

**Welcome Home
Impact and Effectiveness of the Dr. Peter Centre's Harm Reduction Model for Those
Living with HIV/AIDS and who use Illicit Drugs.**

**Part of the Mixed Method Study Titled: A Mixed Method Evaluation of the Impact of the
Dr. Peter Centre on Health Care Access and Outcomes for Persons Living with HIV/AIDS.**

by

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BN, University of Manitoba, 2004

A Thesis submitted as Partial Fulfillment of the Requirements for the Degree
MASTER of NURSING
in the School of Nursing

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Supervisory Committee

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Abstract

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The Dr. Peter Centre (DPC), an HIV care facility, provides integrated health care services incorporating harm reduction strategies as part of service provision. These services include a “Harm Reduction Room” for those members who inject drugs, to do so in a supervised environment. In this thesis, I explore the perspectives of DPC members on the harm reduction approach as part of a larger study titled *A mixed Method Evaluation of the Impact of the Dr. Peter Centre on Health Care Access and Outcomes for Persons Living with HIV/AIDS who use Illicit Drugs*. Thirty DPC members were recruited as part of the qualitative portion of the larger mixed-method study. One-on-one in depth interviews were conducted with each participant and audio-recorded and then transcribed verbatim. Participant narratives reflected positive experiences with nurses and other staff, and with the harm reduction philosophy at the DPC. Narratives from both participants who inject drugs and participants who do not inject drugs indicated support for the harm reduction room because of the safety it provides. Safety was related to reducing the direct harmful effects of injection drugs such as infection and overdose, and also to the refuge from the street and freedom from stigma of drug use that the DPC provides. Participant accounts expressed a sense of acceptance and belonging as a part of the community at the DPC highlighting the role of DPC in shifting drug use patterns. This thesis emphasizes that the harm reduction philosophy and the provision of harm reduction services at the DPC contributes to the overall health and well being of participants.

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Acknowledgements

First, I would like to thank the members of the Dr. Peter Centre who agreed to participate in this study and whom I had the opportunity to interview. It was a privilege and an honor to hear your stories, and it was heartening and inspiring to hear of your resilience in the face of struggle.

A heartfelt thank you to my supervisor Dr. Bernie Pauly without whom I would not have embarked on this journey at the Dr. Peter Centre. For your guidance and mentorship, your patience, for your inspiration, and the common love we share for the population we work to serve. Thank you to my committee member Dr. Anne Bruce for your willingness and expertise in guiding this study, and to Dr. Ryan McNeil, from the BC Centre for Excellence in HIV/AIDS, for your guidance, your utmost patience, your diplomacy, your support and your flexibility. Thank you also to Dr. Bruce Wallace for your expertise as external examiner.

To the research team at the BC Centre for Excellence in HIV/AIDS, thank you for your support, your togetherness, comradery, and for arranging participant interviews and transcription.

Thank you also to the Dr. Peter Centre staff and administration for working together to arrange interview times and space.

Thank you to my parents who have been unfailingly supportive and encouraging, always interested in my work and for asking me questions along my journey that offered support and guidance. For your reading and editing. For believing in me, for listening, for your Love.

Finally, thank you to my husband Roop, my daughter Rose and my son Paulson (aka Mister). For your love, your patience and encouragement through this long process. For your smiles and the brightness you brought each time I was stressed through this academic journey.

Dedication

To my Father

Dr. Roy Jeal

You have been my inspiration in so many ways
For your encouragement to pursue academic advancement

For your love of learning

For your unfailing Faith and Love

To my children

Rose and “Mister”

I hope you will also be filled with a love to learn
and filled with the same Faith and Love as my Father

Chapter 1

Situating Myself

I have had extensive experience working as a registered nurse with a population that uses injection drugs and experiences a high rate of HIV. For ten years, I worked in various settings in Vancouver's Downtown Eastside neighborhood providing primary care, HIV care, addictions care, and mental health care to the people living in that neighborhood. Some of the stories I have heard from patients about experiences of stigma and barriers to health care have been horrifying. I have had similarly negative experiences while accompanying patients to health care and social service appointments. I have witnessed firsthand the fear that many of my patients have experienced when accessing care and this has affected me profoundly. My observations of such experiences, and my relationships with patients has given me a great understanding of the importance of non-judgmental care which I have incorporated into my practice, and into my role as a nurse educator. Other fears that patients have expressed are related to the direct risks involved with drug use such as using in unsafe environments, (e.g. back alleys, unsupervised settings) and the risk of experiencing an overdose or contracting an infection or transmitting infections. The nature of the Downtown Eastside is one with high levels of drug use and drug-related harms. Risks exist when using in back alleys where there are no sinks to wash, no alcohol swabs or clean injection equipment, and where potential threats to physical safety are a reality. Triggers to use drugs exist on every corner and on every street and in every back alley and every hotel.

My experiences have shown me that there is a disconnection between the health care needs of this specific population, and many of the services that are available. In addition, stigma exist that create barriers for this population in accessing health care (Pauly, McCall, Browne,

Parker & Mollison, 2015). A population that is already “othered” and thought of negatively, is segregated from mainstream health care by the barriers that have been erected by stigma, by ideology, and by societal fear.

Illicit drug use, particularly injection drug use, is associated with significant harms (Tyndall, Craib, Currie, Li, O’Shaughnessy & Schechter, 2001). The spread of diseases such as HIV/AIDS and Hepatitis C, bacterial infections, the risk of overdose and resultant stigma are some of the most concerning harms (Degenhardt & Hall, 2012; Chan, Stooove & Reidpath, 2008). Those who face such stigma also face challenges in accessing health care (Pauly, 2008). The Dr. Peter Centre (DPC) aims to reduce these challenges by providing equitable and accessible care through a unique model of integrated services. In this thesis, I focus on the experiences that DPC Day Program participants have had with the DPC harm reduction model, and the supervised injection services offered in the DPC harm reduction room. The purpose of this study is to investigate DPC members’ experiences with the DPC harm reduction program. My aim in doing this qualitative study/thesis is to fill gaps in knowledge about the effects of harm reduction at the DPC. In this chapter, I will identify and discuss the problem of the risks and harms associated with injection drug use, the barriers faced by those who use drugs, and then present the Dr. Peter Centre as one response to these problems and how it mitigates risk. In chapter two I will review the literature and the theoretical framework for the study while chapter three presents the methodology. Chapter four will present the findings and finally, chapter five provides a discussion of the findings as related to the literature.

Background and Problem: Harms Related To Injection Drug Use

Overdose

Fatal and non-fatal overdoses are a serious harm associated with injection drug use. Drug overdose fatality rates in British Columbia remained steady from 2004 to 2010 (Vallance, Martin, Stockwell, MacDonald, Chow, Ivsins, et. al., 2012) yet the 2011 rate increased to 371 with the highest rate being in the City of Vancouver (Tanner, Matsukura, Ivkov, Amlani & Buxton, 2014). A recent influx of the powerful opioid fentanyl into the illicit drug market has greatly increased the risk and incidence of overdose death (McKee, Amlani & Buxton, 2015) and the risk of overdose death from any drug is increased when using in an unsafe environment such as on the street, or in any environment that is not supervised. Two supervised injection facilities (SIFs) exist in Vancouver where there have been no recorded overdose deaths (Marshall, Milloy, Wood, Montaner & Kerr, 2011). Additionally there has been a reduction in overdose deaths in the neighborhood surrounding InSite, Vancouver's sanctioned SIF (Marshall, Milloy, Montaner & Kerr, 2011).

Infection and Disease

Infections that can and do occur because of illicit drug use include soft tissue infections like abscesses and cellulitis (Murphy, DeVita, Lui, Vittinghoff, Leung, Ciccarone et. Al, 2001). Additional infections related to injection drug use such as endocarditis, osteomyelitis, and systemic septicaemia or bacteraemia can be fatal if left untreated (Ruotsalainen et. al., 2006; Spaulding et. al., 2012). HIV and Hepatitis C are also big concerns and the national rates of HIV and Hepatitis C in Canada are 5.8 and 33.7 per 100,000 respectively (Public Health Agency of Canada, 2011, 2013). Such communicable diseases are more prevalent among people who use drugs with the 1997 rate of HIV in Vancouver's Downtown Eastside being 23% and Hepatitis 88% (Strathdee, Patrick, Currie, Cornelisse, Rekart, Montaner et. Al, 1997). The rate of HIV skyrocketed in Vancouver's Downtown Eastside neighborhood in the 1990's (Hyshka, Strathdee,

Wood & Kerr, 2012). This increase in HIV was attributed, in part, to the increased availability of powder cocaine in the Vancouver drug market, which, due its short half-life, is injected 15 to 20 or more, times per day (Tyndall, Curies, Spittal, Wood & O'Shaughnessy, 2003). The rate of new HIV infections among those who use injection drugs in Vancouver decreased to 9.4% in 2013 (BCCDC, 2015) whereas Hepatitis C rates remain steady (Public Health Agency of Canada, 2011). HIV rates in Canada have similarly decreased with the 2012 rate being the lowest since HIV surveillance began (Public Health Agency of Canada, 2013).

Needle-exchange programs during the 1990s allotted a maximum of two clean syringes per day for each used syringe returned (Hyshka et al., 2012), but because of the frequency of injection with powder cocaine, syringe borrowing and sharing continued and contributed to the increased rate of HIV (Hyshka et al., 2012). Syringe exchange limits were increased from two to four per day, and then doubled again in 1995. The City of Vancouver declared a health crisis in 1997 due to the high rates of HIV and Hepatitis C and as a response needle exchange limits were increased to 14 per day (Hyshka et al., 2012). InSite, Vancouver's sanctioned SIF, opened in 2003 as part of a response to high rates of HIV and fatal and non-fatal overdoses (Wood, Kerr, Lloyd-Smith, Buchner, Marsh, Montaner & Tyndall, 2004). InSite also houses the city's largest needle exchange. Today, there are no limits to needle exchange and exchanges occur up to the hundreds per person. Operating under a harm reduction model, the DPC also houses a supervised drug consumption room and a needle exchange (Wood, Zettel & Stewart, 2003). The Centre has applied for, but not yet received, an exemption from the federal government to operate as a sanctioned SIF.

Stigmatization and Barriers to Care

People who use and inject illicit drugs are more likely to live in poverty, be homeless, or live in substandard housing (Wood, Tyndall, Li, Lloyd-Smith, Small, Montaner & Kerr, 2005). One's presentation and appearance has a lot to do with how he or she is perceived and treated in society, as well as in the health care system. Stigma associated with drug use affects those who use drugs and others who are perceived and assumed to use drugs, contributing to decreased accessibility to health care services and often to poor treatment by health care professionals when care is accessed (Pauly, 2014; Pauly, McCall, Browne, Parker & Mollison, 2015). Merrill, Rhodes, Deyo, Marlatt and Bradley (2002) found that physicians have a degree of mistrust for those who use drugs, they feel deceived by drug (specifically opiate) using patients, and avoid engaging patients in conversations about their medical complaints. This mistrust compounds the stigmatization already perceived by those who use drugs and causes them to be sensitive to the possibility of poor medical care and perception of, and actual, mistreatment. Similarly, Van Boekel, Brouwers, Van Weeghel, and Garretsen (2013) write that "stigmatizing attitudes of health professionals towards people with substance use problems may negatively affect healthcare delivery and could result in treatment avoidance" (p. 24). Avoidance and delay in seeking health care by those who inject drugs results in poorer health (Merrill et al., 2002). Those who use and inject drugs frequently encounter judgments and other barriers to care and fear being refused care or treatment until they stop using drugs (Pauly et al., 2015). For example, those with mental illness are sometimes excluded from mental health treatment until they cease drug use, but drug use starts and continues, often, because of undiagnosed and/or untreated mental illness. Mental health and addiction services are generally set up as two separate care delivery settings and rarely are both services combined. As such, the source of

mental pain/anguish goes unrecognized and untreated, many individuals self medicate with illicit substances, yet drug use blamed as the cause of pain instead of the response (Mate, 2008).

Dominant societal views of drug use and abstinence create barriers for those who use drugs in accessing care, and these societal views can contribute to harm. Stigmatization is related to a lack of knowledge and understanding, and often is a by-product of fear (Malcolm, Aggleton, Bronfman, Galvao, Mane & Verrall, 1998). In this case, poor understanding of health care needs and of the negative social impact faced by those who use drugs, has led to, and increased, the stigmatization of those who use and inject drugs (Paivinen & Bade, 2008). Similarly, a knowledge deficit has led to stigmatization and fear of those who have been diagnosed with HIV/AIDS, and this stigmatization and fear has led to discrimination, which increases the health inequities and inequities in access to health care for people who use drugs, particularly those who also live with HIV (Malcolm et al., 1998).

The ideology of choice, as described by Lowenberg (1995), is a belief consistently held by many who do not support harm reduction. This ideology holds that those who use drugs choose to use drugs and could choose to stop using drugs. This is similar to the addiction habitus described by Small, Palepu and Tyndall (2005), as the cultural norms, practices and beliefs about drug use that are commonly accepted and expected by society. The habitus posits that those who use drugs are conventionally blamed for their addiction and “should be made more uncomfortable to prevent and not enable addiction” (Small, Palepu & Tyndall, 2005. p. 74). Pauly et al. (2015) also found that nurses in a hospital setting blamed their patients who use drugs for making poor choices, placing responsibility on the individual. This ideology acknowledges abstinence as the moral approach to addiction treatment, and contributes to perceptions that those who use drugs are criminals, rather than victims of addiction, violence and

trauma, mental illness, poor health, poverty and stigmatization, and who are dealing with it in the only way accessible to them. Because of the ideology of choice and societal norms and expectations, many who use drugs do not receive any health care at all (Small, Palepu and Tyndall, 2005) and if they do, they often have to access services in highly stigmatized environments in which they experience blame, criminalization and medicalization of their substance use (Pauly et al., 2015).

In addition to stigma, there are other obstacles that exist such as barriers to addiction treatment. Access to detoxification and treatment centres is limited due to lack of available beds and facilities, and to long waitlists (Milloy, Kerr, Zhang, Tyndall, Montaner & Wood, 2009). Other barriers include low socioeconomic status, geographic location and lack of transportation, pharmaceutical costs, previous negative experiences with health care providers, and the stigma associated with being labeled a “drug user” (Pauly, 2008). Harm reduction attempts to shift the focus of drug use to health and equitable access to health care. To address stigma and the barriers to care, harm reduction services provide safer environments in which those who use drugs and are HIV positive can access care (McNeil and Small, 2014). The Dr. Peter Centre grounds itself in harm reduction and offers such an environment.

Harm Reduction As A Response To The Risks of Illicit Drug Use

Harm reduction is defined by the International Harm Reduction Association (IHRA) as “policies, programs and practices that aim, primarily, to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption” (2010, para. 5). The basic notion of harm reduction, in the context of illicit drug use, is that it provides health care to those who inject drugs without requiring the cessation or reduced use of drugs. Rather, the focus is on reducing harms. Harm reduction is

both a philosophy and set of practices. Philosophically it promotes acceptance, “is facilitative rather than coercive” (IHRA, 2010, para. 10), reduces stigma, judgments, emotional trauma and shame that people who use drugs often feel. Practically, harm reduction reduces the spread of disease, rates of infection and rates of overdose, and overdose death. The principles of harm reduction as outlined by the IHRA above focus on a pragmatic philosophy in which dignity and respect for people who use drugs is emphasized.

Harm reduction has been debated in Canada and harm reduction nursing has been determined by both the College of Registered Nurses of British Columbia (CRNBC) and the Canadian Nurses Association (CNA) Code of Ethics to be an acceptable, ethical, and essential approach to health care. Pauly (2008) and Lightfoot et al. (2009) also provide support for harm reduction nursing, saying that supervised injection services are based on evidence indicating that the prevention of overdose deaths, reduced risk of communicable disease transmission and increased referrals to detoxification facilities are consistent with best practices for reducing drug related harm and therefore consistent with ethical standards for practice. A non-judgmental approach, and high level of client comfort within harm reduction programs has been associated with increased referrals and improved access to primary care, addictions care, and HIV/AIDS testing, education and care for those who inject drugs (Small et al., 2009). Harm reduction is associated with increased access to health care and social services. Harm reduction philosophically opposes the war on drugs which marginalizes and increases barriers to care (Hathaway & Tousaw, 2008). Harm Reduction nurses provide value-neutral harm reduction education and primary care services to a marginalized population. Nursing knowledge and skills are particularly relevant to working with this population and nurse collaboration with their target

population contributes to sense of community, empowerment, health promotion and promotes positive health choices.

Harm reduction has been proposed as one response that has the potential to increase access to health care services for those who are HIV positive and use drugs because it shifts the moral context from one of blame to a context of empowerment, improved health and self-care (Pauly, 2008). By improving access to health care, harm reduction allows for both prevention and treatment of infection, reduction in HIV and other communicable disease transmission, reduction in overdose deaths, increased referrals and uptake of detox and drug treatment services. Harm reduction also works to decrease stigma, and increase safety in drug using practices.

An understanding of the impact of environments in which harm reduction services exist, and how those who use drugs and make use of those services are affected has received limited attention. While people who use harm reduction services identify the importance of them, it is not always clear what role they play in the lives of people who use drugs. MacNeil and Pauly (2011) studied the experiences of participants of needle exchange programs and Fast, Small, Wood and Kerr (2008) studied participant perceptions of safe injection education received at a Vancouver's SIF, however there is no study that describes participant experiences with the DPC harm reduction services as part and the impact of such services. A qualitative inquiry into perceptions of recipients of nursing and harm reduction services at the DPC will help determine the impact and effectiveness of the DPC model on participants who use drugs. Harm Reduction does not exist to replace preventive efforts or drug treatment efforts, but aims to reduce injection-related harms by providing health promoting education for the empowerment of healthy decision making by those who use drugs, and connects people to medical services (Lightfoot, Panessa,

Hayden, Thumath, Goldstone & Pauly, 2009). Harm reduction accepts that drug use occurs despite efforts to prevent it, despite ideological claims that abstinence is the only form of addiction treatment, and the view that drug use would disappear if an adequate number of drug treatment facilities existed (Small, Palepu & Tyndall, 2006).

Harm Reduction reaches a population that is unreachable by traditional health care approaches, and has difficulty accessing the health care system as it is traditionally organized. It is a low threshold service that is free of stigma, builds relationships and works to remove barriers (McNeil & Small, 2014). The reduced barriers increase access to primary care services, referrals to addiction treatment (e.g. methadone and buprenorphine therapy; detoxification), referrals to hospital emergency, housing, community and social services, and the integrated services offered at the DPC (Krusi, Small, Wood & Kerr, 2009; Wood, Zettel & Stewart, 2003). Harm reduction services such as supervised injection also greatly reduce the number of drug overdoses and overdose deaths because highly trained and skilled nurses are on hand to provide harm reduction education to prevent overdoses, and to intervene in the event that overdoses occur (Krusi et al., 2009; Lightfoot et al., 2009). Staff welcome participants to the facility, engage them in professional therapeutic relationships, treat them with dignity and respect, and provide care based on client needs. Conscious efforts is made to treat participants like any person seeking health care, and to accept that by coming to a harm reduction service they *are* actively seeking safety and health care.

The Dr. Peter Centre as a Response to HIV and Drug Related Harms

Harm Reduction at the DPC incorporates the definition provided by the IHRA and provides services including supervised injection, needle exchange, safe sex supplies, sexual health education, and secure money storage for those for whom money is a trigger to use drugs

(Dr. Peter Centre, 2015). The DPC focuses on reducing harms associated with risky behaviors to both the individuals and the community (Dr. Peter Centre, 2015) facilitated by an interdisciplinary clinical team. The DPC strategy aims to meet the complex health needs of program members, the community at the DPC, and the wider communities within which DPC day program members live (Dr. Peter Centre, 2015). Harm Reduction is an effective approach executed through the building of therapeutic, non-judgmental, trusting relationships (Lightfoot et al. 2009; Pauly, 2008) and these relationships are a goal of the DPC. Supervised Injection services exist to reduce the harms related to injection drug use, and make vital referrals to health, mental health and addictions services (Lightfoot et al., 2009; Small, Van Borek, Fairbairn, Wood & Kerr, 2009). The DPC has incorporated a supervised consumption room as a part of the harm reduction strategy.

Objectives and Research Question

The goal of this thesis is to gather, describe, analyze and interpret the narratives of registered Dr. Peter Centre members about their experiences at the DPC. The specific objectives are to engage with participants in order to:

1. Explore and describe participant perceptions of the DPC harm reduction program and DPC nursing care and their experiences (satisfactions and dissatisfactions) with the harm reduction philosophy, harm reduction room, and DPC nurses.
2. Determine outcomes of the DPC harm reduction model and harm reduction room
3. Examine any gaps in the harm reduction program/model.
4. Suggest and discuss solutions to the gaps in the model, barriers to harm reduction room utilization and offer recommendations for the harm reduction program.

The research questions are:

1. What are participants' experiences and perceptions of the harm reduction services provided at the DPC?
2. What is the impact of the DPC harm reduction model on participants' access to clinical and support services, and on drug use?

The harm reduction philosophy and approach at the DPC will be explored in this study, as will participant perceptions of and experiences with the nurses and staff who engage them in harm reduction care. To begin, the DPC will be presented, followed by a review of the literature, after which study findings will be presented and discussed.

Chapter 2: Review of the Literature

In this chapter, I present the historical background of the DPC and then discuss relevant literature. The theoretical framework used for the study will then be presented.

Historical Context of the Dr. Peter Centre

In this section, I will describe the DPC, then discuss the DPC as a response to the stigma and other harms incurred by those who are HIV positive and use illicit drugs. The DPC opened in April 1997 as a ten-bed residence in a wing of St. Paul's Hospital in Vancouver with a mission to "provide comfort care for those living with HIV/AIDS" (Dr. Peter Centre, 2015). The centre's vision is to make a global contribution to HIV/AIDS treatment while being compassionate, courageous, inclusive and innovative in the services offered on site (Dr. Peter Centre, 2015).

Since the emergence of HIV in the 1980s, the disease has been associated with stigma that has been damaging for those living with the diagnosis (Malcolm et al., 1998). Dr. Peter Jepson Young, after whom the DPC was named, provided an account of his own journey living with HIV, broadcast on CBC, titled "The Dr. Peter Diaries" (1992) during a time when stigma and fear and myths about HIV were widespread. The Dr. Peter Centre grew out of this work and is now able to assist the community and the health care system to care for those with HIV/AIDS.

The care offered at the DPC is for those living with HIV, aiming to reduce the stigma of HIV, and providing a level of comfort for members to be accepted within the DPC community and the surrounding neighborhood (Dr. Peter Centre, 2015). The centre has been the focus of several publications and newspaper articles and has played a large role in both the HIV positive community and the social community in Vancouver's West End neighborhood. In addition, some former DPC nurses (Wood, Zettel and Stewart, 2003) have published articles on their

nursing work within the DPC model of care with a specific focus on the role of harm reduction within the Centre.

Mental illness is commonly found to be co-occurring in those who live with HIV and who use drugs and one hundred percent of DPC residents live with mental illness (Dr. Peter Centre AIDS Foundation, 2014). Forty-five percent of residents are co-infected with Hepatitis C, 77% live with active addiction (Dr. Peter Centre AIDS Foundation, 2014) and approximately 70% of all DPC members engage in drug use of some sort (Wood, Zettel & Stewart, 2003).

The DPC has grown and is now situated in its own building with twenty-four residential suites, two respite rooms, and a day program that operates seven days per week. The residence offers twenty-four hour nursing care for persons living with advanced HIV/AIDS and also serves as a hospice. The respite rooms offer short term stays (three to four months) for concerns such as weight gain or medication adherence and stabilization. The day program offers integrated services such as nutrient dense meals, nursing care, medication management including highly active anti-retroviral therapy (HAART), a nurse practitioner, music therapy, art therapy, recreation therapy, and a staff nutritionist. Additionally the centre provides a social context in which members can build relationships and engage in community life. The day program also includes facilities for laundry, showers and daytime napping, a service particularly helpful for those who are unhoused. The DPC also houses a supervised injection room, coined “harm reduction room”, with two booths in which those who inject drugs can do so under the supervision of DPC staff.

The staff and the community environment at the DPC are described as inviting, non-judgmental, and inclusive (Griffiths, 2002; Krusi et al., 2009). The Model of Self-Care offered at the DPC recognizes Maslow’s (1943) basic human needs (food, water, shelter, love,

fulfillment), the need to make one's own decisions (which the DPC supports through information and education through the Model of Self-Care), and the impact that a community can have on both physical and mental health and on health behaviors (Dr. Peter Centre, 2015). The DPC model also incorporates the trans-theoretical model of change, restorative practices to help manage conflict, and employs a harm reduction approach (Dr. Peter Centre, 2015).

There are approximately 400 people registered in the DPC day program which is open seven days per week, 365 days per year (Dr. Peter Centre, 2015). In the fiscal year 2013-14 more than 60,000 meals were served, an increase from 53,000 and 58,000 in the previous two years respectively (Dr. Peter Centre, 2015). 2014 showed increased engagement with members through nursing, counseling, recreation, music and art therapies (Dr. Peter AIDS Foundation, 2014). The integrated services offered at the DPC are used widely among registered members with increases seen in both attendance (28%) and clinical contacts (69%) since 2011 (Dr. Peter Centre, 2015). Despite these numbers there are issues such as environmental factors (employment; lack of energy; lack of transport; geographic location), and "drug talk" from other participants (Shroff, 1998) that have deterred some people from attending regularly. Shroff (1998) also found that in its first year, the DPC was labeled as a service for primarily HIV positive, drug using, gay males and many who did not fit those criteria chose to not be a part of the day program.

The DPC utilizes the Model of Self-Care to empower members to take responsibility for their own health and to use, and increase, their abilities, skills and knowledge in order to improve their health. The DPC uses the community structure and expectations in their Therapeutic Community Model to encourage DPC community members to establish norms which help to engage, retain, and promote acceptance of all individuals (Dr. Peter Centre, 2015).

The DPC model of care includes harm reduction services and the role of the nurse is to engage regularly and build relationships so as to promote HAART adherence and to assist with health goals and issues in a way that is meaningful for both client and nurse, and to help reduce harms associated with substance use (Dr. Peter Centre, 2015). The DPC harm reduction room responds to injection-related harms by providing a safe space for people to inject and a supervised environment where health professionals are available to intervene in the event of overdose. Well-trained nurses provide harm reduction education and engage in health promotion activities and primary care services for soft tissue infections, wounds, sexually transmitted infections, immunizations, and referrals to off-site services (Wood, Zettel & Stewart, 2003). The harm reduction room also exists as part of a group of integrated services at the DPC and internal referrals are made both to and from the harm reduction room (Wood, Zettel & Stewart, 2003). Krusi et al. (2009) have reported that the harm reduction room at the DPC has facilitated “engagement in a broader array of support services” (p. 640) but also that some participants who use the harm reduction room experience feelings of shame and that these feelings mediate their use of the harm reduction room. The most recent published number of DPC members registered to use the harm reduction room is 53 (Krusi et al. 2009).

Literature Review

There is a wealth of literature on the topics of harm reduction and SIF's, and stigma related to both harm reduction and SIF's. The available literature is reviewed below.

Supervised Injection Facilities

SIFs attract those who use drugs and are street entrenched, and who have experienced barriers in accessing care (Small, Van Borek, Fairbairn, Wood & Kerr, 2009). SIFs increase

uptake of health care and addiction services including detox and treatment facilities, primary care clinics, and hospitals (Wood, Tyndall, Montaner & Kerr, 2006; Small et al., 2009). SIF's have also been shown to effect changes in public injecting, and numbers of publicly discarded syringes (Wood et al., 2004). Wood et al. (2006) and Stoltz et al. (2007) show that InSite is associated with reduced syringe sharing among registered participants, increased use of sterile water and alcohol swabs, and increased referrals and intakes to detox and treatment centers. Those who inject at InSite are also much more likely to access primary care services, and addiction services such as methadone maintenance therapy (Small, Wood, Lloyd-Smith, Tyndall & Kerr, 2008). In addition, nurses at SIFs engage in primary care interventions including the prevention of infections and the dressing and treatment of wounds (Small et al., 2008). SIFs have had significant impact on decreasing the rates of overdose mortality (Marshall, Milloy, Wood, Montaner & Kerr, 2011), and HIV transmission (Hyshka, et al., 2012). Additionally, SIFs have been found to provide "refuge from the structural and interpersonal violence of the street... . . .offering environmental-structural support" (Fairbairn, Small, Shannon, Wood & Kerr, 2008. p. 819). Small et al. (2008) found that participants had high levels of comfort seeking care at InSite due to the lack of stigma, and non-judgmental staff, and thus reducing one barrier to accessing to care.

Stigma

Stigmatization is problematic and has created health care inequities and erected barriers to health care for those who use drugs (Pauly, 2008). Stigmatization is also associated with a lack of understanding of the issues and health care needs of the specific population, and a poor understanding of how to address their needs (Paivinen & Bade, 2008). Similarly, HIV stigma decreases quality of life by impeding positive social interaction, and creating barriers to

accessing and engaging with health care professionals and the health care system (Wagner, Hart, McShane, Margoles & Girard, 2014). Pauly et al. (2015) found that nurses in a hospital setting placed judgment and responsibility for drug addiction on those who use drugs, further stigmatizing them and making it more difficult to seek and access care at hospital. A non-judgmental approach and high level of client comfort within harm reduction programs have been associated with increased referrals and improved access to primary care, addictions care, and HIV/AIDS testing, education and care for those who inject drugs (MacNeil & Pauly, 2011; Small et al., 2009).

The Dr. Peter Centre

Multiple barriers exist to providing equal and accessible health care to those living with HIV concurrently with mental health issues and Illicit drug use. Wood, Zettel & Stewart (2003), three former DPC nurses, published an article specific to harm reduction nursing at the DPC, providing a solid basis for the harm reduction room and programs. McNeil, Dilly, Guirguis-Younger, Hwang and Small (2014) found that supervised drug consumption services at the DPC positively affects access to and engagement with care at the DPC. Krusi et al. (2009) also write of the DPC harm reduction room and its integration into the many other services offered at the DPC. However, limitations to that study meant that data regarding DPC members who inject drugs but do not use the harm reduction room were not incorporated, nor does the study explain or discuss the impact that harm reduction has on members as part of the group of integrated health care services at the Dr. Peter Centre. This study aims to fill these gaps and will explore, interpret and describe how the harm reduction philosophy and programs at the Dr. Peter Centre impact DPC member's quality of life, including changes in drug use. To date there is no published study that achieves this objective. The DPC is the only known service for those living

with HIV/AIDS which also provides harm reduction services and there is a paucity of research on such harm reduction programs.

Theoretical Framework

This research study uses the “Risk Environment” framework developed by Rhodes (2002) to understand the experiences of DPC day program participants. The Risk Environment framework is useful for understanding drug use patterns, and issues of drug related harm, particularly HIV and other infections, and drug overdose (Rhodes, 2002). It brings to the forefront how context influences health and vulnerability in general, as well as harm related to drug use, specifically. This framework shifts the focus of HIV and drug addiction from the individual who injects drugs, to a focus on the ‘risk environment’, that is, the environmental factors that affect drug use and affect the health of those who use drugs. Western political and societies continue to engage in “victim blaming” (Rhodes, 2002. p. 88) despite liberal and progressive thinking and softer political environments. The risk environment framework aims to work against this victim blaming mentality by holding environmental factors, not the individuals, responsible. It shifts both the responsibility for harm and the focus for change from individuals alone to social and political structures (Rhodes, 2002), a notion also asserted by Small, Palepu and Tyndall (2006). It is in shifting the responsibility from the individual, to social and political structures that macro level changes such as policy change and legalities around drug use can influence and enable harm reduction services (Rhodes, 2002, 2009). The framework aims to make another shift from issues of drug use to issues of vulnerability and human rights (Rhodes 2002) and in doing so addresses financial, social and health inequities. Changes in the risk environment, reducing risk, and providing equitable health care and health care access will influence drug use and the spread of communicable disease.

Rhodes (2002) describes a risk environment as “the space—whether social or physical—in which a variety of factors interact to increase the chances of drug-related harm” (p. 88). There are two parts to the risk environment. 1. the type of environment (physical; social; economic; policy) and 2: the level of environmental influence (micro, macro) (Rhodes, 2002). Though different, the micro and macro levels of environmental influence are inseparable (Rhodes, 2002). For example, the public health crisis declared in Vancouver in 1997 because of skyrocketing HIV rates was influenced by both policy (macro-level) that allowed for limited syringe exchange, and by injection practices (micro-level) that required increased frequency of injection due to the short half-life of cocaine.

The risk environment is the theoretical framework chosen for this qualitative study, which is a part of a greater mixed method study of DPC funded by Canadian Institutes of Health Research (CIHR). The framework can be applied to both qualitative and quantitative methods. Rhodes (2009) writes that the risk environment framework is not a theory, but “is theoretical in its offering of a generative framework into which empirical and theoretical work might give primacy to *context* when understanding and reducing drug-related harm” (p. 193). The framework is appropriate for this qualitative study and for its purpose, and for its research questions that seek to elicit deep meaning from personal experiences in the risk environments that influence DPC members.

One’s environment (physical, social, economic, political, spiritual) has long been accepted as a determinant of health by regulating nursing bodies in Canada. As such, the environment (risk environment) impacts people’s ability, and the ability of the nurses, to promote health, prevent illness, and to obtain treatment for illness. Harm reduction recognizes individuals’ risk environments, reaches populations unreachable by traditional methods,

increases access to health care services and in doing so fulfills the well known nursing concepts of health promotion, illness prevention and treatment.

Individual (biologic) factors are generally considered to be a major cause of drug use and the risk environment framework challenges this view. Harm reduction has generally, thus far, emphasized individual behavior change and individual context change (Rhodes, 2005). However such change is almost impossible without social support, societal change and increased resources put towards harm reduction efforts, short and long-term treatment efforts, housing, life-skills training and job training. Without such macro-level changes, individual change is difficult and those desiring to make change are frequently unsupported or under-supported.

Chapter 3: Methodology

This thesis was part of a larger CIHR funded mixed-method study (Hogg, Baltzer-Turje & Barrios, 2014) that actively engages DPC community members and seeks to provide new knowledge so as to promote action for new and improved health care for those living with HIV/AIDS, and in that way it is Community Based Research (CBR). The broad CBR framework of the larger study involves a partnership between community based and academic researchers to generate knowledge that informs how those with HIV are cared for at the DPC, within British Columbia, and beyond. The purpose of the larger study is to “determine the effect of exposure to an integrated, risk environment-based, low-barrier primary care intervention on HIV treatment outcomes” (Hogg, Baltzer-Turje & Barrios, 2014). As a graduate student, my role was as qualitative interviewer, and interpreter of community members’ thoughts, expressions and statements with the intention of influencing and promoting change and improvement in HIV and Harm Reduction services.

This thesis aims to explore participant experiences with, and impact of, the harm reduction philosophy and programs at the Dr. Peter Centre through the use of Interpretive Description. Interpretive Description is a qualitative mode of inquiry that claims to be neither a unique method nor a set of sequential steps to qualitative inquiry (Thorne, 2008). Rather, it is qualitative inquiry that requires the researcher to engage with data so as to discover what may not be documented by “extending the interpretive mind beyond the self-evident” (Thorne, 2008. p.35). In doing so, patterns and themes in subject responses and experiences will be identified and brought forward as issues that will influence clinical practice. To do so, the researcher must have integrity of purpose that comes from the research goal and an understanding of what is and

is not known. The researcher must reflexively let go of any personal agenda, yet allow pre-existing knowledge and experience to guide the study (Thorne, 2004).

This research is located within the constructivist paradigm, which seeks a culturally and socially constructed response to the research question (Mayan, 2009). The constructivist/interpretive paradigm acknowledges that all things are connected to, and influenced by, one's interaction with their environment, and that all individuals contribute to learning and to knowledge development through the sharing of their experiences (Williams & Day, 2007). Similarly Rhodes' (2009) risk environment framework considers how multiple environmental and social factors are connected and are "experienced and embodied" (p. 194) and influence drug use and its related harms. As such, the methodology and framework for this study are complementary.

Interpretive description was chosen as the desired method of analysis for this research study as it is suited to the research problem of understanding and interpreting experiences, and it fits well with the theoretical framework with which the greater mixed method study was designed. Interpretive description helps in understanding experiences, and how such understanding can be applied to meaningful nursing practice (Thorne, 2008). Effective application to practice occurs when there is an understanding of why and how it is important to apply (Thorne, 2008). Deep understanding of my interpretation of participant narrative in this study will be described with a view to influencing nurses, policy makers and educators to apply this understanding so as to promote the provision of effective and meaningful nursing care.

Sample and Recruitment

This Master's thesis focuses on harm reduction services at the DPC, and their impact, and that of DPC nurses, on day program members, from the perspective of DPC day program

member. Criteria for the larger mixed-method study required participants to have registered at the DPC within the last three years and be 19 years of age or older. Purposeful sampling is directed by the desire to include a range of variations of the phenomenon under study (Coyne, 1997) and participants for qualitative interviews were purposefully sampled during the quantitative process as currently engaging in active drug use.. Most of the DPC members are male (Dr. Peter Centre, 2015) and so qualitative participants have been recruited purposefully from the quantitative sample so as to provide variation and depth in data. Findings from the qualitative portion of the larger study are not meant to be reflective of DPC member demographics but rather to be representative of demographics of those who use drugs and live with HIV/AIDS, and to facilitate gender-based and indigenous analysis (Hogg, Baltzer-Turje & Barrios, 2014). A study sample that registered at the DPC within the last three years helped to capture variation in terms of levels of engagement with the DPC.

I was not involved in participant recruitment as this occurred from the quantitative sample that had already taken part prior to my involvement. Participants were recruited based on their agreement to participate in a qualitative interview, during data collection for the quantitative portion of the mixed method study. Participants were sent a letter one year after their quantitative involvement inviting them again to participate in a qualitative interview. Participants were contacted by telephone by the mixed method research coordinator and appointments times for interviews were arranged for which I was one of three interviewers.

The qualitative study included interviews with 30 participants. I conducted seven interviews while the remaining interviews were distributed between two other researchers. Data from all 30 participants were analyzed for my Masters thesis. Study participants were interviewed in a “quiet room” located in a low traffic hallway at the Dr. Peter Centre Day

Program facility in Vancouver. Interviews lasted approximately one hour in duration and participants received a \$30 honorarium for their time and sharing their experiences. Interviews utilized an interview guide developed by the DPC research team, and adapted from the Scientific Evaluation of Supervised Injection Services (SEOSIS). The comprehensive guide had five general areas of focus. 1. Living Situation 2. Accessing the Dr. Peter Centre 3. Harm Reduction Approach 4. Integrated services and 5. HAART Adherence. The main focus of this thesis is on exploring the narratives and perspectives of DPC day program members on how the integration of the harm reduction model and philosophy affects their quality of life, with a primary focus on knowledge of and experiences with harm reduction services at the DPC. Each interview was voice recorded and transcribed verbatim by a neutral paid professional transcriptionist.

Data Collection

Upon engagement with qualifying participants, the researcher provided a detailed explanation of the study and ensured that all participants were aware that their consent to participate was confidential, anonymous, completely voluntary and that they were free to withdraw from the study at any time. Participants consented to interviews being audio recorded. Data was collected using assigned study numbers and transcribed data was cleaned of all identifying materials. Field notes were kept and summary notes were written and filed as additional sources of data in a secure password protected file, corresponding with the assigned study code for each participant. Participants were informed that a referral to appropriate services would be made should emotional stress or distress arise during, or as a result of their participation or disclosure of personal information. I did not encounter any situations where this was necessary.

Interviews, or engaging and simply talking to participants, are described by Thorne (2008) as “an essential element in providing health care” (p.126). Allowing study participants time to talk and showing the researcher’s desire and intent to listen, clarify and prompt for elaboration and further discussion is not a common occurrence in clinical settings due to heavy nurse workload, yet a conversation and listening are crucial to discovering, interpreting, understanding and describing the subjective experiences sought. Initial answers to questions might be superficial and may not provide full depth and detail of participants’ true feelings and nuances (Thorne, 2008). Therefore, interviews began according to the interview guide with eliciting demographic information, and progressed into broad open ended questions about experiences with the DPC integrated programs and services. The researcher noted when yes/no answers were being elicited, and when leading questions were asked, and had to work hard to remain open and wait for participant’s responses. Flexibility in the ordering of the questions, and omission or addition of alternate questions was accepted and used to promote and prompt participant elaboration and researcher clarification.

Qualitative inquiry requires simultaneous collection and analysis of data (Thorne, 2004). Theoretical sampling, “the process of data collection whereby the researcher simultaneously collects, codes and analyzes the data in order to decide what data to analyze next” (Coyne, 1997 p.625) was utilized in such a way that allowed for variation in the data collection process in the form of additional interview questions based on participant’ responses that prompted further inquiry. For example questioning on participants sense of belonging and purpose was not a part of the interview script but was discussed based on consistent participant statements about belonging to a community at the DPC. Flexibility in this way was necessary to determine

whether themes were homogeneous throughout the entire sample, or simply a variation (Thorne, 2008).

Data Analysis

“Interpretive description requires an analytic form that extends beyond taking things apart and putting them back together again. It requires that we learn to see beyond the obvious, rigorously testing out that which we think we see, and taking some ownership over the potential meaning and impact of the visions that we eventually present as our findings” (Thorne, 2008 p. 142). Mayan (2009) writes that a serious error in qualitative data analysis is first collecting data and then analyzing it. Data collection and analysis occurred simultaneously in this study and themes that emerged during data collection were used to guide further inquiry and questioning during participant interviews. The data analysis and critical thinking that began during the data collection phase carried over into the formal analysis phase utilizing NVivo 9 software. NVivo is a qualitative data management and analysis software that helps to organize and code data for facilitation of analysis.

Notes, transcriptions and interview recordings were read and re-read multiple times in order for the researcher to be fully immersed in the content and context of study participants. Following this immersion, the data was coded in NVivo and the researcher was able to identify patterns and themes that were consistent throughout the data. Coding was done by identifying common and significant, meaningful words, phrases and themes in the transcribed data from each participant. Thorne (2008) writes that marginal memos are consistent with data analysis in interpretive description and such notes were kept and saved on a password protected file and in NVivo data management software. Notes were revisited and reflected upon continually in the data analysis process.

The identified codes were carefully categorized into persistent themes and these themes compared to the original transcribed interviews from which the codes were identified, in order to confirm accurate interpretation and categorization of their meaning. Constant comparison methods facilitated this process. Categories were determined and themes developed based on in depth immersion in the raw data. Other categories were formed and based on researcher insights into the data. Constant comparison and these two types of categories allowed for both descriptive and explanatory discussion of findings. Mayan (2009) and Thorne (2008) caution researchers from prematurely coding and drawing conclusions because data collection and analysis are simultaneous and circular with a repetitive immersive processes. For this reason, considerable time was spent on data analysis until the researcher was confident that it had been interpreted and analyzed appropriately and accurately.

Rigor

To effectively carry out qualitative research the researcher must have integrity of purpose. There was no personal agenda in this qualitative study yet the researcher does have pre-existing interest in and knowledge of the population, of HIV, extensive interest, knowledge and experience in harm reduction, and in mental health and addiction nursing. These things helped to guide the study and facilitated questioning during the interviews. Rigor is described by Lincoln and Guba (1985) as the trustworthiness of a qualitative research study, requires the fulfillment of four criteria: credibility, transferability, dependability and confirmability. Credibility is a criterion used to determine that the study findings are an accurate representation of the data and is used to ensure that the findings make sense (Mayan, 2009). The researcher ensured credibility through engagement and immersion in the data collection and analysis

processes, through triangulation of data from notes, memos and written interview summaries, and through discussion with other researchers taking part in the larger DPC study.

Transferability is the fittingness of the study findings to be applied or transferred to other settings (Mayan, 2009). The Dr. Peter Centre is a unique facility with a unique model of care and, because of this, transferability may not be possible to other services and facilities. However, one aim of the greater mixed method study is that it will provide knowledge for the promotion of change and for the “development of health interventions that address social or group level challenges, as well as the complex individual health care needs of high risk persons living with HIV/AIDS” (Hogg, Baltzer-Turjie & Barrios, 2014. p. 2). Gaps in care have been identified with a view to making recommendations for better care and this goal is transferable to any clinical setting. Transferability will be promoted through the dissemination of study results and study findings to other service providers and to policy makers in the form of published journal articles.

The researcher ensured dependability and credibility by utilizing notes, memoranda, and participant quotations as an auditable source of data, and by providing sufficient information to allow readers to follow the analytical reasoning process to determine that the analysis and findings are grounded in the data (Lincoln & Guba, 1985; Mayan, 2009).

Ethical Considerations

The population that utilizes the harm reduction and nursing services at the Dr. Peter Centre is unique. Many have experienced stigma related to drug use, mental illness, poor health including the diagnosis of HIV/AIDS, sexual orientation and the perception of low socioeconomic status. It is a population that has encountered structural vulnerabilities, is disadvantaged by social circumstances, and has been marginalized by both professional and

social groups. I have been committed to following ethical processes throughout the study. This included submitting an application for Ethical Review to the University of Victoria Human Research Ethics Committee. The greater research team from the DPC and the BC Centre for Excellence in HIV/AIDS (BC-CfE) sought and was granted ethical approval from both Simon Fraser University and the University of British Columbia. Permission for my involvement was sought and obtained from the combined BC-CfE and DPC research team.

Initiating and completing the data collection and analysis processes took longer than anticipated. This was due to participant availability, including difficulty contacting participants, researcher availability, and the availability of a professional transcriber.

Informed consent was obtained and maintained at the start of each interview and confidentiality was ensured and maintained throughout the process. I was ready to provide appropriate referrals and each participant was informed of this should a situation of emotional distress arise. I did not encounter a situation in which such a referral was necessary.

Funding for the DPC study was from a CIHR PHSI grant, obtained by the DPC/BC-CfE research team. The services of a paid professional transcriptionist was arranged by the BC-CfE. Participants were given a monetary honorarium as a gesture of thanks for their time given during the interview.

Audio data was deleted when transcribed and identifiers were removed. Transcribed data was stored on a password protected USB memory device which was transferred by hand from the transcriptionist to the researcher. Transcribed and other written data was kept on the researcher's secure home office password protected computer in a password protected folder. Data was also kept on a password protected oracle-based server at the BC-CfE and will be kept

until 2020 to be available for secondary analysis if the opportunity arises, according to BC-CfE policies.

Chapter 4: Findings

In this chapter, I describe and explain the conceptions of study participants' experiences with the DPC Harm Reduction philosophy, including the harm reduction room, interactions with DPC staff (specifically nurses), and how these intersect and influence drug using behaviors both within and outside the DPC. Themes and sub-themes are described and interpreted using participant examples and direct quotations to support interpretations. To begin, a description of participant demographics is presented.

Thirty participants were interviewed for the larger DPC mixed method study as described in Chapter Three. The data from all thirty participants were coded, analyzed and interpreted with a focus on data concerning harm reduction and drug use. Of the thirty participants, twenty-four were male, four female and two identified as transgendered. Nineteen identified as Caucasian, eight Aboriginal, and three other. In terms of sexual orientation, fourteen identified as heterosexual, thirteen homosexual and three bisexual (Table 1). Participant's ages ranged from 26 to 77 years old with a mean of 46.6 years. All participants are HIV positive and all except one reported illicit drug use, of some sort, within the last thirty days. One person was in drug treatment and had been abstinent for more than thirty days at the time of the interview.

Illicit drug use among study participants included crystal meth (n=18) followed by marijuana (n=17), methadone (n=15) (either prescribed or illicit), heroin (n=11) and other opiates (n=9). Cocaine and crack cocaine was reported by ten and five participants respectively, four admitted to alcohol within the last thirty days and five reported "other" drug use (Table 2). Ten participants reported daily drug use, three reported using three to four times per week and seventeen participants reported using drugs one or fewer times per week.

Table 1. Participant Demographics

Gender	# Participants
Male	24
Female	4
Transgendered	2
Ethnicity	
Caucasian	19
Aboriginal	8
Other	3
Sexual Orientation	
Homosexual	13
Bisexual	3
Heterosexual	14

Table 2. Substance Use Among Participants within last 30 days of Qualitative Interview

Substance	# Participants
Crystal Meth	18
Marijuana	17
Methadone	15
Heroin	11
Opioids	9
Cocaine	10
Crack	5
Alcohol	4
Other	5

Table 3. Drug use Method and Frequency

Method	# Participants
Inhale	19
Snort	5
Ingest	8
Inject	16
Frequency	
Daily	10
3-4x week	3
≤ 1x week	17

Table 4. DPC Drop-in Frequency

Frequency	#Participants
Daily	17
3-4 x week	9
≤ 1 x week	5

The route of consumption of illicit drugs varied although more than half (n=16) reported injection drug use. Nineteen participants reported that they inhale drugs, five reported snorting and eight reported swallowing or ingesting as alternate routes of drug consumption (Table 3). Several participants reported drug use by more than one route and twenty-eight participants admitted to having injected drugs at least once in their life. Seventeen participants visit the DPC daily, eight visit three to four times per week, and five visit one or fewer times per week (Table 4). Six of the thirty participants reported using the harm reduction room and twenty-five reported using nursing services. Most participants live in the West End of the city though some travel to the DPC from the Downtown Eastside neighborhood, an area known for high rates of illicit drug use.

Emergent Themes

Three main themes and relevant subthemes were identified through extensive and intensive data analysis. A key theme that emerged from participants' accounts of the harm reduction program is the role of the DPC harm reduction approach in "Fostering Safety". Subthemes included "Safer Use", "Safety from the Streets", and "Safety from Stigma". The second theme that emerged, "Taking It Easy", refers to the impact that the DPC has on changes in drug use patterns. The subtheme "Out of Sight Out of Mind" emerged from the data on drug use patterns and participant statements that the DPC environment does not pose a trigger to use drugs. The third theme of "Welcome Home" emerged from participants' accounts of the "Acceptance, Belonging and Sense of Purpose" that they have found since they engaged with the DPC community, and from the commonality of "HIV, We've All Got It". I will describe each theme in depth in this chapter and then discuss the relevance and implications of these findings in Chapter Five.

Fostering Safety

Participants expressed feeling safe while at the DPC and this contributed, in part, to regular DPC attendance. Factors that led to these feelings and expressions of safety include the overall DPC harm reduction philosophy, the presence of the harm reduction room, and relationships with staff. First, a description of participant's conceptions of harm reduction and thoughts about the harm reduction room is presented followed by a presentation of their understanding of the role the room and the overarching role that the harm reduction philosophy plays in the lives of those who use it.

Participants generally understand and support the DPC harm reduction philosophy and spoke about harm reduction in relation to drug use. Nineteen participants described their understanding of harm reduction to be related to safety when using drugs. One participant who uses the DPC harm reduction room a couple of times per month defined harm reduction as:

...just being safe, and let people know you are using, and don't use the same equipment all the time, and just don't use so much.

Another described his conception of harm reduction as:

I just need to live, and harm reduction is giving a person like myself, who's an addict, who's not going to stop, healthy choices I think. Its things like showing them how to use a needle properly, telling them how to drink so it's not going to kill or cause them serious physical and mental harm.

There was one participant who was in a drug treatment program and had not used drugs for more than 30 days and although not currently using, this individual stated that harm reduction is an effort to focus on "*improved health while using safely*". Those who described their conception of harm reduction understood the dangers and risks involved with using drugs, and also understood that harm reduction aims to mitigate those risks.

Participants spoke positively about the harm reduction room and appeared to be comfortable sharing their experiences. One participant shared the strong statement that:

I don't think you have any choice but to have it (harm reduction room). It is a great idea and I don't think there should be any shame in using it.

One participant even expressed pride in the fact that the DPC had a harm reduction room, and expressed an understanding of the harm reduction model as one that not only improves lives, but saves lives.

I think its fantastic, I think you're saving lives, because a lot of people, especially with heroin and crack and stuff like that, so many people would be dying... ..It makes me feel proud because I think our society needs to start really adopting this kind of model.

This statement supports the notion that harm reduction, and the DPC harm reduction room (and other supervised consumption rooms) are a life-saving essential service.

Safer Use

Participants felt that their feelings of safety when using drugs at the DPC were related to the safe space that the harm reduction room provides. Many participants had experiences in unsafe drug using environments such as back alleys or single room occupancy hotels. Most participants who inject drugs expressed that they prefer to use in a safer space that is supervised, particularly because of the risk of overdose. Participants agreed that the DPC harm reduction room is a safe place for injection drug use, whether they used the room or not. For example, one participant who does not use the harm reduction room agreed that the room both promotes and provides a safe, clean space for injection drug use and that:

Its probably better to have, let them have a place to do it safely instead of, they're in the bathroom and doing these things, whatever it could be and it just, you know, you actually have a room and, so you're not huddled next to a [garbage] bin or something.

The harm reduction room is also viewed positively and plays a role in safety by those participants who do not inject drugs. For example one participant stated:

I think its good because, you see someone is going to have a problem right away call the ambulance. Because if they do (drugs) in the house they die by themselves and they find days later or the next day.

This participant also stated that if he injected he would:

...prefer to use here because I know someone is watching me and is going to take care if something happen.

This participant continued to say the he would smoke crack at the DPC if there was a safe inhalation room within in the facility. Other participants who do not inject also expressed that they would use and benefit from a supervised inhalation room.

Other participants commented on the safety that the harm reduction room offers in terms of cleanliness and the availability of staff to help. Those who use the injection room felt safe because of the peace of mind they had when using at the DPC.

Its safe, you don't have to worry about anything... ...it's a safe place and its always clean... ...and somebody standing by who knows how to administer assistance or help if you need it.

Participants compared the safe space at the DPC to other drug using spaces (both regulated and unregulated) and viewed using drugs at the DPC to be much safer. Their understanding of a safe space relates to their experiences in unsafe settings where street level violence occurs. One participant stated that he uses the harm reduction room:

Just to feel safe so I won't get myself into problems doing it on the street.

Another participant who uses the harm reduction room further supports the notion of safe space in terms of the physical location people inject in by stating:

I think it's an advantage because you're not using in a back alley somewhere with drugs you don't know that could affect you.

This participant, and others, had an awareness of the risks involved with drug use, particularly overdose and other potential reactions to drugs. Participants were aware of the risks

involved with using street drugs and with being unable to accurately identify drugs or other additives that they may contain and there was a desire to be safe when using drugs. Participants also felt safe utilizing the DPC harm reduction services because of the close proximity of the DPC to one of the city's major hospitals. One participant expressed this by saying:

Its safe, you know, if you're going to do a bad drug you could at least get to a hospital close enough.

Overdose is a potential reality for those who use drugs and the DPC environment, harm reduction philosophy, and staff, provide increased safety from this risk. One participant indicated feeling safe in the DPC harm reduction room because of the availability of staff to help in the event of a drug overdose.

...if you did heroin or something and OD'd, yeah they're here to help.

Another participant echoed these thoughts about overdose, indicating knowledge of the increased risk of overdose involved with decreased tolerance and sporadic drug use. He stated:

I think its (harm reduction room) necessary for people who stopped using and they'll start up again and they're not sure about the amounts or this or that, they don't realize how easy it is to OD.

Safety for participants was not simply about the availability of intervention in the event of overdose, but a small number of participants also spoke about the safety from transmission of communicable disease that is offered by harm reduction. Some participants access needles and other safer injection supplies offered at the DPC and state that they dispose of each needle after use, others deny ever sharing crack pipes. Safety also encompassed respect for others, a desire to improve personal health and to avoid compromising the health and well being of others. One participant expressed concern for others (youth) whom he has observed engaging in unsafe drug use and sex practices, outside of the DPC, and whom he understands to be unaware of the risk of HIV. This concern for others was implicit in my interpretations of participant narratives

A necessary part of any harm reduction program is education about drug use and safer injection and this is an important characteristic of the safety that participants expressed. Participants were aware of the health risks involved with injection drugs, and learned how to mitigate those risks through the harm reduction education they received from DPC nurses who had profound impact on their practices. One participant expressed that since becoming a DPC member he has modified his drug use practices to be less harmful. Specifically he now uses new syringes, alcohol swabs and sterile water rather than reusing old syringes, tap water, or other unsterile water sources. He also states that he has taken the safer drug use education that he has had from DPC nurses and disseminated that knowledge to others with whom he engages, and who use drugs on the streets.

Six of the thirty participants interviewed in this study have accessed the DPC harm reduction room at least once. The notion of safety was raised by each of them in terms of the availability of staff to supervise and provide safer injection education. Participants mentioned the staff's accepting and non-judgmental approach in their descriptions of safety. For example, one of the six participants stated being

“supported in what we’re trying to do, as individuals, but its free of judgment or punishment”.

Participants who do not use the harm reduction room view the harm reduction education that is offered as important, and admit that it helps them feel safer, and feel positive about having the room at the DPC. For example:

It teaches people to use in a safer way, to be more careful how they inject or whatever, not too much.

Several participants recalled negative experiences with health care professionals outside of the DPC and felt down and hopeless after such interactions. Participants affirmed the

importance of the non-judgmental philosophical stance that the DPC has adopted and how it has made services more accessible. For example:

I'm an intravenous drug user, and there was a time that we were showing people how to do it properly, especially the cocaine. When you go through out and out rejection, people are really going to harm themselves. So to have that available to you if you're going to use intravenously, you can say I need help without being scrutinized, I think its great.

The non-judgmental approach was an important aspect of the supervised injection education and participants were invited to access the harm reduction education from DPC nurses.

Another characteristic of the theme “Safer Use” is that several participants agreed that the harm reduction room is a positive component of the DPC program but preferred not to use it. Some participants stated that they have witnessed other DPC members utilize the room however chose to not use the harm reduction room for varying reasons. One participant preferred to use alone and stated he would use at the DPC if he had his own room in the residence where he could be alone with no one “*peeking on me*”. There were other participants who agreed that they appreciate the harm reduction room being available but also prefer to use alone. These participants preferred to use alone for reasons such as not being able to communicate or interact well after using, a preference to not be watched or feel scrutinized when using, or feeling more comfortable in their home environment. One stated that he prefers to use at home because “*I get a pretty good high at home,*” referring to some discomfort using outside of his personal home environment. Others experienced increased feelings of paranoia when using in a space outside of the comfort of their homes.

Other reasons were expressed for not using at the DPC. One participant expressed an aversion to using at the DPC because of feeling “weird”. Another expressed that he would feel “*guilty*” about using at the DPC because it is “*such a nice program*”. Still another described

how he was fast at injecting, indicating that using in the bathroom was efficient and using in the harm reduction room would take too much time

Two participants confirmed feeling safe injecting at the DPC but did not use the harm reduction room in spite of its presence. These participants admitted to injecting drugs in the bathroom. The first reported:

I snuck a hit in the bathroom. They (nurses) were all over me, hanging outside the door. They knew exactly what I was doing but, you know, I was safe.

This participant expressed safety because he believed the staff knew he was using in the bathroom and would intervene if necessary. However, the statement “snuck” suggests that he was attempting to be secretive while using in the bathroom which indicates a different level of safety than was expressed. The second participant stated:

I just use in the bathroom. There's a box (sharps disposal container) in there so I just do it in there.

The presence of a sharps container made injection in the bathroom quick, accessible, and participants felt safer there than in environments outside of the DPC. This also suggests a perception that drug use is acceptable in the DPC bathroom. A third participant admitted to snorting drugs in the bathroom and he does so to be safe (close proximity to staff), and to be discreet, not wanting to draw attention upon himself by doing it in common areas. This participant felt an obligation to keep his drug use invisible to other DPC members, thinking that open drug use would be disrespectful to staff and to other members. He stated:

I try to always make sure that I respect the space and not, you know, disrespect any staff members or anything, like, I'm not someone who acts out....

Other participants were supportive of the harm reduction philosophy and the harm reduction room at the DPC but did not use the room for other reasons. For example one participant was in a period of transition to not using drugs and stated:

I think it's really good, I've seen it, I haven't used any of it because I'm trying to abstain.

Another participant was fearful about internal stigma from other DPC members or staff due to being high at the DPC and stated:

I wouldn't be comfortable using anywhere because of the way I am when I'm high. Its like, you gotta do your thing and then go out in front of all kinds of people and everybody knows, your eyes are all big.

Another participant expressed a similar fear of stigma:

I would not go in there and do drugs... ..I'm not going to sit there and look stupid.

The fear of being recognized as a drug user was present for some participants who had experienced mistreatment in other health care settings. Additionally, not all DPC members use drugs and the fear of being “othered” from the DPC community impacted feelings of safety and belonging. Refraining from drug use at the DPC helped some participants to maintain their sense of safety and security at the DPC.

Safety from the streets

The DPC is located in a section of downtown at a distance from the city's core drug scene. As such, it is also separate from the structural violence that exists in terms of drug enforcement (both from police and informal street law) and that associated with drug use in unregulated and/or public settings. The DPC provides a refuge from drug use settings such as back alleys, that increase the risks of such structural violence. In the city's core drug scene there is threat of arrest by police, theft, verbal and physical aggression from others, and the threat of overdose. One participant expressed how the DPC harm reduction room provides safety from such environments by saying:

It's (DPC) more relaxed, I guess you could say, because there is no pressure, you're not worried about fucking police or (law) shit or anything like that. You're just sort of in your own little world until you step back out of that room... .. you're in a contained

area... .. you're in a controlled environment, when you're in a controlled environment you don't have to worry about outside shit.

This suggests a fear of unsafe injection environments, and that the impact of safer injecting environments is profound. Another participant expressed the safety that the DPC provides from the street because he feels like he can hide from the drug scene and be a part of the community at the DPC where no one notices his scars like they do out on the streets.

You can get high, sweat it out, shower, have a nap, its like nothing happened, right? But out there its like you're in the eye of everybody and people don't see shit get better. They only see it get progressively worse. That's all they see if there are drugs involved.

Another added that she feels safer at the DPC than at her housing and that her engagement with DPC staff and programs has helped her to “*get out of the fear, to get out of that trap, the hole*” that was her housing. Her drug use at her housing was rampant, there were people in the halls selling drugs and she was unable to get away from it. Another participant comments that he comes to the DPC because “*it's a positive place*”.

The geographical location of the DPC is safer than the city's core drug scene according to participants. One participant who has used InSite, the sanctioned SIF in Vancouver states that he constantly faces the threat of arrest in that neighborhood,

...because first you had to buy the drug, then you had to walk 10 blocks to get there (SIF). On the way the cops stop you, you go to jail. Every time they find me there with syringe. And they just arrest... .. possession of narcotic.

The DPC is recognized as a safe place for other reasons. It was mentioned during some interviews that individuals sometimes isolate themselves, and this isolation influences their level of drug use. The DPC provides a safe place for participants to immerse in a social and therapeutic community. Even the interview time required for this study provided safety for one participant.

My isolation is part of it right? It definitely gets worse, the more isolated I get the more I do drugs. The more I'm out, the less... ..the more I'm active the less drugs I use. It's pretty simple. Very easy because as I said, you're keeping me away from the drugs right now... ..I'd much rather have participated in the study and do something productive, and it's a big deal for me.

Participants recognize that the DPC not only provides safety from the streets for participants, but also provides safety for those living in the surrounding neighborhoods. One participant stated:

And by allowing their choices not to destroy them so completely is not only good for them but its good for us in general, cause they're not out robbing and stealing... ..its gives them more options.

The safety that the DPC provides relative to the structural violence that exists on the streets has shown to be an important part of the harm reduction approach and has played a role in the consistent attendance of participants.

Safety From Stigma

There is a powerful stigma around HIV/AIDS and drug use. Stigma related to HIV positive health status negatively affects accessibility to health care and participation in many social circles. The incorporation of the harm reduction room as part of the integrated services at the DPC makes it different than other HIV services. The harm reduction approach helps to create the DPC's welcoming and non-judgmental atmosphere, where services are targeted to a specific population with HIV/AIDS. This stigma and discrimination affects how open individuals are with their health status, their drug use, and their sexuality. One participant recalled his discomfort with openly disclosing his HIV status:

I remember Gay Pride Parade, they wanted me to be on their float and I was like, 'no, I'm not doing that,' I'm still not comfortable doing that, and that's what makes it hard for a lot of people to come here.

Another participant similarly felt that in he had to "out myself" in order to attend the

DPC in its current location:

because people know, when you come through these doors, what this place is... ...so it's Dr. Peter AIDS, and AIDS is written on every single one of their t-shirts.

Despite attempts to reduce stigma and provide a stigma-free environment within the DPC, the problem still exists and is still perceived widely outside the DPC. Conversely, the DPC is viewed by other participants as a place that is accessible and offers anonymity because of its location.

I wouldn't want to have to pass by all these people I've known for a long time and have to walk in the doors, off a popular street where there's tens, you know a hundred people that I know and then I have them 'oh ya, you've got this (HIV), how long have you had it and how did you get it? And label me.

Stigma related to drug use is as prevalent as that related to HIV and sexual orientation.

The DPC is attempting to remove barriers to health care and to improve drug-using practices through its harm reduction program however, drug use, particularly injection drug use, is still highly stigmatized in other health care settings. One participant described an experience at hospital:

I think I had an abscess or something and they, as soon as they know it's any kind of drug related thing, it was all of a sudden, their attitude changes towards you.

Another participant contrasted the DPC model with the stigma surrounding drug use experienced on the street.

Well it's a good model because otherwise people just get treated like it's their fault that they're that way and they really don't know if the addiction and that kind of stuff, where it starts and comes from... ...it manifests itself later on in life and people are like blaming, you know. Society is blaming you for being a drug addict instead of, you know, some people are just, they've been backed into a corner. They have no other choices and what are you going to do? Like, they're just trying to deal with escapism...And so not treating them like a criminal or something like that or them making them feel like they're less than or whatever is a much better model.

This statement confirms the ideological and judgmental views that many hold about addiction, and offers insight into the workings of the harm reduction model at the DPC. One participant affirmed the impact of the DPC model by stating:

I would more than rather come here any day for anything. They take you seriously, you don't walk in the door and there's some kind of feat to see if you're actually telling the truth.

Another expressed feelings of safety from stigma by stating:

As soon as we got involved with the DPC, this was our place to stay. I was feeling that no one was judging me and I was feeling safe.

Participants expressed feeling safe from prevalent social stigma that exists, and attribute the stigma free environment at the DPC, in part, to the nurses and other staff who work within the centre's harm reduction philosophy. One participant stated feeling comfortable and welcomed by the nurses:

...because here they have more, they have more experience with people, drug users. So they know how to treat people, this kind of people. But there is, you know, very different. Here is like they (nurses) say "oh you need a Doctor? You need any help? Tell me, what can I do for you? You need a glass of water or something?"

The approach taken by the nurses at the DPC is about service for people, set up according to their stated needs, rather than a service set up that requires patients to adjust to the model of care delivery. The nurses are open and inviting and participants recognize that they receive genuine care. One participant states:

Well, they welcome you, you know, they're happy, they talk to you, and asking you what you want.

Still another stated that the nurses are supportive and available if needed, and that they engage in conversation even when nursing services are not required. It was expressed that DPC nurses do not point fingers, lay blame or pass judgment for being drug users. One participant states:

Ya I think its good, because its kind of just accepting addicts for who they are and not their addiction (the nurses are) so nice and caring... ..don't give up on you, you know. They're more on your side than not.

The staff, specifically the nurses, at the DPC are seen as supportive and different than nurses at other health care services. Participants feel accepted by the nurses and do not feel judged or looked down upon like many have by health care providers in other settings. DPC nurses have made an impact on participants and have contributed positively to their sense of acceptance.

They're a great bunch of people, waiting to help if we use or don't use. They're willing to help.

Participants expressed a high level of satisfaction with DPC services and a general dissatisfaction and avoidance of other health care services because of stigma. One participant recalled an interaction with health care providers in an emergency room when he was having chest pain related to cocaine use.

they don't believe me... ..and I was waiting four hours, five hours... ..[they] say the Doctor already left I thought he had seen you.

This participant experienced stigma and unequal access to care because of his drug use. DPC nurses have been described positively and have helped to decrease barriers to health care that many participants have experienced. Some participants included non-nursing staff in their descriptions:

Because I think the people here are actually, they are professional, they do care and I have seen the interaction amongst staff and the people here is genuine you know. And sometimes I'm even surprised by the level of – what I actually find is there is no fear involved in any of the interaction here. You don't see people standing off to the side. Even the cleaning staff, you can smile at them and they will smile back. Everybody is friendly here. The whole atmosphere is really good. I'm impressed.

Some participants stated that they have continued to attend the DPC because of the staff and because of the inclusiveness of the DPC community.

*...well that's why I come here is because of the staff. They talk with you and not at you...
...they come down to your level and so its like they understand.*

The safety from stigma that the DPC and staff provide plays a role in attendance and participants agree that DPC staff have played an important role in decreasing stigma. The genuine concern that staff and nurses display is perceived and readily accepted by participants who are motivated to return and engage further at the DPC.

Taking It Easy

Data from this study revealed that participants' drug use practices and levels of drug use have changed since they began to engage at the DPC. Essentially, participants felt that the DPC has helped to facilitate reduced risks associated with drug use, and reduced drug use. As already discussed, the DPC acts as a refuge from the street and helps to decrease stigma related to drug use for many of its members. In addition, the DPC has also served as a deterrent from drug use and consequently, the harms related to drug use. For example, one participant stated that he views the DPC as a “*treat*” where he does not engage in drug use. This has occurred, in part, through sustained engagement with the DPC, a setting where drug use, although accepted, is less common, and is correlated with decreased drug scene involvement. Some participants have challenged the assumption that harm reduction enables drug use, by referencing it as a route to abstinence or recovery. Participants recognize this and share their thoughts and experiences. One participant commented:

Cause its there to help you out. Harm reduction helps you to stop drugs.

Another described harm reduction and the DPC as a support for him to reduce drug consumption. He describes it as using:

...safely and hopefully to reduce the amount of use... ...if I could say on the days that I come here from 9-3, that I don't use drugs, that is harm reduction for me.

Participants attribute changes in their drug use patterns to the non-judgmental atmosphere and their relationships with staff. This was explained well by a participant who stated:

Just acceptance is harm reduction. The fact that people don't have to hide it (drugs) from you. And that's funny, when people know they don't have to hide it from you, it actually slows down.

Those who attend the DPC regularly are noted to have decreased involvement in the city's core drug scene and regular prolonged engagement with the DPC further distinguishes participant involvement with the drug scene. This is, in part, because drug use seems to be less common at the DPC, and also because of the DPC staff group who are present and available and who interact non-judgmentally with participants. Participants felt welcomed regardless of their drug use and were appreciative of the nurses. Some participants confirmed that interactions with DPC nurses, and the privacy and anonymity offered at the DPC in terms of drug use were helpful during drug use transitions.

Some participants expressed that they have transitioned their route of drug administration from injection to other less harmful routes since they began to attend the DPC. One participant who now smokes drugs and no longer injects affirmed the importance of the DPC in this transition, and the importance of the harm reduction room in the event of a relapse. He said:

I haven't used (injected) for so long I would probably use the safe injection site so that I wouldn't like kill myself or something...

Still another stated that the DPC has helped her to lower her drug use by providing a healthy distraction. The integrated services offered at the DPC, under the harm reduction model, has proved effective to this participant who stated:

You can spend the whole day here, they let you stay here and dry off your clothes, let you take a nap and talk, go to counseling meetings, they take you out... ...they keep you busy.

Relationships that are built at the DPC have proved to be meaningful and therapeutic for many, and have prompted them to change their drug use patterns.

Because that is what – there are certain elements of those relationships that were being developed. I don't know really how to explain it. I started to see that maybe stopping drugs would be beneficial for me... ...I could see that something would make it worth quitting.

Some participants expressed that refraining from drug use while at the DPC has resulted in using less overall. For example one participant stated

(I) just don't use so much... ...just slowly doing things differently and reducing harm... ...safely and less often.

This participant also reports feeling happier since becoming a DPC member and now focuses on personal happiness as opposed to drugs. Another explained that the DPC harm reduction approach has given him a sense of meaning and responsibility. This has impacted his drug use and his spending habits. He says that money used to be a trigger for him to use, however now when he has money he will:

...pay back some of the money that I owe and buy some cigarettes instead of going out and getting more drugs.

Several participants expressed their discomfort with using drugs at the DPC and reference the centre as a place to rest and take a break from the drug scene. One participant said that he used a lot of drugs prior to becoming a DPC member and now attends the DPC regularly keeps it as a place where he does not think of using. Another statement echoed this:

I don't feel comfortable involving that lifestyle with this lifestyle. There's no place for it to intersect at all.

Harm reduction philosophy does not require reduction in or cessation of drug use, however some individuals made personal decisions to reduce their drug consumption, or to refrain from drug use while at the DPC. Others recognized a change in the own behavior

preferred to be alone when high, for example one participant prefers to be alone *“because I’m high and don’t want to embarrass myself by running along, verbal diarrhea”*.

Others distance their drug use from the DPC for other reasons. Some prefer to use alone, or to use at home as discussed above. Another states that he scores drugs in a different area of the city and finds it too far to return to the DPC to use there. Overall, the DPC and staff have had a positive effect on participants and have played a role in drug use transitions to less drugs or an alternate and less harmful route of drug administration. The DPC has also fostered feelings of safety and increased DPC attendance is correlated with decreased drug scene involvement.

Out of sight out of mind

Triggers to use drugs exist within high drug use settings and environments. Triggers similarly exist within the DPC, however the supportive social and physical environment at the DPC as a lower risk environment helps to distance participants from the core drug scene, from drug use itself, and thus decreases exposure triggers. This was explained by one participant who said *“I don’t know, it doesn’t really trigger me to crave a toke or anything like that”*.

Those who are engaged at the DPC tend to use less, or to use different methods of drug administration (i.e. smoke versus inject). This is due, in part, to the location of the DPC, but also due to the relationships that have been built by and with DPC nurses and staff. It is also due to the availability of programs that are offered at the DPC which serve as a refuge from the street, a distraction from boredom and from drugs, and which also serve as a model for healthy living. This model is transformational for many participants. One participant stated that the DPC has helped him to *“reduce the amount of use, replacing the urges and triggers with something more positive.”*

Several participants agreed that if drug use was not visible then they were not triggered.

One participant remarked:

I never use it, but other people use it and they're always OK when they come out... ...it doesn't bother me... ...out of sight out of mind, if I don't see it, it doesn't bother me.

Another states he does not feel triggered “as long as I don't have it rubbed in my face.”

One reason that several participants denied feeling triggered to use when at the DPC is because they did not know that the harm reduction room existed. Some of them learned out about the room during the qualitative interview for this study. Participants did not feel any more or less triggered upon learning of the existence of the room.

Participants are aware that their actions could impact others who are trying to not use and by not using at the DPC they are in fact refraining from being a trigger to others. One participant says he leaves the DPC and goes for a walk after he uses the harm reduction room so as not to be a trigger to other members. Others are indifferent. For example, one participant thinks the harm reduction room is great but uses only at home out of preference, “*Its never bothered me that its here... ... I can just wait*” (to use at home). He is not triggered to use and does not feel the need to use at the DPC.

There is an interesting distinction indicated between smoking marijuana, and injection drug use. Those participants who smoke pot regularly did not necessarily consider themselves drug users. Their definition of a drug user was someone who injects, specifically someone who injects heroin. Participants do not find marijuana smoke to be triggering however two participants stated that injection drug use is triggering. The first stated:

I'm fine with the marijuana thing. I'm actually 100% fine with the marijuana thing. It's the needle drugs that are causing people to doze off.

The second stated expressed concern and frustration at seeing people falling asleep in their food when high and had an interesting suggestion to mitigate such frustration.

*a decompression room, where those people can all come in here and stay in here and decompress, until they're capable or deemed okay, to come back into the centre again...
...If someone comes into a rehabilitation centre intoxicated, they separate that person immediately from the crowd, immediately, so it doesn't trigger, because it takes just the smell of alcohol to trigger an alcoholic. It takes the waft of that smoker, or the look, something to trigger a crack addict. It doesn't take much, and they say one's physical, one's mental, it doesn't matter, drugs are drugs, and there are triggers that will affect the lizard brain, and the lizard brain just goes 'zoom , oh I'd like that'.*

One participant denied feeling triggered while at the DPC, but expressed frustration at seeing people there who are intoxicated. He had a suggestion for how to minimize potential triggers, and in making this suggestion, was attempting to segregate those who inject drugs from those who do not.

They are high as a kite walking in and they should have a rule that too high you shouldn't come in here. Most people are high as a kite, start singing in the lunch room and eating breakfast. You know what? I came here for breakfast. I want music I will bring my own music with me.

Some participants express that they had felt triggered to use when they initially began attending the DPC but that those triggers have diminished.

At the beginning people would say 'yeah I'll give you a rock'. I say "you keep reminding me, why don't you just give me the ten dollars then you can do what you want and I can do what I want". In the beginning saying no was a funny word, a funny feeling.

Participants were accepting of the harm reduction room whether or not they used it themselves, and were not generally affected or triggered by the use of the room by other participants, in fact the structural and social environment at the DPC has prompted many to use less.

Welcome Home

Two participants referred to the concept of home in reference to the DPC. The first stated that at the DPC “*we were all welcome home.*” The other stated

These nurses here, they talk to you, they make you feel, they make you, it's like home.

Other participants feel at home because they are acknowledged and recognized at the DPC. A male participant describes the DPC as a safe, common meeting place and said that he feels at home because nurses refer to him by name and acknowledge him.

The fact that they know you by name, that's pretty cool to a lot of people here... ..They know my name, I'm not patient 196, I'm not the AIDS guy.

This concept of home, and the comfort that one feels at home is attributed to the “Acceptance, Belonging and Purpose” that participants expressed experiencing at the DPC. The shared experience of “HIV, We’ve All Got It” further contributes to the sense of belonging that one feels at home.

Acceptance, Belonging and Purpose

The *Diagnostic and Statistical Manual of Mental Disorders IV* (2013) defines substance abuse as a “maladaptive pattern of substance use, leading to clinically significant impairment or distress.” Tolerance and withdrawal are listed as criteria for substance use disorder (American Psychiatric Association, 2013). The opposite of addiction has recently been described as “connection” (Hari, 2014; Alexander, 2008). Personal connection to community or a group of loved ones, and the provision of care have been shown to play a role in drug use transitions, and in the cessation of drug use (Hari, 2014). The DPC offers a social community where such connections can be established and participants report feeling connected and cared for, and expressed a sense of acceptance and belonging. This sense of belonging contributes to an atmosphere of community and sense of purpose for DPC members and this theme is, again, facilitated by the relationships that DPC members have with staff. The harm reduction model

adopted at the DPC, the non-judgmental atmosphere, the acceptance regardless of drug use, and the social inclusion create an environment where change can and does occur.

Participants feel a sense of community at the DPC because of the safety that health care providers foster. One participant stated.

At the Dr. Peter Centre I was feeling safe. I was feeling that no one was judging me.

Participants feel bonded to others because of the atmosphere of acceptance at the DPC. One participant described the DPC as more of a “community centre” in comparison to other services that operate as drop-in centres and do not have the same level of community and acceptance and support. Another participant stated

I think that the DPC is one of the most positive things I've encountered in the past ten years of my life.

Staff help to foster social inclusion by creating a warm and welcoming environment, and by building positive relationships. Participants perceive these relationships as authentic and meaningful, with a profound impact on their sense of belonging at the DPC. This was expressed by one participant who stated:

In a round about way it was their interaction. It was there. I wasn't really as concerned about my health as they were. But I think it was because of the interaction itself.

Participants include the nurses in their definition of the DPC community.

Well they're on your level, they're accessible. They're not here to supervise you and guide you through the rules, they're here to help you with what you want. But they're not less than and they're not better than and its really cool.

Participants emphasized how their attendance has increased because of staff who demonstrate that they care. Staff have impacted participants in terms of creating accessible welcoming care, empowering participants to make informed positive health decisions, and in

terms of the sense of belonging and purpose that participants expressed. Participant statements affirm this.

*Well, that why I come here is because of the staff. They talk with you and not at you...
...they come down to your level*

And also,

*They don't seem to judge... ...you will attend more often and its better for your health
and stuff like that if you're feeling comfortable in a place, because you will access the
services and then do what you need to do for yourself*

This was echoed by another participant who was impacted by the sense of community at the DPC:

*I look around me and I see people feeling safe and valued, in an environment where
they're supported in what they're trying to do, as individuals.*

There were two participants who expressed that they initially did not feel like a part of the DPC community and both attributed this to being a minority because of their heterosexual orientation. One of them said that he did not take part in the men's groups offered at the DPC because it was attended by homosexual males, and expressed a desire for a heterosexual men's group. This participant did, however, report a change of heart after sustained engagement with and at the DPC.

*I just felt like I don't belong here... ...I was straight, it's a lot of gay guys here, I had
nothing against them, but just not my scene. I used to be homophobic, now I get a long
with everybody, we just became friends, its normal.*

Within the sense of acceptance and belonging felt by DPC participants is a sense of purpose that some participants now have. This was attributed, in part, to staff who have

*shown me there's a place for me in this world. I don't have to walk the streets or the
alleys. There are people that genuinely care... ...about people like myself, whether they
live or die.*

Participants expressed feeling grateful for belonging to the DPC community where they are not judged, where they are recognized and empowered and uplifted.

You've done so much good for so many people, like, just letting me in. I don't think I was even a top quality candidate but you let me in anyway.... ...Everyone falls down, I certainly have, but you helped me pick up the pieces and did so with dignity.

Being part of the DPC community provides participants with a sense of belonging. Positive relationships, the harm reduction approach, the harm reduction room, helped participants to feel “welcome home” at the DPC, a place where there is freedom from stigma, from the risks of using drugs on the street, from triggers to use, and for some, freedom from drugs themselves.

HIV, We've All Got It

HIV stigma is prevalent and judgments are made against those who are HIV positive, particularly in terms of moral judgments about how the disease was contracted. The DPC offers a community where this stigma is non-existent. This is because of the accepting relationships that have been built between staff and participants, and also this relationships that exists among peers. Participants feel accepted as members of the DPC community and are bonded to one another because of the stigma they have experienced, and because of the common experience of HIV. As one participant eloquently stated:

We all have one thing in common.

This was echoed by another participant who felt that the commonality provided a sense of support and comfort,

...well, everybody is HIV, (it) gives moral support.

Relationships built at the DPC have helped participants to be confident and accepting of themselves, their substance use, and their diagnosis. Participants also feel that differences

among members are not important when there is a shared commonality. For example one participant said:

I've just accepted who I am, what I am, and what I have right now... ...When I found out we all had the same disease, sexual orientation was not important...

Other participants expressed similar feelings and described a sense of community because of the common bond shared between all members, despite differing backgrounds and experiences.

...well they are no different than I am. A lot of us come from similar backgrounds, (but) there are a good deal of them I don't have something in common (with). Not everyone has been on the street. Some of these guys have been professionals, they had lives before they ended up with this thing (HIV), it took some of them up and some of them down. I've got something in common with everyone I think, even with the people I don't obviously have. And I don't judge them, I can still talk, I can still relate. I don't judge them or anything and they don't judge me.

That participants feel accepted by staff and their peers is significant. The overall theme of “Welcome Home” serves to highlight the importance of community for those who have been stigmatized and marginalized, and the importance of an open and accepting harm reduction approach. The impact that the DPC harm reduction approach and staff have on participants is positive. The DPC provides safety from the harms of injection drug use, has had an impact on drug use patterns, and has not been shown to trigger drug use. The DPC has further impacted participants to feel a sense of acceptance and belonging. Amid the risks inherent with injection drug use and the struggles involved with being HIV positive, participants have expressed how the DPC has impacted their lives positively and contributed to their sense of power and their ability to make positive health choices. Given the multiplicity of healthcare challenges that those living with HIV and who use drugs face, an approach where nurses walk alongside patients is imperative and critical to ensuring positive health care interactions and positive health outcomes.

A discussion of the impact of the themes presented in this chapter will be discussed in the next chapter.

Chapter 5

The purpose of this chapter is, first, to summarize the purpose and findings of the study, and, second, to relate the findings back to the literature. This chapter includes a discussion of the strengths, limitations, and ethical considerations of this study as well as the implications the study has for nurses working in HIV, the implications for nursing research and education, and the implications that this study may have for policy makers, other HIV and harm reduction service providers.

Overview

There are three main findings to this portion of the greater mixed method study. From analysis of participant interviews the prominent and important theme of safety emerged. The harm reduction philosophy, from which the DPC operates, addresses participants' sense of safety. Safety had different meanings among participants and three subthemes of safety emerged. The first, "Safer Use," was prominent for both participants who inject in the harm reduction room and those who do not. The second subtheme, "Safety from the Streets," is about safety from the structural violence that exists around drug use, particularly the violence that can occur when using on the streets and in back alleys. The DPC provides a refuge from high risk drug use locations, and from the threat of law enforcement and implicit street law. The third subtheme is related to the "Safety from Stigma" that the DPC provides. The DPC provides a refuge not only from structural violence, but also from the judgments and stigma imposed on those who use drugs by those who work within the health care system, and by society in general.

The second prominent theme of "Taking it Easy" emerged from participant accounts of changes in drug use patterns. The DPC staff (nurses) welcome participants and provide a safe

environment and harm reduction education that has led to reduced drug use risks. This in turn, has brought about changes in drug use patterns. Some participants reduced their use, or refrained from using while at the DPC. Others reduced their use of injection drugs, while still others modified their drug use to reduce harm whether using at the DPC or elsewhere. The subtheme to “Taking it Easy” is “Out of Sight Out of Mind”. This sub-theme describes how participants have not felt triggered to use drugs while at the DPC.

The third dominant theme, “Welcome Home” that emerged from participant narratives developed from the sense of acceptance and belonging that participants experienced, and the commonalities that they share with other members as a part of the DPC community. These experiences were attributed to nurse-participant relationships, the harm reduction philosophy adopted at the DPC, and to the safety that the DPC provides in the ways described by the first theme of “Fostering Safety”. Participants were welcomed and at ease when at the DPC, and had a sense of belonging to the DPC community. This experience has had positive impact on their health and their drug using practices.

The specific research questions posed were:

1. What are participant’s experiences and perceptions of the harm reduction services offered at the Dr. Peter Centre?
2. What is the impact of the DPC harm reduction model on participants’ access to clinical and support services, and on drug use?

My experience working with and for a population that is marginalized and stigmatized because of drug use, socio-economic status and HIV positive health status has increased my passion for serving them and their unique and specific needs. My own work as a casual RN at the DPC instilled in me an interest in the community and the struggles and inequities that

community members face. My work in nursing outreach to residents of single room occupancy hotels has helped me understand the complexities of the lives of this population. My involvement in the greater mixed-method study as a graduate student is a good fit with my interests and experience. Participant interviews were informative and helped me to understand their individual experiences both prior to and since their engagement with the DPC. Participant narratives have also shown me the importance of the environment in which care is offered and received, and the impact that risk environments have on drug use, health, health care and health care accessibility.

Discussion of Findings

The findings of this study reflect previous research in a three main ways. The first is about how this study demonstrates and exemplifies that the harm reduction services at the DPC overcome a number myths that are held about the concept of harm reduction. Second, the effect that harm reduction has on the stigma faced by those who use and inject drugs and its effect on accessibility to care is described in the literature and is clearly reflected in this study. Finally, the findings reflect the literature in the way that the accepting nature of harm reduction practice affects drug use, and drug use patterns. Each of these findings relate to the concept of resilience that exists among participants and how resiliency is affected by personal connection to a supportive community that is a feature of the DPC harm reduction model.

Overcoming the Myths

Enabling

There are several myths about harm reduction, the first and most obvious being about what harm reduction actually is and does. The myth is that harm reduction keeps people on drugs, promotes addiction, and enables drug use (Hathaway & Tousaw, 2008). Haden (2003)

states that “enabling” in the context of drug use means to help people use drugs and support addiction. Harm reduction provides health education and empowers those who use drugs to “make better choices around both the addiction and the related harmful behaviors” (Haden, 2003). Participant narratives in this study reflect Haden’s (2003) definition in that participants expressed making changes to their drug using practices and patterns. Participants were also empowered to engage in activities (including health care services) offered at the DPC and these activities served as effective distraction from drug use. This is consistent with Gowan, Whetstone, and Andic (2012) who found that decreased drug use is correlated with increased empowerment and increased ability and confidence in making personal health decisions. Wood, Tyndall, Montaner and Kerr (2006) found that harm reduction programs such as needle exchange and supervised injection services neither increased drug use, nor facilitated initiation of drug use. This study has similarly determined that the DPC harm reduction room is not a trigger, and thus does not enable drug use among participants.

The CNA (2011) write that “harm reduction strategies can be viewed as part of a continuum of prevention and treatment strategies” (p.42). This addresses addiction on multiple levels. Harm reduction education serves as a method of prevention of drug related harm. Increased access to primary care services and referrals to health care and addictions services are similarly effective treatment strategies. Uptake of social service referrals, detox and addiction treatment services, methadone maintenance and primary care services are increased with harm reduction, and connection to social supports contribute to positive health choices and health outcomes (Wood, Tyndall, Qui et al., 2006; Wood, Tyndall, Zhang et al., 2006). The findings of this study reflect this in that the model at the DPC has contributed to positive drug use pattern changes and positive health outcomes. Harm reduction, in the context of this study, not only

defies the myth that it enables drug use, it is a route to abstinence and recovery for those who are empowered to make that change.

Harm Reduction Doesn't Work

Harms related to drug use continue to occur, people use drugs, people overdose and people contract disease and infection. Because of this, harm reduction has been criticized, deemed ineffective and lacking in scientific support (Pauly et al., 2015). The goals and markers of a successful harm reduction program are increased accessibility to care, uptake of services and referrals, and reduced disease transmission (Marlatt, 1996). Harm reduction does not intend to reduce drug use but this study has shown that changed or decreased drug use patterns are an observable effect of the DPC harm reduction model. The CNA (2011) also write that harm reduction reaches 80% of its intended population while abstinence based approaches to drug treatment reach only a small portion (20%) of their target population. Marlatt and Witkiewitz (2002) found that harm reduction approaches are at least as effective as abstinence based approaches, and that abstinence based approaches “may hinder individuals who are wanting to reduce the risks” associated with addictive substances (p. 869).

Hathaway and Tousaw (2008) write that “the authority of harm reduction exists because it works, and has repeatedly been proven to improve the lives of addicts” (p. 13). Most participants in this study had utilized the nursing services at the DPC and had high levels of satisfaction and positive outcomes from these encounters, found the clinical team accessible and engaging, and were likely to return to them for subsequent clinical needs. In these ways harm reduction at the DPC is meeting its intended population and its intended goals.

Harm Reduction Increases Crime

Harm reduction has been criticized for contributing to crime, public disorder and the public discarding of needles (Wood, Kerr, Small, Li, March, Montaner & Tyndall, 2004). However SIFs have not been found to increase rates of crime, public disorder or public discarding of needles (Wood et al., 2004). This study has found the DPC to be a place of refuge for participants from the structural violence associated with drug use. Consistent with MacNeil and Pauly (2011) and McNeil and Small (2014), participants in this study are safe from, and not engaging in the structural issues that exist in procuring and using drugs on the street, when at the DPC.

Harm Reduction, Stigma and Accessibility to Care

Stigma, in the context of this study, refers to a negative stereotype inflicted on those who use drugs and are HIV positive. This population faces perceived and actual stigma when seeking health care services. Negative stereotypes and subsequent poor treatment are prevalent and pervasive in both health care and social settings (Van Boekel, Brouwers, Van Weeghel & Garretson, 2013). Nurses in particular have high rates of stigma and negative attitudes towards those who use drugs and this is compounded by homelessness, poverty, communicable disease, sexual orientation and mental illness (Pauly, et al., 2015). Wagner, Hart, McShane, Margolese and Girard (2014) identified the same attitude among medical students who have a reduced sense of obligation to care for those who are living with HIV. Study participants recalled experiences of stigma in which they were mistreated or made to feel shame in health care and social services settings, however there were no experiences of stigma from health care professionals expressed at the DPC.

Stigma creates a mistrust of the medical system and those health care professionals who work within it (Pauly et al., 2015). Because of actual and perceived stigma, those who use drugs and are HIV positive frequently avoid or delay seeking medical attention, and are often in stages of severe illness when care is sought (Pauly, et al., 2015). Upon seeking care, shame related to stigma contributes to lack of treatment completion, and self-discharge from hospital before illnesses are fully treated (Pauly et al., 2015). Although some participants in this study commented on feeling “guilty” or “weird” when asked about drug use at the DPC, all participants responded positively on being accepted non-judgmentally as a part of the DPC community. The mistrust that many have for the health care system can be addressed by a climate of trust (Pauly, 2014). Trust can be built between patients and nurses through the development of positive relationships over time through listening, respect, and “moving beyond judgments and stereotypes” (Pauly, 2014. p.216) and such relationships can decrease stigma and barriers to care. DPC staff, working from within a harm reduction philosophy, have created a welcoming space for members and in doing so have built and maintained trusting relationships with participants and made the health care services at the DPC very accessible.

Despite an awareness of HIV and its transmission, there is a societal judgment against people who have HIV and use illicit drugs as people who engage in morally wrong activities, and have made poor choices which resulted in HIV (Wagner et al., 2014). They are blamed and made to be at fault for using drugs, and for contracting HIV (Small, Palepu & Tyndall, 2006). Society responds to these aversions from socially accepted norms by trying to treat, fix, or punish those who use drugs and this serves to blame, reinforcing the problem, further isolating, marginalizing and stigmatizing, making health care even less accessible (Simmonds & Coomber, 2009). The DPC model takes the opposite stance and the risk environment framework for this

study assists in understanding how harm reduction shifts responsibility for the damage caused by drug use, including HIV, from the individual, to factors uncontrollable to the individual.

In my experience working as a nurse at Vancouver's SIF, and doing outreach into single room occupancy hotels, I encountered very few clients who had not been physically, emotionally, or sexually abused, who were introduced to drugs by a trusted family member or loved one, who lived within the foster care system and faced isolation and loneliness, who lacked a sense of personal identity, who experienced bullying, poor social and economic resources, were neglected, and struggled with mental illness. Blaming the individuals effectively blames them for the traumas they have experienced and a shift toward social responsibility will help overcome stigma and is a starting point for treatment (Small, Palepu & Tyndall, 2005). Through the building and maintenance of an accepting community of staff and peers, the DPC is overcoming stigma and helping participants to engage in treatment.

Gowan, Whetstone and Andic, (2012) found that being a part of a group or community provides a sense of purpose which gives a sense of control over one's life. All DPC members are HIV positive, many use drugs, and although the stigma associated with HIV exists and is perceived in many social contexts, it does not exist within the DPC walls. Mitchell, Edwards, McKenzie, Knowlton, Valverde, Arnsten et.al. (2007) point out that the common experiences of those who use drugs bring them together despite the stigma and isolation associated with being HIV positive. They offer a quotation that reflects findings in this study: "Oh, but it's (HIV) a burden and we all share it together" (Mitchell, et al., 2007. p.58). The emotional and social support received from nurses, staff and other participants in Mitchell's et al. (2007) study contributed to being accepted and valued and these supports increased participant utilization of health services. This study has found similar outcomes, which are particularly relevant in light of

the stigma and rejection that many participants experience outside of the DPC. Participants feel validated and welcomed at the DPC and this motivates them to return to and maintain their connection with the DPC.

The DPC has helped to mitigate blame and stigma with the community that has been built. Participants have been empowered to make positive health decisions and to have a sense of control over their own lives. Other studies have also found that a welcoming environment, creation of a safe space, and connection to others with common experiences has helped to empower, increase confidence and positive health decision making. For example, Pavinen and Bade (2008) described their experiences creating a safe space for women struggling with addiction. Their hope was to find commonalities and establish a trusting community with the women, and they achieved this by actively participating and working alongside their program participants. The present study has found that the relationships with caring and non-judgmental DPC nurses and staff have facilitated a sense of safety and acceptance among participants.

Tzemis, Forrest, Puskaks, Zhang, Orchard, Palmer et al. (2012) suggest that social factors, financial insecurity or insufficiency and low education level “contribute to stigma because individuals may lack a sense of personal control in their lives and tools that promote resiliency”(p. 98). They also identify stigma as a holistic health issue that should be addressed as such by health care professionals. The DPC addresses the issue of stigma holistically by providing harm reduction services in a group of integrated health care and social services.

Changes In Drug Use Patterns

A significant finding of this study is that participants expressed changes in their drug use patterns since becoming involved at the DPC. Although reduced drug use is itself not a goal of

harm reduction programs (Wood, Tyndall, Qui et al., 2006; Wood, Tyndall, Zhang et al., 2006), it is noted to be a relevant by-product of harm reduction, in this study. This can be attributed to the supportive DPC community where participants feel a sense of purpose, and are empowered to make positive health choices, some of which have involved a change or a reduction in drug use.

Some studies have found that a sense of acceptance and belonging, connection to a supportive community and harm reduction services impacts drug use levels, and prompts changes in drug use patterns. For example the CNA (2011) reviewed research that evaluated outreach harm reduction programs and consistently found that such programs reduced frequency of drug injection and facilitated cessation of injection drugs. Similarly, Battistich & Hom (1997) found that “higher levels of sense of community were associated with lower average levels of drug use” (pp. 1999). Coyle, Needle and Normand (1998) evaluated public health interventions and found a reduction in risky behaviors including reduced frequency of drug injection, and cessation of drug use. This was in conjunction with increased access and entry into detoxification and drug treatment. InSite has also been shown to increase uptake of referrals to addictions services (Kerr, et al., 2006) as has the DPC (Krusi, et al., 2009). This study has also found that connection to a community in which harm reduction is used to embrace and welcome participants has resulted in changed drug use patterns, and reduced drug use for some participants.

Referrals and uptake of referrals to detox and drug treatment programs are a documented benefit of harm reduction programs such as supervised injection (Wood, Tyndall, Qui et al., 2006; Wood, Tyndall, Zhang et al., 2006). One participant in this study was in a drug treatment program at the time of the interview, others expressed a reduction or change in drugs use since becoming involved with the DPC. The harm reduction model and philosophical approach taken

by staff at the DPC has contributed to changes in drug use patterns and reduced drug use, as has the location and physical environment of the facility.

Battistich and Hom (1997) write that socialization is facilitated in a functional community where consensus (in this case the commonalities of HIV positive health status and engagement in drug use) exists among community members. They emphasize that the social bonds that develop are the mechanism that promotes acceptance. DPC nurses and staff in this study have created a welcoming atmosphere in which the community of members has formed. The social networks that have been formed among DPC members contribute further to the sense of acceptance and belonging and are in part, responsible for the maintenance of the DPC community. Rhodes (2002) writes that risk environment research suggests that perception of risk and the resulting behaviors are a product of perceived social norms, rules and values, peer relationships and social influence. The DPC has a positive effect in terms of participant commonalities, shared values and beliefs, and in terms of social networks and peer influence. This risk environment at the DPC is one of low risk where participants denied feeling triggered to use, and where they often refrained from drug use.

Resilience

Resilience is the ability to rise up from adversity and to adapt to stressful situations (Merriam-Webster, 2015). Resilience involves multiple factors and interactions between the individual and their personal environment and context, and it fluctuates depending on the situation and level of stress. The use of coping mechanisms can increase resilience and the chances of positive adaptation to stressors (Stajduhar, Funk, Shaw, Bottorf & Johnson, 2009). Stressors related to injection drug use include the risks involved in procuring the drug, and the risks involved with injecting it. Social issues such as poverty, homelessness and mental illness

that are often associated with drug use are additional causes of stress that can be difficult to cope with, particularly in the absence of social supports. The resilience seen in study participants who have experienced multiple traumas became evident during interviews. Tzemis, Forrest, Puskaks, Zhang, Orchard, Palmer, et al. (2012) suggest that increased personal control is related positively to resilience. When surrounded by support, participants in this study experienced feelings of empowerment and were able to make positive health decisions. Resilience was noted in how participants became motivated and interested in activities at the DPC, in how drug use practices changed (i.e. safer drug use practices or reduced drug use), and in how participants recognized a sense of purpose in the face adversity. Stajduhar, Funk, Shaw, Bottorf and Johnson (2009) write that emotional pain, feelings of hopelessness, and lacking a sense of purpose, negatively affect resilience. This study has found, however, that resilience is increased with sustained engagement with the DPC integrated services and the welcoming atmosphere and community. The support offered at the DPC increases resilience by providing a source of distraction from drug, and a sense of belonging for members

Gaps in Services

There are few gaps in service at the DPC. Participants spoke positively about the program and the harm reduction model. In fact one participant expressed that the DPC had so much to offer that it was overwhelming. There were some ideas expressed by participants such as a heterosexual mens group, and a “decompression room” for those who were intoxicated to “decompress” in before entering the common areas at the DPC. Another gap in service is that several participants were not aware that the harm reduction room at the DPC existed. Incorporating a discussion of the harm reduction with DPC members, if not already done, might be beneficial.

Strengths

A strength of this study is that it has added to the body of knowledge about the impact of harm reduction services. The finding of the trend of reduced drug consumption as a result of harm reduction interventions at the DPC is a contribution to research which has occurred as a side effect of harm reduction services. This is a positive side effect which also helps to overcome some myths associated with harm reduction services.

Second, the sample size for this study was thirty-one participants, a high number for interpretive description methodology. This made for a large amount of data which allowed for variation and eventual saturation of the data. This facilitated the analysis and interpretation process and allowed for in depth understanding of participant experiences.

Limitations

This is the first known attempt at a qualitative study of DPC member perceptions of the harm reduction philosophy and programs (including nurses), and their impact on drug use and quality of life. As such, a limitation of this study is that there is little to which it can be compared in the literature. Similarly, the DPC is a unique facility with a unique model of integrated services and there is little to which the centre can be compared. Gaps that exist in the services at the DPC, and impacts of the harm reduction model have not been studied and there is, similarly, nothing available for comparative study. Additionally, this study uses the perspective of those who are in active addiction and does not incorporate perspectives about the DPC harm reduction philosophy and programs from those who do not use, not does it incorporate the observations or perceptions of DPC staff.

This study sampled a cross section of DPC members and included males, females and transgendered individuals, however, most of the participants (n=24) were male. As such, this

study does not provide an equally gendered perspective that includes perspectives of women and those who identify as transgendered. Most of the participants were from a demographic background of poly-substance use and low socioeconomic status. This study does not reflect the perspectives of those DPC members who are from a demographic of higher socioeconomic status and who do not have a history of drug use or abuse.

Participants in this study provided narrative responses to questions specific to the harm reduction program at the DPC. It is possible that these narratives may have been generated partly in response to the questions asked, or *how* the questions were asked by interviewers and may not accurately reflect participant experiences, particularly with respect to decreased drug use patterns.

Implications for Nursing Practice

Implications for nursing practice are important to discuss because they can promote nurses working in HIV, addictions and harm reduction, to critically examine their practice and effectiveness. Nursing practice at the Dr. Peter Centre utilizes a unique set of social and clinical skills to provide service to a specific and unique population. It is hoped that this study will inspire nurses to continue in their specialized care for unique populations, and motivate nurses working in HIV/AIDS care to engage in further education to provide additional services, and to celebrate and continue the work that is already being done.

This study offered participants the opportunity to reflect on the community of which they have become a part at the DPC, and how the DPC model has impacted their lives. This study has also opened the door to insights about how nurses can explore, interpret, and understand the concept of harm reduction, and its effects on those who use and are affected by harm reduction services. It is important for nurses and all health care providers to deliver sensitive, holistic care

that accepts, rather than blames, so that health care for this population can be more easily accessed, and so that stigmatization is reduced. Many injection drug users suffer from pain and previous trauma. Nurses' awareness of this will impact the care that is provided, the care that is received, and the likelihood of patients seeking care when problems arise. An important implication of this study for nurses is that it displays how harm reduction is incorporated into the nursing concepts of health promotion (via harm reduction education and empowering informed decisions) and prevention of illness (prevention of harms related to injection drug use). These are concepts familiar to nurses and can help to promote changes in understanding and in practice.

Finally, nurses can reflect on how their own values and biases and beliefs affect the care that they provide, and how they perceive, and then approach and interact with marginalized populations in their practice.

Implications for Nursing Research

This study makes a specific and significant contribution to the literature in that it uncovers participants' experiences with the DPC harm reduction model, and the impact that the model has on changes in drug using behaviors and on quality of life. In order to improve understanding of this relationship further research is warranted in other harm reduction settings. Research that assists in transforming nurses and other health care professionals attitudes and beliefs about those who are HIV-positive and use drugs, and which improves the health care experiences of this populations is also needed.

Implications for Nursing Education

HIV and drug use are prevalent in society and populations struggling with such issues face significant and specific challenges. Stigma is similarly prevalent. It makes sense for nursing education to be inclusive of the health and health care challenges associated with HIV

and illicit drug use so that targeted, appropriate, and effective care is provided. Increased incorporation of HIV and substance use theory would be a benefit to nursing education, and to graduating nurses who are entering the work force. Incorporation of clinical experiences specific to HIV/AIDs and injection drug use would also benefit students who are preparing for work as registered nurses. Veteran nurses would benefit from education about these issues and the importance of an understanding of the contexts and stigma surrounding HIV and drug use. With such education the health inequities that exist for those who have HIV and use drugs could be addressed and leveled.

Implications for Policy Development

Policy change toward a harm reduction model will increase accessibility to health care for those who are HIV positive and who use drugs. The model of integrated services, including harm reduction, at the DPC is an effective model that reaches its intended population and has been shown to facilitate drug use practice changes and impact levels and routes of drug use. It is hoped that the findings of this study will be considered by local health authorities, governing and funding bodies and that they will be sympathetic to the valid health, mental health and social needs of the population served by the DPC. It is also hoped that they will become aware of, and sympathetic to, the gaps in care that this population is offered, and the significant gains that have been made through the harm reduction model.

This study has implications for the DPC in terms of how it might be improved. A number of participants stated during their interview that they were not aware that the DPC had a harm reduction room. Knowledge of the room by all participants, and information about the DPC harm reduction policy and philosophy could further increase access to care for DPC members. A “*decompression room*” was suggested by one participant as a way of ensuring that

no DPC member feels triggered by injection drug use at the DPC. The inclusion of such a room would keep this trigger invisible to other members trying to abstain, and may also prompt those who inject but do not use the harm reduction room, to begin to do so.

Conclusion

The DPC integrated services, particularly the integration of harm reduction into the model of care, has impacted DPC participants positively. The participants in this study provided insights into their experiences both prior to and since their engagement with the DPC, and into their understandings of harm reduction, and how it has impacted them individually. The resilience that they showed is inspiring as many of them faced personal difficulties that would be too much for me to bear.

The stigma that those with HIV and who use drugs face is both humbling and troubling and my support and belief in harm reduction as an effective health promotion, and treatment modality has only increased throughout this research process. My hope is that others will recognize the difficulties faced by this population and recognize the harm reduction approach as an effective way to reach and provide health care.

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Appendix A
Recruitment Poster



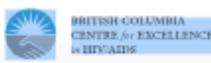
The Dr. Peter Study wants to know how our model of care is impacting your health and well-being.

As an eligible participant, you will:

- have joined the Dr. Peter Centre in the last 3 years
- complete a 1-hour survey and provide your full name, date of birth, and PHN
- be compensated \$30 for your time

The Dr. Peter Study office can be reached at 604-806-9003.

Please see Reception for more details or to join.



Appendix B Mixed Method Study Protocol

Principle Investigator: Dr. Robert Hogg

A mixed method evaluation of the impact of the Dr. Peter Centre on health care access and outcomes for persons living with HIV/AIDS

A. BACKGROUND

The availability of highly active antiretroviral therapy (HAART) has produced significant health benefits for persons living with HIV/AIDS (PLHIV) (1,2). Unfortunately, many PLHIV face substantial barriers to accessing and adhering to HIV-related health care and support services, and typically experience sub-optimal treatment outcomes (3), even in British Columbia, where HIV treatment including medications and related care is delivered free of charge (4). **The focus of this study is to determine the effectiveness of integrated health care and harm reduction programming on HIV/AIDS related outcomes of PHA who face multiple and complex barriers to optimal treatment experiences.**

The Dr. Peter Centre (DPC), where this study will be conducted, offers low barrier access to services that facilitate greater engagement in health care and support including services that reduce environmental risk factors and drug-related harms for PHA. In addition to a day health program, the DPC has a residence that provides care to 24 individuals who require 24-hour specialized nursing care, as well as two enhanced, supportive housing units. To date, the DPC is the only facility in North America that offers Supervised Injection Site as a component of its primary health care programming.

B. RESEARCH AIM AND OBJECTIVES

1. Identify psychosocial, behavioural and social-structural level barriers to, and facilitators of, optimal HIV treatment outcomes among DPC clients, as well as the specific Dr. Peter Centre services/programs that are associated with improvement in treatment outcomes over time.
2. Investigate the effectiveness of exposure to the Dr. Peter Centre (DPC) on HIV treatment, including timely uptake of highly-active antiretroviral therapy (HAART), adherence to HAART and plasma HIV RNA viral load (VL) suppression.
3. Explore the narratives and perspectives of DPC clients on how the integration of health and support services affects their quality of life.

C. METHODS

C.1. Overview: We are undertaking a three-year, mixed-method community based research (CBR) study of the DPC's integrated model of HIV/AIDS health care by establishing a longitudinal cohort of recently enrolled Dr. Peter Centre clients. The project team is a collaborative partnership between the DPC, the BC Centre for Excellence in HIV/AIDS (BCCfE), decision-makers from BC, Saskatchewan and the Ministry of Health, researchers from across Canada, and affected community members. A community advisory group consisting of local stakeholders and a minimum of two DPC clients has been convened for this project. Two to three peer researchers will be hired to

facilitate the greater involvement of the affected community in this study, provide administrative and research support, as well as contribute their perspective to the project.

To address study objectives 1 and 2, we propose to create a prospective longitudinal cohort comprised of DPC clients who have enrolled in the Dr. Peter Centre within the 36 months preceding time of recruitment to the cohort. Based on Dr. Peter Centre enrolment statistics from the past three years, we expect to recruit approximately 150 individuals over two years. To address the final study objective, 25 participants from the longitudinal cohort will be selected for ethnographic and qualitative interviews.

C.2. Recruitment, Data collection and analysis:

C.2.1 Objective 1

Recruitment and Data Collection:

Upon referral to the Dr. Peter Centre, new clients undergo an intake interview with a DPC staff member. At this time, the staff member may verbally inform the prospective participant of the study and their eligibility to participate if they wish to do so. Alternatively, for eligible clients who have enrolled at the Dr. Peter Centre within the 36 months prior to the time that recruitment begins, will receive a recruitment letter at the Dr. Peter Centre reception desk explaining the study. There will also be recruitment posters posted throughout the Dr. Peter Centre to help inform clients of the study. Trained Peer Research Associates (PRAs) will also be available at various times throughout the week at an “Ask Me” desk to help answer prospective participants’ study-related inquiries and to help develop awareness of the study. PRAs will be provided with recruitment brochure cards to distribute to prospective participants that summarize basic study-related information such as eligibility, where to find more information and which personal information participants will be required to bring to their interview.

Prospective participants can then go to the Dr. Peter Centre Reception desk where a staff member will confirm their eligibility to participate in the study. If the prospective participant is eligible for participation, they will then sign up for a time to meet with a Peer Research Associate who will obtain their informed consent and administer the study questionnaire. Participants will know at the time of booking which PRAs are available to administer the questionnaire, and will be able to choose which PRA they prefer to complete the questionnaire with. The participant will then complete a structured 60-minute interviewer-administered questionnaire, which will be loaded onto a computer and will be completed in a quiet and secure location at the Dr. Peter Centre. For participants who require more than one visit to complete the questionnaire, the option to schedule up to two additional appointments will be provided, for a maximum total of up to three visits.

The interviewer-administered questionnaire will elicit demographic and socio-economic information, data on housing, transportation, social supports, treatment behaviours and attitudes, as well as specific information on how the integration of health and supportive services offered at the DPC affects quality of life and HIV-related outcomes. The interviewer-administered questionnaire also includes standardized scales to measure aspects of mental health (e.g. depression, anxiety, coping), and drug and alcohol use.

One year following the baseline interviewer-administered questionnaire, participants will receive a second letter at the Dr. Peter Centre reception desk inviting them to participate in a follow up

interviewer-administered questionnaire. The same procedures will be followed for the follow up interviewer-administered questionnaire.

Participants will be compensated \$30 per questionnaire that is completed. In this context, completion of the questionnaire is defined as any of the following: participant completes the questionnaire in entirety, participant decides they do not want to complete the rest of the questionnaire/do not want to proceed any further with the questionnaire or the participant has reached the maximum of three visits during which they can complete the questionnaire. At any of these defined completion points, the participant will receive their \$30 honorarium for their time.

Data analysis: To identify factors associated with sub-optimal treatment outcomes among DPC clients, our outcomes of interest will be non-adherence to prescribed HAART and viral non-suppression. Adherence to HAART will be defined as the number of days prescribed medication over the number of days eligible for treatment in the previous six months, dichotomized at $\geq 95\%$ vs. $< 95\%$, as in previous studies (5). We have shown this validated measure of pharmacy refill to be strongly associated with clinical outcomes including survival (6). We will define virologic response as a median VL < 50 copies/mm³ in the previous six months. We will define VL non-suppression as a median VL > 1000 copies/mm³ in the previous six months. We will identify modifiable social and structural factors associated with these outcomes using longitudinal mixed effects modelling adjusted for relevant individual- and clinical-level variables.

C.2.2 Objective 2

Recruitment and Data Collection: Individual-, social- and structural-level information gathered in interviewer-administered questionnaire will be augmented with clinical information held by the BCCfE and supportive and ancillary service usage information held by the Dr. Peter Centre. A complete record of all HIV treatment including antiretroviral dispensations and clinical monitoring (CD4+ cell counts and plasma HIV RNA viral load [VL] tests) is available through the BCCfE's Drug Treatment Program, as described previously (7). The Dr. Peter Center's Electronic Client Records store information on ancillary clinical care, social service uptake, housing and illicit drug use. Consent to facilitate these linkages will be obtained during the informed consent process.

Data analysis: To assess the effectiveness of DPC exposure on HIV treatment outcomes, our outcomes of interest will include time to initiation of HAART; adherence to prescribed HAART; and virologic response to HAART. Information on HAART adherence and VL testing will be gathered as described above. Our primary explanatory variable of interest is at least one day of exposure to DPC programming in the previous six months. We will assess the relationship between DPC exposure and the outcomes of interest using multivariate mixed-effects regression models adjusted for relevant confounders. In addition, to address the selection bias introduced through non-random assignment to the DPC, we will weight observations using marginal structural modeling, previously employed to evaluate the independent effect of interventions using observational study designs (8).

Sample size: Assuming a sample size of 150 participants completing 80% of study follow-ups with a loss to follow-up rate including death of 15 per 100 person years, a prevalence of VL non-suppression of 40%, an alpha of 0.05 and an intra-cluster correlation of 0.002, we will have $> 80\%$ power to detect an Odds Ratio of 1.50 after three years (9).

C.2.3 Objective 3

Recruitment and Data Collection: Qualitative ethnographic research methods, including semi-structured interviews, will be used to explore the perspectives of DPC clients in order to develop a deeper understanding of patients' experiences and the context in which these experiences are mediated. The semi-structured, qualitative interviews will explore participants' perspectives of a range of topics, including how they feel: a) the DPC's harm reduction policy affects access to clinical and support services; b) the DPC programming affects HAART adherence; and, c) clinical and support services at the DPC could be improved. These interviews will be conducted with day health program participants and residents (n = 25). Participants will be purposefully sampled to allow us to over-sample women (and Aboriginal persons relative to their populations at the DPC, to facilitate gender-based and indigenous analysis).

Up to 25 potential participants will be selected to participate in this portion of the study. They will be provided with information about the study by the Dr. Peter Centre reception staff and will be invited to participate. Day health program participants will be interviewed in a conference room at the DPC, which is equipped with blinds to ensure confidentiality of activities taking place there. Residents will be interviewed in their rooms or the conference room, according to their preference. Interviews will be undertaken by a trained qualitative researcher and facilitated using interview topic guides adapted from the Scientific Evaluation of Supervised Injection Services (SEOSIS) (10). These interview topic guides have been revised to reflect input received during recent focus groups with DPC clients. Informed consent will be obtained prior to the interviews and the informed consent protocol will be read aloud to all participants to avoid any discomfort among participants with low literacy levels. Interviews will last approximately one hour and participants will receive a \$30 honorarium to acknowledge their contribution. Interviews will be audio recorded with the consent of participants and transcribed verbatim by a professional transcriptionist and a member of the study team will review the transcripts while listening to the audio files to check their accuracy and make necessary corrections. In addition to providing qualitative data per se, the information gathered will inform further qualitative fieldwork and contextualize quantitative findings.

Qualitative data analysis: Data analysis will be inductive and iterative insofar as emerging themes will be identified and elucidated in the course of data collection and used to guide further inquiry. All transcripts and field notes will be imported into NVivo 9 qualitative data management software. NVivo is a qualitative data management and analysis software that can be used across multiple sites to facilitate data coding and analysis. A preliminary set of categories will be extracted from the interview topic guides and ethnographic field notes to provide a preliminary framework for qualitative analysis. We will then use constant comparative methods to collaboratively code the data, whereby emerging themes will be identified and explicated through systematic comparison of participants' accounts (11, 12). Members of the qualitative team will meet regularly to discuss the coding and further revise the coding framework. Any changes to the coding framework will be made by consensus. Once the final categories are established, at least two members of the qualitative team will independently recode sections of the data to verify the validity of these categories.

C.3. Integrating analysis of qualitative and quantitative data: A case study analytic approach (13) will allow us to use the risk environment theoretical framework to integrate the interviewer-administered questionnaire (quantitative) and ethnographic interview (qualitative) findings, and produce richer results than either alone could yield. Each of the core risk factors (e.g., homelessness, interpersonal violence) will be used to anchor comparisons of data analysis results. Results from preliminary data analysis from each objective will be tabulated according to the risk environment framework, annotated with questions generated from each set of analyses. These will then be

contrasted. Qualitative data may confirm or contrast with findings from the interviewer-administered questionnaire, thus assisting in elucidating potential causal pathways, or the identification of confounding or effect modifier variables. The qualitative analysis may also suggest new testable hypotheses for the interviewer-administered questionnaire.

C.4. Data management and security: Electronic data management for the study will be conducted at a central location at the BCCfE at St Paul's Hospital. Staff at the BCCfE has extensive experience with data entry, management, linkage, and analysis. Upon consent, each participant is assigned a unique identification number, and no personally identifying information is entered into the database. Data from interviewer-administered questionnaire will be linked using this unique ID. The database is password protected and only designated research personnel will have access to the passwords. Interviewer-administered questionnaire data will be transmitted electronically through a secured and encrypted broadband connection to be stored on an Oracle server at the BCCfE. The system is protected by a firewall and access to the building is restricted and protected by 24-hour security. Data is extracted and analyzed using SASTM software version 9.1 (SAS, Cary, NC). Confidentiality will be maintained through the use of participant codes, code names, and the removal of personal identifiers from all documents. All electronic files will be password-protected. Hard copies of consent and other confidential forms are filed in locked cabinets kept in individually-locked offices on the card-access controlled premises of the Dr. Peter Centre. The investigators of this study have operated this system for more than a decade without breaches of confidentiality or harm to study participants.

D. ETHICAL ISSUES

All study procedures, including recruitment and consent, will be subject to approval by the Institutional Review Boards of the University of British Columbia and Simon Fraser University. Study investigators will not interfere with access to or regular use of antiretroviral therapy or supportive and ancillary care services provided by the Dr. Peter Centre by any study participant. Loss of confidentiality is the most significant potential adverse event. We will set up several mechanisms to ensure confidentiality of participants. All original study consent and other related forms will be stored in locked cabinets at the Dr. Peter Centre. All study-related data will be associated with the participant's identification number only. Participants' names will not be associated with any study data. Finally, confidentiality policies and procedures will be reviewed with all new staff as well as annually with current staff.

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Appendix C Qualitative Consent Form

The Dr. Peter Study

PARTICIPANT CONSENT: QUALITATIVE INTERVIEW

Before agreeing to participate in this research study, it is important that you read and understand this research consent form. Please read this form carefully or have it read to you by someone you trust. Please ask a member of the study team to explain any words or information that you do not understand.

WHO IS CONDUCTING THIS STUDY?

This study is being conducted by the Dr. Peter AIDS Foundation and the BC Centre for Excellence in HIV/AIDS, **not the Dr. Peter Centre staff.**

Nominated Principal Applicant: Dr. Robert Hogg 604-806-8516

Principal Applicant: Rosalind Baltzer Turje 604-608-1874

WHO IS FUNDING THIS STUDY?

This study is funded by the Canadian Institutes of Health Research & the Michael Smith Foundation for Health Research.

WHY ARE WE DOING THIS STUDY?

The Dr. Peter Centre provides Comfort Care to people living with HIV/AIDS. It is important to evaluate the Dr. Peter Centre model of care so that the programs and services clients find effective can be expanded, and programs and services that are less effective can be eliminated or changed.

You are being invited to take part in a study entitled, *The Dr. Peter Study*. **The purpose of this study is to learn about the effectiveness of the Dr. Peter Centre model of care on HIV/AIDS related outcomes of people living with HIV.**

There are two parts to this study. You participated in the first part, which involved an interviewer-administered questionnaire that asked a large number of people questions about their experience living with HIV and using the Dr. Peter Centre. You are now being asked to participate in a smaller related study, which will ask you more questions that might allow you the chance to talk about your experiences in more depth.

Participation in research is voluntary and will not affect your access to medical care, treatment or supportive services and programs at the Dr. Peter Centre, the Immuno Deficiency Clinic at St. Paul's or anywhere else.

If you choose to participate in this study you can withdraw from the study at any time without any effect on your access to treatment and care. If you choose to withdraw from this study, the investigators will destroy any data that has been collected up to your withdrawal.

WHO CAN PARTICIPATE IN THIS STUDY?

You are eligible to participate if you are 19 years of age or older, HIV positive, you are able to understand and complete an interviewer-administered questionnaire in English, you are able to provide informed consent, you were first enrolled in the Dr. Peter Centre in the 12 months preceding recruitment to the study and you completed the interviewer-administered questionnaire.

HOW IS THE STUDY DONE?

Study participants will be people enrolled at the Dr. Peter Centre within the previous 12 months. If you agree to participate in this study and have reviewed and signed this consent form (of which you will be given a copy), you will be invited to schedule an interview with a person trained in qualitative research. Qualitative research, just like all research, seeks answers to a question. Qualitative research involves collecting information about personal experiences, life story, interviews, observations and interactions which are significant moments and meaningful in peoples' lives.

The interview will take approximately one hour. You will be asked different questions than you were asked in the larger study. The topics will be similar, touching on your living conditions, health status, whether you are depressed, what your experience has been like being on treatment, and how the services at the Dr. Peter Centre affect your quality of life. The interviews will be audio recorded and transcribed, meaning that a written copy of your interview will be made. You will have the opportunity to review the written copy. After the interview, the interviewer will make field notes, which are observations they made during your conversation.

STUDY RESULTS

The main study findings will be shared with service providers, physicians, academics and the general public. The findings will be shared locally, nationally and internationally through publication in journals, information posted to the Dr. Peter Centre website and at community engagement events.

IS THERE ANY WAY THIS STUDY COULD BE BAD FOR YOU?

Some of the questions are of a personal nature and may cause you to feel uncomfortable or emotional or upset. Please keep in mind that you are not required to answer any questions that may make you feel uncomfortable and that you are welcome to stop the interview at any time. At the end of the interview, the interviewer will provide you with a list of places or people you can contact or help to arrange for an appointment if you would like to speak to someone about how you are feeling. If the interview triggers feelings of anxiety or regret, and you require immediate attention, counselors and staff at the Dr. Peter Centre will be available to help.

WHAT ARE THE BENEFITS OF PARTICIPATING?

There are no direct benefits in participating in this study. There may be indirect benefits to people living with HIV/AIDS as the findings of this study may provide evidence of the effectiveness of the Dr. Peter Centre model, which may lead to the development of similar or improved programs and services for this population.

WILL YOU BE PAID FOR TAKING PART IN THIS RESEARCH STUDY?

You will receive \$30 to compensate you for your time, upon completion of the interview.

HOW WILL YOUR PRIVACY BE MAINTAINED?

All records identifying you will be kept confidential. To protect your personal identity, only the interviewer will listen to the audio recording of the sessions. Pseudonyms, fictitious names to conceal people's real identities, will be used in the field notes generated from the audio recordings. Field notes will not include any identifiers. Your name or other identifying information will not appear on any publications or reports produced by the study. Only the research study personnel will have access to all the information over the course of the study.

Information that discloses your identity will not be released without your consent unless required by law or to access your electronic medical health records from administrative databases and registries including the Dr. Peter Centre records (attendance, programs attended), St. Paul's laboratory (CD4 cell count, viral load), Medical Service Plan (healthcare utilization, prescriptions), hospital discharge information and vital statistics. The release of any personal information will also comply with the BC Freedom of Information and Protection of Privacy Act. By signing this consent form, you are authorizing this access.

All consent forms, written notes and electronic audio files of interviews (on password protected USB keys) will be kept in a secure area in locked cabinets at the Dr. Peter Centre. Electronic data (including copies of audio files) will be stored on a secure server at the BC Centre for Excellence in HIV/AIDS. Study materials will be kept until May 2020, at which time they will be destroyed. Written notes and consent forms will be shredded and audio files will be deleted. **The Dr. Peter Staff and any person who provides services and programming will not have access to the information you provide in this interview.**

WHO CAN YOU CONTACT IF YOU HAVE QUESTIONS ABOUT THE STUDY?

You will be informed of any important new information discovered during the course of this study. If you wish to know more about the study, you may contact the Nominated Principal Applicant, Robert Hogg at 604-806-8516 or the Principal Applicant, Rosalind Baltzer Turje, at 604-608-1874.

WHO CAN YOU CONTACT IF YOU HAVE CONCERNS ABOUT THE STUDY?

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the UBC

Office of Research Services at 604-822-8598 or if long distance email RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, you may contact Dr. Jeffrey Toward, Director, Office of Research Ethics at jtoward@sfu.ca or 778-782-6593, or the Chair of the UBC Providence Health Care Research Ethics Board at 604-682-2344 local 63496.

The Dr. Peter Study

PARTICIPANT CONSENT AND SIGNATURE PAGE

By signing this consent form you acknowledge that: the research study described above has been explained to you, that any questions you have asked have been answered to your satisfaction, that you have been informed of the alternatives to participation in this study, including the right not to participate and the right to withdraw without compromising the quality of treatment, care and services received at the Dr. Peter Centre, St. Paul's Hospital or elsewhere. As well, signing this form indicates that the potential risks, harms and discomforts have been explained to you and you also understand the benefits (if any) of participating in the research study.

By signing this form you have not waived your legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional duties. Records relating to you and your care will be kept confidential and no information will be released or printed that would disclose your personal identity without your permission unless required by law.

Your signature below indicates that you have received a copy of this consent form for your own records and that you consent to participate in this study.

Signature of Participant

Name (please print)

Date

Signature of Person Conducting Informed Consent discussion

Name (please print)

Date

**Appendix D
Interview Guide**

**A MIXED METHOD EVALUATION OF THE IMPACT OF THE
DR. PETER CENTRE ON HEALTH CARE ACCESS AND OUTCOMES
FOR PERSONS LIVING WITH HIV/AIDS WHO USE ILLICIT DRUGS**

QUALITATIVE INTERVIEW COVER SHEET

Interviewer: _____

Date and Time: _____

Study Code: _____

Filename: _____

DEMOGRAPHICS – DO NOT TURN ON AUDIO RECORDER

1. Do you identify your gender as:

Male Female Transgender

2. How old are you?

3. What do you identify your race or ethnicity as?

<input type="checkbox"/> White (Caucasian)	<input type="checkbox"/> Aboriginal Ancestry	<input type="checkbox"/> East or Southeast Asian
<input type="checkbox"/> South Asian	<input type="checkbox"/> Black / African-Canadian	<input type="checkbox"/> Other _____

4. What do you identify as your sexual orientation? (check all that apply)

<input type="checkbox"/> Straight	<input type="checkbox"/> Gay	<input type="checkbox"/> Lesbian
<input type="checkbox"/> Bisexual	<input type="checkbox"/> Two-spirited	<input type="checkbox"/> Other: _____

5. What type of housing are you currently living in?

House Apartment SRO Hotel (privately-owned)

- SRO Hotel (publicly-owned) Emergency Shelter Friend's place
 Unsheltered / Outside Other: _____

6. What neighbourhood do you currently live in?

- West End Downtown South Downtown Eastside
 SRO Hotel (publicly-owned) Emergency Shelter Friend's place
 Unsheltered / Outside Other: _____

7. In what year were you diagnosed with HIV?

8. In what year did you begin taking HAART?

9. Since beginning to take HAART, have you ever stopped taking your medication for 30 or more consecutive days?

- Once Two or Three Times Four or more times

10. How often are you currently taking HAART?

- Everyday Several times per week Never

11. Do you get your HIV medication at the Dr. Peter Centre?

- Yes No

12. Have you been diagnosed with hepatitis C?

- Yes No

13. Have you been diagnosed with any health condition other than HIV that requires you to take medication daily?

- Yes (list): _____ No

14. (If applicable) How often are you currently taking that medication (check all that apply)?

- Everyday Several times per week Never

15. Which of the following substances have you used in the past 30 days? (Check all that apply and Circle drug of choice)

<input type="checkbox"/>	Cocaine (powder)	<input type="checkbox"/>	Crack cocaine(rock)	<input type="checkbox"/>	Crystal Methamphetamine
<input type="checkbox"/>	Heroin	<input type="checkbox"/>	Opiates (other)	<input type="checkbox"/>	Methadone
<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Other: _____				

16. How often are you currently using your drug of choice?

<input type="checkbox"/>	Daily	<input type="checkbox"/>	3-4 times per week	<input type="checkbox"/>	One or fewer times per week
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17. How often are you currently using other drugs (specify: _____)?

<input type="checkbox"/>	Daily	<input type="checkbox"/>	3-4 times per week	<input type="checkbox"/>	One or fewer times per week
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18. Which methods have you used to consume drugs in the past 30 days? (Check all that apply)

<input type="checkbox"/>	Inject	<input type="checkbox"/>	Smoke / Inhale	<input type="checkbox"/>	Snort	<input type="checkbox"/>	Ingest / Swallow
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19. (If participant has not injected in past 30 days) Have you ever injected drugs?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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20. How often do you visit the Dr. Peter Centre?

<input type="checkbox"/>	Daily	<input type="checkbox"/>	3-4 times per week	<input type="checkbox"/>	One or fewer times per week
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21. What services have you accessed at the Dr. Peter Centre in the past 30 days?

<input type="checkbox"/>	Supervised injection services	<input type="checkbox"/>	Food services	<input type="checkbox"/>	Amenities (laundry, shower)
<input type="checkbox"/>	Nursing care	<input type="checkbox"/>	Medication support	<input type="checkbox"/>	Arts therapies (music, art)
<input type="checkbox"/>	Counselling support	<input type="checkbox"/>	Recreational therapies		
<input type="checkbox"/>	Other: _____				
<input type="checkbox"/>	_____				

Other: _____

22. Which of the following ways have you made money in the past 30 days? (Check all that apply)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Full-time employment | <input type="checkbox"/> Part-time employment | <input type="checkbox"/> Drug selling |
| <input type="checkbox"/> Sex work | <input type="checkbox"/> Recycling / binning | <input type="checkbox"/> Panhandling |
| <input type="checkbox"/> Social assistance | <input type="checkbox"/> Other: _____ | |

NOTES:

**A MIXED METHOD EVALUATION OF THE IMPACT OF THE
DR. PETER CENTRE ON HEALTH CARE ACCESS AND OUTCOMES
FOR PERSONS LIVING WITH HIV/AIDS WHO USE ILLICIT DRUGS**

QUALITATIVE INTERVIEW GUIDE

DIRECTIONS

This interview topic guide seeks to facilitate discussion regarding how the Dr. Peter Centre shapes health care access and outcomes among people living with HIV/AIDS who use drugs, with an emphasis on treatment adherence. Interviewers are expected to draw upon data collected through the cover sheet to structure the interview, and complete only those sections that are applicable to each participant. Interviewers are expected to pay particular attention to how characteristics of the risk environment (e.g., housing, poverty, stigma) impact health care access and outcomes, and how these vary as a result of the participant's gender, race or sexuality.

IN-DEPTH INTERVIEW – START RECORDING

SECTION ONE: CURRENT LIVING SITUATION

"We are interested in learning about what is going on in your life right now..."

<u>Questions</u>	<u>Probes</u>
Where are you currently staying?	<p><i>How long have you been staying there?</i></p> <ul style="list-style-type: none"> ▪ <i>(If moved within past six months)</i> <i>Where were you living before? What was it like there?</i> ▪ <i>(If moved within past six months)</i> <i>Do you feel that living there had impacted your health? Why?</i> ▪ <i>(If moved within past six months)</i> <i>Why did you move?</i> <p><i>Can you tell me what it is like where you live now?</i></p>

	<ul style="list-style-type: none"> ▪ (If applicable) Do you find it better than where you were living before? Why? <p>How do you feel staying where you live now? For example, do you feel safe or unsafe living there?</p> <p>Do you feel that where you are living impacts your health in any way? If so, how?</p>
Do you ever spend the night anywhere else?	<p>Where do you stay sometimes?</p> <p>For example, do you ever stay:</p> <ul style="list-style-type: none"> ▪ outside? ▪ at an emergency shelter? ▪ at a friend or family member's place? <p>Why do you sometimes spend the night elsewhere?</p>
Where do you spend most of your time?	<p>Do you hang out:</p> <ul style="list-style-type: none"> ▪ at home? ▪ at a friend's place? ▪ In a particular area? ▪ at the Dr. Peter Centre? ▪ Drop-in centres? <p>(If at home) Why do you spend most of your time at home?</p> <p>(If at home) How often do you leave home? Why?</p> <p>(If at home) Does wanting to stay close to home ever impact your accessing services or supports (i.e. prevents you from going to the doctor's or the dr. peter centre)? Why or why not?</p> <p>(If at home) Does staying at home ever make you feel isolated? Why or why not?</p> <p>(If friend's place) Why do you spend most of your time</p>

	<p><i>at your friend's place?</i></p> <p><i>(If friend's place) What do you do at your friend's place?</i></p> <p><i>(If particular area) Why do you usually stay in that area?</i></p> <p><i>(If particular area) Does staying in that area impact your ability to access services or supports? Why or why not?</i></p> <p><i>(If particular area) Do you feel that you are welcome in other areas? Why or why not?</i></p> <p>Note: If the participant identifies the Dr. Peter Centre, wait until the appropriate section to ask follow-up questions.</p>
<p>How often are you currently using drugs?</p>	<p><i>Are you using every day? A few times per week?</i></p> <p><i>Has your drug use changed in any way over the past six months?</i></p> <ul style="list-style-type: none"> ▪ <i>(If yes) Why has your drug use changed?</i> ▪ <i>(If yes) How have you been impacted by these changes in your drug use?</i> <p><i>What influences your drug use patterns?</i></p> <p><i>For example, do you tend to use more or less depending on:</i></p> <ul style="list-style-type: none"> ▪ <i>where you are living?</i> ▪ <i>who you are spending time with?</i> ▪ <i>how you are feeling?</i> ▪ <i>how much money you have?</i> <p><i>Why do these things influence your drug use?</i></p> <p><i>Do you sometimes use different drugs than others? Why?</i></p> <p><i>How do you feel your drug use impacts your life? Why?</i></p>

<p>Where do you usually score your drugs?</p>	<p><i>Do you score drugs from a regular dealer?</i></p> <ul style="list-style-type: none"> ▪ <i>(If regular dealer) How long have you been going to that dealer?</i> ▪ <i>(If regular dealer) Why do you go to that dealer?</i> ▪ <i>(If no regular dealer) Where do you find a dealer when you want to score drugs?</i> ▪ <i>(If no regular dealer) Do you ever have any concerns in buying drugs from an unfamiliar dealer?</i> ▪ <i>(If no regular dealer) Do you ever have any concerns in buying drugs from an unfamiliar dealer? For example, do you feel safe buying drugs?</i>
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SECTION TWO: ACCESSING THE DR. PETER CENTRE

"We are interested in learning more about why you started coming to the Dr. Peter Centre..."

DECISION TO START GOING TO THE DR. PETER CENTRE

<u>Questions</u>	<u>Probes</u>
<p>Could you tell me what was going on in your life when you started going to the Dr. Peter Centre?</p>	<p><i>Had you recently experienced any major changes in your life? For example:</i></p> <ul style="list-style-type: none"> ▪ <i>Had you recently moved or lost your housing?</i> ▪ <i>Had you experienced any changes in your health or mental health?</i>
<p>How would you describe your drug use at that time?</p>	<p><i>What drugs were you using and how often were you using?</i></p> <p><i>Had there been any recent changes in your drug use patterns?</i></p> <ul style="list-style-type: none"> ▪ <i>(If applicable) Why had your drug use patterns</i>

	<p><i>changed?</i></p> <p><i>Where were you mostly using drugs? Why?</i></p>
<p>When did you learn about the Dr. Peter Centre?</p>	<p><i>What did you know about the Dr. Peter Centre at that time?</i></p> <p><i>Who did you talk to about the Dr. Peter Centre?</i></p> <ul style="list-style-type: none"> ▪ <i>(If peer) Were they members of the Dr. Peter Centre?</i> ▪ <i>(If peer) What did they tell you about the Dr. Peter Centre?</i> ▪ <i>(If peer) How did you feel about what they told you?</i> ▪ <i>(If health professional) What was the nature of your relationship [nurse or doctor or other]?</i> ▪ <i>(If health professional) How comfortable did you feel with this [nurse or doctor or other] in comparison to other [nurses or doctors or other] you had seen? Why?</i> ▪ <i>(If health professional) What did they tell you about the Dr. Peter Centre?</i> ▪ <i>(If health professional) How did you feel about what they told you?</i>
<p>Why did you decide to start going to the Dr. Peter Centre?</p>	<p><i>Why did you feel that it would be a good idea to start going to the Dr. Peter Centre?</i></p> <ul style="list-style-type: none"> ▪ <i>(If referred to the Dr. Peter Centre) Who referred you to the Dr. Peter Centre? What did they tell you?</i> ▪ <i>(If referred to the Dr. Peter Centre) Did you feel that you needed the services and supports that they described? Why or why not?</i> ▪ <i>(If referred to the Dr. Peter Centre) Why did you decide to follow-up on their referral?</i> ▪ <i>(If change in housing) How did the change in housing impact your decision to go to the Dr. Peter</i>

	<p>Centre?</p> <ul style="list-style-type: none"> ▪ <i>(If change in housing)</i> For example, did you feel that you needed the services and supports provided by the Dr. Peter Centre? Why or why not? ▪ <i>(If change in housing)</i> Did anyone where you live/lived help you access the Dr. Peter Centre? ▪ <i>(If change in housing)</i> Did where you were living impact your decision to go to the Dr. Peter Centre? If so, why? ▪ <i>(If health changed)</i> How were you feeling at that time? ▪ <i>(If health changed)</i> Was how you were feeling impacted by your drug use? If so, how? ▪ <i>(If health changed)</i> How did this change in your health impact your decision to go to the Dr. Peter Centre? ▪ <i>(If health changed)</i> Did you feel that going to the Dr. Peter Centre would positively impact your health? Why or why not?
<p>Did you have any questions about the Dr. Peter Centre when you decided to go there?</p>	<p>Did you have any concerns about going to the Dr. Peter Centre? Why or why not?</p> <p>Did you ask someone at the Dr. Peter Centre any questions when you first started to go there?</p> <ul style="list-style-type: none"> ▪ If so, what did you ask? ▪ Is there anything that you wish you had asked?
<p>What did you hope to get out of going to the Dr. Peter Centre?</p>	<p>Were there specific things that you were hoping to achieve by going to the Dr. Peter Centre? If so, what and why?</p> <p>Did you discuss your goals with anyone and, if so, what did you discuss?</p>

ACCESSING THE DR. PETER CENTRE	
<p>Could you describe to me what happened the first time you went to the Dr. Peter Centre?</p>	<p><i>How did you feel the first time that you went to the Dr. Peter Centre?</i></p> <ul style="list-style-type: none"> ▪ <i>For example, did you find it welcoming or unwelcoming? Why?</i> ▪ <i>Did you feel safe or unsafe at the Dr. Peter Centre? Why?</i> ▪ <i>Did anyone assist you when you first went to the Dr. Peter Centre?</i> ▪ <i>Who and how did they assist you?</i> ▪ <i>Did you find their assistance to be helpful? Why or why not?</i> <p><i>What services or supports did you access when you went to the Dr. Peter Centre for the first time?</i></p> <ul style="list-style-type: none"> ▪ <i>Why did you access [name of service or support]?</i> ▪ <i>Did you find [name or service or support] helpful? Why or why not?</i>
<p>How often have you been going to the Dr. Peter Centre since the first time you went? Why?</p>	<p><i>For example, has going to the Dr. Peter Centre become part of your regular routine? Why or why not?</i></p> <p><i>What motivates you to go to the Dr. Peter Centre?</i></p> <ul style="list-style-type: none"> ▪ <i>What services or supports do you go to the Dr. Peter Centre to access?</i> ▪ <i>Why do you access these services or supports?</i> ▪ <i>How do you feel these services and supports impact you?</i>
<p>Could you tell me about anything that makes it easier go to the Dr. Peter Centre? More difficult?</p>	<p><i>For example, do you ever find it easier or more difficult to go to the Dr. Peter Centre because of:</i></p>

	<ul style="list-style-type: none"> ▪ <i>your drug use patterns?</i> ▪ <i>your health?</i> ▪ <i>how you feel about Dr. Peter Centre staff?</i> ▪ <i>where you are living?</i>
<p>(If drug use patterns) How do you feel that your drug use patterns make it [easier or more difficult] to go to the Dr. Peter Centre?</p>	<p>(If more difficult) Why does your drug use make it more difficult to go to the Dr. Peter Centre?</p> <p>(If more difficult) For example:</p> <ul style="list-style-type: none"> ▪ <i>Does your drug use itself make you unlikely to go to the Dr. Peter Centre? If so, why?</i> ▪ <i>Were you concerned about how you will be treated by staff? If so, why?</i> ▪ <i>Did you need to work more because of your drug use? If so, can you tell me how this impacts you?</i> <p>(If easier) Why have your drug use patterns made it easier for you to go to the Dr. Peter Centre?</p> <p>(If easier) For example:</p> <ul style="list-style-type: none"> ▪ <i>Have recent changes in your drug use patterns better enabled you to go to the Dr. Peter Centre? Why?</i> ▪ <i>Has the Dr. Peter Centre harm reduction policy impacted your ability to go to the Dr. Peter Centre? If so, how?</i>
<p>(If health) How do you feel that your health makes it [easier or more difficult] to go to the Dr. Peter Centre?</p>	<p><i>Have there been any recent changes in your health that have impacted your ability to go to the Dr. Peter Centre?</i></p> <ul style="list-style-type: none"> ▪ <i>If so, how have these changes in your health impacted your ability to go there?</i> <p>(If more difficult) Why do you feel that your health makes it more difficult to go to the Dr. Peter Centre?</p> <p>(If more difficult) For example:</p> <ul style="list-style-type: none"> ▪ <i>Do you ever feel too sick to go to the Dr. Peter Centre?</i>

	<p><i>If so, how does this feel?</i></p> <ul style="list-style-type: none"> ▪ <i>Can you think of an example of when you did not feel well enough to go to the Dr. Peter Centre?</i>
<p>(If staff) How do you feel that Dr. Peter Centre staff members make it [easier or more difficult] to go there?</p>	<p>(If easier) For example:</p> <ul style="list-style-type: none"> ▪ <i>Do you feel welcome at the Dr. Peter Centre? Why or why not?</i> ▪ <i>Do staff members do anything to make it easier for you to get there?</i> <p>(If more difficult) For example:</p> <ul style="list-style-type: none"> ▪ <i>How do you feel that Dr. Peter Centre staff members treat you?</i> ▪ <i>Are you ever concerned that staff might judge you? Why or why not?</i>
<p>(If where lives) How do you feel that where you are living makes it [easier or more difficult] to go to the Dr. Peter Centre?</p>	<p>(If easier) Why does where you are living make it easier for you to go to the Dr. Peter Centre?</p> <p>(If easier) For example:</p> <ul style="list-style-type: none"> ▪ <i>Are you usually able to get to where you want to go? Why or why not?</i> ▪ <i>Do you live close to the Dr. Peter Centre? If so, how does this impact your ability to go there?</i> ▪ <i>Does anyone help you get to the Dr. Peter Centre? If so, how do they help you?</i> <p>(If more difficult) Why does where you are living make it more difficult for you to get to the Dr. Peter Centre?</p> <p>(If more difficult) For example:</p> <ul style="list-style-type: none"> ▪ <i>Do you usually have a difficult time getting to where you want to go? Why or why not?</i> ▪ <i>Do you live far away from the Dr. Peter Centre? If so,</i>

	<p><i>how does this impact your ability to get there?</i></p> <p><i>Do you have a difficult time getting access to transportation? Why or why not?</i></p>
<p>Is there anything that you feel would make it easier to go to the Dr. Peter Centre? If so, what?</p>	<p><i>Why do you feel that these things would make it easier to go to the Dr. Peter Centre?</i></p>

SECTION THREE: HARM REDUCTION APPROACH

"We are interested in learning more about how you feel about the harm reduction approach taken by the Dr. Peter Centre..."

<u>Questions</u>	<u>Probes</u>
<p>Can you tell me what you know about the harm reduction approach at the Dr. Peter Centre?</p>	<p><i>How would you describe the harm reduction approach to someone?</i></p> <p><i>What supports do you consider to be part of the harm reduction approach?</i></p> <p><i>Do you feel that the harm reduction approach includes supports for things other than drug use?</i></p> <ul style="list-style-type: none"> ▪ <i>If so, what supports do you consider to be part of the harm reduction approach?</i> ▪ <i>Why do you consider these other things to be part of the harm reduction approach?</i>
<p>What are your thoughts about the harm reduction approach at the Dr. peter Centre?</p>	<p><i>Why do you feel that the harm reduction approach is in place?</i></p> <p><i>Do you like the harm reduction approach? Why or why not?</i></p> <p><i>Do you feel that the harm reduction approach has a positive or negative impact on the Dr. Peter Centre? Why?</i></p>

<p>Does the harm reduction approach impact your decision to go to the Dr. Peter Centre?</p>	<p><i>Why does the harm reduction approach impact your decision to go to the Dr. Peter Centre?</i></p> <p><i>Does it make it easier or more difficult to go to the Dr. Peter Centre? If so, how?</i></p> <p><i>Would you go to the Dr. Peter Centre if it did not have a harm reduction policy? Why or why not?</i></p>
<p>Has the harm reduction approach at the Dr. Peter Centre impacted your drug use in any way?</p>	<p><i>For example:</i></p> <ul style="list-style-type: none"> ▪ <i>Do you find it easier to access harm reduction supplies, such as rigs or pipes? Why?</i> ▪ <i>Do you find it easier to practice harm reduction when using drugs? Why?</i> ▪ <i>Have your drug use patterns changed in any way? If so, how and why?</i>
<p>Do you ever inject drugs at the Dr. Peter Centre?</p> <p>N.B., Ask targeted probes on harm reduction practices in accordance with participant responses</p>	<p><i>(If yes) Why do you use at the Dr. Peter Centre?</i></p> <ul style="list-style-type: none"> ▪ <i>How often do you use at the Dr. Peter Centre? Why?</i> ▪ <i>Do you feel that using at the Dr. Peter Centre is different from using elsewhere? If so, why?</i> ▪ <i>For example, do you feel safe or unsafe using at the Dr. Peter Centre?</i> ▪ <i>Could you walk me through what it is like to use at the Dr. Peter Centre?</i> <p><i>Where do you inject at the Dr. Peter Centre?</i></p> <ul style="list-style-type: none"> ▪ <i>Do you inject in the harm reduction room or somewhere else?</i> ▪ <i>Why do you inject in this place (or these places)?</i> ▪ <i>How do you feel injecting in this place (or these places)?</i> <p><i>How do you feel injecting at the Dr. Peter Centre impacts your ability to access other services?</i></p>

	<ul style="list-style-type: none"> ▪ <i>Are you more or less likely to access other services because you can inject at the Dr. Peter Centre? Why?</i> ▪ <i>Do you feel more or less welcome? Why?</i> <p><i>(If no) Why do you not use at the DPC?</i></p> <ul style="list-style-type: none"> ▪ <i>Are there any rules that discourage you from using at the DPC? If so, which rules and why?</i> ▪ <i>Do you need help injecting and does this prevent you from using drugs at the Dr. Peter Centre?</i> ▪ <i>(If applicable) Who do you go to in order to get help injecting? Why?</i> ▪ <i>(If applicable) Do you ever have anything bad happen to you from getting help injecting from this person? If so, what happens and how does this make you feel?</i>
<p>Do you ever smoke drugs (other than marijuana) at the Dr. Peter Centre?</p> <p>N.B., Ask targeted probes on harm reduction practices in accordance with participant responses.</p>	<p><i>(If yes) Where do you smoke drugs at the Dr. Peter Centre?</i></p> <ul style="list-style-type: none"> ▪ <i>How often do you smoke drugs at the Dr. Peter Centre? Why?</i> ▪ <i>Do you feel that smoking drugs at the Dr. Peter Centre different from using elsewhere? If so, why?</i> ▪ <i>For example, do you feel safe or unsafe using at the Dr. Peter Centre?</i> ▪ <i>Do you feel that people are accepting of smoking drugs at the Dr. Peter Centre? Why or why not?</i> ▪ <i>Does the lack of an indoor space to smoke drugs ever make it difficult for you? Why or why not?</i> ▪ <i>Could you walk me through what it is like to smoke drugs at the Dr. Peter Centre?</i> <p><i>(If no) Why do you not smoke drugs at the DPC?</i></p> <ul style="list-style-type: none"> ▪ <i>Do you feel that people are allowed to smoke drugs at the Dr. Peter Centre? Why or why not?</i> ▪ <i>Does the lack of an indoor space discourage you from</i>

	<p><i>smoking drugs at the Dr. Peter Centre? Why or why not?</i></p> <ul style="list-style-type: none"> ▪ <i>Where do you go to smoke drugs if you are at the Dr. Peter Centre? Why?</i> ▪ <i>Does not smoking drugs at the Dr. Peter Centre impact your ability to use safely? If so, how?</i> ▪ <i>What changes do you feel would make it easier for you to smoke drugs at the Dr. Peter Centre? Why?</i>
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<p>Do you ever use drugs to manage pain or HIV-related symptoms?</p>	<p><i>(If applicable) What health concerns are you trying to manage by using drugs?</i></p> <ul style="list-style-type: none"> ▪ <i>Why do you use drugs to manage pain or HIV-related symptoms?</i> ▪ <i>In what ways do you feel that using drugs helps to address pain or HIV-related symptoms? Why?</i> ▪ <i>Do you feel that being able to use drugs at the Dr. Peter Centre helps you to better manage pain and HIV-related symptoms? If so, how and why?</i>
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SECTION FOUR: INTEGRATED SERVICES

"We are interested in learning more about the services and supports that you access when you go to the Dr. Peter Centre..."

<u>Questions</u>	<u>Probes</u>
<p>How does going to the Dr. Peter Centre compare to going to other places?</p>	<ul style="list-style-type: none"> ▪ <i>Why do you feel this way when you go to the Dr. Peter Centre?</i> ▪ <i>For example, do you feel differently at the Dr. Peter Centre than you do other places? Why or why not?</i> ▪ <i>Do you feel safe at the Dr. Peter Centre? Why or why not?</i> ▪ <i>Does how you feel when you go to the Dr. Peter Centre impact your decision to go there? Why or why not?</i>

<p><i>How do you feel about the other people who come to the DPC? Why?</i></p>	<ul style="list-style-type: none"> ▪ <i>Do you feel comfortable with the other people who go to the Dr. Peter Centre? Why or why not?</i> ▪ <i>Do you feel that you have things in common with the other people who go to the Dr. Peter Centre? Why or why not?</i>
<p>What services do you typically access when you go to the Dr. Peter Centre?</p> <p>N.B., Tailor the probes to the specific services identified by the participant.</p>	<p><i>Do you go to the Dr. Peter Centre to access one, or more than one, service or support? Why?</i></p> <p><i>(If only one) Why do you only go to the Dr. Peter Centre to access that particular service?</i></p> <ul style="list-style-type: none"> ▪ <i>Could you describe to me how this service helps you?</i> ▪ <i>Do you ever access any other supports or services when you go to access that service? Why or why not?</i> ▪ <i>Had you ever accessed any other services at the Dr. Peter Centre? If so, which services and why?</i> ▪ <i>Why do you no longer access those services when going to the Dr. Peter Centre?</i> ▪ <i>Are there any other services that you would like to access at the Dr. Peter Centre? Why or why not?</i> ▪ <i>(If applicable) Why have you not tried to access these services before?</i> <p><i>(If more than one) Why do you go to the Dr. Peter Centre to access these services?</i></p> <ul style="list-style-type: none"> ▪ <i>Which service did you first access? Why?</i> ▪ <i>Could you tell me when you started accessing the other services?</i> ▪ <i>Why did you start accessing these other services?</i> ▪ <i>Could you describe to me how these services help you?</i> ▪ <i>Do you find it easier to access these services because they are located in the same place? Why or why not?</i> ▪ <i>Are some of the services that you access more</i>

	<p><i>important to you than others? Why or why not?</i></p>
<p>Do you go to the Dr. Peter Centre for meals? Why or why not?</p>	<ul style="list-style-type: none"> ▪ <i>Do you ever have difficulty accessing food when you're hungry? Why or why not?</i> ▪ <i>[If yes] How do you feel that having poor access to food has impacted your health?</i> ▪ <i>Do you feel that going to the Dr. Peter Centre for meals has helped you?</i> ▪ <i>[If yes] How do you feel you have benefitted from the meals program?</i> ▪ <i>Do you ever connect with other services when you go the Dr. Peter Centre for meals? Why or why not?</i> ▪ <i>Do you feel that having meals at the Dr. Peter Centre helps you access other services? Which services?</i> ▪ <i>How important is the meals program to you? To your health?</i>
<p>Do you receive any care or support from nurses at the Dr. Peter Centre? Why or why not?</p>	<ul style="list-style-type: none"> ▪ <i>[If not] Why do you not access nursing supports at the Dr. Peter Centre?</i> ▪ <i>[If not] For example, do you feel that you do not need these supports? Why or why not?</i> ▪ <i>[If not] Are there other places that you go to access this support when needed? If so, where and why?</i> ▪ <i>[If not] Would you ever access nursing care or support at the Dr. Peter Centre in the future? Why or why not?</i> ▪ <i>[If yes] What kinds of things do nurses help you with at the Dr. Peter Centre?</i> ▪ <i>[If yes] Why do you get help with these things at the Dr. Peter Centre?</i> ▪ <i>[If yes] How do you feel that this help has impacted your health?</i>

	<ul style="list-style-type: none"> ▪ <i>[If yes] Do you find it easier to access nursing care and support at the Dr. Peter Centre than elsewhere? Why or why not?</i> ▪ <i>[If yes] How do you feel about the nursing services provided at the Dr. Peter Centre? Why?</i> ▪ <i>[If yes] Do you feel that the other services provided at the Dr. Peter Centre help you get access to nursing care? Why or why not?</i> ▪ <i>[If yes] For example, do you access nursing care when going to the Dr. Peter Centre for other reasons? If so, can you tell me about a time when this happened?</i>
<p>Do you ever access counselling at the Dr. Peter Centre?</p>	<ul style="list-style-type: none"> ▪ <i>When did you start accessing counselling supports at the Dr. Peter Centre?</i> ▪ <i>For example, did you start accessing these when you first went there or after a while? Why?</i> ▪ <i>Why did you decide to access counselling supports at the Dr. Peter Centre?</i> ▪ <i>For example, did you find it easier to access these supports because you were already going to the Dr. Peter Centre?</i> ▪ <i>Why were you seeking counselling support? How you were feeling? Your drug use? Something else?</i> ▪ <i>Could you tell me about the counselling support you receive at the Dr. Peter Centre?</i> ▪ <i>How do you feel that the counselling supports have impacted you?</i> ▪ <i>For example, have you noticed any changes because of these supports?</i> ▪ <i>Has receiving counselling supports at the Dr. Peter Centre helped you receive any other services? If so, what? How?</i>

<p>Do you access any arts or recreation programs at the Dr. Peter Centre? Why or why not?</p>	<ul style="list-style-type: none"> ▪ <i>[If not] Are there other places that you go to access these types of programs? If so, where and why?</i> ▪ <i>[If not] Why do you go to these programs instead of the Dr. Peter Centre?</i> ▪ <i>[If not] Would you ever access the programs offered by the Dr. Peter Centre in the future? Why or why not?</i> ▪ <i>[If yes] How do you feel about the arts & recreation programs offered by the Dr. Peter Centre?</i> ▪ <i>[If yes] How do you feel participating in these programs impacts you? Why?</i> ▪ <i>[If yes] Can you recall any particularly memorable experiences you have had with these programs? If so, what happened?</i> ▪ <i>[If yes] Does accessing these programs make it easier for you to get help with other things? Why or why not?</i> ▪ <i>[If yes] Do these programs impact how you feel when you are at the Dr. Peter Centre? If so, how?</i>
<p>Do you access any other services, like laundry or showers, at the Dr. Peter Centre?</p>	<ul style="list-style-type: none"> ▪ <i>Why do you access these services at the Dr. Peter Centre?</i> ▪ <i>Do these services make you more likely to go to the Dr. Peter Centre? Why or why not?</i> ▪ <i>Would you be able to access these services if you were unable to access them at the Dr. Peter Centre? Why?</i>
<p>What are your thoughts about having different kinds of services all offered at the Dr. Peter Centre?</p>	<ul style="list-style-type: none"> ▪ <i>Do you feel that having these services available in one place makes it easier to access them?</i> ▪ <i>Why or why not?</i> ▪ <i>Do you have any concerns about having all of these services in one place? If so, what and why?</i>

<p>Has someone at the Dr. Peter Centre ever referred you to any outside services? If so, what services?</p>	<p><i>(If medical services)</i> Could you tell me why you were referred to <u>[name of medical service]</u>?</p> <ul style="list-style-type: none"> ▪ <i>Have you ever been referred to <u>[name of medical service]</u> for that health concern before? If so, did you follow-through on that referral? Why or why not?</i> ▪ <i>Why do you feel that you were referred to <u>[name of medical service]</u>?</i> ▪ <i>Did you feel that you needed <u>[name of medical service]</u> at that time? Why or why not?</i> ▪ <i>Did you follow-through on your referral? If so, did anything or anyone help you follow-through?</i> ▪ <i>Could you tell me what happened after you [did or did not] follow through on the referral?</i> <p><i>(If drug treatment)</i> Could you tell me who referred you to the drug treatment program?</p> <ul style="list-style-type: none"> ▪ <i>Had you spoken with them before about entering drug treatment? Why?</i> ▪ <i>Why do you feel that they referred you to drug treatment at that time?</i> ▪ <i>How did you feel about being referred to drug treatment at that time?</i> ▪ <i>Did you follow-through on the referral to drug treatment? Why or why not?</i> ▪ <i>Could you tell me what happened after you were referred to treatment?</i> <p><i>(If housing)</i> Could you tell me who referred you to housing?</p> <ul style="list-style-type: none"> ▪ <i>Had you spoken with them about where you were living at that time? What did you talk about?</i> ▪ <i>Why do you feel that they referred you to housing?</i> ▪ <i>How did you feel about being referred to housing?</i> ▪ <i>Did you end up getting housing as a result of the</i>
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	<p><i>referral? Why or why not?</i></p> <ul style="list-style-type: none"> ▪ <i>Could you tell me what happened after you were referred to housing?</i>
<p>How do you feel that going to the Dr. Peter Centre has impacted you?</p>	<ul style="list-style-type: none"> ▪ <i>Do you feel that the Dr. Peter Centre has positively impacted your life? Why or why not?</i> ▪ <i>In what ways has the Dr. Peter Centre impacted your life?</i> ▪ <i>Do you feel that your life would be the same if the Dr. Peter Centre had not been opened? Why or why not?</i>

SECTION FIVE: TREATMENT ADHERENCE

"We are interested in learning more about the things that impact treatment..."

HAART ADHERENCE

<u>Questions</u>	<u>Probes</u>
<p>Could you describe to me how your health was before you began taking HIV medication?</p>	<p><i>How long had you been living with HIV?</i></p> <p><i>Were you experiencing any HIV-related symptoms?</i></p> <p><i>Had you noticed any recent changes in your health?</i></p> <ul style="list-style-type: none"> ▪ <i>What changes had you noticed?</i>
<p>When did you begin taking HIV medication?</p>	<p><i>(If before going to the Dr. Peter Centre) How long had you been living with HIV at that time?</i></p> <ul style="list-style-type: none"> ▪ <i>Why did you decide to start taking HIV medication?</i> ▪ <i>What was going on in your life when you started HIV treatment?</i> ▪ <i>Had there recently been any changes in your life? If so, did they influence your decision to start treatment?</i> ▪ <i>Did you decide to start taking HIV medication on your own or did someone else, like your doctor, recommend</i>

	<p><i>that you begin treatment?</i></p> <p><i>(If after going to the Dr. Peter Centre)</i> Why did you decide to start taking HIV medication after going to the Dr. Peter Centre?</p> <ul style="list-style-type: none"> ▪ <i>Did you decide to start taking HIV medication on your own or did someone at the Dr. Peter Centre recommend that you begin treatment?</i> ▪ <i>What were your opinions about HIV treatment at that time?</i> ▪ <i>For example, did you feel that you would benefit from HIV treatment? Why or why not?</i>
<p>Could you tell me how your HIV medication was managed when you started taking it?</p>	<p><i>For example, did you take your medication on your own or was it administered or dispensed by someone else, such as your housing provider, pharmacy, or the Dr. Peter Centre?</i></p> <p><i>(If took on own)</i> How did you manage your medication on your own?</p> <ul style="list-style-type: none"> ▪ <i>For example, did you find that it was easy to take your medication every day? Why or why not?</i> ▪ <i>What made it easier or more difficult to take your medication? Why?</i> <p><i>(If housing provider)</i> Could you tell me how your housing provider assisted with your medication?</p> <ul style="list-style-type: none"> ▪ <i>For example, did they administer your medication on a daily basis?</i> ▪ <i>If so, how did this impact your ability to take your medication?</i> ▪ <i>Did your housing provider help you with anything else? For example, did they administer any other medications?</i>

	<ul style="list-style-type: none"> ▪ <i>How did you feel about your medication being administered by your housing provider? For example, were you comfortable with this? Why or why not?</i> <p><i>(If pharmacy) Did you have to go to pick up your medication every day or did you have it delivered to you?</i></p> <ul style="list-style-type: none"> ▪ <i>(If applicable) Was your HIV medication delivered along with your methadone?</i> ▪ <i>(If applicable) How did this impact your ability to take your HIV medication? Why?</i> ▪ <i>Were you comfortable having your pharmacy administer your HIV medication? Why or why not?</i> <p><i>(If Dr. Peter Centre) Could you tell me how the Dr. Peter Centre assisted with your medication?</i></p> <ul style="list-style-type: none"> ▪ <i>For example, do you take your medication at the Dr. Peter Centre daily?</i> ▪ <i>Why did you choose to have your medication administered by the Dr. Peter Centre?</i> ▪ <i>How does your comfort level with Dr. Peter Centre staff members impact your willingness to have your medication administered there? Why?</i>
<p>Have there been any changes in how your HIV medication is administered in the past year?</p>	<p><i>What changes have there been in how your medication is administered?</i></p> <ul style="list-style-type: none"> ▪ <i>For example, do you now take your medication somewhere else?</i> ▪ <i>If so, where do you take your medication now?</i> ▪ <i>Why do you get your medication there now?</i> <p><i>Has the change in where you take your medication made it easier or more difficult to take it regularly?</i></p> <ul style="list-style-type: none"> ▪ <i>Why do you feel that this change has made it <u>easier</u></i>

	<i>or more difficult] to take your medication?</i>
<p>How often are you currently taking your HIV medication?</p>	<p><i>For example, are you taking your medication everyday, most days, or rarely?</i></p> <p><i>Do you feel that it is important to take your medication every day? Why or why not?</i></p> <p><i>Have you often not taken your HIV medication regularly since you first started treatment? Why or why not?</i></p>
<p><i>(If suboptimal adherence) What do you feel prevents you from taking your HIV medication every day?</i></p> <p>n.b., Probe for both housing type and geographic location</p> <p>n.b., Probe for social-structural factors influencing drug use patterns</p>	<p><i>(If housing) How does where you are living prevent you from taking your medication every day?</i></p> <ul style="list-style-type: none"> ▪ <i>How do you feel that where you are living impacts your health?</i> ▪ <i>Do you have a place to safely store your medication? Why?</i> ▪ <i>Does where you are living make it difficult for you to access the Dr. Peter Centre? Your pharmacy? HIV doctor?</i> ▪ <i>(If applicable) How does where you are living make it difficult to access these services?</i> ▪ <i>In what other ways does where you live prevent you from taking your HIV medication? Why?</i> <p><i>(If drug use) How does your drug use prevent you from taking your medication every day?</i></p> <ul style="list-style-type: none"> ▪ <i>Have there been any changes in your drug use patterns that have impacted your HIV treatment?</i> ▪ <i>If so, how have these changes impacted your ability to take your medication every day?</i> ▪ <i>Did your drug use make it more difficult to remember to pick up your medication? Why or why not?</i> ▪ <i>How do the ways that you make money to support your drug use impact your ability to take your</i>

medication? Why?

- *Do you feel that your drug use is preventing your HIV medication from being effective? If so, does this cause you to not take it every day?*

(If methadone-related) How does being enrolled in the methadone program impact your HIV treatment?

- *Are your methadone and HIV medication administered together? If so, how does this impact your HIV treatment?*
- *For example, are you sometimes not able to pick up your methadone and medication? If so, why and what do you do to manage methadone withdrawal?*
- *How have changes in the methadone program prevented you from taking your medication every day?*
- *For example, was your HIV medication previously delivered with your methadone? If so, how have the changes prevented you from taking your medication?*
- *How do you feel about how these changes to the methadone program have impacted your treatment?*

(If arrest or release conditions) How did being arrested impact your HIV treatment?

- *Were you able to take your HIV medication while in jail? Why or why not?*
- *How did this impact how you felt about your HIV treatment?*
- *Do you currently have—or did you previously have—any release conditions, like a ‘red zone’, that made it difficult for you to take your HIV medication?*
- *If so, how did this impact your HIV treatment?*

(If working) How does how you make money make it difficult for you to take your medication every day?

- *Does where you work make it difficult for you to access HIV treatment? Why or why not?*
- *Does how you make money sometimes impact your*

n.b., Probe how specific changes to the methadone program have impacted HIV treatment

n.b., Probe how specific types of work (e.g., recycling, drug selling, sex work) impact treatment adherence, with an emphasis on the time demands, geographical locations, and relationship with drug use.

	<p><i>HIV treatment more than others? Why or why not?</i></p> <p><i>(If mental health) Can you tell me how feeling down or depressed or your overall mental health sometimes prevents you from taking your HIV medication?</i></p> <ul style="list-style-type: none"> ▪ <i>Can you tell me how you were feeling at that time?</i> ▪ <i>Why were you feeling depressed or down at that time?</i> ▪ <i>Did this change your attitudes toward HIV medication? How so?</i> ▪ <i>How did this impact your motivation to take your medication? Can you think of an example?</i> ▪ <i>How did this impact other areas in your life?</i>
<p><i>(If achieved adherence) What do you feel helps you take your HIV medication every day?</i></p> <p>n.b., Important to probe for both housing type and geographic location</p> <p>n.b., Important to probe for social-structural factors influencing drug use patterns</p>	<p><i>(If housing) How does where you are living help you take your medication every day?</i></p> <ul style="list-style-type: none"> ▪ <i>Does anyone where you live help you with your medication? If so, who helps you?</i> ▪ <i>How does getting help with your medication where you live help you take it every day?</i> ▪ <i>Do you have any concerns about getting your medication from your housing provider? Why or why not?</i> ▪ <i>Are you able to safely store your medication? If so, does this help you in any way?</i> ▪ <i>Does where you are living make it easier for you to access services, like the Dr. Peter Centre, your pharmacy, or your HIV doctor?</i> ▪ <i>(If applicable) Do you feel that being able to easily access these services helps with your HIV treatment? Why or why not?</i> ▪ <i>In what other ways does where you live help you take your HIV medication? Why?</i> <p><i>(If drug use cessation or stabilization) How has decreasing or stabilizing your drug use helped you to</i></p>

<p>n.b., Important to probe how specific changes to the methadone program have impacted HIV treatment</p>	<p><i>take your medication regularly?</i></p> <ul style="list-style-type: none"> ▪ <i>For example, do you spend less time trying to generate money to buy drugs? If so, how has this helped you to take your HIV medication?</i> ▪ <i>Do you find it easier to stick to a regular schedule?</i> ▪ <i>Why are you using less or better able to regulate your drug use?</i> ▪ <i>Has the Dr. Peter Centre helped you to decrease or better regulate your drug use? If so, how?</i> <p><i>(If methadone-related) How does being enrolled in the methadone program help you take your HIV medication?</i></p> <ul style="list-style-type: none"> ▪ <i>Are your methadone and HIV medication administered together? If so, how does this impact your HIV treatment?</i> ▪ <i>Does taking them together help you to take your HIV medication regularly? Why or why not?</i> ▪ <i>How has taking methadone impacted your health, in general?</i> ▪ <i>Do you feel that these improvements have also been the result of taking your HIV medication regularly? Why or why not?</i>
<p>In what ways do you feel the Dr. Peter Centre impacts your ability to take your medication?</p>	<p><i>Do you feel that the Dr. Peter Centre helps you take your medication? Why or why not?</i></p> <p><i>(If administered at Dr. Peter Centre) Does taking your medication at the Dr. Peter Centre help you to take it every day? Why or why not?</i></p> <ul style="list-style-type: none"> ▪ <i>How do you feel about having to go to the Dr. Peter Centre to take your medication? Why?</i> ▪ <i>Do you ever find it difficult to make it to the Dr. Peter Centre to take your medication? Why or why not?</i>

- *What do you do if you are unable to make it to the Dr. Peter Centre to take your medication?*
 - *For example, do you miss your medication or do you have another way of getting it? If so, how?*
 - *How do you feel about the people who give you your medication at the Dr. Peter Centre? Why?*
 - *For example, do you trust them? Why or why not?*
 - *Do they ever help you in getting any other services or care? If so, what?*
 - *How do you feel that these other services or care impact your health? Why?*
- (If not administered at Dr. Peter Centre) In what ways do you feel the Dr. Peter Centre impacts your ability to take your HIV medication?*
- *For example, do they help you address other needs that make it easier for you to take your medication?*
 - *If so, could you tell me what they do and how it helps with your medication?*

“Thank you for sharing your experiences with HIV treatment with us. We have a couple of final questions about your experiences with treatment...”

Is there anything that we have not discussed that you feel has a significant impact on your ability to take your HIV medication? If so, can you tell me more about how it impacts your HIV treatment?

Based on your experiences, how would you describe the overall impact that HIV treatment has had on your life? For example, what have you gotten out of HIV treatment?

Based on your experiences, what do you feel are the most important changes that could be made to improve HIV treatment for people who use drugs?

TREATMENT ADHERENCE (GENERAL)

“We are interested in learning more about how going to the Dr. Peter Centre impacts other types of treatment that you receive...”

<p>Does the Dr. Peter Centre help you with any other types of care or treatment?</p>	<p><i>If so, what types of care or treatment does the Dr. Peter Centre help you with?</i></p> <p><i>(If injection-related infections) How does coming to the Dr. Peter Centre help you to receive care for abscesses or injection-related infections?</i></p> <ul style="list-style-type: none"> ▪ <i>Do you like that you are able to receive this type of care at the Dr. Peter Centre? Why or why not?</i> ▪ <i>How do you feel that receiving this care for abscesses or injection-related infections at the Dr. Peter Centre has impacted your health?</i> ▪ <i>Do you prefer receiving this care at the Dr. Peter Centre in comparison to other places, like hospitals? Why or why not?</i> <p><i>(If chronic diseases) In what ways do you feel the Dr. Peter Centre impacts your ability to manage chronic health conditions?</i></p> <ul style="list-style-type: none"> ▪ <i>For example, do they help you to take your medication for these conditions? If so, how do you feel this impacts your treatment?</i> ▪ <i>Do they help you to access other resources that you need to manage these conditions? If so, can you tell me how?</i> <p><i>(If mental illness) Why do you receive care to address your mental health concerns at the Dr. Peter Centre?</i></p> <ul style="list-style-type: none"> ▪ <i>Do you like that you are able to receive this care at the Dr. Peter Centre? Why or why not?</i> ▪ <i>Does receiving this care at the Dr. Peter Centre make it easier for you to adhere to your treatment? Why or why not?</i>
<p>Do you feel comfortable receiving treatment</p>	<p><i>Why do you feel [comfortable or uncomfortable]</i></p>

<p>for non-HIV-related health issues at the Dr. Peter Centre?</p>	<p><i>receiving this care at the Dr. Peter Centre?</i></p> <p><i>Does anyone at the Dr. Peter Centre do anything that makes you feel <u>[comfortable or uncomfortable]</u> receiving care? If so, who and what do they do?</i></p> <p><i>Do you feel that the Dr. Peter Centre is an appropriate place to receive care for these conditions? Why or why not?</i></p> <p><i>Do you prefer receiving care from people at the Dr. Peter Centre than people in hospitals or other health settings? Why or why not?</i></p>
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SECTION NINE: WRAP-UP QUESTIONS

WRAP-UP QUESTIONS

"I would like to thank you for sharing your experiences at the Dr. Peter Centre with us. Your thoughts will be important in helping us to better understand how the Dr. Peter Centre impacts people living with HIV..."

Is there anything that we have not discussed about your experiences at the Dr. Peter Centre that you feel would be important for us to know? If so, what?

Finally, if someone who had never heard of the Dr. Peter Centre asked you to describe it to them, what would you tell them?