

Streetlight People: Perspectives of Street Outreach Services Staff on the Loss of Harm Reduction
Services in Victoria, BC

by

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BA, University of Victoria, 2002
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Supervisory Committee

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Abstract

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On May 31, 2008, one of Canada's oldest needle exchange programs was forced to close its doors. Street Outreach Services (SOS), run by AIDS Vancouver Island, was evicted from its fixed site location in downtown Victoria, BC, due to years of inadequate funding and resources, and pressure from community members who blamed SOS for "public disorder" on the city streets. Without a new location from which to house the program, SOS has since operated as a mobile service. This case study documents the context surrounding the closure of SOS and the perspectives of outreach staff regarding the transition from fixed site to mobile services-only. Specifically, this study addresses the question: How have service delivery changes and restrictions impacted SOS outreach work? In addition to participant-observation, media and report analysis, primary data are derived from six semi-structured interviews with SOS outreach workers and a thematic analysis highlights common experiences of loss, isolation and changes in relationships with clients. A discussion of strategies for collective responses to ethical distress includes social justice perspectives.

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Chapter 1: Introduction

On June 1, 2008, Victoria, British Columbia lost its only “fixed site” needle exchange¹ program. Street Outreach Services (SOS), run by AIDS Vancouver Island (AVI), was evicted from its downtown location due to years of inadequate funding and resources, and pressure from community members who blamed SOS for “public disorder” on the city streets. Without a new location to house the on-site health services specifically for people who use illicit drugs, SOS has since operated as a mobile service. This case study documents the context surrounding the closure of the SOS fixed site and inquires into the perspectives of SOS outreach staff on the transition from fixed site to mobile services-only. Specifically, this study addresses the question: How has the transition from fixed site to mobile services impacted SOS outreach work? In addition to participant-observation, media and report analysis, primary data are derived from six semi-structured interviews with SOS outreach workers².

1.1 Street Outreach Services (SOS)

A small needle exchange service was started in Victoria, BC, in the late 1980s by two people who used injection drugs with the help of a provincial employment grant. In 1988 (reports on the specific date vary), the service was taken over by a newly formed organization, AIDS Vancouver Island (AVI), and has long been recognized as one of the first needle exchange programs in Canada. Officially named “Street Outreach Services” (SOS), the program is still

¹ The provision of sterile syringes is still often referred to as ‘needle exchange’, although in BC, for example, it is acknowledged that requiring one-for-one exchange is not acceptable in order to meet public health objectives of using a clean syringe for each injection (Chandler, 2008). All needle exchange services in Victoria provide unlimited clean supplies, regardless of whether or not the client has returned used syringes in exchange.

² The title of this thesis includes the term “Streetlight People” which is an allusion to the phrase “Streetlights, people...” from the lyrics of the 1981 song “Don’t Stop Believin” by American rock band, Journey. The song was used as an inside joke and theme song by the SOS staff team.

often referred to locally “the exchange,” because it was the largest and only fixed site needle exchange program in Victoria.

1.2 Situating SOS

SOS operated in a separate location from other AVI programs until 2001 when the entire organization moved into a leased building at the corner of Blanshard and Cormorant Streets³. Here, AVI’s administration, support, prevention and harm reduction services were all housed under one roof at the border of the Downtown Victoria and North Park neighbourhoods. Close by, the Harris Green neighbourhood also includes a number of services used by SOS clients⁴.

Victoria is the capital city of BC, located at the southern tip of Vancouver Island. A small urban center of approximately 78,000, the greater metropolitan area is home to approximately 330,000 residents. The City of Victoria is divided into 14 neighbourhoods, including those mentioned above. As of 2006, Downtown Victoria was home to over 3000 residents, North Park neighbourhood had 2800 residents and Harris Green had over 1600 residents. Public administration and retail provide the primary employment sectors in Downtown, while North Park and Harris Green are both mixed-income, mixed use areas.

AVI’s location on Cormorant Street provided a central site for many of Victoria’s most marginalized residents. While Blanshard Street is a main corridor in Downtown and a connector

³ The street address was 1601 Blanshard Street, however most people referred to the needle exchange as being located on Cormorant Street because both entries into the building were from Cormorant Street.

⁴ The term ‘client’ will be used to refer to people that utilize the services offered by SOS outreach workers. This term is problematic because it does not accurately convey the agency and authority of people who use drugs in their own lives. It also makes a distinction between people who use drugs and people who deliver outreach services. In reality this distinction may not exist. However the term will be used for brevity and to correspond with its common usage by the research participants.

to the two main highways into the City, Cormorant Street is quieter with a mix of public administration offices, private businesses, apartment and condominium buildings. The main landmark of the block, across from the Cormorant entrances to the AVI building, is the large white office building occupied by the provincial Ministry of Health. Within a short walking distance into the Downtown, North Park and Harris Green neighbourhoods, SOS clients could access a number of health and social services, including welfare offices; mental health and addictions services; the Cool-Aid Community Health Centre and Dental Clinic (serving low-income clients); a number of homeless shelters, transitional housing and low-income housing; churches; advocacy organizations; and Our Place Society (formerly “The Open Door”) which offers transitional housing and a drop-in program often referred to as the “living room” for Victoria’s homeless population.

In 2008, SOS was evicted from its location with AVI on Cormorant Street. The context surrounding the eviction and transition from fixed site to mobile services will be discussed in Chapter 4 of this case study.

1.3 Starting From Experience

My interest in pursuing this particular research project emerged directly from my experiences as an outreach worker and community organizer. I was employed by AVI in 2004 after completing a practicum placement with the organization as part of my Social Work undergraduate degree. Since then, I have worked in a variety of roles with the organization including outreach worker, counselor/advocate, program manager, educator, and evaluator. When SOS came under intense public scrutiny in 2007-8, and was closed down, I became more active in community organizing and activism around the issues of health services for people who use illicit drugs both within

AVI and in the broader community. Through my years of experience working with people who were accessing AVI's various programs, I became aware of the particular stigma surrounding people who use drugs, even within the population of people affected by HIV/AIDS.

In 2007, when negative media attention turned toward SOS, I felt angry and defensive of the people who worked in the program and especially those who accessed the program for supplies and support. I had come to understand and believe in a harm reduction approach to working with people who use drugs as I had observed it to be a compassionate and practical way to engage and support my clients. I also believed that a harm reduction approach was an important and effective way to address the impacts of illicit drug use in the community. I understood the complicated and often traumatic experiences that led my clients to use illicit drugs and despised the idea that they would experience such stigmatization in the community. I felt angry that SOS and its clients were being blamed for the so-called "social disorder" on Victoria's downtown streets, when it seemed so clear to me that a visible homeless population was indicative of growing poverty, lack of housing, and limited social services and supports. At AVI, I began to work more closely with people who use drugs and I looked for outlets outside of the organization to turn my anger into action.

Since SOS was evicted from its Cormorant Street location and was forced to become a mobile service, myself and my coworkers have faced daily challenges to adjusting our practice in order to best meet the needs of our clients while experiencing complex and ongoing pressures and demands from multiple sources, both internal and external to our organization. It is through this ongoing personal experience in my workplace, and through the community organizing I have

engaged in outside of my workplace, that has led me to an interest in exploring the collective experiences of myself and my coworkers during a very challenging time in our program's history.

1.4 Thesis Overview

This introductory chapter describes how my own experience as an outreach worker was the starting place for the research I have conducted around the closure of the SOS fixed site needle exchange, and some of the impacts that the switch to mobile services have had.

To give context to the work of SOS outreach workers, Chapter 2 provides a description of harm reduction as it relates to illicit drug use and grounds harm reduction as a movement in the experiences of people who use drugs. I describe the links between harm reduction and social justice movements that serve as the underpinnings of the work undertaken in needle exchange programs and outreach work. In many mainstream health care systems, harm reduction is being integrated and used as a public health strategy to reduce disease transmission. Harm reduction work challenges deeply held moral opinions regarding drug use, and the stigma that is attached to people who use drugs has consequences that impact the accessibility of health care. The chapter concludes by describing how the consequences of stigma and discrimination impact the ability of outreach workers to build and maintain relationships with their clients and may lead to moral distress and a sense of isolation in their work.

Chapter 3 describes the process through which I designed this thesis research, with my own experience as a starting place. Case study methodology and methods enabled me to focus on my own experiences of a local situation and its impacts on my community. The unique perspectives

of SOS workers on the closure of the fixed site needle exchange and the changes to their work since are of local interest and also may have relevance for those elsewhere addressing stigma in their own communities. I describe how the methods of observation, document and media research, and interviews with outreach workers allowed me to delve into the case and obtain a deeper understanding of my own experiences of the case.

Chapter 4 provides an account of the local events that occurred leading up to the closure of the fixed site needle exchange. My experiences as an outreach worker and community organizer provide the lens through which media coverage and locally-produced reports are analyzed. While Victoria holds a wealth of knowledge regarding the contributions of harm reduction policies and practices to our community, stigma, discrimination, ignorance and moral opinions continue to stand in the way of putting international and local knowledge in to practice and moving forward with harm reduction services provision.

Chapter 5 offers the narrative findings derived from the six interviews I conducted with current and former SOS workers. The chapter begins with a description of SOS on Cormorant Street and outreach workers' perspectives on the strengths and challenges of fixed site services at that location. The impacts of the transition to a mobile model following the closure of the fixed site are most apparent in the relationships between outreach workers and their clients, the ability of outreach workers to offer services that are effective and respectful of their clients' needs, and the challenges faced by outreach workers to do their work in accordance with best practices, and their own values and ethics.

Finally, Chapter 6 offers a summary of the findings and highlights the distress experienced by outreach workers in the wake of the closure of the fixed site needle exchange. The chapter troubles the individualizing concept of “burnout” and looks to a social justice framework to build an ethical foundation of solidarity for outreach workers. I include recommendations as to how outreach workers may be supported by their employers and support one another through principles of solidarity, ethical practice, and social justice work.

Chapter 2: Harm Reduction, Outreach Work and the Impacts of Contested Health Care

2.1 Harm Reduction

Harm reduction is often a foundation of practice for outreach workers and is generally understood as both a philosophy and a set of strategies aimed at reducing the harms associated with illicit drug use. A significant body of international evidence supports harm reduction programs as a primary means to reduce risk behaviours, prevent the spread of blood-borne pathogens, and to provide cost-effective reduction and treatment of disease for people who use illicit drugs (for example, Wodak & Cooney, 2005; World Health Organization, 2007). Through principles of pragmatism and humanistic values, harm reduction practices include prevention education, peer support, provision of safer drug use and safer sex supplies, recovery of used supplies, outreach, drug substitution therapies and supervised consumption.

A harm reduction approach recognizes that drug use is a reality and that it occurs on a spectrum. Not all drug use is problematic, nor does it necessarily lead to addiction. Rather, drug use must be considered on a case-by-case basis to determine if it is causing harm, how that harm might be immediately reduced, if the person using the drugs wants to change their relationship to the drug(s) they use, and how change might be best achieved for that individual (Zinberg, 1984). Harm reduction is a process model informed by self-determination and its goal is to provide support for a variety of outcomes, of which abstinence may or may not be a desired or intended goal (Harm Reduction Therapy Centre, 2009).

[H]arm reduction is concerned with the most immediate aspects of drug users' lived experiences. This includes the ways drugs are sourced and consumed; how information about their harms, pleasures and effects is generated; how this information circulates in diverse social networks, as well as the effects this information has on patterns of use and related harms over time (Duff, 2010, p. 343).

Public health advocates of harm reduction note its ability to shift the “marginalizing and dehumanizing discourses that accompany drug use” for people who use drugs by its commitment to recognizing and honouring the autonomy that people that people must have over their own bodies (MacNeil & Pauly, 2010, p. 6).

2.1.1 Historical Context

The harm reduction movement emerged from grassroots, political organizing by people who use drugs and can be traced back to the 1960s opposition to the legal suppression of drugs (Roe, 2005). In the 1970s and 1980s, people using drugs in Western Europe responded to the threats of hepatitis and the human immunodeficiency virus (HIV) by organizing themselves around harm reduction principles and practices (Campbell & Shaw, 2008). A union for people who use drugs emerged in Rotterdam in the 1980s which organized around drug policies and pressured policy makers and drug treatment organizations to provide support and recognize their rights. The ‘Junkie-bonden’ (Junkie Union) initiated an underground needle exchange and it is acknowledged that these efforts likely stabilized HIV prevalence among people using drugs in that area (Friedman, de Jong, Rossi, Touzé, Rockwell, Des Jarlais & Elovich, 2007). Grassroots responses to the AIDS epidemic in New York City in the late 1970s and early 1980s were documented by Friedman et al. (2007) who noted that, by contrast, public health responses were delayed. People with experience with drug use used their own observations of the spreading epidemic to organize themselves and ensure their own ability to access sterile, disposable needles and syringes.

2.1.2 A Grassroots Movement

People who use drugs have long been active in organizing themselves. (Friedman et al., 2007). Their actions are rooted in day-to-day experiences and harm reduction evolved from their collective knowledge of practical, humane responses to the harms related to the criminalization of drugs and associated risks to health. Acknowledging the agency, self-determination, and dignity of people who use drugs is fundamental to working within a harm reduction context. There are public health, ethical and human rights imperatives to involving people who use drugs in all harm reduction initiatives (Canadian HIV/AIDS Legal Network, 2005). Activists have expressed concern that the voices of people who use drugs must be at the forefront of the movement in order to combat stigma and the misconception that people who use drugs are incapable of self-determination (Campbell & Shaw, 2008). The Society of Living Intravenous Drug Users (SOLID) in Victoria and the Vancouver Area Network of Drug Users (VANDU) are local examples of people who use drugs organizing themselves and taking leadership roles in their communities. People who use drugs are the “primary practitioners of harm reduction” and they contest narrow definitions of harm reduction as solely policies and programs delivered *to* them (Friedman et al., 2007, p. 107). Community-based, peer, grassroots and activist groups are more interested in a political analysis of harm reduction that takes into account social, economic, racial and political inequality, political and moral contexts. The leadership of people who use drugs on these accounts is pivotal to the sustainability of the movement and the rights of people who use drugs (Roe, 2005).

2.1.3 The ‘Mainstreaming’ of Harm Reduction

It is widely acknowledged among harm reduction advocates that drug prohibition and the criminalization of people who use drugs are the primary sources of harm related to illicit drug

use (Boyd, 2004; Boyd & Marcellus, 2007; Broadhead, Van Hulst & Heckathorn, 1999a; Buchanan, Shaw, Ford & Singer, 2003; Tomolillo, Crothers & Aberson, 2007; Treloar & Fraser, 2007; Wodak & Cooney, 2005). Yet as harm reduction becomes a brand that is used by public health officials who are perhaps unaware of the political beginnings and foundations of the movement, or are attempting to make harm reduction more palatable, the harms of prohibition are not addressed. It is important to note cautions around the institutionalization of harm reduction: “Newly mainstreamed harm reduction is reluctant to engage in political criticism of drug prohibition and prefers to express opposition to the social marginalization of drug users in terms of medical outcomes” (Roe, 2005, p. 243). Locally, a British Columbia Ministry of Health (2007) publication states that “legalization is not part of harm reduction.” Here,

...[t]he radical potential of drug users’ self-defined concepts of harm reduction, identity, and social responsibility risks being obscured by the technocratic enactment of harm reduction for the ethnographic eyes of the state (Campbell & Shaw, 2008, p. 709).

Critical harm reduction advocates state that this co-option of a movement is dangerous for people who use drugs because it erases much of the context that shapes illicit drug use such as the criminalization of drugs and the people who use them.

Harm reduction that lacks attention to symptoms of structural inequalities such as homelessness, incarceration, poverty and racism risks becoming a regulatory mechanism. For example, when public health policy profiles certain groups into simplified categories such as “high-risk,” such groups may be blamed for their own health problems and shunned as vectors of disease, increasing the stigmatization they experience (Erickson & Hathaway, 2004). Neo-liberal notions of the responsibility of the individual blame people who use drugs for their homelessness and

drug use and hold them accountable for HIV prevalence and prevention (Campbell & Shaw, 2008). Yet,

[t]he health of drug users is inextricably bound to their social environment. Drug-taking and drug-use risk behaviors are affected by social processes, and the health of drug users is a product of both drug-use behaviors and social determinants (Galea & Vlahov, 2002, p. S136).

By dwelling on personal responsibility and individual choice, we fail to link behavioural risk to larger social structures. A political agenda and the leadership of experiential⁵ people in the governance of their own lives, is the only manner in which the potential of harm reduction may be fully realized (Campbell & Shaw, 2008). Policy change and behavioural interventions are both critical in addressing the determinants of disease, health and wellness for people who use drugs (Galea & Vlahov, 2002).

2.1.4 Harm Reduction and Social Justice

People who use drugs are frequently conceptualized as “undeserving” or “unworthy” and their use of drugs is conceptualized as a matter of choice (MacNeil & Pauly, 2010). A social justice framework uncovers drug use “not as a matter of choice but as a matter of health and well-being” (Pauly, 2008a, p. 8). A social justice approach acknowledges inequities in access to health care, for example, and “takes seriously the rightful claims of all persons to life, health, dignity and hope” (Selznick, 2002, p.12). The value of a harm reduction approach to drug use is that it has the potential to “[create] a moral context in which drug use is acknowledged but not judged and action is supportive rather than punitive” (Pauly, 2008a, p. 6).

⁵ The word “experiential” is used here to refer to someone who has “day-to-day lived experience, currently or in the past,” with the subject at hand (Rabinovitch, 2004, p. 13).

Harm reduction policies and practices work to shift values from “an ideology of fixing to reducing harm; stigma to moral worth” (Pauly, 2008b, p. 195). Harm reduction approaches do not force people who use drugs to change: they utilize a non-judgmental, respectful way of engaging people in order to maximize opportunities to access health care, social and economic supports (Pauly, 2008b). Thus, the provision of harm reduction services is in line with the movement for social justice because it recognizes the systemic production of oppression through economic, social, political and cultural institutions and works with individuals who experience ongoing oppression in a manner that is attuned to sound ethics and the moral worth of all people (Young, 1990; Pauly, 2008a). “Harm reduction ... works best as a bottom-up philosophy and practice allied with movements for social justice, and shaped by those most in need” (Boyd, MacPherson & Osborn, 2009, p. 188). While harm reduction programs, such as needle distribution and outreach, do not combat societal oppression on a macro scale, they engage people who are significantly marginalized in a manner that aims to keep people alive, offers hope, and provides support by honouring dignity and self-determination.

2.2 Needle Exchange

Health and social services guided by harm reduction policies and practices are a critical component of a comprehensive approach to responding to the symptoms of structural inequalities at the root of illicit drug use. One example of harm reduction services offered in many parts of the world is the distribution of clean and sterile drug use equipment such as needles. Over 20 years of research has shown that the practice of providing sterile syringes plays a significant role to “prevent, control and ultimately reduce prevalence of HIV and other blood-borne infections among injecting drug users” (World Health Organization, 2007, p. 5) and is supported by a wide range of mainstream medical, scientific and government bodies (Small, Glickman, Rigger &

Walter, 2010). Needle exchange services operate in more than 60 countries in all regions of the world and the World Health Organization acknowledges that while there may be moral opposition to harm reduction, “the evidence for [needle exchange programs] is irrefutable and health authorities should establish full-scale programmes wherever possible (World Health Organization, 2007, p. 6).

In Victoria, many people who accessed the fixed site needle exchange program experience homelessness and unstable housing and the majority live in poverty. “Access to health care is one determinant of health. Those who are street involved not only experience poorer health but they encounter multiple barriers in accessing health care services” (Pauly, 2008a, p. 5). As a result of these barriers to health care, many people who use drugs also face higher rates of morbidity, mortality and stigma and discrimination (Pauly, 2008b). For many highly marginalized people who use drugs, needle exchange programs are their only link to any health service. Harm reduction programs often operate as a “one-stop-shop” model, an effective way to deliver services that provide support that address the social determinants of health, such as access to food, housing options and social connection (Boyd & Marcellus, 2007). For example, dedicated fixed site needle exchanges are a critical gateway to other health and social supports:

People who inject drugs are often marginalized and live in poverty, and because [harm reduction supply distribution programs] are often the only contact with health and community services, it is essential that ... staff assist clients in accessing other related services (Chandler, 2008, p. 8).

Different points of access for needle exchange are important in meeting the different needs of people who use drugs (Bryant, Topp, Hopwood, Iversen, Treloar & Maher, 2010). Harm reduction services should be specific to the needs and resources of each community (Chandler,

2008). Needle exchange services may be offered at fixed locations specifically dedicated to providing services for illicit drug users, at secondary locations (such as pharmacies and general health clinics), through mobile services (such as vans, bicycles or on foot) and vending machines. It is important to tailor the mode of service delivery to client profiles. For example, fixed sites serve the most marginalized and most likely to engage in higher risk drug use practices, whereas pharmacies are more likely to serve people with lower risk profiles (Miller, Tyndall, Spittal, Li, Palepu & Schechter, 2002). Dedicated fixed sites are those that offer needle exchange as their express purpose. They provide a consistent location offering non-judgmental and relatively confidential service to people who, due to the stigma associated with illicit drug use, may not be comfortable obtaining supplies at more public locations such as pharmacies. Fixed sites provide an effective response in areas where drugs are bought, sold and used openly and in areas where there is a higher concentration of people who use illicit drugs (Chandler, 2008).

While mobile services are useful in reaching people who do not access fixed sites, it is not a substitute for fixed site service provision. Regular hours and a permanent site mean that people know when and where to access harm reduction supplies. Further, fixed sites have the capacity to provide additional services such as primary health care and addiction counseling services (Chandler, 2008, p. 4).

2.2.1 Responsibility for Needle Exchange in BC

Needle exchange started to receive federal and provincial monies in Canada in the 1980s and has become a relatively standard preventative public health practice (Canadian HIV/AIDS Legal Network, 2004). In BC, needle exchange services are the responsibility of the Health Authorities, which were formed in 2001 as a result of the re-structuring of provincial health jurisdictions. The Health Authorities are responsible for “planning, delivering and evaluating prevention and care services”, including the development of “evidence-based responses to

disease transmission” and “ensuring services engage and serve vulnerable populations” (Chandler, 2008, pg. 11). There are five geographically-defined Health Authorities and one Provincial Health Services Authority which ensures that there is a coordinated network of health care accessible to British Columbians. The BC Centre for Disease Control (BCCDC) is an agency of the Provincial Health Services Authority, and aims to prevent and control communicable diseases (Chandler, 2008). The BCCDC authored the *BC Harm Reduction Strategies and Services Policy and Guidelines* (2009) with the goals of reducing drug-related health and social harms, promoting and facilitating referral to primary health care services, increasing “public awareness of harm reduction principles, policies and programs,” and improving access to harm reduction supply programs (p.2). BC’s Harm Reduction Strategies and Services Committee, which includes representatives from the province’s Health Authorities and Ministry of Health, among others, published a best practices document for BC Harm Reduction Supply Distribution Programs which expands on the BC Centre for Disease Control’s harm reduction policies (Chandler, 2008). The Health Authorities are led and supported by the Provincial Government, specifically the Ministry of Health Services and the Provincial Health Officer. Contracted agencies work with the Health Authorities to plan, deliver and evaluate prevention and care services (Chandler, 2008). AIDS Vancouver Island has been contracted by the Vancouver Island Health Authority (VIHA) to provide needle exchange services since the Health Authorities were formed in 2001.

2.3 Outreach Work

Outreach work is a model of social service delivery that attempts to reach populations that have been marginalized and stigmatized and therefore hidden, ignored, despised, and often reluctant to participate in service settings (Strike, O’Grady, Myers & Millson, 2004). Outreach work within

a harm reduction context aims to connect with individuals in a manner that is non-judgmental, respectful and highly practical, including education, support, provision of safer drug use and safer sex equipment, retrieval and disposal of used equipment, and brief assessment and referral (New South Wales Department of Health, 2006; Strike, O'Grady, Myers & Millson, 2004).

Examples of techniques utilized by outreach workers may include motivational interviewing and the "Stages of Change" and "Drug/Set/Setting" models to guide their conversations with clients (Harm Reduction Therapy Centre, 2009). Common to these techniques are a commitment to matching interventions and counseling approaches with the client's unique situation, and supporting the client to take the lead in their own goal setting and attempts at change. For example, the Stages of Change model accepts relapse as a likely occurrence and learning opportunity, and allows the client to re-enter the process of change without judgment or punishment (Love, 2007). To understand why someone uses a drug and how it affects them, Zinberg (1984) developed the Drug-Set-Setting model in order to consider the drug(s) being used, the individual using the drug (the set), and the setting(s) in which they use it. Motivational interviewing is a technique that may be used to ground conversations in the client's own life experiences and develops their own motivations for change without imposing external agendas (Love, 2007).

The primary goals of outreach work in a harm reduction context are to ensure that people who use drugs are aware of the risks associated with doing so, to provide information to support them in reducing or eliminating those risks, and to provide support so that they may increase their own health and well-being (Strike, O'Grady, Myers, & Millson, 2004). To do so, relationship building between workers and clients is incredibly important: "Development of trusting

relationships is a core feature of successful outreach work” (Strike, O’Grady, Myers, & Millson, 2004, p. 217). People who use drugs are highly stigmatized and many have been, or continue to be, badly mistreated by various professionals and health care workers. Engagement with the people they serve must be the means by which outreach workers are able to fulfill their primary goals in working with clients. Without establishing some level of trust and relationship, the work of support, education and advocacy could not happen (Moore & Dietze, 2005). While including educational information in safer drug use supply packages is one way to spread health promoting messages, for example, face-to-face discussions between outreach workers and clients are critical in ensuring that such messages are understood (Grau, Green, Singer, Bluthenthal, Marshall & Heimer, 2009). “[O]nce clients develop a trusting relationship with the needle exchange, they often ask workers to assist with problems that others in the community cannot or will not address” (Strike, O’Grady, Myers, & Millson, 2004, p. 212).

Outreach workers are often the only service providers that people who use drugs connect with, and workers may feel driven to try and address a wider array of needs than they are required to.

In an Ontario study on needle exchange outreach workers, one worker explains:

[W]e’re the only people they saw so it was basically, well let me see what we can do and if we can help you out we can and if we can’t we’ll get you to someone who can kind of thing. So we found ourselves doing, you know, not necessarily just needle exchange (Strike, O’Grady, Myers, & Millson, 2004, p. 213).

Unfortunately, training and support for such “ad-hoc case management” is not often available to outreach workers who often operate in “hectic, chaotic and unpredictable contexts with few financial resources and little recognition” (Strike, O’Grady, Myers, & Millson, 2004, p. 217).

Outreach workers recognize that the complex circumstances experienced by people who use

drugs often necessitates that they go beyond the goal of providing information and support about safer drug use and safer sex. Factors such as mental health, poverty, homelessness, incarceration, violence, disease, and lack of social support converge in unique ways for each individual client, and thus outreach workers maintain that their role as a source of support should remain less structured than their actual job descriptions may be (Strike, O'Grady, Myers, & Millson, 2004).

In recent years, the standardization of work and neo-liberal modes of surveillance have impacted outreach work so that workers find themselves required to increase the documentation of their work and therefore spend less time with their clients (Baines, 2008). Much of the relationship building and referral work that outreach workers do may be unacknowledged or undervalued by funders (Strike, O'Grady, Myers, & Millson, 2004). Yet outreach workers commonly have strong beliefs in social justice and hold to their ethics in the face of neoliberal constraints such as funding cuts to health and social programs, surveillance, and the business-oriented organization of major funders. In a Canadian study of social services, workers in community, non-profit and activist organizations offered the most politically aware analyses and comprehensive potential solutions to social problems compared to managers and workers in more bureaucratic settings (Baines, 2006).

2.4 Contested Health Care

It is virtually impossible to dispute the merits of needle exchange programs given the abundance of evidence, research and scientific study supporting such services (for example, see Wodak & Cooney, 2005). Needle exchange programs prevent the transmission of HIV and other blood-borne pathogens and have not been found to encourage or increase drug use (Buchanan, Shaw,

Ford & Singer, 2003). Yet prohibitionist policy in Canada continues to be touted by the current Conservative federal government that views people who use illicit drugs “as criminal and deviant, rather than as individuals in need of harm reduction education and equipment, treatment, and social support” (Boyd, Johnson & Moffat, 2008, p. 27). Harm reduction remains largely misunderstood and contentious in mainstream Canadian society. Services such as needle exchange programs may be viewed as “enabling” drug use and are often blamed for larger social problems such as homelessness and poverty. In reality, such programs are only a small part of a much more complex system of harm reduction tools and techniques for addressing drug use.

The pervasiveness of a War on Drugs approach to addressing drug use, and the scrutiny of harm reduction approaches by members of the general public and local police forces have emerged from the reinforcement of such approaches by national governments and mainstream media. While outreach workers ground their work in human rights, rights-to-health, social justice and public health perspectives, outside scrutiny of their work is fuelled by outdated, ineffective and punitive approaches to illicit drugs such as Canada’s current “National Anti-Drug Strategy” implemented in 2007. The Strategy follows the example of the US War on Drugs approach to drug policy at a time when, ironically, many states in the US are starting to take a new approach that is more informed by health policy perspectives. The Strategy includes mandatory minimum sentences, fear-based media messaging, abstinence-based treatment and more funding for enforcement and policing, and leaves harm reduction out of the equation altogether (Government of Canada, 2010). These federal policy positions are exacerbated in BC by provincial policies that have led to sweeping cutbacks in social services, housing, education, and health care since the election of the Liberal government in 2001.

In a recent survey of over 900 studies and reports on links between human rights violations, vulnerability to HIV and people who use drugs, researchers note: “The dominant approach to drug use is the attempt to reduce or prevent the supply and use of controlled substances” including increased street-level policing (Jürgens, Csete, Amon, Baral & Beyrer, 2010, pg. 476). Yet worldwide, this approach has not been effective in decreasing crime or lowering the availability of illicit drugs, and has increased human rights abuses and health problems for people who use drugs (Jürgens et al., 2010). Local evidence in Vancouver has shown that a focus on law enforcement seems to have no impact in reducing illicit drug availability (Urban Health Research Initiative, 2009). Researchers there have declared the War on Drugs to be “an unmitigated failure” under which an illicit market has emerged “with an estimated annual value of US \$320 billion... [I]ncreased drug-law expenditures have not prevented the growth of this market; instead, a long-term pattern of falling drug prices and increasing drug purity and supply has been observed” (Wood, Werb, Marshall, Montaner & Kerr, 2009, p. 989).

A particularly damaging impact of a War on Drugs approach has been the reinforcement of a view of people who use drugs as a separate and deviant group from the rest of society (Lenton & Phillips, 1997). Opponents of needle exchange programs often ignore scientific evidence and base their beliefs on moral judgements of illicit substance use. They believe needle exchange programs to be representative of societal degeneration, a view which is often fuelled and reinforced by governments pursuing the War on Drugs (Buchanan et al., 2003). These judgments create barriers of fear, ignorance and discrimination towards people who use drugs and the health services intended to serve them (Buchanan et al., 2003). There is evidence to

show that public support for harm reduction is generally strong and that negative media coverage focusing on a small but vocal minority of opponents and inaccurate perceptions may be partially to blame for political posturing that has resulted in closures of needle exchange programs (Treloar & Fraser, 2007). Needle exchange programs have been closed in Australia, for example:

...in response to localized incidents and the opening of new services is considered a highly sensitive process requiring careful management in the anticipation of political and community opposition. Most other areas of health policy-making and health care delivery are not subject to the same constraints and scrutiny (Treloar & Fraser, 2007, p. 356).

In one Australian example, a needle exchange program was shut down after two young boys found some (wrapped and unused) syringes in a nearby playground. Media discourse often plays an important part in fuelling fear of disease transmission, and in this instance, highly personalized responses from local parents who were fearful and had little information about the actual risk for harm were featured in media reports (Broadhead, van Hulst, & Heckathorn, 1999a, b; Körner & Treloar, 2003). The perspectives of staff and clients of the needle exchange and of drug educators were absent in the media accounts, whereas politicians were given plenty of air-time. There is evidence in this situation that the media provided misinformation, promoted stereotypes of people who use drugs and undermined the community support for harm reduction programs (Körner & Treloar, 2003). Similarly, a critical discourse analysis of the media coverage of the Cormorant Street needle exchange in Victoria noted that Cormorant Street was branded by the media as an unsafe place, that people who use drugs in the area were portrayed in dehumanizing terms and as contaminated victims of disease, and that needle exchange programs were blamed for issues of “public disorder” (Langlois, Pauly, & Perkin, 2010).

“Public disorder”, in the case of illicit drug use, commonly refers to the gathering of people who use drugs on the streets, unsafe disposal of used needles and public drug use. These conditions create environments in which there is increased chance of needle sharing, rushed injections, overdose, and the potential for violence (Urban Health Research Initiative, 2009). The images of people on the streets publically using drugs are often what fuel negative media attention and increased pressure on policy decision-makers to “clean up” the situation. Despite scientific evidence supporting needle exchanges and other harm reduction services, politicians may not be willing to change “long-standing legal, public policy, and philosophical determinations that are embodied in current law” (Buchanan et al., 2003, p. 431). It has been suggested that perhaps politicians dismiss support for needle exchange programs because a “tough on drugs” approach may be more appealing, particularly for those who need to blame someone or something for unemployment and budget deficits (Treloar & Fraser, 2007). Yet health researchers and advocates argue that the lives of people who use drugs are at stake:

We cannot choose to use evidence only when it suits policy objectives and ignore it when it contradicts them. Nor can we discourage the collection of evidence base, using scientific methods, for initiatives that are politically unpopular... Once science has demonstrated the evidence-based outcomes for an efficacious medical treatment, then governments have a medical legal obligation to citizens and prospective patients to grant the legal authority to practitioners to provide them as part of the continuum of available treatments (Small, Drucker & Editorial, 2006, “Beyond Randomized Control Trials,” para. 4).

2.5 Impact of Closure of Facilities

Various studies have explored the impact of the closure of needle exchange programs and have primarily focused on the impact on people who use those services (Broadhead, Van Hulst & Heckathorn, 1999a, b; Körner & Treloar, 2003; MacNeil & Pauly, 2010). For example, a study of the closure of a needle exchange in Windham, Connecticut in 1997 reads similarly to what

happened in Victoria in 2008. The Windham needle exchange was blamed for the City's "drug problems", discarded syringes in the community and even the economic decline in the region (Broadhead, Van Hulst & Heckathorn, 1999b). A Windham City Council member even went so far as to claim that "the needle exchange is one gear in the big drug addiction machine. By allowing its presence here, we're condoning and enabling drug use" (Broadhead, Van Hulst and Heckathorn, 1999b, p. 441). The study found that after the exchange was closed, people who had used the service had more difficulty accessing clean supplies and that their sources for supplies were unreliable, that there was a higher rate of re-using and sharing of drug use equipment, and that there was no decrease in the amount of discarded syringes in the community. The drug scene in Windham remained large and active after the closure (Broadhead, Van Hulst and Heckathorn, 1999a, b).

Similarly, participants in a study about the impact of the closure of Victoria's fixed site needle exchange reported an increase in re-use of their needles after the closure and that a street trade in needles had emerged (MacNeil & Pauly, 2010). A key theme explored in this study was what the fixed site had meant to participants. They described the fixed site as a positive, safe place and symbol that someone cared about them (MacNeil & Pauly, 2010). In contrast, after the exchange was shut down "the move to mobile only services did not facilitate the development of trusting relationships nor provide the same opportunities for access to referrals not only to nursing and counseling services, but to income and housing supports" (MacNeil & Pauly, 2010, p. 6).

In New South Wales, Australia, similar findings were documented following the closure of a fixed site needle exchange and the switch to mobile services only. Outreach workers described the change in service delivery: “we were a good first point of contact to a range of health services...It’s just as seedy as a drug deal now. We’re [parked] in a paddock and [clients are] looking behind, over their shoulder...[they] pick up their equipment...and take off” (Southgate, Blair & Hopwood, 2000, p.38). People who used the needle exchange services also indicated that they felt rushed when accessing the new mobile services and that they felt exposed to the public and the police. They noted that they did not feel as though they were able to talk to the outreach workers for any length of time and that they were not able to access the kind of information they needed for referrals. A worker described their perspective on this:

At the [fixed site] it was good being able to sit somewhere in a space when the client is in crisis or in need, and you can give them a cup of tea...and they can just have that space, five or ten minutes and go from there...I feel that the real core...has gone. They’ll come up [to the van], they’ll have a bit of a yarn and stuff, but they’re looking over their shoulder. They’re looking behind [and then] they’re gone (Southgate, Blair & Hopwood, 2000, p. 35).

Workers also reported losing contact with certain groups such as Aboriginal clients, younger clients, steroid users and people who were employed. The time that they used to spend with clients shifted to stocking secondary services with supplies and supporting other workers at secondary sites. Workers also reported concerns about the loss of control of their work space when working from a vehicle, and that there were limited facilities, such as washrooms, for staff to access while on the job. Staff reported feeling angry and disempowered by the changes to service provision and felt the loss of not being able to connect with their clients (Southgate, Blair & Hopwood, 2000). The study found that “the views of workers and clients on diminished quality of service were almost identical” (Southgate, Blair & Hopwood, 2000, p. 37).

2.6 Stigma

In a recent study on the impact of the closure of Victoria's fixed site needle exchange, the majority of participants identified that they had experienced trauma, physical pain, and abuse in childhood and/or adulthood (MacNeil & Pauly, 2010). This is consistent with the idea that many people who use illicit drugs do so as a coping mechanism to address ongoing physical, emotional and spiritual pain. This pain is further reinforced by the stigma associated with visible illicit drug use. In her research on Canadian women and illicit drug use, Boyd (1999) described how the women she interviewed felt that they were "perceived as 'addicts' rather than as individual women who use illicit drugs, and their humanity was obscured" (pg. 51).

Nowhere is the social element of illness more unmistakable than in the life world of people living with addiction, and their families, where their social being is as much under threat by the tarnishing effects of a disparaging society as their physical being by the hazards of unhealthy drugs and unhygienic needles (Small, Drucker, & Editorial, 2006, "An Exit Strategy," para. 7).

Stigmatization is a process by which some people are socially constructed as acceptable and others as unacceptable (Strike, Myers, & Millson, 2004). Stigma may include labelling, stereotyping, discrimination, loss of status and isolation (Phillips, 2010). It is a significant barrier to accessing health care services and reinforces the feelings of negative self-worth that stigmatized individuals experience (Parr & Bullen, 2010). People who use drugs are often blamed for their own drug use and therefore, responsible for their own stigma, leading to further stigma (Lloyd, 2010). Moral concerns about enabling (visible) drug use and fears of social degeneration are interconnected with the stigma associated with being a person who uses illicit drugs (MacNeil & Pauly, 2010).

Stigma and place come together in a phenomenon known as “Not In My Back Yard” or “NIMBY” (Strike, Myers & Millson, 2004). Some people may feel threatened when those who are visibly poor cross the spatial boundaries of their social, political and economic lives and threaten their sense of self, community and neighbourhood (Strike, Myers and Millson, 2004; Tempalski & McQuie, 2009). NIMBY tactics have emerged from, and further fuelled, stigmatizing attitudes towards people who use drugs and the services intended to support them (Tempalski & McQuie, 2009) and have impacted “the effectiveness and reach of health and harm reduction services” (Shannon, Rusch, Shoveller, Alexson, Gibson, & Tyndall, 2008, p. 140). While Boyd’s (1999) research participants suggest that stigma has no class boundaries when related to illicit drug use, people who use drugs and who also live in poverty are more likely to experience stigma in the form of NIMBYism and police regulation, for example, because they are more visible (Boyd, 1999). “[W]hether one is a visible or a non-visible illicit drug user...[t]he barrage of negative images reinforces both stereotypes and harsh drug policy and legislation” (Boyd, 1999, pg. 56-7). In general, it is still socially acceptable to act on negative stereotypes towards illicit drug users by demanding that *they* and the services intended to support *them*, are Not In My Back Yard.

When people who use drugs are prevented from accessing the support and clean supplies they need to keep themselves as safe as possible while using drugs, risk environments may be produced. Risk environments are social and/or physical spaces where a number of factors interconnect to increase the chances of harm related to drug use. This “social production of risk” (Duff, 2010, p. 337) or “social construction of a public health hazard” (Broadhead, Van Hulst & Heckathorn, 1999a, p. 50) has real potential impacts on the ability of people who use drugs to

practice harm reduction. Without changing policies and practices to alter the socio-structural conditions that marginalize people who use drugs, and thereby reinforce street-based drug use, drug-related harm will continue (Moore & Dietze, 2005). For example, policies that restrict the ability of people who use drugs to access clean supplies when and where they are needed, or police crackdowns in areas where many people who use drugs are doing so publicly, increase risk behaviours such as needle sharing and rushed drug use which may lead to overdose or other preventable health complications such as abscesses (Shannon et al., 2008).

In contrast, policies and practices may also foster enabling environments, or places that have access to and encourage the production and circulation of resources that support and promote health and well-being (Duff, 2010). Rather than increasing police presence solely for the sake of surveillance, and rather than restricting the access of people who use drugs to health and social supports, enabling environments for people who use drugs would include spaces and services such as drop-in centres, needle exchange programs, supervised consumption sites and other places to access support and information. The impacts of stigma may often be reduced when people who use drugs are given the opportunity to build trusting relationships with outreach workers (MacNeil & Pauly, 2010). “Creating enabling environments might allow drug users to put into practice some of the harm reduction measures disseminated in education campaigns” (Moore & Dietze, 2005, p. 279). Additionally, enabling environments are places in which people who use drugs could be engaged by other community members rather than pushed away, and places where hope rather than fear could be cultivated. “To feel hopeful about one’s prognosis is to more assertively seek treatment offered and work more assiduously on one’s

recovery” (Duff, 2010, p. 341). When we reinforce stigma, we remove hope and only exacerbate the further potential for harm to individuals and communities.

The clients of needle exchange and other harm reduction programs often struggle with the impacts of stigma and finding acceptance in their community. Workers in such programs may also face similar challenges as stigma may impact people associated with stigmatized individuals. This form of stigma has been referred to as “courtesy stigma,” “stigma-by-association,” or “associative stigma” (Phillips, 2010). Similar to courtesy stigma, “vicarious stigma” describes the distress experienced by people witnessing the negative impacts of stigma on individuals they are close to and care about (Corrigan & Miller, 2004). Stigma in any form may lead to feelings of isolation and loss of support which may in turn develop into health impacts from exposure to chronic stress (Lloyd, 2010; Phillips, 2010).

Concerns about “dangerous” clients, contaminated injection equipment, and the presence of stigmatized individuals may prevent needle exchange clients and workers from being welcomed into organizations and communities (Strike, Myers & Millson, 2004). Some organizations may feel that the inclusion of needle exchange services as a primary or secondary purpose may change their identity and many still regard such programs as marginal. In a study about needle exchange outreach work in Ontario, researchers discovered that outreach workers had been verbally harassed by community members while on the job, and that some people had even hit the mobile needle exchange vehicle with their fists as the vehicle was stopped at stop signs or red lights (Strike, Myers & Millson, 2004).

2.7 Outreach Workers in Moral Distress

Common values held by outreach workers include “social justice, dignity and worth of person, importance of human relationships, integrity, and competence” (Selznick in Buchanan et al., 2003, p. 438) as well as the foundational belief that people who use drugs are worthy of basic health care services that have also been proven to help prevent the spread of disease (World Health Organization, 2004). Yet some people hold strong moral judgments and stigmatizing views of people who use drugs, and they call into question the merit and value harm reduction services. In the nursing field, the concept of moral distress has been defined as “*a painful feeling and/or psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires but cannot carry out that action because of institutional obstacles*” (O’Donnell et al., 2008, p. 34). For example, when a harm reduction service is shut down because of moral opposition by the community, outreach workers are put in the stressful situation of being unable to provide the life-saving health services that their clients rely on and unable to act upon the information and experience they have with regards to reducing drug-related harm for people they know and care about. The majority of research about needle exchange programs points to the need for greater accessibility of such services for people that use the programs (Tomolillo, Crothers & Aberson, 2007). In contrast, accessibility to needle exchange has been further and significantly restricted in Victoria due to the closure of the fixed site needle exchange and the severe limitations of the mobile service. Outreach workers in Victoria find themselves as part of a public health care system that has decreased the accessibility to safer drug use supplies and supports rather than creating enabling environments which foster health and well-being for people who use drugs.

When outreach workers “face constraints on their ability to practice ethically and feel forced to compromise professional values and standards of practice they may experience moral distress” (Pauly, Varcoe, Storch & Newton, 2009, p. 561). Outreach workers most commonly face ethical dilemmas when there are conflicts between their obligations to clients’ rights and their responsibilities to their employer which may, in turn, be restricted by the requirements of their funders (Papadaki & Papadaki, 2008). When workers feel that they are unable to “do the right thing” in their workplace, such value conflicts can lead to significant stress (O’Donnell, Farrar, BrintzenhofeSzoc, Conrad, Danis, Grady, Taylor & Ulrich, 2008). Ethical compromise and moral distress impacts job satisfaction and may bring on feelings of anger, frustration, anxiety. Further reactive stress symptoms such as depression, headaches and feelings of worthlessness may emerge if initial symptoms of distress are not acted upon. Such experiences may further lead to absenteeism, poor staff morale and high turnover (Kälvemark, Höglund, Hansson, Westerholm & Arnetz, 2004; Lloyd, McKenna & King, 2005; O’Donnell et al., 2008). While workers are likely to express resistance in various forms, they may not risk “breaking the rules” if it was to put their organization at risk and they may rely on their co-workers as primary supports (Kälvemark et al., 2004; O’Donnell et al, 2008). This is concerning when workers face situations that cause stress throughout the entire staff team, such as public contestation of the work they do.

The language of “burnout” tends to reinforce the individualization of moral distress, when really what is happening to the worker is a response to social injustice (Reynolds, 2009). When workers are able to “work in accord with their ethical stance, sustainability becomes possible. But social structures and limited resources, which force [workers] to work in ways that go

against their ethics, result in spiritual pain” (Reynolds, 2009, p. 6). Individual coping strategies are simply not enough, and organizations must provide support to their workers in a manner by which social justice perspectives and exploration of solidarity practices and resistance may foster a sense of collective ethics (Kälvemark et al., 2004; Reynolds, 2009). Through collective ethics and solidarity practices, outreach workers may sustain themselves in the important work they do (Reynolds, 2009).

Chapter 3: Research Design

3.1 Intentions for the Research

My research is framed by values expressed in anti-oppressive and feminist research including social justice, working for change, community building, researcher reflexivity, and the privileging of “experiential” voices (Coy, 2006; Potts & Brown, 2005). I am drawn to feminist inquiry in its assertion that knowledge and experience are inseparable (Ramazanoğlu & Holland, 2002). I honour the everyday experiences of SOS outreach workers and the knowledge they acquire and produce through their working relationships with the people who use their services. My interest in this research was partially fuelled by frustration and curiosity about how health policy can be so greatly removed from the knowledge of people directly impacted by it. My intention was to make space for outreach workers to share their experiences and to explore how contradictions and fissures between policy and practice impact their work.

Feminist inquiry calls attention to multiplicity, to layering and multi-faceted knowledges (Ramazanoğlu & Holland, 2002). Not all outreach workers have the same experience and their knowledge is diverse, complex and not spoken in a singular voice. I am interested in sharing a story that weaves together multiple voices that are not often heard in the public and media debates about public health services for people who use illicit drugs. My intention is to uncover not one unified voice, but to give space for outreach workers to express how they make meaning of their experience. This space for meaning-making is critical to creating opportunities for people to work together for change. Scientific evidence is often used by harm reduction advocates to argue for policy change and they are often opposed by those who have no interest in rational and analytical information. Instead, the struggle is often rooted in the meaning that is

made around concepts, ideas and beliefs. Individuals may be motivated to come together for collective action when meanings of experiences are shared; my hope is that in offering space for outreach workers to share their experience, further possibilities for collective action will emerge.

3.2 Choosing Methodology

As I considered my focus for this thesis, I was curious to explore the experiences of my co-workers regarding the closure of the Cormorant Street needle exchange site and the implications of this event for our work, and I also wanted to have some part in documenting the eviction of our program and loss of services. My standpoint as an outreach worker and my interest in these twin goals of exploration and documentation of a very particular “case” led me directly to case study methodology.

3.3 Case Study Methodology

My decision to explore this case preceded my inquiry into methodological options. Stake (2005) argues that “case study is not a methodological choice but a choice of what is to be studied” (p. 443). It is the case that is of particular interest, and methods of inquiry follow from the choice of what to study. “Good social science is problem-driven and not methodology-driven, in the sense that it employs those methods that for a given problematic best help answer the research questions at hand” (Flyvbjerg, 2004, p. 432). My primary goal in this research was to explore the perspectives of my co-workers regarding the issues that I personally was grappling with related to the SOS eviction and the resulting changes to our work practices and our relationships with our clients and the community. Qualitative case studies include “thick descriptions,” “experiential understanding[s]” and the multiple perspectives that I wanted to begin with (Stake, 1995, p. 43).

An advantage of qualitative case study methodology is its ability to focus on real-life situations and allow the reader to experience the phenomena vicariously (Donmoyer, 2000; Flyvbjerg, 2004). As a researcher-participant, I am able to develop and describe a deeper understanding through my placement “within the context being studied” (Flyvbjerg, 2004, p. 429). Harm reduction services provision is a contentious context for some, and my intention in this research is to invite curiosity and open-mindedness. A case study approach fits well with this intention in its quality of vicariousness that “is less likely to produce defensiveness and resistance to learning” (Donmoyer, 2000, p. 65).

Case studies “can bring about the discovery of new meaning, extend the reader’s experience, or confirm what is known” (Merriam, 2001, p. 30). Qualitative case studies

focus on a particular situation, event, program, or phenomenon ... This specificity of focus makes it an especially good design for practical problems - for questions, situations, or puzzling occurrences arising from everyday practice (Merriam, 2001, p. 29).

In qualitative research literature, case studies are referred to as method, research design, strategy of inquiry, tradition, as well as methodology (Creswell, 1998; Hammersly & Gomm, 2000; Merriam, 2001; Stake, 2005). Yin (1994) describes case study in a manner that is perhaps most relevant to this thesis work: “A case study is an empirical inquiry that investigates a contemporary phenomenon with its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (p. 13). How SOS workers experienced the eviction of their program and the changes to their work are intermeshed with the local context in which this phenomenon occurred. I was interested to explore how the experiential knowledge held by the research participants interacted with the political, social, historical and personal

contexts of the case in order to understand the case as a microcosm and barometer of what is going on more generally (Gomm, Hammersley & Foster, 2000).

3.4 A Unique Case

Case studies may include one or more cases. The rationale for a single case study includes the extreme or unique nature of the case and the researcher's belief that there is something to be learned from the case that the reader needs to know (Stake, 2005). The complexities of special interest cases may be uncovered by delving into a case in some detail. Stake (2005) makes the distinction between instrumental and intrinsic case studies. Instrumental case studies provide insight into an issue and hold the case itself as a secondary interest that facilitates further understanding of something else. Intrinsic case studies make the case the most important element and "try to discern and pursue issues critical to [it]" (Stake, 2005, p.4). In this research, the case of the closure of the Cormorant Street needle exchange is the intrinsic case and the experiences of outreach workers in this context is made the critical issue. Intrinsic case studies aim to understand the relationships, the issues and the data. There is no line in the sand between intrinsic and instrumental case studies; rather case study researchers have a common purpose of presenting the case itself for the interest of the reader and generating further interest in what often are emerging issues (Stake, 2005). My broader interest is in the stigmatizing and marginalizing of drug users and the programs intended to address their needs. I agree with some case study researchers who suggest that the goal of their work is not to produce general conclusions or theory but that the "case story is itself the result. It is a 'virtual reality'...[and] the payback is meant to be a sensitivity to the issues at hand that cannot be obtained from theory" (Flyvbjerg, 2004, p. 430).

3.5 Elements of a Case Study

Case study methodology is instructive in the common elements usually included in a final report, which generally features complex descriptions, narrative writing style influenced by data that is often gathered by personal observation among other methods, and a focus on understanding the case rather than developing hypotheses (Stake, 2000). Case studies⁶ also generally include, but are not limited to: vignettes to provide a vicarious experience for the reader; the typical components of most research reports such as objectives, issue identification and literature review; contextual information that situates the case physically, socially, historically; field procedures and data collection, extensive narrative description; and chronologies of major events (Creswell, 1998; Stake, 1995; Yin, 1994). Key to case studies is their use of multiple sources of data which may include two or more of the following: archival records, interviews, direct observation, participant-observation, physical artefacts, audio-visual, reports, media, correspondence, minutes, narratives, etc. (Yin, 1994; Stake, 1995).

3.6 Methods

Case study methodology is useful in exploring cases that are of special interest because it emphasizes “in-depth data collection involving multiple sources of information rich in context” (Creswell, 1998, p. 61). In this case study I have used observations and analysis of documents and media to supplement data acquired in semi-structured interviews. These four sources of information ensure that the case is described from multiple angles.

⁶ In addition to referring to the research design, the term ‘case study’ may also be used to refer to a final report.

3.6.1 Observation

I have been employed as a casual outreach worker with SOS since 2004. Between 2008 and the present time, my shifts with SOS have been the most consistent and regularly-scheduled (approximately 2-3 shifts per week). I did not accompany my co-workers for separate specific observation shifts; however while working, I have been able to add a new layer of awareness of my work as a researcher.

There is no particular moment when data gathering begins. It begins before there is commitment to do the study ... A considerable proportion of all data is impressionistic, picked up informally as the researcher first becomes acquainted with the case (Stake, 1995, p. 49).

My observations have been gathered informally not only as an SOS employee, but also through my work with other local harm reduction organizations including the Society of Living Intravenous Drug Users (SOLID) and Harm Reduction Victoria (HRV). SOLID is an organization run by and for people who use illicit drugs and my work there has been as an educator and providing program support. HRV is a grassroots collective formed in response to the eviction of SOS and has used research, education and action tactics to advocate for people who use illicit drugs in Victoria, particularly those living in poverty. In all of these roles, my observations allowed me to provide descriptions of the fixed site on Cormorant Street and surrounding areas, and descriptions of the mobile service that informed my analysis of the contextual and narrative data.

3.6.2 Document and Media Analysis

Victoria has a wealth of local knowledge of harm reduction approaches to illicit drug use and a recent history of well-researched reports that call for enhanced harm reduction services as a critical component of addressing homelessness, mental health, addictions and poverty in the

Greater Victoria area. Increased access to safer drug use supplies and the establishment of supervised consumption services have been identified consistently over the past 10 years in Victoria as necessary steps to reducing the harms related to illicit drug use.

Earlier local reports analysed include “Missed Opportunities: Putting a Face on Injection Drug Use and HIV/AIDS in the Capital Health Region” (Stajduhar, Poffenroth & Wong, 2000), “Serving the Homeless: Social Agencies in ‘The Red Zone’” (Downtown Service Providers Group, 2003), “A Report on the City of Victoria’s Harm Reduction Information Sessions” (Jones & Hagen, 2005), and “Fitting the Pieces Together: Towards an Integrated Harm Reduction Response to Illicit Intravenous Drug Use in Victoria, BC” (City of Victoria, 2005). On the global scale, I examined information from “Evidence for Action Technical Papers: Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users”, a 2004 publication of the World Health Organization. Nationally, the Canadian HIV/AIDS Legal Network (2005) published a policy document that has been critical to my understanding of how harm reduction services must be operated: “Nothing About Us Without Us: Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative.”

Other pertinent reports included two publications in 2006 by the Public Health Agency of Canada and their local partner, the Vancouver Island Health Authority (VIHA). Both reports detailed the results of an ongoing research initiative called I-Track, which monitors HIV and hepatitis C prevalence and risk behaviours among illicit drug users across Canada. That same year, VIHA published their strategic plan related to HIV/AIDS and hepatitis C entitled, “Closing

the Gap: Integrated HIV/AIDS and Hepatitis C Strategic Directions for Vancouver Island Health Authority, 2006/07-2008/09”.

Links between housing supports and harm reduction were repeated clearly in two 2007 reports: “Housing First- Plus Supports” (Victoria Cool Aid Society) and the City of Victoria’s “Mayor’s Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness”. Provincial policy documents were helpful to me in clarifying BC’s support for harm reduction, at least on paper: “Understanding Harm Reduction” (British Columbia Ministry of Health, 2007), “BC Harm Reduction Strategies and Services Policy and Guidelines” (British Columbia Centre for Disease Control, 2009), and “Best Practices for British Columbia’s Harm Reduction Supply Distribution Program” (Chandler, 2008).

Calls for supervised consumption services in BC came from the University of Victoria in “The Case for a Supervised Drug Consumption Site Trial in Victoria, British Columbia” (Fischer, Kendall & Allard, 2008) and were supported by the Health Officers Council of BC (2008) in “Resolution 2008: Supervised Injection Services”.

An evaluation of Vancouver Island harm reduction services produced by University of Victoria nursing researchers shortly after SOS transitioned to mobile services was helpful for adding to local context (Pauly & MacNeil, 2008).

Local and national newspaper articles chronicling the closure of the Cormorant Street site and the transition to mobile services only, also provided context for what research participants shared

with me about their own experiences. Articles related to Street Outreach Services between 2007 and 2010 from Canada's two national newspapers, the *National Post* and the *Globe and Mail*, from Victoria's major newspaper, the *Times Colonist*, and from Victoria's news and entertainment weekly newspaper, *Monday Magazine* were included in contextual data analysis.

3.6.3 Interviews

I conducted six semi-structured interviews with SOS outreach workers, including myself. I interviewed myself using the same questions and methods for analyzing the data. This approach enabled me to provide a structure for the inclusion of my own experiences, perspectives, and observations as an outreach worker.

Two principle uses of case study are to obtain the descriptions and interpretations of others. The case will not be seen the same by everyone. Qualitative researchers take pride in discovering and portraying the multiple views of the case. The interview is the main road to multiple realities (Stake, 1995, p.64).

I was able to easily recruit participants because they were all my co-workers, and I used purposeful sampling based on the specific attributes of the participants. I invited three people (including myself) who were hired by SOS before the closure of the fixed site needle exchange, and three people who were hired after the closure. My intention was not to conduct a 'compare and contrast' analysis but to ensure that I included the perspectives of outreach workers from both groups. In inviting outreach workers to participate, I took into account their educational and practice backgrounds in order to include the perspectives of individuals with both formal and informal education and experience. All of the outreach workers I invited to participate agreed to do so.

3.7 Ethical Considerations

A commitment to critical reflexivity guides my conduct as a researcher. I acknowledge the dual role that I play as a researcher investigating my own experiences and the experiences of my co-workers. I am clear about the fact that I deeply believe in my work and have a great appreciation and respect for my co-workers because of their own convictions and commitment to doing work that is stigmatized and contested. I am aware of this strong bias and do not attempt to shield the reader from these personal perspectives. However, I have taken care to follow case study methodological guidelines, to respect ethical tenets of critically reflective research, and to include the perspectives of my fellow participants when they have not aligned with my own. “Our problem is to make sure that, whatever point of view we take, our research meets the standards of good scientific work, that our unavoidable sympathies do not render our results invalid” (Becker, 1970, p. 214).

When I was recruiting potential participants, I contacted them in person and/or by e-mail and from our very first conversations about the research, I assured them that their participation was voluntary and in no way would impact their employee status or treatment by AVI management. I am not in a managerial role however I do have relatively high seniority on the casual list and am one of the most long-standing employees amongst the current staff team. Nevertheless, this research was conducted independently of AVI, was not conducted during mine or my fellow participants’ work hours and the names of the participants have not, and will not, be shared with anyone. Despite the fact that they will not be guaranteed anonymity due to the small number of staff members, I was able to assure some level of confidentiality through the use of pseudonyms. The interview guide focuses on illuminating the experiences of workers through descriptions of

typical days at work before and after the closure of the fixed site needle exchange and it was made clear to participants that I was not interested in judging the quality of their work. My “insider” status as a researcher-participant has allowed me to be more in-tune with issues of confidentiality because I have an intimate knowledge of the work and the dynamics that have played out within the organization and between the organization and other parties; I thus have an informed gauge of what information is meant to be kept confidential within the organization. As a researcher with “insider” privileges, I have approached the analysis of interview data with humbleness and critical reflexivity in recognizing that my own experiences do not define the experiences of others (Smith, 2006).

3.8 Data Analysis

“Of all the roles, the role of interpreter, and gatherer of interpretations, is central. Most contemporary qualitative researchers nourish the belief that knowledge is constructed rather than discovered” (Stake, 1995, p. 99). As a gatherer of interpretations, my most central role in this research is to facilitate the co-construction of new understandings. The conceptual foundation of this research lies in the issues related to the case which deepen our understanding of the coded data from the interviews and the context acquired from observation, document and media analysis (Stake, 1995).

I transcribed the recorded interviews myself. I then followed the methodological recommendation of “member-checking” and sent each of the participants a transcription of their interview for corrections and feedback. I received very minimal feedback, but clear support, from all participants to proceed with the data analysis. I reviewed the transcriptions through several close readings, arranged the data into common themes, and paid attention to where the

data fit into any particular moments that I could identify along the chronology of events regarding the closure of the fixed site needle exchange (Patton, 2002). As a participant in the research, I had some assumptions about what themes might emerge from the interviews with my fellow participants, but I was careful to watch for content that did not fit into the themes that I had anticipated.

Ultimately, the interpretations of the researcher are likely to be emphasized more than the interpretations of those people studied, but the qualitative case researcher tries to preserve the multiple realities, the different and even contradictory views of what is happening (Stake, 1995, p.12).

One participant focused quite extensively on a theme that was not as prominent in any of the other interviews. In order to “preserve the multiple realities”, I included the participant’s comments in the findings of the research, though not as a major theme. My goal for the data analysis was not in theory generating, but rather understanding the issues from the perspectives of different workers.

The real business of case study is particularization, not generalization. We take a particular case and come to know it well, not primarily as to how it is different from others, but what it is, what it does. There is emphasis on uniqueness, and that implies knowledge of others that the case is different from, but the first emphasis is on understanding the case itself (Stake, 1995, p. 8).

While some argue that generalizable, theoretical knowledge must be a key contribution of research, there is also value in the accumulation of concrete, practical knowledge in a given field (Flyvbjerg, 2004). The concept of “naturalistic generalization” is more fitting to this research than the more rational generalization associated with scientific discourse because it emphasizes the intuitive, the empirical, and is “based on personal direct and vicarious experience” (Lincoln & Guba, 2000, p. 36). Nevertheless, it is my intention that this research may be of some interest

to evaluators, policy-makers, and health and social services providers, and therefore it is worth considering the extent to which the implications of my findings may fit with other situations.

3.9 Strengths and Limitations

This research project is limited by the time constraints and resources of a Masters program.

Were there more time and funding available to me, the project could be widened in scope. While this project focuses on the experiences of a small number of outreach workers at a local non-profit organization, the themes that emerge from this study may well be of interest and relevance to other people working in the outreach and harm reduction fields, and particularly with workers from needle exchange programs. The impacts of the disconnect between the experience and knowledges of outreach workers and the policy that regulates their work will hopefully find resonance across a wider audience. My intention with this work is to “assist readers in the construction of knowledge” and to open the possibilities for policy intervention that affects social change, even at a local level (Stake, 2005, p. 454).

Chapter 4: Contextual Findings

My observations and experience of the unfolding SOS story and my reading of local reports and media coverage inform the political, social, historical and personal context presented in this chapter and set the stage for the interview data in Chapter 5.

4.1 Support for Expanded Harm Reduction Services in Victoria

In 2000, a report published for the Capital Health Region (CHR) entitled “Missed Opportunities: Putting a Face on Injection Drug Use and HIV/AIDS in the Capital Health Region” found that there had been a marked increase in injection drug use within the CHR over the previous five to ten years, and along with it, an increase in overdoses, overdose deaths and blood borne infections. The report noted that “[T]here is a lack of services for drug users who do want to protect themselves. The single fixed Needle Exchange site with its limited hours of operation cannot meet the needs of its clients” (Stajduhar, Poffenroth & Wong, 2000, p. v). Notable recommendations in the report included a comprehensive harm reduction strategy including fixed site needle exchange services with expanded hours and the full gamut of safer drug use supplies, an outreach component for youth and adults including social workers and nurses, mobile harm reduction services, and satellite needle exchange sites in all health units as well as select businesses and pharmacies. Further, the report recommended that planning and development of a supervised injection facility should be initiated, including “active participation by the community and by injection drug users” (Stajduhar, Poffenroth & Wong, 2000, p. 69).

Momentum would build in subsequent years to carry out the recommendations of the 2000 report. The Downtown Service Providers Group, a coalition of organizations serving

marginalized populations in the downtown core, called for increased harm reduction services, including supervised consumption services (Downtown Service Providers Group, 2003). The City followed up in 2004 by endorsing a harm reduction policy framework and by co-hosting a series of public consultations with VIHA regarding harm reduction services (Jones & Hagen, 2005). In 2005, the City of Victoria released a new report entitled “Fitting the Pieces Together: Towards an Integrated Harm Reduction Response to Illicit Intravenous Drug Use in Victoria, BC”. The report was developed in consultation with VIHA, the Victoria Police Department, service providers and drug users and echoed the 2000 CHR report (Stajduhar, Poffenroth, Wong, 2000) by calling for comprehensive harm reduction services including access to safer drug use supplies 24 hours each day, the piloted distribution of crack pipes, and the development of a plan for supervised consumption services. Calls for supervised consumption services continued in 2006 when the Public Health Agency of Canada and VIHA released the results of their I-Track survey of people who use injection drugs. In Victoria, it was reported that the street was the most common place for a high proportion of people to inject, with 68 percent of surveyed individuals injecting in a public place in the last six months (Public Health Agency of Canada, 2006; Vancouver Island Health Authority, 2006).

By 2007, a significant body of evidence had accumulated in Victoria regarding homelessness, mental health, addictions, and the need for comprehensive harm reduction services for people who use illicit drugs, and the reports continued to be published. The “Mayor’s Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness” report was published in October 2007 by the City of Victoria, less than a year prior to the closure of the Cormorant Street needle exchange. The report recommended “strengthen[ing] harm reduction services to help

mitigate public health and public order issues; in particular, investigate ... indoor supervised consumption sites and services” (p.15).

4.1 Manufacturing Victoria’s “War Zone”

The year 2007 also saw a different kind of response in Victoria regarding homelessness, needle exchange, and what was being referred to as “public disorder.” Media headlines included inflammatory language about the Cormorant Street “war zone,” a “tribe-like” group of “junkies” taking over the City, and calls to “take back our streets!” Stewart Johnston, a lawyer with offices on Cormorant Street, published a commentary in the *Victoria Times Colonist* describing his disgust with “hardcore junkies” whom he referred to as “the effluent” flowing from the exchange (Johnston, 2007). He made the distinction between individuals he identified as being homeless versus other individuals he identified as being “hardcore intravenous users who live in a homeless tribal culture.” The *National Post* published an article entitled “Disgusted in Victoria” in which it was described how “junkies, panhandlers and drunks” were scaring tourists away (“Disgusted in Victoria,” 2007). The exchange was demonized in the media and blamed for issues that were actually the result of a lack of services, supports and housing for a very marginalized population of people who use drugs. “Cormorant Street” became a catchphrase used by those who were convinced that the exchange had caused the deterioration of the downtown core.

A common myth plaguing needle exchange programs is that they attract people who use drugs to the neighbourhoods in which they’re located, yet evidence from around the world contradicts such claims. Needle exchanges are a public health response to areas of high illicit drug use and to be most effective, they must be established where people who use drugs live and use or buy

drugs (Williams & Ouellet, 2010; World Health Organization, 2007). The World Health Organization (2007) emphasizes that for people who use drugs, “[a] convenient location is probably the most important feature of a fixed-site” (p. 12). Drug markets are strong in particular neighbourhoods, and this is not caused by needle exchange programs, but rather the context of the drug market, including the fact that it is a source of income for people living in poverty (Williams & Ouellet, 2010). People who use drugs often serve as societal scapegoats, as symbols of larger societal problems, but harm reduction programs alone cannot address structural inequities that feed violence, health problems and poverty (Bungay, Johnson, Varcoe and Boyd, 2010; International HIV/AIDS Alliance, 2010). Particularly concerning is the fact that negative attitudes towards people who use drugs, often fuelled by sensationalist media stories such as those seen in Victoria in 2007, have the ability to impact decision makers and complicate what is an often cumbersome process of needle exchange policy and practice thanks to the varied social, political and moral perspectives of people who consider themselves stakeholders (Australian Injecting and Illicit Drug Users League, 2010).

4.2 Under Pressure

In January, 2007, VIHA announced that it would cut over one-third of its funding for HIV and hepatitis C programming in Victoria in order to re-distribute the funds to other regions on Vancouver Island, but promised a one-time grant of “transitional funding” to allow AVI and other Victoria organizations to adjust. AVI was feeling a significant amount of pressure; client numbers had tripled since the last time the organization had received an increase in funding, and now its funds would be cut back even further. Clients spilled out of the small space on Cormorant, the only evening drop-in space in the City. A survey of Victoria’s homeless population conducted in 2007 found that over 1200 people were homeless in Victoria and that

41% of those surveyed cited alcohol or drug use as a contributing factor to their inadequate housing situation (Victoria Cool Aid Society, 2007). People who used the exchange were being blamed for their own poverty, homelessness and addictions in a provincial climate where 13% of the population lived in poverty (the highest rate of poverty in Canada), rental vacancy rates hit an all-time low, and waiting lists for limited social housing were impossibly long (Canadian Centre for Policy Alternatives, 2008). AVI announced in March, 2007 that it intended to move the needle exchange program and was seeking additional funds to cover the costs of the move and the additional space and facilities required to accommodate client numbers. VIHA responded by abdicating responsibility for covering any moving costs (“Needle exchange,” 2007). By April, finding a new location was proving to be difficult for a number of reasons including zoning restrictions and neighbourhood opposition to needle exchange services. The damage of financial neglect and media sensationalism had been done, and no one wanted another “Cormorant Street” in their backyard.

In July 2007, Mr. Johnston and fifteen other Cormorant Street businesses and residents filed an injunction lawsuit against the BC Ministry of Health, VIHA, AVI and AVI’s landlords, Yentl Properties, to seek a temporary injunction to have the exchange moved or shut down. By October, 2007, the pressure on the exchange became too much for AVI’s landlord and the organization was given a one-month notice to “clean up” or face eviction in six months time. In response, VIHA ordered a \$12,000 external review of the exchange and then conceded an additional \$125,000 in one-time funding to hire an additional staff person. VIHA also announced \$7.6 million in additional services in Victoria to address mental health, addictions and homelessness issues in response to the “Mayor’s Task Force on Breaking the Cycle of

Mental Illness, Addictions and Homelessness.” The funds were to support the creation of new outreach teams, support existing detoxification and housing programs, and support the development of the new interdisciplinary ACCESS Health Centre, of which AVI is a partner. For the exchange however, these funds came years too late.

In March 2008, VIHA purchased a building on Pandora Avenue, only blocks away from AVI’s site at Blanshard and Cormorant, and next to the Our Place Society transitional housing and drop-in facility. The building was purchased with the intention that it would be the new location for SOS. The facility was larger than the Cormorant Street space, in an appropriate location for the clientele, and had room for other related services to be housed under the same roof. Yet VIHA failed to educate and inform the residents and business owners in the surrounding neighbourhood about their plans. A public meeting of angry parents from the nearby independent Catholic school, St. Andrew’s Elementary, applied enough pressure to the VIHA Executive that they announced less than two weeks later that the newly-purchased building would not include a needle exchange program. By late March, VIHA announced it would be going ahead with plans for AVI to run the exchange as a mobile service in the absence of any option for a new fixed site.

4.3 Going Mobile

With sensationalized media stories, public concern over used syringes on the streets, and the news that the exchange would be closed, harm reduction advocates renewed their calls for services. BC’s Provincial Health Officer, Dr. Perry Kendall, joined then-CARBC researcher, Dr. Benedikt Fischer, in again calling on relevant authorities to implement a supervised consumption site trial for Victoria in the *BC Medical Journal* (Fischer, Kendall & Allard, 2008). Rather than

responding to such calls with action, both the City of Victoria and VIHA continued to stall and cited other priorities.

In the meantime, the exchange was shut down on May 31, 2008. Outreach workers got to work running the new mobile service and experienced significant challenges. The transition was difficult and worrisome for outreach workers who described their frustrations in trying to find their clients, the difficulties of trying to offer support and information on public streets, and concern for many clients who had been dispersed and simply not seen since the exchange closed (Harnett, 2008).

4.4 Challenges with Mobile Services Only

In September, 2008, AVI and VIHA released their first round of statistics describing the first three months of the new mobile service. In 2008, SOS distributed a monthly average of 34 900 syringes between January and April and recovered an average of 24 400 syringes during the same time period. During the first month after the Cormorant site was closed, these numbers dropped drastically to 16 700 distributed and 7500 recovered syringes, representing an over 50% drop in distribution. Both clients and outreach workers criticized the new system in the press, and the *Times Colonist* printed an editorial blaming a lack of leadership for the neglect and demise of the exchange and the people who relied on it. Finally, rather than sensationalizing and demonizing harm reduction services and the people who use them, the local media was starting to realize that the City had lost a health service and that the community was in much worse shape than it had been when the exchange was operating. A random sample of 500 residents in the Capital Regional District showed that 71% of participants supported harm reduction and that support for needle exchange was almost as high (Fyfe, 2009). Distribution and recovery rates

slowly began to climb throughout the summer and fall of 2008, but a particularly cold winter in Victoria made it incredibly difficult for outreach workers and clients to find one another. The ability of the mobile team to distribute and recover syringes was significantly impacted by the weather and limited the opportunity for outreach worker-client connections.

A further hindrance to worker-client connections was the existence of what was being referred to as the “no-go zone.” It became known that VIHA had made a verbal commitment to St. Andrew’s Elementary School that none of their funded organizations would distribute clean needles in a two-block radius around the School. This commitment was made in addition to the formal “Code of Conduct” that AVI had committed to regarding mobile services (for example, that outreach workers would not distribute supplies directly in front of a school, daycare, or open business). The no-go zone primarily impacts a particularly marginalized group of people who use drugs that spend time and access support services along Pandora Avenue, and requires them to follow the mobile outreach team out of the zone to access supplies. On November 30, 2008 the six-month anniversary of the eviction of the exchange, grassroots collective and advocacy group, Harm Reduction Victoria, distributed syringes in the no-go zone as an act of defiance and to draw attention to the unwritten policy.

In December, 2008, University of Victoria Nursing Researchers, Joan MacNeil and Bernie Pauly published a report entitled “Reaching Out: Evaluating Outreach and Needle Exchange Services throughout Vancouver Island.” Results from data collected in Victoria revealed

that the closure of the fixed site decreased access to not only the needle exchange services but also decreased access to other services, thus exposing already vulnerable clients to increased health risks (MacNeil & Pauly, 2008, p. 3).

Police call data indicated that the closure of the exchange dispersed people who use drugs throughout the City. Drug use had been pushed further underground and outreach workers were having less success finding clients, ensuring they had clean supplies, and maintaining the connections that helped to reduce risk behaviours (MacNeil & Pauly, 2008). The report reaffirmed what outreach workers had described and what had been written ten years earlier in the “Missed Opportunities” report:

[while] some might conclude that a mobile rather than a fixed site harm reduction service should exist ... a fixed site provides drug users with a consistent location to receive care, treatment and support. For some, it is their main source of support ... Both a fixed site harm reduction service and a mobile component are needed (Stajduhar, Poffenroth, & Wong, 2000, p.33).

The mobile service continued to produce disappointing numbers. Distribution of needles plummeted to 16 300 in January 2009 and recovery hovered at 10 100. In 2009, a similar seasonal pattern emerged whereby distribution and recovery rates began to return to levels more resembling that of pre-closure of the Cormorant site, and then plummeting during inclement weather. In November 2009, the mobile team saw their lowest numbers ever with distribution lowering to 15 866 and recovery close to June 2008 levels at 8389.

4.5 Inertia

While the mobile service floundered without fixed locations to connect with people requiring harm reduction supplies, calls for enhanced harm reduction services continued to accumulate in BC. The Health Officers Council of BC, a society of public health physicians who advise and advocate for public policies and programs, passed a resolution supporting supervised injection services and asked BC Health Authorities to go ahead with developing such services and integrate them into community primary care (Health Officers Council of BC, 2008). Dr.

Thomas Kerr, a health researcher with the BC Centre for Excellence in HIV/AIDS, visited Victoria for a public forum about harm reduction services and stated that the City was breaking international guidelines on HIV/AIDS prevention by not providing basic services such as fixed sites for needle exchange.

In 2009, as the one-year anniversary of the closure of the exchange loomed, *Monday Magazine* staffer, Jason Youmans, wrote a scathing critique of the state of harm reduction services in Victoria. He pointed out concerns about the “Needle Exchange Advisory Committee,” a group that had been set up by VIHA to help develop a plan for a new fixed site needle exchange. The Committee was comprised of neighbourhood association representatives, the police, services providers and representatives from the Province, but noticeably sparse among committee members were people who actually use illicit drugs. As Youmans pointed out, local advocates viewed the committee as “VIHA’s attempt to placate a broad array of non-addicted stakeholders [and abandon] internationally-recognized best practices for disease prevention in favour of good PR” (Youmans, 2009). VIHA Director of Public Health, Shannon Turner, was quoted in the article, blaming the media for aggravating a sensitive issue:

I think there were serious public disorder issues, not made by the needle exchange, but made by a number of complex social issues, like mental health and addiction, service shortfalls, etcetera. A broad range of factors unfortunately crystallized in front of the Cormorant Street needle exchange and it became a flashpoint for a lot of intensive negative media. A lot of harm was done in the media around the importance of this service, and what it means, and we have spend considerable effort over the last few years addressing those concerns with key decision makers so that we will be able to move forward constructively (Youmans, 2009).

To mark May 31, 2009, one year since the exchange had closed, and to maintain pressure on decision makers, Harm Reduction Victoria organized a “March for Dignity” and launched a

“Guerilla Needle Exchange” in the no-go zone, handing out safer drug use supplies in an area where VIHA-funded outreach workers were restricted from doing so. The Guerilla Needle Exchange operated for three months during the summer evenings, handing out over 7500 needles, and recovering over 5000. There was little opposition from local residents, minimal response from the police, and unfortunately, no response from VIHA to reinstate services. A small group of office workers from the nearby provincial Ministry of Health building visited the Guerilla Needle Exchange one afternoon on a coffee break to express their support, but officially, the provincial government remained silent.

In July 2009, it was finally announced that a new site for a needle exchange was being considered. The site, a small house requiring significant upgrades, was located on Princess Avenue, one block away from where AVI’s mobile vehicle parks nightly as a make-shift “fixed site” for bare-bones needle exchange service. The location was just far enough of out of the downtown core that it was not being accessed by very many people requiring safer drug use supplies. The house was also located next to another house that was observed by outreach workers and known to people who use drugs as a “crackhouse” and place where people could purchase and use drugs. SOLID (Society for Living Intravenous Drug Users) and Harm Reduction Victoria both publically expressed concerns about the location. However, when it became clear that the proposed Princess Avenue was the only option for a chance at a new site, SOLID threw their support behind the proposal. In June, SOLID had withdrawn from VIHA’s Needle Exchange Advisory Committee citing tokenism, a flawed process, and frustration over who was being represented on the committee. With no other option to consider, SOLID pledged to work with VIHA to ensure a fixed site would happen on Princess Avenue. By Fall 2009,

residents, business owners and the neighbourhood association representing the area in which the proposed site was located spoke out against VIHA's proposal. Concerns that "another Cormorant Street" would be created in their neighbourhood, residents and the neighbourhood association successfully pressured VIHA to stop the process of pursuing a new site at Princess Avenue. Twice in less than two years, a small group of Victoria residents had successfully blocked essential health care services for people who use illicit drugs from being located in their "backyards."

In November, 2009, VIHA announced that the Needle Exchange Advisory Committee would fold and that they would turn their attention to developing a "distributed model" of needle exchange for Victoria. Rather than pursuing fixed sites for harm reduction services, they would be looking for ways to ensure that supplies were available in existing clinics, health centres and pharmacies. They advertised the move as "increasing" needle exchange services, when, in reality, harm reduction services had already been significantly reduced with the closure of the exchange. Harm Reduction Victoria, among others, voiced concern that a distributed model without fixed locations offering service specifically for people who use illicit drugs was inadequate and would not meet the needs of the most marginalized of that population. For example, many people who are assumed to be drug users due to their appearance are highly stigmatized and consequently would not enter a pharmacy or health unit to access clean drug use supplies. Street-level drug users are more likely to use dedicated fixed site needle exchange services and mobile services.

4.6 Conclusion

Data gathering for this case study only extended to November, 2009. Since then, SOS staff have developed creative and innovative ways to provide services, programming and support to their clients, but two years later, little has changed. SOS continues to be run as a mobile service and is still restricted by the unwritten “no-go zone.” The zone still exists in practice primarily due to pressure from the Victoria Police Department to maintain it, VIHA’s unwillingness to stand up to police pressure and community fear of drug users, and AVI’s fear of losing VIHA funding should SOS staff defy the zone. There are no plans in place for new, fixed site locations for harm reduction services for people who use drugs. This inaction is in contradiction to all available local evidence calling for increased harm reduction services in Victoria, and has been a source of incredible frustration and anger for outreach workers and those who rely on harm reduction services. Chapter 5 turns to the experiences of SOS outreach workers and their perspectives on the loss of the fixed site and transition to mobile needle exchange services in Victoria.

Chapter 5: Narrative Findings: Perspectives of Outreach Workers

5.1 Street Outreach Services on Cormorant Street

From 2001 until May 31, 2008, SOS operated from the small AVI drop-in space on Cormorant Street during the afternoon and evening hours, seven days each week. Upon entering the SOS small lobby area, a counter to the right served as the area where clients could return used needles and access new, clean harm reduction supplies. Behind the exchange counter, there was a small, enclosed office space for staff and volunteers. A drop-in space that could be separated from the lobby by an accordion door included a kitchen, washroom, and adjoining room used by the VIHA Street Nurses. The nurses were often present, mingling with clients and offering nursing care, including immunizations, testing for sexually transmitted infections, and wound care, for example. Usually the stereo was on, coffee was made and, depending on donations, food was laid out on a table for people to help themselves. The program was staffed by two needle exchange workers whose primary duties were to provide safer drug use and safer sex supplies to clients (eg. sterile needles and syringes, condoms, alcohol wipes, etc) and to engage clients in casual, non-judgmental, supportive conversation. There were a number of other services provided that were not necessarily included in the job description, and these were largely responsive to the immediate needs of the clients.

Outreach workers described what a typical shift looked like in their own words:

basically the shift was like ... chatting with people, making sure they got the supplies that we could offer them, um, and trying to meet their very basic needs as best we could so, if they came in soaking wet, or they were, you know, didn't have adequate clothing then we would, you know, point them towards our clothing donation bin and try and help them get what they needed in that way. If they came in and they were really hungry, you know, we'd try and hook them up with a snack or, if we had extra ingredients maybe make some soup...

...giving people support over the phone...breaking up fights, kicking people out for dealing or using in the space...trying to monitor what was going on out front...doing dishes and trying to keep the space tidy... training volunteers or practicum students... (Tess)

Outreach workers were able to monitor how clients were doing by keeping in phone contact during hospital stays, ensuring client mail was delivered, keeping track of missing persons reports and helping to connect people with family members. The fixed site was about much more than just access to harm reduction supplies and information. “Perhaps as important as the distribution of clean needles, [needle exchange programs] have been shown to establish links between health services and difficult-to-reach [injection drug users]” (Miller et al., 2002, p. 262). SOS was a community hub and a consistent place that clients relied on for many reasons, including access to washrooms and clean water, phones, and referrals to health care, particularly in the evenings when no other drop-in service was available.

Clients came to us in the fixed site for lots of different things; they may have come in for needles but ... they'd [also] come to wash their hands and see the street nurse and get a cup of coffee, some fresh water...we could always make referrals, we also had, like, hygiene supplies...they always knew that there'd be someone there to listen to them and make time for that...if they needed to call their family they could do that; guys from jail, women from jail would call to check on their family...and also like, make plans for their release... (Ginger)

...it was so consistent and people always knew where we were... we saw people on a daily basis and we really built relationships with them...It was sort of a hub and people knew that they could come there and they would be supported whether by staff or by their fellow peers and, um, ...and it was amazing how quickly news spread on the street and how quickly it got to us as well and so we were able to be a, an information hub and so [for example], if somebody... was having adverse reactions to drugs [related to the cutting agent used]... we could get that information out quickly to people... (Tess)

5.1.1 Limited Resources

The fixed site was a challenging place to work. Without any increase in funding, a growing clientele with complex needs, and a limited physical space from which to run the program, the

staff were challenged to meet the needs of an increasing population. Due to the limited physical space available and the fact that SOS was the only drop-in service available during evenings and weekends, people also spread out on to the street outside.

At the time that I was hired, there was only two staff on at once, and we had no administrative time, so no time for staff meetings, no time for, um, pre or post shift debriefing... there was a lot of, a lot of stuff going on in there for two people...in a pretty small space there could be, you know, 20 people and um, and just all with very sort of urgent needs... a real diversity of people, coming in and... people would spill out on to the street and ...there was just, a lot of activity and the cops would come by all the time and, um, you know so, you really had to be so hyper-alert all the time about what was going on... (Tess)

Prior to the eviction of SOS from the Cormorant Street site, VIHA provided some extra funding to AVI in order to increase staffing in hopes that SOS staff could decrease the level of activity on the streets nearby. One worker notes that

with the threat of eviction, um...you know, we got more funding and we were able to have three people on at once, and that definitely made a difference you know, one person could sort of hang out outside and, and manage that space a bit better and there was just more hands on deck kind of thing (Tess)

The third staff person was helpful but ultimately could not alleviate the larger societal problems of poverty, lack of available housing, and limited services that contributed to the number of people on the streets.

5.1.2 A Community Refuge

Despite the challenges of limited resources, a small program space and the magnitude of client needs, the outreach staff valued the opportunity to offer a gathering place for a highly marginalized community.

People could cook or, make food...cleaning and helping out, bundling rigs ...they felt like they could give back so there was more of an ownership of the service for them ...it was more of a time for them, all of us to sort of just be, you know, to be together. We kind of built rapport spending so much time there day after day...even just funny things...sometimes, you know, people need to

laugh...watch crazy YouTube videos or, you know, like the clients would sometimes really enjoy that or, having movie night...there'd be a lot of talk about...their identity, um, other than just their immediate needs, so things like, that they liked, or music they liked or, um, things that made them feel really good, um, connections they had with animals or people...[we] got to know people as more than just someone who needed harm reduction supplies. And I think that was a really important piece of what we did was ...just having a space to be more than... when you're homeless and using substances, that you're more than just, like, that person...(Ginger)

A participant describes how people came to the fixed site to relax, to connect with their friends and family, and to seek comfort:

There was times when people were dancing...wearing wigs and dancing and (laughs), you know and just, life happened and I learned so much about community and all of the strengths of that community by working in the fixed site and watching people supporting each other... there was just such an amazing cross-section of real life and how they negotiate sex and survival and companionship and humour and you know, and I remember people coming in and pacing for an hour and then picking up the phone and calling their kid, you know, and how hard that was and amazing...and their resilience and sense of community and survival is phenomenal, you know and I also remember being, you know the place that people could go when they'd been hurt (Olivia)

The fixed site provided a physical, social and emotional centre for people who use drugs, and even played the role of a place of sanctuary and refuge. Many clients did not have access to their own private space and the fixed site provided a sense of home and a social centre. For many, it was also a crisis centre.

It was just a really interesting environment...just kind of this...unique community...a space that offered a bit of a refuge from everything else...There was time where people really would come in and it was sanctuary; I remember one individual who was on a huge flailing run and who came in was very paranoid and frightened and hid under the desk...was in the fetal position and rocking and just like, it was, it was terrible and so I just stood in front of them and kind of protected them and just let them be there. (Olivia)

people would sleep under the table or, um, just kind of hang out like find refuge...like if something had gone wrong in their peer group or something they would kind of hang out and sort of have a, sort of, respite from the outside world. (Ginger)

there was a night where one of the clients had died and...we spent most of the evening trying to confirm the information and...the whole community was really in crisis and...we were able to confirm for people that this person had died and set up kind of a...almost like a crisis centre and then that's what we dealt with, people were walking in and falling apart and bawling...(Olivia)

it was like a crisis centre as well so if...like if a sex worker had a 'bad date' they could come in and get support ... if somebody...was in the hospital or...in jail or...needed support...(Tess)

The fixed site also provided a safe space for clients to talk to outreach workers about their personal experiences. Researchers in Vancouver working with women who use crack found that despite the multitude of physical health issues experienced by the women, it was access to compassionate care for physical and emotional pain that was identified as a priority (Bungay, Johnson, Varcoe & Boyd, 2010) Spaces identified as “safe” by marginalized women are crucial to their ability to share stories together, a process which was found to be supportive and potentially transformational (Bungay, Johnson, Boyd, Malchy, Buxton & Loudfoot, 2009).

Outreach workers described how the exchange was a safe space and refuge for clients:

I remember being in the back office talking to a person who was transgendered and just in the process of going through changes and, so, still presenting as a male but identifying as a woman and came into the back and took her pants off (laughs), had tights and a skirt underneath and a bra and...we talked about like shaving tips and ...that was a really cool experience...(Olivia)

I remember this person coming in right after they'd been grabbed and, on the side of the road and picked up and taken for like, 3 or 4 days by some random guys, and the shit kicked out of her and whatever else happened, you know but one of the first stops was with us right, like it was, you know...there was that sanctuary... (Olivia)

I think that from what clients reported to me anyways, it was just the only all-rounded, accepting place, like no matter who you are or what you're doing, or what condition you're in in the moment, it was, it was the only place in town for most people that they could go and be exactly who they are...(Ruby)

Outreach workers spoke about what they enjoyed most about their work at the fixed site and the most common response was the opportunities they had to get to know the people accessing the service, to make space for them to share their stories, and to provide them with support. They described how they missed these opportunities the most since the fixed site had been closed.

When we had the fixed site, the most rewarding part about my job, would have been... providing support to our clients and, listening to our clients um, I feel like it was a very privileged position to be in, to hear the life stories of the people that we served, to be trusted in that way, to listen to their stories...and that we could... just even in a small way, walk through life with them a little bit. I miss that...I miss the, the privilege of getting to know them, on a, on a deeper level and I miss the privilege of being trusted by them...of having the opportunity to earn their trust, that was a hugely rewarding part of my job because I have a lot of respect for the people that we serve. There's a lot of characters (laughs) and a lot of really amazing people and some of the most genuine people I have ever met. And I, and I miss that, a lot, that was very rewarding for me. (Tess)

Some of the things I really enjoyed were the opportunity to sit down and have a cup of coffee with somebody...and listen to somebody, I found that happened a lot. People would come in and they would just, almost unburden themselves and, and share some amazing, horrendous stories...(Olivia)

...you know, maybe get into a conversation that was deeper than just a superficial, you know, "how are you and where are you sleeping tonight" kind-of-thing. (Tess)

The relationships that outreach workers build with clients is a central part of their job, and one that was identified consistently by participants as the most rewarding aspect of their work. In fact, all six participants identified that working with clients is the least challenging aspect of the job.

I think one of the things I first fell in love with the exchange is...that one-on-one connection with people. Especially people who...have had bad histories with health care providers. There's just a rush, I guess, from that, in that real connection, reaching people in those moments are, is really rewarding even if it's...transient and I never have that connection again there's just something...really...satisfying in that. You know I mean obviously if I can help people stabilize in a more tangible way that's rewarding as well but just that,

those connections, making connections with people, is the most rewarding thing.
(Olivia)

I guess another element that I find really positive at work is that...I, I would call it a privileged perspective in...witnessing or experiencing...um, the lives of people that, that society's marginalized so harshly. Um...and the opportunities to build those relationships that you know in any other context would be very, very difficult...I just find that so...amazing, um, cause I love building...bridges and those connections between classes, between class difference essentially...
(Sam)

In the 2007 independent review of SOS conducted at the request of VIHA, the authors noted that SOS staff had “positive interactions” and “very good rapport” with clients, knew the majority of the clients by name, and appeared to be trusted and appreciated by the clients. “The importance of this cannot be overstated, as the service depends heavily on its interactivity with clients” (Campbell & Fair, 2007, pg. 11).

5.2 Hitting the Pavement: SOS Goes Mobile

The SOS review noted that major changes in service operations were not advisable because they “may decrease the consistency of the service and therefore its reliability for clients, thereby decreasing its effectiveness” (Campbell and Fair, 2007, pg. 18). Despite the authors’ recommendations to develop and resource SOS, the program was eventually evicted with nowhere else to go. The new mobile service temporarily ran from the Cormorant Street location; outreach workers maintained an office and their supplies at Cormorant, but only delivered services on the street. In fall 2009, outreach workers moved their office from Cormorant into a small, one-room office in the new ACCESS Health Centre, located only a few blocks away. AVI had moved to occupy the entire third floor of the ACCESS building and had originally hoped SOS could be housed separately, and potentially with supervised consumption services. In fact, as part of their partnership in the Centre, AVI had agreed not operate a needle exchange

program from that location. Over a year after the eviction and still with no other options for program space, SOS crammed supplies into their new office and continued to deliver needle exchange services on foot, on bikes, and from outreach vehicles.

As a mobile service, outreach workers described how difficult it became to connect with clients.

They spend a lot of time and energy looking for where clients may be gathering.

as a mobile service, we spend much of our time looking for people...people are just so spread out and it is so hard to find people, I mean, you know, we can pretty reasonably [be] guaranteed to find people on Pandora which is sort of the place where people have, have been congregating since they were shunned from the Cormorant Street neighbourhood um, but even sometimes we don't see people on Pandora... and we ask people...you know, where should we go tonight ...and nobody even knows where anyone else is you know, it's just really weird and really scary because...those people used to use our services, they used to rely on our services... (Tess)

When they did connect with clients on the street, conveying information and engaging in discussions became limited due to the new physical context. Here, a participant describes the challenges of interacting with clients that are in a rush to obtain supplies and then move on:

I asked if I could give them extra mouthpieces and they said that they would just share one pipe. I tried to share some info about risk for transmission...They refused to take mouthpieces, insisting it was ok. They were in a rush and I sensed that if we had not been on the street with a number of other people around, things may have gone differently...there were a number of people around, all impatient and getting wet... people are uncomfortable getting supplies on the street, they're jumpy, they're in a rush, they don't want to hang out, um, and so those conversations are really short and, I find that where I used to have relationships with people, I don't have relationships with them anymore, um I'm basically a human vending machine a lot of times... (Tess)

An Australian worker expressed the same sentiment in a study that described the impact of the closure of an Australian fixed site needle exchange and switch to mobile services: “Now we're...just not being able to provide (an adequate) service...I felt like a vending machine that

just didn't offer anything" (Southgate, Blair & Hopwood, 2000, p. 33). People who use drugs may feel rushed not only in obtaining their supplies, but scrutiny from the public or police may lead them to hurry their injections and not take their usual precautions for safer drug use, and thus increase their risk of contracting HIV, hepatitis C, or other preventable health problems (Canadian HIV/AIDS Legal Network, 2007).

Rather than being primarily focused on relationship building as a means to encouraging harm reduction and health promotion, the job became more task-oriented and conversations more targeted than organic.

A lot of what our job has become as well is about managing logistics. So, you know, figuring out who's doing what mode of delivery...ensuring...that we have all the supplies in all the various places that we might need them so that our various bags are stocked with stuff... I talk mostly to my co-workers now and it's great that we have more time to talk and debrief but (laughing) you know, most of what I'm debriefing with the staff about right now has nothing to do with clients...it's about how frustrated I am with how our jobs have changed. (Tess)

...we don't have the time to kind of build the relationships in the relaxed way that happened...the interactions have to be more targeted and more seen as a possibility for interventions... (Ginger)

Two participants describe their experiences of being in a public space with clients (both sex workers in these examples) and the challenge of providing support on the street:

... a woman says to us like, oh I need some flavoured condoms or whatever and I always feel like we're super encroaching [on her workplace]...we're like, definitely stopping business from happening in her life. So I have it in my mind that we should try to be as efficient as possible, and then you know, the ziplock bag that you go to get is not closed and you spill like, four hundred condoms on the ground you're like...I'm very sorry, like you just look so unprofessional...I get really broken down by those little things... (Nyla)

I remember walking up to a sex worker on the corner and she just kind of unloaded... and, like I put down my clipboard and all of a sudden papers and shit were flying everywhere and I was trying to get her a number... We're not able to connect with them in the same way. (Olivia)

One of the positive impacts resulting from the eviction of SOS was the extra funding that was allotted to AVI by VIHA to help with the transition to mobile services. The funding allowed the program to start supplying clients with a more comprehensive array of safer drug using tools. Whereas the program had primarily distributed needles, syringes, alcohol wipes and condoms prior to the eviction, outreach workers were able to add other safer drug use tools to their backpacks (for example, cookers, ties, filters, and other equipment used to reduce the risk of infection when using illicit drugs, particularly with other people). However, without a counter to display the variety of harm reduction tools, it was challenging to ensure clients got all of the supplies they needed.

in the old space we'd have those things out on the counter and so people kind of, would know, "oh well these are all the things that I'd need" or if someone was new to injection but didn't want to admit that they were new to injection, they could see all the things that they needed for safer injection...and now...everything's in our bags so if we forget to offer something to someone, they may not ask or may not know that they need that, or they just may re-use or may share because they don't necessarily know... (Ginger)

At the time of data collection, AVI had negotiated two locations as consistent places for outreach staff to connect with clients; 30 minutes daily at one of the local shelters, and an outreach vehicle (a second-hand ambulance) parked at a consistent time and place each evening. Unfortunately, the location for the vehicle to park was chosen by VIHA, the City of Victoria and the Victoria Police as one of the only options they would support. The location is just outside of the downtown core and not particularly accessible to many of the most marginalized needle exchange clients. Nyla talks about how the 30-minute shelter shift added some consistency to the mobile outreach schedule for clients:

I'm finding that to be a good thing. Like, it's nice for people to know where we are and how they can find us, and they don't necessarily have to identify our faces...they can just like walk in to that office and find [us].

However, Ruby noted that despite the consistency of hours during which the outreach vehicle was parked, the inconvenient location and limitations of providing outreach support from a vehicle added to the difficulties of mobile services:

The ambulance shift basically you're stuck there ...usually I've been finding that sometimes there's people there when we arrive ...some nights I won't see anybody, or people will come by but they'll be asking for, you know, food or asking if there's somewhere they can go inside to stay warm ...wanting to have a conversation and hang out with somebody...

When conducting outreach by foot or bike, workers seemed to be concerned about covering as much ground and reaching as many clients as possible rather than lingering to have conversations. Staff that had not worked at the fixed site, in particular, expressed concerns about the need to be efficient.

...my beef with like, with walking is that I don't find that we cover enough ground...and it's very often, we become, inefficient, and like, casual chatting, um not that I'm against discussion with our clients at all but I find our ability to kind of, end a conversation and...leaving is much, much more difficult if we're walking. (Nyla)

I feel this pressure where I just have to keep going you know, uh, because I think in, for me it's the limitation of services that can be provided so... sitting around and chatting for 20 minutes just means that other people aren't getting service. (Sam)

Some workers complained that working at the ambulance was boring because they did not see many clients there.

I've definitely...spent my time in those, those ambulances in those parking spots and not seen a soul ... like you know you can bundle rigs...but I shouldn't have to... I should be doing needle exchange... (Nyla)

I think that psychologically that's been hard for me...yeah I can keep busy, but like...really is that what you want me to do is just keep busy? ...before when we

had the fixed site it was all about...connecting with people and talking to people and supporting people and listening to people and... um...connecting them with other services, and really being quite a fast-paced job at some times; a typical shift now is um, sometimes mind-numbingly boring...(Tess)

For participants that had never worked in the fixed site, the ambulance did provide some opportunity to have longer conversations with clients as Sam describes below, but for those, like Olivia, who knew what it was like to work at the fixed site, mobile outreach was all the more difficult:

in the [ambulance]...I just feel more efficient...whereas sometimes I feel a little bit hopeless being out on the streets...in the ambo...I just uh, organize the space...tend to clients that are coming... the majority of people are just brief contacts, there's not a ton of exchanges in my experience that go on in the ambo. But it's a good space to build relationships with people... you can take the time and have those conversations. (Sam)

trying to figure out where everybody is and knowing they're out there and knowing they're displaced and knowing they have nowhere to go and there's not a lot of food on the weekend and the weather's the shits and the cops... and feeling so powerless, it's just really hard. You know, and the complaints from the clients who can't fuckin find you... "I'm not getting rid of my dirty rigs anymore"...I think it's great that there's new staff that have never done it any other way in some ways because they find it less frustrating... but there also the risk is I feel like they don't know what they're fighting for and they don't know what they've lost because...we've lost so much. (Olivia)

5.3 Under Surveillance: Restrictions on Mobile Services

At the time of data collection, connecting with clients had been even further restricted by the existence of a so-called “no-go zone”, an area of the city where needle exchange services were restricted by VIHA and police in order to appease the concerns of a small group of individuals whose children attend a private elementary school. The zone goes beyond AVI’s own “Code of Conduct” for mobile services, which stipulates that services will not be provided in front of residences, open businesses, or schools, for example. Outreach workers expressed considerable

frustration over the no-go zone restriction because clients could not access essential health services in areas where they are most needed.

that's the two-block radius around St Andrew's [School] which happens to be, in my opinion, the most densely occupied area of street-involved people because there's health services right in the area and because there's food and shelter services...in the same block and so that's been a constant hassle as far as I'm concerned, as far as best practices in trying to just meet basic needs...
(Ruby)

In order to access harm reduction supplies from outreach workers in the no-go zone, clients are required to follow the workers out of the zone and many refused to do so.

it just feels like a cruel joke sometimes because it kills me to have to say to people that I can't give them what they need when it's in my backpack in that space. And knowing that a lot of people have mobility...issues or whatever else is happening for them in that moment in which they can't follow, I find, so beyond unfair. It's just an unreasonable request and an unreasonable limitation that we have to abide by. So it is something that I take home, with me, you know... (Sam)

You know, I've got the supplies in my backpack on my back, and I cannot give them to you here because of fear and ignorance in our community... and that really stands out for me...when we say no, we can't give you the supplies here...(Tess)

I know that, the ['no-go'] zone was, and is...continuously the biggest barrier to providing service. So that, is for sure the biggest challenge, in the workplace ... it feels like that hinders the quality of service that can be delivered. (Sam)

Outreach workers have had more interaction with the Victoria Police Department since delivering services in a mobile model. The police are highly invested in maintaining the no-go zone due to their efforts to reduce “public disorder” in the area. Some of the interactions between SOS outreach workers and police officers have been troublesome.

this guy that we worked with a lot, and, he's just like doing nothing at all and... there was a bunch of cops ... and then one of them comes over to him and stands in front of his bike and holds the handlebars of his bike so they're pretty face-to-face, and is like “Oh, so-and-so...out of jail are you, how long till you fuck up again?” Then he asked him, “what are you doing here” and [the client] said he was with us and...[the police officer said] “what are you doing hanging

out with the needle exchange”, so now I’m like, oh so now this is going to reflect badly on the client [even though] he’s... accessing support and having a conversation with people who he trusts...I couldn’t stand by and watch anymore so I just went... “do you have any police business with this person” ...and [the police officer] was like, “uh no,” ...it’s like “ok, are we free to go?” (Ruby)

I actually had one female officer one night just get really angry with me and say, “All I do all day long is move people along and this is not why I signed up to be a police officer...” So I said to her, “I hear what you’re saying. My job is to do what you’re asking ...like help them find a place to be inside and safe and find some food and find some shelter.” I just found that [she] was like, completely closed off to hearing anything I had to say cause I’m just...an outreach worker. (Ruby)

Interactions with the police and police sweeps of certain areas displace clients and create barriers to accessing the mobile services. In Vancouver, researchers found similar conclusions when a “Citywide Enforcement Team” (CET) was created to eliminate “public disorder.” Researchers discovered that the CET “compromised public health by discouraging drug users from accessing health service by driving them ‘underground’, and thereby also increased risks associated with unsafe injection and overdose” (Small, Kerr, Charette, Schechter & Spittal, 2006, p. 86). Police displacement of people who use drugs may decrease the visibility of such individuals on the streets and also result in negative public health consequences such as increased sharing of supplies, rushed injections and discarded needles on the streets. Displacement of people who use drugs from their usual locations and sources of clean supplies may also increase exposure of drug use to “at-risk” youth (Small, Kerr, Charette, Schechter & Spittal, 2006). An outreach worker explains how police presence impacts their ability to connect with clients:

if the police have done a sweep of a certain area we can kind of guesstimate where people may have moved to and go check there... I felt some days like the police were anticipating our route and going just in front of us and basically scaring everyone away or following right behind and jacking people up. So people seem to sort of be developing that fear of accessing the service... (Ruby)

5.4 “That Sanctuary is Gone”: Limitations on Connection

Outreach workers expressed how difficult it was to continue to build and maintain relationships with their clients after transitioning to mobile services. Without a physical location where clients and staff could connect, outreach work became less about relationship and more about the distribution of supplies. While the distribution of supplies is an important and primary goal of the program, “development of trusting relationships is a core feature of successful outreach work” (Strike, O’Grady, Myers, & Millson, 2004, p. 217), particularly in light of the fact that people who use drugs experience significant stigma and subsequent barriers to health care (New South Wales Department of Health, 2006). Without the social connection and opportunities to build relationships and trust, harm reduction services are only partial. Such relationships are vital to the successful sharing of harm reduction and health promotion information and the uptake of that information in the everyday drug use and sexual practices of clients.

I think that’s been a huge, huge impact of going mobile is, is the damage that has been done to the relationship that we used to have with our clients. A lot of our clients are folks that have had various life experiences that have taught them not to trust people, that it is in fact dangerous to trust people...especially service providers. And so, what was so amazing about, um, our job was that we used to be able to build relationships with our clients that were relatively trusting, you know... people came to trust our consistency...Since we’ve closed, I don’t think they trust us anymore. In those moments when they need urgently need supplies from us, they don’t understand why we can’t give them those supplies in certain places. They don’t understand why, this long after our eviction, we still don’t have a fixed site. You know, um, they don’t trust us because they don’t... there’s not the opportunity for them to get to know us. (Tess)

When the fixed site closed down, outreach workers described how they were limited in providing support, sanctuary, and the opportunity to build relationships and trust. All were identified as necessary components of harm reduction services.

I think a lot of times the reason why people showed us their arms or talked to us about emotional stuff...was because they did have a relationship...because they had trust. And now...I think a lot of those things might slip through the cracks

... because they don't have that relationship with us anymore and don't see us as those kinds of people that can provide that kind of support. (Ginger)

When the service changed to a mobile model, staffing increased in order to increase program hours and cover more ground in the city. However, the extra staff could not realistically make up for the loss of the consistent, reliable support provided at the fixed site:

with four people we're still not reaching or doing the amount of numbers we did when we had two people and it just seems like, a bit of a waste of resources and, it's not what the clients need... [we did a focus group with clients and asked how] we could address some of their emotional needs and emotional stress by having, like, a trauma [support] group and the response was, "if you want to be able to help us with that stuff, open another fixed site because...when I am upset I want to be able to know that I can come and talk with someone just like at the old fixed site...I knew that you guys would be there for me if I needed someone and that's what you need to do" (Ginger)

Outreach workers noted the difficulties in providing a “continuum of care” for their clients.

Providing harm reduction supplies on the street was much more limiting than being able to build and maintain relationships within a consistent, physical space. The lack of a fixed site meant that a private, safe and secure space was no longer available to clients. Ultimately, this negatively affected the level of support clients could receive.

there was sort of a continuum of care ...that doesn't happen now ...like before I think it used to be really on meeting clients' needs, and, and um...I think I got a lot of satisfaction out of like, helping to be a part of a really warm, welcoming, fun environment and addressing people's public health needs that weren't being addressed anywhere else, by any other ... public health provider...We don't have time or the space, like, it's really public...there's no privacy... (Ginger)

Here, a participant observes that the mobile model does not allow clients to access services on their own terms, whereas at the fixed site, clients could choose when they were ready engage with service providers. This observation is critically important when considering social justice for marginalized populations and a harm reduction approach, whereby clients are able to assert their own autonomy in accessing health care:

And that sanctuary is gone and we're so exposed and our clients are so exposed and, I mean we are reaching the most visible part of our clientele but I remember lots of people who used to use our services that were white-collar workers that came on their way home, from work... we've lost the people who used to come in for piercing needles, the um...the steroid using group, you know...I'm still able to walk and see people and be like, hey...! But it is harder for us to do for sure...when we approach them on the street it doesn't mean that they're ready to engage with us, but for them to come to a fixed site...it's an agreed-upon environment almost, whereas us going out on the street...you know, and it's almost like a violation, to go up to them on the street because it's like, you know, they're in a different space. (Olivia)

Outreach workers observed that without a fixed site, their ability to provide preventative and responsive health care was limited and was potentially putting clients at further risk for health problems. Workers were able to do some informal monitoring of clients' health when they saw them on a regular basis at the fixed site. For example, clients could wash their hands prior to injecting and they could sit down in a warm space and have some food. After the fixed site closed, some clients' health appeared to suffer, particularly because they were not able to connect as regularly with outreach workers to access clean supplies.

we can't do sort of more comprehensive health services ... like trying to have that conversation about ...common health prevention stuff like oh, washing your hands before you inject, well that's great I don't have any place for you to wash your hands...right after we closed there was a guy who used to come in and... may not always get syringes but he'd always come in and wash his hands, maybe get a bite to eat, we haven't really seen him [since the closure of the fixed site] and then...we ran into him and he had been in the hospital because he had been re-using his own syringes over and over and got a blood infection and was in there for like 6 weeks (Ginger)

...we used to be able to keep such a, an idea of like where they were at...like the woman that died...after we closed and...it was really difficult because...we had um...some of her medication, like an extra inhaler there because she would often come to the fixed site 'cause she was homeless and she didn't, you know, her stuff would get farmed⁷ and ...so she always knew that she could come and see us and, get her medication and she died due to lung-related...failure...[with a fixed site] you can listen to people's breathing and you can get them a hot cup of coffee and some comfort and give them the space to maybe think about seeking medical attention...(Ginger)

⁷ slang for "harvested" or stolen

After the Cormorant Street site was shut down and outreach workers were experiencing the challenges of “going mobile,” a number of clients passed away and workers were faced with their deaths without a place for the community to mourn.

...there's been a lot of deaths of our clients and that stands out for me. A lot of deaths of people who...I had, you know...strong relationships with, that a lot of the staff had strong relationships with that were real characters and real, you know, strong members of our community and their deaths have had a huge impact on me and the rest of the staff I think and...you know, not having a central space for us all to gather really and think about that, those people and, and be together around that has, has been a huge loss. (Tess)

...[in] no other aspect of my life have I known three people to die in, you know...what, six months? (Nyla)

... that isn't something that, most other people ever deal with in the workplace...and I think that's not...an element that's very appreciated from outsiders' perspectives. (Sam)

5.5 “Detestable Meddlers”⁸: Outreach Workers and Stigma

SOS was thrown into the local media spotlight in 2007 when its Cormorant Street location was made a flashpoint for the “public disorder” related to Victoria’s lack of housing for people living in poverty, people with unsupported mental health problems and people using illicit drugs.

Outreach workers found their jobs to be under public scrutiny and misunderstood by those uneducated about public health and harm reduction approaches to illicit drug use. The influence of the War on Drugs approach of criminalizing and incarcerating people who use drugs is still strong in Canada, as is the notion that abstinence-based treatment is the only answer to addiction.

The conventional media has been slow to catch up to what is well-established in international health and social policy research that shows that effective and humanitarian ways to addressing

⁸ Victoria, BC blogger and self-proclaimed “addictions expert”, David Berner, referred to SOS outreach workers in his December 31, 2009 blog entry entitled “Detestable Meddling” written after an article posted on the *Globe and Mail* website (updated version: Hunter, 2010) featured comments from SOS manager and outreach worker, Erin Gibson. <http://thebernermonologues.blogspot.com/2009/12/detestable-meddling.html>

illicit drug use emerge from public health, harm reduction and social justice paradigms (World Health Organization, 2007). The failure of AVI, VIHA, the BC Ministry of Health, and the City of Victoria to work together to oppose the stigma related to people who use drugs and ensure that essential health services, such as the SOS needle exchange, were able to continue to operate only reinforced the ignorance, fear and discrimination that resulted in the loss of the SOS fixed site.

When SOS became a solely mobile service, outreach workers found that their work was under constant public scrutiny and surveillance and expressed their frustration about this new dynamic. They also found it difficult because the scrutiny came at the same time they were feeling that they were no longer able to provide the best services to their clients. Outreach workers noted that the media scrutiny was accompanied by strangers, neighbours, and friends commenting on their work.

I think what's changed since the fixed site closed was that my job was never questioned in the... way that it is questioned now since, you know, our service was sort of thrown into the media spotlight and...I never...have had so many people offer their opinion about what I do and why I do it...it's certainly not supportive to have such a wide and constant criticism of my work...that's been some of the most challenging um, aspects of my job is that constant questioning and having to defend the work that I do, in a very public way and just in day-to-day life... I think... there's a lot of people in Victoria who say that they support harm reduction but they would never want a needle exchange in their own neighbourhood...or say they do but don't really have an understanding of what that means. (Tess)

A participant describes how, when her work was focused on meeting client needs, she felt confident that she was doing “good work.” With the restrictions of the mobile service and the constant public scrutiny, the value of her work has been publically called into question.

we have to not only respond to the clients' needs but we need to respond to the pressures from the community, the media and from VIHA, in terms of how we do our work. The public scrutiny...that's been really hard...before we kind of worked in isolation and we knew we did good work, and now it's sort of, that's

been brought into question like, are we doing good work? Sometimes I don't feel like we're doing good work 'cause the clients are telling us that...they can't find us or...[they say] "this is fucked, we shouldn't have to follow you...two blocks to get our supplies" (Ginger)

Outreach workers have been confronted on the street about their work by passers-by since starting mobile services. The following quotes illuminate how outreach workers have been confronted by members of the public.

I've had, many, many occasions where people have walked by us and asked us what we're doing or things like that and it's obvious that they're not supportive...I've been threatened a couple of times actually by members of the public...you know sometimes when people have been really abusive to me like, personally attacking me and calling me names and stuff that I can't really do anything, and ... I don't do well with that...to be disrespected and called out like that... (Ruby)

I was standing on the street corner one day during an outreach shift with my co-worker and three other clients and we were offering them supplies and some middle-aged-looking white man walked right by us...and yelled out um, something like, you know, "why don't you just let them all die", I think was what he said and...there's been other things written about us in the media or on blogs that have been...highly critical of the work that we do, people who call us enabling... (Tess)

[They've yelled things like] "how you gonna feel when all these people die from the needles that you gave them" and...[I] just find it really bizarre that there's such an anger, or people like from the public yelling at us because they, live in a condominium next to a homeless shelter and they're angry that there's homeless people outside? (Ruby)

Workers recognized that there *is* support in Victoria for harm reduction services, but that unfortunately, it is usually the unsupportive individuals that outreach workers hear from. Most workers believe that people who are opposed to harm reduction services don't have enough information about them.

...there's strong voices in the community that are like...people should just be going to jail for using drugs...and that real negative stuff, but the rest of the community does come together and they do push back against that... (Ginger)

I think people are really confused and they're afraid to be considered enabling...they're afraid of condoning behaviour that's not considered culturally acceptable...(Olivia)

I think a lot of people who dislike our work don't understand our work. Um, not only do they not understand but they ...they don't really see how professional it really is...(Nyla)

... misconceptions...are being used to build this...anti-[needle] exchange sentiment...It's like a movement almost... (Sam)

Many of the barriers that outreach workers face are moral arguments. Recent research in Australia found that people may be highly invested in their negative stereotypes, attitudes and behaviours toward illicit drug users and believed that their attitudes made “a positive contribution to society in that it would discourage people from participating in injecting drug use” (Australian Injecting and Illicit Drug Users League, 2010, p. 9). These negative views were also held towards needle exchange programs (Australian Injecting and Illicit Drug Users League, 2010). Outreach workers in Victoria have experienced negative judgment and disapproval stemming from such attitudes and erroneous opinions regarding harm reduction services:

Moral politics. That is the sole issue affecting our work, in my opinion. (Sam)

I find that a really frustrating counter-argument to make is against people who call us enabling. And the whole liberal notion of choice, you know, that people choose to, to uh, become drug addicts or you know...they've made their bed now they have to lie in it sort of attitude or, you know, if we simply just didn't supply these things to people then they would have to stop using drugs or, you know that treatment is the ultimate answer and that instead of peddling harm reduction supplies we should be pumping everyone through a treatment program and you know, a lot of those comments really come from ignorance, um they come from, opinions that aren't based in any sort of fact...they really have no clue what they're talking about, but they have very strong moral opinions about the subject and...I find that, um...really difficult and really exhausting. (Tess)

And they don't see [people who use drugs] as being part of their community, you know, and they see them...[as] being so disconnected because they're not a part of their reality...they want them in the jails or in institutions so they can be outside of our community ...it's frustrating that the things that we're trying to do

are well-established in literature, I mean they're based on [the] determinants of health...(Olivia)

The stigma and lack of understanding experienced by people who use drugs is also directed towards services such as needle exchange programs. Outreach workers experience feelings of isolation and of being judged.

I feel like we're a renegade organization, you know? That's completely isolated from a lot of people...and stigmatized...(Sam)

I think we've really felt the stigma... I find I have to defend my job a lot more since we were shut (Olivia)

it gets really exhausting to have to constantly uh, defend my job and also be really wary about who I talk to about my job, you know, I'm never quite sure meeting somebody new what their response is going to be when they say, "so what do you do", and I tell them that I work for a needle exchange and you know, sometimes I just don't want to have that conversation because if they're not supportive or they start going on a tirade...that's just so exhausting because...it really cuts to the core of my beliefs and I hold those beliefs so strongly. (Tess)

it really does, cause me to be disgruntled when people think that like, all I do is sit on the corner and throw out rigs...it's like no actually...I know some pieces of information that can maybe help this person's life, maybe for a week, maybe forever like, how dare you...take the professionalism out of our job. (Nyla)

it's interesting also the way in which these 'concerned citizen' people talk to you when you're wearing a uniform and when you're not wearing a uniform, it's like I've become a person again when I'm not wearing a uniform, and though they still express that same kind of hatred and violence, it's not actually like, towards me, but it's still towards an issue that is really close to my heart... (Sam)

I think some people view us as heroes and some people view us as pariahs...some people think of us as pretty amazing and then there's some people who think of us as just outreach workers like, no skill. (Ginger)

Ginger described the reaction of an auto repair shop manager when she took the outreach vehicle, an old ambulance, in to the shop for service. The mechanics were backed by the shop manager in their decision to refuse to work on the vehicle based on concerns about how the vehicle was being used:

...he said that the ambulance would not be able to be worked on...I said 'so why is that?' And he said... 'it's just not at a standard that our mechanics can work on it,' and I said 'what are those things that you're concerned about?' And he said 'well, there's condoms everywhere...and there's a biohazard container and there are...used blue gloves on the dashboard ...it's just not in the state that we're used to having ambulances in,' and I said 'well, it's not an ambulance, it doesn't transport people'...and I said 'all [our] staff are trained and it's a union shop... we would not have people working in an unsafe environment'...I also said 'no one's ever been infected from a discarded syringe'...They refused to work on it... He said 'well there's dirt on the floor,' and I said 'there's dirt on the floor in any vehicle, and the condoms are in wrappers and we don't have used condoms in this vehicle' and um, I said 'everything's in sharps containers, the staff don't actually even handle [used] syringes...' and um, the blue gloves which he thought would have been from like handling blood and syringes and biohazard was actually a paper towel that was used to wipe off the inside of the windshield because the fan was broken. So I pointed all this out and...he was pretty understanding, but [said] 'my mechanics have the right to...refuse to work on a vehicle...we're not just gonna work on it a vehicle that, that does this kind of work because of the hazards it might present'...I got off the phone and I burst into tears...and even talking about it now, I'm quite upset because it, it really emphasizes to me, like ... that's the stigma our clients face on a daily basis and I'm educated, I'm housed, I don't look different ...[and] we can't even get a vehicle serviced...to deliver the service to our clients. And because there was time wasted in them not fixing the vehicle in a timely manner; the service for our clients was interrupted which was also really upsetting, but just that this sort of, stigma-by-association... and then also just the reality of like, that... I'm not even dependent on this, and just how upsetting that was for me that, it even extends to people who are being paid. Not even to deal directly with our folks but to deal with a service vehicle that works with people that use drugs. Just it really...it was really upsetting. And it really just exemplified how much of a fight we have, and how...vulnerable people are and it's like, I should have the energy to fight... and it just was really degrading...It was really difficult because... people judge us because of what we carry around...And it just really reiterated how ignorant people are and how they wield that ignorance and its power.

In this case, it seems that the mechanics were basing their decision not to work on the outreach vehicle due to fear of contamination, which highlights the ignorance and misunderstanding that is still present around how infectious diseases are spread and how services for people who use drugs operate. The message heard by the outreach worker was that the vehicle (SOS work environment) was considered to be dirty and contaminated because of the articles it contained

(packaged condoms, biohazard containers, etc) and because of the people who accessed the service (read: dirty and contaminated drug users).

Even when outreach workers experience responses to their work that are meant to be supportive, often such responses are framed within a context that reinforces the stigma experienced by people who use drugs. “[T]here are often conditions attached to this valorization that emanate directly from the discursive boundaries of the stigmas associated with the client group” (Phillips, 2010, p. 45). People may elevate the status of outreach workers based on their work with people who are viewed to be “hard to work with” but the elevation is also isolating for workers and abdicates community social responsibility (Reynolds, 2011).

on one hand she’s calling me amazing for working with people who live on the street and on the other hand she’s telling me that she’s terrified of them, and so...it’s like, I’m a hero because I’m dealing with people that she doesn’t want to go near. (Tess)

“it must be so hard working with people like that or dealing with their trauma’ and, and I’m just like...that is the least of the challenges in my job is dealing with people that other people don’t want to deal with. That is, that is the most rewarding part of my job... They’re missing out on a great chunk of humanity. (Ginger)

5.6 Political Inaction: Neoliberalism and Lack of Political Will

Outreach workers identified challenges of working in the social services field under a neoliberal agenda. Neoliberalism has been the primary government track in Canada since the mid-1980s and the neoliberal New Public Management (NPM) model has drastically impacted human services work (Baines, 2004). A strength of social service work has been in its “grounding in the everyday lives of individuals and communities” (Baines, 2004, p. 277) but neoliberal and NPM labour practices are more concerned with efficiency, standardized organization of work, performance results, and lowering the cost of labour by an increased reliance on unpaid work

(Baines, 2004). In 2001, the Liberal party was elected to power in BC, and its neoliberal stance has ensured wide sweeping cuts to social funding and harsh restrictions on welfare rates and eligibility (Wallace, Klein & and Reitsma-Street, 2006; Klein & Pulkingham, 2008).

Consequences of neoliberal policy agendas at both the federal and provincial levels were noted by a City of Victoria taskforce on mental illness, addictions and homelessness which found unprecedented levels of poverty, homelessness and substance use in the City (City of Victoria, 2007). Outreach workers emphasized that their clients' drug use is often deeply rooted in the impacts of systemic social problems such as poverty, trauma and abuse, and is made more problematic by a lack of affordable, appropriate housing options. The BC government has not committed to creating any new permanent housing stock since being elected to power in 2001.

Set against rising housing costs, stagnant incomes, frozen welfare rates, a minimum wage that has not increased in almost a decade and is now the lowest in Canada, and a growing population, the picture that emerges...helps to explain why so many communities across BC continue to see an increase in the housing and homelessness crisis” (Klein & Copas, 2010, p.11).

One participant noted that the greatest challenge of their job is facing the lack of action to improve the social conditions in which their clients live:

...the lack of action around housing, around health care for people who are extremely marginalized, around poverty, um, you know uh, the lack of action by of our health authority and our local politicians and local leaders has been the most challenging part of my job. It directly impacts my job, it directly impacts the life of my clients, literally, and it is the most infuriating, most maddening element of my job... that lack of action. (Tess)

Outreach workers identified that the lack of action around restoring and enhancing harm reduction services in Victoria could partially be attributed to a neoliberal environment that relies “on the *altruism* of social service workers...to fill the ‘caring gap’ created by standardized and

thinly staffed paid caring work” (Baines, 2004, p. 268). One participant explains the neoliberal reliance on worker benevolence and an ambivalence to social services staff turnover:

...there's such a great degree of under-funding because I think that there's an expectation... by local governments and funding agencies that the organization will...express a certain degree of benevolence towards helping because helping professions are always exploited in that manner, and I think that...you know, they're running us down...at the exchange...but I think they also feel quite confident that the people who work here...are passionate about their work and... will continue working ...we care about the best interests of the client and we need to provide that service...and that dependency on benevolence I think is hugely problematic in the social services field, and in specifically relating to us because it's uh...exceptionally exploitative. (Sam)

Outreach workers feel limited in their ability to challenge funding limitations and are unable to speak out publicly about their frustrations related to the political dynamics with their organization's funders. Within the provincial neoliberal social services environment, the reality of ongoing funding cuts ensures that contracted agencies strictly adhere to the directives from government funders. Speaking out against funders means increasing the probability that funds will be further cut back. Being silenced has taken a toll on outreach workers:

...we do a damn good job...with what we've got...[but] I find [it] really challenging...[to have] the energy to keep going and keep doing this... when there's no sort of real change in sight...And, that we have the evidence and... there doesn't seem to be any support in the ranks of public health to do what needs to be done, to support people and prevent the spread of HIV and hepatitis C...it's really challenging to think ...where are my ethics in terms of like, knowing what needs to be done and not being allowed to do it and...how ethical is it to run a sub-par service...and how much [that] sucks out of me... (Ginger)

I find it really hard to work and not be pissed off at what's happened, to be honest. I find it frustrating because I think a lot of the [current] staff didn't work [at the fixed site], so they don't have a context for what it was that we used to be able to do. I think...[the mobile restrictions are] really demoralizing in a lot of ways...it just feels like...we're just always trying to compensate for new restrictions... (Olivia)

I'm finding it personally hard to sustain... I'm having a hard time reconciling the fact that this is still the way it is and it's just so ridiculous, you know... I

can't advocate for clients anymore the way that I think they need to be advocated for... the conditions of the job have made it really difficult to do that one-on-one work which is the sustaining part of the work, right like, you can't go in every day and take the fight to the man because...you're gonna...be done in a month. (Olivia)

...I can't really stand by and watch and I feel like because we're so controlled and like, silenced on so many levels...so just trying to figure out how to do something and help without it having AVI get punished or shut down... I, feel like VIHA's constantly threatening to pull everything and so I don't want to step out of line... (Ruby)

I've been so incredibly frustrated and enraged and outraged and um... disgusted by our city's response to, and lack of action around...replacing the evicted fixed site with something comparable or better...I care about these issues, I care about my work... I care about the people that I work for, I care about the staff and um, I can't let this go...so I've had to find other, other channels... because I feel like I need to act, I need to speak, I need to, um, work on this with other people who care about these issues...When people talk to me about my job, um, and they say oh that must be a really tough job and I say yeah it's tough because...you know, my job is so dictated by people who are so disconnected from practice. (Tess)

The silencing and isolating of outreach workers has led to incredible frustration; outreach workers know how best to work with their clients, and while this knowledge is supported in best practices documents and reports, the neoliberal policy and funding environment has, in some cases, put workers at odds with ethical practice.

A lack of solidarity and support from other service providers who serve many of the same clients has been disappointing to outreach workers and added to their feelings of isolation. Limitations on solidarity may be due a number of reasons including, but not limited to, ignorance of harm reduction practices, fear of being associated with a stigmatized population and the programs intended to support it, or the divisive environment created by an increasingly limited funding pool for health and social services.

...other service providers that work with the same clients, they know how essential this service is to the people that they also work with and yet, they also put up barriers ...for us, and I don't think they're very...supportive, I find that really challenging like ...we're meeting the needs of the same people that they're serving and, they're not willing to...participate in a very supportive dialogue... (Ginger)

... we need to stick together and, and we need to be supportive of one another and...the atmosphere of distrust and stress and tension that has been brought upon us by our funders and by other community leaders has been detrimental I think to our relationship with other service providers, and um...I think that's so counter-productive and so unhealthy in a small town that has some pretty significant socio-economic and health issues. (Tess)

Outreach workers have also felt abandoned by community leaders and other health and social service providers who have not advocated for harm reduction services, and may not even understand why they are important. An absence of coordinated action and political will at all levels of governance and leadership has been frustrating.

...the authorities, and...the police and VIHA. I feel like they're completely absent...in...taking a stand...(Sam)

I've been...so profoundly disappointed and disgusted by the inaction of our community leaders. I know that there is support for harm reduction and for health services for people who use drugs and for the work that we do...but there's also a lot of opposition and...a lot of apathy and a lot of inaction on the part of community leaders and funders, and that has really stood out for me and been a colossal disappointment and source of anger. (Tess)

5.7 Sources of Support

As outreach workers face the challenges of their work, one of the strongest sources of support for is their fellow staff members:

It's always been rewarding to work with our staff...the staff have performed with incredible grace under pressure and remain some of the most incredible people that I've met, because of their commitment and...the heart that they put into their work and uh, just because of the people they are and the work that we do you know, um, some of the most non-judgmental, compassionate, fiercely political people that I know and I really respect them and it's always been a rewarding aspect of my job to work with the staff. And so I rely on that more now than ever. (Tess)

...the staff are amazing...people that I work with that are, really good, they're really resilient...it's really rewarding to work with such a group of like dedicated, hard-working...staff right, that you're not alone in that, that's pretty rewarding. And knowing that we keep doing the work even though it's hard...And so working with a bunch of people that really believe that people deserve access to this, and sort of have no judgment. (Ginger)

...the co-workers are great, our manager is outstanding...the team is a blast, it's like a really interesting group of people and lots of great humour, is key I find. (Ruby)

I really enjoy my time working with them because in these times of... chaos, uh, I find it essential in building momentum, building some positive energy and when I can have a good connection with the staff, it makes...the quality of the service I deliver that much better ...because we're excited to be there...SOS staffers...serve a positive example to the rest of the community...around coming together...(Sam)

Outreach workers operate in unique conditions; the work environment can be chaotic at times, unpredictable, and often under-resourced (Strike, O'Grady, Myers & Millson, 2004). Outreach work may not be well-understood or supported by others outside of the work environment, and it is not surprising that a primary source of support is co-workers with similar experiences. It is crucial that outreach workers have access to supportive forums in which they are able to be self-reflexive (Strike, O'Grady, Myers & Millson, 2004).

When there is public support shown for their work, outreach workers feel invigorated.

...one night I was...sitting down in the ambo and this guy came by...he was...in his mid-30s probably...very sort of 'mainstream-looking', and he brought down a bunch of clothes...and said, you know, "I heard about you guys in the paper and I just wanted to come by with these clothing donations 'cause I really appreciate what you do and I think that the work that you do is amazing and thank you so much" and he was just this totally random guy who came by and wanted to offer his support...and it was the most incredible thing and totally made our night. (Tess)

One outreach worker felt affirmed by the fact that despite all of the controversy around harm reduction services in Victoria, they are appreciated by the people that rely on their support.

I feel supported by...working with people that access our service and...knowing that...they believe in our work. (Ginger)

Another worker noted the energy and gratitude that was generated for her in the moments that she was able to connect with clients and this was echoed by other participants.

I find my job rewarding 'cause I, I absolutely believe in the work so, I just have to like keep in touch with that part... you know, more of those moments where we're like 'yes!' we just connected and brought health care and, you know, support to somebody, even if it was a 3 minute moment. So, that's rewarding and even though they're little moments, they stand out really strongly for me...something that I love about the job is just the diversity of the people that I meet and... you know, touching base with these human spirits, you know, and seeing that resilience and that light in people...It's incredible! (Ruby)

5.8 Conclusion

Outreach worker perspectives narrate a story of the transition of SOS from fixed site to mobile services. While the Cormorant Street location of SOS was cramped and operated with limited resources, outreach workers emphasized their ability to build and maintain relationships in a consistent and reliable manner in a space that was a community refuge for a highly marginalized population. The forced transition to mobile services left outreach workers feeling a sense of loss for the private space in which they were able to consistently provide more comprehensive care to their clients. Increased public and police surveillance, restrictions on service delivery and the impact of stigma towards people who use drugs left outreach workers feeling frustrated and angry. Living and working conditions under neoliberal policies exacerbate the sense of isolation and silencing felt by SOS outreach workers and they look to their co-workers for support and a source of resiliency in their commitment to providing support, care and information to their clients.

Chapter 6: Concluding Remarks and Recommendations

This case study pursued the twin goals of making space for SOS outreach workers to share their perspectives on the closure of the Cormorant Street fixed site needle exchange and exploring the impact of the transition from fixed site to mobile services on their work. Coupled with the analysis of related reports and media coverage about harm reduction and needle exchange, outreach workers' perspectives capture a moment in time in an evolving story of harm reduction policy and practice in Victoria, BC. When the data were collected, I discovered that many of the frustrations I was feeling as an outreach worker were shared by the other participants, particularly around how our knowledge is contradicted by organizational and institutional policy and practice. This research provided an opportunity for myself and my fellow participants to reflect on our work, assert our beliefs in the work we do, and speak out as witnesses to the social injustices faced by our clients. Our perspectives are not often included in public debates and media coverage. In this study, they have added texture and meaning to what can be found in the literature about the value of a harm reduction approach to health services for people who use drugs, and the contested nature of harm reduction services. This study has shown how, despite the challenges they faced on Cormorant Street, SOS staff were able to provide at a fixed site what the mobile service struggles to: a consistent, reliable, easily accessed space where highly marginalized illicit drug users are offered some respite from the social injustice they face in their everyday lives. The impact of the loss of the fixed site and transition to mobile-only services has increased the stress on outreach workers, limited their ability to best address the needs of their clients, and increased not only the vulnerability of SOS clients, but the program itself, by undermining the importance of integrating harm reduction as an essential part of health services.

6.1 Benefits of Fixed Site Harm Reduction Services

When stigmatized individuals are able to access spaces that provide them with a sense of increased safety and sanctuary, they have the opportunity to build trust and relationship. A space to be together, to be oneself, to celebrate, to grieve, and that is accessible when one is ready is rare and cannot be underestimated in the context of the potential for healing from trauma.

Relationships with outreach workers are often the only links that people who use drugs have with health care providers. These links can be a catalyst for sharing health-promoting information, including strategies for reducing the harms associated with illicit drug use and the harms of an unjust society.

Harm reduction services and supports, such as needle exchange programs, must match the needs of people using those services. In the case of people living in poverty and homelessness, in thriving illicit drug markets, and within environments with limited mental health, housing, health care and income supports, dedicated fixed site needle exchange programs are the most effective, most appropriate model of needle exchange. Mobile services, secondary sites (where needle exchange is offered, but not as the primary service) and vending machines do not provide consistent access for large numbers of clients; meet the demands for clean supplies and recovery of used supplies; link to other services and supports; and offer social refuge, peer support, and sense of community that fixed site services can. These more secondary modes of service are important to include in a comprehensive model of needle exchange, but cannot and should not replace dedicated fixed site locations. The SOS outreach workers that participated in this study identified the clear benefits of the Cormorant Street fixed site and these are also identified in the literature around modes of harm reduction services. Participants highlighted how much they

enjoyed the sense of community that was generated in the Cormorant Street site, and the privilege of “walking through life” with their clients thanks to the consistent refuge provided by a physical space from which to operate SOS.

6.2 Limitations of Mobile Services

Mobile services and secondary sites for needle exchange services are not enough to address the public health needs and social determinants of health for people who use illicit drugs in Victoria. This is supported in the literature and was a primary theme that emerged from the interview data. Without a physical location for outreach workers and SOS clients to connect, comprehensive services are not possible. Opportunities for relationship and community building, providing referrals, partnering with other health care providers, offering psychosocial support, and harm reduction education are significantly limited on the street corner. SOS outreach workers emphasized that further limitations on mobile services such as police presence and the directive of the “no go zone” make connecting with clients and providing them with the care and information they need even more difficult. Outreach workers in Victoria echoed observations that have been documented elsewhere when harm reduction services are restricted or shut down, including increased risks related to the limited supply of safer drug use tools, rushed drug use associated with public scrutiny and police surveillance, a loss of contact between people who use drugs and outreach workers, and increased stigma and discrimination in the form of “NIMBY” attitudes. These impacts have negative consequences for people who use drugs, for the larger community, and for outreach workers.

6.3 Impact on Outreach Workers

SOS outreach workers spoke most ardently in their interviews about their relationships with their clients. Violence in the form of stigma and discrimination perpetuates the trauma experienced by stigmatized individuals, and also impacts on workers who are constrained in their ability to work according to their ethics in marginalized spaces. SOS outreach workers spoke of their feelings of demoralization around, on one hand, knowing how best to serve their clients and on the other, not being able to do so because of the forced transition to mobile service. They described the scrutiny and surveillance they have experienced since the fixed site was shut down, and the lack of support from VIHA in defence of the important work that they do. Public education around the benefits of a harm reduction health care approach to illicit drug use has been limited in Victoria to a damage control approach by VIHA, and the efforts of grassroots, community organizing of Harm Reduction Victoria. The impacts of fear, ignorance and stigma towards people who use illicit drugs has also contributed to the feelings of isolation experienced by outreach workers. The reality of a neoliberal funding environment has amplified this isolation when contracted agencies are made to vie for funding from the same pot.

The findings of this study will resonate particularly for people working with populations that experience stigma and discrimination, who come face-to-face with the systemic marginalization experienced by their clients. In this context, they may struggle to practice in a manner that reflects their ethical principles of social justice and resistance (Reynolds, 2010). For example, following the SOS eviction, SOS workers reported increased scrutiny and surveillance of their work, restrictions on service delivery, and loss of connection with some of their clients. These experiences led feelings of isolation, stress and strain that may be commonly categorized as

symptoms of “burnout.” All six participants spoke of feeling worn down, frustrated, isolated, angry and fed up. However, the language of “burnout” is problematic; it reinforces the individualization of moral distress and response to social injustice (Reynolds, 2009). While workers may be constrained within the limits of their jobs to transform social injustice in more tangible ways, their work of walking alongside clients to minimize the impacts of social injustice and create possibilities for change are important. This work must be supported by employers in a manner that goes beyond the tendency to ask workers to adopt individual coping strategies.

Vancouver activist and therapist, Vikki Reynolds, has developed an approach to clinical supervision that she calls a “Supervision of Solidarity” which merges concepts and practices from her experiences as an activist with the more individual focus of therapy with people experiencing pain and trauma. She brings practitioners together to “engage a spirit of solidarity within contexts of social injustice and extreme marginalization” (Reynolds, 2010, p. 255). Reynolds emphasizes a collective effort to build an ethical foundation of solidarity which provides the opportunity for sustainability in the work of supporting people who are marginalized.

Among Reynolds’ key principles of solidarity work, the principles of “doing solidarity”, “centring ethics”, and “fostering collective sustainability” resonate the most deeply in me as I consider the experiences of SOS outreach workers (Reynolds, 2010). Research participants expressed feelings of isolation in their work and disappointment that there was not a sense of solidarity between their program and other organizations that work with similar clients. “Doing solidarity” asks us to look for common ground and connection in our work, reducing isolation

and affirming that we are not alone in resisting oppression and working towards for social justice (Reynolds, 2010). “Centering ethics” is a practice that challenges us to collectively identify our ethical stance and how it is practiced. Reynolds explains that when practitioners are not able to act according to their ethical stance, as SOS outreach workers identified in relation to the restrictions placed on their work, they experience spiritual pain. “Spiritual pain speaks to the discrepancy between what feels respectful, humane, and generative, and contexts that call on [practitioners] to violate the very beliefs that brought them to this field” (Reynolds, 2009, p. 249). Doing solidarity and centering ethics make clear to us that we are not alone, that we collectively commit to our ethical stance, and that we are aware of when this stance is challenged and the impact that has on us. “Fostering collective sustainability” looks to ways in which we may not only resist the isolating impacts of burnout, but how we can maintain connection with one another, and remain engaged with our collective ethics and our sense of being alive in order to be useful to the people that need our support and services (Reynolds, 2010). We acknowledge that our work is important to us, why it is important to us, and that we are not alone in struggling to practice in a manner that makes us feel the most human. Sustainability in our work means “staying alive” in our “collective ethics” in order that we are able to care for ourselves and, as a result, continue to put our clients at the centre of our work (Reynolds, 2010).

6.4 Support and Resources for Services

While the SOS fixed site provided a unique and important environment for SOS clients and outreach workers alike, it also faced significant challenges due to a lack of support and resources from VIHA. Without a funding increase in over 10 years and a client population bursting at the seams, the Cormorant Street site was a sanctuary that had long been outgrown by the time SOS was evicted. It is the responsibility of the Health Authorities in BC to provide leadership and

ensure that harm reduction is integrated into health services. In their 2007 external review of SOS, Campbell and Fair noted that “among service providers and management in the system of care, harm reduction services do not seem to be understood as a critical piece of the health care continuum” (pg. 6). They noted that VIHA was responsible for providing leadership, training, resources and support to all of their contracted needle exchange services, with a consistent set of standards across all modalities. They called for VIHA leadership to ensure that harm reduction practices were integrated into health care services for people who use drugs, and to educate health service providers “on the concepts of harm reduction and addiction as a health concern” (Campbell & Fair, 2007, pg. 13).

Participants in this study expressed their frustration over the lack of political will and coordinated leadership and the impact of that inaction; namely, that fixed site needle exchange services have not been implemented in Victoria since the Cormorant Street site was forced to close in May 2008. While VIHA is ultimately responsible for ensuring such services are available, a coordinated effort with the municipal and provincial governments, and the local police services, is necessary to challenge the social, political and legal contexts that undermine public health and human rights evidence about the need for harm reduction services. In order for fixed site harm reduction services to be viable in Victoria, where public perception of needle exchange services has been negatively influenced by the neglect of SOS on Cormorant Street, VIHA must fulfill its leadership role through funding, education and training; repair relationships with stakeholders (people who use drugs); and actively advocate for harm reduction modalities that appropriately address the needs of the community.

6.5 Implications for SOS

This case study has intentionally foregrounded the perspectives of SOS outreach workers and my recommendations that emerge from the findings, and from the model of practice offered by Vikki Reynolds, do the same. In order to more fully support SOS outreach workers in ways that are reflective of Reynolds' solidarity principles, AVI could implement the recommendations listed here:

1. Take a social justice stance.

The act of working for AVI, and particularly with SOS, is political and an act of resistance:

I believe that frontline work dealing with violence is activism and a collective resistance to an unjust society. Frontline workers are asked by society to deal with the life experiences of people whose human rights are ignored or abused. The cost of this unjust society falls on both the impoverished and the frontline workers who struggle alongside them and bear witness to the suffering that other citizens have the privilege of choosing not to see. This inherently political work requires an Ethic of Resistance that takes a position for justice (Reynolds, 2008, p. 5).

AVI is a registered charity, and in Canada, charities are restricted in the amount of advocacy work they can do: "At present, the federal Income Tax Act prohibits charities from spending more than 10 per cent of their revenue on advocacy activities that are deemed too "political" (Family Service Toronto, n.d.). However, AVI still retains the ability to speak out, to call attention to issues of concern for their clients, to decry stigma and discrimination and to adopt a social justice stance.

SOS outreach workers struggle to work in line with their ethics under current restrictions on their work, including the lack of fixed site services and the no-go zone, which are fuelled by stigma, discrimination, fear and ignorance. Fostering collective sustainability means take a stance of “doing justice” together (Reynolds, 2010). It is important for outreach workers to feel that, at minimum, their employer stands strongly in solidarity with them as they work in spaces of marginalization. This solidarity must be enacted, not merely stated.

SOS outreach workers described feeling silenced and frustrated about not being able to speak out and advocate with and for their clients. I, personally, have been supported by my employers at AVI to engage in political activism related to my work, on my own time. My experience as an outreach worker and my perspective as a researcher have motivated me and some of my coworkers to organize collectively and take action through our work with local group, Harm Reduction Victoria. This has been an important outlet for the anger, frustration and moral distress I have experienced in relation to my work. By continuing to support their employees’ rights to organize outside the bounds of the organization, and out from under the gaze of government funders, AVI sends a message to SOS outreach workers that their desire to work for a more just society is valued.

2. Campaign vigorously to re-establish fixed site needle exchange services and move forward with the establishment of supervised consumption services.

Advocacy with funders and other organizations, and at all levels of government, is ongoing and must continue. Advocacy work done by AVI representatives at the Board and Management

levels must be grounded in the collective ethics of the organization and in solidarity with staff working directly with clients. As part of this work, AVI could engage in education and social media campaigns with a focus on reducing the stigma related to illicit drug use, poverty, mental health, et cetera (Phillips, 2010). This action would also express solidarity with SOS outreach workers and clients by identifying and rejecting the stigma experienced by their clients and directed towards the services such as needle exchange.

3. Develop and maintain an ongoing plan for care of workers in marginalized spaces.

Acknowledge the ongoing impacts of moral distress, spiritual pain, stress and strain that is experienced by outreach workers by providing regular opportunities for staff to speak about these experiences with one another. Organized debriefing, mentorship, peer training and team building should be considered “a precondition to effective service delivery, rather than an opportunity to be explored when resources permit” (Phillips, 2010, p. 138). Reaching out to other organizations working with marginalized populations to form “solidarity groups” could be one way to reduce isolation and build a sense of collective ethics for “doing justice” together.

The kinds of support systems described above are even more important when we consider that outreach workers may come from an experiential place with regards to illicit drug use.

According to the principle of “Nothing About Us Without Us” adopted by movements of people who use drugs in relation to policies, practices, programs and services intended to benefit them, experiential people *must* be at the forefront of social movements, political campaigns, service provision and supports, and outreach work *must* include the leadership and involvement of people who use(d) drugs (Canadian HIV/AIDS Legal Network, 2005; World Health

Organization, 2007). A collective ethical stance and a foundation of solidarity for the work of “doing justice” is integral to the spiritual and emotional sustainability of all outreach workers and in particular, those who have used, or continue to use, illicit drugs.

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Appendix A: Interview Guide for SOS Staff Hired Pre-May 31/08

1. Please describe your age, gender and racialized identity.
2. Please describe any formal and informal background experience that led you to your work with SOS.
3. How long have you been working with SOS?
4. What did a typical outreach shift in the fixed site look like for you?
5. What does a typical outreach shift look like for you now?
6. How have you responded to the changes to your job since the fixed site closed?
 - a. Have you adapted your ways of working?
 - b. What has worked for you? What hasn't?
7. Looking back on the past year since the fixed site closed, what stands out for you?
 - a. Are there any significant events or changes that stand out?
8. What do you find most rewarding about your job?
 - a. Has this changed for you since the closure of the fixed site?
9. What supports you to do your job?
 - a. Has this changed for you since the closure of the fixed site?
10. What do you find most challenging about your job?
 - a. Has this changed for you since the closure of the fixed site?
11. How do you think your work is viewed by other people outside of your workplace?
 - a. Who are they?
 - b. How would you describe their opinion of your work?
12. Are there any other issues that are affecting your work?
13. Is there anything else you'd like to add?

Appendix B: Interview Guide for SOS Staff Hired Post-May 31/08

1. Please describe your age, gender and racialized identity.
2. Please describe any formal and informal background experience that led you to your work with SOS.
3. How long have you been working with SOS?
4. Currently, what does a typical outreach shift look like for you?
5. Has this changed from when you were first hired?
 - a. How have you responded to the changes to the mobile service?
6. As you look back on your time with SOS so far, what stands out for you?
 - a. Are there any significant events or changes in your work that stand out?
7. What do you find most rewarding about your job?
8. What supports you to do your job?
9. What do you find most challenging about your job?
10. How do you think your work is viewed by other people outside of your workplace?
 - a. Who are they?
 - b. How would you describe their opinion of your work?
11. Are there any other issues that are affecting your work?
12. Is there anything else you'd like to add?

Appendix C: Invitation to Participate and Informed Consent

Dear Street Outreach Services Staff,

You are invited to participate in my Master's thesis research on Street Outreach Services (SOS) staff experiences of the closure of the fixed site needle exchange.

I am a graduate student in the Studies in Policy and Practice program in the Faculty of Human and Social Development at the University of Victoria. My research is being conducted under the supervision of Dr. Susan Boyd.

The purpose of my research is to document how service delivery changes and restrictions have impacted your work since May, 2008. My research findings will be of interest to health and social service workers who work with people that use illicit drugs and to policy-makers working on issues related to illicit drug use and public health care. The results will have the potential to inform and improve public health policy and delivery for people who use illicit drugs, and improve the working conditions of people who are engaged in street outreach work.

I am asking you to participate in this research because it is your experiences as outreach workers that are of most interest to me. Outreach workers' voices and perspectives are valuable because they have a specific, intimate knowledge of the experiences of people who use illicit drugs and the impacts of attempting to navigate difficult and often prohibitive social support and health care systems.

What is Involved

If you agree to participate in this research, your participation will include a short time commitment to be interviewed outside of your regular working hours.

The potential benefits of your participation in this research include a better understanding of your own work and exploring possibilities for change. It is my hope that the research findings, with the help of your participation, will contribute to improving the ways in which public health care services are available to people who use illicit drugs.

Voluntary Participation

Your participation in this research is completely voluntary. **You are under no obligation to participate in this research.** If you do decide to participate, you may withdraw at any time without any consequence or explanation. If you do withdraw from the study your data will be included in the study unless you prefer it also to be withdrawn or that it be used as background information only.

Anonymity and Confidentiality

In order to protect your anonymity, I will use a pseudonym for you, rather than your real name, and I will alter any identifying information about you or any agency service users that you may mention in our discussions. **I will also be interviewing myself and giving myself a pseudonym, just as I will for all other participants.** Neither you nor any service users will be

identified in my Master's thesis or any other paper, publication or presentation that results from my research.

It may be that you could be identified by what you say in any direct quotes that I may use in writing up my research. Any direct quotes I use will be written in a non-identifying way so that particular views cannot easily be traced to particular individuals. **Further limitations on ensuring your confidentiality include the fact that SOS has a small staff and I will be interviewing about 25% of the total number of SOS staff. Some staff members have also publicly expressed an interest in participating and thus I cannot completely ensure their confidentiality.**

I will store my notes and audio recordings of interviews in a secure setting in my home. I will also take steps to remove or alter identifying material from these documents and audio recordings.

I will dispose of the data I collect from this research at the completion of my Master's degree. If I decide to do further research outreach work after my Master's degree, I will provide you with a new consent form, requesting to use the information I received from you in this research for my future research.

Research Results

I anticipate that I will share the results of this research with others in the following ways: in my Master's thesis, academic conferences and/or scholarly meetings, possible publications and with SOS and AIDS Vancouver Island.

Contacts

If at any time you have questions or concerns, you may contact either myself, Heather Hobbs, by email, heather.hobbs@gmail.com, or by phone at 250-477-8546, or my supervisor, Susan Boyd, by email, sboyd@uvic.ca, or by phone at 250-721-8203.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand and agree to the above conditions of participation in this research and that you have had the opportunity to have your questions answered by me.

Name

Date

Signature

Please check if you agree that your data may be used in any potential future research.

I will leave a copy of this consent form with you and I will take a signed copy with me.