn't fun."
Said another, "I've been using for over 30 years and I had no idea a needle had an upside and a downside."
A third said, "I'm just a back alley user. I'm so grateful for the link between me and the nurses."
(Wood, Zettel, & Stewart, 2003, p. 23).

The Scientific Evaluation of Supervised Injecting (SEOSI) is a prospective cohort study that hopes to follow societal and clinical outcomes of over 1000 SIS clients. Some of the societal factors that are being studied include housing, criminal involvement and public drug use. Clinically, HIV and hepatitis C transmission, as well as the use of antiretroviral treatments, will be investigated. This cohort group is also providing information in the area of client satisfaction with Insite. At the time of writing, information on client satisfaction is not available.

Two external cohort studies, Community Health and Safety Evaluation (CHASE) and Vancouver Injection Drug Users Study (VIDUS), have pre-existed the SIS. These studies will be used to compare IDUs using and not using the SIS. The Centre will conduct a variety of qualitative studies with the community, local businesses and IDUs. Community impact will be studied throughout the three-year trial using an ethnographic approach to assess public injection drug use and amount of discarded syringes and injection-related materials. Ongoing surveys are being conducted to assess the attitudes of, and support for Insite by, the local businesses. A baseline survey asking if they supported the trial of Insite showed that out of 117 business people, 46% were in favour, 20% were undecided, and 34% were opposed. Finally, qualitative interviews with people who use and do not use the SIS are planned. "Interviews will focus on a variety of processes and outcomes associated with the SIF" (VCH, 2004, p. 8). Unfortunately no more details are given.

Research from Insite's second year of operation has shown that there is a reduction of harm to injection drug using clients and the community (VCH, 2005). There has been a reduction of the number of people injecting on the streets and the amount of

drug paraphernalia litter (Wood et al., 2004). In a study that surveyed 400 active injection drug users, the researchers found that Insite attracted younger IDUs who tended to inject on the street, and were homeless or had unstable housing. These clients were daily heroin users that have recently overdosed (BC Centre for Excellence in HIV/AIDS, 2006). The study also showed that injection cocaine users are 1.6 times more likely to use the site (BC Centre for Excellence in HIV/AIDS, 2006).

Another study showed that high-risk users reduced the amount of needle sharing and thereby decreased their risk for HIV and hepatitis C infection (BC Centre for Excellence in HIV/AIDS, 2006). There were 197 overdoses leading to zero deaths from September 2004 to August 2005. It is unknown how many overdoses would have resulted in deaths. Insite refers about 28 people per week to addiction treatment, and two per week to methadone maintenance. The researchers studied the changes in public order after the opening of Insite. They found that there were decreases in public injecting, publicly discarded syringes, and injection-related litter (Wood et al., 2004).

LITERATURE SUMMARY AND GAPS IN THE KNOWLEDGE

This literature review has shown that the injection of illicit drugs, such as cocaine and heroin, is an international phenomenon. Certain constitutional characteristics and environmental experiences can place people at risk for substance abuse. Women, First Nations populations, and the homeless, including street youth, have unique risk factors related to substance abuse. Vancouver, Canada has an open drug scene and it is not uncommon to see people actively injecting in public. Although the smoking of crack is popular, people are still injecting drugs. Injection drug users have high morbidity and

mortality rates, and injection drug use has led to a variety of health problems such as HIV/AIDS and hepatitis C.

There is an enormous financial cost related to healthcare and drug enforcement. The City of Vancouver has set out a Four Pillar Approach to deal with drug problems. Supervised injections sites are one strategy under the harm reduction pillar. Vancouver has opened up the only two official SISs in North America. The Moral Model and the Medical Model dominate society's view of substance abuse and they have therefore framed the discussion about SISs. Since SISs are relatively new in Canada, I looked at research from other countries that operate sites. Studies from Germany, Spain, Switzerland, Australia and Canada helped to shape this research project. A few studies discussed IDUs' reasons for not using DCFs and SISs, while some studies presented IDUs' suggestions for improving the sites. The Dutch study indicated that their DCFs were designed as either a medical establishment or a social place for IDUs. Missing in these studies is the perspective of the IDU. Considering the high human and financial cost of injection drug use, it is important to hear directly from IDUs.

Researchers of most major studies conducted face-to-face, focus group, and telephone interviews with politicians, administrators, management, staff, community informants and the police, but used surveys and questionnaires to solicit data from IDUs. Surveys and questionnaires placed restrictions on the types of experiences IDUs can share. Survey questions were limited to demographic information such as age, gender, attendance, drug of choice, etc. Although questionnaires are cheaper, and can maintain participant anonymity, the disadvantages of questionnaires, particularly the lack of rich data, have led many researchers to believe interviews are better suited for

most research (Polit & Hungler, 1999). Polit and Hungler (1999) describe some of the strengths of face-to-face interviews. Some members of the population may have difficulty reading a questionnaire due to vision problems or low literacy levels. An interviewer can provide immediate clarification to a participant who has misunderstood a question. In the research described earlier, the majority of questionnaires used closed-ended questions. Closed-ended questions have predetermined answer options that limit the variety and depth of the responses, thereby missing the opportunity to capture the rich diversity and complexity of the human experience. Another benefit of interviews mentioned by Polit and Hungler (1999) is the collection of supplementary data through observing the participant and listening to their tone of voice and the context in which they are speaking.

Throughout this chapter, I have reviewed and analyzed both the formal (literature) and the informal (professional knowledge) as they relate to the experiences of IDUs and SISs. As described in Thorne et al. (1997), the literature review, along with the knowledge I have gained from my professional experience, constitute the foundational forestructure necessary to conduct an interpretive description research study. A gap in the existing knowledge that I wish to explore is IDUs' experiences with SISs. Some of the international studies identified issues that have not been explored at the Canadian sites. Asking IDUs about their experiences in and around the SISs will be helpful when comparing them to other studies.

CHAPTER THREE: METHODOLOGY

The methodology[6] I selected for this research study, interpretive description, is a qualitative approach developed to meet the needs of nurses (Thorne et al, 1997). The goal of this chapter is to make clear its theoretical underpinnings as well as the process I followed and the choices I made in conceptualizing, designing and conducting this research study. This chapter is divided into three parts: 1) Conceptualizing and Designing the Study, 2) The Research Process, and 3) Researcher Considerations. I structured the chapter in this way because the conceptualization and the design of the study directly relate to my choice of research approach.

To allow for easier reading and understanding of the first two parts, the details of researcher considerations, such as participant compensation and researcher safety, are left to the end. In the first part, I explain how the research topic was selected, provide a brief explanation of interpretive description and my rationale for selecting it, and describe the process of accessing and recruiting participants. In the middle part of this chapter, the research process is presented. It includes sections on sampling, data collection, data analysis, and rigour. In the final part of the chapter, I discuss the choices I made concerning research ethics, including decisions related to working with a vulnerable population, inclusion/exclusion criteria, participant compensation, and researcher safety. Throughout this chapter, examples are provided to help illustrate how and why choices were made.

---

[6] Methodology implies an underlying philosophy that guides the research while methods are suggestions for how to conduct the research (Strauss & Corbin, 1998).

CONCEPTUALIZING AND DESIGNING THE STUDY

In this part of the chapter, I provide the background that led to the point of conducting the research. For two reasons, I begin by explaining the process of selecting a topic. First, all three books I used to guide me through the research have a section on selecting a topic (Morse & Field, 1995; Morse & Richards, 2002; Polit & Hungler, 1999). Second, the topic I chose had a great influence on my decision to use interpretive description as a research approach. The philosophical underpinnings, focus, approach, and intended results of interpretive description are discussed in the second section, where I also explain why interpretive description is appropriate for addressing the research question. In the third section, I describe the process, including the challenges, of accessing and recruiting participants.

Identifying the Study Topic

Choosing a topic takes time and requires self-reflection, creativity and discussion with others (Morse & Field, 1995; Morse & Richards, 2002; Polit & Hungler, 1999). Since this is a preliminary stage, topics are expected to be very general (Morse & Field, 1995). I started the process of selecting a topic by spending time reflecting on topics that would be useful or interesting to me as an educator. According to Morse and Field (1995), "discussing one's ideas with colleagues and experienced qualitative researchers is essential" (p. 45). Colleagues unanimously suggested I find a topic related to my work because it would be easier. Although I considered a few such topics (for example, the use of handheld computers for clinical instructors), nothing interested me enough to proceed. At that time, there was a lot of discussion in the Vancouver media about the

missing women from the DTES[7], the injection of illicit drugs in public areas, and the possibility that a supervised injection site would be created in Vancouver. The Vancouver Film Festival was showing the documentary *Fix: The Story of an Addicted City* about the grassroots struggle of drug users and community advocates in pressing the City of Vancouver to open an SIS (Wild, 2002). Listening to the news, reading the print media, and watching this documentary stirred up my memories of working as a street nurse in Toronto. I recalled seeing a video on the police and drug users in the DTES called *Through a Blue Lens* (Odd Squad, 1999). I borrowed this video and watched it again. *Through a Blue Lens* chronicles the lives of six drug addicts through their interactions with Vancouver police officers. Both this Odd Squad documentary and the Wild documentary influenced my research topic selection. In both films, I found the drug users' stories and their interactions with each other compelling and fascinating.

With so much media attention focused on the DTES, and after seeing the two documentaries, I chose my topic, going against the advice of colleagues to stay within my field of work. After consulting with experienced qualitative researchers, my professors, I selected injection drug users and supervised injection sites as a topic that could hold my interest throughout the process of completing a thesis. To narrow the research focus, I followed the recommendations of Morse and Richard (2002) to ask how the topic would be studied and to consider the intended outcomes. They suggest looking for a gap in the literature, determining whether a new way of viewing the topic is necessary, asking "what's going on here?", and considering the purpose of a qualitative

---

[7] Women started disappearing from the DTES in 1978. In 2002, a man was arrested for the murder of some of these women (CTV News, 2006). There are 68 women officially listed as missing according to the Joint Women's Task Force (Royal Canadian Mounted Police, 2006).

approach. Since official SISs at that time only existed in Europe and Australia, I realized that if and when a government-sanctioned SIS opened in Canada, it would be a new initiative[8] that would require study.

Looking at the literature, I noted that IDUs had limited participation in the research. I saw a need for IDUs to "tell their story". When asking "what's going on here?", I had to imagine the future, with SISs up and running. I wanted to know what would be going on at the SIS from IDUs' perspectives. The literature on SISs was dominated by quantitative research. There was clearly a need to supplement these quantitative inquiries with qualitative approaches which could provide richer descriptions of individual experiences and contexts. Having chosen this topic, and recognizing the need to hear directly from IDUs about their own views and experiences, I knew I was going to use a qualitative approach. In the next section, I provide an explanation of interpretive description and why it is appropriate for studying IDUs' experiences with SISs.

Interpretive description

Interpretive description, a non-categorical qualitative approach, was chosen as appropriate for addressing the research question, "What are injection drug users' experiences with supervised injection sites?" I begin this section by describing the decision-making process that led to using interpretive description as the methodological foundation for this study. I then make clear why interpretive description is appropriate for this study. Finally, I describe the process taken in building a foundational forestructure for this study.

---

[8] New initiative, in this case, refers to an official, sanctioned SIS because there was a user-run site in the past.

My first step was aligning myself with a research paradigm. My life experiences, including those as a nurse, help to shape my outlook on life. I find myself more drawn to the naturalistic than to the positivist paradigm. In other words, I am more comfortable with the basic assumptions of the naturalistic paradigm. I will state and explain these assumptions as described by Polit and Hungler (1999). Due to time and space issues, I will not specifically contrast the positivist assumptions, since they are diametrically opposite to those of the naturalistic paradigm.

The first assumption, according to Polit and Hungler, is that reality is constructed by individuals. It is subjective; no two people share the exact same view or understanding of reality. Since reality is different for each person, it cannot be measured, but researchers can only seek to increase the understanding of the phenomena. The second major assumption is that there is an interaction between the researcher and the participant. The interactive process, between the researcher and the participant, shapes the understandings that become the product of the research (Polit & Hungler, 1999). The third assumption is that objectivity, in its absolute sense, is unattainable and that subjectivity and values are inevitable (Polit & Hungler, 1999). Finally, since reality is complex, knowledge is obtained in an inductive process that seeks an understanding of the whole by identifying patterns, and cannot be broken down into distinct generalizations (Polit & Hungler, 1999). Qualitative research methods are congruent with the assumptions of the naturalistic paradigm.

Qualitative research provided a general guide for me when initially conceptualizing the research study. Its strengths lie in understanding meaning, context, and process, through its inductive exploration of phenomena, while identifying

unanticipated events and influences, and developing tentative explanations (Maxwell, 1996; Morse & Field, 1995; Morse & Richards, 2002). To be clear, it does not provide proof of cause, but it can suggest possible explanations. Qualitative research methods can yield rich descriptions of complex phenomena from an emic point of view and thus it is a useful style when there is a dearth of information (Morse & Field, 1995).

Nursing has enthusiastically embraced qualitative methods but many researchers have found that traditional approaches, such as phenomenology, grounded theory and ethnography, do not always match the needs of nursing as a practice discipline (Morse & Chung, 2003; Thorne et al., 1997). Morse (as cited by Thorne et al., 1997) identified that some nurses were conducting legitimate but unnamed qualitative research that described and interpreted health and illness phenomena from an emic viewpoint. Thorne et al. (1997) responded to nurses' desire for a qualitative methodology that recognizes that "human health and illness experiences are comprised of complex interactions between psychosocial and biological phenomena" (p. 172) by developing an interpretive description approach and articulating methods that are congruent with nursing as a practice profession. The goal of interpretive description is to develop nursing knowledge that could have implications for nursing education, research and practice (Thorne et al., 1997).

Interpretive description is best suited to exploring the research question because its background philosophy and methods provide me with a guide to understanding the individual perspective of each participant. Interpretive description was also selected because it is a nursing method, developed by nurses, for nurses and for members of

other practice professions where the end goal is to provide better care. I believe it is important to add to nursing's body of knowledge and I hope that this study will do that.

Rather than jumping in blind and conducting research, Thorne et al. (1997) recommend building a foundational forestructure of what is known. Along with formal research, nurses' clinical interpretations are equally valued and desired. Formal knowledge from published articles was sought out through literature searches on Medline and Cumulated Index to Nursing and Allied Health Literature (CINAHL) databases. Google, an Internet search engine, was particularly useful in identifying "grey" literature[9]. The informal knowledge came from my personal and professional experience, as well as from anecdotal comments from health and social service professionals who work with IDUs. For example, prior to beginning this research, I met with a nurse who founded a non-profit organization that works with homeless illicit drug users. During our meeting we discussed the need for SISs, the complex lives of IDUs, and strategies for accessing participants. The combination of formal and informal knowledge was essential in formulating my understanding of the complexity of the phenomena. This background knowledge helped to orient the inquiry. I did not construct an analytic framework as recommended by Thorne et al. (1997) because I did not find literature on the experiences of IDUs with SISs upon which I could thoughtfully construct my findings. The next stage in preparing to conduct the research was to find community organizations willing to support the study. In the following section, I recount my experiences, including some challenges, in accessing and recruiting members of the injection drug-using community.

---

[9] "Scientific grey literature comprises newsletters, reports, working papers, theses, government documents, bulletins, fact sheets, conference proceedings and other publications distributed free, available by subscription, or for sale" (Weintraub, n.d., Introduction).

Access to Participants and Recruitment Process

When conceptualizing this research study, I initially envisioned accessing participants directly from the SISs. The sites are operating as a three-year research trial coordinated by the British Columbia Centre for Excellence in HIV/AIDS team. I informally asked a member of the team for advice and support for my research. At the time of my enquiry, I was informed that the qualitative component of the trial was not in place but that they planned to conduct focus group interviews. There was a concern about having a number of different researchers doing similar work at the site. Knowing I would not be able to access clients directly from the site, but still seeing the need to conduct in-depth interviews, I turned my attention toward community agencies for support.

One of the challenges I faced was finding community agencies that would be willing to assist me in accessing participants. I met with representatives from five agencies and spoke to another two on the phone. Although everyone verbalized support for the study, decisions to participate could not be made quickly. Many organizations had supported researchers in the past and they required a presentation of the planned study prior to acceptance. All agencies asked for a University of British Columbia (UBC) ethics review approval prior to supporting the study.

Envisioning a sample size of between eight and ten participants, I decided to try to get two or three organizations to agree to support my research. I felt it would be easier to get organizations to commit if I only needed to interview two to three participants per site. In the end, the recruitment of participants took place in two locations: an emergency shelter and a drop-in centre. I chose the emergency shelter

because the population I wished to study is directly served by that organization. Prior to undertaking this study, I had met the executive director of the organization that runs the shelter while surveying the number of homeless people in the west end of Vancouver. Since that time, I have routinely donated used clothing and medical supplies to that organization. Because of our previous connection, the executive director was quick to provide permission to conduct this research. The executive director[10] provided me with the name of the shelter manager and notified that person that I would be calling.

I heard about the second site through a nursing friend of mine who worked in that area. She provided me with the name and contact number of the drop-in centre and the nurse in charge. When I called, I did not mention my friend. After two emails and a couple of telephone conversations, in which I explained the research, the nurse in charge agreed to support my study on the condition that I get ethics approval from the University of British Columbia. A letter was sent to both of these organizations asking for permission to put up a notice explaining the research and seeking participants (Appendix A). Both organizations provided a letter to the UBC Office of Research Services ethics review. After ethics approval was granted, a participant advertisement was placed on bulletin boards at the two locations (Appendix B). This notice briefly explained the research, provided the criteria for participation, and listed a time and place where I would be available to meet with potential participants to discuss the research, obtain consent and book an interview time.

Although two locations were used in the recruitment of participants, only the first participant came from the emergency shelter; I recruited the other six from the drop-in

---

[10] Although there are many service providers in the DTES, I believe it is necessary to refrain from ascribing gender pronouns, such as "her" and "he" in this section to maintain confidentiality.

centre. In the beginning, I concentrated my time on the emergency shelter. I met with the manager of the shelter. We agreed that the staff would keep participant information letters at the front desk and they would hand them out to clients who might be interested. The manager offered me a room in which I could conduct interviews. The manager suggested I come in the evening, just after dinner, as there are usually more people around. We arranged the dates when I would come over and spend time in the shelter.

My first drop-in session to meet potential participants was a non-starter. Although I came in at a prearranged time and my recruitment advertisements were on the wall, the staff working that evening were unaware of my study and did not have my information sheets. I asked if they could recommend anyone but upon hearing I was providing a $10 gift certificate they felt few people would be interested in participating because the compensation was so low. A couple of staff members told me that the person they would recommend probably would not be interested because "she can make [through prostitution] that [money] in five minutes". The compensation could not be changed but I realized I needed the advertisements to stand out more. I reprinted them on colourful paper and returned a couple of evenings later to repost the new-look advertisements. I stayed approximately one hour. The only person that showed interest in participating did not meet the qualifications. She had not injected in years and had no experience with SISs. When I thanked her for her interest and informed her that she did not meet the qualifications for the study, she became verbally angry and started yelling at me. I realized that discussing this situation would have been pointless and may even have further aggravated the woman, so I left.

I later received a phone call from another client at the shelter. We arranged to meet and he became my first participant. The interview will be discussed later in the paper. I returned for another recruiting session the following week but, again, I was unsuccessful. Although the staff were friendly, they did not introduce or even suggest any of their clients to me. After about 45 minutes, the woman from the previous week arrived and started to berate me once again for not allowing her to be part of the study. Once again, I decided to leave in order to defuse the situation. With the challenges I experienced at the emergency shelter, I decided it would be better in the short term to turn my attention to the drop-in centre.

As with the shelter, I put coloured advertisement posters on the walls. The staff volunteered to introduce me to clients they felt met the qualifications and might be interested. They even announced aloud to all people present that I was doing research. Immediately, I was surrounded by the drop-in centre clients. Most of them wanted to know how much I was paying. I was surprised to see that a number of people continued to be interested in participating even after hearing it was a $10 gift certificate. I had willing participants, but only one participant showed up at the prearranged time for the interview.

Due to the nature of drug use, setting appointments too far in the future would have been unrealistic. I tried to set up interview times for the following day. Knowing that keeping appointments could be difficult for this population, I waited half an hour from the time of our booked appointment. After half an hour, I either left to go home or asked another person to be interviewed. I expected a few to miss their appointments

based on my nursing experience, but I was surprised that almost all missed their scheduled time.

It took close to one month before I was able to interview the second participant. After having so many people miss their appointment, I started doing on-the-spot (not prearranged) interviews with people who, on a previous date, had read the participant information letter and had verbally expressed interest in being interviewed for the study. I did a couple of these on-the-spot interviews with people who had missed an earlier appointment. This was the case with the first person I was supposed to interview at the drop-in centre. He agreed to be interviewed and we arranged to meet two days later. He did not show up for his interview. I saw him a few times after that, but each time I was busy talking to other potential participants. While waiting for the fourth overall participant, who did not show up, I saw him again. He consented to be interviewed right then and I arranged for a private room for confidentiality and conducted the interview.

RESEARCH PROCESS

In the following sections, I describe the stages of the research process and the methods employed. This is the heart of how the research was conducted and analyzed. The four sections in this part are sampling, data collection, data analysis and rigour. I chose to include rigour in this section because "the most important strategies to enhance and maintain rigour take place during the actual conduct of the study itself" (Morse & Richards, 2002, p. 172). Examples from this research study are provided in all sections to allow a concrete understanding of how methods were used. The examples will also clarify the choices I made throughout the research process.

Sampling

In keeping with the interpretive description design by Thorne et al. (1997), I selected most of the participants by using purposive and theoretical sampling. In purposive sampling, the researcher selects participants based on their ability to inform about the phenomena under study (Morse & Richards, 2002). Theoretical sampling is used as the data unfolds in order to select participants that are best able to inform the researcher, with the goal of achieving maximum variation of themes within the parameter of the study (Morse & Richards, 2002; Sandelowski, 1995). The participants were chosen through purposive sampling for being the best source of information because they had the lived experience of a person who injects drugs and uses SISs (Morse & Field, 1995; Thorne et al., 1997).

Because data collection and analysis occur concurrently in interpretive description, as in most qualitative approaches, themes were emerging through the analysis of the early interviews before the later interviews were conducted. These themes helped to provide direction for participant selection in the later interviews. Later participants were selected according to their potential ability to add new data to certain underdescribed themes. This was an inductive process, so as the data unfolded some participants were selected because of their unique characteristics or experience that could validate or refute tentative findings and provide a richer description. For example, after conducting six interviews and reflecting on that data, I realized a developing theme was the knowledge deficit of the participants regarding the purpose of the mirrors in the injection room.

I interviewed participants who used the site rarely and occasionally. I decided to use theoretical sampling to select someone who frequents a SIS multiple times per day. I thought that maybe a person who used the site more frequently would have a different perspective. I was unsure whether the experiences of females and males were different and since four of the six participants were men, I decided to look for a female participant. The seventh and final participant was selected to meet these criteria.

I initially expected to have a sample size of eight to ten participants. Seven people were interviewed. Even with the theoretical sampling of the last participant, I was hearing the participants say many of the same things. At that point, the data was repeating and no new themes were emerging (Sandelowski, 1995). For this reason, I decided I had enough data and I stopped conducting interviews. Having seven participants had allowed me to select participants based on data that emerged from earlier interviews. I determined that I had met the criteria of appropriateness and adequacy described by Morse and Field (1995). Appropriateness refers to whether the participants were selected to best inform and meet the theoretical requirements of the study. Adequacy refers to whether sufficient data was obtained and whether findings were confirmed with other participants.

Data Collection

Although data collection and data analysis occurred concurrently, for the sake of clarity I write about them separately. In keeping with interpretive description, a variety of data sources was used. The primary source of data was audiotaped, open-ended interviews with IDUs. I collected supplementary information from collateral sources such

as my field notes and journal, notes taken from conversations with key informants such as health and social service providers, and print, radio, and video media.

Prior to leaving home for an interview, I would ensure that I had packed my notebook, journal, two tape recorders and audiotapes into a knapsack. I decided to carry extra audiotapes as a precaution. This worked well since my first interview was three times longer than I expected and I needed all the audiotapes. I usually arrived 15 minutes before the planned meeting time, as I would not know where I would be interviewing the participants and I wanted time to secure a room and get organized. As it turned out, for the seven interviews conducted, four different rooms were used.

When setting up the rooms, I first looked for the electrical outlets in order to set up the tape recorders. I arranged the chairs so they were in a position that would be comfortable and conducive to talking. In most cases, I was able to have the chairs at a close but non-threatening distance without any tables or obstacles in the way. I was able to judge this from my experience interviewing potential students for college programs and candidates for employment and by observing participants' non-verbal cues. For one interview, the layout of the room forced me to sit across a large table from the participant.

Prior to starting each interview, I set up and tested the tape recorders. The tapes were 120 minutes in length, equalling one hour per side. I used two tape recorders as a precaution against human or mechanical error. A problem did occur with the very first interview when, at some point during the interview process, I accidentally unplugged one of the tape recorders. Before starting the interviews, I asked the

participants if they needed anything such as a drink of water or coffee. Next, I turned on the tape recorders and obtained consent.

I followed some of the suggestions of Rubin and Rubin (1995) to guide and structure the interviews. For example, I tried to create a natural interaction with the participant by starting with a casual chat that showed interest in them as a person. If the participant was nervous, I tried to be encouraging and understanding. Techniques such as silence and probing questions were used to indicate that I would like the participant to speak in more depth. If a topic was very emotional, I offered to stop the tape and let them have a break. I sought clarification when necessary. I estimated the interviews would take approximately one hour. The interviews ranged from approximately 40 minutes to 1 hour and 15 minutes, except for the first one, which lasted almost 3 hours and 15 minutes. If an interview went beyond one hour, I informed the participant of the time and asked if she or he was willing to continue. In the first interview, for example, as the interview progressed longer than one hour, I began to check regularly with the participant to see if he was OK and if he wanted to stop. He continually reassured me that he was enjoying the interview and that he wanted to continue. At one point during the interview, the participant mentioned that he had not eaten all day. Although he wanted to continue with the interview, I stopped the tape and asked the staff if they had any food for him. I told the participant that if he still wanted to continue, we could resume the interview after dinner. The participant took about 20 minutes to eat and he decided to continue. A second break, that lasted 5 minutes, occurred when the participant requested a coffee.

At the end of every interview, I asked if there was anything else the participant wanted to say before stopping. By doing this, I allowed the participant to finish his or her thoughts and to choose when to stop. Upon leaving the interview, I went to a local establishment and found a quiet area to sit, reflect upon the interview and jot down field notes.

One of the biggest challenges related to my ability as a researcher. As a neophyte, I often felt disorganized as an interviewer. I was not always able to interject a question at the appropriate moment in order to hear more from the participant about something that I thought was interesting and worthy of further exploration. For example, one participant intimated that he had considered suicide. He spoke briefly about it and used the past tense. Using my nursing experience, observation skills, and knowledge of the warning signs of suicide risk, I decided almost instantly that he was not currently suicidal (Appendix I). I really wanted to explore this with him but he continued talking and went on to other topics and I felt I had lost the opportunity to probe more about the issue of suicide. As I conducted more interviews, I felt my interviewing skills were improving with the experience. After conducting only seven interviews, it would be presumptuous to say that my abilities improved enough that it had an effect on the overall interview process.

Data Analysis

Data analysis in the interpretive description method is an inductive process. Thorne et al. (1997) advise repeated immersion in the interview data as a whole to avoid coming to premature conclusions. As stated earlier, the data analysis took place concurrently with the data collection process. It was an active process of repeatedly

reading the transcripts, thinking and reflecting. Regarding data analysis, Morse and

Field (1995, p. 126) state:

> It is a process of fitting data together, of making the invisible obvious, of linking
> and attributing consequences to antecedents. It is a process of conjecture and
> verification, of correction and modification, of suggestion and defense.

Data analysis is a time-consuming process that requires the researcher to be

thoughtful, creative, and imaginative. She or he must have the courage to let go of the

concrete, to speculate on possibilities, to examine different ideas and to see where

those ideas lead. The researcher must also have the strength to turn away from an idea

when the data do not support it. For example, for the longest time while I worked with

the data, I thought I saw a need for each participant to distinguish herself or himself as a

unique individual, different from other users. Quotes like the following led me to

consider this possibility:

> I must say that I never actually needed to, I never relied on
> crime for making money. And in that fact I almost must be
> unique down here but I never did.

> So I try to do it moderately right, you know. I don't consider
> myself as a junkie right.

> I have no criminal record which is…strange eh?…
> You know, because most people do.

Although, the participants mention they are different – "I almost must be unique"; "I don't

consider myself a junkie"; "I have no criminal record…most people do" – I did not find

sufficient data to support this line of thinking.

Following the recommendation of Thorne et al. (1997), I was guided by Giorgi's

(1985) four-step method for analyzing the data. For each step, I provide an example of

what I did. The first step is to understand the language used by the participant in order

to get a general sense of the whole description. To do this, I listened to the tape and wrote in my field notes about anything I remembered concerning the environment or the interview that I felt might be significant. For example, while listening to one tape I remembered that the participant did not make eye contact with me for almost five minutes. Listening to the tape brought a picture in my mind of the participant looking at the floor, the desk, the bookshelf, but not at me. Since I was unsure whether this would be an important piece of information or not, I chose to write it down.

After listening to the interviews once, I began to transcribe. All but the last interview were transcribed by me. Due to time restrictions, the last taped interview was entrusted to a transcriptionist. I transcribed the interviews verbatim. This decreased the chance of misinterpretation of words (Easton, McComish, & Greenberg, 2000). When a transcript was finished, it was checked against the tape for accuracy. Thus, I listened to the tape two more times. Transcribing the tapes myself gave me a very good understanding of the whole description. In the margin of the transcripts, I added some of my thoughts, ideas or observations, such as the participant's tone of voice or facial expressions, to provide a richer context.

Following the principles of interpretive description, I refrained from creating linkages too early. Instead, I allowed myself time to become immersed in the data. During this time, I asked myself general questions, such as "what is happening here?" and "what am I learning about this?", to help me understand the data as a whole rather than as separate parts (Thorne et al., 1997). This foundational understanding was necessary for guiding future interviews and for creating a base for the next step, the discrimination of meaning units. Prior to conducting a subsequent interview, I once

again listened to the tape with the express purpose of critiquing my performance as an interviewer. This was motivated by a desire to become a better interviewer. After listening to one earlier tape and reflecting on my interview skills, I realized I was jumping in too early and suggesting words when the participant appeared to hesitate. In later interviews, I consciously tried to allow the participants more time to speak without interruption.

In the second step of data analysis, I reread the transcript with a nursing perspective to identify passages relevant to the research. My perspective is based on my professional experiences as well as on the policies, positions and code of ethics of the Canadian Nurses Association (CNA). In a broad sense, my perspective is congruent with the CNA policy of endorsing the Canadian Charter of Rights and Freedoms and the United Nations Universal Declaration of Human Rights (CNA, 2004). More specifically, I used the objectives from the CNA (2001) position statement on "Collecting data to reflect the impact of nursing practice"[11] as a lens through which I viewed the data. With this nursing perspective, I read the transcripts to discern passages that describe the participant's life in relation to the research. In identifying sections, I was influenced by my nursing education and experience and the understanding of the epistemology of my profession.

Obviously taking a nursing perspective is methodologically valid in interpretive description, but Giorgi (2000a & b), a psychologist, also supports this approach by

[11] Objectives:
• Describing nursing care across all practice settings, client types and dimensions of care;
• Standardizing language that describes nursing practice across the country and the world;
• Identifying data on patient outcomes that are relevant to nursing interventions;
• Aggregating and comparing data across sites, settings and time;
• Integrating nursing data into broad multidisciplinary health information systems; and
• Abstracting/retrieving nursing data in an efficient and cost-effective manner.

arguing that nursing conducts human science research, and therefore the nursing perspective is necessary in order to contribute to nursing praxis. The identified relevant quotes, or spontaneous discriminations, as Giorgi terms them, are then expressed, in the participant's language, as meaning units. For this step, I used both paper and computer files of the transcripts to identify the meaning units. I found it easier and more convenient to read a hard copy of the transcripts. As I read the transcripts, I identified the spontaneous discriminations on a paper copy. I then went to the electronic version of the transcript and changed the font colour on the corresponding spontaneous descriptions. I copied the section into a new document where I reworded it into meaning units. The following is an example of the process.

Spontaneous Discrimination (SD)	Meaning Units Expressed in Own Language (MU)
You don't want like…you got children and stuff right that some things are best concealed right. So that's what I feel. I feel it is best to go to your house right or go to the injection site, story end of story do your drug right. You don't gotta do it in front of your child right and the child's friends and all that. I think that is kind of absurd OK.	I feel drugs should be concealed from children by injecting at home or in the SIS. People have a choice and they do not need to do drugs in front of their children or their children's friends.

The third step of data analysis transformed the meaning unit, expressed in the participant's language, into a nursing taxonomy that more clearly revealed the participant's description. This was achieved through a combination of reflection and imaginative variation (Giorgi, 1985). I reflected on what I thought was the essence of the meaning unit. I then allowed my imagination the freedom to come up with possible

variations to the wording of the text. These possibilities were critically examined to try to refine the text to its essential meaning.

MU	Meaning Units Expressed in a Language Useful for Nursing Research (LUNR)
I feel drugs should be concealed from children by injecting at home or in the SIS. People have a choice and they do not need to do drugs in front of their children or their children's friends.	Bruce has a concern for others (children). He believes people have a choice and should choose to use their drugs so as not to harm others (children).

Finally, in the last step, I synthesized the transformed meaning units and integrated them into a statement that best described the experiences of the participants. This statement reflects both implicitly and explicitly the meanings derived from the transformed units. This stage did not begin until after data saturation was achieved. The example below shows the progression from a direct quote (spontaneous discrimination: SD) to a meaningful statement in the participants' language (meaning unit: MU) to a statement in language structured to be useful to nursing research (LUNR).

SD	MU	LUNR
You don't want like…you got children and stuff right that some things are best concealed right. So that's what I feel. I feel it is best to go to your house right or go to the injection site, story end of story do your drug right. You don't gotta do it in front of your child right and the child's friends and all that. I think that is kind of absurd ok.	I feel drugs should be concealed from children by injecting at home or in the SIS. People have a choice and they do not need to do drugs in front of their children or their children's friends.	Bruce has a concern for others (children). He believes people have a choice and should choose to use their drugs so as not to harm others (children).

I have saved a couple of lives [laughter]. I took St. John Ambulance when I was younger because my Mother had epilepsy. So I had to take a good First Aid course so I am good, I know CPR, I know mouth to mouth all that stuff. I have saved a couple of lives [laughter]. I was happy to do it.	I have taken a First Aid and CPR course and I am comfortable with the skills. I saved the lives of a couple of people by performing CRP and AR. I was happy to help.	By performing CPR, Felicity showed concern for other people. She felt good about helping others.
...leaving things behind, injectable paraphernalia ... is very, very criminal thing to do. It endangers the public safety, it endangers the safety of children, it should not be tolerated and...the opposite should be encouraged strongly.	Leaving injection equipment in public places threatens the safety of others. It is a criminal act that should not be tolerated but should be actively opposed.	Allan is concerned about others because the environment is not safe. Discarded injection equipment poses a serious risk to people and this issue needs to be dealt with more seriously.

The above table shows the comments of three different participants. Through Giorgi's (1985) method of analysis, I derived that they all expressed concern for others. This will be explored further, along with other findings, in Chapter 4.

Rigour

Rigour is essential in maintaining the integrity of the research (Thorne et al., 1997) and without it, "research is worthless, becomes fiction, and loses its utility" (Morse et al., 2002, para. 1). For this reason, more space is given to this section of the research process. Rigour was not an afterthought; it is discussed in this part of the chapter because strategies to maintain rigour occurred throughout all parts of the research process. Therefore, there may be an overlap of ideas in this section with those

presented in the sections on sampling, data collection and data analysis. Because of the iterative process followed by qualitative researchers and the emergent nature of data, rigour is critical when using interpretive description (Thorne et al., 1997). I addressed rigour in this study by following the strategies recommended by both Thorne et al. (1997) and Morse et al. (2002). Although I used the strategies suggested by Thorn et al. (1997), I focused on Morse et al.'s (2002) verification[12] strategies for reliability and validity. Since this is a departure from recent qualitative nursing studies that follow Lincoln and Guba's (1985) work on "trustworthiness" of qualitative research, I provide reasons for this decision before detailing each verification strategy.

Identifying personal and inherent biases is one of the strategies recommended by Thorne et al. (1997) in order to maintain rigour. It is important to note that my perspective has been shaped by culture, religion, education, profession, gender, and experience, just to name a few. The researcher's assumptions section in Chapter 1 provides insight into my biases. Since the researcher is the instrument by which data are collected, my qualifications must be stated in order to address the issue of researcher credibility (Polit & Hungler, 1999). I am a registered nurse with over twelve years of work experience. This thesis is in partial fulfillment of the requirements for a master's degree in nursing. University courses that I have successfully completed which relate to this study include Qualitative Research, Health Care Ethics, Trans-cultural Health, and Addictions. I have both worked and volunteered with organizations that

---

[12] "Verification is the process of checking, confirming, making sure, and being certain." (Morse et al., 2002, The Nature of Verification in Qualitative Research section, para. 1)

focus on assisting the homeless, the substance addicted, and people with chronic mental and physical health issues such as depression, hepatitis C and HIV/AIDS.

A second strategy in order to maintain rigour is to accurately report and document the research process (Thorne et al., 1997). I recorded the research process using field notes and a reflective journal. Field notes are a written account of the researcher's data-collecting experience. In the field notes, I described my thoughts, feelings, and observations before and immediately after an interview. I tried keeping a reflective journal in both paper and electronic format. I have to admit it was not kept up to date as it was difficult to find the time to record my reflections. I initially started the journal in a notebook. I found that it was too difficult to put pen to paper since I am more comfortable typing on a computer than writing on paper. Early in the research process I decided to keep the reflective journal in a Word document on the computer. I found it difficult to reflect and write at the same time. More often than not, I would not be around a computer when I was thinking about the data.

In the rigour section of Thorne et al.'s (1997) foundational paper on interpretive description, no explicit recommendation is given to use Lincoln and Guba's (1985) criteria of "credibility", "transferability", "dependability", and "confirmability". I felt this provided me with some latitude to follow Morse et al.'s (2002) verification strategies of methodological coherence, sampling sufficiency, dynamic relationship of sampling, data collection and analysis, thinking theoretically, and theory development. Before elaborating on each strategy, I will justify this decision. Within the discussion of the last strategy, I will address the apparent conflict between theoretical development and interpretive description outcomes.

There are three reasons why I chose to follow Morse et al. (2002). Since the use of injection drugs is an international phenomenon and SISs are in operation in Europe and Australia, this study may be of interest to an international audience. Morse et al. (2002) argue that the terms "reliability" and "validity" are still being used in qualitative research coming out of Europe, including the United Kingdom, and that they can be applied to all forms of research to show that findings are both credible and plausible. In other words, the terms "reliability" and "validity" are used internationally and are appropriate for qualitative research.

The responsibility to ensure rigour is that of the researcher and not the reader. Morse et al. (2002) maintain that the procedures to attain rigour have subtly shifted over time from constructive (during the research process) to evaluative (after the fact) and that this opens the researcher up to unnoticed threats to the integrity of the work until it is too late to correct. If rigour is addressed in an evaluative fashion, the burden falls upon the readers of the study to evaluate whether the findings are valid and the analysis is reliable. Verification strategies of reliability and validity occur throughout the research process, allowing the researcher to make immediate changes to minimize threats and maintain rigour.

A final reason for following Morse et al.'s (2002) format is that it was, in part, developed by nurses. Since the authors make compelling arguments, and their strategies fit this research study, I chose to use their work to add, in a small part, to its legitimacy as well as to promote scholarly discourse. To be clear, I used Morse et al.'s (2002) strategies primarily because they may be better understood internationally and are appropriate for maintaining rigour. These strategies are presented below.

Methodological Coherence

Methodological coherence is the congruence of all parts of the research process from the question to the sampling, to data collecting, to data analyzing (Morse et al., 2002). Each part of the research process is interdependent because the process is iterative (Morse et al., 2002). This implies more than simply the simultaneous occurrence of the data collection and data analysis; it refers to the responsiveness of the researcher as the data is being interpreted to ensure that all parts of the study remains logical and congruent. For example, as the data unfolded, I realized I needed to make changes to the guiding questions (Appendix E) in order to reflect my developing understanding of the gaps in the data and the issues that required further exploration. To illustrate this, I changed the guiding questions after an interview in which a participant talked about her mother and sister injecting drugs. For the next interview, I included a question about family members and drug use (Appendix F).

Sample must be Appropriate

Appropriate sampling means the participants selected are those best able to provide information relevant to the research question and to the guiding questions as the data emerges. The research question asks "what are IDUs experiences with SISs?" The best sources of information are people who live the experience, can reflect upon the question, and have the time and willingness to participate (Morse & Field, 1995; Morse & Richards, 2002). For this study, all participants were injection drug users who have had experience using SISs, and were able and willing to participate in the study. As mentioned in the section on sampling, theoretical sampling was also used to ensure each participant best met the needs of the evolving research, in order to ensure data

adequacy. Adequacy refers to the amount of data needed to attain repetition in the data, which signals saturation (Morse & Field, 1995).

One variable in participants' experiences is the frequency with which they reported using the SIS. Some said they use it only occasionally, others often, and a couple said they use it almost every time they inject. Since the focus of this study is on experiences with SISs, I did not interview IDUs who had not used a SIS because they would lack the knowledge gained from experience necessary to respond to the question. The inclusion of negative cases is essential to bring to light the less obvious aspects of the data and thereby increase the scope of the study (Morse et al., 2002). I addressed the need to have negative cases by ensuring that the participants represented a maximum variation in the frequency of experiences using the site. The last participant was theoretically selected to complete this maximum variation. She was only the second participant to report using the site almost every time she injects.

Collecting and Analyzing Concurrently

Reliability and validity can only be established when there is an interconnection between the collection and analysis of data. Going back and forth between collection and analysis, and allowing time for both to occur, prevents the researcher from holding onto premature (superficial) understandings, instead encouraging "deeper and more meaningful analytic interpretations" (Thorne et al., 1997, p. 174). Almost one month elapsed between the first and second interviews, and another month between the third and fourth interviews. The data collection occurred not just during interview but post-interview as well, when I noted relevant information from my recollections, both immediately after the interview and as I transcribed it. The breaks between the

interviews afforded me the time to immerse myself in the data so that I became very familiar with what was in the data and what I still needed to know.

Thinking Theoretically

Thinking theoretically is a slow and steady process of forming ideas about the data, exploring these ideas in the new data collected, reforming the ideas and rechecking them against the previously collected data. The researcher's early understandings derived from the data are constantly evolving to build a solid foundation of understanding (Morse et al., 2002). To build this foundation, the researcher must balance creativity and imagination to see that data from all angles, but must avoid quick assumptions in one direction or another. The example I provide here relates to actual and perceived barriers encountered by IDUs when accessing the SIS.

When working with the data from Allan and Bruce, I did not identify difficulties accessing the site as an issue. Charlotte, on the other hand, stated there were barriers that limited or prevented access to the site. After contemplating what she said, I returned to look for verification in the data from Allan and Bruce. Although I did not see supporting data for Charlotte's concerns, it was important enough for me to explore in the next interview. Dennis did mention problems with entering into the site. I took his information, merged it with my understanding of Charlotte's and once again returned to the previously collected data. In revisiting Bruce's transcript, I saw a connection to this topic. He had mentioned a barrier, but it was not initially visible to me. Once again, my understanding of the data evolved with the addition of Bruce's information to my thoughts about the combined of information from Charlotte and Dennis. The issue of barriers is further explained in Chapter 4, the Findings.

Theory Development

Theory development as a strategy to ensure validity and reliability appears, on the surface, to be in conflict with interpretive description since the outcome of interpretive description is a "tentative truth claim" (Thorne, 2004) rather than the development of theory. Morse et al. (2002) state that "theory development is to move with deliberation between a micro perspective of the data and a macro conceptual/theoretical understanding". The authors contend that theory development is the product of the research process and it can be looked upon as a template for comparison. It is here that I contemplated what is germane to this strategy. It is not the development of theory per se, but the ability to take the small units of data at their individual micro level and draw theoretical links by seeing patterns and common themes. These links may form the basis for a "tentative truth claim" which may be useful to other health practitioners and researchers. For this research, the individual pieces of data concerning paranoia, privacy, withdrawal, atmosphere, and difficulty injecting, among others, fit together to lead to a tentative claim that although SISs are considered to be a low threshold service, they still have barriers which limit or prevent access by the people they are trying to reach.

RESEARCHER CONSIDERATIONS

In this third and last part of the methodology chapter, I address all the background problems and issues related to the conceptualization of this research study. In the first section, I discuss ethical considerations. I explain how anonymity, confidentiality and respect for the participants were maintained. The second section confirms receipt of ethics approval from the University of British Columbia's Office of

Research Services and outlines the items included in that application. The subsequent sections discuss inclusion and exclusion criteria for participant selection, the potential risks and benefits of the research, participant compensation, informed consent and researcher safety.

Ethical Considerations

There are three principles of ethical research, "Beneficence", "Respect for Persons", and "Justice" (USFDA, 1998). Beneficence, as the maxim simply states, is to "First, Do No Harm". I was aware that, as a registered nurse, if I perceived any actual or imminent threat to the well-being of the participant, I would be ethically bound to attend to the issue even if it meant putting the research at risk (Munhall, 1988). I chose not to predefine "threat", but I relied on my nursing judgement. A situation did arise where I stopped the interview temporarily. In the course of an interview, but unrelated to the topic of discussion, a participant told me he had not eaten for a very long time and was hungry. Although the participant verbalized that he wanted to continue, I stopped the tape and told the participant that if he still wanted to continue after eating we would continue the interview then. After eating, the participant consented once again to the research and the interview continued.

Sensitive topics such as participation in crime and overdose deaths were discussed in this research. As the interviewer, I tried to be attentive to the participants by actively listening to them and carefully considering the phrasing of questions. At times I was consciously aware of my interactions and at other times I fell back on my nursing instincts when communicating.

Another aspect of beneficence is freedom from exploitation. This research is not associated with any agency or institution other than the University of British Columbia. Therefore, information was not shared with any organization directly or indirectly associated with the participants. Participants were assured that participating in the research would not affect their access to services or treatments in any way (Appendix D).

Respect for persons is based on dignity and encompasses the right to self-determination and the right to full disclosure (Polit & Hungler, 1999). Participants freely chose to participate without any pressure due to prejudicial treatment or coercion. They were informed that they had the right to stop the interview at any time. Full disclosure about the research was provided in the information letter to participants (Appendix C) and in the consent form (Appendix D). Participants were encouraged to ask clarifying questions about the research. Full disclosure can also mean providing feedback on the findings. I plan to present my findings to the public. I encouraged the participants to look for information flyers that will be posted at the community agencies and service providers. After each presentation, I will respond to questions and solicit feedback.

The right to be treated fairly and the right to privacy fall under the principle of justice. Fair treatment was addressed in this study by offering contact with both the researcher (interviewer) and the principle investigator (my faculty advisor). Participants were assured that no negative repercussions would result from withdrawing from the study. Finally, all participants were compensated at the end of their interview as per the agreement found in the consent form (Appendix D).

There are two aspects found in the right to privacy, anonymity and confidentiality. Anonymity was maintained by ascribing a pseudonym to each participant. Due to the emergent nature of this qualitative design, I chose to alphabetize the participants' pseudonyms following the order in which they were interviewed. For example, the name Charlotte begins with a "C". Since "C" is the third letter in the alphabet, Charlotte was the third person to be interviewed. In this way, the flow of data collection and analysis is more obvious; the influence of earlier data collection and analysis on later interviews can be followed. To further address anonymity, identifying tags such as names of people and places were removed from the transcripts and from this thesis. There must be a balance between strategies to maintain anonymity and stripping away the quality of the data.

Access to the data was limited to my thesis committee, one transcriptionist (who only transcribed the last interview) and myself. The thesis committee are all UBC faculty members and were well aware of their responsibilities to maintain privacy and confidentiality. The transcriptionist was informed about the need for confidentiality and she signed an agreement stating so. All study documents are kept in a locked filing cabinet. When the data was transported, I sealed it in an envelope with my contact name and number on it. All computer files are password protected and will be completely deleted from the computer system after the thesis is completed, a hard copy is printed and a computer disk made. As per the University of British Columbia policy, I will store the data for five years. After that time the audiotapes will be erased (demagnetized) and then destroyed. All paper data will be shredded at that time.

This research was approved by the University of British Columbia's Office of Research Services and Administration's Behavioural Research Ethics Board on February 18, 2005. The application for ethics approval included descriptions of the following items:

1. My qualifications (see section on rigour)
2. Inclusion/exclusion criteria
3. Potential risks and benefits
4. Participant compensation
5. Confidentiality (see above section)
6. Participant feedback (see section on participant opinions and recommendations)

The reader is directed to the appropriate section in another part of this paper in the case of the three topics which have already been addressed. The remaining issues are the focus of the sections which follow. The issues of informed consent and researcher safety are also relevant to this study and they complete the list of researcher considerations.

Inclusion/Exclusion Criteria

To be included in this study, participants must have been nineteen years of age or older at the time of consenting to be interviewed. I decided on this age after finding out the age policy of one of the SISs. An SIS allows people sixteen to eighteen to use their services after the teen is connected with support groups and assessed to determine if he or she is being forced into using drugs. Those over the age of eighteen just need to state that they are an experienced IDU. Due to the complexities and vulnerability of this population, I decided to make nineteen the minimum age.

I decided to let the participant self-screen for three reasons. First, many IDUs lack proper identification from which they can prove their age. Second, from my experiences working as a street nurse, IDUs often distrust people whom they consider

part of the establishment. Finally, I wanted to develop a relationship in which the participant felt comfortable talking to me in an interview. I felt that asking for proof of age would hinder my ability as an interviewer. I did manage to find out the ages of all but one of the participants during the course of the interview. I later obtained the age of the one participant who did not disclose her age during the interview.

I required that participants be current or former IDUs who had used an SIS at least once. All but one participant was using injection drugs at the time of interviewing. The participants were required to have injected drugs for over one year. I included this criteria so that the participants would have the necessary experiences in order to discuss their use of injection drugs. I sought out participants who used an SIS from a few times in total to a few times per day. This was done in order to get a variety of perspectives. I was interested neither in the casual user, nor in the user with the financial ability to inject in a safe location, thus having no need for an SIS. Because heroin and cocaine require frequent injecting, I limited participation to IDUs who used one or both of those drugs. In order to foster a respectful relationship and allow participants to maintain their dignity, I did not ask them to prove they injected drugs.

People were excluded from the study if they met any of the following criteria. Anyone under the age of nineteen was not allowed to participate. If a person had less than one year of experience injecting drugs prior to the opening of the SIS, they were not considered. People injecting drugs other than psychoactive drugs (e.g. steroids) did not qualify. Because participants were interviewed, those unable to communicate in English or to carry on a conversation were to be excluded. Finally, any person showing signs of acute intoxication or acute withdrawal (anxiety, irritability, extreme fatigue,

acute paranoia, etc.) at the time of consent, just prior to the interview, was to be excluded.

Risks and Benefits of the Research

All participants were informed of the potential risks and benefits. The risk that I envisioned as possibly occurring was the triggering of strong emotions like sadness, frustration, agitation or even anger from the interview process. Throughout each interview, I paid attention to the participant's tone of voice and body language to identify if the participant was upset. Although the discussions sometimes triggered emotions, there were only a few times when I felt it was necessary to address this issue. In my ethics proposal, I stated that I would acknowledge the participant's feelings and offer to take a break or stop the interview entirely. In reality, I considered the individual, our relationship as nurse researcher-participant, the topic of discussion and the type of emotion. I relied on my nursing experience and skill as a communicator and handled each situation differently.

The predicted benefit of this research, for some individuals, centres around the problem of social isolation, which can be common for this population (Alexander, 2001; Darke & Ross, 2002; Lafuente & Lane, 1995). I expected that some participants would benefit from being given an opportunity to talk about their life and their experiences. Some participants may also feel that sharing their experience may benefit others, and this feeling could increase participants' self-esteem. As it turned out, two participants expressed their enjoyment of the experience and stated they were happy to contribute to the study. One participant said: "I am just glad I can be part of this and help. Every little bit of information we can gather is going to help." All the others, except one,

appeared to be comfortable if not happy upon departure. The situation surrounding the one exception will be discussed in the next section.

Participant Compensation

When debating whether to compensate participants for their time, I first looked at the UBC policy #89: Research and Other Studies Involving Human Subjects (2002). Although I found no specific guidelines on payment, two points within the purpose section stood out:

1. Respect is shown for the dignity of the research subject.

2. Vulnerable persons are protected against abuse, exploitation and discrimination.

After considering these two points, I decided that compensation would be fair and I would demonstrate respect for the participants' time and effort.

My next step was to look at the literature. Money given to participants was also termed payment, reimbursement, and compensation. Although the terms have slightly different meanings, for this paper I use them synonymously.

Financial compensation to research participants is common (Borzekowski, Rickert, Ipp, & Fortenberry, 2003; Dickert, Emanuel, & Grady, 2002; Grady, 2001). Borzekowski et al. (2003) examined 120 different primarily authored pieces of research on adolescence, from a variety of disciplines, for monetary value, form of compensation, and predictor variables for giving and receiving payment. I was unable to find research on this scale for compensating adults. Of the 30 studies that came from the field of health and medicine, 39.3% provided payment. All seven studies recruited participants from the street and shelters, and 81.3% of the research that involved interviews gave

compensation. Seventy-five percent of low-income participants and 60% of cigarette, alcohol and drug using participants received reimbursement. In all cases the payments were in the form of cash (50%), coupons (37.5%), gifts (7.8%), or cheques (4.7%). The mean payment for sample sizes of fewer than 100 participants was US$12.06.

Finally, I looked to see if there was a precedent for reimbursing the population I wanted to study. IDUs in the DTES have participated in a plethora of research studies. Many of these investigations provided payment to the participants. For example, the British Columbia Centre for Excellence in HIV/AIDS offered participants $20 as a financial incentive in their qualitative study of HIV outbreak in the IDU community (Harvey et al., 1998).

Turning towards the ethics of reimbursing participants, Ulrich and Grady (2004) agree that paying participants is fair compensation and not morally problematic for nursing research. This being said, some ethical considerations must be addressed, such as the undue inducement to participate in research, especially for economically disadvantaged individuals (Dickert et al., 2002). In order to bring clarity to this issue, the question of why a participant should be reimbursed must be explored. For this, I refer back to the two points in the UBC policy. Proportional reward (reimbursement), discussed by Sears (2001), compensates only for the participant's time and inconvenience. This therefore reduces the undue financial incentive for participation. Grady (2001) argues that this type of compensation demonstrates respect and appreciation to the participants for giving up their time and contributing to the study. It is my belief that all people, including homeless IDUs, deserve to be treated with respect and should not be exploited or discriminated against. Their time and knowledge is

valuable. Providing a proportional reimbursement for the approximately one-hour interview will acknowledge the participants' efforts.

I decided to compensate participants for their time by providing a $10 gift certificate from a store located near the interview site. For researcher safety reasons, I chose to give a gift certificate. In providing informed consent, I posted information about the study on bulletin boards (Appendix B). I did not want to state in the letter that I would be carrying money.

My choice of compensation sparked discussions among the clients of the emergency shelter and drop-in centre. Many people were eager to participate in the study until they found out the compensation was a $10 gift certificate. Many felt that $10 was not enough, and since it was in the form of a gift certificate, the actual street value was less. A research participant told me that he would probably get only $4 if he sold it on the street. One woman was interested in buying the gift certificates from participants. She tried to convince other clients to participate in the research by offering to buy their $10 gift certificate for $6. Although nobody took her up on the offer, there was back and forth discussion about how much the gift certificate was worth.

A few women stated they thought the gift certificate was a good idea. They said they could use it for buying clothes and food. Another client said the store was too far away[13]. One participant mentioned that offering a gift certificate was a sign of disrespect. He waited until after the interview was over and the tape stopped before expressing his thoughts. He said that he felt I gave a gift certificate instead of cash because I did not want the money to go towards the purchasing of drugs. He said that although that may be true, it is his business what he does with the compensation money

---

[13] The store is roughly four or five blocks away from the drop-in centre.

and not the researcher's. Upon further visits to recruit participants, this particular participant yelled out to other clients, telling them that I was cheap and people should not participate because the money was not worth it. This hampered my ability to get participants.

I realized that the issue of compensation is more complex than I originally thought. If I were to conduct research again with this population, I certainly would consider another form of compensation. I returned to the literature and found an article that provides suggestions for compensating women who were victims of domestic violence for the sharing of their time and expertise as research participants (Sullivan & Cain, 2004). The authors recommend compensation in cash or gift certificates selected by the participant, from a variety of local and easily accessible retailers and restaurants.

Informed Consent

Prior to the start of an interview, I asked for consent. The participant was required to read the consent. I then asked the participant if he or she had any questions. None of the participants asked questions. I asked each participant to summarize the content from the consent form so I could be sure that he or she comprehended the form and truly provided informed consent. One participant did not appear to be reading the consent, so I asked if she was OK with the consent form, not wanting to presume she was having difficulty reading it. The participant said she was fine. As it turned out the participant was reading it. I misinterpreted my observations because of the constant movement of the participant.

On a couple of occasions, I asked participants to renew their consent. The first time was after a participant had a break in the middle of the interview so that he could

eat. Prior to restarting the interview, I asked that participant if he would like to continue or stop. The second situation occurred when a different participant appeared fatigued.

Participant: [yawn] Sorry my methadone is starting to work on me.

Researcher: Oh, is it. Are you doing OK? Do you want to stop for a bit?

Participant: No.

Researcher Safety

Qualitative researchers need to be aware of potential harm to their physical and psychological well-being while working in the field. Threats to researcher safety can happen in any setting, but the researcher is at greater risk when interviewing people who are addicted to psychoactive substances and who live in economically disadvantaged areas, with high rates of crime and violence (Lewis & Hallburg, 1980; Schulte et al., 1998). Potentially harmful situations include physical or verbal aggression in which the safety and/or security of the researcher is compromised. The behaviour of people addicted to psychoactive drugs may be unpredictable and potentially volatile. I therefore used Patterson, Gregory, and Thorne's (1999) researcher safety protocol of assessment, prevention, response and follow up as a framework to address safety concerns in the research setting.

The most effective strategies for maintaining the safety of the researcher are prevention and avoidance (Nadwairiski, 1992). Both of these require a critical assessment of the potential risks. The participant group, the research topic and the environment each need to be considered in the assessment. The participant group, IDUs, some of whom may have a mental illness, are considered to be at higher risk for displaying aggression, and it has been suggested that the participant be telephoned

prior to the interview in order to assess intoxication (Patterson et al., 1999). The population I studied were homeless or living in unstable housing situations, such as shelters or single room occupancy (SRO) hotels, and most did not have reliable access to a telephone. In order to assess potential aggression related to intoxication, I set a meeting place in a public area, close to the interview location. The assessment consisted of looking at facial expression, pupil dilation, gait, and listening for impaired speech.

Although politically sensitive, SISs were initiated through the grassroots lobbying of IDUs and their advocacy groups. SISs garner a great deal of support, though not unanimous, in the injecting drug community. No matter what stance the participant has, the research question seeks the interviewee's perspective and the method allows the IDU to speak her or his mind without judgement or critique. I therefore did not foresee the topic as being a risk factor for triggering aggression, nor did it.

The environment in which I conducted the interviews, a single-room occupancy neighbourhood where drug use and criminal activity are common, fits within Lewis and Hallburg's (1980) description of a high-risk setting. As a result of my experience working as a street nurse in one of the poorest neighbourhoods in the city of Toronto, and donating a wide variety of items on a regular basis to non-profit organizations in Vancouver's DTES, I felt comfortable conducting interviews in that environment. I am familiar with the DTES. I frequently drive, bicycle, run and walk through the area. My prior experience also improved my "street smarts" when it comes to safety.

I employed prevention strategies to minimize potential danger. Prior to entering into the field, I notified a contact person and let her know where I would be and when I

anticipated being finished. I checked in with that person when I was done or if I needed to revise my time frame. I attempted to dress professionally without looking out of place for the area. I modified the items in my wallet to carry only a small amount of money for emergency, and one piece of identification. All cards such as social insurance, credit and debit cards were left at home or in a secure place. I brought my fully-charged cell phone in case I needed to call 911. I took my car to avoid locking up a bicycle or standing waiting for public transportation. All valuables were removed from the car and it was locked with the windows up and parked on a main street within public view.

Maintaining awareness of the area and activities surrounding me was important for safety. All interview times were set during daylight hours so that it was easier to see the surrounding environment. This also increased my sense of security by having more people around on the street. Upon completion of the interview I left the field area and returned home, about ten minutes away by car, to write my field notes.

As an instructor, I teach a variety of strategies to care for potentially aggressive residents in a locked-up dementia unit. Many of these approaches can be useful for research safety. I always made sure I had an unimpeded exit behind me. I was observant for non-verbal signs of agitation, frustration or any sign of aggression. I paid attention to the participant's tone of voice and body language. I planned that if I sensed potential agitation or danger, I would try to defuse the situation by acknowledging the participant's feelings or I would end the interview as diplomatically as possible. If there was a threat or actual harm I would have reported the incident to the police, and to my committee. Neither of these situations arose.

SUMMARY

In this chapter, I laid out my rationale for selecting interpretive description as a methodology. There were three parts to this chapter. In the first part, I discussed the process taken in conceptualizing and designing this study. This started with presenting how the topic was identified and then proceeding to explain interpretive description and justify it as an appropriate approach to the research question. The first part concluded with a description of the process of accessing and recruiting participants. The middle part of the chapter dealt with the research process. In it, I described the sampling, data collection and analysis as well as rigour. The section on rigour was emphasized in order to demonstrate the strategies taken to maintain validity and reliability. In the final part of this chapter, I focused on the issues and concerns that required my consideration. Sections in this part include ethical considerations, participant compensation, informed consent and researcher safety. In the following chapter, I present the findings, while adhering to the ethical principle of anonymity as outlined in this chapter.

CHAPTER FOUR: FINDINGS: INJECTION DRUG USERS' EXPERIENCES

INTRODUCTION

In this chapter, I will present the findings that describe injection drug users' experiences with supervised injection sites. There are seven parts to this chapter: 1) Participant Background; 2) Injection Drug Users' Experiences; 3) Experiences with Supervised Injection Sites; 4) Participants' Opinions and Recommendations; 5) Main Findings: Barriers; 6) Unexpected Findings; and 7) Summary. In part one, I begin by presenting an overview of the participants as a group. IDUs are often viewed superficially by society and are stereotyped as a homogeneous group. To give an appreciation of the diversity of IDUs, and the complexities of their lives, a brief description of each participant is provided. Both relevant and interesting information about the interviews will be included. For example, participants often used street and drug slang terms that were unfamiliar to me at the time of the interview. I describe my response to this situation and provide a list of slang terms with definitions.

The second part of this chapter, Injection Drug Users' Experiences, covers a variety of issues. Participants described to me their first experience injecting drugs, how they came to live in the DTES, their housing situation, how they make money, threats to their safety and security, and experiences injecting drugs. These descriptions provide a background to the participants' lives and are stepping-stones to the next part, Experiences with a Supervised Injection Site. This part of the chapter responds directly to the research question: "What are injection drug users' experiences with supervised injection sites?" Participants' experiences in and around a supervised injection site are

explored. This section will also describe the relationship the participants have with nurses, peer support workers and other users of the site. During the interviews, participants shared their opinions and I asked them for their recommendations concerning the SIS.

In part four, I provide a list of these opinions and recommendations, thereby giving a voice to the participants. The previous four parts set the stage for the remainder of this chapter. In the Main Findings part, I provide my interpretations of the data. Although participants unanimously support SISs because they believe the sites save lives, most use the sites only rarely or occasionally when injecting. Although SISs are designed as a low-threshold service to meet the needs of high risk IDUs, many actual or perceived barriers limit access to the service. Referring to the data, I explore the various barriers facing IDUs. In the sixth part of this chapter, unexpected findings are presented. Participants have expressed concern for their community and have acted to make positive changes through advocacy, action and acts of kindness. At the end of this chapter, a summary will be provided.

Throughout this chapter, I describe issues and challenges I faced while conducting this study. I describe my thoughts at the time and explain the decisions I made, so that the reader understands how this research unfolded. My goal is to make clear the reasoning behind the decisions and actions that ultimately led to my interpretation of the data. Although I have used direct quotes from the participants, their accounts are presented through my subjective lens as a nurse and a researcher. Please note that the quotes included here are chosen to illustrate and make sense of the findings and are not used gratuitously to provide a shock to the reader. Some quotes

contain language some people may find offensive. Most quotes will not be ascribed to a particular participant unless it is necessary for understanding the situation, in which it will be done with the caveat that identification does not threaten the anonymity or confidentiality of the participant.

PARTICIPANT BACKGROUND

In this part of the chapter, I provide a general overview of the participant group, as well as a brief description of each participant. During the interviews, participants used street and drug slang terms that were unfamiliar to me. I include a description of the steps taken to understand the vocabulary used by the participants. Below is a table which provides general information on the participants and can be used for easy referral.

	Allan	Bruce	Charlotte	Dennis	Eric	Felicity	Gabrielle
Gender	M	M	F	M	M	F	F
Age	54	52	27	29	46	38	47
Number of years injecting	8	13	6	7	27	14 / 8*	29 / 21*
Age of first injection drug use	46	39	20–21	22	18–19	23	18
Family history of drug use	?	?	yes	yes	yes	no	yes
Has OD'd	yes	yes	yes	no	no	no	yes
Has attempted treatment	yes	?	yes	yes	yes	yes	yes
Currently uses methadone	yes	?	yes	yes	yes	yes	yes
Has difficulty injecting	?	yes	yes	?	yes	yes	yes

Has been doctored	?	yes	yes	yes	yes	yes	yes
Has doctored others	?	?	?	?	yes	yes	?
Prefers to inject	at home	at home	?	anywhere	at home	at home	at home
Uses SIS	occasion-ally	occasion-ally	often	rarely	rarely	occasion-ally**	almost always

* Had long periods without using injecting (1st # = total years since first injection; 2nd # = total yrs. actively injecting).
** Not injecting at the time of the interview.

Group Overview

Between March and May 2005, I conducted seven open-ended interviews with three women and four men. Their ages ranged from 27 to 54 years old. The number of years actively injecting drugs spanned from 6 to 27 years. Two participants stated they stopped injecting for numerous years before starting again. At the time of being interviewed, six participants were injecting, and one had stopped injecting in the previous few months. All participants had injected heroin or cocaine or both. Five of the participants said they inject other opioids, including morphine and oxycodone. Almost all the participants occasionally smoked crack. For one participant, crack was his regular drug of choice. This person was the only participant to state the use of crystal methamphetamine. Most of the participants stated they use more than one drug. Five participants were on methadone maintenance but continued to inject drugs. One participant stated he is not interested in stopping his injection drug use while another has tried methadone but did not like it.

Prior to conducting the interview, I put considerable thought into whether I should identify participants' ethnicity. I chose not to ask participants about their culture or ethnicity for three specific reasons. The first reason is based on my experiences that

many people have a diverse culturoethnic background and it may be hard for participants to clearly identify their background. The second reason focuses on my need as a research interviewer to quickly create a relationship with the participants which fosters the sense of trust and openness needed for the sharing of sensitive and personal information. I was reluctant to start the interview by asking about the participant's culture and ethnicity because this can be a sensitive topic for some people. The final reason for not asking about ethnicity directly relates to the nature and time constraints of this study. This is an introductory qualitative study with a small number of participants. I therefore did not make ethnicity a focus. The interviews were rich and, for the most part, flowed very well and the question of ethnicity did not seem important enough to ask. This being said, I was aware from my literature review that members of the First Nations population are over-represented in the DTES and in the injection drug using community (Riley, 1998) and I included participants who self-identified as First Nations in the sample of participants.

With respect to health, all participants identified themselves as having a variety of chronic health issues such as HIV or hepatitis C, and one self-identified as having a mental illness. Their exact diagnosis is not directly relevant to this research so this was not explored further with the participants. Four participants had overdosed and another stated he came "incredibly close a few times".

Throughout all the interviews there were times when I found contradictions in the data. Conflicting data often related to dates and times. This was expected, as recalling specific dates and times at a moment's notice usually results in providing a best guess. For example, a 47-year-old participant said she started injecting at the age of 18, quit

injecting at the age of 25, but restarted 10 years ago. She went on to say she quit for 8 years but, looking specifically at the numbers, there are 4 years unaccounted for. This type of incongruence is not important for this study because the focus is on the experience and not on recording specific details.

To address this type of discordance in this paper, I chose to either present the conflict or write more generally to encompass the gap in time. In other situations, I received surprising answers that may have contradicted earlier statements. When this occurred, I asked the same question again, rephrased the question, or questioned the participants about their response. An example of this occurred when I asked a participant whether he used methadone. He responded by saying no. Although that was a clear response, I vaguely recalled that earlier he had mentioned using methadone. I responded by repeating his answer "no" using a questioning tone. The participant changed his answer. I believe the conflicting remarks have to do with memory recall and understanding the question. I have no reason to suspect that any of the responses were made up. There were numerous times when the participants indicated to me they were unsure of their answers, by using words and phrases like "about" or "I think". The flexibility inherent in the interpretive description methodology allowed me to go beyond the conflicting detailed descriptions by using an inductive approach to "seek understandings of clinical phenomena that illuminate their characteristics, patterns, and structure in some theoretically useful manner" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p. 6).

All participants were given a fictitious name to maintain anonymity. I purposefully assigned names in an alphabetical format to represent the order in which they were

interviewed. Thus, the reader can see immediately if the participant was interviewed earlier or later. This is important because the data collected from earlier interviews helped to shape the questions of the later interviews. Over the course of the research, I changed the guiding questions twice, thereby having three different, albeit only slightly different, interview guides (Appendix D, E and F). The participants interviewed earlier provided me with the background data but I may not have asked specific questions of them as I did with the later participants. For example, although four participants shared with me that other family members had substance addictions, the issue of family was not discussed with the first two participants. Therefore, the number of participants who have a family member with a substance addiction is four out of five, rather than four out of seven. The changes to the guiding questions are in keeping with the interpretive description methodology of using an inductive approach whereby the process of data collection and analysis are concurrent (Thorne et al., 1997).

Participant Descriptions

Understanding the context in which the participants live is essential in understanding the data. The following descriptions shed light on the participants' backgrounds and life in the DTES. I only briefly discuss their experiences with the SIS since these will be explored in detail later in this chapter. As individuals, the participants have unique backgrounds and experiences that influence how they talk about their lives. These brief descriptions provide an important key to understanding each participant's perspective. They can also be used as a background reference when reading later sections of this thesis.

Although this study focuses on IDUs as a group, I feel it is important to recognize and appreciate the diversity in the backgrounds and experiences of the individuals who participated in this study. Their unique characters offered a great richness to the research data. Injection drug users are often stereotyped as a homogeneous group whose lives centre on committing crimes to obtain money for the procurement and consumption of illicit drugs (Turner, 1984). This is a superficial understanding that neglects to appreciate the diversity of IDUs, and the complexities of their lives. With these brief descriptions, I hope to bring to light the individuality of each participant. I include my observations from the interview as recorded in my field notes. The participants' experiences will be addressed later in this chapter.

Allan

Allan was the oldest participant at 54 years old and the first person interviewed. His interview was unlike any of the others. It was the only one conducted in the evening and it lasted approximately 3 hours and 15 minutes. Allan mentioned that he had attended university, had worked for many years in the financial sector, and had been married before starting to inject drugs at the age of 46. His education and career set him apart from most of the other participants. Allan was the only one to have completed a post-secondary education and to have worked in a well-paying job.

Allan did not mention his upbringing, but he did share that both his father and his ex-wife are healthcare professionals and that he was always financially well off. He did not mention his mother at all. Allan discussed his family in relation to his drug use. He said he tried to keep his drug use hidden from his family. He believed they knew he was

using drugs but they did not want to talk openly about it. "So it was almost as if this was an open secret. Not as if, it was an open secret."

Although Allan said that money was never a problem, he compromised his work situation and he borrowed large sums of money from friends and family in order to support his drug use. He appeared quite proud of his creativity in financial dealing and of not needing to resort to crime to fund his drug use.

> And sometimes, some of the financial dealings I did, well they weren't fraudulent, but they were awfully close. You know they were really sharp dealing. And very, very, some of the stuff that I did was pretty wild.

Allan stated his drug use started after being hospitalized for an infection. While in hospital, his pain was treated with intravenous morphine. After the morphine was discontinued in favour of oxycodone, an oral opioid tablet, Allan still found himself in pain. After deciding to leave the hospital against medical advice, he met a woman who introduced him to heroin as a replacement for the prescription narcotics.

Allan looked malnourished, his cheeks were hollowed and he had numerous facial sores, some closed and scabbed over, others still open and fresh. Throughout the interview, Allan occasionally picked at the scabs, causing some of them to bleed. As an interviewee, Allan was articulate, chatty and displayed a sense of humour. He told a few stories but he often became sidetracked and talked about other topics. Prior to my interview with Allan, a couple of staff members "warned" me that he was not like their other clients. They indicated that with Allan's education and intellect, he should be doing more. One staff member said, "if only he lived up to his words". Another said, "if he just did half of what he says".

Although all participants mentioned having chronic physical health problems, Allan was the only one to state he has a chronic mental illness. He told me he has a mental health disorder called "cyclotonia". I did not know of this disorder so I asked Allan to spell it. After the interview, I went home and looked up cyclotonia but I was unable to find it. Allan may have meant cyclothymia[14]. Allan said he is receiving money for disability. He stated he has hepatitis C, recurrent infections, including cellulitis, and motor problems remaining from a broken arm that occurred after being robbed.

Allan only slept outside on rare occasions. He indicated that he usually stayed in SRO hotels or with friends. At the time of the interview, Allan was staying in an emergency shelter. He said he had a room in a hotel, but he was trying to get away from all the drugs there because he was in the process of quitting. Allan is a poly drug user who primarily injects either heroin or morphine while taking methadone. He uses the SIS occasionally. Allan overdosed once and required the use of Naloxone[15] to be revived. Allan set himself apart from most other users.

> Now I am one of the very, very few people that I have ever seen that manages to keep a heroin habit below $10 a day. That's hard. That is not common.

He explained that his desire to quit drugs was based on wanting to go back to university, to do a PhD in mathematics. He hoped to be employed in one of his areas of interest, constructive mathematics, constructive engineering or software engineering. Allan pulled out a folder from his frayed shoulder bag and gave it to me. Although I was initially sceptical about the claims of job offers, after briefly looking over the documents

---

[14] "Cyclothymic Disorder is a chronic bipolar disorder consisting of short periods of mild depression and short periods of hypomania. These symptoms may last a few days to a number of weeks. The onset is separated by short periods of normal mood. Individuals with cyclothymia are never totally free of symptoms of either depression or hypomania for more than a number of months at a time" (http://www.psychnet-uk.com/dsm_iv/cyclothymic_disorder.htm).

[15] Naloxone (Narcan) "…used to prevent or reverse the effects of narcotic pain relievers" (Pharmacy Online, n.d.).

that were on company letterhead, I realized there was much more to Allan's story than would come out in the interview.

Bruce

Bruce, a 52-year-old, had been injecting drugs for 13 years. Like Allan, Bruce started injecting drugs at a later age than the other participants. Bruce did not talk about his childhood, where he grew up, or any family members. He started the interview by telling me he had been deported from the United States and subsequently immigrated to Canada after serving time in a United States federal penitentiary for armed bank robbery. Although Bruce snorted drugs, he did not start to inject until after he moved to the DTES. Upon his arrival, Bruce found inexpensive accommodation in a hotel near the central train station. It was there, feeling alone and alienated, that Bruce met a group of people who regularly injected drugs. One of the women in the group, an ex-Hell's Angels member, first introduced Bruce to injecting. She injected him with cocaine until he eventually learned to inject himself.

Bruce said he had overdosed, but was vague when asked where, when and how often it happened. He did indicate it was before he started injecting drugs. Bruce was not interested in quitting and did not consider he had a problem even though he has contacted HIV and hepatitis C from his drug use.

> I kinda like it. So I try to do it moderately right, you know. I don't consider myself as a junkie right, I just consider myself a person who consumes cocaine.

Although Bruce has multiple chronic health problems, he says he only has trouble with shortness of breath. He was very upbeat and cheerful during the interview. Bruce expressed a positive attitude in the following way:

I feel like a million bucks. You know what I'm saying. No matter how, how, um how, how, how, how bad, how many bad things done in my life I feel like God, God can see me and understand it and that's how I feel. If God is OK with it then I'm OK with it. My conscience is OK with it. I can sleep at night. I feel groovy just like in the movies. That's the way I feel right. And every day I wake up that's the way I feel good. I look myself in the mirror I say damn man you still here having the time of your life.

Like Allan, Bruce was a very thoughtful interviewee. He expressed a great deal of concern for his community. He volunteered with VANDU and was active in advocating the establishment of SISs. He commented a few times that children should be protected from being around injection drugs. Bruce was very supportive of the site but only uses it occasionally, preferring to inject at home.

Charlotte

Charlotte was the youngest participant at 27 years old. She had injected drugs for six years, the shortest period of all the participants. She is the only one that identified as growing up in the same province as the SISs. Charlotte spent her early years living with her mother and two biological sisters. She did not mention her father. All three children were removed from their injection drug-using mother, and sent to live with different families.

My biological mother was a drug user, really bad. She just died a year ago. When I was a kid we got taken out of the home for injecting.

Charlotte's mother injected in front of her daughters. Watching her mother inject had a profound impact on Charlotte. Charlotte told me a story about how her older sister Samantha [pseudonym], at the age of 10, had to help their mother to inject. Their mother then overdosed and since that time, Samantha became afraid of needles.

My older sister actually had to help her inject once and my mother OD'd [overdosed]...yeah, and she was like ten years old. And Samantha, she was so freaked out about needles, she won't be in the same room with someone fixing.

Which is probably a good thing. Maybe if I was the one to OD my mother, I'd be afraid to touch needles.

Charlotte was curious about injecting drugs. She said: "I always wanted to use, try needles." She went on to say that she "fell in love with the needle right away" and that there was the ritualistic aspect that she craved.

While in college, Charlotte decided to go for counselling because of her alcohol drinking. She believes that the counselling triggered something in her that led her to start injecting. While in a recovery home, she met a man who used injection drugs. Both of them left the recovery home and stayed at Charlotte's home. It was there that he introduced Charlotte to injection drugs. Charlotte does not blame him because she always wanted to use drugs.

Yeah, I mean if it wasn't him it would be someone else. So…he started me off and at first, I mean in the beginning I was sure I could quit.

Charlotte said she was, at that time, using more because of the needle than because of the drug. This could be a manifestation of self-injury. Self-injury is an ineffective response to negative emotional feelings such as psychological pain, loneliness, depression, or even anger. Injuring oneself could be a form of self-punishment. For others, self-injury can temporarily heighten feelings and emotions when people feel numb (Canadian Mental Health Association, 2006). The Canadian Mental Health Association (2006) affirms that drug use could be a form of self-injury.

Since starting to inject, Charlotte stated, she lost her home, her car and her son. Charlotte did not explain what happened to her son or how old he is. I was unable to explore this issue with her because we were discussing other issues at the time.

Charlotte spent time describing her life in the DTES and her experiences with an SIS. She told me about the dangers of being in the alleyways in and around the open drug scene as well as the challenges of injecting in public places. She told a story about her experience overdosing. Her experience living in the DTES will be addressed later in this chapter. Charlotte described her challenges with using the site and her feelings of being uncomfortable with injecting in front of others.

Charlotte is on methadone but she still injects, and smokes crack. She uses an SIS often because she is afraid that her boyfriend will kick her out of the apartment if he finds out she is injecting.

Charlotte was the third participant and the first woman to be interviewed. The staff at the drop-in centre provided a private office for the interview to take place. Like the previous two interviewees, Charlotte provided rich descriptions and shared her insights, leading me to feel like the interview captured a significant amount of data. Physically she looked thin but not frail. Charlotte spoke in a very soft voice. I was able to understand everything she said during the interview but a couple of times her voice was inaudible on the audio recording. Although I struggled to hear parts of the recording, I was able to piece together what she said from my memory of the interview. At one point in the interview, Charlotte told me she was feeling the effects of her methadone.

Charlotte: "Sorry, my methadone is starting to work on me."

Researcher: "Oh, is it? Are you doing OK? Do you want to stop for a bit?

Charlotte: "No." [responding to the last question: "Do you want to stop for a bit?"]

In this situation, Charlotte was looking tired and when she said "sorry" she was referring to the fact that the sedation effect of the methadone was slowing down her

responses. My observations lead me to believe that, although Charlotte was tired, she was not too tired to continue with the interview. My observations were congruent with Charlotte's decision to continue with the interview. Later in the interview Charlotte was slow to respond to a question and finally said "mm, no…my methadone is working". At this point I decided to wrap up the interview because I felt Charlotte was too tired to continue. I offered Charlotte the opportunity to finish any thoughts that she may have had.

It was during the transcription phase that I noticed Charlotte used storytelling to help describe her experiences. I decided to look back at the previous two interviews, and paid more attention in the subsequent interviews to whether other participants used stories as a means to convey their experiences.

Dennis

At the age of 29, Dennis was the youngest male participant. Dennis told me he had found out recently that his mother had died of an overdose. He went on to say that alcoholism runs in his family. His grandmother is an alcoholic but most of his family do not abuse substances. He had injected drugs for seven years, since 1998. The first time he used injection drugs, he agreed to have a woman inject him in one of the alleys. At the time of the interview, Dennis was on methadone and he was going to school to try to get his high school diploma. His injecting had decreased to once a week but he was still smoking crack regularly.

Dennis appeared very tired; he was yawning throughout the entire interview. Although he spoke softly and slowly, he was able to answer the questions and follow along with the interview. Within a few minutes after the start of the interview, Dennis

accidentally knocked his coffee over onto the table. I had to stop the tape recorder and get paper towels to dry the table. I was uncertain whether to continue because of Dennis' apparent fatigue and lack of coordination. I knew he was on methadone so there could be the sedation effect from that medication. Before starting the tape again, I spoke with Dennis about his tiredness. Dennis was able to carry on a conversation and demonstrated to me that he was competent and that he understood the situation. I asked Dennis if he was OK to continue and he provided me with verbal consent to resume recording.

After the interview was over, I initially thought that the interview did not go very well. His was the shortest interview; his answers were brief. After taking time to reflect on the data, I changed my opinion. After immersing myself in the data and having other interviews to compare and contrast, I realized that Dennis provided a voice for younger male IDUs. He presented a youthful, carefree, even careless attitude about his drug use. Dennis was the only participant not to have a preferred location for injecting; he did not care where or when he injected. For example:

> I inject all over the place...I inject at home, I inject in the alleys, I inject wherever. Yeah, and I have injected at the needle injection site.

With Dennis' interview, I realized he lacked knowledge about the SIS services. For example, he was unaware that registered nurses worked at the SIS. I began to wonder if other participants had knowledge gaps concerning SISs. Once again, I returned to previous interview transcripts to look for signs of a knowledge deficit.

Eric

Eric, a 46-year-old, had a very abusive childhood while growing up in Northern Canada. At the time of the interview, he had not been in contact with his family for many

years, but he did believe his brothers struggle with alcoholism. At a very early age, he ran away from home and ended up in a number of group homes. In his teens, he set out on his own and worked for a carnival in the summer and at highway lodges in the winter. It was during this time that he started drinking alcohol, smoking marijuana and occasionally taking lysergic acid diethylamide (LSD)[16]. Eric was introduced to injecting at the age of 18 or 19. Eric is the only participant who was introduced to injecting by a person of the same sex, but he was also living in a very small community. All the others started injecting in larger Canadian cities. I realized there may be a correlation between gender relationships and the initiation of injection drug use. The first drug he injected was cocaine. In the interview, Eric described his feelings after the first injection.

> The very first time I did a fix, I was in love. It was better than movies, better than sex, it was better than fucking anything. And I have been an IV drug user ever since.

Eric has injected heroin but cocaine has always been his drug of choice. Originally he bought it as a treat when he received his income tax reimbursement. After making many trips down to DTES he decided to stay.

Having injected drugs for 27 years, Eric had the longest history of injecting of all the participants. As a result, his veins are very poor. Eric estimated that 75–90% of the time he smokes his dope because his veins are so bad and he hates to pay someone to inject him, called doctoring. The issue of being dependant on another person to perform injections interested me. Looking back on previous interviews, I found that most participants had been "doctored", and both Bruce and Charlotte indicated that they had

---

[16] LSD (lysergic acid diethylamide) is a potent hallucinogen. The term "hallucinogen" describes a drug that can alter a person's perception of reality and vividly distort the senses. LSD was originally derived from "ergot," a fungus that grows on rye and other grains (Centre for Addiction and Mental Health, http://www.camh.net/About_ Addiction_Mental_Health/Drug_and_Addiction_Information/lsd_dyk.html).

difficulty injecting. I was curious to explore the issue of doctoring with the future participants.

Eric said he was a member of VANDU. Even when VANDU was advocating an SIS, Eric was against the idea because he felt SISs would promote drug use. At the time of the interview, he felt that the SIS was doing good work but he still had some concerns. Erroneously, he believed it is officially called a safe injection site. Eric took issue with the word "safe" saying he did not believe anyone could inject drugs safely. He put forth the word "safer" as a better description for the site. As stated earlier, the SIS is not a "safe" injection site; it is a supervised injection site.

Eric's experiences with the SIS differed from those of other participants. As a client, he only used the site a handful of times. However, Eric volunteered at the SIS as a peer support worker. I did not know this until the interview. Eric provided thoughtful insight into the operations of the site.

The interview was conducted in a small, cramped office. For the first five minutes, Eric did not look at me. His eyes darted from one side to the other. Initially, I thought this was due to nervousness, but I think it may have had more to do with distrust. It seemed like he was used to a question and answer session. Some of his answers were brief and he would say "OK, next question". After the tape stopped and the interview was over, Eric questioned my choice of giving a $10 gift certificate instead of money. He said that this showed a lack of trust and respect for people. He said it is their money and they should be able to do anything they want with it. He went on to say that I am probably right that most people would spend it on drugs. (At no time did I indicate to Eric that I believed money would be used on drugs; this was his assumption.)

Eric then said he could only get $4 on the street for the $10 certificate. I informed him that I was not funded and that I paid for all the gift certificates. Eric was correct in pointing out that I still had to spend $10 to get a $10 gift certificate. I acknowledged that he was right, but I added that I decided to use the gift certificate so as to not carry money. I let him know I would bring his comment to the attention of my committee and I would address this issue in my thesis. Throughout this whole time, Eric was direct and straight to the point, though he did not appear to be angry.

Felicity

Felicity, a 37-year-old, moved to the DTES in 1986, after growing up in a major city in one of the Prairie Provinces. Felicity said that she had smoked marijuana and drank alcohol since her early teens and that she is the only one in her family with a substance addiction. After moving to Vancouver at the age of 19, she met a man who used a variety of drugs, which included heroin and cocaine for injecting. Their marriage did not last, although Felicity did not say what happened or when it ended. She did not start injecting with him right away, but after four or five years, at the age of 23, she started to inject. One of her boyfriends used opium, so Felicity became addicted to that. Felicity went on to methadone and was able to stop injecting for a six-year period. Since that time, Felicity has injected off and on, with morphine as her drug of choice. At the time of the interview, Felicity was not injecting drugs but she was still smoking crack.

Felicity usually injected indoors with one or more people. Felicity commented on doctoring:

> I would usually get other people to inject me too because I wasn't very good at doing it myself for some reason. And I could fix other person too but I just couldn't do myself. It is really weird; it is a common thing with addicts actually. You know, you can fix other people better than you can fix yourself.

Felicity's comments solidified in my mind that the issue of doctoring was important.

Felicity's interview was not planned. When another participant did not show up for her interview, one of the staff members suggested that Felicity would be a very good source of information. Felicity was very eager to participate. She wanted to help with research because she said she believed it may assist others in the future. In contrast to Eric, she thought giving a gift certificate was a good idea. In the interview, Felicity was alert and talkative. We were both able to laugh at different points in the interview.

Gabrielle

Gabrielle was a 47-year-old who self-identified as having a First Nations background. She grew up on a reservation. She smoked marijuana in her youth. At the age of 18, Gabrielle moved to a city in the prairies. It was there that her roommate introduced her to street drugs. Other family members have injected drugs, but of those who have, she is the only one still living. She injected for approximately seven years before quitting. She said she stopped injecting because of her children. Gabrielle did not indicate how many children she had. After eight years without injecting drugs, Gabrielle started again. "It started; it came back into my life, because I don't have my children." Gabrielle did not explain what happened to her children except to say "they're grown up and stuff and then I moved downtown here". At the time of the interview, it had been approximately fifteen years since Gabrielle began injecting again. She had spent the last ten plus years living in the East Side. At the time of the interview, she lived in an apartment with her partner.

During her time in the ES, Gabrielle has switched back and forth using heroin and cocaine, with the latter being her drug of choice at the time of her interview. At one

point, she tried going on methadone but did not like it and stopped. Gabrielle overdosed a couple of times.

Gabrielle used to rely on other people, especially her partner, to inject her. She mentioned in the interview that it was only three years prior that she learned how to inject herself. She said she self-injects most of the time but occasionally gets "doctored" by her partner when she is having problems. After so many years of injecting, Gabrielle lost use of all her veins except one: "I only got one vein left and that's this one [she pointed to her arm]...I'm really, really careful with it." Gabrielle never liked injecting on the streets. She expressed a preference to inject at home, but acknowledged using the SIS up to four times a day. She will rarely inject by herself for fear of having an OD while she is alone.

Gabrielle is a former VANDU member and was aware of the struggle to get a SIS for Vancouver. She did not think a SIS would be a good idea and was surprised when it officially opened. Gabrielle's curiosity, combined with her partner's urging, led her to try the SIS. During the interview, Gabrielle's arms were constantly moving. She spoke clearly but was reluctant to speak about a few topics such as family and involvement in crime.

Learning the Language

As I listened to the participants during the interviews, I quickly realized that they all used slang words that were not part of my vocabulary. Each time an unfamiliar word came up, I asked the participant to explain the meaning. I was unsure whether these terms are unique to the East Side or are common among IDUs living in other areas. Therefore, I decided to use the Google search engine to look up some of these words. I

searched "slang dictionary", "drug slang dictionary", and "street drug terms". I searched through ten of the top Web sites. Some words the participants used were not found on these sites. I suspected that some of these words may be unique to the East Side. I then asked a few healthcare and service providers about these words. Many words used by the participants were unfamiliar to them. In order to learn the language of IDUs, I decided to list all the slang drug and street terms and definitions used by the participants (Appendix G). This list is limited to the words the participants used during their interview and is not comprehensive.

INJECTION DRUG USERS' EXPERIENCES

Participants talked about their lives in their interviews. Most shared where they grew up, how they started to use drugs, and when they came to the DTES. As stated earlier, the interviews were packed with rich descriptions. Since there was so much that could be included, I selected what I thought would be important and useful and clustered the information into five sections: 1) The Drug Trap; 2) Homelessness, Housing and Home; 3) Money: Sex, Drugs and Crime; 4) Safety and Security; and 5) Drug Use.

The Drug Trap

In this section, I explore why some people with substance abuse problems end up living in, or close to, open drug scenes. Allan, the first person to be interviewed, did not mention where he grew up. Bruce originally came from another country. After my interview with Bruce, I thought it would be interesting to know where the participants came from and what brought them to the East Side. In the subsequent interviews, if participants did not state where they came from, I made it a point to ask. Therefore, only

six participants identified the place where they grew up. Of the six, one grew up in a nearby city, one came from northern Canada, two from a neighbouring province, and the last participant grew up two provinces away from the research location.

The open drug scene in the DTES is well known both nationally and internationally. It is a "drug tourism" destination spot. I was unable to find a definition for "drug tourism" from a scholarly source, or any source at all except Wikipedia[17]. Wikipedia defines "drug tourism" as "travel for the purpose of obtaining or using drugs for personal use that are unavailable or illegal in one's home jurisdiction" (2006). One participant stated that on 47 different occasions he hitchhiked long distances to get to the DTES. After all those trips, he finally stayed. Most of the other out-of-province participants came to the DTES and stayed. Two participants talked about commuting to the DTES to get drugs. Commuting to get drugs is dependent upon the frequency and amount of drug use, and financial ability. One participant explained the pull to move closer to the source of the drugs:

> Coming to the DTES was related to the fact when you begin to use drugs you run out of money on a regular basis. It is just as much an economic disease as it is a metabolic disease...So when you need them, you must be where they are, there is no other option...And when you don't have very much money then you are required to get the substances on an ongoing small-time basis, which you are forced to do so you can't go very, very far away from the other people that have them.

One of the participants that lived close by would often take trips to the open drug scene. She would consume the drugs in her car. Eventually, she could no longer afford her car so she travelled by public transit to get the drugs. No longer having a car in which to inject, she was forced to use the alleys in the DTES. She started spending more and

---

[17] Wikipedia is a multilingual Web-based free-content encyclopedia. It exists as a wiki, and thus is written collaboratively by volunteers, allowing most articles to be changed by anyone with access to a Web browser and an Internet connection.

more time in the DTES. Her reluctance to move there caused her to sleep out on the

streets.

> I was on the street. I didn't want a…move into a place downtown for the longest
> time, 'cause I didn't want to live down here. So I never got a place, so I was on
> the street and stuff.

In this section, I presented participants' experiences coming to the DTES. The

DTES is a well-known place where drugs are openly bought and sold. People come to

the DTES to acquire drugs. When their frequency of use increases and/or they do not

have enough money to buy larger amounts to take away, drug users often end up living

near the drug dealers.

Homelessness, Housing and Home

At the time of being interviewed, one participant was staying in an emergency

shelter, four were living in SRO hotels, and two had apartments. Only two participants

said they had never been homeless. The others had spent varying lengths of time out

on the streets.

> There has been occasions that I spent a month or two out on the streets. Not
> often because I have been HIV (+) since '91, 14 years or whatever.

All participants had at one time lived in an SRO. These hotel rooms are

infamous. The *Vancouver Courier* (a community paper) ran a two-part story on SRO

hotels which brought to light many problems including high rental costs, illegal fees for

visitors, lack of cooking equipment, break-ins, inadequate shower facilities, unhygienic

conditions, intimidating and threatening managers, lack of privacy, bed bugs, and illegal

evictions (Rossi, 2005a; Rossi 2005b). Below is Bruce's description of his first SRO

hotel room:

rent is expensive…you only had one room and you had to share a bath right. No sink, no stove there neither right. So you'd have to use your hotplate. I can't remember if we had a fridge or not…I don't think we had a fridge no…It's very unromantic it is dreary right.

Throughout the course of the interviews, I noticed that many participants mentioned that they had lived in numerous hotel rooms in the DTES. This in itself was not surprising considering the many challenges faced by this population. Despite the conditions of many of these SROs, and the somewhat temporary nature of their living arrangements, it was interesting to note that all the participants living in SROs called their room home. Even with all the problems associated with SROs, the participants seemed to be able to gain a sense of comfort and security in having a room to themselves. I was unable to locate in the literature the concept of home for IDUs.

All participants, except one, stated they preferred to inject in the comfort of their own home or a friend's place than the SIS. They found that their home was usually more convenient and private. Although some participants were concerned about overdosing alone in their room, a couple said they felt safer there than going out on the streets.

Supplementing Welfare: Sex, Drugs and Crime

In 2002, the Government of British Columbia made significant changes to the welfare system that resulted in a 42% decrease in successful applications between 2001 and 2003 (Wallace, Klein, & Reitsma-Street, 2006). Welfare is a government program that provides income assistance to individuals and families who do not have the financial resources to meet their basic needs; it is a program of last resort (Wallace et al., 2006). A few of the participants mentioned that they receive welfare or disability cheques. In order to receive a disability cheque, a person with a disability must have

severe restrictions to performing the activities of daily living. No participant fit this criterion. A person with persistent and multiple barriers to employment must have a health issue which prevents her or him from being employed. Even though substance addiction is officially considered a healthcare problem, the eligibility criteria restrict people with addictions (BCCPD, 2006). Therefore participants receiving government assistance receive between $510 and $608 per month.

WELFARE	SHELTER	SUPPORT	TOTAL BENEFITS
1 Person with No Disability	$325.00	$185.00	$510.00
1 Person with Disabilities	$325.00	$531.42	$856.42
1 Person with Persistent and Multiple Barriers to Employment	$325.00	$282.92	$607.92

(BCCPD, 2006; Wallace et al., 2006)

Even though the shelter rate is $325 per month, the average SRO monthly rental rate in March 2003 was $351. From 2001 to 2003, 56% of SRO hotels have increased their rents. Fifteen percent of these SROs had a rental increase of over 10% during the same period (City of Vancouver, 2003). The price of accommodation per square foot in the DTES is one of the most expensive in all of Vancouver (Rossi, 2005a). With the more stringent eligibility criteria for welfare, there has been a doubling of the homeless rates in Vancouver from 2001 to 2004. The number of homeless people not receiving welfare went from 15% in 2001 to 75% by the summer of 2004 (Wallace et al., 2006).

Although some of the participants receive some government financial assistance, many have resorted to other means of bringing in money. All seven participants described activities that supplemented their income. These activities include prostitution, selling of drugs and syringes, carrying drugs for dealers, doctoring, and

smash and grab. Two of the female participants stated they had worked as prostitutes; none of the men talked about prostituting for money. Participants used the term "dope deals" to refer to the selling of drugs. It is common for drug users to also sell drugs to make money. Here is an example of this type of transaction:

> I might buy a bottle right. I'd take half and still sell half for 10 bucks right. Pay 10 for it, in other words you get 10 back right, your money back. And sometimes I'd take a $10 bottle and sell for 20 or I'd take a $20 and you know what I'm saying right.

Another participant said he occasionally made money by holding on to drugs for someone else. The selling of syringes ("rigs") still occurs, but it is not as popular since free needles are easily obtained.

> Part of how I got my money is I would sell new rigs on the corner. This was back before there was so many available that it became more effort. It just became too damn hard. Like I can walk out of here and within a minute, let's say 5 minutes, go get a box of rigs for free. If I can do that so can a lot of other people. There is just no money in it. Too much work for too little money.

Money or drugs can also be earned by injecting another person. This is called "doctoring". With repeated injection into the same veins over the long term, it can become increasingly difficult for IDUs to access a vein to inject themselves. This becomes even more difficult when a person is going through withdrawals and may be tremulous. In this case, paying another user with money or drugs is a common practice.

Crime is the final revenue source. All but one participant said they had committed a crime to get money for drugs. Breaking into cars, for money and items that can easily be sold, is a popular and relatively easy way to get fast cash. Crimes could be either planned or committed impulsively. One participant told me that in a couple of hours "there is a little bit of illegal stuff happening", but she was reluctant to talk to me about the situation. Some participants described committing crimes out of desperation.

I know a guy…he really did this, his mother was making Christmas dinner, she had just purchased a turkey. He stole the turkey from his mother's fridge on Christmas eve…Yes, he sold his mother's Christmas turkey. The worst possible thing you could do and he did it. He stole his mother's Christmas turkey right out of the fridge. And…she was in a cab downtown going bar to bar trying to get there before he did. She didn't make it of course; it got sold.

Challenges to accessing welfare, rental rates higher than government assistance, and the cost of drug addiction are just some of the reasons why IDUs turn to alternative means to acquire money.

Threats to Safety and Security

Concerns about safety and security were dominant topics in all the interviews. The participants spoke at length on this issue, giving personal examples of how their safety was threatened and describing the effects of these threats on their sense of security. The participants perceived members of the general public, other users, and the police as threats. Some identified their drug intake as a cause of paranoia. As a participant explained, "when I am high on coke I get really insecure and that's when I think about people watching me and stuff". It can also bring to the surface and exacerbate a current concern:

I'm not a harsh loner but most of the time when I get high, you've heard of cocaine psychosis, that tends to kick in and there are things that I have done in my past that come to the front. Like when I get high, like if I owe money down here and I haven't paid back that money, I'm worried about getting my ass kicked.

Threats from the General Public

Only two participants commented about interactions with people from outside the DTES. The first participant believed that the public is more aware and tolerant of drug use. He told me that 20 years ago an IDU would be attacked if he was caught injecting in public but that now it is tolerated by everyone. Another participant said he is

occasionally verbally abused by the public for his drug use. He countered this with a live-and-let-live perspective: "You do your thing and I'll do my thing." He said if people want to smoke, drink too much coffee or too much alcohol, he is not going to pick on them, so people should not pick on him for consuming his drugs.

Threats from Other Users

Participants spoke of a variety of threats from other users. These fall into two categories: deception and physical violence. In the case of deception, the goal is to get money or drugs. One participant commented that he prefers to inject alone because other users try to get his drugs by bothering him while injecting. Violence is a common occurrence. One participant described an attack that left him with long-term injuries:

> Someone tried to rob me. They ran me into a wall which stunned me by grabbing my shoulders and swinging me around in circles and hitting my head into a brick wall. And then when I was stunned, they tried to throw me on the ground and I put my left arm out to stop my fall but they were on top of me.

Sometimes the bizarre and unexpected happens and no amount of precaution, given that entering into an alley is risky, will prevent an attack. A participant shared a story of how she was attacked by someone up in an apartment while she was injecting in an alley:

> I was doing a fix under the [hotel]…and a guy upstairs on the stairs used to throw the big needles down, like it is full of his blood. Not the regular needles, but I got one into my arm, but I was so high, and so concerned about my fix, as I was standing there doing my fix while this needle is in my arm…and I knew right away I had HIV, cause he had done it to three other girls.

The female participants spoke about their experiences in the alleys and the strategies they used to try to keep safe. Fear of physical and sexual assault was ever-present. Often, they inject in the alleys with a buddy, usually a very close friend. One person will inject while the other keeps a look out.

One participant said he used to feel comfortable walking in the alley and on the streets of the DTES: "Everybody knew everybody. Because I don't fix outside anymore at all, you don't know anybody anymore." A few participants blamed younger crack users. One participant believes that some of the younger drug users are out of control and violent:

> Young kids, some of them in their early teens, they don't have the fear of the consequences of beating somebody with a club until they are dead. They don't think about it. It just happens.

IDUs must learn to be cautious and streetwise. It is not surprising that many of the participants prefer to inject in their own homes, away from other users.

Threats from the Police

The Vancouver Police Department was mentioned in every single interview. Most of the comments indicated a fear and distrust of the police force. The fear stems from the confiscation of drugs and drug paraphernalia and from arrest. The participants commented that when they see the police, they try to inject their drugs more quickly and some will inject more drugs that they had planned, risking overdose, rather than lose their drugs to the police.

> Yeah, oh yeah. You know if the cops are coming by, they can interrupt you when you are in the middle of it, even though they are not supposed to, they are supposed to wait until you are finished and then they can arrest you or whatever. Yeah and to try and get it in before the police came around...Well I would either muscle it, just shoot it right into my muscle or I don't know, sometime I would do it all or faster and actually find a vein that was the worst having them there.

In contrast, a couple of participants indicated that communication with the police helps to ease the situation. They felt that the police took a less confrontational approach when they let the police know what they were doing"

No, I have never really had a problem with the cops. When they do drive up and I have just done a shot of powder it is freaky for me. I always tell them this "I can't talk very well I just did some powder" and they, they're more understandable about that.

One participant singled out one experienced police officer as being a good

example of the way the police should interact with IDUs:

Cause they like care they like, they, they...there's this one guy right, I've seen him since 1990s, since the back alley right. He knows what's going on right, he knows OK. That what people are coming down here for, he knows. He can just look and say you're a consumer, you're a consumer, you're a consumer, he knows right. He knows that they're either going to the injection site or to the alley, or to their house right, he knows that right.

Other participants mentioned they had more problems with younger and newer police

officers:

[The police were] not necessarily [there] to help me but to not scare me. I have seen times where I have just taken the needle out of my arm and the guy takes his baton and whacks the wall besides me. Well I'll tell you when you are just starting to get off on a nice coke rush that is not the thing to do and he was an idiot to do it.

The participants told stories of physical assaults by the police:

The police don't appreciate people injecting in the alleys. People have been beaten senseless for doing that. And it is a certainty the drugs and equipment will be taken away and destroyed if the police catch them in the alley.

Before the injection site you would see them grabbing girl's throats, spit 'em up. I hate seeing that...

And I still see the police still there grabbing people by the neck making them spit up their cocaine and arresting them for being out of bounds.

Safety and security issues were front and centre with IDUs. They face verbal

threats and physical and sexual violence from many sources. Paranoia associated with

their drug use often heightens the insecurity and fear. The increasing numbers of users

makes it harder for IDUs to know each other. When people are strangers, the feeling of

community is diminished and there is a corresponding decrease in feelings of safety and security. Some of the participants expressed fear of younger users. The police, to whom most of society turns for protection, were often the source of fear for most of the participants. Fear of the police fell into two categories. First, IDUs fear physical harm from the police. Second, the users fear the police will take away their drugs. This is the overwhelming concern of users. Heroin, cocaine and other street drugs are often viewed as medicine to be taken when a person is sick. The participants referred to their withdrawal as an illness and used words like "sick" or "down sick". The fear of having their "medicine" taken away can cause IDUs to inject quicker in an unsafe manner. They sometimes inject more than they usually would do if they think the police will take away their drugs. This places the IDUs at a higher risk for infections, abscesses and overdose.

Injecting Drugs

In this section, I will present the participants' experiences with injecting drugs prior to using the SIS. I will cover what drugs they used, where and with whom they used them, and their experience with overdosing. Although some of the participants discussed how much drugs cost, the strength of the drugs and how they were purchased, I do not include those topics in this paper. This decision was made for two reasons. First, the information was not consistent from one participant to another. As this was not the focus of the research, I did not get enough information to present this topic in a clear and understandable way. Secondly, I want this thesis to focus on the experiences of the participants and not on the actual drugs themselves.

The most common drugs used by the participants were heroin and cocaine. Most used one or the other but would occasionally use both together. Almost all smoked crack as well as injecting. At least five of the participants were also on methadone. Methadone is used along with other street drugs. I did not explore in greater depth why the participants were on methadone and still injecting drugs.

Prior to using SISs, the participants injected in a variety of locations, both indoor and outdoor. Indoor locations included their homes (SROs or apartments), friends' homes, and public bathrooms in establishments like fast food restaurants and pubs. For most, injecting indoors in their own room was their first choice because it is convenient, more comfortable and less threatening than injecting outside.

> Yeah, yeah, in an apartment usually. I didn't use outside. No, not back then. I have injected outside but I didn't at that time. I was more into being inside.

> If I were down here and didn't have a place, it would be someone else's apartment, um possibly in a washroom. I've done that a few times, no, more than a few times.

Although some IDUs have a place to live, it cannot be assumed that it is a safe and comfortable location.

> The guy I am living with, he doesn't like me doing needles. If he catches me doing needles, he will throw me out.

Injecting in indoor public places can be tricky. Charlotte mentioned that she felt everyone knew she was injecting when she went into a bar washroom. She knew she was not welcome and staff members would try to kick her out.

> Oh in bar washrooms that was awful. Yeah cause I mean downtown everyone knows what you are doing and they try to kick you out and for the longest time these places changed the lighting.

The lighting in many public places changed to a blue or white light that made it very difficult to see veins. This was done to deter IDUs from injecting in public areas. Injecting outside has its challenges. In earlier sections, I talked about other users and police possibly interfering with the injection. Allan mentioned temperature as an important factor. The cool temperatures will vasoconstrict a vein, thereby making it very difficult to find and inject into.

> If you are outdoors the reduction in your skin temperature causes your veins to constrict and most people who use drugs have trouble finding a vein. That is not true in my case but ah it is because I have been careful and I didn't want to inject outside partially for that reason because when you poke around and cause scar tissue to form which you will do if you miss all the time.

A few of the participants mentioned the alleys as places where they injected. The alleys were described as rat infested, dirty, and littered with garbage and drug paraphernalia.

> Oh they were filthy, they were filthy and littered with syringes and just disgusting, smelling like pee.

Using good injecting techniques and hygienic practices is difficult outdoors. Often IDUs will not have clean supplies. When this is the case, instead of waiting to get what they need, they often put themselves at risk with their creativity in injecting.

> There is the needle exchange but when you are dope sick and you need a needle, you just buy one off the street. They are always new but then there was water. I remember taking raindrops, you know off poles, the little drops and put my needle in and I sucked up the water. I had a friend who took puddle water once like and soon the bacteria attacked his forearm and he was in the hospital for almost a year.

Four of the seven participants have overdosed. Once again, Charlotte told a story about her experience. I found the best information came in the form of true stories.

Well, I OD'd in the [bar] washroom and that was one of the times when the managers came in. I OD'd on the toilet, I wasn't going to the washroom, I was fixing. Ah, the bartenders or whatever came in, dragged me, this is what I'm told, dragged me out to the alley and left me there. While I was ODing. I don't know if I was dead or whatever but I was out. And it was someone in the alley that recognized me who dragged me to the top of the alley right where the ambulance sit. And I got that Narcan [pause] which was such a horrible feeling. It is like ice going through your veins, through your whole body.

Injecting drugs can be a very personal thing. Many participants preferred to inject on their own, while a few were more social.

I do most of my dope by myself, because I don't want to share. I am a pig that way. And I can't afford to share. Dope seems to be cheaper than what it used to be, especially if you are buying quantities but it doesn't even go as far.

We'd go to a drug store and buy a party pack we'd call it 10 syringes or something like that and just use those until our money ran out or our dope ran out or whatever.

Injecting in public is a misnomer. Although people inject in public places, they are looking for privacy. In the case of the alleys, IDUs will often find a doorway to stand or sit in to create a private area.

EXPERIENCES USING SUPERVISED INJECTION SITES

This section will focus on participants' experiences with supervised injection sites. It is divided into seven sections: First Impressions, Reception Wait Room, Injection Room, Post-Injection Chill Out Room, The Zone, The Staff, and Other Users. In the first section, I look at how the participants first heard about SISs as well as their beliefs about SISs. Participants' impressions of their first visit to an SIS are then presented. I divided the site tour into four sections that correspond to the four rooms or areas of the SIS: the intake room, the injection room, the chill out room, and the areas

surrounding the site. In the final section I present the participants' experiences with the registered nurses and the peer support workers.

Great Expectations

The rumour of SISs in Europe spread through the streets of the DTES. Amsterdam was like a far off Disneyland to many IDUs. Amsterdam's drug policies intrigued users and provided ideas that helped advocates strive for the development of an SIS in Vancouver.

> Yeah, there was a lot of talk about it [SIS]. I remember I used to say, "Oh I want to go to Amsterdam just so I can go and legally do heroin." Not that it is legal, but it is the place to do it.

A few of the participants were members of VANDU and they were involved with advocating the establishment of an SIS. The participants' expectations for the SIS varied. One commented, "I thought safe injection site is the answer. I thought it was a silver bullet you know." This sentiment was echoed by many people prior to the opening of the site. In December 2002, Vancouver's Mayor Larry Campbell was quoted as saying, "If we do our work well, we should be able to eliminate the open drug market on the Downtown Eastside by the next election" (Howell, 2005). Bruce also believed the SIS was going to make a positive difference:

> I thought that it would save more lives right cause you are amongst somebody like the buddy buddy system where you can see that your friend is not going to OD right or get…or your girl, she not going to do too much you know. And then like um I thought it would be safer right and more fun right. That's what most who inject drugs for the blues right, to take the blues away right.

Others were more guarded, while some thought it was a bad idea:

> And I had no idea of what it would be like if I recall correctly. I just didn't know anything whatsoever about the concept, nothing.

> I didn't think, you know, it was going to come true. It's there but…I didn't think it was a good idea…Like, I thought it was such a stupid idea.

> A lot of people are saying it's not no silver bullet it is not the answer right. It's going to make the problem worse.

Experience helps to shape people's opinions and can affect their expectations of the future. Although the SISs at the Dr. Peter Centre and Insite were the first official ones in Vancouver, they were preceded by two illegal user-run sites. The Back Alley Drop-In ran from 1995 to 1996 and, on its busiest night, 200 supervised injections took place (Drug War Chronicle, 2005). This was a place where people could use drugs indoors under the supervision of other users and community advocates. VANDU started another SIS at 327 Carroll Street in 2003 that ran for 181 days. This location had a nurse onsite supervising the clients as they injected.

I initially present the participants' comments about the two user-led sites. Because both places were user-run I do not differentiate between the two in the comments provided. I then turn the attention over to the participants' comments and experiences with the "officially sanctioned" site.

Participants had mixed reactions to the Back Alley and 327 Carroll SISs. Most felt those sites were helpful, although Allan did not have anything good to say:

> I was there. Very unimpressed. I ranked, my emotions ranged from unimpressed to disgusted…It may just have been the people that were there at the time. It might not have related so much to the site, but if I recall, all I can remember is it being a whole bunch of lowlifes stealing each other drugs.

One participant, like a few others, felt the user-run site was helpful:

> There was that place across the street. That was way before [the SIS] or anything. But, um, that place got shut down because people were fixing in there and sleeping in there. But that place was helpful…
> You were off the street, you were safe. I mean in those alleys you got to worry about people watching us, seeing how much dope or money we have.

There were mixed expectations about supervised sites. Those who were advocating it did so by promoting positive aspects seen in Europe. SISs became a political issue that was played out in the media and the accuracy of information was lost. For example, as stated earlier, SISs were incorrectly called shooting galleries and safe injection sites in the media and it was major topic for a municipal election. Nothing is black or white. Those who felt SISs would be the answer to IDUs' problems were disappointed and predictions that it would make things much worse have not transpired.

First Impressions

The participants' first impressions of the SIS varied from positive amazement to cold discomfort. One participant commented on the structure and layout of the site:

> I came to the conclusion rapidly that it had been a very good architectural design job. It was functionally, the, the design of the rooms etcetera were functionally correlated to the activities that were going on. Security was adequately addressed. The ah, the overall concept was viable from a physical and functional point of view. And I thought I, it was a very good first attempt...

Another participant's first experience was at Christmas time. It was really busy and she had to wait 15 minutes. Although she thought the site looked nice, the experience of waiting made a lasting negative impression on her. Most participants were impressed with the cleanliness. One participant commented that she was put off by the hospital-like environment.

The sterile cleanliness of the site prompted this comment from another participant:

> OK when I first went in there and you see those little booth sort of things it reminded me of a, of a hairdressing salon.

In general, all the participants seem impressed with the site.

Reception: The Wait Room

To enter the SIS, people must be buzzed in through a locked door by the person at the reception desk. Gabrielle was the only one to talk about the entrance doors: "It got a bit confusing getting in those doors because people were trying to get ahead of you." Upon entering, the client signs in using his or her confidential username. A staff member then leads the client through a locked door and into the injection room. If the twelve-seat injection room is full, the client remains in the waiting room until it is his or her turn.

Some participants expressed frustration with the wait to get into the injection room. For Gabrielle, waiting was not the problem; she indicated that she leaves when the waiting room is loud and disorderly, with many clients all wanting to get in right away:

> Sometimes I'll go in and I'll wait to go in but then I'll just, you know, you have to sit and wait your turn and then there's people in there, like, wanting to get in there too and I'll just leave. Ah, I'll go home and do this…it depends on who's waiting too. Like sometimes people are just all up in the air and then no patience and they're losing it and they're yelling and that's when I usually leave because next thing you know I'm yelling at them and they're yelling, you know, it's just…

Symptoms of withdrawal can be so strong that waiting to inject may be too much for some. This is not surprising since IDUs often have a sense of urgency prior to taking drugs. The wait can dissuade IDUs from using the site. In the case of Charlotte, the very first time she went to the site, there was a line-up and she had to wait. She related this negative experience in such a way that the reader can clearly picture her desperation:

> I had to wait about fifteen minutes to get in. Yeah, so that really turned me off being the first time here. And in the waiting room, with nothing else to do, I was fixing up my stuff so it was ready for the next room but you are not allowed to do that. I would run outside I did, or I would have to go running back and forth to do a toke of…crack, to cover me. Yeah, I know how it sounds…[embarrassed

laugh]. It is pretty bad, just those few little minutes but...when I am anxious, when I know I am about to get high, and I am supposed to be getting high right then and I am not I get anxious.

Felicity had a different perspective. When asked about the wait time, she did not understand how IDUs could be so desperate that they cannot wait a few minutes:

No, no man, you can't be that dope simple that you can't wait 5 min. If it is the difference between a safe environment or the street, I can wait 5 min. for a safe environment.

Injection drug users' experiences in the waiting room indicate there are problems with clients leaving before entering into the injection area. Two issues arose from the comments. The atmosphere in the waiting room has an effect on the clients. If there are a lot of people in the waiting room the noise will inevitably be higher. For those seeking a quiet environment or are very private, the waiting room can become too chaotic for them. This is directly related to the second problem identified, the wait time. When IDUs are in withdrawal, they need to inject as soon as possible. Waiting even a few minutes might be too much. Decreasing the wait time will decrease the number of people in the waiting room and therefore decrease the noise level.

Injection Room

Upon entering the injection room, clients are asked to wash their hands and then pick up an injection kit. The kit includes syringes with needles, a tourniquet, a cooker, and clean water. The client then proceeds to a stall located against one of the walls. There, the client prepares the drug. Partitions divide the stalls from each other. Each stall has a chair, a stainless steel table and a large mirror on the wall. The set up reminded Gabrielle of a hairdressing salon. The client sits down facing a wall, which comprises of a large mirror. The mirrors are there for two reasons: the clients can look

in the mirror and see what is going on behind them, and the mirrors enable the nursing staff to see the clients better. The nurses can therefore intervene more quickly and prevent potential problems. The mirrors were a source of great discussion. Many participants were uncomfortable with the mirrors. Mirrors are generally used by IDUs to assist them in fixing so part of the problem is a lack of awareness of their purpose. This lack of knowledge caused distress and paranoia:

> No, I was, felt paran, paranoid too thinking the staff are sitting there watching what I am doing; they can see what I am doing. I felt like um, they are not users, I felt I was being judged. So I always like turn myself [she twists her body in the chair] so they can't see. It is such a private thing that is why I really would prefer it if we were facing...the people. And actually having a smaller mirror, like a mirror that only, you know, if I wanted to see what was going on behind me I could, but having the whole wall as a mirror it's...intimidating.

The same participant said she also felt rushed by the staff to quickly inject and let someone else use the cubicle: "When you are rushed and you're high trying to do a fix, you never get yourself, you will never find a vein and people are telling you to hurry up."

There appeared to be a lack of knowledge about the site. For example, there were many comments about the large mirrors in the injection room:

> I thought it was kind of weird that you sit there and there is a mirror in front of you know [uncomfortable laugh]...it was quite strange that they all these mirrors in there. I don't know what the mirrors are for, like I don't know. I really don't know what purpose they serve.

> I didn't like them. I don't like the mirror. I don't look at the mirror. I don't, you know, because...I don't know, I don't like that...when I'm stoned. But some people get off it. I don't...Why it's there, I figured, I don't know, so you watch what you're doing, watch your reaction? I don't know?

The mirrors for others either did not stand out, or did not cause any problems, but like the other participants, there was a lack of understanding concerning why they were there.

I think there is a camera there [in the mirror] watching you or whatever probably, right? So, other thnn that it doesn't really bother me. I mean, I'm not, if anything it might help with your fixing or whatever because you can see what you are doing from another angle you know, so that is kind of good. But it didn't really, I don't really care one way or another.

The more clients understand the reasons for the design, the less anxious and paranoid they will be. The mirrors were not memorable for one participant but the lighting helped him see his veins better:

> I don't particularly remember a mirror. What I do remember is I really like the light. Yeah, over the years, my eyes aren't as great as they were and the lighting and just thinking about a mirror and lighting it would have the tendency to improve things. I think it was a good thing. I like the lighting in the place. If I ever was going to use the place on a regular basis, that would be the cause of it.

The injection area can be disruptive with twelve injection stalls. Sometimes other injection drug users leave their area and move around while others are injecting:

> Some guy all of the sudden running back and forth across the room is not conducive to me doing a fix, especially if I am struggling. I am liable to take a chair and bat him across the head just so that they are out of the way so I can do my hit.

In general, the injection area was perceived to be clean and sterile, safe but not as comfortable as "home" as a place to inject. The environment plays a part in drug use. Some of the participants said they want to be in a comfortable environment.

Post-Injection Chill Out Room

After leaving the injection area, the client goes to a chill out room. This room serves two purposes: it is designed to allow the IDU to relax in a safer environment, and to be monitored for overdose. Drinks and snacks are provided. In this area, peer support workers check to make sure the clients are doing OK. The chill out room is not designed for clients to stay for extended periods at a time. Although the purpose of the

chill out area is for IDUs to relax, it has received contradictory reviews from the

participants. Some feel it is good to sit, have food and enjoy the high:

> That's nice. You get a coffee, a sandwich or something like that if you feel like it, you know. It is like a nice little, instead of going right out onto the street after you have done your fix. You got a little time to you know, if it was a really good one, you might need to sit down for a few minutes or something or whatever.

Other participants did not feel relaxed in that room. Some decided

to leave right away:

> Yeah, they have the chill out room but it depends, again, who's in the chill out room; who's around and what they're doing, who the other addicts are. And it depends on my mood too. Sometimes I just want to get the hell out of there. Like, fast. I don't know what the hell I'm running from. You know it just depends...it does get a little crazy up there sometimes.

The interactions of the other users in the chill out room was a

popular topic:

> Gets crazy there sometimes...people yelling, fighting. You know the yelling, the twirling around, the twisting of the bodies. You know that's a little unnerving. You see, I don't have to see that at home.

> I get irritated with people that are like that around me. In the chill out room I don't see it...there are some very obnoxious people...I just can't stand it. When I go there now, I never go in the middle part. I go way at the end in the corner. The farthest from everyone. Along the centre, when people are jumping around, bouncing around, it drives me nuts. [pause] If they had booths, actual booths they, right down to the floor. You can see what is going on down there. You got to make sure your jacket is safe because people on the side are sticking their hands in your jacket. I had a girl try that once.

One participant speculated that having to be with others may be a good thing:

> I'm not a very sociable drug addict. And now, I find that I'm sort of able to talk to people. I didn't want to before, you know. I don't know if it's a good thing or a bad thing.

The Zone

Participants' experiences using Insite were not limited to the inside of the facility. A buffer zone was created around Insite so that IDUs can bring their drugs to the site without police intervention.

A few participants commented on their experiences leaving the SIS. Their comments suggest they have some anxiety about walking out of the site having just injected their drugs. This stems, at least in part, from a desire for privacy, not wanting anyone to know they have just taken drugs:

> I don't know to this day I feel bad, right, when I walk out, right. I look different, right, now you have done that, right, you know what I'm saying. You can't say, hey, I going in there to talk to somebody, right. They know your eyes come bugging out your head. You stoned out of your mind. They know.

For Gabrielle, who prefers to inject in the safety and comfort of her own home, leaving the SIS high is frightening:

> ...the first time I came out [of the SIS] high I had to, you know, grab my partner because I'm usually at home. But I've gotten used to that now, you know, you know.

Even with the buffer zone, the police are still present. Fear of the police has scared some IDUs away. One participant avoided the site because of her concern about the police.

When asked about their observations of the streets and alleys since the SIS started, the participants gave a range of responses. Some said the streets are better, some said they are the same, and some said they are worse. I do not think I have enough data to comment on why there was such a variation in the responses.

The Staff

IDUs' experiences with SISs are not restricted to physical layout. This section will cover the participants' experiences with the nurses and peer support workers. The participants talked about their relationship or lack of relationship with the nurses. Although I asked the participants to tell me about their experiences with the SIS nurses, they commented in general about the nurses that work in the DTES. In general, the comments were very supportive of the nurses. One participant did not know that nurses worked at the site: "Actually when I go in there I never actually talked to them. I didn't even know they were nurses." The following are some of the positive comments about the nurses:

> The nurses are not judgmental, which would be easy to be considering the topic and they are supportive.

> They are nice, they are cool, they are polite. They don't treat us like second class citizens you know they treat us with respect and, and they are good as far as I have experienced. I have never had any negative experience with them.

> I mean, some of the nurses are great. They don't care, they have seen it enough. Some of the younger ones, were str...like, what do you call it, straight by the book.

Comments were made about the nurses' supportive and teaching roles at the site:

> When I do have questions or whatever, I know I can talk to the nurses or whoever is available.

> Oh there are lots of positives, having the staff there in case anything does happen, it is great, and they are all nurses, so they know how to prevent anyone from dying at least. You can't maybe prevent them from ODing but you can prevent them from dying. Maybe you can prevent them from ODing too, if you see them mixing up a quite a big amount or something like that. You can say to them "Oh you might want to put in a little more water in there and a little less", or something." And the addicts, usually they know that you're doing it, you are not doing it to get their dope. They know you are doing it out of concern. Whereas another addict might be trying to get their dope so they are not going to listen to

them, but they are going to listen to you guys [nurses] because you don't have an angle right. You are not trying to get something from them.

A couple of the participants had some concerns about some of the nurses:

I felt like um, they are not users I felt I was being judged.

...the people that wanted to do this job because they wanted, they thought it would be cool and feel sorry for us or and they just seem so nosey and eager and kind of grossed out by us. Maybe I'm, that's the way I felt about users and it is reflecting on them? But that is how I feel.

Another participant commented:

I've had nurses scare the shit out of me again about an abscess, so much so that when they walked into the room I left running. For a person with an abscess on the foot to run is very much fear and that person no longer working in the Downtown Eastside because I wasn't the only person who responded in that way.

One participant believed the nurses were breaking the rules and putting

themselves at risk. He verbalized this concern with a great deal of passion. It must be

noted that he did not witness this himself but he heard it from someone else:

They don't like to say it, but I have even heard of the nurses actually fixing people. OK ah, which is a very *stupid* thing to do. You know, 'cause God knows one of these times they are going to make a mistake and they are going to kill somebody. And then they are going to be charged for murder.

The same participant described what he believed to be the qualities of a good nurse:

Good nurse is one, and this is strictly my opinion, that deals with the issue at hand and leaves whatever core issues or other issues to me to decide whether I would need to deal with those. We all realize there are other issues, whether they are addiction or whatever [intelligible possible funding issues]. A good nurse will be aware of those other issues and having contacts to deal with them if I so choose. Will do nothing more than ask about them and is very sensitive to whether I wish to deal with them or not. And if not they want to leave it and deal with whatever it is I am willing to deal with.

Although there were a few concerns about the nurses, the vast majority of comments

were positive.

The participants had a mixed reaction when in came to their relationship with the peer support workers. It appeared that only the participants that knew the peer support workers from previous encounters had anything to say:

> Most of them I know. Like I said I used to go to Back Alley I know them. They good people right you know what I'm saying. They got one goal in mind, to be paid and they do their job. That's what they're going to do. It's a job to them you know.

Their comments were supportive. Those who did not know the workers personally had very little to say, such as "I don't think I had any peer support." Another participant commented, "[I] don't talk to the peer support workers." In general, the participants had very little to say about the peer support workers.

Other Users

Participants made comments about other drug users. These comments, related to IDUs both inside and outside the site, revealed a culture of pride and boastfulness regarding the use of drugs and committing crimes. Participants mentioned that some IDUs inject large amounts of drugs to impress others:

> They just doing it to be, to try to get some attention, or you know, act like a big shot, you know what I'm saying, or show off, right. They don't really realize that this is serious drugs, you know what I'm saying, and injecting is serious. Yeah. Trying to show people how much they can do in the alley and stuff like that.

> But like I say, you will always have people that think it makes them tough or makes them better just to show you how much they can do. Like how much, um, ah, or how much trouble they can cause by doing. That don't be the drug, be the person, you know.

Sometimes the source of pride is not the amount of drugs injected, but where on the body an IDU is able to access a vein:

> But I don't show off, right. I, I, you know, except around people you know, really, really, really comfortable with. See, I know how to do you. You put it right here,

you see, you look at the blood, you do it like that, you see. Well look at me I've got it. You know, I show off to a girl, let me see I got it. I'm doing, right. See, see. I look I can do it in my foot, I can do it in my foot, I can do it in my leg.

This boastfulness bothered some of the participants:

> Bragging. How much they scored ah, ah, the car they
> broke into, money they stole, um…fights they have
> been into, they always overexaggerate. How they
> beat the hell out of this guy and how they are going to
> kill this guy and it's just complete bullshit.

One of the most important findings from this research related to where the participants prefer to inject their drugs. Despite being designed for street entrenched drug users, all but one of the participants stated they preferred to inject in their room or apartment. The SIS was not the first choice of location to inject, but the participants believed it was the safest place to use drugs.

PARTICIPANTS' OPINIONS AND RECOMMENDATIONS

In the following two sections, I will list the participants' opinions about the SIS and their recommendations. Participants provided their opinions throughout the interviews. Near the end of every interview, I solicited recommendations from the participant. This is a small part of the research that gives the participants a voice. I have chosen to include all participant recommendations. The Primary Health Care Room is absent in the recommendations because it was not mentioned by any participant during the interviews.

Participant Opinions

Allan

- I have seen a relaxing, it is a side effect, a relaxing of the attitudes of everyone, police and passers-by alike…The

reason is the injection site has established an air of viability to that activity, which is perhaps not a good thing.

- I think that the site is an ideal solution socially although that is not its main object

Bruce

- ...still feel the injection site is the best thing to happen.

- I don't think it is having an effect on crime but I think it will.

- I think we need more time for people to start realizing what the purpose of it [SIS] is.

- It looks like it is worse, but really I think the injection site is going to be the answer in the long run.

Charlotte

- I think it's great. I think it has cut down a lot of people in those alleys, a lot of people being robbed, or being hurt, especially girls.

Dennis

- It is a helpful place...if people are going to OD they will have immediate attention.

Eric

- The site is very well run it's long past due. I don't know whether I necessarily want to see any more of them because it does seem to concentrate the addicts in the area. I am not blaming the safe fixing site for concentrating the addicts in the area. Again, there is no one thing that causes anything.

Felicity

- If I did use needles again to know that it is there is a comforting thought.

- Having the staff there in case anything does happen, it is great, and they are all nurses, so they know how to prevent

anyone from dying at least. You can't maybe prevent them
from ODing but you can prevent them from dying.

Gabrielle

- I thought the safe injection site was not a good idea and then
  I found out, hey, it's probably the best thing that happened. It
  took a lot of people off the streets that fixed on the streets.

Participant Recommendations

1. The SIS's hours of operation should be expanded to 24 hours a day.
2. Play some music in the SIS to create a relaxed atmosphere.
3. The SIS should have a private entranceway so users avoid being seen.
4. Users should be given a place to sit in the waiting room so they are not pacing.
5. Users should face inwards towards people when injecting instead of facing the mirrored wall.
6. There should be greater privacy from other users while injecting but still maintaining the nursing supervision.
7. The injection room needs better pill crushers.
8. The rules should be changed, so that users requiring assistance can have someone else inject them.
9. There should be a sink in the post-injection room for users to wash their hands.

MAIN FINDINGS: BARRIERS

This is the heart of the interpretive description study on injection drug users'
experiences with supervised injection sites. The earlier parts of this chapter provide the
necessary background of the participants, their experiences living in the DTES and
using the SIS, as well as opinions and recommendations that are needed to provide an
interpretive description. Findings revealed that while participants unanimously support
SISs, because they believe the sites save lives, most use the sites only rarely or
occasionally. Although SISs are designed as a low-threshold service to meet the needs
of high risk IDUs, five barriers that limit access to the service have been identified: 1)
Limited Hours of Operation; 2) Public Entrance – Lack of Anonymity; 3) Waiting Time; 4)
The Atmosphere; and 5) Prohibition of Assisted Injection.

Limited Hours of Operation

Operating 18 hours a day, from 1000h to 0400h, may not seem limited, but many participants recommended that the SIS should be open 24 hours, or at least earlier in the morning. One participant explained his rationale:

> At the very least they should open at 8 o'clock in the morning because, especially on weekdays, you have addicts getting their cheques at 8:30 in the morning. So, if the safe injecting site isn't open till 10, a lot of them have done their dope by 10. So you have missed a big segment of the addict population.

Opening earlier seems logical, especially after hearing other users say that when they wake up they need to do their drugs first thing in the morning before the withdrawal symptoms start. There were reports from a few users that people would be injecting out on the doorstep in front of the site because it was closed.

Public Entrance – Lack of Anonymity

The SIS, used by the participants, is open onto a busy street and the entranceway is easily visible. Since the SIS is specifically designed for the supervision of drug users, people entering are assumed to be clients. The ability of others to identify those entering the SIS has been identified by participants as a serious concern. Anonymity was mentioned by over half of the participants as a concern:

> Anonymity issue is probably one of the things front and centre, because people don't want other people knowing they use the safe injection site.

Participants feared that people that they know would identify them as they enter the site. Some participants did not want people from their past knowing that they are IDUs, and they did not want other people knowing they use drugs. One of the women was concerned that her current boyfriend would find out she is injecting and he would kick her out of their apartment. The same participant expressed fear that her ex-

boyfriend would find her. A participant said that while she was at the SIS she spoke with IDUs that have full-time jobs and work in offices in the downtown area. She said that they are fearful someone will recognize them. Participants expressed fear that being seen going into the SIS could lead to attacks from other users or drug dealers.

Waiting Time

Participants stated that they often have to wait in the SIS to inject their drugs. Some participants said that when it is time to take their drugs, they need to take them right away because they are feeling the symptoms of withdrawal. For them, any delay is too long. A few participants have said they have left the SIS and injected outside because the wait was too long. One participant explained that he is not the type of IDU that is willing to wait:

> Usually I don't go there because I have to wait. Sometimes I have been there and I have signed in and I had to wait and I just left and I just grabbed a rig and go and did it in the alley.

Atmosphere

The atmosphere in the SIS was mentioned by some participants as a factor for not using the SIS. When discussing the atmosphere, participants mentioned that the clinical setting was off putting. They also mentioned the behaviour of other users as being a source of problems. With both of these factors, the participants felt uncomfortable injecting in that environment.

The Canadian SISs are designed to be healthcare facilities. This has both positive and negative aspects. On the positive side, IDUs are looking for a safe, hygienic place to inject (Wolf, Linssen, & Graff, 2003). Not all IDUs are looking for that type of environment. One participant preferred the social aspect of injecting and chose

not to use the site because it was a clinical environment. He suggested that if the site was more comfortable, more people would use it; however, the SIS was not a comfortable place to inject. The same participant stated he injected for enjoyment, and therefore wants to be with people that are also having fun, and the SIS is not fun.

> I like to turn on the music you know what I'm sayin'. I like to share some time with a girly friend right. I like socializing right instead of being off to myself right. That like a a comfort, that like um...leisure hour for me right. That's the way I relax right. Where I just reward myself when I have had a good day right.

Prohibition of Assisted Injection

As mentioned earlier, "doctoring" is the injecting of drugs into another person. There are three groups of IDUs who usually get doctored: new users, women, and long-term users with poor veins. Both the person doing the doctoring and the person receiving the injection are placed at a higher risk for contracting blood borne infections. Five out of the seven participants were doctored the first time they experienced injected drugs. I did not get clear enough information to comment on the other two. All five were introduced to injection drugs and doctored by a person of the opposite sex.

> I heard about it. I snorted before but I never injected. Yeah so, this girl she was showing me, she is gone now, she was an ex-Hell's Angels. She was sticking needles in my arm.

Women are frequently dependant upon their partner for injecting. There may be issues of power and control tied in with such a relationship. This is an area that is worth further exploration. This usually means that the man injects himself before he injects his partner. Being the second person to be injected, possibly with the same needle, puts these women at risk. After about seven years of being doctored, Gabrielle explains how she learned to inject herself:

I couldn't. I don't know why. I couldn't handle the needle. My hands couldn't handle it and then three years ago my partner was taking so long getting it ready and then he did himself and I thought "ah, the hell with this" and I just took it and that was it. He just about fell off his chair and he says "I bet you could do that all along" and I says "no, you know..."

Long-term injection drug users have difficulty finding a vein because of scar tissue, vein collapse, visual difficulties, and tremulous hands. In the case of the SIS, there is a policy that IDUs cannot have anyone "doctor" them. Therefore, those that cannot inject themselves cannot use the SIS. Since the goal for SISs is to reach the long-term, chronic user, the policy of not allowing physical assistance to inject places a barrier that will prevent these users from using the site.

UNEXPECTED FINDINGS

Two unexpected findings were identified. Many participants mentioned that the streets and alleys seem to be more dangerous; they blame younger crack smokers for the increased degree of violence. While this is going on, most of the participants described how they advocated for services, cleaned up the environment and even acted in a compassionate way towards others. The dichotomy between the violence and the concern for the community was interesting. At first, I thought they were happening simultaneously; that some participants were still able to contribute to their community within an unsafe situation. I am not sure to what degree this is happening. One participant used to inject outside and spent time picking up used needles. However, he is so fearful now that that he often stays in his hotel room.

Increased Street Violence

Some of the participants have been injecting out on the streets for many years. There has always been an element of crime and violence, but some participants

mentioned that the violence is much worse now. A participant described to me how he was the victim of an attack:

> Someone tried to rob me. They ran me into a wall which stunned me by grabbing my shoulders and swinging me around in circles and hitting my head into a brick wall. And then when I was stunned, they tried to throw me on the ground and I put my left arm out to stop my fall but they were on top of me while I was falling so stopped my fall and his fall which didn't help me…and my wrist bent backwards, I think, I can't remember, I think it went this way. And the bone contacted the pavement and broke in a kind of slightly spiral fracture from the wrist all the way to the elbow…I don't think I will ever have the use my left, it hurts, I mean three months after it was broken I couldn't pick up a glass or a cup of coffee.

This description brought reality to the reported statistics found in academic journals. There is value in reading the participant's words. The description is so rich, it is not difficult to see this being played out in your mind. What I found interesting was the way in which the participant told me this story. There was a cross between relaying what happened as a matter of fact, but it seemed to me that he felt pride in telling the story. As a nurse, this story provides me with a greater understanding of how violent the streets are.

According to some of the participants, the degree of violence has increased since crack cocaine has become more popular. There appears to be subgroups in the drug-using community. Some of the heroin and cocaine users, although they smoke crack occasionally, blame younger crack smokers for the heightened violence:

> A lot of the crackheads are related sociologically to the speedfreaks. And the speedfreaks have a habit of being really nasty criminals. Nasty criminals…As a group, they are evil. There are some really, really evil people there.

A few of the participants related this violence to the attitudes that some drug users have.

Advocacy, Actions and Acts of Compassion

Throughout almost all of the interviews, the participants expressed concern for their community. Their concerns related to the environment, to other users, and to children. Most interestingly, many participants acted on their concern and volunteered their time to make things better. I first address the concerns expressed, and then I list the different actions taken by participants to assist their community.

The Environment

The environment that I speak about here is not the natural environment, but the environment in which the participant lives. I am specifically referring to the safety of the streets and alleys. Discarded drug paraphernalia on the streets caused a strong reaction from a few participants:

> ...leaving things behind, injectable paraphernalia, injection paraphernalia is very, very criminal thing to do. It endangers the public safety, it endangers the safety of children, it should not be tolerated and should be the, the opposite should be encouraged strongly.

> I so hated like, I don't care if someone's an addict, take care of your equipment.

> I don't like to see needles on the ground either.

One participant in particular made it a routine to help make the streets safer. When he was still injecting in the alleys, he would pick up discarded syringes. One day, he said, he picked up 183 needles.

Concern for Others

Some of the participants expressed thoughtful concern for others:

> You don't want to be fixing in somebody's alley, where they live. Like think about it, you know. There's a little bit of respect, you know.

> I have saved a couple of lives [laughter]. I took St. John Ambulance when I was younger because my mother had epilepsy. So I had to take a good First Aid

course so I am good, I know CPR, I know mouth to mouth, all that stuff. I have saved a couple of lives [laughter]. I was happy to do it. I was happy to do it.

Protection of Children

Children were singled out as a group that some of the participants were concerned about. Children were mentioned by the participants, independent of any guiding questions. Some participants were concerned that children would either be exposed to used and discarded injection equipment, or they would witness others injecting.

> …pervasive potential for injecting injectable paraphernalia, to get into a child's hands, 'cause there are children all over now, they are not in nurseries in [name of a city], they're being dragged around on the street to the bus by the Mom. They are laying around and grab anything that happens to be laying on the ground. They only need to do it once for their entire human life to be ruined. It is very serious. [pause] And I feel strongly about it.

> Cause like the alley, you don't want kids to see you do that right, for one, right, OK.

> …you got children and stuff, right, that some things are best concealed, right. So that's what I feel. I feel it is best to go to your house, right, or go to the injection site, story end of story do your drug, right. You don't gotta do it in front of your child, right, and the child's friends and all that. I think that is kind of absurd, OK.

These quotes, although strong, do not do justice to the feelings expressed by the participants. The tone of voice used and the non-verbal expressions underlie the conviction expressed. As the interviewer, I was surprised that children were mentioned and amazed at the concern shown.

Volunteerism

With 1500 of approximately 5000 IDUs in the DTES on the Vancouver Area Network of Drug Users (VANDU) membership/volunteer list, I was not surprised to hear three participants identify that they were members of VANDU. It is interesting that all

three said they are former members. Only Eric elaborated on why he was no longer a member, saying he left because there was too much politics within VANDU. Bruce, on the other hand, described the work he did with VANDU:

> I was with VANDU, Vancouver Area Network of Drug Users, right…that what I was advocating for…protesting, and planning and plotting and scheming for, right. Cause that's what we was doin'. Like we started the Back Alley, right. So we…we even drew a mur, mur, murol, how do you say that?
>
> Researcher: A mural?
>
> And ah… so you know. So you know, we can let people see what we really wanted, right. And an, I felt it was really needed. So I spent my energy and my time doin' that right. Because like um every city I've ever been to man, has, has drugs right. Every major city you know…has drugs, right. And like I've always wanted, you know, to know, out of curiosity, why hell, you know, people get hooked on this stuff, right. It just can't be that good, right, but now I see.

IDUs are stereotyped by society as being only concerned about their next fix. There is a belief that all IDUs do is buy drugs, use drugs, laze around high on drugs, commit petty crimes for money so that they can buy more drugs, and repeat the cycle. Obviously, by the very nature of this research, I do not subscribe to this belief. This study was structured because I believe IDUs are the best informants of their experiences. I expected the participants to comment on issues of concern to them, but I was surprised by the passion and emotion that many of them expressed when talking about their community. Three areas of concern stood out in the interviews: the environment, the safety of others, and the protection of children. These concerns were expressed through the statement of beliefs and the recounting of stories. Many participants did not just stop at identifying concerns; they took actions as concerned neighbours to make things better for their community.

Although I realized from the first few interviews that participants were expressing concern and speaking about volunteer activities, I chose not to actively explore this area. By that, I mean that I did not ask trigger questions to prompt a participant to talk about their community concerns. The decision not to explore this in the interviews was made because the interviews were rich in data and I decided to focus on the individuals' experiences and not on the community. I wonder now, after the fact, what I would have discovered from the participants if I had addressed this.

SUMMARY OF THE FINDINGS

Every single participant shared their unique perspective and experiences. Although they are all injecting drugs in the DTES, it is clear that every participant is a true individual with her or his own thoughts and feelings. I was continually surprised with what was said. There were differing opinions on some issues, including whether the streets were better or the same since the opening of the SIS. It was for this reason that I decided to write a little about each participant as well as pulling together a composite of the group.

All participants started using psychoactive drugs prior to moving to the DTES. For all but two, use of these drugs started in their teenage years or early twenties. Many were smoking marijuana and drinking alcohol before using drugs like heroin and cocaine. Introduction to injecting seemed to take place with an individual of the opposite sex. That person initially "doctored" the participant until he or she learned how to self-inject or until another person took over the injecting. All the participants have been trapped in the cycle of needing drugs and needing money for drugs. This cycle has brought them all to the DTES. It is there that the participants struggle to find a home.

Despite all the problems with housing and periods of homelessness, almost all of them were able to say they had a home. All the participants were comfortable enough to verbalize their thoughts and feelings. All except one preferred to inject in the comfort of their own home rather than anywhere else, including the SIS.

As they told me of their experiences using the site, I realized they were giving their opinions and making recommendations. I will be discussing this in the following chapter. Many participants felt that the SIS should open earlier than 1000h. They were impressed with the layout and cleanliness, but it does not meet their needs as a place that is comfortable. For some, the waiting period can be too long. There was also a lack of knowledge about why the SIS is laid out with a large mirror, and for one participant, the role of the nurse. The chill out room did not appear to be universally used. The participants that got the most out of it tended to have known the peer support workers from an earlier time. Finally, there is a misconception that IDUs are only concerned about their next fix. There are numerous examples of how these people demonstrated commitment to their community.

CHAPTER FIVE: SUMMARY, IMPLICATIONS, AND CONCLUSIONS

SUMMARY

This qualitative, interpretive description study was conducted to gain a better understanding of injection drug users' experiences with supervised injection sites. This topic was selected because my past work as a street nurse has sparked my interest in issues related to homelessness and psychoactive substance use. As a nurse, I know from my education and professional experience that the best sources of information about a phenomenon are the people who are directly involved. In 2003, Health Canada approved two SISs to operate as part of a three-year research trial, which is due to be completed in the fall of 2006. There are two officially sanctioned sites in North America, both located in Vancouver, Canada. Since SISs have only been in operation in Canada for a few years, there is limited Canadian research. The research available from other countries focuses on statistical measures that do not explore IDUs' experiences with SISs. For these reasons, I decided to investigate IDUs' experiences with supervised injection sites.

The strengths of qualitative research, and more specifically interpretive description, fit the research question. When there is little information about the phenomenon under investigation, as in the case of IDUs' experiences with SISs, a qualitative study would, as Morse and Field state, "enable us to make sense of reality, to describe and explain the social world, and to develop explanatory models and theories" (1995, p. 1). As stated earlier, the best information about a phenomenon comes directly from those who experience it (Thorne et al., 1997). Of the various

qualitative methods, interpretive description was selected because its methodological strategies and research outcomes are suited to practice-base professions such as nursing (Thorne et al., 1997, 2004).

The primary source of data was seven audiotaped, open-ended interviews with IDUs. Participants were interviewed once. All the interviews were conducted using guiding questions (Appendix D–F). In keeping with the inductive nature of qualitative research and the interpretive description method of simultaneous data collection and analysis, the guiding questions were modified to reflect the emergent nature of the data. Supporting data came from conversations with health and social service providers who work with the injection drug using population, and a video on SISs produced by Vancouver Coastal Health (2003). Although the focus was on their experiences with the site, most participants talked about how they started using drugs, what brought them to the DTES, and their lives there prior to SISs becoming operational. When discussing SISs, participants commented on the entrance/reception area, the injection room, the post-injection chill out room, and the area surrounding the site.

Although the participants were experienced IDUs who had used the SIS, they were a diverse group. This diversity occurred "naturally"; it was only with the seventh and final participant that I felt I needed to theoretically select a participant. All participants agreed that the SIS was helpful and that it is an important strategy in preventing harm.

After conducting this study and analyzing the data, I found that although SISs are designed as a low-threshold service to meet the needs of long-term IDUs, barriers to access exist. Five barriers have been identified. The first barrier is the hours of

operation. IDUs indicated that the SIS does not open early enough for their needs. The second barrier is the public entrance. Participants expressed concern for their safety and feared that they would be identified by others. The third barrier is the wait time to inject. Often participants had to wait to inject their drugs. For some, waiting is not an option and they leave to inject outside. The fourth barrier is the atmosphere. Participants find the site cold and hospital like. Often there is a feeling of tension because of the actions of other users. The fifth barrier is the rule that a person can only inject herself or himself. Many injection drug-using women rely on their partners to inject them. This rule further marginalized these women. Long-term IDUs often have poor veins and require assistance to inject. Like the women that require "doctoring", the most street-entrenched, high-risk users are prevented from accessing an SIS that is designed for them.

This study was not undertaken to evaluate Insite but to allow the voices of its clients to be heard by front-line health and social service providers, especially nurses, educators, policymakers and politicians. SISs were designed to meet the needs of the chronic, street-entrenched IDUs for whom traditional healthcare strategies have failed. Participants agreed that the SIS has succeeded in helping many people but that it has failed to reach all high-risk IDUs. This research will have implications in the areas of policy development, education, nursing practice and research.

RESEARCH CONCLUSIONS

Supervised injection sites were controversial among IDUs prior to the sites becoming operational. Some supported the creation of SISs, while others thought the sites would be a mistake. This was reflected in the opinions of the research participants.

This being said, after using the SIS, all the participants support the operation of SISs because they believe they have saved people from dying from an overdose. The participants mentioned five barriers that limited their access to the SIS. First, the hours of operation are limited. The site opens up at 1000h, which is too late for many IDUs. Participants want to see the site open 24 hours a day, or at the very least, they want it opened at 0800h. The second barrier is the public entrance that prevents anonymity for those going into the site. Participants feared they would be identified by people they know. These people could be past or current acquaintances. Some participants were fearful that they could be spotted by people who want to harm them. The wait time was also too long for some of the participants.

The fourth barrier related to the atmosphere, a combination of the physical design and the behaviours of those who use the service. The décor was too cold and clinical for some. One participant stated that the SIS is not comfortable or conducive for getting high. Many participants feel injecting is a private issue. Even though many people inject in public spaces, users often try to find private locations such as doorways in the alleys as locations to inject. The openness of the twelve-cubicle injection room was a drawback for some of the users. Since they prefer to inject in a quiet and private location, whether indoors or outdoors, they were uncomfortable with having other users whom they did not know injecting close by.

The behaviours of others, such as yelling, crying, pacing, running, etc., have been identified as distracting and not the type of environment that IDUs want to be in to get high. The policy of not allowing one person to inject another creates a barrier that restricts some chronic, street-entrenched IDUs, the very people for whom the site is

designed. Long-term injection drug use can cause scarring and can collapse veins making injecting more difficult. Withdrawal symptoms such as tremors of the hands can also make needling difficult. Some participants said that they do not use the SISs because they are not allowed to have their partner or another person inject them.

Two unexpected finding emerged. First, participants believed the streets and alleys were becoming more violent. They associated the increase in violence with younger, crack smoking individuals who have no fear of the consequences of their actions. Second, even with the crime and the street violence, most participants took steps to make a positive contribution to their community through advocacy, action and acts of compassion.

Supervised injection sites are not the preferred injection location for IDUs. All participants, except one, stated that they preferred to inject in the comfort of their own home or a friend's place. Three reasons were given for this choice. First, home is often more convenient. Second, there is more privacy and comfort at home. Third, besides the risk of overdosing, injecting in one's own hotel room or apartment is less threatening to some of the users.

IMPLICATIONS

After conceptualizing, designing, and conducting this research, much time was spent on analyzing the data to identify the findings. All this work would be wasted if I did not contemplate the implications of the findings. Since this research was designed to be broad in scope, its findings may be relevant to a variety of people. This research may be of interest to the public, especially those who live near SISs. Injection drug users may find this research helpful because it presents their peers' perspectives. This research

can have implications for policymakers in both the health and political fields, nationally and internationally. Since this is a nursing study, I focus on the implications for nursing education, practice and research. However, nurses often work as part of an interdisciplinary team, therefore this research could be of interest and use to other healthcare professionals such as social workers and physicians who work with IDUs.

General Public

The findings of this research may be of interest to the public. SISs continue to be a controversial topic. There was great discussion in the media leading up to the opening of the sites. This was even a municipal election issue that generated discussion and public demonstration in favour of and against SISs. Since SISs have been operational, there has been less media coverage. In Vancouver, where the two sites are located, the public is aware of SISs but they often do not have an understanding of them. Throughout this research process, I have been asked by friends and acquaintances "what is happening" or "what is going on" with the SIS. By asking IDUs about their experiences with SISs, this research can bring their voices to a large audience. It is important for the health authority to keep the public informed. Without accurate information, the public will inevitably rely on speculation to form their opinions.

Injection Drug Users

This research identified that some IDUs had knowledge gaps regarding SISs. Some participants knew other users who had not tried the site. For those users, hearing about the experiences of people who have used the site may decrease fear, reluctance and/or nervousness about trying the site. The description of participants' experiences as

they move through each part of the SIS may help reluctant users of the service know what to expect.

This research identified that some participants were unaware of the purpose of some aspects of the site. For example, many participants mentioned that they did not know why there are mirrors in the injection room, and felt uncomfortable with them. One participant did not know that there were nurses at the site. Clients need to know how nurses, peer support workers and other staff members can assist them. A multi-pronged approach is needed to inform users about the site's operation and the services offered. At some point during their visit to the site, new clients could benefit from an orientation. However, it would be best to be flexible concerning the time at which this takes place in order to meet individual needs. Due to the effects of drug use, users are not always in an optimal state for learning. For example, if a person comes to the site wanting to inject immediately, they will be neither willing to take the time for an orientation, nor able to process the information. For some, post-injection may not be a suitable time either. Education could also take place outside the site, at community or drop-in centres. These orientations may help the client feel more comfortable using the site and the services it offers.

Many SISs were started as grassroots initiatives. This work may be helpful to those considering opening a site. Since users' perspectives have been largely absent from the literature, the barriers identified by the participants in this study can be incorporated into the design and implementation of a new site.

Health and Political Policy

Supervised injection sites have been, and continue to be, a controversial initiative (Wright & Tompkins, 2004). When they were first being discussed as a possible strategy in Canada, there were many people in support and many people against their creation. In the 2002 Vancouver municipal election, SISs were a prominent election issue (Thompson, 2005; Thomson, 2003). "There are few issues in Vancouver more controversial than the creation of safe [supervised] injection sites for the addicts in the city's Downtown Eastside. In a recent municipal election, this issue played a major role in the upset of an entire slate of city councillors" (Thomson, 2003). A federal government exemption opened the door for Vancouver's two SISs to operate, but only as a three-year research trial. This research is timely since the three years are almost up and SISs will once again become a topic for discussion. The change in the federal government has brought a different outlook on SISs. The new Conservative government has indicated it will not support SISs. (Mulgrew, 2005; Woods, 2005)

Those who criticise SISs often do it on moral grounds. John Walters, the United States White House Director of National Drug Control Policy, was very critical of Canada's decision to open SISs. Walters referred to substance abuse as a deadly disease and he believes it is "immoral to allow people to suffer and die from a disease we know how to treat" (Nelson, 2003). The argument that treatment is effective for everyone is naïve. The participants in this research have tried treatment many times and have gone back to injecting drugs. All six participants who are on a methadone maintenance program still inject drugs. SISs are designed for long-term drug users who have not been successful with treatment. Participants unanimously support SISs. This is

in line with other studies that indicate IDUs are supportive of SISs (Wood et al., 2005). Supervised injection sites have been criticized because many IDUs are still injecting on the streets. This research identified five barriers to access. The identification of these barriers may assist planners and policy makers to identify potential problems. For example, knowing that some IDUs are requesting a change in the hours of operation, planners may want to explore this issue further to see if a change in time would attract more IDUs.

Nursing Education

The culture of drug use, due to its illicit nature, is often hidden from public view. Learning about the perspectives of clients is key to developing a successful nurse-client relationship. This study provides a glimpse into the lives of injection drug users. It sheds light on the lived experience of IDUs, and with a specific focus on their experiences with SISs. This study does challenge the popular assumptions that those addicted to drugs can only focus on being high and getting their next fix. The strong concern expressed by the participants for children and others in their community will help nursing students gain a better appreciation for, and understanding of, IDUs. This research study provides information on a wide variety of topics that might be discussed in certain nursing classes. For example, the concepts of harm reduction, homelessness, and substance abuse, among others that were touched upon in this study, may add to classroom discussions.

Nursing Practice

Injections drugs users have multiple health complications and come into contact with nurses in a variety of settings, such as drop-in centres, on the street, in clinics, in

emergency departments and in-patients acute care floors. These contacts are often disjointed and the complex challenges faced by IDUs may not be met with a comprehensive, cohesive approach. This research can inform nurses about aspects of their clients' lives that may have been unknown.

One of the most important findings was the identification of a unique vocabulary used by IDUs, which may not be known to the nurses providing care for them. I spoke with some nurses working with IDUs who were unaware of the meaning of some of the terms I encountered during interviews. The slang words or expressions used by the participants described different drugs, withdrawal symptoms and threats to safety and security, among others things. It is important that nurses and other health and social service providers understand the meaning of the language used by clients.

Recognizing that IDUs have identified barriers that increase their reluctance to use the site, nurses are in a prime position to address these concerns and advocate for change. Since nurses are in direct contact with users, they are best able to address possible knowledge gaps, to alleviate concerns, and to increase clients' level of comfort with the service. Identification of barriers to use of SISs can help nurses to question their practices and challenge policies that cause more harm to the user. Nurses can help to bridge the gap between IDUs and those making operational and policy decisions.

Nursing Research

This research was an introductory study into IDUs' experiences with a SIS. It was broad in scope. For this reason, the data collected touched upon many topics that are worthy of further exploration but may not have been germane to the research question.

This study identifies that six of the seven participants were introduced to injecting by a member of the opposite sex. Future research can shed some light into the dynamics at play between the genders that facilitate introduction of the use of injection drugs. Most of the participants moved to the DTES from another province. Exploration into the factors that bring people to the DTES from out of province could be useful because issues of addiction may be addressed closer to home and with potentially more social support. Most of the participants were on methadone but continued to inject. Questions exploring IDUs' perceptions of the benefits and drawbacks of methadone maintenance while currently injecting could provide an interesting study.

A host of questions concerning SISs can spring from this research. his study indicated that IDUs use SISs to different degrees. Further exploration into why a person might decide to use the site one day and not another could be helpful. Five barriers that limit access to the site were identified. Each one of these barriers merits further exploration.

CONCLUSION

In this study, I explored IDUs' experiences with SISs, primarily through audio taped interviews. A chronological approach was taken. Participants talked about their childhood, their use of drugs, including their first time injecting, life in the DTES, and their experiences with SISs. Participants' opinions about SISs and their recommendations for improvement were presented. The interviews were rich with data. As the researcher, I selected the most significant findings to present. In doing so, difficult decisions were made and some interesting data was left out. Initially, opinions were split among participants as to the benefits of SISs. After using the site, all

participants stated that SISs are beneficial. Frequency of use of a SIS varied among participants, although most attended only rarely or occasionally. All but one participant preferred to inject in the comfort of their own home or at a friend's place. Five barriers that limit use have been identified: 1) Limited Hours of Operation; 2) Public Entrance – Lack of Anonymity; 3) Waiting Time; 4) Atmosphere; and 5) Prohibition of Assisted Injection. After analysing the interviews, some unexpected findings surfaced. First, many participants feel unsafe because they perceive the degree of violence on the streets has increased and they blame this on younger crack smoking addicts. Second, participants expressed a concern for others and they have acted to make positive changes through advocacy, action and acts of compassion. These findings highlight the importance of including IDUs' perspectives regarding health interventions, such as SISs, that are specifically directed at them. SISs were ushered in with much media attention and fanfare. Many people thought this was going to be a silver bullet that would solve many problems in the DTES. Although SISs did not live up to their billing by some people, they did not turn into a monumental mistake as preached by others. This research showed that although SISs were not used regularly by all participants, the participants believe they did decrease the harm experienced by many of the users. Just as importantly, all the participants stated that they believe SISs are one piece of the puzzle that can help improve their lives. In summary, this research paints a more realistic picture of IDUs and SISs.

REFERENCES

Alcoholics Anonymous. (2006). Retrieved March 13, 2006, from http://www.alcoholics-anonymous.org/en_information_aa.cfm

Alexander, B. K. (2001). *The roots of addiction in free market society.* Retrieved August 23, 2002, from http://www.cfdp.ca/roots.pdf

Anis, A., Sun, H., Guh, D., Palepu, A., Schechter, M., & O'Shaughnessy, M. (2002). Leaving hospital against medical advice among HIV-positive patients. *Canadian Medical Association Journal, 167*(6), 633–641.

Anoro, M., Ilundain, E., & Santisteban, O. (2003). Barcelona's safer injecting facility – EVA: A harm reduction program lacking official support. *Journal of Drug Issues, 33*(3), 689–712.

Armstrong, J. (2003, September 15). Safe-injection site opens in Vancouver. *Globe and Mail.* Retrieved October 16, 2005, from http://www.theglobeandmail.com/servlet/Page/document/v4/sub/MarketingPage?user_URL=http://www.theglobeandmail.com%2Fservlet%2Fstory%2FRTGAM.20030915.winje0915%2FBNStory%2FNational%2F&ord=1104477970344&brand=theglobeandmail&force_login=true

Askwith, R. (1998). How aspirin turned hero. *Sunday Times.* 13 September 1998. Retrieved March 8, 2003, from http://www.suntimes.co.za/1998/09/13/lifestyle/life04.htmS

Auditor General of Canada. (2001). *Report of the Auditor General of Canada: Chapter 11 – Illicit Drugs: The Federal Government's Role* [Electronic version]. Ottawa, ON, Canada: Government of Canada.

AVERT. (2004). *Injecting drug users and HIV.* Retrieved September 11, 2005, from http://www.avert.org/injecting.htm

Baumann, S. L. (1993). The meaning of being homeless. *Scholarly Inquiry for Nursing Practice: An International Journal, 7*(1), 59–70.

BBC News UK Edition. (2003). *'Shooting gallery' plan dismissed.* Retrieved June 9, 2003, from http://news.bbc.co.uk/1/hi/scotland/2973664.stm

BC Coalition of People with Disabilities (BCCPD). (2006). Persons with Persistent and Multiple Barriers (PPMB) to Employment Application. Retrieved March 13, 2006 from http://www.bccpd.bc.ca/i/pdf/helpsheets/HS6.pdf

BC Coroner Service. (2004). *Illicit drug deaths – 1995 to 2003.* Office of the Chief Coroner of British Columbia. Retrieved Dec 11, 2004, from http://www.pssg.gov.bc.ca/coroners/index.htm.

BC Ministry of Health Services. (2004). *Every door is the right door: A British Columbia framework to address problematic substance abuse and addiction.* Retrieved November 6, 2005, from http://www.health.gov.bc.ca/mhd/pdf/framework_for_ substance_use_and_addiction.pdf

Borzekowski, D., Rickert, V., Ipp, L., & Fortenberry, J. (2003). At what price? The current state of subject payment in adolescent research. *Journal of Adolescent Health, 33*(5), 378–384.

Brands, B., & Marsh, D. C. (1997). Methadone maintenance treatment: a Canadian perspective. *Canadian Medical Association Journal, 157,* 399–401.

British Columbia Provincial Health Officer. (2003). *Report on the Health of British Columbians. Provincial Health Officer's Annual Report 2002. The health and well-being of people in British Columbia.* Victoria, BC: Ministry of Health Planning.

Broadhead, R. S., Borch, C. A., van Hulst, Y., Farrell, W, Villemez, J, & Altice, F. L. (2003). Safer injections sites in New York City: A utilization survey of injection drug users. *Journal of Drug Issues,* summer 2003, 733-750.

Brown, D. L. (2003, August 2). With injection sites, Canadian drug policy seeks a fix. *Washington Post.*

Browne, A. J. (2005). Discourses influencing nurses' perceptions of First Nations patients. *Canadian Journal of Nursing Research, 37*(4), 62–87.

Browne, A. J., Smye, V. L., & Varcoe, C. (2005). The relevance of postcolonial theoretical perspectives to research in aboriginal health. *Canadian Journal of Nursing Research, 37*(4), 17–37.

Buxtom, J. (2003). *Vancouver drug use epidemiology.* Site report for the Canadian Community Epidemiology Network on Drug Use.

Canadian Mental Health Association. (2006). Youth and self-injury. Retrieved January 28, 2006, from http://www.cmha.ca/bins/content_page.asp?cid=3-1036&lang=1

Canadian Nurses Association. (2001). CNA Position Statement: Collecting data to reflect the impact of nursing practice. Retrieved May 22, 2005, from http://www.cna-nurses.ca/CNA/documents/pdf/publications/PS54_Collecting_ Data_Nov_2001_e.pdf

Canadian Nurses Association. (2004). CNA Position Statement: Registered nurses and human rights. Retrieved May 22, 2005, from http://www.cnaaiic.ca/CNA/documents/pdf/publications/PS78_Human_Rights_e.pdf

Centre for Addiction and Mental Health (CAMH) (2005). Do you know…heroin. Retrieved April 24, 2006, from http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/heroin_dyk_pr.html

City of Vancouver. (1996). *Administrative Report: 1996 Capital Grant Allocations from the Director of Community Services, Social Planning and Director, Office of Cultural Affairs to the Standing Committee on City Services and Budgets.* Retrieved March 24, 2006, from http://www.city.vancouver.bc.ca/ctyclerk/cclerk/960725/csb1.htm

City of Vancouver. (2003). *Survey of low-income housing in the downtown core.* Retrieved April 2, 2006, from http://www.city.vancouver.bc.ca/commsvcs/housing/pdf/SRO2003.pdf

City of Vancouver. (2005). *Preventing harm from Psychoactive Substance Use – Draft Plan.* Retrieved October 15, 2005, from http://www.city.vancouver.bc.ca/fourpillars/pdf/preventingharm_report.pdf

Cook S., Moeschler, O., Michaud, K., & Yersin, B. (1998). Acute opiate overdose: characteristics of 190 consecutive cases. *Addiction, 93*(10), 1559–1565.

Coffin, P., Galea, S., Ahern, J., Leon, A., Vlahov, D., & Tardiff, K. (2003). Opiate, cocaine, and alcohol combinations in accidental drug overdose deaths in New York City, 1990–98. *Addiction, 98*(6), 739–747.

Compton, W., Lamb, R. & Fletcher, B. (1995). Results of NIDA treatment demonstration grants' cocaine workgroup: characteristics of cocaine users and HIV risk behaviours. *Drug and Alcohol Dependence, 37*, 1–6.

Csiernik, R. (1993). *Substance use and abuse: an overview.* Course Material: Addictions I – Ryerson Polytechnic University, Toronto, ON (unpublished).

CTV News. (2006). BC missing women. Retrieved April 6, 2006, from http://popups.ctv.ca/content/publish/popups/bc_missing_women/frameset3.html

Darke, S. (2003). Polydrug use and overdose: overthrowing old myths. *Addiction, 98*(6), 711.

Darke, S. & Hall, W. (1995). Levels and correlates of polydrug use among heroin users and regular amphetamine users. *Drug and Alcohol Dependence, 39*, 231–235.

Darke, S. & Ross, J. (2002). Suicide among heroine users: rates, risk factors and methods. *Addiction, 97*, 1383–1394.

Darke, S. & Zador, D. (1996). Fatal Heroin "Overdose": A Review. *Addiction, 91*(12), 1765–1773.

Darwin, C. (1871). *The Descent of Man*. John Murray: London.

Deas, D. & Thomas, S. (2002). Comorbid psychiatric factors contributing to adolescent alcohol and other drug use. *Alcohol Research & Health, 26*(2), 116-121.

Denning, P., Little, J., & Glickman, A. (2004). *Over the influence: The harm reduction guide to manage drugs and alcohol*. New York: The Guilford Press.

Dickert, N., Emanuel, E., & Grady, C. (2002). Paying research subjects: An analysis of current policies. *Annals of Internal Medicine, 136*(5), 368–373.

Dr. Peter Centre. (2004). *What is Harm Reduction?* Retrieved October 15, 2005, from http://www.drpeter.org/html/programs_harmredux.htm

Drug War Chronicles. (2005). DRCNet interview: Ten years of organizing hard drug users – Ann Livingston of the Vancouver Area Network of Drug Users. Retrieved September 17, 2005, from: http://stopthedrugwar.org/chronicle/384/livingston.shtml

Easton, K., McComish, J., & Greenberg, R. (2000). Avoiding common pitfalls in qualitative data collection and transcription. *Qualitative Health Research, 10*(5), 703–708.

Fischer, B., Chin, A., Kuo, I., Kirst, M., & Vlahov, D. (2002). Canadian illicit opiate users' views on methadone and other opiate prescription treatment: An exploratory qualitative study. *Substance use & misuse, 37*(4), 495–522.

Giorgi, A. (Ed.). (1985). *Phenomenological and Psychological Research*. Pittsburgh: Duquesne University Press.

Giorgi, A. (2000a). The status of Husserlian phenomenology in caring research. *Scandinavian Journal of Caring Sciences, 14*(1), 3–10.

Giorgi, A. (2000b). Concerning the application of phenomenology to caring research. *Scandinavian Journal of Caring Sciences, 14*(1), 11–15.

Gold, F. (2003). Supervised Injection Facilities. *Canadian Nurse, 99*(2), 14–18.

Grady, C. (2001). Money for research participation: Does it jeopardize informed consent? *American Journal of Bioethics, 1*(2), 40–44.

Graves, J. (2004). *Shelterless in Vancouver 2004.* Administrative Report. Vancouver City Council. February 10.

Hanson, G. R. (2002). Director's column. In drug abuse, gender matters. *Nida Notes, 17*(2), 3–4.

Hardie, T. (2002). The genetics of substance abuse. *AACN Clinical Issues, 13*(4), 511–522.

Harvey, E., Strathdee, S., Patrick, D., Ofner, M., Archibald, C., Eades, G., & O'Shaughnessy, M. (1998). *IDS Care, 10*(3), 313–321.

Hawkins, D. J., Catalano, R. F., Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse. *Psychological Bulletin, 112*(1), 64-105.

Health Canada (1997). *Risk, vulnerability, resilience – Health system implications.* Ottawa, ON: Health Canada Publications.

Health Canada. (2001). *Reducing the harm associated with injection drug use in Canada.* Ottawa, ON. Retrieved November 15, 2005, from http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/injection/index_e.html

Health Canada. (2002). *Interim Guidance Document: Application for an Exemption Under Section 56 of the* Controlled Drugs and Substances Act *for a Scientific Purpose for a Pilot Supervised Injection Site Research Project.* Canada: Drug Strategy and Controlled Substances Program.

Health Canada. (2005). *Straight Facts About Drugs and Drug Abuse.* Ottawa, ON. Retrieved November 12, 2005, from http://www.hc-sc.gc.ca/ahc-asc/alt_formats/ hecs-sesc/pdf/pubs/drugs-drogues/straight_facts-faits_mefaits/facts-faits_e.pdf

Hedrich, D. (2004). *European report on drug consumption rooms.* European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Retrieved September 18, 2004, from http://www.emcdda.eu.int/?nnodeid=1327

Hilton, A., Thompson, R., Moore-Dempsey, L., & Hutchinson K. (2000). AIDS prevention on the streets. *Canadian Nurse, 96*(8), 24–28.

Howell, M. (2005, November 2). Facing reality. *Vancouver Courier.* Retrieved January 15, 2006 from http://www.vancourier.com/issues05/111105/news/111105nn1. html

Human Rights Watch. (2003). *Abusing the user: Police misconduct, harm reduction and HIV/AIDS in Vancouver. 15*(2), 1–28.

Johnson, T. P., Freels, S. A., Parsons, J. A., & Vangeest, J. B. (1997). Substance abuse and homelessness: social selection or social adaptation? *Addiction, 92*(4), 437–445.

KC Adherence Project. (2005). Retrieved March 8, 2006, from http://www.kcfree.org/

Kaiser Youth Foundation. (2001). *Addictions Task Group Report. Weaving threads together: a new approach to address addictions in BC.*

Kemmesies, U. E. (1999). *The open drug scene and the safe injection room offers in Frankfurt am Main, Germany 1999 – Final report.* The City of Frankfurt. Retrieved October 21, 2004, from http://www.drugtext.org/library/articles/InjectionRoom/default.htm

Kerr, T. (2000). *Safe injection facilities: Proposal for a Vancouver pilot project.* Harm Reduction Action Society.

Kerr, T., Oleson, M. & Wood, E. (2004). Harm-reduction activism: a case study of an unsanctioned user-run safe injection site. *Canadian HIV/AIDS Policy & Law Review, 9*(2), 13–19.

Klein, H., Levy, J. A. (2003). Shooting gallery users and HIV risk. *Journal of Drug Issues, 33*(3), 751–768.

Kral, A. H., Bluthenthal, R. N., Erringer, E. A., Lorvick, J. & Edlin, B. R. (1999). Risk factors among IDUs who give injections to or receive injections from other drug users. *Addiction, 94*(5), 675–683.

Lafuente, C. R., & Lane, P. L. (1995). The lived experiences of homeless men. *Journal of Community Health Nursing, 12*(4), 211–219.

Lewis, I., & Hallburg, J. (1980). Strategies for safe home visits. *Urban Health, 9*, 40–41.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Sage Publications: Beverly Hills.

Lithgow, M. (2003). "In order to make positive change, you have to get involved!": Participatory development and CED (an overview). Unpublished paper. Simon Fraser University. Retrieved March 10, 2006, from http://www.sfu.ca/cscd/resources/students%20papers/Lithgow,.pdf

McCreary Centre Society. (2001). No Place To Call Home: A profile of street youth in British Columbia.

MacPherson, D. (2001). *A framework for action: A four-pillar approach to drug problems in Vancouver – Revised.* City of Vancouver.

MacRae, R., & Aalto, E., (2000). Gendered power dynamics and HIV risk in drug-using sexual relationships. *AIDS Care, 12*(4), 505–515.

Maxwell, J. (1996). *Qualitative Research Design.* Sage Publications, Thousand Oaks.

Merriam-Webster Online Dictionary. (2006). *Ontology.* Retrieved March 13, 2006, from http://www.m-w.com/dictionary/ontology

MSIC Evaluation Committee. (2003). *Final report on the evaluation of the Sydney Medically Supervised injection Centre.* Sydney: authors.

Millar, J. (1998). *Injection drug use in British Columbia – pay now or pay later?* BC Ministry of Health, June.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), Article 2. Retrieved November 14, 2005, from http://www.ualberta.ca/~ijqm/

Morse, J. M., & Chung, S. E. (2003). Toward holism: The significance of methodological pluralism. *International Journal of Qualitative Methods, 2*(3). Article 2. Retrieved September 11, 2004, from http://www.ualberta.ca/~iiqm/backissues/2_3final/html/ morsechung.html

Morse, J. M., & Field, P. A. (1995). *Qualitative Research Methods for Health Care Professionals.* Second Edition. Thousand Oaks, CA: Sage Publications.

Morse, J. M., & Richards, L. (2002). *Read me first for a user's guide to qualitative methods.* Thousand Oaks, CA: Sage Publications.

Munhall, P. L. (1988). Ethical considerations in qualitative research. *Western Journal of Nursing Research, 10*, 150–162.

Mulgrew, I. (2005, December 6). Harper's war will have no exit strategy. *Vancouver Sun.* Retrieved January 24, 2006, from http://www.canada.com/vancouversun/ story.html?id=02fdc298-b081-456d-ab12-113fa0c87d95&k=72409

Nadwairiski, J. (1992). Inner-city safety for home care providers. *Journal of Nursing Administration, 22*(9), 42–47.

Nelson, K. (2003, June 30). Safe injection site opening in Vancouver, BC. *Alternet.* Retrieved March 14, 2006, from http://www.alternet.org/drugreporter/16286/

NIDA (2000, September). Boys and girls encounter different drug offers, use different refusal strategies. *NIDA Notes, 15*(4). Retrieved April 24, 2006, from http://www.drugabuse.gov/NIDA_Notes/NNVol15N4/Boys.html

Norton, G. R., Weinrath, M., & Bonin, M. (2000). *Cocaine use: recommendations in treatment and rehabilitation.* Health Canada. Retrieved October 19, 2004, from www.cds.sca.com

Odd Squad (Producers), (1999). *Through a blue lens* [Documentary]. Canada: National Film Board of Canada.

Palepu, A., Tyndall, M. W., Leon, H., Muller, J., O'Shaughnessy, M. V., Schechter, M. T., & Anis, A. H. (2001). Hospital utilization and costs in a cohort of injection drug users. *Canadian Medical Association Journal, 165*(4), 415–420.

Patterson, B., Gregory, D., & Thorne, S. (1999). A protocol for researcher safety. *Qualitative Health Research, 9*(2), 259–269.

Pernanen, K., Cousineau, M., Brochu, S., & Sun, F. (2002). *Proportion of crimes associated with alcohol and other drugs in Canada.* Canadian Centre on Substance Abuse. Retrieved November 6, 2004, from http://www.ccsa.ca/ plwebcgi/fastweb.exe?getdoc+view1+General+485+4++crime%20associated%20with%20alcohol

Perry, N. (1995). Instant Death: Purer heroin is killing users while their needles are still in their arms. *Emergency Medical Services.*

Polit, D. F., & Hungler, B. P. (1999). *Nursing research: Principles and methods.* Philadelphia, PA: Lippincott.

Potvin, K. (2004, August 5). 'Shooting galleries' making economic sense. *Vancouver Courier.* Retrieved November 20, 2005 from http://vancourier.com/issues02/ 054202/opinion/054202op2.html

Public Health Agency of Canada (PHAC). (2004). *I-Track: Enhanced surveillance of risk behaviours among injection drug users in Canada. Pilot study report.* Ottawa, ON: PHAC. Retrieved March 8, 2005, from http://www.phac-aspc.gc.ca/i-track/psr-rep04/

Public Safety and Emergency Preparedness Canada (PSEPC). (2003). *Fact sheet: illegal drugs.* Government of Canada. Retrieved November 15, 2005, from http://www.psepc.gc.ca/policing/organized_crime/FactSheet/illiegal_drugs_e.asp

Pumariega, A. J., Rodriguez, L., & Kilgus, M. D. (2004). Substance abuse among adolescents. *Addictive Disorders & Their Treatment, 3*(4), 145–155.

Riehman, K. S., Iguchi, M. Y., Zeller, M., & Morral, A. R. (2004). The influences of partner drug use and relationship power on treatment engagement. *Drug and Alcohol Dependence, 70,* 1–10.

Riehman, K. S., Kral, A. H., Anderson, R., Flynn, N., & Bluthenthal, R. N. (2004). Sexual relationships, secondary syringe exchange, and gender differences in HIV risk among drug injectors. *Journal of Urban Health, 81*(2), 249–59.

Riley, D. (1994). *The harm reduction model: Pragmatic approaches to drug use from the area between intolerance and neglect.* Ottawa: Canadian Centre on Substance Abuse.

Riley, D. (1998). *Drugs and drug policy in Canada: a brief review and commentary. Canadian Foundation for Drug Policy.* [online source http://www.cfdp.ca/ sen1841.htm]

Rossi, C. (2005, September 7). A room of one's own. *Vancouver Courier, 15*(36), p. 1, 4–6.

Rossi, C. (2005, September 14). Around the block. *Vancouver Courier, 15*(37), p. 1, 4–6.

Royal Canadian Mounted Police. (2006). Media relations website. Joint Missing Women's Task Force. Retrieved April 6, 2006, from http://www.rcmp-bcmedia.ca/ pressrelease.jsp?vRelease=7380

Royal Commission on Aboriginal Peoples (1996). *Report of the Royal Commission on Aboriginal Peoples. Vol. 3: Gathering Strength.* Ottawa: Royal Commission on Aboriginal Peoples.

Rubin, H., & Rubin, I. (1995). *Qualitative interviewing: The art of hearing data.* Thousand Oaks, CA: Sage.

Rudgley, R. (1999). *The lost civilizations of the stone age.* New York: New York Free Press.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health, 18*(2), 179–183.

Schechter, M., & O'Shaughnessy, M. (2000). Distribution of injection drug users in the lower mainland. *BC Medical Journal, 42*(2), 80.

Schulte, J., Nolt, B., Williams, R., Spinks, C., & Hellsten, J. (1998). Violence and threats of violence experienced by public health field workers. *Journal of American Medical Association, 280*(5), 439–442.

Sears, J. (2001). The payment of research subjects: Ethical concerns. *Oncology Nursing Forum, 28*(4), 657–663.

The Shipman Inquiry. (2005). *Chapter three – A brief history of the regulation of controlled drugs.* The Rolleston Report 1926. Retrieved January 19, 2005, from http://www.the-shipman-inquiry.org.uk/4r_page.asp?ID=3110

Sheehan, M., Oppenheimer, E., & Taylor, C. (1993). Opiate users and the first years after treatment: outcome analysis of the proportion of follow up time spent in abstinence. *Addiction* 88, 1679–1689.

Single, E., Robson, L., Rehm, J., & Xie, X. (1999). Morbidity and mortality attributable to alcohol, tobacco and illicit drug use in Canada. *American Journal of Public Health, 89*(3), 385–391.

Single, E., Robson, L., Xie, X. & Rehm, J. (1996). The costs of substance abuse in Canada -- Highlights. Ottawa: Canadian Centre on Substance Abuse.

Social Planning and Research Council of BC. (2005). Homeless count 2005. Retrieved December 18, 2005, from http://www.gvrd.bc.ca/homelessness/pdfs/ HomelessCount2005Final.pdf

Spittal, P. M., Craib, K. J. P., Wood, E., Laliberte, N., Li, K., Tyndall, M. W., O'Shaughnessy, M. V, & Schechter, M. T. (2002). Risk factors for the elevated HIV incidence rates among female injection drug users in Vancouver. *Canadian Medical Association Journal, 166*(7), 894–899.

Sporer, K. A. (2003). Strategies for preventing heroin overdose. *British Medical Journal, 326,* 442–444.

Statistics Canada. (2004). Retrieved July 12, 2005, from http://www.statcan.ca/ Daily/English/050721/d050721a.htm

Strathdee, S. A. (1997). Social determinants predict needle-sharing behaviour among injection drug users in Vancouver, Canada. *Addiction, 92*(10), 1339–1347.

Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Thousand Oaks, London: Sage.

Sullivan, C. M., & Cain, D. (2004). Ethical and safety considerations when obtaining information from or about battered women for research purposes. *Journal of interpersonal violence, 19*(5), 603–618.

Sullivan, R. J., & Hagen, E. H. (1997). Psychotropic substance-seeking: evolutionary pathology or adaptation? *Addiction, 97,* 389–400.

Swadi, H. (1999). Individual risk factors for adolescent substance abuse. *Drug and Alcohol Dependence, 55,* 209–224.

Thompson, S. (2005) Supervised injection site (SIS) presentation: How enforcement initiatives can support a healthier community. Issues of Substance Conference 2005. Retrieved March 14, 2006, from http://www.issuesofsubstance.ca/NR/rdonlyres/76994EC3-1106-4ED8-B572-CD80C786688B/0/BriefPaperEN4ScottThompson.pdf

Thomson, H. (2003). Vancouver ready for safe injection sites, say UBC experts: Research indicates lives and money will be saved. *UBC Reports, 49*(1). Retrieved February 15, 2006, from http://www.publicaffairs.ubc.ca/ ubcreports/2003/03jan02/injection.html

Thorne, S. (2004). *Interpretive description in action: Issues and strategies.* Program Notes, Pre-forum Workshop, Ethel Johns Nursing research Forum, Vancouver, BC, February 6, 2004.

Thorne, S., Kirkam, S. R., & MacDonald-Emes, J. (1997). Interpretive description: A non-categorical qualitative alternative for developing nursing knowledge. *Research in Nursing, 20*(2), 169–177.

Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3*(1). Article 1. Retrieved February 14, 2006, from http://www.ualberta.ca/~iiqm/backissues/ 3_1/pdf/thorneetal.pdf

Tjepkema (2004). How healthy are Canadians? Annual report 2004. Retrieved April 24, 2006, from http://www.statcan.ca/english/freepub/82-003-SIE/82-003-SIE2004000.htm

Torres, C. M. (1996). Archaeological evidence for the antiquity of psychoactive plant use in the central Andes. *Annali del Museo civico di Rovereto, 11,* 291–326. Retrieved November 15, 2005, from http://www.museocivico.rovereto.tn.it/ UploadDocs/17_art10.pdf

Turner, D. (1984, October). ...still dealing with the drug problem. *New Internationalist, 140.* Retrieved March 10, 2006, from http://www.newint.org/issue140/dealing.htm

Ulrich, C., & Grady, C. (2004). Financial incentives and response rates in nursing research. *Nursing Research, 53*(2), 73–74.

United Nations Office of Drugs and Crime. (2004). *World drug report 2004.* Retrieved September 24, 2005, from http://www.unodc.org/pdf/WDR_2004/ Chap1_injecting_drugs.pdf

University of British Columbia. (2002). *Research and other studies involving humans.* Retrieved November 14, 2004, from http://www.universitycounsel.ubc.ca/policies/policy89.pdf

USFDA. (1998). Guidance for institutional review boards and clinical investigators. Retrieved March 10, 2006, from http://www.fda.gov/oc/ohrt/irbs/belmont.html

van Beek, I. (2003). The Sydney Medically Supervised Injection Centre: A clinical model. *Journal of Drug Issues, 3*(3), 625–638.

Vangeest, J. B., & Johnson, T. P. (2002). Substance abuse and homeless: direct or indirect effects? *Annals of epidemiology, 12,* 455–461.

Vancouver Coastal Health (VCH). (2003). *Vancouver Coastal Health unveils North America's first supervised injection site research project.* News Release September 15. Retrieved October 14, 2004, from http://www.vch.ca/sis/Docs/SIS_Opening_Release.pdf

Vancouver Coastal Health (VCH). (2003a). *How the SIS will work* [Video]. Retrieved December 1, 2003, from http://www.vch.ca/sis/

Vancouver Coastal Health (VCH). (2004). *Evaluation of the supervised injection site: one year summary.* BC Centre for Excellence in HIV/AIDS. Retrieved September 30, 2004, from http://www.vch.ca/sis/Docs/esis_year_one_sept16_042.pdf

Vancouver Coastal Health (VCH). (2005). *Pilot supervised injection site marks second anniversary: Evidence reveals Insite improving public order, reducing harm, facilitating treatment.* Retrieved September 21, 2005, from http://www.vch.ca/sis/Docs/2005_09_15_sis_release.pdf

Wallace, B., Klein, S. & Reitsma-Street. (2006). *Denied assistance: Closing the front door on welfare in BC.* Canadian Centre for Policy Alternatives.

Weintraub, I. (n.d.). *The role of grey literature in the sciences.* Retrieved April 6, 2006, from http://library.brooklyn.cuny.edu/access/greyliter.htm

White, W. L. & Webber, R. (2003). Substance Use Trends: History and Principles. *Counselor, The Magazine for Addiction Professionals, 4*(3), 18–20.

Whynot, E. M. (1998). Women who use injection drugs: The social context of risk. *Canadian Medical Association Journal, 159*(4), 355–358.

Wild, N. (Producer/Director), (2002). *Fix: The story of an addicted city* [Documentary]. Canada: Canada Wild Distribution.

Wolf, J., Linssen, L., & de Graaf, I. (2003). Drug Consumption Facilities in the Netherlands. *Journal of Drug Issues, 33*(3), 649–662.

Wood, E., Kerr, T., Small, W., Li, K., Marsh, D., Montaner, J., & Tyndall, M. (2004). Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *Canadian Medical Association Journal, 171*(7), 731–734.

Wood, E., Tyndall, M. W., Li, K., Lloyd-Smith, E., Small, W., Montaner, J., & Kerr, T. (2005). Do supervised injecting facilities attract higher-risk injection drug users? *American Journal of Preventive Medicine, 29*(2), 126–130.

Wood, E., Tyndall, M. W., Spittal, P. M., Li, K., Kerr, T., Hogg, R. S., Montaner, J. S. G., O'Shaughnessy, M. V., & Schechter, M. T. (2001). Unsafe injection practices in a cohort of injection drug users in Vancouver: Could safer injecting rooms help? *Canadian Medical Association Journal, 165*, 405–410.

Wood, R. A., Zettel, P., & Stewart, W. (2003). Harm reduction nursing. *Canadian Nurse, 99*(5), 20–24.

Woods, A. (2005, December 5). Drug crackdown may cut safe-injection site funds. *CanWest News Service*. Retrieved March 6, 2006, from http://www.canada.com/ national/features/decisioncanada/story_05.html?id=135e9983-3c42-42e6-83dc-e71c05150925

World Health Organization. (2003). Management of substance dependence. Retrieved December 11, 2005, from http://www.who.int/substance_abuse/facts/en/

World Health Organization. (2006). *Lexicon of alcohol and drug terms published by the World Health Organization*. Retrieved September 30, 2006, from http://www.who.int/substance_abuse/terminology/who_lexicon/en/index.html

Wright, N. M. J., & Tompkins, C. N. E. (2004). Supervised injecting centres. *BMJ, 328*, 100–102. Retrieved June 4, 2005, from bmj.com

Zobel, F., & Dubois-Arber, F. (2004). Short appraisal of the role and usefulness of drug consumption facilities (DCF) in the reduction of drug-related problems in Switzerland. Produced for the Swiss Federal Office of Public Health by University institute of Social and Preventive Medicine, Lausanne.

Zurhold, H., Degkwitz, P., Verthein, U., & Haasen, C. (2003). Drug consumption rooms in Hamburg, Germany: Evaluation of the effects on harm reduction and the reduction of public nuisance. *The Journal of Drug Issues, 33*(3), 663–688.

APPENDIX A

SAMPLE OF INTRODUCTION LETTER

January 6, 2005

Doreen Littlejohn RN
Program Coordinator, Positive Outlook Program
Vancouver Native Health Society

Dear Doreen,

My name is Patrick de Sousa. I will be researching injection drug users' experiences with supervised injection sites (SIS) for my masters' thesis in nursing at the UBC. Although I currently teach at Capilano College, I have worked as a street nurse in Toronto and my professional interest lies with working with those marginalized by society.

The goal of the study is to describe injection drug users' perspectives of their experiences using SIS so that health and social service providers, especially nurses, and non-profit organizations have a greater understanding of the people they serve. The information may also be useful when planning programs. Upon completion of the research, I will be willing to present the findings to your organization.

I am seeking approximately eight to ten people, nineteen years of age and older, who, on a regular basis, inject psychoactive drugs, such as heroin and cocaine, and have utilized a SIS. I will be conducting one audiotaped interview per person. Each interview will be approximately one hour long. During the interview, I will be asking participants about their experiences as injecting drug users who have used SISs. To compensate participants for their time and to thank them for sharing their knowledge, an honorarium of a $10 Army and Navy gift certificate will be given at the end of the interview.

With the support of four or five organizations like yours, I will only need one or two participants from each location. I am asking for your permission to post on your bulletin board a flyer that briefly describes the research. I will provide a more detailed letter for those interested so that it can be taken away and read. Can a time be set up that I can come to the drop in, or another location to answer any questions you or potential participants may have?

I am applying for ethics approval from UBC. If you are interested and able to help me with this study, would you please write a short letter, using letterhead if available, stating

that you will support this research when it is approved by the UBC ethics board. I can supply you with a sample letter if needed.

If you have any questions about this research study, please feel free to contact me at (604) XXX XXXX, or my supervisor, Dr. Angela Henderson, at (604) XXX XXXX.

Thank you for your consideration,
Patrick de Sousa RN, BScN.

APPENDIX B

PARTICIPANT ADVERTISEMENT

The University of   [UBC Department Letterhead]
British Columbia
[Your UBC
Department]

RESEARCH PARTICIPANTS REQUIRED

INJECTION DRUG USERS' EXPERIENCES WITH SUPERVISED

INJECTION SITES

Principal Investigator:
Dr. Angela Henderson, RN, PhD

Co-Investigator/Contact Person:
Patrick de Sousa RN, BScN
Contact telephone number: (604) XXX XXXX
This is a study to meet the requirements for a master's thesis in nursing.

Purpose:
The purpose of this research is to gain an understanding of your experience as an injection drug user who has used a supervised injection site.

Requirements:
> Must be 19 years or older
> Must have more than one year experience injecting drugs
> Must have used a supervised injection site at least once

Study Procedures:
> Read the information letter
> Consent to an audiotaped interview
> Interview will be approximately 1 hour long

Honorarium:
All participants will receive a $10 gift certificate for Army and Navy.

Information Times: (these are examples)

Mon.	Feb. X	XXXX AM	to	XXXX PM
Wed.	Feb. X	XXXX PM	to	XXXX PM
Thu.	Feb. XX	XXXX AM	to	XXXX PM
Mon.	Feb. XX	XXXX PM	to	XXXX PM
Mon.	March X	XXXX PM	to	XXXX PM

APPENDIX C

PARTICIPANT INFORMATION LETTER

(UBC Letterhead)
Title of the Study: Injection Drug Users' Experiences with Supervised Injection Sites

My name is Patrick de Sousa. I am a registered nurse and a student in the Masters of Science in Nursing Program at the University of British Columbia. I will be researching injection drug users' experiences with supervised injection sites. The goal is to describe injection drug users' perspectives so that health and social service providers, especially nurses, and non-profit organizations have a greater understanding of the people they serve. This information may be useful when planning programs.

I am seeking approximately eight to ten people, nineteen years of age and older, who, on a regular basis, inject psychoactive drugs, such as heroin and cocaine, and have utilized a supervised injection site. I will be conducting one audiotaped interview per person. Each interview will be approximately one hour long. During the interview, I will be asking participants about their experiences as injection drug users who have used supervised injection sites.

Your identity will be protected and will not be disclosed to anyone. All information gathered from your interview will be given a code number. A fictitious name may be used to make the reading of the findings easier.

The audiotape will be transcribed either by Patrick de Sousa or a transcriptionist. The audiotape, written transcription, and documents on paper will be kept secure in a locked filing cabinet. All information on computer can only be accessed by a computer password. A copy of the information will be kept on a computer disk that will be kept locked in the filing cabinet when not in use.

There is a potential risk that while you are describing your experiences as an injection drug user the topic may trigger strong emotions. You can request to stop the tape and the interview at any time. If you seem upset, you will be asked if you want the interview to be stopped and the tape to be turned off. Prior to continuing, you will be asked to consent to restarting the interview.

This research is independent of all health and social services and therefore will not have any effect on the services you may be participating in. You may or may not gain some benefit from talking about your life as an injection drug user and your experiences with supervised injection sites.

You will receive an honorarium to compensate you for your time and to thank you for sharing your knowledge. The honorarium will be a gift certificate from Army and Navy for $10. The gift certificate will be given at the end of the interview.

If you have any questions about this research study, please feel free to contact me at (604) XXX XXXX, or my supervisor, Dr. Angela Henderson, at (604) XXX XXXX.

Thank you for your consideration.

Patrick de Sousa

Study Procedures:
You will be interviewed in a place that is convenient for both you and the researcher. There will be one audiotaped interview lasting approximately one hour. You may be contacted in the future for clarification of information or to provide feedback on the researcher's analysis. During the interview, questions will be asked regarding your injection drug use history and experience with supervised injection sites. Participation in the study is voluntary and you have the right to refuse to answer any question, terminate the interview, or withdraw from the study at any time. At any time during the interview you can request to have the audiotape turned off.

Confidentiality:
Your identity will be protected and will not be disclosed to anyone. All information gathered from your interview will be given a code number. A fictitious name may be used to make the reading of the findings easier.

The audiotape will be transcribed either by Patrick de Sousa or a transcriptionist. The audiotape, written transcription, and documents on paper will be kept secure in a locked filing cabinet. All information on computer can only be accessed by a computer password. A copy of the information will be kept on a computer disk that will be kept locked in the filing cabinet when not in use.

Potential Risks of Participating in the Study:
There is a potential risk that while you are describing your experiences as an injection drug user the topic may trigger strong emotions. You can request to stop the tape and the interview at any time. If you seem upset, you will be asked if you want the interview to be stopped and the tape to be turned off. Prior to continuing, you will be asked to consent to restarting the interview.

Benefits of Participating in the Study:
This research is independent of all health and social services and therefore will not have any effect on the services you may be participating in. You may or may not gain some benefit from talking about your life as an injection drug user and your experiences with supervised injection sites.

You will receive an honorarium to compensate you for your time and to thank you for sharing your knowledge. The honorarium will be a gift certificate to Army and Navy for $10. The gift certificate will be given at the end of the interview.

After the research has been completed a copy of the report will be given to you at your request.

Contact for information about the study:
If you have any questions or desire further information with respect to this study, you may contact Dr. Angela Henderson at (604) XXX XXXX.

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without repercussion. Your decisions will not jeopardise your access to current or future community services including supervised injection sites. Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study and that you have received a copy of the full consent form.

_____

Subject Signature   Date

_____

Printed Name of the Subject

APPENDIX E

INTERVIEW GUIDE – 1

Preamble

As you know, I am conducting a research study to explore the experiences people who inject drugs have concerning supervised injection sites. Your perspectives on injection drug use and supervised inject sites are important. To help me understand your point of view, I am would like to begin by asking you: When did you start to use drugs?

Trigger questions:

1. When did you start to use drugs?

2. What has life been like as an injection drug user?

3. What were your impressions the first time you used the SIS?

4. What has having access to an SIS meant to you?

5. Has the use of an SIS changed anything? How?

APPENDIX F

INTERVIEW GUIDE – 2

Preamble:

As you know, I am doing a study on the experiences people have with SISs. Your views are important. This research will help people gain an understanding of IDUs' experiences with SISs. I hope this research will help to give IDUs like yourself a voice in the future of SISs.

Trigger questions:

1. When did you start to use drugs?

2. Are you the only person in your family to use drugs?

3. What has life been like as an injection drug user?

4. Describe a typical day for you.

5. What were your impressions the first time you used the SIS?

6. Describe your relationship with the nurses at the site.

7. Describe your relationship with the peer support workers at the site.

8. What has having access to an SIS meant to you?

9. Has the use of an SIS changed anything? How?

APPENDIX G

INTERVIEW GUIDE – 3

Preamble:

As you know, I am doing a study on the experiences people have with SISs. Your

views are important. This research will help people gain an understanding of

IDUs' experiences with SISs. I hope this research will help to give IDUs like

yourself a voice in the future of SISs.

Trigger questions:

1. When did you start to use drugs?

2. What has life been like as an injection drug user?

3. What were your impressions the first time you used the SIS?

4. Describe your experiences in the injecting area.

5. Describe your experiences in the chill out room.

6. Describe your relationship with the nurses at the site.

7. Describe your relationship with the peer support workers at the site.

8. What has having access to an SIS meant to you?

9. Has the use of an SIS changed anything? How?

APPENDIX H

TERMINOLOGY

1. Bogart
    a. To keep something all for oneself, thus depriving anyone else of having any.
    b. A slang term derived from the last name of famous actor Humphrey Bogart because he often kept a cigarette in the corner of his mouth, seemingly never actually drawing on it or smoking it.
2. Coconuts
    a. Cocaine users
3. Cokehead
    a. Someone addicted to cocaine
4. Crackheads
    a. Crack addicts
5. Doctoring
    a. Helping an addict by injecting them
6. Dope
    a. Any hard drugs (e.g. heroin or cocaine), not marijuana
7. Dope Fiend Move
    "an act or effort by a drug addict to trick or mislead another person to gain advantage" (Urban Dictionary, 2005)
8. Dope
    a. Simple
9. Down
    a. Heroin
10. Down
    a. Sick
11. Fixing
    a. Preparing to inject hard drugs...adding water, cooking, drawing up into syringe
12. Flap
    a. Square piece of paper that they fold up to put the drugs in
13. Get off
    a. Get high
14. Greys
    a. 100 mg Morphine
15. High
    a. Tolerate
16. Jack you up
    a. Origin from 'hijacked'
    b. Stolen in a violent fashion
    c. Commonly refers to robbery, theft, misuse, seizure, possession
17. Jug
    a. Relating to the jugular vein

18. Junkie
   a. A person who is consumed by an addiction. Aspects of their life suffer as he/she satisfies the addiction
19. Nod
   a. To doze off when high on opiates
20. Oxys
   a. Oxycodone is a very strong narcotic pain reliever. It is meant to be taken in pill form not broken, eaten, or crushed
21. Paper
22. Party Pack
   a. Package of 10 or more syringes
23. Powder
   a. Cocaine
24. Rig
   a. Needle/syringe used for injecting street drugs
25. Score
   a. Procure drugs
26. Shooting
   a. A slang term for injecting
27. Speedball
   a. Combination of cocaine and heroin
28. Speed freaks
29. Tie
   a. A tourniquet
30. Toilet Paper
   a. Poor quality drugs (garbage)
31. Tweaker
   a   Once the name of desperate crack cocaine addicts, tweaker is now used primarily to describe users of crystal methamphetamine
   b. Name derived because users tend to be restless and fidgety
32. Tweaking
33. 8-ball
   a.   One eighth of an ounce, or 3.5 grams of cocaine
34. Using
   a. Injecting not doing drugs in other forms like smoking
35. Whack
   a. A large amount of drugs

APPENDIX I

SUICIDAL BEHAVIOUR CHECKLIST

Emotional Clues
- depressed and sad
- mood change (depressed to elated or vice versa)
- tearful, sullen, quiet, withdrawn
- inability to concentrate, agitated
- feelings of hopelessness, worthlessness, self-hate

Behavioural Clues
- sudden change in behaviour
- giving away favourite possessions
- drug and/or alcohol abuse
- thanking people for their kindness, settling affairs, tying up loose ends, writing good-bye letters
- previous suicide attempt by themselves or family members or friends

Physical Clues
- loss of interest in appearance
- loss of interest in friends, activities, and/or intimate (or sexual) relationships
- loss of energy
- poor sleep habits (either sleeping all the time or hardly ever sleeping)
- weight gain or loss

Verbal Clues
- no longer communicating effectively with others
- speaks of not being here in the future: e.g. "They'd be better off without me" or "You won't have to worry about me much longer"
- a noticeable absence of any future in conversation
- asks questions about dying
- talks openly about suicide
- talks of issues related to sexual or gender identity; in particular concern about being gay/lesbian
- talks of identity or cultural conflicts that lead to beliefs such as, "I don't know who I am", or "I'm different and don't fit in anywhere"

From: NEED Crisis and Information Line website: http://www.needcrisis.bc.ca/