

**Stigma and Discrimination in an Emergency Department:
Policy and practice guiding care for people who use illegal drugs**

by

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BSW, University of Victoria, 1997

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of

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Abstract

People who use illegal drugs all too often experience stigma and discrimination, criminalization and marginalization in Canada. Substance use has both immediate and chronic health consequences that may require healthcare. However, people who use illegal drugs often experience difficulty accessing equitable care, and stigma has been identified as a key barrier to access. This study explores the provision of health care by nurses in an emergency department for people who use illegal drugs, and the impact of hospital policies and procedures on nurses' capacity to provide care. The study uses data from in-depth interviews with nurses and policy leaders, and analyses policy documents discussed by nurses in the interviews. This study found that neoliberal policies that result in downsizing of social programs means that patients come to emergency departments with a broad set of health and social needs that extend beyond what nurses can do. The study also uncovered a lack of cultural safety for Aboriginal patients seeking care. Finally, the study discovered the existence of a culture of stigma in the emergency department. The culture of stigma is transmitted and taken up through individual

attitudes, relations of power, intake and treatment protocols, critical policy absences and problematic policy. This study concludes with recommendations for policy development and for future research in this area.

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Dedication

I would like to dedicate this project to the memory of all the drug war survivors. Your courage inspires me. I would also like to dedicate the project to everyone engaged in harm reduction. Your work matters.

Chapter 1: Introduction

Summary of Problem

People who use illegal drugs are at increased risk of drug-related harms including HIV/AIDS, Hepatitis C, sexually transmitted infections, overdose, tuberculosis, bacterial and other infections and respiratory problems (E.g., Loxley et al., 2004; Pauly, 2008a, 2008b; Smye et al., 2011). Health harms exacerbated by law enforcement policies and practices include increased abscesses and bacterial infections, increased syringe sharing and rushed injections, and increased risk of overdose (Bungay et al., 2010; Kerr et al., 2005; Pauly et al., 2009; Shannon et al., 2007). Substance use has both immediate and chronic health consequences that may require healthcare. Injection drug use and other chronic use of drugs are associated with high use of emergency departments (Cherpitel & Ye, 2008; Chitwood et al., 2002; Henderson et al., 2008; Kerr et al., 2005; McGeary & French, 2000). However, people who use illegal drugs often experience difficulty accessing health care and stigma has been identified as a key barrier to access (Henderson et al., 2008; Jurgens, 2008; Pauly, 2009; Lloyd, 2010). People who use illegal drugs are among the most marginalized and discriminated against population in society. While health care providers value assisting vulnerable patients, the complexity of managing patient care, patients' behaviour, concerns about drug-seeking behaviour and a lack of compliance with treatment can provide challenges for providers (Henderson et al., 2008). Additionally, structural discrimination can be reflected in institutional policies and practices that work to disadvantage specific groups and can work in the absence of interpersonal prejudice and discrimination (Paterson et al., 2007).

Research Purpose and Question

The purpose of this project is to explore care provided by nurses in emergency departments for people who use illegal drugs, and the impact of hospital policies and procedures on nurses' capacity to provide care for this population. A secondary purpose is to examine whether the societal stigma about substance use, applied to people who use illegal drugs and who access care in emergency departments, is reflected and reproduced in health care policy, procedures and practice.

The key research questions guiding this project are:

1. What are nurses' perceptions about the care they provide in emergency departments for people who use illegal drugs, and how are those perceptions shaped by policies including harm reduction policies?
2. What are the organizational policies guiding the provision of care for people who use illegal drugs?

The sub questions are:

1. How might policies enable or constrain the provision of care for people who are marginalized by social disadvantage and drug use?
2. How do policies foster or reduce stigma and discrimination?

Methodology

Social constructionism is the epistemology, or theory of knowledge, informing this project. Social constructionism fits my research questions, in terms of utilizing local knowledge as an analytical framework and the notion that 'reality' is understood in multiple ways and constructed through interactions. Social constructionism is a useful frame for articulating the effects of the production of knowledge and connection

to power on people living at various intersections of oppression. Critical Social Theory (CST) provides a theoretical framework for this project. CST asserts that knowledge is not value neutral; claims of ‘truth’ are informed by values and by ideological inscription, which aligns well with both social constructionism and my own critical approach (outlined below in the section titled ‘the Researcher, Situated). CST will focus attention on the socio-political context of health and health care provision.

Method

I utilized an ethnographic approach informed by critical social theory for this research project. It is an approach rather than a full scale critical ethnography because I utilized interview data and policy documents, but not participant observation. It is ethnographic in that I focused on hospital culture, policies and practices, and linked site-specific findings to the wider societal context and relations of power. Critical ethnography provided a means to examine social and cultural processes surrounding health care for people who use illegal drugs.

Using a semi-structured interview format, I interviewed four nurses/nurse leaders and two policy leaders. I recorded and transcribed the interviews, and recorded field notes after each interview. In terms of policy, I first reviewed publicly available health authority documents before conducting interviews, then accessed the policies that respondents discussed in those interviews. The documents examined in this project are:

- 1. Searching Patients Belongings, Room and Person For Weapons and Prohibited Items*
- 2. Emergency Department and Opiates Policy*

3. *Clinical Institute Withdrawal Assessment for Alcohol Withdrawal*
4. *Mental Health and Substance Use: Child, Youth, Adult and Seniors Operating Themes and Priorities, 2012-2015.*

I utilized an interpretive approach to analyze interview and document data, in order to examine policy, nurses' interpretation of policy, implementation, and the impact on the provision of health care for people who use illegal drugs. In this interpretive approach I utilized interpretive description (Thorne, 2004, 1997). This approach provided a means to examine nurses' experiences providing care for people who use illegal drugs; nurses' interpretation and enactment of policy; and the impact of policy on their capacity to provide equitable care for people who use illegal drugs. Further, an interpretive approach to data analysis allowed me to focus on the meanings of policies, the values and beliefs they express, and the processes by which those meanings are communicated and read.

Additionally, I applied an additional level of analysis to the security policy, which was both impactful on nursing practice, and the most clearly articulated and detailed policy of the four I examined. Bacchi's (2009) problem-posing approach presents six questions to apply to policy. The questions provided a useful frame to critically examine the assumptions and effects of the security policy.

The Researcher, Situated

This project was informed by my work as a health policy analyst, by my feminist and critical thinking, and by my social justice activism. My work in policy analysis at the Ministry of Health, Government of BC, is guided by provincial health policy, particularly the 2010 cross-government initiative *Healthy Minds, Healthy*

People—A Ten-Year Plan to Address Substance Use and Mental Health in BC

(HMHP). I focus on prevention of problematic substance use (illegal drugs, prescription drugs, alcohol), harm reduction, and reduction of stigma and discrimination associated with substance use and mental health.

While HMHP articulates a goal for the reduction of stigma and discrimination, the means to do so is not clearly articulated, for a complex set of reasons. I am interested, both professionally and personally, in exploring the means to reduce stigma and discrimination and promote social inclusion, particularly for people who use illegal drugs. I concur with Jürgens (2008) statement that people who use illegal drugs are the most marginalized and discriminated against population.

My work within and outside the ministry is grounded in a philosophy of harm reduction. Before joining the ministry, I worked in a harm reduction service run by a not for profit agency in my community, and wrote the provincial best practices document for harm reduction supply distribution (Chandler, 2008). My theatre work often contains opportunities for creative dialogue on reducing harm and increasing safety and well being in many situations.

In my policy and community activist work I focus on increasing equity and reducing harms caused by systemic oppression and marginalization/exclusion from mainstream society. As a White, middle-class, able-bodied, educated professional, I experience privilege and dominance in society. My commitment is to offer my tools, particularly my location(s) of dominance and power, to work for social justice with those who have been oppressed.

This thesis is divided into 5 chapters. In chapter 2, the literature review articulates the theoretical perspectives of structural violence and neoliberalism that guided my work, and summarizes the literature on stigma and discrimination; health and barriers to health care, and harm reduction. This chapter also outlines the policy context for this study. In chapter 3, I present my research design. Chapter 4 describes my findings, and in Chapter 5 I analyze and discuss those findings. I end with a conclusion including recommendations for policy change, and further research.

Chapter 2: Literature Review

Structural Violence and Social Suffering

As an approach to guide my research, I utilized the theoretical framework of structural violence and social suffering as an overall framework for this project. Castro and Farmer (2005) contend that the large-scale economically rooted social forces of poverty, racism, sexism, political violence and other social inequalities together define structural violence. These forces structure unequal access to goods and services, and affect the health of marginalized people (Farmer, 1999). Structural violence as a theoretical approach examines the “ethnographically embedded evidence” within the social and economic structures that impact people’s lives (Farmer, 2004, p. 312): stories illustrate at least some of the mechanisms through which social forces “crystallize into...individual suffering” (2009, p.12). Farmer (2009) asserts that in order to explain suffering we must embed individual experience in the larger matrix of culture, history and political economy (p. 20). As Kleinman et al. articulate, “Social suffering results from what political, economic and institutional power does to people” (1997, p. ix).

Structural violence manifests as disparate access to resources, political power, education and health care, to name a few. Factors including unequal opportunities and discrimination based on gender, race and class play a role in rendering people vulnerable to suffering. Nguyen & Peschard (2003) use the language of social inequality, explaining that inequality becomes embodied, with people lower on the socioeconomic ladder suffering health inequities such as higher levels of poor health including chronic illness as well as higher levels of mortality.

In their discussion of structural violence and social suffering, Rhodes et al. (2005) underline the importance of social and cultural factors as structural forces in the reproduction of discrimination against people who use injection drugs. They assert that, “stigmatizing practices against IDUs [injection drug users]—whether that be at the level of individuals, communities, institutions or policies—can be views as instances of structural violence contributing toward a collective experience of social suffering” (p. 1034). They note that any distinguishing characteristic, be it social or biological, can serve as a reason to discriminate against individuals or a group. This discrimination is one of the causes of social suffering.

Farmer argues that structural violence is exerted systemically, or indirectly, and in the process produces inequity in health and health risk: “In short, the concept of structural violence is intended to inform the study of the social machinery of oppression” (2004, p. 307). Scholars working with structural violence as a theoretical approach often utilize ethnography to examine individual experiences with the social and economic structures that impact people’s lives. Use of structural violence as a theoretical approach can illuminate the connection between the structural forces of poverty, racism and sexism, the health of people who use illegal drugs, and health care provision for this population.

Neoliberalism as Structural Violence

Theories about structural violence and social suffering must be contextualized for particular political-geographic contexts. The provincial government of British Columbia has, particularly since 2001, adopted neoliberal policies aimed at budgetary efficiencies, market solutions and program downsizing (Teghtsoonian, 2003). These

policies downplay both structural issues and material constraints on human agency while stressing the primacy of values such as choice, autonomy and productivity (Larner, 2000, p. 6). As Farmer (1999) notes, one of the hallmarks of neo-liberalism is a competition-driven market economy that reinforces inequalities of power and economics. Neoliberal policies specifically downplay the structural issues that shape the lives and health of individuals, and fail to acknowledge the political and economic context of people's lives; this approach supports ideas that blame individuals for their circumstances—circumstances more likely produced by political and social policies and practices that shape gender, race and poverty.

Several authors provide definitions of neoliberalism and explore the application of neoliberal ideology and resulting discourses and practices in a range of settings including hospitals and other health care sites. Harvey (2005) defines neoliberalism as:

A set of political economic practices that proposes that human well being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade. (p. 2).

Within such practices, state intervention in markets is intended to be kept at a minimum. This approach has been transferred to the management of large-scale public institutions such as education and health care resulting in increased pressure on managers to find budgetary efficiencies.

Scholars such as Wendy Larner (2000) note that the rise of neoliberalism is entwined with the emergence of governmentality, a modern form of power that rules at a distance and through an ensemble of institutions, procedures, analyses and tactics that

facilitate the governance of public institutions in a way that is distanced from the centres of power (p. 6). Hospitals, as part of large health care bureaucracies, are set in a neoliberal environment of budget efficiencies and limited resource allocation. The devolution of health care services to regional health authorities in BC provides examples of how governments rule at a distance by maintaining control over funding but devolving responsibility for service provision and budgetary accountability to other units. In this context, policy development is limited by availability of resources, and by the cultural and social practices of an institution such as health care (Rose, 2006).

As well, the practices of “responsibilization” work at the level of individuals to make people responsible for changing the circumstances of their health. In these practices and policies, “the role of the state is de-emphasized in favour of an emphasis on citizens taking responsibility for their own health and welfare” (Lupton, 1999, p. 292), including problematic substance use. Examples include government programs to encourage people to exercise and eat healthy foods without acknowledging the economic constraints that affect the ability of individuals to enact these practices. These practices fuel a “marginalizing discourse of blame and responsibility” (Pauly et al., 2009) for the negative health impacts of a variety of behaviours including illegal drug use. Because these approaches tend to blame the individuals for their health problems, they contribute to and reinforce stigmatizing attitudes and behaviours in a variety of health care settings, including emergency rooms, toward people who use illegal drugs.

Neoliberalism is an example of a political and economic context that helps to produce and reinforce structural violence and social suffering. Its focus on resource management in the context of shrinking public monies for services creates conditions

that negatively impact health and access to health care for people who use illegal drugs, particularly people marginalized by issues of poverty, and systemic practices of racism and colonialism. As Coburn and Coburn (2000) contend, “the political, social and ideological arrangements that underpin neo-liberalism also produce and exacerbate the social conditions which underlie health inequalities” (p. 20). Neoliberal policies most acutely restrict access to resources that shape health outcomes such as adequate income levels and access to basic resources including healthy food and safe and stable housing. Health harms are also caused or exacerbated by large scale economically rooted social forces including poverty, racism, sexism and political violence (Browne et al., 2007; Bungay et al., 2010; Farmer, 2004, 2009; Mahajan et al., 2008).

Stigma and Discrimination

Several authors have traced the development of modern stigma theory (e.g., British Columbia Ministry of Health, 2007; Lloyd, 2012; Lloyd, 2010; Smye et al., 2011). These authors begin with sociologist Irving Goffman’s early work (1963), where he posits that stigma arises when a person has an attribute that makes her/him different from others in a supposedly non-desirable way. Goffman theorized that we understand other people through socially constructed generalizations. People who are perceived as different from us or who do not conform to social norms are sometimes “reduced in our minds from a whole and usual person to a tainted and discounted one” (p. 3). Goffman was particularly interested in stigmatizing attitudes that are based on perceptions that a person has a history of mental disorder, imprisonment and addiction, among others.

Jones et al. (1984) describe stigma as one of the ways people make sense of the world. The process of stigmatization categorizes people into groups. Each person is

defined by the shared devalued attribute(s) of this group, and is then perceived as Other, undesirable and potentially dangerous. These authors suggest that the perceived danger posed by people in a stigmatized group is related to the degree to which that group is rejected.

In their conceptualization of stigma and stigmatizing processes, Link & Phelan (2001) challenge the individual focus of Goffman's and Jones et al.'s definitions of stigma, arguing for the importance of examining both the sources and consequences of "pervasive, socially shaped exclusion from social and economic life" (p. 376). The authors propose five interrelated components of stigma: labeling, stereotyping, separation of 'us and them' and status loss, all of which take place in the context of differences in power. They suggest that the creation of stigma and the capacity to resist it is "entirely dependent on social, economic and political power" (p. 375). Parker and Aggleton (2003) echo Link and Phelan, asserting that stigma is a social process, shaped by existing inequalities such as race, class and gender. The authors emphasize that stigma processes affect "the distribution of life chances" such as housing, employment and access and medical care (Link & Phelan, 2006, p. 528).

Lloyd's (2012) literature review on the stigmatization of people who use illegal drugs highlights the greater stigmatization of drug addiction in relation to mental illness, and the high level of blame attached to people who use illegal drugs. Jürgens (2008) contends that people who use illegal drugs are "the most marginalized and discriminated against populations in society" (p. 7). He argues that criminalization of drug use fuels stigma and discrimination against people who use drugs, pushing people away from health care services that prevent and treat communicable disease. I discuss

criminalization at length in the section on federal drug policy later in this literature review.

Many people who use illegal drugs experience discrimination as a result of stigmatizing attitudes, procedures and in societal institutions including the health care system. Processes of stigmatization occur in an interpersonal context, as evident in the literature examining stigmatization at the site of health care experienced by people who use illegal drugs (E. g., Henderson et al., 2008; Lloyd, 2010). But as I noted above, scholars such as Mahajan (2008) and Parker and Aggelton (2003) contend that processes of stigmatization play a key role in producing and reproducing relations of power. Farmer (1999) takes this further and asserts that stigmatizing practices against people who use illegal drugs can be viewed as instances of structural violence or visible and deeply felt manifestations of deep-rooted social inequity. Thus, a focus on the individual actions of health care providers fails to illuminate structural aspects of stigma and discrimination, and potential solutions.

Stigma and Health Care

For the purposes of my research, I will use McGibbon et al. (2008) conceptualization of “access” to health care; they suggest that it is a two-fold concept that includes both how services are delivered as well as their overall availability (p. 24). People who use illegal drugs often experience difficulty accessing health care and stigma has been identified as a key barrier to access (Henderson et al., 2008; Jurgens, 2008; Pauly et al., 2009). Many scholars have documented how stereotypical perceptions of problematic substance use on the part of health care professionals result in judgmental, stigmatizing and discriminatory attitudes and beliefs (Browne et al.,

2007; Bungay et al., 2010; Butters & Erikson, 2003; Culhane, 2009; Khandor & Mason, 2008; Lloyd, 2010; Pauly et al., 2009; VANDU Women CARE Team, 2009). In turn these attitudes are concretized into practices that act as barriers to accessible, respectful and equitable care (Henderson et al., 2008; McCreadie et al., 2010; Peckover & Chidlaw, 2007).

The structural context of hospitals can foster or prohibit stigmatization of people who use illegal drugs. The available resources, communication and reporting structures, physical environment, and policies, procedures and protocols of the emergency department and across the hospital are key forces in the production and reproduction of stigma (Paterson et al., 2007). Issues such as scarce and overburdened resources, assessment routines and procedures and protocols were identified by health care providers as organizational policies and practices that contribute to providers' struggles to deliver equitable care in complex and challenging situations.

Mahajan et al. (2008) propose that structural discrimination can work in the absence of individual prejudice and discrimination. Pauly et al. (2009) note that "nurses working in hospital settings may be constrained by institutional structures and work processes" (p. 123) such as the process of completing medical charts and administrative demands. Paterson et al. (2007) suggest that institutional and structural forces within the health care system can result in discriminatory practices, despite health care practitioners' positive attitudes.

Stigma is embedded in hospital practice and policy, and in social beliefs that influence care and treatment. In such a context, it can be easy to overlook the constraints imposed by social structural forces related to poverty and social inequity,

and overemphasize individual agency. As I noted above, much scholarly work has focused on discrimination against people who use drugs. This work is important for illustrating the multiple ways in which discrimination can occur in the relationship between client and health care provider. But, as Farmer's articulation of structural violence suggests, structural issues inherent in health care facilitate stigma.

Health of People Who Use Illegal Drugs

People who use illegal drugs are at increased risk of drug-related harms including HIV/AIDS, Hepatitis C, sexually transmitted infections, overdose, tuberculosis, bacterial and other infections and respiratory problems (e.g., Loxley et al., 2004; Pauly, 2008a, 2008b; Smye et al., 2011). Crack use is associated with increased violence; cardiac and respiratory illness; depression; unplanned pregnancy; sexually transmitted infections; HIV; hepatitis C; and finger, lip, mouth and throat burns (e.g., Bungay et al., 2010; Butters & Erikson, 2003, Fischer et al., 2008).

In Canada, people who use drugs have long faced the effects of the criminalization of some drugs (Boyd, 2004). Law enforcement practices have been shown to drive people away from services and into the shadows. If people are afraid to access health care because of possible criminal justice repercussions, health issues such as abscesses and bacterial infections may go untreated, and people may be at increased risk for increased syringe sharing and rushed injections, and increased risk of overdose injury and death (e.g., Bungay et al., 2010; Kerr et al., 2005; Pauly et al., 2009; Shannon et al., 2007).

Barriers to Health Care Access

Substance use has both immediate and chronic health consequences, making access to preventative and acute health care services important to promote health and recovery. People who use illegal drugs often access health care at hospital emergency departments. Injection drug use and other chronic use of drugs are associated with high use of emergency departments (Cherpitel & Ye, 2008; Chitwood et al., 2002; Henderson et al., 2008; Kerr et al., 2005; McGeary and French, 2000). Lack of access to primary health care services can lead to delays in seeking care, resulting in people attending emergency departments with more advanced health problems (Lloyd, 2012; Weiss et al., 2004). Overreliance on emergency departments results in delays seeking treatment and a need for more frequent and/or lengthy stays in hospitals (Kerr et al., 2005).

Client/patient Perspectives.

Researchers have documented the numerous forms of structural violence perpetuated against people who use drugs (Browne et al., 2007; Bungay et al., 2010; Butters & Erickson, 2003; Culhane, 2009; Khandor & Mason, 2008; Pauly et al., 2009; Pauly, 2008; Tang & Browne, 2008; VANDU Women CARE Team, 2009). People who are homeless and using drugs experience higher levels of illness and mortality than the general population (e.g., Cheung & Hwang, 2004, Spittal et al., 2006). They may legitimately seek pain medication, but can be under-medicated or denied medication because they are labeled as “drug-seeking” (Bungay et al., 2010; Butters and Erickson, 2003; Henderson et al., 2008; VANDU, 2009). Khandor and Mason (2008) found that

homeless adults who use crack cocaine do not have a stable source of health care, face discrimination and poor treatment from health care providers (including verbal and physical violence) and report unmet treatment and harm reduction service needs. Ahern et al. (2007) found that stress related to stigma and discrimination experienced by people who use illegal drugs adversely affects health and serves as a barrier to accessing health care.

Women who engage in street-level sex work and use injection drugs experience pervasive violence including physical and sexual assault (Shannon et al., 2008). Shannon et al. (2007) note that local and international evidence suggests that absence of women specific' services, high levels of stigma and concerns about privacy and disclosure are barriers to health care for women who use drugs and who engage in sex work. Further, enhanced surveillance and police crackdowns on open drug use and sex work markets displace women to outlying areas and away from health care services. Spittal et al. (2006) found that women who use injection drugs have rates of mortality almost 50 times that of the province's female population.

Butters and Erikson (2003) found that women who use illegal drugs were turned away from Toronto emergency departments even with serious health problems because the notation 'addiction' was on their medical file, including women who were denied care in serious situations including mental health crises and sexual assault. In Pauly et al.'s (2008b) study of ethical nursing practices with homeless, substance-using patients, nurse and patient research participants describe concerns about people being treated "less than human" in health care interactions (p. 199). The VANDU Women's CARE Project (2009) found that 70% of the women in their study describe stigma related to

their drug use as a regular aspect of their primary health care experience. Some of the women reported avoiding the health care system due to previous experiences of stigma and discrimination.

Boyd (2004) notes that conventional responses to pregnant women who use drugs have been moralization, stigmatization and criminalization. Women's fears about apprehension of their children by child welfare authorities as response to their substance use are evident in the literature (Buchanan & Young, 2002; Poole & Hanson, 2009; Poole & Issac, 2001; Rutman et al., 2007; Swift & Callahan, 2009). Poole and Issac, for example, found that 62% of the women in the study feared that the child welfare system would apprehend their children on the basis of their drug use alone. Their fears were not unfounded: the majority of the women in the study had lost custody of their children or were currently experiencing child custody issues. Rutman et al. (2007) assert that a focus on women's drug use, regardless of how or if their children are affected, is "a sign of, undoubtedly, of cultural values about proper maternal behaviour and of society's regulation of women as reflective of those values" (p. 269). Poole and Hanson's (2009) literature review examining studies with women who use substances found that stigma is a key issue—that women and girls who use substances are judged more harshly than men for their behaviour. They conclude that stigma creates significant barriers to accessing care and treatment.

Health Care Provider Perspectives

In a study of care provision in an emergency department in California for people who use drugs, Henderson et al. (2008) found that while providers valued assisting vulnerable patients, interactions could be challenging or unpleasant. Health care

providers reported being challenged by the complexity of managing patient care, patients' behaviour and a perceived lack of compliance with treatment. As well, providers were concerned about drug-seeking behaviour and were not sure that patients were providing accurate and complete medical histories. Use of resources by patients for non-emergency medical needs and to meet needs for rest and food further complicated the work of providers. The study also found that "care dynamics" including clinical assessment routines, scarce and overburdened resources, limited time and overcrowding (p. 1345) were contributing factors. The providers had to balance the needs of substance-involved patients with the requirement to manage limited resources.

Pauly et al. (2012) highlight institutional constraints on nurses' ability to practice ethically—constraints which create moral distress for nurses due to their inability to "act on what they believe is the right thing to do" (p. 3). Nurses find it difficult to enact their professional and ethical values as a consequence, highlighting the importance of political and policy influences that shape the context of health care practice.

Paterson et al. (2007) suggest that institutional and structural forces within the health care system can result in discriminatory practices, despite health care practitioners' positive attitudes. From the perspective of practitioners, the available resources, communication and reporting structures, physical environment, and policies, procedures and protocols of the emergency department and across the hospital are key forces constraining practitioners capacity to deliver equitable care for people who use illegal drugs. Paterson et al. note that recent authors "have indicated the need to reframe stigmatization as playing a significant role in producing and reproducing social

relations of power and control” (p. 371), suggesting that stigmatizing processes are embedded in practices and policy.

The authors of these studies articulate the challenge of attending to the clinical and social needs of people who use drugs in the context of structural limits imposed on health care providers’ work, and highlight the important role of hospital resource allocation, organization, and policy. Therefore, it is important to look at hospital policies and practices as factors that contribute to inequitable and sometimes inadequate care for people who use illegal drugs, by interviewing health care providers and analysing relevant policy.

Access to Health Care: Intersecting Social, Cultural and Structural Factors

Utilizing a lens of intersectionality serves to bring the complexity of social locations and experiences to the forefront in order to understand differences in health and health care access. Moosa-Mitha (2005) defines intersectionality as “the interweaving of oppressions on the basis of multiple social identities as well as marginalization that [is] both relational and structural” (p. 62). This theory recognizes the often multiple oppressions experienced by people related to their identity and social position. The differences between people and groups of people arise from historical processes that construct categories of persons based on race, class and gender. Groups are defined in relation to one another, often as subject and Other, which benefits some groups and marginalizes others. Individuals occupy social positions that are both complex and dynamic, depending on the historical and situational context. Health care takes place within a context of history, political economy and race, class and gendered relations: as Tang and Browne (2008) state, “we cannot decontextualize our

understanding and interpretation of health care encounters” (p. 124). Browne and Fisk (2001) echo the authors, asserting that, “The micropolitics of health care encounters cannot be separated from the broader sociopolitical and historic context in which they occur” (p. 129). Current day systemic barriers to health care access include racism, poverty, sexism, social exclusion and discrimination. Health literature highlights intersections of oppression and structural violence based on race, class and gender, in a context of criminalization for people who use illegal drugs. As Pauly et al. (2009) note, examining differences in both health and health care access between groups “draws attention to social, political, historical and economic conditions related to social positioning” (p. 122): the conditions underlying inequities.

Power

An intersectional analysis places the importance of power and its role in creating and perpetuating the personal and social structures of discrimination and oppression front and centre in considerations of health and access to health care. The focus of this analysis “is not on the intersection itself, but what the intersection reveals about power” (Dhamoon, 2008, p. 398). Structural violence and power relations mediate agency and access to resources. As Castro and Farmer (2005) note, “suffering is structured by historically given (and often economically driven) processes and forces that conspire—whether through routine, ritual, or as is more commonly the case, the hard surfaces of life—to constrain agency” (p. 54). For people experiencing inequity in health and access to health services and other resources, racism, sexism, political violence and poverty all place constraints on human agency.

Aboriginal People and Racism

For Aboriginal people, health and health care take place in a context of a historical legacy of colonization and ongoing colonial politics including loss of traditional lands, cultural genocide, economic deprivation and the impact of residential school and child welfare practices (Browne and Fisk, 2001; Bungay et al., 2010; Culhane, 2009; Mehrabadi et al., 2008; Tang and Browne, 2008).

Culhane (2009) notes that “a foundational premise of Aboriginal health is that health and illness are irreducibly interrelated with, and interconnected to, the social, cultural, economic and political contexts in which Aboriginal people(s) live” (p. 162). Culhane discusses the importance of moving beyond a class analysis that centres poverty as dominant to include the impact of racism and colonial domination in the “realities of everyday life in which Aboriginality, female gender, racism, sexism and poverty are lived and experienced simultaneously, not sequentially” (p. 162). Tang and Browne (2008) support her argument, asserting, “‘race’ matters in health care as it intersects with other social categories including class, substance use and history to organize inequitable access to health and health care for marginalized populations” (p. 109). Systemic barriers include racism, poverty, social exclusion and discrimination (Adelson, 2005; Benoit et al., 2003; Culhane, 2003; Fiske & Browne, 2006).

Browne et al. (2007) contend that experiences of racism, poverty and sexism, that play out over structural inequities in the fields of health care, social services and law enforcement, shape health in its broadest sense. Concrete manifestations of structural violence in the authors’ study include a lack of cultural safety, individual and institutional discrimination and a lack of regard for the limits imposed by and impact of

socio-economic conditions for Aboriginal people. Similarly, Browne and Fisk's (2001) interviews uncovered experiences of individual and institutional discrimination on the basis of race, gender and class in the health care system, resulting in a lack of cultural safety, and a system that fails to acknowledge or challenge this discrimination.

Mehrabadi et al. (2008) found that experiences of intergenerational trauma resulting from colonization continues to affect the health and wellbeing of Aboriginal women. The cumulative effects of historical and lifetime trauma are key factors contributing to the HIV epidemic among young Aboriginal women in North America. Health programming for Aboriginal women who use drugs often ignores the effects of experiences of sexual violence so prevalent in the lives of women who use illegal drugs. This historical and current violence, both in intimate relationships and in the wider community, has a profound effect on the health and health care experiences of Aboriginal women.

It is critical to note Tang and Browne's (2008) contention that we should not, in our analysis, contribute to an understanding of Aboriginal people as lacking agency, and as solely victims, as doing so reinforces unequal power relations and justifies paternalistic state interventions. As Culhane (2009) notes, while it is imperative to describe the ways that structured inequality limits opportunities, "there is always a danger that such descriptions and representations may result in confirming the very stereotypes they seek to subvert" (p. 166). While there is no question that historical and ongoing relations of inequality continue to impact Aboriginal people, focusing solely on these fails to acknowledge complexities in people's lives, as well as their capacity to survive and thrive.

Intersections: Race, Class and Gender

Some authors highlight poverty as the most fundamental instance of structural violence (Farmer, 2004; Ho, 2007; Rhodes et al., 2005). Farmer (2004) asserts, “The world’s poor are the chief victims of structural violence...the poor are not only most likely to suffer, they are less likely to have their suffering noticed” (p. 307). Poverty is the deprivation of the most basic human needs.

Studies of the social and structural production of HIV risk highlight the increased risk for and prevalence of HIV among people living in poverty. Rhodes et al. (2005) note that elevated levels of HIV prevalence exist among people who use injection drugs and who experience economic disadvantage. Where income inequality is highest there are more injection drug users per capita, higher rates of HIV prevalence and increased new cases of HIV among people who use injection drugs (Hunt et al., 2003; Friedman, 2006).

Other authors focus on intersections between poverty and gendered individual and structural violence (Bungay et al., 2010; Farmer, 2009; Mahajan et al., 2008; Shannon et al., 2008, 2007). Bungay et al. apply an analysis of structural violence to examine the gendered violence and gendered relations of power affecting the health of women who use crack cocaine. The authors assert the critical importance of moving beyond an emphasis on individual risk factors for HIV infection in order to understand the “larger structural and interpersonal contexts in which crack use occurs” (p. 322). Experiences of poverty, malnutrition, unstable housing, unemployment, violence and involvement in the criminal justice system reflect systemic structural inequities—structural violence—experienced every day by women who use crack and live in

poverty. Gendered violence is evident in women's experiences of increased risk of HIV infection resulting from unprotected sex with intimate partners and receiving assistance injecting, often with used needles.

Shannon et al. (2008) articulate the interplay of micro, meso and macro factors that interact in the physical and social space—what they call the risk environment—of the lives of women who use drugs and engage in survival sex work. The authors identify gendered relations of power in intimate partnerships as an example of social norms that negatively impact women's safety and communicable disease prevention practices at the micro level. Meso factors included the current legal framework impacting sex work that act as a direct structural barrier to HIV prevention. Because of the illegality of sex work, there is a lack of safe spaces to take dates, increasing the risk of violence and reducing women's ability to negotiate condom use. Police crackdowns and policies of enforcement regarding drug use are also meso factors, directly impacting syringe acquisition and safer drug use practices. At the macro level, sex work becomes a means of economic survival in a policy environment of inadequate income assistance and affordable housing.

Browne et al. (2007) contend that experiences of racism, poverty and sexism, that play out over structural inequalities in the fields of health care, social services and law enforcement, shape health in its broadest sense. The authors discuss the impact on access to health care for women in their discussion of the ways in which race, class, and gender mutually construct one another. They argue that women experience “differing constellations of inequities based on their social positioning within hierarchies of power relations” (p. 127). Manifestations of structural violence for the women in the study

include a lack of cultural safety, individual and institutional discrimination and a lack of regard for socio-economic conditions. Similarly, Browne and Fisk's (2001) study uncovered experiences of individual and institutional discrimination on the basis of race, gender and class in the healthcare system, resulting in a lack of cultural safety, and a system that fails to acknowledge or challenge this discrimination.

Policy Context

Federal Drug Policy

In Canada, public safety is often linked to illegal drug use or drug production and selling. Historically the federal government's response to these issues has been to increase the scope of laws, the severity of punishments and the scale of policing. Drugs were first prohibited in Canada in 1908 with the establishment of the *Opium Act*, which made it an offense to import, manufacture, or sell opium for non-medical purposes. Studies examining the adoption of this legislation argue that regulating opium reflected existing anti-Asian sentiments far more than concerns about the pharmacological effects of this drug (Carstairs, 2006; Fischer et al., 2003; Grayson, 2008). The subsequent *Opium and Drug Act* of 1911 criminalized possession of other opiates and cocaine derivatives, and granted exceptional powers to police. In the 1920's the Opium and Drug Branch was established to coordinate enforcement efforts, "reflecting a move away from a public health approach and toward a crime prevention approach" (Canadian Nurses Association, 2011, p. 25).

Between 1920 and 1922 the *Opium and Drug Act* was renamed and amended twice, adding drugs including marijuana, increasing penalties, further expanding police

powers, and adding deportation of Chinese people found guilty of drug offenses (Carstairs, 2006).

Until 1961, Canada's drug laws were a patchwork of legislation and amendments. The 1961 *Narcotic Control Act* consolidated drug laws and enacted some of the harshest penalties of any Western nation (Boyd & Carter, 2014).

In 1996, sections of the Food and Drug Act and the Narcotic Control Act were merged into the *Controlled Drugs and Substances Act* (CDSA), the first major reform of Canada's drug legislation since the 1960's. One hundred and fifty new substances and their precursors were added to the regulation of the Act. The CDSA designates which substances are prohibited in Canada and creates a series of schedules that govern the severity of penalties associated with drug crimes (Boyd & Carter, 2014).

Since 2006, the federal government has expanded the range of mandatory minimum penalties for drug crimes; abolished or tightened parole review criteria; reduced credit for time served in pre-trial custody and restricted use of conditional sentences (DeBeck et al., 2009), including in the most recent legislation, the *Safe Streets and Communities Act* (2012). A wide range of evidence suggests these approaches have limited effects in deterring drug demand and supply (Reuter & Room, 2012).

In addition to Canada's drug laws, a series of drug strategies have outlined the principles of federal policy. In 1987, the Government of Canada launched the five-year, \$210-million *National Drug Strategy*. The strategy includes six key components: education and prevention; treatment and rehabilitation; enforcement and control; information and research; international cooperation; and a national focus aimed at

identifying drug demand reduction programs that could serve a national purpose (Collins, 2006, p. 2). In 1992, the federal government released a second version of the strategy by merging the *National Strategy to Reduce Impaired Driving* and the *National Drug Strategy*. This strategy was further refined in 1998 with the inclusion of four pillars as key strategic priorities: education and prevention; treatment and rehabilitation; harm reduction; and enforcement and control. In 2003, the federal government announced that it would invest \$245 million over the next five years in its drug strategy. By 2004, the federal government supported harm reduction services, including Vancouver's supervised injection site.

Despite efforts to create a more public health oriented approach to drug policy, a review of the 2003 *Canada's Drug Strategy* found that approximately three-quarters of the resources had been directed towards enforcement-related efforts, notwithstanding a lack of scientific evidence to support this approach and little, if any, evaluation of the impacts of this investment. The authors concluded that from a scientific perspective, an effective national drug strategy should ensure that federal funds are directed towards cost-effective, evidence-based prevention, treatment and harm reduction services, and that these services should be available to all Canadians (DeBeck, Wood, Montaner & Kerr, 2006).

In 2007, the newly elected Conservative minority government introduced a new drug policy framework for Canada entitled the *National Anti-Drug Strategy* (NADS). This strategy is notable for the elimination of harm reduction, and a greater focus on and investment in law enforcement (Canadian Nurses Association, 2011; DeBeck et al., 2009). Since then, the federal government has actively opposed renewing the CDSA

section 56 exemption that allows Insite, Vancouver's supervised injection site, to continue to operate.¹ This lack of support is in direct opposition to the endorsement of harm reduction programs including supervised injection services by the World Health Organization and other international, national and provincial bodies.

Despite the limitations of drug law enforcement in reducing harm related to drug use, Canadian federal funding to address substance use is largely focused in this area. In an informal audit of funding allocation for substance use, DeBeck et al. (2009) found that 70% of spending is directed toward law enforcement, while prevention, treatment and harm reduction are funded at 4%, 10% and 2% respectively. Coordination and research investments are 7% of the total budget. This analysis does not support the federal government's claim that it is investing heavily in drug use prevention and treatment. This approach is also inconsistent with Canada's *National Framework for Action to Reduce the Harms from Alcohol, Drugs and Other Substances*, which, among other things, calls for evidence-based drug policy. This approach is, however, consistent with neoliberalism, particularly in regards to increased resources for enforcement.

If drug law enforcement was achieving its stated objectives of reducing drug supply, we would see higher drug prices, decreased drug potency and less availability of drugs. But global evidence indicates this has not been the case: increased production, lower prices and increased potency is evident around the world. For example, countries

¹ Section 56 of the CDSA state that the Minister of Health may exempt controlled substances from the provisions of the act if it deemed necessary for medical or scientific purposes, or otherwise in the public interest. Health Canada, CDSA, accessed at laws-lois.justice.gc.ca/eng/acts/C-38/index.html. January 4, 2014.

with stringent drug policies do not have lower levels of use than countries with more liberal policies (Wood et al., 2012, Global Commission on Drug Policy, 2012). Further, as Werb et al. (2011) note, increasing drug law enforcement does not reduce drug market violence.

Apart from the failure of prohibitionist policies to achieve their goals, there are growing concerns regarding the contribution of these policies to violations of human rights and the promotion of health risks that are otherwise preventable. As Rhodes (2009) notes, “one of the most visible structural mechanisms perpetuating social suffering is the criminal justice system.” (p. 196). A large body of literature links policing practices, and fear of the criminal justice system, to drug harms including HIV, overdose, tuberculosis, bacterial infections and violence (Friedman et al., 2006; Kerr et al., 2005; Reuter & Room, 2012; Rhodes, 2009, Rhodes et al., 2007, 2003; Shannon et al., 2008; Werb et al., 2008).

Policing policies reproduce and reinforce social inequalities, combining with other forces of structural violence to “sustain environments of risk and social suffering” (Sarang et al., 2010, p. 815). Policing based on criminal drug laws creates environmental and structural barriers to accessing harm reduction, HIV prevention and other health services (Global Commission on Drug Policy, 2012; Rhodes, 2009; Shannon et al., 2007, 2008). Fear of arrest and punishment drive people away from prevention, harm reduction and testing services.

Criminalization of drug use fuels stigma and discrimination against people who use drugs. As Hunt and Derricott (2001) point out, “through legislation the state says drug use is a crime and is therefore bad, ipso facto, drug users are bad and rightly

stigmatized” (p. 191). Criminalization and labeling people as criminals reduces public concern for and fuels stigma and discrimination against people who use illegal drugs. Stigma and discrimination help maintain social and economic disadvantages that are an impediment to seeking services, supports and recovery, which compromises the health and well-being of vulnerable populations.

Provincial Policy

Healthy Minds, Healthy People—A Ten Year Plan to Address Mental Health and Substance Use in British Columbia (British Columbia Ministry of Health & British Columbia Ministry of Children and Family Development, 2010) is a cross-ministry policy that aligns with existing child, youth and adult mental health and substance use policies and strategies in BC, and guides the mental health and substance use health promotion, prevention, harm reduction and treatment work in the province. The stated intention of this policy is to establish “a decade-long vision for collaborative and integrated action on mental health and psychoactive substance use in British Columbia” (p. 2).

Healthy Minds, Healthy People (HMHP) utilizes a population health approach, addressing the health needs of groups of people rather than individuals, and attempts to consider the range of factors that influence health such as employment and income, education and housing; the social determinants of health. The policy divides the population into four groups: all people of British Columbia; people vulnerable to mental health and substance use problems; people experiencing mild to moderate mental health or substance use problems; and the population on which this research

project is focused; people with severe and complex mental disorders and/or substance dependence.

In its goal statements, HMHP focuses on the dual priorities of improving service quality and accessibility for people struggling with mental illness and substance dependence, and reducing costs to public and private sectors that result from mental health and substance use problems (p. 6).

Reducing stigma and discrimination for people who experience mental illness or substance dependence is one of four priorities identified in HMHP. The policy indicates an awareness that stigma contributes to marginalization, and discrimination at the site of health care, as well as in employment, housing, and the education and criminal justice systems. It notes, “Many [people] do not receive the services they need, live in poverty, and are unstably housed” as a result of stigma and discrimination (p. 18). The measure for the reduction of stigma and discrimination is, “By 2015, more people living with mental illness and/or substance dependence will report that they experience a great sense of belonging within their communities” (p. 18). The difficulty with meeting this goal is that the means for achieving it no longer exists. The action to meet the goal was to utilize the Mental Health Commission of Canada’s (MHCC) national anti-stigma initiative *Opening Minds* to fund and support the reach of local and provincial initiatives. However, shortly after HMHP was released, MHCC took their initiative in a different direction, meaning that financial support for anti-stigma initiatives in BC no longer existed. In terms of the stigma and discrimination experienced by people who use illegal drugs this was never a strong action to start with, as *Opening Minds* primarily focused on stigma associated with mental health.

By 2011, however, the province was able to move forward on the goal of reducing stigma. The HMHP 2012 Annual Report noted, “As part of efforts to address stigma and discrimination, the Community Action Initiative (CAI) is awarding grants to eligible community agencies to promote social inclusion for adults with severe and persistent mental health problems or chronic problematic substance use. In 2012 and early 2013, the CAI expects to fund up to ten community projects that can demonstrate innovative solutions to increasing social inclusion among groups of people who experience marginalization.” (British Columbia Ministry of Health & Ministry of Children and Families, 2012, p. 11).²

It’s important to note that the work of CAI, while definitely contributing to social inclusion and reduced stigma and discrimination, is community-focused, and consequently does not address discrimination experienced at the site of health care by people who use illegal drugs.

Health Authority Policy

Vancouver Island Health Authority’s *Five Year Strategic Plan 2008-2013* (VIHA, 2009) identifies seven strategic priorities for health service delivery in the region. The priorities related to people experiencing substance dependence are outlined below.

1. Improved Health of High Needs Populations

VIHA acknowledges the differences in the health of some populations, including Aboriginal people and homeless/hard to serve populations. VIHA

²The CAI was created through a \$10 million grant from the provincial government in 2008. The initiative funds projects in the non-government, not-for-profit sector so that it can participate in the continuum of response to mental health and substance use in BC. <http://www.communityactioninitiative.ca/>

articulates a commitment to focus efforts “where the need for better health is clear, and where we have the ability to make improvements” (p. iii).

2. High Quality and Safe Services

This priority outlines improving service quality and maintaining the safety of staff and patients. Issues of safety and questions regarding whose safety is prioritized (in some cases staff safety over patient wellbeing) are prominent in this research project’s data.

In the section of the Strategic Plan titled “Accomplishments since 2005”, VIHA notes that, while there have been some improvements in services for people living with mental illness and substance dependence, particularly the development of the Integrated Crisis Mobile Response Team, major gaps in services for this population still exist (p. 3).

VIHA’s Operational Plan “Mental Health and Substance Use: Child/Youth, Adult and Seniors Operating Themes and Priorities 2012-2015”³ is also a key contextual policy document for this research project. One of the priorities addressed in this document speaks specifically to reducing stigma for people experiencing mental illness and substance dependence. The document does not define stigma, it merely states that, “stigma is experienced by people living with mental health and addictions issues, their family members and among care providers” (p. 3), and articulates an aim: to “reduce the negative impacts that result from stigmatization” (p. 3). The document does not, however, discuss the nature of those negative impacts. Two specific actions

³ Accessed September 21, 2013 at: http://www.viha.ca/NR/ronlyres/4E4FF6CD-B4AB-4BCF-88E1-299896B674BF/0/MHAS_OperationalPlan_Nov2012.pdf

to achieve this aim focus on integration of services: strengthening the integration of primary care with other levels of care, and enhancing integration of levels of service in the community. This document also articulates a goal of improving services for people who experience mental illness and substance dependence. The specifics of this goal include developing strategies to increase the capacity of care providers to support this population, and to increase awareness and understanding among health care providers and members of the public. There is no discussion of how these goals might be achieved.

Harm Reduction

Harm reduction is a public health policy approach, a philosophical approach, and a set of programs and interventions to reduce harms from the use of psychoactive drugs (legal and illegal) including controlled drugs, prescription drugs, tobacco and alcohol. The International Harm Reduction Association (IHRA) defines harm reduction in the following way: “‘Harm Reduction’ refers to policies, programmes 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. Harm reduction benefits people who use drugs, their families and the community” (2010, p. 1). The World Health Organization; the Joint United Nations Programme on HIV/AIDS; the United Nations Office on Drugs and Crime (UNODC); the United Nations Children’s Fund; and the International Federation of Red Cross and Red Crescent Societies Bank have endorsed harm reduction (Wodak, 2009). Strong evidence exists for the efficacy of harm reduction programs including needle and syringe programs, opioid substitution treatment and supervised consumption sites (i.e.,

Ball, 2007; Kerr et al., 2010; Office of the Provincial Health Officer, 2011; Van Den Berg et al., 2007; Wodak & Cooney, 2006, 2005; World Health Organization, 2004).

British Columbia's Harm Reduction Policy

British Columbia's evidence-based harm reduction policy is articulated in several key government policy documents, including *A Path Forward: BC's First Nations and Aboriginal Peoples Mental Wellness and Substance Use – 10 Year Plan* (First Nations Health Authority, the British Columbia Ministry of Health and Health Canada, 2013); *From Hope to Health: Towards an AIDS-free Generation* (Ministry of Health, 2012); *Healthy Minds, Healthy People—A Ten Year Plan to Address Mental Health and Substance Use in British Columbia* (Ministry of Health Services, Ministry of Children and Family Development, 2010); and *Harm Reduction: a BC Community Guide* (Ministry of Health, 2005). *A Path Forward* provides the most current provincial definition of harm reduction:

Harm reduction refers to policies, programs and practices that aim to reduce the adverse health, social, and economic consequences of psychoactive substance use for people unable or unwilling to stop using immediately. Harm reduction is a pragmatic response that focuses on keeping people immediately safe and minimizing death, disease, and injury from high-risk behaviour. It involves a range of strategies and services to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier (p. 43).

This definition expands on the IHRA definition by articulating pragmatism, one of the fundamental principles of harm reduction, which acknowledges that substance use

behaviour may continue despite the risks. *Healthy Minds, Healthy People* also outlines this principle: “harm reduction seeks to lessen the harms associated with substance use while recognizing that many individuals may not be ready or in a position to cease use.” (p. 15). Other principles of harm reduction include acknowledgement that drug use is part of society; the importance of evidence of costs and benefits; an emphasis on human rights; taking action to challenge policies and practices that maximize harm (such as policing policy and practice); and the meaningful participation of people who use illegal drugs in policymaking and program development. Harm reduction emphasizes treating all people with respect, dignity and compassion regardless of drug use. This approach is key given the stigma and societal and individual judgments experienced by people who use illegal drugs. (Canadian Centre on Substance Abuse, 1996; Canadian Nurses Association, 2011; Hunt et al., 2003; IHRA, 2010; Riley & O’Hare, 2000; Thomas, 2005).

Harm reduction policies and programs in BC include the provision of harm reduction supplies (injection and crack smoking supplies); education about safer drug use; referral to health and social services; opioid substitution therapy; and supervised injection services. In BC, harm reduction is viewed as an essential part of a comprehensive response to problematic substance use that complements prevention, treatment and enforcement.

Harm Reduction and Nursing Values and Practice

Harm reduction is aligned with the values, goals and commitments of nursing, including recognition of the intersections of the social determinants of health with use of illegal drugs, and is based on an understanding of social conditions underlying social

inequities (Canadian Nurses Association, 2011). Several authors have noted that the values and practices of harm reduction are consistent with professional and ethical standards of nursing practice (E.g., Canadian Nurses Association, 2011 & 2008; Lightfoot et al., 2009; Pauly, Goldstone, et al., 2007; Wood, Zettel & Stewart, 2003). These values include “the provision of safe, ethical, competent and compassionate care; the promotion of health and wellbeing; the promotion of and respect for informed decision-making; the preservation of dignity, in which care is provided on the basis of need; and the promotion of justice” (Canadian Nurses Association, 2011, p. 49). Further, *The Code of Ethics for Registered Nurses* (Canadian Nurses Association, 2008) and the College of Registered Nurses of British Columbia professional standards (2008) direct nurses to use current research and the best available evidence to guide practice (Pauly et al., 2007). Strong, long term international and local evidence clearly supports a harm reduction approach, as discussed earlier in this section.

Opportunities to practice harm reduction occur in a range of settings for nursing practice; as the Canadian Nurses Association notes, “In many situations, RNs have embraced harm reduction where it has the potential to promote health, reduce harm and enhance access to health care”. (2011, p. 18). Settings include opioid substitution clinics, street outreach, primary care, and hospitals (i.e., Carriere, 2008; Mistral and Hollingworth, 2001; Self & Peters, 2005).

Barriers to the adoption of harm reduction practices include societal values and organizational policies and norms (Canadian Nurses Association, 2011; Pauly et al., 2007). Lack of harm reduction policy may contribute to existing stigma. As Pauly et al. note, “Nurses working in an environment that has no needle exchange policy may feel

morally conflicted over their duty to prevent the harms associated with injection drug use.”(2007, p. 20). Nurses may be concerned about “legal and organizational censure” if they utilize harm reduction in their practice (Canadian Nurses Association, 2011, p. 49).

Rachlis et al. (2009) assert, “Given the contact that many injection drug users have with EDs, it seems fitting that harm reduction programs should continue to expand into the hospital setting” (p. 22), in order to reduce harms from injection drug use. Further, Pauly’s (2008) study of ethical nursing practice found that when nurses used harm reduction as an approach to practice, it enhanced patient access to health care. A change in the moral values of nurses in the practice created a shift in stigmatizing attitudes toward people who use illegal drugs.

In this chapter, I outlined the literature relevant to the research question for this study. Structural violence and social suffering, including neoliberalism as structural violence, provided a theoretical framework for the research. I outlined the development of modern stigma theory, and summarized the literature on stigma and related barriers to health care, including patient and provider perspectives. I also discussed the intersecting social, cultural and structural factors impacting health and access to care for people who use illegal drugs. I concluded the chapter with a description of the policy context for this project, including federal and provincial government, health authority and harm reduction policy. In the following chapter, I present my research design.

Chapter 3: Research Design

Methodology

Social Constructionism

Social constructionism is the epistemology, or theory of knowledge, informing this project. Differing orientations, and a number of different approaches to research, knowledge and theorizing, exist within social constructionism. This research project will be informed by an approach to social constructionism influenced by critical and post-structuralist theory, based on an understanding that “the product and the process of social construction are infused with power relations, which privilege some groups and individuals over others” (Cunliffe, 2008, p. 128). This post-positivist approach recognizes the subjectivity of human experience, contingencies of truth claims, the value-laden nature of inquiry and local knowledge as an analytical framework (Madison, 2012). While not all forms of social constructionism are utilized in a critical way, macro-level social constructionism has at its heart a concept of power related to the construction of knowledge in social relations and institutional practices.

There are several key assumptions of this approach. A critical stance toward knowledge challenges the positivist view that knowledge is based on objective and unbiased interpretations of the world. Rather, knowledge and knowledge claims are socially constructed. “Recognizing that knowledge is socially constructed means understanding that knowledge doesn’t exist ‘out there’ but is embedded in people and the power relations between us” (Potts & Brown, 2005, p. 261). Knowledge is sustained by social processes: people construct and maintain knowledge in everyday social interactions and relationships; “truth, or meaning, comes into existence in and out of

engagement with the realities in our world” (Crotty, 1998, p. 8). As a consequence, there is no absolute ‘truth’; rather, reality is understood and represented in multiple ways and as constructed through interactions in a broader social context.

Further, the ways in which we understand the world, categories and concepts are both historically and culturally specific. As Burr (2003) notes, “ways of understanding... are seen as products of that culture and history, and are dependent upon the particular social and economic arrangements prevailing in that culture at that time” (p. 4).

Language is an important tool for understanding the social construction of knowledge and truth claims. It provides categories and concepts for frameworks of meanings. The constructive power of language is derived from and situated in social structures, social relationships and institutionalized practices.

In order to change dominant ideology and hegemony, it is key to link the production of knowledge to power in the political economy, and to articulate the effects on individuals living at various intersections of oppression, thus connecting individual struggles to issues of power and justice. As Kincheloe and McLaren (2002) note, “Claims to truth are always discursively situated and implicated in relations of power” (p. 327). Such discourses are an expression of power relations and are themselves an embodiment of power.

Finally, constructionism is praxis-oriented, meaning it is a framework for critical reflection for the purpose of transformation: overcoming oppression and alleviating suffering. Such critical research has the potential to illuminate the fields of power in which knowledge creation takes place; using a critical lens provides a means

to analyze social inequity with a view to challenging such inequity through research and practice.

Critical Social Theory

Critical Social Theory (CST) provides a theoretical framework for examining and critiquing oppression, power relations and political conditions, and informs praxis and social action and therefore is a valuable approach to a researcher who adheres to the social constructivist paradigm. As Freeman and Vasconcelos (2010) state:

A ‘critical social theory’ is both the process and the outcome of a transformational agenda...it is an evaluative as well as a political activity that involved assessing how things are in order to transform them (p. 7).

In other words, an ongoing process of reflection and action—praxis—is at the heart of critical social theory.

Browne (2000) articulates the central tenets of CST. First, some form of power and domination is present in every social order, and all knowledge is mediated by social and historical power relations. Second, knowledge is not value neutral; claims of ‘truth’ are informed by values and by ideological inscription. Third, language is central to the creation of knowledge and meaning. Fourth, mainstream research reflects and reproduces class, race and gender oppression. As Freeman and Vasconcelos (2010) note, systems such as capitalism produce knowledge in a way that obscures their oppressive consequences. CST rejects the tenets of positivism to acknowledge contingencies of truth claims, and recognizes the subjectivity of human experience and the value-laden nature of inquiry. Assumptions about the existence and pervasiveness

of unequal power relations and oppressive structures in society are implicit in these tenets.

Browne (2000) names CST an emancipatory science, in that it shifts inquiry from pure knowledge acquisition to the generation of useful and/or practical knowledge, interruptions of patterns of power, and engagement in transformative processes. Such praxis is one of the goals of this project. As she notes, CST is a theoretical and philosophical orientation to research that “refocuses attention on the socio-political and historical context of health and health care” (p. 36), making it an excellent approach for this project.

Freeman and Vasconcelos (2010) assert that CST is: participatory, through engaging stakeholders in identifying and naming oppression and injustice; pedagogical, in that it utilizes a critical perspective to learn new ways of understanding people’s roles and locations in perpetrating or resisting oppressive structures; and action oriented, focused on contributing to a more just society through the development of new understandings contributing to changes in practice and material conditions. Critical reflection on people’s experiences in everyday practices, grounded in an analysis of how those practices were developed historically and how they are supported in modern systems, provides understanding about ways to move forward to address systemic oppression.

Method

I utilized an ethnographic approach informed by critical social theory for this research project. It is an approach rather than a full scale critical ethnography because I conducted interviews and policy analysis, but not participant observation. It is

ethnographic in that I focused on hospital culture, policies and practices, and attempted to link site-specific findings to the wider societal context and relations of power.

Fetterman (2008) defines ethnography as the art and science of understanding and describing a culture. Cresswell (2007) notes that ethnography is appropriate for describing how a cultural group works, and for exploring the beliefs, values, language and behaviour of that group. Ritchie and Lewis (2003) explain that ethnography provides descriptive accounts detailing ways of life of individuals, groups and organizations in order to understand the conditions of the community being studied. Wolf (2012) refers to meaning making in his definition; “Ethnographers study the processes of sense making that members of cultures use to create the social world” (p. 287). Ethnographers render cultural knowledge explicit by uncovering what the social worlds mean for the people living and working in those worlds.

From Ethnography to Critical Ethnography

Critiques of traditional ethnographies suggest that such an approach fails to describe the complexity of cultures due to neglect of issues of power and dominance. As an alternative, some authors have proposed a critical ethnography. Wolf (2012) describes critical ethnography as “conventional ethnography with political purpose”, one that focuses on issues of power, oppression and struggle in a political, social and economic context (p. 289). Crotty (1998) explains critical ethnography as an examination of culture using political and critical lenses in an attempt to unmask hegemony. A critical approach adds an explicit political focus to ethnographic research, enabling the researcher to examine power-laden social and cultural processes in specific

social sites.

Kincheloe and McLaren (2002) outline the assumptions underlying critical research (including critical ethnography). These include an assumption that inequality exists, that mainstream practices reproduce inequality, that oppression occurs in many forms, and that critical research should engage in social criticism in order to support efforts for change.

Madison (2012) claims that the critical ethnographer “takes us beneath surface appearances, disrupts the status quo, and unsettles both neutrality and taken-for-granted assumptions by bringing to light underlying and obscure operations of power and control” (p. 5). Critical ethnography has the potential to expose hegemonic practices that benefit dominant groups. Madison also discusses the ethnographer’s ethical responsibility to address unfairness and injustice, and in doing so, contribute to “emancipatory knowledge and discourses of social justice” (p. 6).

This project utilized a critical ethnography approach drawing on the tenets, assumptions, goals and ethical responsibility outlined above. Critical ethnography provides a means to examine social and cultural processes surrounding health care for people who use illegal drugs. It provides an opportunity to explore the issues of power, oppression and struggle that are central in the production and reproduction of stigmatizing processes experienced by people who use illegal drugs. Stigmatizing practices at the individual, community, institutional and policy level against people who use illegal drugs can be viewed as instances of structural violence. Critical ethnography has the potential to uncover the links between structural violence at the social level, and how it is embedded in hospital policy and practice.

Finally, critical ethnography aims not only to uncover processes of injustice and inequity, but also to contribute to emancipatory knowledge for the purpose of social change. The findings of this project will, wherever possible, be utilized to increase knowledge and articulate potential means for change. The action imperative in critical ethnography requires dissemination in a range of formats and settings to reach the widest possible audience.

Sampling

People

I utilized a combination of purposive and snowball sampling in order to interview a small group of nurses and managers working in the emergency department of an urban hospital in British Columbia. I anticipated interviewing 5 to 6 nurses and 2 managers. My sampling process was purposive in that, as my interviews progressed, I made a series of strategic choices about who to interview. For example, in the first two interviews, I found that my respondents had very little knowledge about policy guiding their work providing care for people who use illegal drugs, and decided to interview people in policy leadership positions in Mental Health and Substance Use in the health authority in order to understand relevant policy and begin to link policy and practice. Snowball sampling occurred when, during that interview, I learned about a policy review process underway, was given the contact information for the coordinator of that process, and contacted her for an interview.

During these two policy level interviews, further snowball sampling occurred. Both respondents suggested I speak with a nurse from a specialized mental health

emergency service, as people who are dealing with a substance use issue who also may have a mental illness are referred to this service from the regular emergency department.

Policy

The health authority research ethics approval requires a project sponsor. The manager of the emergency department agreed to be this sponsor, and to provide any policy identified by respondents during the interviews. Toward the end of the interview process I met with a staff member delegated by the sponsor to provide this information, who gave me copies of the following documents: *Searching Patients Belongings, Room and Person For Weapons and Prohibited Items; Communicating and Assessing Risk of Violence; Emergency Departments and Opiates Policy*; and *Clinical Institute Withdrawal Assessment for Alcohol Withdrawal*. As discussed in the policy section of the literature review for this project, I obtained the *Mental Health and Substance Use Child/Youth, Adult and Seniors Operating Themes and Priorities 2012-2015* document from the health authority website prior to the interviews.

Recruitment

Ethnographers rely on gatekeepers for access to potential participants (Wolf, 2012). The ethics application for my research required a VIHA sponsor, and the emergency department manager agreed to both sponsor the research and to advertise my project. I also used my networks to advertise the project.

In order to recruit participants I created a poster outlining the project, the goals, what would be asked of potential participants, and information about who I am and how

to contact me (Appendix 1). The emergency department manager posted these advertisements in the emergency department staff room. The manager also offered to include the information in the staff newsletter, so I wrote a short description of the research project for that purpose. I provided a letter of invitation containing a more fulsome description of the project for nurses who respond to my initial promotion of the project (Appendix 2).

During the two interviews with policy leaders they both spoke about the specialized mental health emergency service and the fact that people who use illegal drugs who may also have a mental illness are referred there from the regular emergency department. It made sense to me at this point to approach staff in this service for potential interviews. I was given the contact information for a nurse lead and subsequently conducted an interview. After the interview the respondent sent out an email containing information about and an endorsement of the project to all nursing staff in that program, including an offer to them to use work time for the interview.

When I decided to interview health authority leadership about policy, I contacted a health authority mental health and substance use policy leader, whose name is in the public domain.

With the project sponsor's support I conducted a second round of advertising for additional respondents via email and put new posters up in the emergency department staff room. As well, a nurse friend and colleague who works in a different area of the health authority (she was not a respondent) sent an email to her emergency department colleagues on my behalf. No additional respondents came forward as a result of this additional advertising. My sixth and final interview took place when I met

with a clinical nurse educator in the emergency department who had been assigned to assist me in accessing the policies that were referred to in the interviews. I invited her to participate in the project, and she accepted.

I believe there are two main reasons why recruitment was so difficult. My friend and colleague who works for the health authority, who sent out the recruitment email on my behalf, said that her colleagues reported that the health authority was ‘in chaos’ and were unwilling to participate as a result. As well, a nurse leader reported that the department was very busy and that staff tensions were high. In the end, I conducted four interviews with nurses and nurse leaders, and two interviews with policy leaders.

Interviews

My research process began with interviews. I anticipated an iterative process: interviews providing information about specific policy, and policy review leading to further and more specific interview questions. However, in reality, the interviews provided little information leading to specific policies, with the notable exception of security policy. Considerable confusion existed about whether policy existed (in some cases it did, in some it did not), where that policy ‘lives’, and in what ways it was being developed in the current process. This topic will be explored in depth in the Findings chapter of this thesis.

I conducted face-to-face interviews with two nurses in direct practice, two nurse leaders and two policy leaders. I offered to meet each of the respondents away from their site in order to protect confidentiality, however, the respondents indicated they would like to meet with me on site. In the interviews with nurses and nurse leaders, I sought to understand participants’ experiences delivering acute health care nursing

services, the context in which that care takes place, and the meanings ascribed to their experiences by participants. I also explored participants' knowledge and understanding of the distal and proximal policies that guide and influence their work. In the interviews with policy leaders, I sought to understand the recent history of substance use policy and development, existing substance use policies and the values and beliefs underlying those policies, and the policy development process underway at the time of this study. The two sets of interview questions can be found in Appendix 3 and 4. The questions were suggested in part by the literature review and in part through discussion with the nurse researcher who is a member of my committee. The interviews followed a semi-structured format, starting with a list of predetermined questions. I was attentive to emergent issues and concerns specific to each interview, and asked follow up and clarifying questions to ensure my understanding. Each interview took between an hour and an hour and a half. As the project progressed, I changed and refined the questions. For example, I developed new questions for the policy leader interviews, seeking to learn more about the history of policy development in the health authority, and the current policy process. I did, however, ask some similar questions as those I asked of nurses and nurse leaders, such as questions about current policies guiding nurses' work, and the potential impact of criminalization of drug use on patient care and experiences. During the interviews space was provided for other topics to emerge, to probe for further information, and for participants to expand on their points. I recorded all the interviews with the permission of the participants. I transcribed the recordings after each interview. The transcription process provided the first opportunity to become familiar with the data.

Field Notes

I recorded field notes immediately after each interview, documenting characteristics of the interviews, the setting, and insights about and links between ideas and any other information. As an outsider, a non-nurse, I expected that I would gain new knowledge about the provision of health care and the context in which it takes place, and this certainly proved to be true. I included such knowledge in my field notes, and some of this knowledge is reflected in the findings section of this thesis. I was also surprised by the extent and overlap of my own knowledge of substance use, policy, and barriers to provision of care, and noted examples of these in my field notes.

I used these notes to guide the development of future interviews and questions. For example, early in the interviews the topic of the existence of a culture of stigma in the ED came up. This was a surprise in that it had not come up in my literature review. In subsequent interviews, I asked more explicitly about a culture of stigma. In a further example, quite intense discussions about provision of care for First Nations people took place. Nurses articulated the provision of care for First Nations people as challenging, in part due to patients' expectations of unequal treatment. I decided to add a question about the Indigenous Cultural Competency Course (ICC), which is intended to be required training for all health authority staff. The training was created in response to the Transformative Change Accord: First Nations Health Plan requirement to increase cultural competency within health authorities.⁴ ICC is discussed in the findings and discussion chapters of this study.

⁴ <http://www.culturalcompetency.ca/about-us>

Finally, the field notes were the site of my engagement in a process of self-reflection throughout the data collection, analysis and presentation. I discuss this process in more detail in the section of this chapter titled ‘Strengths and Limitations of Constructivist Research Methods’.

Data Analysis

In this section I describe my use of an interpretive approach to examine the two sets of data, the interview transcripts and the policies, and the relationship between the two. I also describe a problem-posing method for analyzing policy, which I applied to analysis of the security policy.

In my data analysis I utilized interpretive description (Thorne et al., 2004, 1997). This approach provided a means to examine nurses’ experiences providing care for people who use illegal drugs; nurses’ interpretation and enactment of policy; and the impact of policy on their capacity to provide equitable care for people who use illegal drugs. Further, an interpretive approach to data analysis allowed me to focus on the meanings of policies, the values and beliefs they express, and the processes by which those meanings are communicated and read.

An interpretive orientation to data analysis fits the social constructionist approach of this study, in that it acknowledges the constructed and contextual nature of experience, and allows for shared realities (Thorne, 2004). Further, interpretive description “provides a grounding for the conceptual linkages that become apparent when one attempts to locate the particular within the general [and] the state within the process” (Thorne, 2004, p. 3), which fits the dual purposes of this research project: examining the impact of health authority and hospital policies on nurses’ capacity to

provide care in a specific setting, and examining the impact of broader state ideology, policy, and the values of the dominant culture, including societal stigma.

The central question in interpretive analysis is, how is the issue or issues framed by the various players? Policy frames use language to shape perception and understanding and propose action (Yanow, 2000, p. 4). The frames direct attention toward some elements while excluding others. The discussion of different frames for use of illegal drugs is an example: drug use can be framed as a health issue or a criminal justice issue. Action based on the frames will have very different impacts on people who use illegal drugs. The ED security policy discussed in this study, with its frame of criminalization and enforcement, is one such frame. It echoes dominant discourses in federal policy. It also fuels a discourse of blame. Interpretive approaches to policy analysis focus on the meanings policies have for a broad range of stakeholders. The role of the policy analyst is to “map the architecture of debate” (Yanow, *ibid*, p. 12); in this example the debate between health and criminalization approaches to use of illegal drugs.

The purpose of interpretive description in research about the provision of nursing care is, “capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding” (Thorne et al., 2004, p. 5). For the purposes of my project, I hope to also extend understanding about policy, including the role of policy in the provision of care for people who use illegal drugs, and the role of policy in producing/reproducing or reducing stigma.

Interpretive description utilizes inductive analysis and various verification

strategies including concurrent data collection and analysis, and comparative and iterative analysis, to “locate the findings within the framework of the existing body of knowledge...and in locating explanatory factors that might arise from the analysis within that larger perspective” (Thorne et al., 2004, p. 6). Using interpretive description certainly aligned with the existing body of knowledge, and in some cases provided illustrations of existing literature, such as the examples of stigmatizing processes in intake and treatment in the ED.

Fischer (2003) highlights a social constructionism perspective in his discussion of policy analysis, asserting, “the social and political life under investigation is embedded in a web of social meanings produced and reproduced through discursive practices” (p. 13). He names the role of power in policy as a struggle to create and control systems of social meanings. He goes on to explain that organizational structures and strategies, roles and routines form an “‘institutional construction of meaning’ that shapes actors preferences expectations, and experiences (p. 20).” His analysis supports Paterson et al.’s (2007) contention that the structural context of hospitals can foster or prohibit stigmatization of people who use illegal drugs through communication and reporting structures, physical environment, and policies, procedures and protocols of the emergency department and across the hospital.

Examining symbolic representation in policy is key. As Stone (1997) notes, “symbolic representation is a fundamental part of all discourse, political or other, and by conveying images of good or bad, right and wrong, suffering and relief, these devices are instruments in the struggle over public policy” (p. 156). Stone outlines several symbolic devices, one of which seems relevant to this project. Narrative stories,

often unspoken, taken for granted and widely shared, are explanations of how the world works. Understandings, beliefs and values underlie narratives of substance use. An example of a narrative in the findings is that of ‘everyone being treated the same’ (despite considerable evidence to the contrary).

Examining policy as context and analyzing policy is an appropriate task for an ethnographic approach to research. Interpretive analysis can be used to analyze policy as well as interview data; in this approach, policy is part of the data. However, I wanted to apply an additional level of analysis to one particular policy. The security policy was the most impactful ED level policy, for both nurses and patients, and was discussed the most in the nurse interviews. As well, it was, of all the policies, the most clearly articulated. I wanted to understand not only the impact on nurses and patients (which is profound) but also how the “problem” of use of illegal drugs and the relationship with “safety” in the hospital is framed in the policy. In her post-structuralist problem-posing approach to policy analysis, Bacchi (2009) suggests that we are “governed through problematizations rather than through policies” (p. xi), and argues that if we read a policy in a particular way, we can clarify how it implicitly represents problems, leading to particular courses of action. In the case of the security policy, I hoped that this analysis would reveal how people who use illegal drugs, and how the acts of drug use, are problematized. Bacchi proposes six questions to apply to the analysis of policies (2009, p. 2):

1. What is the problem represented to be in a specific policy?
2. What presuppositions or assumptions underlie this representation of the problem?

3. How has this representation come about?
4. What is left unproblematic? Where are the silences?
5. What effects are produced?
6. How has this representation of the problem been produced, disseminated and defended? How could it be questioned?

These questions provided a useful frame to critically examine the assumptions and effects of the security policy, as well as providing the means to question and propose alternatives to this policy. In my analysis I primarily focused on questions 2 and 5.

Coding Data

Madison (2012) describes coding data in critical ethnography as “the process of grouping together themes and categories...accumulated in the field” (p. 43). I immersed myself in the data throughout the process of coding, identifying themes, analyzing and writing, and returning to the data time and again with different perspectives and questions. I hand coded the interviews and policy documents, flagging data elements by jotting down memos in the margins and highlighting possible themes. A thematic approach instinctively made sense to me from early in my process. I utilized a thematic analysis to get at underlying narratives in the interviews and documents. My initial process was inductive, allowing the themes to emerge. Later reviews of the data were deductive, making connections to the themes identified in the literature review. I repeatedly read through each transcribed interview to identify patterns and recurring themes. I moved in and out of the details in an iterative manner, asking ‘what is happening here?’ and, ‘so what?’ A significant part of my work was looking at the relationships between themes, as I found considerable overlap between themes, such as

the range of elements that together produce and reproduce stigma.

Strengths and Limitations of Constructivist Research Methods in Health Research

Ethical Considerations

I followed all regulations relating to research with human subjects, and submitted an application for permission to conduct interviews with human subjects, which was approved after some changes requested by the University of Victoria and health authority review committees. A copy of my research ethics approval is included in Appendix 5.

Before each interview, participants were asked to review and sign a Letter of Informed Consent (Appendix 6). The confidentiality of their information was protected at all times, and I assured complete anonymity in the presentation of my findings. The personal identities of all interviewees have been kept strictly confidential in the analysis and reporting of data. Any written material uses only pseudonyms for each respondent (R1, R2, etc.). The audiotapes from the interviews were labeled only with these pseudonyms, as were the transcripts. Tapes and transcripts were stored separately from any participant information and will be destroyed after this research project is completed.

Beyond the institutional ethics requirements of the university and the health authority, other ethical questions exist. For example, the security policy clearly presents an ongoing ethical dilemma for nurses, and some nurses choose to ‘turn a blind eye’ to possession and use of illegal drugs at the ED. There could be repercussions for nurses if it becomes known they are doing so. As one respondent said when we discussed

choosing not to enact this policy, she could be reprimanded, or potentially lose her nursing licence, hence the importance of confidentiality and anonymity.

Self Reflexivity

Tracy (2010) suggests, “self-reflexive practice moves from early stages of research through negotiating access and trust, data collection, analysis and presentation” (p. 842). She also asserts that ‘good ethnography’ weaves the researcher’s reactions and considerations into the research report. Engaging in self-reflexivity provides a means to render explicit my influences in the project. The research design, process and findings are shaped in part by the worldview and analytical lens I bring to the project. For example, there are clear places where my work in health policy shaped this project. This project did not have a strong policy focus to begin with, but in my choices throughout the project I pushed it in that direction, such as choosing to interview policy-level respondents. Further, my long-standing frustration with this health authority’s reluctance to support harm reduction policy and services resulted in a strong focus in this area in the literature review, interviews, and discussion chapters of this project.

My biases include a belief in the need for drug policy reform, from international narcotic control policies to policies in EDs such as the site of my research. My belief reflects the importance of health, rather than a criminal/enforcement approach to drug policy.

This project is based theoretically in social constructionism, in the belief that people construct and maintain knowledge in everyday social interactions and relationships, and that there is no absolute ‘truth’; rather, reality is understood and

represented in multiple ways as constructed through interactions. It follows that knowledge was mutually constructed in the interview dialogue between the respondents and me.

Social Change

Social constructionism is praxis-oriented, meaning it is a framework for critical reflection for the purpose of transformation: overcoming oppression and alleviating suffering. In order to change dominant ideology and hegemony, it is key to link the production of knowledge to power in the political economy, and to articulate the effects on individuals living at various intersections of oppression, thus connecting individual struggles to issues of power and justice. It is my hope that disseminating the findings of this project will inform change in policy and practice at the ED, hospital and health authority levels, and result in more equitable care and reduced stigma and discrimination for people who use illegal drugs.

Limitations of the Research

As with any study of this kind, there were several limitations. The number of respondents was a clear limitation. Further interviews may have strengthened the existing findings, and perhaps raised other issues not discussed in the interviews I did conduct. While this number of interviews by no means provided data saturation, the interviews certainly provided a range of perspectives that give me a sense of the structural and individual challenges faced by nurses providing care for people who use illegal drugs. The interviews illuminated some of the diversity of understanding of policy, gaps between policy and practice, and the influence and/or lack of policy in the

provision of care. As well, I chose not to employ member checking as a means to strengthen the rigour and validity of my findings, because of the time and resource constraints of this study's respondents. I did, however, utilize peer examination, both informally in discussions about the process, findings and analysis of the data, and by having my work colleagues provide feedback on my work. Finally, the question of confidentiality was challenging in this project—not in the interview process itself, but as I came to write the findings. I strove to find a balance between providing enough information to clarify who is speaking without revealing the respondent's identity.

Evaluating the Research

This project drew on methods for evaluating qualitative research that are most closely aligned with critical social theory and critical constructionism, including rigour, validity, credibility and authenticity. Northcote (2012) describes rigour in qualitative research as “systematic and transparent collection, analysis and interpretation of qualitative data” (p. 106). Attention to the methods, auditability of the data collection and analysis of the data, and reflexivity contributed to achieving rigour in this project. Porter's (2007) definition of validity in qualitative research is useful to this project—he defines validity as “the extent to which research reflects accurately that to which it refers” (p. 79). Peer examination helped to ensure both rigour and validity.

James (2008) discusses credibility in research, suggesting that the data analysis process should demonstrate a clear link between what the participants say and the themes that emerge. Throughout the presentation of my findings I have illustrated each thematic discussion with quotations from participants, provided and analyzed participant narratives, and created a coherent story.

James also discusses the authenticity of research findings. He says, “In establishing authenticity, researchers seek reassurance that both the conduct and the evaluation of research is genuine and credible not only in terms of participants’ lived experiences but also with respect to the wider political and social implications” (p. 49). Examining whether societal stigma about substance use is reflected and reproduced in health care settings through policy, procedures and practice was one of the purposes of this study. Throughout my discussion and analysis of the findings I strove to understand and describe the influence of wider societal norms, policies and practices on the health care setting.

Chapter 4: Research Findings

Structural Violence and Social Suffering

Large-scale, economically rooted social forces of poverty, racism and sexism and other social inequities define structural violence. It structures unequal access to goods and services and impacts the health of affected people. These social forces are reflected in nurses' stories about providing care for people who use illegal drugs and live in poverty. Readers will also see in the data that complex and sometimes subtle forms of racism are present, alongside some degree of awareness of the history of colonization. Intersections of oppression—racism, poverty and gender—are also evident. Structural violence is also apparent in the interviews in discussions of stigmatizing attitudes and language about drug use. As Rhodes et al. (2005) assert, stigmatizing practices can be seen as instances of structural violence contributing to social suffering. In the ED, the effects of structural violence are seen; social suffering is visible. In the next sections of this chapter, I detail how research participants describe and understand the intersecting nature of structural violence with substance dependence.

Poverty and Homelessness: “Treat them and street them”

When asked about the challenges they face in providing care for people who use illegal drugs, nurses talked first and at length about poverty, homelessness and hunger. Nurses witness daily the impact of poverty, homeless, and lack of resources on patients' lives and health. They note that, “there's a huge homeless population that accesses our services on a regular basis” because the ED is located in an inner city hospital (R6).

People who use illegal drugs who are also homeless or unstably housed are part of this population. When asked about the challenges of providing care for people who use illegal drugs, one respondent noted,

It's a little bit more challenging than it is with the average Joe walking through the front door because there's such diverse needs with a lot of this population, um, as opposed to you and I walk in the front door. We have a nice house to go to, we have a car to drive, we have money to buy the medication we need, we have, you know, we have somewhere to go and recover, we can get the bandages, we can, you know? But very often, a certain population anyway, don't have those resources that we have.” (R1).

A second respondent used a population health terms to name this overall lack of resources, saying, “the determinants of health play a massive role” (R5). The social determinants of health⁵ highlighted by respondents are income, social status and environment, specifically housing. It's interesting to note that these comments do not focus on drug use per se, but on the conditions in which people who use illegal drugs live. The nurses demonstrate awareness of the broader issues such as homelessness that impact the lives of people who use illegal drugs.

Nurses understand that, after providing care to patients, they are releasing them to the street where the conditions include little shelter and food. One respondent said simply, “We treat them...and street them”. Another respondent explained: “These guys

⁵ The World Health Organization defines the social determinants of health as the conditions in which people are born, grow, live, work and age.
<http://www.who.int/hia/evidence/doh/en/>

and girls that just have nobody and you know you're discharging them out to the street with the clothes on their back" (R1). R2 gives a specific example, "This is a crippled man with horrific arthritis, he uses a walker...he lives in the park." Nurses and the hospital social worker provide referrals and transportation to shelters, but this is not always a workable solution, such as when patients are banned from shelters, or when people choose to sleep outside rather than in shelters.

The nurses also highlighted the ways in which the health of patients and the capacity to provide treatment for substance use related and other illnesses are impacted by homelessness. For example, "You have people who come in and they have no facilities to come back every day to our clinic and get their IV antibiotics, they have nowhere clean to go to keep their wound clean and dry and let themselves heal" (R1). This respondent also understood that the treatment she is able to provide minimally meets patients' needs. She says "we could do better...if we were able to totally make them comfortable and let them complete their course of treatment, that would be a benefit to everybody, to them particularly but to the rest of us as well. And to the system as a whole." (R2)

Nurses in the ED strive to meet patients' basic needs by providing food and clothing for patients. "The first thing they'll say at triage, I haven't eaten for two days, I want something to eat" (R1). In response, "we give him clean clothes, feed him, give him a bus ticket or a cab. And I've given away my lunch, before" (R1). Another nurse says, "I stuff the bags of homeless people with food, and milk" (R2). A third nurse explains, "The majority of staff here bring in all of their clothes that they don't need

anymore. We have a Red Cross cupboard, we regularly give people clothes to go home” (R6). Nurses do their best to fill needs that are not met by the broader system.

R2 concluded, “That’s what our inner city emergency room has turned into [a provider of social services]. We don’t take care of these people. We shut down needle exchanges, make it difficult for [a downtown social service agency] to operate because it happens to be across the street from a school, not keeping in our minds that if they had a place to go maybe they wouldn’t be shooting up in the playground. Insite, huge controversy in Insite. We need one here” (R2).⁶ Here, the respondent spoke to the lack of state provision of basic resources, to assumptions that services for marginalized people should not be located next to a school, and to resistance to and restriction of the provision of a supervised injection site. In a further discussion about supervised injection services in the city, this respondent went on to say, “It’s not going to happen.” When asked why, she said “[Rich] Bay.”⁷ Because there’s the very, very, very poor and the very, very, very wealthy.” She identified class and poverty as key issues in the provision of harm reduction services for people who use illegal drugs.

When asked about the challenges they face in providing health care for people who use illegal drugs, nurses talked about the structural issues of poverty and homelessness and the impact on the health of their patients and on their own capacity to provide care. Nurses attempt to meet basic needs of patients such as emergency health

⁶ Insite is the Vancouver supervised injection site funded by the BC Ministry of Health and operated by Vancouver Coastal Health Authority in conjunction with Portland Hotel Society. While a preliminary study examining the feasibility of a supervised injection site for the city in which this study took place has been conducted, and several discussions have taken place among stakeholders, the health authority has not taken steps to put one in place.

⁷ Rich Bay is a pseudonym for a wealthy suburb near the hospital.

care, food and clothing in the moment, but are unable to affect change over the longer term for patients.

Questions about Cultural Competence

In each of the front line interviews with nurses and nurse leaders, I asked a question about approaches that they use or are familiar with, including harm reduction, trauma informed practice and cultural safety. In response to the question about cultural safety, three nurses discussed their experiences of and with Aboriginal patients in the ED. The remaining nurse was unaware of the concept of cultural safety and competency. Respondents reflected dominant stereotypes about Aboriginal people. Further, they were not literate in anti-racist, culturally competent theory and practice, and did not understand the importance of this approach for Aboriginal patients including those who use illegal drugs.

This lack of literacy was exemplified in a stereotypical comment when a nurse said, “The vast majority of our homeless population, drug addicted, alcoholics, are First Nations. It’s a statistic, it’s a stereotype, it is what it is” (R2). A second respondent said, “the native population comes in and they're drunk” (R6). Here the nurses reflected dominant discourses about First Nations people. The first respondent later said, “I have a little term that I got into trouble when I used it once, it’s ‘reverse racism’. I’m not racist toward you because you’re Native, you are to me because I’m not...and you’re expecting me to treat you like garbage, so you treat me like garbage first. It happens all the time” (R2). This comment ignores the structural power inherent in the nurse’s Whiteness and in her role as middle class professional. In the face of the health disparities experienced by Aboriginal people (and evident in the literature), and other

disparities such as education and employment faced by Aboriginal people that are both historically and currently perpetuated individually and structurally, the notion of the capacity for 'reverse racism' to be enacted is difficult to accept. The stereotyping of Aboriginal patients and the claims of reverse racism in the nurses stories and assertions about providing care for are two examples of the influence of wider societal claims about Aboriginal people on the provision of care in the ED. I will return to this issue in my discussion section.

Respondents discussed their belief that Aboriginal people come to the ED expecting to be treated badly because of their racialized identity. One respondent said, "People come in with the feeling they're going to be judged, and they're going to have to struggle to get what they want" (R1), while a second respondent said, "They're expecting me to treat them like garbage". She explained, "The vast majority of people who are in that demographic come in, looking through that lens, and only see, you are treating me like this because I'm First Nations." She went on to say, "People have these ideas, because of past experience again, where they're going to have to fight for what they need or they're going to be treated in a certain way, and then one little thing happens and it's like 'well, see, there I told you.'" Both respondents acknowledge that Aboriginal people have had discriminatory and otherwise difficult experiences at the site of health care, which fuels their fears and expectations of being treated badly when they seek care in the present. However, they fail to recognize and acknowledge that a culturally competent approach to care has the capacity to change their own approach and thus the experiences of Aboriginal people.

Indigenous Cultural Competency Course: promoting cultural safety

In 2006, *The Transformative Change Accord: First Nations Health Plan Supporting the Health and Wellness of First Nations in British Columbia* was signed by the Province of BC, the First Nations Leadership Council and the Government of Canada. The Accord was developed with several goals, one of which was to close the health gaps between First Nations and other British Columbians. The Accord contains outcome statements, including the following: “Health services will be more culturally sensitive, better tailored to the specific needs of First Nations communities and more often delivered by First Nations health professionals” (p. 11). One of the means to achieve this goal is the creation and provision of training in cultural competency. The Provincial Health Services Authority developed the ICC in 2007/08. The Core ICC Health Training component is designed for health care professionals working with Indigenous people in British Columbia. The goal is “to improve access to health services and health outcomes for Aboriginal people.”⁸ In a clear policy directive, the Ministry of Health has mandated all ministry and health authority staff take this training, meaning it is one of the policies that potentially impacts nurses’ provision of care for Aboriginal people.

The discussions about the training made it clear that individual and structural barriers to developing cultural competency and an environment of cultural safety in the provision of care for Aboriginal people exist in the ED.

⁸ Accessed at <http://www.culturalcompetency.ca/training/core-icc-health>. January 20, 2014.

Two respondents expressed concerns about the length of time it takes to complete the online course (the suggested time is eight hours). One respondent said, “My issue with that course is that it’s too long. I’m not sure that it’s reasonable to expect general staff to spend that much time focused on one thing...if I did something like that with every single specific population, it would be unmanageable” (R2). Interestingly, this is the same respondent who claimed that the majority of the homeless, substance dependent population who access care at the ED are First Nations people. The second respondent said, “If they could make it a one hour, online learning module, just kind of cover the highlights, then absolutely people would do it” (R1). In addition to this lack of understanding of the importance and potential positive impact of nurses engaging in this training, there are structural constraints on nurses’ capacity to participate. As one respondent described,

Yes, we have ongoing yeah, requirements in the emergency department. You have to keep up with the latest medications and the latest trends and this new hypothermia protocol and this new process of triage and we've got so many new things coming, and so many, like the Gallup surveys they want us to do, and the online things we're required to do. And we need to do our violence prevention for the government and we, you know. It's an eight-hour commitment by itself. So there's a lot of ongoing continuing competencies that we have to keep up with.

Further discussion by this respondent indicated her understanding of the importance of a course (a one hour version) because she wants to know what she needs to be aware of, what she can do differently. And yet, later she said, “But does it take

eight hours to tell me how I can make you feel comfortable in the moment?” demonstrating a lack of awareness of or belief in the need for a longer experience of cultural competency training. Nurses do not have access to information about Aboriginal people nor do they understand the need for sufficient time to gain this knowledge. They also do not have the support of the health authority and hospital to participate in training, despite the mandate.

Intersections: Race, Class and Gender

Intersectionality is defined as the interweaving of oppressions based on multiple and complex social identities/locations that result in marginalization. Two narratives of women seeking health care illustrate some of the complexity of social locations and experience, including class, race, gender and drug use, that are evident in this ED.

One nurse described a story told her by an Aboriginal woman.

I spoke with a woman many years ago...she was telling a story about her experience as the mother of a small child in the emergency department, I can't remember what was wrong with him. He was ten or eleven years old and the nurses, she felt, were naturally assuming he'd gotten into drugs, and he was the way he was because he was under the influence of whatever. And she attributed all of that to the fact she was Native...because she expected that treatment, that's all she saw. That probably wasn't how she was being treated (R2).

This complex moment reflects intersections of race and gender (mothering) in the ED. The nurse telling the story failed to acknowledge that the assumptions about the mother and about her child's condition could have been a reflection of discrimination based on race (and intersecting with gender).

Very little conversation about gender and illegal drug use and mothering took place beyond this story. A respondent gave one possible reason:

Luckily we, not being [another hospital in the same city] I don't deal with that very much. We do get the notices from the Ministry that if a certain person presents and delivers that they're to be notified because the child is to be taken. Um, but, very rarely do we have people with pregnancy related problems come into our emergency department so we don't have to deal with that very often. So I'm not very experienced with that, but that is definitely an issue, because you're not just dealing with yourself then, you're putting somebody else at risk and do we have a right to do that (R1).

The comment about the other hospital reflects the reality that most pregnancy, labour and delivery health care is delivered at that hospital, and not at the site of this study. The respondent touches on the issue of maternal drug use and ethical and political decisions that often attend conversations about the rights of the unborn child. One might ask if a woman would attend the hospital given the threat of apprehension of her child based on her substance use, and what this would mean for her own and her child's health and health care.

An unexpected finding came later in the conversation, when the respondent talked about upper class mothers who use prescription medication.

Probably the most experience I've had with women who have children and addiction issues are kind of, so called, upper class or a higher class Mom who comes in, and they need their oxy [Oxycontin, a prescription pain medication] or whatever it is, or their Dilaudid or whatever it is that they happen to be

taking, but I find that their children are physically well cared for, emotionally I'm not so sure but they have what they need, and these moms, at least have the appearance of being a good mom and taking care of their children.

The resources of middle class women, reflected in children appearing to be “well cared for” make a difference in how they are ‘read’ as mothers in the ED. Because the first story about the Aboriginal mother who brought her ill child into the hospital is only told from the nurse’s perspective, it is important to acknowledge that we have only part of the story. However, at face value, we have two sets of competing assumptions about mothers: an Aboriginal mother whose child was suspected of drug use, and White mothers who, while presenting as potentially dealing with an addiction to prescription drugs, are seen as providing good care for their children. This is not a story of White women being ‘bad’ mothers; rather, it is about differing assumptions based on race and class.

A Culture of Stigma

In the interviews for this project, three respondents explicitly identified the existence of a culture of stigma in the ED. The culture is comprised of individual discriminatory attitudes; a setting that lacks privacy and facilitates stigma; and transmission of the culture through relations of power, significant absences of policy guiding care, and problematic policy.

Early in the interviews, some respondents asserted that, as one person stated succinctly, “Everybody here gets treated the same” (R5), and referred to the health authority vision statement: “Excellent care—for everyone, everywhere, every time” (Vision, Purpose and Values, accessed at http://www.viha.ca/about_viha/vision.htm,

October 4, 2013).

In a lot of respects it's just like providing care for anybody else who walks through the front door. They have a problem and you fix it, that's what we do. We treat people, it doesn't matter kind of what walk of life you come from whether you're off the streets or whether you're the mayor of [Rich] Bay. (R1)

This respondent suggested that everyone who seeks care in the ED is treated the same, and that issues of poverty and homelessness do not impact the provision of care.

Further conversations, however, underscored the reality that people who use illegal drugs are not treated equally. As a policy leader noted, "people who present in emergency rooms who are high on illegal drugs, they may be the population that served least well" (R3). He went on to explain: "while people with psychiatric conditions are seen as people with serious medical conditions, the same progress has not been made with people with substance use." He spoke to the progress made in understanding and framing mental illness, and the subsequent change in attitudes, contrasting it with the lack of progress in attitudes toward and care for those who use illegal drugs.

Two respondents discussed what could be described as a "discourse of blame" and the link to discriminatory attitudes toward people who use illegal drugs. "I think some of it is people think that they bring it on themselves, so, we're going to help the people who need it before you, kind of attitude." (R5) Another respondent clearly articulated a link to stigma: "There's still the stigma, an element of you did this to yourself, it's still very much alive and well within our health services" (R3). A lack of understanding of substance use as a chronic, relapsing illness, compounded by experiences of poverty, is evident in these comments.

A nurse leader addressed one of the difficulties of providing care for people who use illegal drugs.

We don't have an effective way to handle substance abuse... people come in with medical problems and they happen to be people that abuse drugs for whatever reason and whichever drug it is, and obviously if they aren't having access to that medication they're going to withdraw from it, and we have no way to deal with that. (R1)

Here the nurse points to absences in policy and protocol for people who use illegal drugs. I discuss these absences in more detail in the policy section of this study.

The challenge of caring for someone who is experiencing withdrawal from the substance they currently use is complicated by physician attitudes toward people who use illegal drugs. One respondent walked me through what happens when someone who uses illegal drugs comes in to the ED seeking care, and highlighted physician attitudes as a barrier to providing good care.

The other big thing is the physician that they end up the luck of the draw of seeing. Good scenario is you get a physician who isn't judgmental, who is patient and kind of understands some of the issues that go along with addiction. All of our physicians do, but a lot of them are not nearly as tolerant as you would hope. They're quite abrupt and gruff, they dismiss patients quite often, they're like 'Yep, just take your antibiotics and if you'd stop doing such and such behaviour, then you wouldn't have this, there wouldn't be a problem.'
(R6).

In this situation, the physician did provide the necessary antibiotic medication.

However, when it comes to providing pain medication, the outcome is often different.

As one nurse explained, “She [the patient] is going to be in a really bad place because the physician that’s on tonight will not allow me to give her any more narcotic” (R2). A second nurse says that finding a physician open to prescribing pain medication can be very challenging. “The doctors will say ‘they’re just drug-seeking. Whatever. Give them Tylenol. So and so, they’re just ridiculous.’ And they walk away. ” (R6). Given the power inherent in the position of physician, a lack of understanding and tolerance and judgmental attitudes toward people who use illegal drugs on the part of physicians has a significant impact on the experiences of people seeking care, and on their health and wellbeing.

A nurse leader provided insight about how the setting facilitates stigma and discrimination from the moment a person enters the ED. In triage, the point of entry for treatment, the nurses ask “those hard sort of questions in a very open space” including questions such as when was the last time they used drugs, and how long the person has had an abscess (from injecting drugs). As a consequence, “They’re in a waiting room full of people who have already heard their story and now they’re already pinned as the druggie guy in the corner.” A lack of privacy contributes to experiences of judgment. For people who use illegal drugs, in particular those who regularly visit the ED for health care, “they know right off the bat they’re going to be judged on why they are there” (R6).

This respondent also noted that quite a few of regular visitors to the ED are methicillin-resistant *Staphylococcus aureus* (MRSA) positive⁹, and they are segregated to a separate waiting area to minimize transmission. “It isn’t just our drug users that end up down there, but more often than not it is...so that again is another kind of stigma.”

Another respondent also identified the lack of privacy in the ED treatment area as contributing to stigma: “It’s not a very private area. The curtains do not denote sound barriers. You’re asking very personal questions of everyone, and everybody can hear” (R2). A second respondent elaborates; “Privacy is a challenge...if you suspect somebody is using and just want to know before you give them a great big dose of morphine, is there a private place where you can kind of broach that subject, say, “have you used drugs today, have you ever used drugs? Have you used any today, what have you had? I don’t care, I just need to know so I don’t kill you” (R1). While this respondent understands the problems with lack of privacy, she is aware that this specific knowledge about the patient’s substance use can be a matter of life or death.

Lack of privacy also means that the patients overhear judgmental comments by individual nurses. “Staff often forget and they’ll have sidebars about people behind curtains. ‘Oh, yeah, I saw her down on the corner the other day prostituting again, and here she is tonight’” (R2). Another respondent gave a further example: “one person says well this person is just a coke user, you know, then all of a sudden that's what they're labeled as. The coke user in 10.” (R5).

⁹ People with histories of illicit drug use, homelessness or recent incarceration are at highest risk for skin and soft tissue infections with MRSA (Gilbert et al., 2006).

As these quotes make evident, the procedures of triage, and the lack of privacy at both triage and treatment, contribute to experiences of labeling, judgment and stigma.

Transmitting the culture

In addition to individual discriminatory beliefs and behaviour, and lack of privacy in intake and in treatment areas, a culture of stigma is maintained in relationships between nurses, and nurses and physicians. One nurse stated, “There are younger nurses...who just don’t stand up for their own beliefs and bow to the stigma and the culture that’s in the emergency department. It’s a huge culture in the emergency room” (R2). The second respondent also acknowledged the existence of a culture of stigma, though he asserted that “the culture, most of the time, is behind closed doors. That culture is sort of a way to release...because to be around [drug use] is stressful” (R5). He went on to explain his understanding of the development of a culture in which stigma is more the norm: “Those group of people, I don’t what you’d call it, jaded, or if they’ve got this culture of stigma...it does quickly and easily transfer to new nurses. Especially ones that want to fit in” (R5). (R5). Respondents gave specific examples of the ways in which this culture is maintained. “One person says, ‘well this person is just a coke user’ you know, and then all of a sudden that’s what they’re labeled as, ‘the coke user in 10’ or whatever. I’ve heard it here, stigma, phrases of stigma” (R5). Another nurse discussed pressure from her nursing colleagues to change her practice: “There’s a huge stigma that comes in with someone who uses drugs, that’s the bottom line. It makes it very difficult to practice holistically in the way I want to when I have my peers pressuring me, ‘oh, why are you listening to her nonsense? Oh, she’s just looking for, you know, her welfare money has run out” (R2). Judgemental comments, negative

assumptions about why someone might be seeking health care in the ED and peer pressure contribute to a culture of stigma and discrimination.

These stigmatizing judgments and attitudes can have an impact on the health care that people receive. “If they get a nurse like me, hopefully they get their pain control, they're feeling ok. They get one of the older nurses who are not so great, they sit in the corner and suffer, because that's just how it rolls.” (R2).

The attitudes toward people who use illegal drugs are not uniformly negative. For example, a clinical lead said, “I know all the clinical nurse leads treat people with respect. There are a few staff members who you can sort of see that their attitude is not respectful...but due to conformity you need to behave a certain way at work...I've occasionally heard something derogatory or witnessed something that was kind of not really kosher as far as I'm concerned but it's really very rare” (R1). A nurse expressed her own approach: “I don't care who you are or what you want or what you've done with your life, or what decisions you make, I just want to help you with what you need...I'm not here to judge you” (R1).

However, later in the interview, as she discussed the high levels of ED resource use by this population, the same respondent said of nurses, “Everybody has their preconceived notions and your past experience and how you feel about certain people and certain things and it's difficult to just put them behind you and focus on what we need to do right now, what we're doing here.” (R2). Her focus on why people might have judgmental attitudes is clearly at the individual level, though ‘preconceived notions’ can certainly refer to the influence of societal norms. The intersection between

personal beliefs and dominant cultural stories of drug users are important aspects of this study that will be discussed at greater length in the discussion chapter.

Policy as Context

By using interpretive description as an approach, the texts of policies are analyzed as sources of data similar to interview data. Themes found in policies are woven into a discussion of findings in the same way as interview data. I have chosen to approach the exploration of the relationships between policy and practice in a different way. I begin with highlighting the history of substance use policy development in the health authority, then go on to discuss the contested nature of policy, and the challenges of policy implementation. I also go on to analyze policy that was addressed by interviewees, by mostly utilizing interpretive description, but, as discussed in the Method section of this paper, I also draw on Bacchi's (2008) approach to explore the implications of the "security policy". Finally, I examine the impact of policy on practice as articulated in the interviews. I chose this approach in part, because I see value in outlining policy and critically examining it as a first step to understanding the intersections and relationships between policy and practice. As I indicated in the method section of this study, I layered Bacchi's approach to policy analysis on to interpretive description, as I found that this post-structuralist approach facilitated an exploration of how drug users and drug use are problematized in policy and practice.

One policy leader referred at different times to "executive" and "leadership". By this he meant the board of directors for the health authority.

In the interviews the respondents indicated that a considerable amount of confusion and contradiction surrounds policy and the policy development process. I

have attempted to present salient findings as clearly as possible, but the reader will find that the confusion within the health authority system about existing policy, policy development and responsibility for development, and how policy is defined and understood at the board of directors, management and health care delivery levels, is reflected in my discussion of the findings.

History of Policy Development

A policy leader noted that, “structurally, systemically, the development of policy [for substance use services] has been a challenge for us” (R3). He went on to discuss limitations that impact the development of policy.

I think a program needs to develop a certain level of maturity or structure or something to be able to generate policy. And I'm not sure we've been there in the past. And the organization itself has not really provided the programs with clarity and tools to generate policy either. So it's been, I think, we acknowledge that that's been a gap and perhaps in the past we've had things we thought were more urgent focus, to focus on as opposed to policy.

While this participant mentioned limitations regarding readiness at the service delivery (program) level, he focused mainly on the lack of policy knowledge, focus, capacity and interest at the board of directors' level.

And also maybe we haven't had people in leadership positions that have been, kind of, policy oriented individuals so it just hasn't happened. So I would say it's a bit of a lack from an executive, centralized, VIHA perspective because we do have corporate departments on quality, etc. And you'd think they certainly create policy there, and at a high central level.

He also noted that the development of policy “has been a very mysterious process, and consequently it didn’t happen much. How do you get there, how do you do that right?”

Finally, the respondent explained that, “there is...a fair bit of grey area and wiggle room in decision making that’s hard to pin down in a policy, so you want to keep it pretty high level” (R3). As we will see later in nurses’ comments about policy, this ‘high level’ nature of substance use policy fails to provide guidance for front line practice, and is, I suggest, part of what renders so much of policy an unknown for health care providers.

The Contested Nature of Policy

A lack of clarity about what exactly policy *is* compounds policy development. In a conversation about the current review of policy and procedures guiding practice in the ED, a policy leader noted about the existing policy binder that, “this booklet, this significant binder of material was really not policies and procedures per se...it was an operational description...real policy, that wasn’t there.” He defined “real” policy as “anything that’s actually formally approved on the VIHA website” (R3). This respondent went on to say, “clearly policies are critically important, and they need to be understood, what’s a policy, what’s a procedure, what’s a guideline, what’s a protocol, what’s a workflow description. And there does need to be, I’m convinced, I’ve learned this, quite a formal and rigorous process before you say this is actually a policy”. He also addressed legal concerns, “from a court perspective, what policy means is this is a must do. Everyone must do this, this must happen” (R3). The other policy leader

reflected a different understanding, saying that policy is “anything that’s actually formally approved on the VIHA website” (R4).

A nurse leader discussed a definition of policy, one that includes another reference to legal concerns. “How I differentiate it is I think of policy, like these are the things that guide us legally.” (R5). This respondent also addressed the importance of including guidelines for best practice in policy: “We need to do this, this is best practice, this, as far as we know it’s the best possible practice to care for patients appropriately”. He outlined his understanding of how policy, protocol and procedure should be structured, as well as the reality of the current situation. “So I think you have a lot of situations where I know, the way it's supposed to work is, you've got policy, and then all this stuff kind of hangs down from the policy. What you have in reality is a lot of protocol and procedure without a policy up there.” (R5) He articulated an ideal situation, where protocols and procedures are guided by policy, while explaining the reality of lack of guiding policy.

The absence of policy to guide the care of people with substance use problems is acknowledged in the policy level interviews, and, is strongly evident in the interviews with nurses. A policy leader spoke to the potential role of policy in this situation; “ I do think that the development of policy is a very legitimate and a powerful way to shift practice” (R3).

Nurses also reflected on the absence of policy-in fact, aside from the security policy, opiate policy, and alcohol withdrawal protocol, which will be discussed later in this section, nurses were not aware of *any policy* guiding provision of care for people who use illegal drugs. One nurse commented, “I think the biggest problem is that there

are no rules that allow us to treat people how they should be, in my opinion, treated” (R2). This respondent attempted to find relevant policy on the VIHA website during this part of the interview, and was unsuccessful, saying “I don’t see a policy here... but I’m sure there’s gotta be a policy” (R2). Another respondent noted, “we don’t really have an effective way to handle substance use, we have no way to deal with that” (R1). The same respondent said that when she started nursing and then particularly as she stepped into a management position temporarily she found that in many cases there was no policy to guide nursing practice with people who use illegal drugs: “I found in so many cases that there was no policy. I would ask why it is we do x,y,z and it would turn out that was always how it was done.” (R1). Nurses clearly identified policy as a needed and helpful tool for practice.

Impetus for Current Policy Review

The absence of meaningful policy guiding front line practice was not the main driver for the policy review that was underway during the time of the interviews for this study. Rather, the impetus for this work was provided by a number of factors, including a lawsuit against the health authority and the media attention surrounding the incident and subsequent lawsuit; the requirements of WorkSafe BC; the specialized mental health service moving to the main building at the hospital; and the BC Nurses Union concerns about staff safety.

The lawsuit resulted from a bad outcome after a patient was discharged (the respondent was not in a position to supply further details). In a clear link to policy, a policy leader said, “we had this out of date [policy] document that many folks weren't aware of, that really weren't used as policy per se but more as guidelines on how work

happens” (R3). However, again referring to legal issues, he said that from a court perspective, “what policy means is this is a must do” (R3). In this instance, policy was not followed, and a need for clear policy was identified in both the lawsuit and the health authority’s review.

Both WorkSafe BC and the BC Nurses Union have expressed concerns about safety, and demanded policy to protect nurses and other staff. R3 identified this driver as “legal requirements that are governed and monitored outside VIHA”. The need for policy to address staff safety was also identified when the specialized mental health service moved from their separate location to the main building at the hospital. It became clear to the health authority board of directors that, “What came out of that [process] was the need to actually have a policy development framework for mental health and substance use” (R4).

Having highlighted the absence/importance of organizational policy, one might expect the health authority to develop policy at a system level, in the health authority as a whole or within Mental Health and Addiction Services. However, the current project to create a framework for developing policy at the individual program level may well result in a fragmented set of policies across various components of mental health and substance use services.

Policy Implementation

Policy is clearly key to enacting best practices; yet policy documents don’t guide practice unless these become part of an individual or system’s ongoing repertoire of required practice. Therefore implementation or enactment of policy is key. In this

next section I discuss how participants describe their understanding of how policy implementation is managed within the ED context and the organizational overall.

One of the first concerns identified by participants included mechanisms within program areas for implementing policy. As a policy leader articulated, “If you do create governance documentation, they have to be real and living and known by the staff and followed and all that stuff because, why else would you do it, right?” (R3). However, when asked how he will ensure that staff members know about policies, he said, “I don’t think there’s anything really in place.”

He articulated an important question: “And the big thing...which is really in many ways the hardest part, is ok, how do we make this a living, breathing actually impactful document and it doesn’t just disappear on the shelf, which this thing [the specialized services policy] did. It got completely forgotten” (R3). The PES clinical lead echoed this contention, saying, “It was a useless document...no one knew about it, there was no education about it and it wasn’t readily available.” (R5). The first respondent expressed hope that education did and will in the future take place, saying, “Hopefully part of the implementation policy was getting assurance from all emergency rooms, departments and crisis centres that they would make this policy part of their orientation training and their leadership would supervise the policy and make sure it’s happening” (R3). When considering how participants described their lack of knowledge of policies at the service provision level however, it appears that such training is not taking place.

The Role of Policy

One policy leader expressed a belief that the development of clear policy will influence positive change in health care in the ED for people who use illegal drugs. He said, “The development of policy is a legitimate and powerful way to shift practice. Practice could certainly use some shifting in this area” (R3). In particular, he identified policy as a tool for outlining appropriate practice, legitimizing existing practice, and ensuring accountability, in some cases through enforcement.

Along with policy comes accountability, so what is the appropriate way to assess and treat someone who presents in emergency with a substance use related crisis. What is that, let’s spell that out in a way that emphasizes being respectful and all of that, and make that into policy, so that if it doesn’t happen and we do a review and a bad outcome comes then we’ll say, well, why didn’t you follow policy? And people will be held to task for that.” (R3).

He went on to explain the process of accountability as he envision it; “If someone doesn’t do this, there’s actually something to say you know what? This was clear, you knew this, it didn’t happen” (R3). This respondent has faith in policy as significant tool for changing practice and for holding practitioners responsible if policy is not followed. Perhaps surprisingly, no other respondents discussed policy in these terms.

Specific Policies

An exploration of health authority policy, Mental Health and Addiction Program policy and Emergency Department policy for the provision of care for people

who use illegal drugs is a key part of this study. I sought to identify those policies, to understand how policies enable or constrain provision of care, and to understand how policies might foster or reduce stigma and discrimination experienced by this population of patients. In this section of the chapter, I discuss the policies identified in the interviews, and explore the impact of those policies on provision of care. The documents are:

1. *Searching Patients Belongings, Room and Person For Weapons and Prohibited Items* (universally referred to as “security policy” in the interviews with nurses)
2. *Emergency Departments and Opiates Policy*
3. *Clinical Institute Withdrawal Assessment for Alcohol Withdrawal* (which is a protocol, rather than a policy)
4. *Mental Health and Substance Use: Child/Youth, Adult and Seniors Operating Themes and Priorities 2012-2015*

These policies were selected for discussion because they were identified in the interviews. As discussed in the Methods section of this thesis the Research Project Sponsor from VIHA agreed, during the health authority ethics approval process, to provide all policies discussed in the interviews.

9.2.8 P. Searching Patients’ Belongings, Room and Person For Weapons and Prohibited Items Policy.

This policy is universally referred to in the interviews as the ‘security policy’. It is a sub-section of *9.0: Safety Policy*, and can be found in Appendix 7. The document outlines the times and conditions under which patients’ belongings, room (if they are admitted) and person may be searched. Staff must seek consent, except “when there is

an immediate and serious risk to the safety of the patient, staff or others” (p. 2).

There must be reasonable grounds to suspect the person is in possession of a prohibited item. While the policy articulates a commitment to the *Canadian Charter of Rights and Freedoms*, and the *BC Human Rights Code*, where the principles of this policy legitimately conflict, protecting safety and security takes precedence. The list of prohibited items in the policy includes,

Illegal substances/drugs including but not limited to all psychoactive drugs and their derivatives which are used or distributed in a manner prohibited by the *Controlled Drugs and Substances Act* (e.g., cocaine, opiates, and cannabis that have not been prescribed by a physician) and equipment for using drugs such as pipes, syringes and needles that are not part of a treatment plan. (p. 7).

The note at the end of the definition of prohibited items notes that any drug in addition to those described “has the potential to contribute to violent behaviour and jeopardize the security of [health authority] staff and/or the safety of others.” (p. 7).

There are several additional references to violence throughout the policy, and the policy is explicitly linked to policy 9.1.23P, *Communicating and Assessing Risk of Violence*.

When asked about policy that guides respondents’ practice with people who use illegal drugs, security policy was first and foremost in the interviews. Nurses are very clear about the conditions and expectations of this policy. At the same time, they choose, under certain circumstances, to ignore it, turning a blind eye to possession of illegal drugs and sometimes to use of those drugs in the hospital setting. “People are not allowed to use illegal drugs in hospital. As a nurse, if I see you go into the bathroom and I know that you’re going to shoot heroin, I am to call security. Security is to search

you, remove your paraphernalia, get rid of your drugs, and carry on with your day.”

(R2).

A second respondent also discussed her understanding of the security policy:

I'm not sure if it's a written policy, but we are supposed to [report to security when someone has drugs in their possession]. We report to security and then security can escalate it or not escalate it from there. Usually if there's a large amount, somebody drops 20 baggies out of their shirt or whatever, then security apprehends it, they phone the police, the police come and they seize the narcotic or whatever it is, and sometimes they go and talk to the person and issue them a summons, sometimes they don't just depending on the situation. (R1).

A nurse leader also discussed the security process: “We ask someone to give over those items [drug equipment, drugs], they can do it voluntarily or not. If they choose not to, and we have a high suspicion of them having it, then we can ask security to search...as far as I know, they don't give this to police; the police don't charge the person, as far as I know? “ (R5).

However, in practice, at times nurses make decisions that do not follow this policy. After outlining her understanding of the policy, R2 went on to say, “If you were to ask me if I've seen a patient take a syringe full of whatever, I figured, what, heroin, go into the bathroom and inject and I turned a blind eye, I would have to say I did that.” The respondent acknowledged that doing so is against policy, calling her decision “bad”, but articulated clear reasons for doing so. She knew the patient was going to go into drug withdrawal, she was clear that the particular physician that was working in the ED that night would not allow her to give the patient opiates, and that she would have

to deal with the outcome. “I’m looking at the person lying in the bed, writhing in pain, moaning, carrying on, feeling horrible, and I can’t do anything.” In that moment she decided her course of action, “So if she wants to go into the bathroom, and I happen to see her take a little drug kit with her, I might just turn a blind eye” (R2). Later she concluded, “Work would say I should have called security and tell him.”

The second respondent also discussed her approach with people who are carrying illegal drugs: “If it’s one or two bags I’ll tuck it back in their jacket and pretend I didn’t see it, you know the one little thing...pipe or whatever I’ll just tuck it back into their stuff, and, cheerful and dumb.” She had questions: “How do I dispose of it? Can I give it to security and can they pick it up on their way out, you know, things like that. Because really it’s their property whether it’s legal or illegal, it’s their property. Just because they come in here unconscious, do I have the right to remove that from them? Put it in safe keeping with their watch and their rings? Can they pick up their package of whatever on their way out with their watch and ring?” She suggested that drugs could be treated as any other property brought into the hospital by patients. But clearly, because it’s illegal, she chose to approach the situation in a different way. Like the previous respondent, she turns a blind eye, and approaches illegal substances with an attitude of what she names, “cheerful and dumb”. (R1)

R 2 told a story about a difficult patient that illustrates both the challenging patient behaviours that nurses face, and problems posed by enactment of security policy.

The first thing out of this man’s mouth was that he going to rape my virgin ass, because he was full out, boom, like he was just full out. He was in drug

withdrawal, he was having terrific amounts of pain, he was having a personal crisis, and we all had to listen to it...I put him in one of our quieter rooms with a door...and the next thing I know he's got his fricken cook set out. And he's trying to up his Ritalin or whatever the hell it was that he was going to shoot. You know, security sees this, they search him, they take his drugs they take his paraphernalia. Huge escalation, someone who's already so escalated."

Another respondent also discussed a problematic outcome of this approach, "If we know they're injecting and they get interrupted, then it turns into an angry confrontation, and then security is there, and then they're escorted out." (R6).

Clearly this policy creates ethical dilemmas for nurses. They are required to engage security staff when they suspect or become aware of the presence or use of illegal drugs, but as one nurse explained, the decision to do so is a complicated one, saying, "Nurses are there for the betterment of the patient. Is allowing the patient to use drugs the betterment of her? No. Is preventing her from going into drug withdrawal and feeling like she's going to die for the better of her? Yes. So what do you do?" (R2). As discussed earlier, withdrawal from opiates can be a painful and sometimes life threatening experience. In order to ease or prevent withdrawal symptoms, patients leave the hospital and treatment to find drugs, and, as one nurse put it, "they come right back through the emergency room" (R2) in a revolving door of treatment. As well as presenting an ethical dilemma in practice, failing to follow the security policy means that nurses potentially risk their jobs and their licenses: "oh, reprimanded, that could be my nursing license. I'd never tell my manager that I did that" (R 2).

In the following paragraphs I utilize Bacchi's (2012) problem-posing process, "what's the problem represented to be?" (p. 4), in order to examine and problematize the security policy. Bacchi's approach rests on the premise that, "what we say we want to do about something indicates what we think needs to change and how we constitute the problem" (p. 4). I chose this method of policy analysis in order to understand how this policy constructs the meanings attached to the use of illegal drugs and, by extension, the people who use these drugs. This policy provides guidance to hospital personnel on how to conduct a search of a person, and is not explicitly a policy for dealing with use of illegal drugs. However, it clearly reflects the health authority's position that possession of illegal drugs and harm reduction supplies is a criminal matter. The appearance of illegal drug use in a policy meant to provide guidance on conducting searches demonstrates, as Moore and Fraser (2011) assert, "how policy can work to instantiate matters and objects as problems even as it actively refuses to confirm them as such outright" (p. 505). Although all six of Bacchi's questions could be utilized to analyse the policy document, I focus on two of her questions.

What is the problem represented to be?

In this policy, possession of illegal drugs and drug use equipment, including but not limited to drugs prohibited by the federal *Controlled Drugs and Substances Act*, is seen as threatening the safety of staff (first) and patients (second). Although the policy is not clear on this matter, it appears that concerns about patient safety are meant to focus on patients other than the one possessing the drugs. There are numerous references throughout the policy to the potential for violence that arises from the possession of drugs and equipment. On page seven of the policy it states,

Any substance/drug not described above that has mind-altering effects has the potential to contribute to violent behaviour and jeopardize the security of VIHA staff and/or the safety of others (VIHA, 2012a, p. 7).

This risk is also made explicit in another policy *9.1.23 P Communicating and Assessing Risk of Violence*. These references to violence reinforce the representation of people who use drugs as potentially threatening to the safety of nurses and other patients.

Further, drugs themselves are seen as having the potential to contribute to violence without regard for the type of drug, or the drug-using situation. The policy specifically avoids discussion of alcohol, a substance that contributes to violence. The policy also defines the possession of drug using equipment as dangerous despite the fact that this equipment is not illegal, and is in fact potentially part of a harm reduction practice.

What presuppositions or assumptions underlie this representation of the problem?

This policy assumes that drug use induces violence, and that as a result that people who use drugs are a threat to the safety of staff and patients. Further, drug use supplies such as needles are included in the list of prohibited items, and the list of items is directly linked to possession of weapons. The assumption is that supplies are dangerous weapons, and that people who use drugs will utilize supplies for this purpose. Representing drug use as dangerous and capable of inciting violent behaviour serves to justify this assumption, and to support the use of searches by security staff. Although this policy states that the health authority is committed to promoting an environment where human rights are in accordance with the Charter and BC's Human Rights Code, it undermines this commitment with the following statement: "when these principles legitimately conflict, protecting safety and security of all must prevail." (p.

4). The policy assumes that safety trumps rights and that it is acceptable to constrain individual liberty and charter and human rights in the interests of providing a violence-free environment.

What effects are produced?

This policy produces and sustains an environment that actually contributes to health harms. This application of this policy might mean that urgent health care needs may not be met. As one interviewee reported, the police escorted out a patient who attempted to inject drugs in a treatment room before treatment had occurred. The policy also potentially contributes to health harms by forcing people to use drugs circumspectly and in rushed circumstances. Rushed injecting can lead to overdose, bacterial infection and vein trauma. This policy also produces ethical dilemmas for nurses who, as several interviewees reported, are forced to choose between following the dictates of the policy, or providing care that is aligned with the ethics and standards of the nursing profession. This policy undermines efforts to support the dignity of people who use drugs. The policy promotes “search and seizure” as an appropriate response to possession and use of illegal drugs and drug equipment. In this way, it echoes how people who use illegal drugs are treated by other institutional actors, including police. The problem is represented as a risk of violent acts committed by people who use illegal drugs, potentially using drug equipment to do so.

Emergency Departments and Opiates Policy, and Assessment and Intervention for Alcohol Withdrawal.

One of the few policies discussed by respondents was the opiates policy (see Appendix 8). The policy states:

“Why is this policy needed? This policy was developed to help achieve the appropriate use, and avoid misuse, of opiate medications.”

“What is the policy? In general, VIHA’s Royal Jubilee Hospital and Victoria General Hospital Emergency Departments do not provide prescriptions or provide opiates to be used outside of the Emergency Department.” (p. 1).

The policy was developed using guidelines from the BC College of Physicians and Surgeons. These guidelines are supposed to help physicians achieve a balance between optimal pain control and prevention of harms including addiction and overdose. A nurse leader explained how the policy is applied in the ED,

We do have an opiate policy, and opiate prescribing policy in the emergency department of not prescribing opiates, as a general rule. You come in and say I'm on whatever, I'm on morphine, 10 mg, twice a day for my chronic back pain, and I've run out and I can't get in to see my GP, kindness dictates that we have to relieve your pain right now. So we'd probably give you something to take away your pain. So that's really our opiate policy” (R1).

This policy provides guidelines for nurses who are caring for patients who are currently prescribed opiates; it does not apply for people who currently use illegal opiates, such as heroin, or to the non-medical use of prescription opiates. As one respondent noted, “We have nothing for narcotics” (R1). As I indicated earlier, when patients who use illegal opiates request pain medication, the attending physician makes the decision as to the provision of these medications. This can pose problems, because studies on stigma have found that it is difficult to find physicians who are open to prescribing opiates for pain for people who use illegal drugs can be challenging, in part, because these patients

are often perceived as “drug-seeking” rather than possibly having legitimate pain medication needs. The absence of a policy on this matter means that professional discretion will prevail.

A nurse leader also noted that the ED likely needs a withdrawal protocol for illegal opiates.

I think we should have a withdrawal protocol for narcotics, like we have for alcohol (*Clinical Institute Withdrawal Assessment for Alcohol*, Appendix 9). Because it is very helpful, and I mean, granted alcohol is a very serious withdrawal, but so is withdrawal from some narcotics. The opiates, it can be quite serious as well. Some of the other drugs, it's very uncomfortable for people but it's not life threatening like alcohol or narcotics or opiates, but uh I think it would be good to have some sort of withdrawal protocol, even if it was just for opiates. Because that's primarily what people choose. Cocaine and the crystal meth...yeah, it's uncomfortable, I'm not denying that its' not, but you're not going to die. You're not going to have seizures and die or anything like that like you do with alcohol or opiates. (R1).

A second respondent echoed the call for a withdrawal policy or protocol similar to the one for alcohol, commenting that, “we’re a little bit kinder to people with alcohol withdrawal” (R 2). Both respondents suggested that ED should be using medications such as methadone to support patients withdrawing from opiates including heroin. “If we had something like the methadone program or something where this was prescribed as soon as you came through the door, and you were assessed every hour and based on your symptoms of withdrawal you were given a certain amount of methadone” (R1).

Methadone is an opiate substitution treatment used for the immediate treatment of opiate withdrawal, and as a longer-term opiate substitution therapy (Amate et al., 2013).

Mental Health and Substance Use: Child/Youth, Adult and Seniors Operating Themes and Priorities 2012-2015.

Before conducting interviews for this study, I performed a search of publicly available health authority policies that might apply to people using illegal drugs. I identified the above noted policy as a key document because it specifically addressed care for people who use illegal drugs (see Appendix 10). It is one of the few policies to do so. As discussed in the literature review, the principles in this policy address the need to reduce discrimination against people experiencing mental illness and substance dependence. The policy also supports, at least in theory, improving services for people who use illegal drugs, including increasing the capacity of care providers to support this population. Of the six people interviewed for this project, only one person, a nurse leader, knew of and referred to this specific policy. He struggled to identify it, saying “it’s a PDF, or it looks like it’s got a nice little picture on the front” (R5). He went on to say, however, that he wouldn’t call it policy: “I would call it, just like a, more of a mission, values, how we serve, who we serve.”

A policy leader stated in his interview that the health authority has 4 or 5 policies for mental health and substance use. At first he said they were available on the health authority website, but when I was unable to find them we engaged in a lengthy email exchange that concluded with his comment that they are “not related to my area

of interest [meaning me the Researcher], they are about falls, etc.”¹⁰ He did not mention the Operating Themes and Priorities document. This confusion about which policies applied or whether any existed to guide care for people who use illegal drugs was reflected in every interview completed for this study.

Harm Reduction?

As discussed in the literature review, harm reduction refers to policies, programs and practices that aim to reduce the adverse effects of the use of psychoactive drugs. It is an evidence-based and pragmatic approach focused on minimizing injury, disease and death, and emphasizes treating all people with respect, dignity and compassion regardless of drug use. While it is aligned with nursing values and standards, and while opportunities to practice harm reduction occur in a range of settings for nursing practice, societal values and organizational policies and norms can be barriers to the adoption of harm reduction practices.

Harm reduction principles and practice are part of nursing practice at the site of this study. However, there appear to be no policies or protocols to guide this practice, and, while some of this project’s respondents understand harm reduction philosophy and utilize harm reduction practices in the care of people who use illegal drugs, it is neither understood nor applied in any consistent way.

A nurse leader described harm reduction practice in the ED: “It is part of what we do as nurses [but] there’s no real official protocol for it in the emergency department” (R 1). In the specialized service, a nurse leader also reflected the lack of

¹⁰ Personal communication via email, September 10, 2013

knowledge about policy and existing practice: “Harm reduction, maybe not as much as well as we could...without polling all the nurses as to how they do harm reduction strategies, I don’t know. Personally, as a nurse, I didn’t do a lot of harm reduction teaching” (R5). By this he means teaching patients about safer substance use, such as using a clean needle for each injection. A nurse respondent noted that, “I think we absolutely do harm reduction, we may not label it harm reduction” (R 2). This respondent articulated one of the principles of harm reduction, “meeting people where they are at”, and addresses the importance of referrals to services, including the hospital social worker and a not for profit peer support mental health and addiction service.

A nurse leader understands one of the values of harm reduction: “it is a realistic way of trying to establish a relationship...because at least that way they will access our services when they need it” (R 6). This respondent also articulates the referral component of harm reduction services: “we utilize and connect people with the [addiction education and peer support service]”. She also articulated one of the tenets of harm reduction in her discussion, that of ‘meeting people where they are at’.

Some nurses distribute harm reduction supplies: “Yeah, I happily will give saline [clean water for mixing drugs for injecting] and swabs and needles...we are allowed to give out harm reduction supplies” (R 6). A second respondent explained that if a patient has used needles, the respondent will exchange used needles for unused ones and provide alcohol swabs. While this provision of supplies is positive, ‘one for one’ exchange is an old model of harm reduction, discarded because it restricts the availability of a clean needle for every injection, a World Health Organization best practice. In the specialized service, a nurse leader said: “Do we give needles out?

Probably if someone asked, but we don't ask actively" (R5). One respondent has a different understanding of provision of harm reduction supplies: "we don't give supplies out, that's the one thing we don't do. I think we probably should." (R6). It's possible she means not in a formal way, not as a stated practice or guideline.

What became evident in the interviews completed for this study is that the nurses and nurse leaders interviewed for this project practice harm reduction, but don't always label their practices as such. For example, one nurse discussed the practice of establishing a port for daily administration of intravenous antibiotics. She tells patients, "If you're going to use it [for other drugs] make sure you clean it, if you're going to use it flush it with saline afterward" (R6). Here, the respondent articulated a pragmatic approach, one that reflects the harm reduction philosophy and practice of acknowledging and meeting the patient 'where they are at', and providing education about safer drug use.

Clearly the respondents' understanding of health authority policy and best practices for harm reduction, as well as their own front line harm reduction practices, varies widely. This hospital and ED is not alone in its lack of harm reduction policy: as the Canadian Nurses Association (2011) notes, there is often a gap or absence of nursing policies in relation to harm reduction in the majority of health-care settings: "harm reduction policies or programs remain absent from acute care settings" (p. 26), while Rachlis et al. (2009) note that abstinence-based policies in hospital settings are the norm.

Harm reduction is mentioned briefly in the health authority Strategic Plan: "We work with substance abusers to minimize harm to themselves and others. We have a

sobering and assessment centre in Victoria available 24 hours a day, and provide or fund outreach services for homeless people with mental health and addictions problems. We engage them in programs that can lead to healthier lifestyles free of addictions” (VIHA, 2008, p. 7).¹¹ One respondent in this study refers to health authority policy: “Well VIHA has a policy that they will provide [harm reduction supplies], it’s basically downtown and out of the mobile vans as far as I’m aware” (R6). She understands that a broader policy and practice of harm reduction exists at a community level, but not in the ED.

In some cases, respondents set the provision of harm reduction services against the needs of other patients. For example,

I think on the one hand that if people need it, they should get it, so that it will cut down on the crime rate and there’s no risk to them and there’s no risk to the public. But then, how far do you take that? When there’s old people that can’t afford their blood pressure medication, why should someone else get heroin free? So it’s a bit of a dilemma” (R1).

While dispensing harm reduction supplies makes sense to this respondent, the prescribing and dispensing of heroin in the two heroin-assisted medication treatment trials in Vancouver are set against the needs of other patients.

There are sort of ethical things in your mind...the little old men that can’t afford their blood pressure medication so why would this person get harm reduction needles and drugs and everything provided for them. How long can someone abuse the system; why is that allowed? (R1).

¹¹ www.viha.ca

The language of “abusing the system” not only reflects some nurses’ beliefs; it also reflects a broader dominant discourse about people who use illegal drugs.

Chapter 5: Discussion

I began this study with a desire to understand how stigma and discrimination experienced by people who use illegal drugs is produced and reproduced. In my work in harm reduction policy-making, I have encountered individual attitudes, public discourses, and policies and practices at municipal government, health authority and law enforcement levels that perpetuate stigma. I wanted to understand how these forms of stigma were enacted in order to explore ways to counter the stigmatization and marginalization of people who use illegal drugs. My early reviews of the literature led me to understand more about health harms and barriers to health care experienced by this population. The literature also emphasized emergency departments as a place where people who use illegal drugs seek health care, and as a common site of stigmatizing experiences, making an emergency department an excellent place to situate my study. Interviewing nurses helped to ground this study of stigma in hospital policy and practice. This project explored health care provision in the emergency department of an urban hospital for people who use illegal drugs. An examination of health authority and hospital policy, the ways in which nurses understand and enact policy, and how policy impacts nurses' capacity to provide equitable care was central to this study.

The key research questions guiding this project were:

1. What are nurses' perceptions about the care they provide in emergency departments for people who use illegal drugs, and how are those perceptions shaped by policies including harm reduction policies?

2. What are the organizational policies guiding the provision of care for people who use illegal drugs?

In regards to the second question, I also wanted to explore how policies might enable or constrain the provision of care for people who are marginalized by social disadvantage and drugs use, and how policies foster or reduce stigma and discrimination.

This study provided rich data that reflected the literature in regard to structural violence and social suffering. It uncovered a complicated policy context, including history of policy development, the role of policy, questions about implementation, absence of key policy and problematic policy. The findings clearly illuminated the impact of emergency department policy on people who use illegal drugs, and on nurses' capacity to provide equitable care for this population. Finally, a culture of stigma in the ED was uncovered in this study. In this culture, individual attitudes; neoliberal discourses of responsabilization and blame; structural and procedural issues; relations of power, and policy work together to continually reinforce one another in the production and reproduction of stigma.

Class, Race and Gender

The findings of this project reflect and reinforce the literature regarding the effects of structural violence—particularly poverty and racism—on people who use illegal drugs. When asked about the challenges they face providing care for people who use illegal drugs, nurses talked first and at length about poverty, homelessness and hunger. These respondents witness daily the impact of lack of economic resources on patients' lives and health. They understand that they are discharging patients to the street—"treat them and street them"—where the conditions have a profoundly negative

impact on patients' health. They reference the influence of the broader socio-political system's impact on the provision of care, such as public and media contention about the provision of services in the inner city for the most marginalized citizens. The adoption of neoliberal approaches to governance at the provincial level have led to budget cuts in health care, social income assistance, education and housing support, all of which impact the lives and health of people who use illegal drugs and who are otherwise marginalized. The failures of the welfare system and other intersecting systems intended to provide for the basic needs of citizens are evident, and the resources in the emergency department are insufficient to address those needs. The ED could be a point of entry into a larger system of supports—but that system does not exist.

For Aboriginal people, health and health care take place in a context of a historical legacy of colonization and ongoing colonial politics including loss of traditional land, cultural genocide, economic deprivation and impact of residential school and child welfare practices (Browne and Fisk, 2001; Bungay et al, 2010; Culhane, 2009; Mehrabadi et al, 2008; Tang and Browne, 2008). The literature outlines lack of cultural safety and individual and institutional discrimination at the site of health care, and an individual and system failure to acknowledge the context of health and health care for Aboriginal people and to provide appropriate services in response.

The political and ongoing colonizing discourses in the conversations about provision of care for Aboriginal people, for those who use illegal drugs and for those who do not, are expressive of social relations and historical and current conditions that shape nurses' ability to understand the complexity of Aboriginal patients' lives, and

shape how Aboriginal people are ‘read’ and treated in the ED. Nurses acknowledged that Aboriginal people have experienced discrimination at the site of health care in the past, and may come to the ED expecting to be treated in a stigmatizing and discriminatory way. However, respondents expressed frustration in particular instances when Aboriginal people attend the ED with such an expectation. Their lack of understanding about this expectation reflects a failure to acknowledge the impact of racialized individual and systemic discrimination at the site of health care. Their lack of understanding means that they fail to appreciate that when patients expect poor care and present as angry or hostile, they are in fact, enacting a form of resistance to discrimination, albeit one that only functions on a one-to-one basis.

The discussions about the Indigenous Cultural Competency training make it clear that individual and structural barriers to developing cultural competency and cultural safety in the provision of care for Aboriginal people exist in the health care system. Cultural safety focuses on developing awareness of the political and historical forces that affect the health of Indigenous people, with a goal of transforming attitudes, policies and practices in health care (Browne and Fisk, 2001). Individually, nurses talked about “just wanting an overview” to “cover the highlights”. As noted earlier, one nurse suggested an hour-long training, asking, “How long does it take to help someone feel comfortable in the moment?” in a failure to understand that eight hours is in fact very short amount of time to devote to unlearning systemic colonial attitudes and practices. Clearly, nurses fail to understand and value the purpose and content of cultural competency training.

Further, institutional discrimination is reflected in the hospital's and health authority's failure to ensure enrolment in the Indigenous Cultural Competency Training mandated in the *Transformative Change Accord*. The reasons for this failure are complex, such as institutional requirements for nurse training in a number of other areas combined with a lack of staffing resources to free nurses from care provision in order to complete the training. The outcome is the perpetuation of racism by the system's failure to acknowledge the importance of the provision of culturally appropriate care within that system. The ICC training is not a magic bullet; however, there is strong evidence that the training improves the knowledge, skills and attitudes of health care providers, and positively impacts patient satisfaction (Beach, et al., 2005).

For the purposes of this study, intersectionality was defined as the interweaving of oppressions based on multiple and complex social identities/locations that result in marginalization, and that takes place within a context of history, political economy, and race, class and gendered relations. Two narratives of women seeking care at the ED highlighted the ways in which race, class and gender intersect and result in experiences of differential treatment based on identity and social location. An Aboriginal mother seeking care for her child believed that nurses in the ED assumed her child had been using drugs, in part because they checked for drug use, and that this assumption was based on her racialized identity. Given that hospitals are a symbol of a recent colonial past and a site of enacted racism, this is a fair assumption on the mother's part. Further, historical and current experiences with the child welfare system heighten Aboriginal mothers' fears of child apprehension. While this particular case does not involve parental substance use, the impact of racism and the intersection with gender and

mothering is clear. As articulated by Browne and Fisk (2001), “Perhaps the most troubling consequences of the colonial legacy in health and social service sectors are the discriminatory judgements levelled against Aboriginal women as mothers” (p. 136).

This story contrasts with a nurse’s discussion about upper and middle class women who come to the ED seeking opiate pain medication. In this story, these women are read as ‘good’ mothers who take care of their children, in part because their children appear well cared for. I can only speculate at this point, but I wonder if the children appeared cared for because the mothers have economic resources, and if this is the means by which the mothers are judged to be ‘good’. These contrasting stories of motherhood exemplify Link and Phelan’s (2001) contention that the creation of stigma and the capacity to resist it are dependent on social, economic and political power.

Aside from these stories there was little discussion of gender-specific issues, concerns and experiences in the ED. The literature about women and health care reflects the significant barriers to health care for women who use illegal drugs, including attitudes of moralization, stigmatization and criminalization directed at pregnant women; concerns about privacy and disclosure; experiences of child apprehension based solely on drug use rather than child health and wellbeing, and stigma and discrimination at the site of health care, all of which contribute to women delaying access to or avoiding health care services. Given the limited discussion about women in this study, and the robust literature detailing the significant barriers to health care for women who use illegal drugs, I suggest that this finding highlights a gender differential in accessing emergency care in the first place—that women who use illegal drugs access health care far less than men.

Policy

In this study, I sought to identify policies that guide the provision of care for people who use illegal drugs. I also strove to understand how policies enable or constrain provision of care, and to understand how policies might foster or reduce stigma and discrimination experienced by patients who use drugs. I uncovered a complex policy terrain that included an absence of policy to guide provision of care, problematic policy, and high level policy that, while articulating goals of reduced stigma and discrimination and increased capacity to provide equitable care, failed to outline concrete, achievable measures to do so.

As noted earlier, in an interview with one of the policy leaders, he said, “people who present in emergency rooms who are high on illegal drugs...may be the population that is served least well”, and spoke to the potential role of policy in this situation; “I do think that the development of policy is a very legitimate and a powerful way to shift practice.” However, a lack of policy knowledge, focus, capacity and interest on the part of the board of directors hampers the development and implementation of effective policy for the care of people who use illegal drugs. The few policies that do exist fail to provide guidance, reinforce stigmatizing ideas about violence and drug use, or create ethical and professional dilemmas for nurses. As one nurse commented, “I think the biggest problem here is that there are no rules that allow us to treat people how they should be, in my opinion, treated.”

I examined four policies in this study. The *Mental Health and Substance Use: Child/Youth, Adult and Seniors Operating Themes and Priorities 2012-2015* speaks specifically to reducing stigma for people experiencing mental illness and substance

dependence, articulating an aim of “reduc[ing] the negative impacts that result from stigmatization” (p. 3). This document also articulates a goal of improving services for people who experience mental illness and substance dependence by developing strategies to increase the capacity of care providers to support this population. The difficulties with this policy are twofold: first and foremost, the interviews revealed that there is little to no awareness of the policy itself, or its contents, among the study respondents. Second, the policy articulates high-level statements of ideals that are pleasing to read, but are vague and contain no discussion or plans for how these ideals might be achieved. As my interviews with nurses revealed, there is a distinct disconnection between the values expressed in this policy and the actual delivery of care on a day-to-day basis.

The *Emergency Departments and Opiates Policy* applies to provision of opiate pain medication for patients who use prescription, but not illegal opiates. Given the unevenness and uncertainty of provision of pain medication for people who use illegal drugs—often based on judgmental and discriminatory beliefs on the part of care providers—this limitation can result in inequitable treatment. Similarly, there is no parallel protocol to the *Clinical Institute Withdrawal Assessment for Alcohol Withdrawal* for other substances. What this means is that despite clear evidence of patient suffering, nurses do not have guidelines to assist them in caring for patients who are withdrawing from illegal opiate use.

Nurse and nurse leader respondents universally referred to the policy titled *Searching Patients Belongings, Room and Person For Weapons and Prohibited Items* as the “security policy.” Unlike other policies, respondents were well aware of this one.

The interviews revealed that this policy creates ethical dilemmas for nurses. They described being forced to choose between following the rules of the policy (alerting security), or providing what they described as the best possible care for patients, by ‘turning a blind eye’ to substance use in the hospital. Nurses described turning a blind eye so that their patients would not experience unnecessary and painful forms of drug withdrawal, and would, as a consequence, be more likely to stay in the ED and receive treatment. The language of the policy connects possession of illegal drugs to weapons, violence, and questions of safety for staff and other patients. In doing so, it reflects the long-standing criminalization and enforcement focus of federal government policies and strategies on illegal drugs discussed in the literature review. The policy also fuels stigma and discrimination. As discussed previously, labeling people as criminal reduces public concern for and promotes stigma and discrimination against people who use illegal drugs. The policy also criminalizes the possession of harm reduction supplies by including them in the list of prohibited items, even though possession of supplies is not against the law. This policy not only reinforces criminalization, stigmatization and resulting marginalization of drug users, in some cases it can prevent or delay access to needed health care.

The impact of the absence of harm reduction policy in the emergency department is significant. As my literature review and interview data illuminate, this lack of policy means that harm reduction is not understood or applied in a consistent way, and as a result, patients’ harm reduction needs are often not met (Khandor and Mason, 2008). The absence of policy has a significant impact on nurses’ willingness and capacity to provide harm reduction services. As noted by the Canadian Nurses

Association (2011) and Pauly et al. (2007), barriers to adoption of harm reduction practices include organizational policies and norms. Nurses working in settings with no harm reduction policy may feel morally conflicted over their duty to prevent harms associated with substance use (Pauly, 2008) and concerned about legal and organizational censure, as reflected in this study's findings. The absence of harm reduction policy mirrors the absence of this pillar in the federal government's current National Anti-Drug Strategy. This absence also means that provincial harm reduction policy is not reflected in the provision of health care in the hospital. As a result, opportunities to reduce the harms associated with use of illegal drugs are lost.

Stigma and Discrimination

This study's findings of instances of health care providers' judgmental, stigmatizing and discriminatory attitudes and beliefs and negative, stereotypical perceptions of drug users clearly reflect the findings of the literature review (i.e., Bungay et al., 2010; Henderson et al., 2008; Lloyd, 2012; Pauly, 2009). Patients are labeled as "that coke user in bed 10", or "the IDU in curtain 3". Doctors fail to prescribe pain medication, assuming that people are "drug-seeking". Further, attitudes, beliefs and behaviour of health care providers strongly reflected a neoliberal discourse of responsabilization described in my literature review. This discourse assigns blame and responsibility for the negative effects of drug use solely to the individual person who uses drugs (i.e., Lupton, 1999; Pauly et al, 2009). For example, nurses reported that they hear their colleagues make comments such as "there's an element of you 'did this to yourself'" and "if you would stop doing such and such behaviour, then you wouldn't have this...problem". A discourse of responsabilization also assumes and

overemphasizes individual agency with little or no acknowledgement of social and structural forces related to poverty and other inequity. These comments not only overlook the context of people's drug use, but also fail to appreciate the complexity of all choices. A focus on individual choice fuels a discourse of blame and responsibility for the negative impacts of drug use; in turn these blaming comments contribute to a climate of discrimination and disregard for people's needs.

The findings reflect insights in the literature about how the structural context of hospitals fosters stigmatization of people who use illegal drugs. The available resources, physical environment, and policies, procedures and protocols of the emergency department are key forces in the production and reproduction of stigma (Paterson et al., 2007; Mahajen et al., 2008). This study provides clear examples, including procedures at intake that combine personal questions about drug use with a lack of privacy to publicly 'mark' people who use illegal drugs. Other instances of lack of privacy occur in the treatment areas of the ED, and in the relegation of people who have MRSA and who use illegal drugs to a separate waiting room. Policy examples include an absence of policy for people withdrawing from illegal opiates, and a security policy that problematizes drug use at the expense of dignity and care.

The security policy reflects the public safety focus of the federal government's approach to illegal drugs, which directs the majority of resources to enforcement-related efforts. Criminalization of drug use fuels stigma and discrimination; as Hunt and Derricott (2001) point out, "through legislation the state says drug use is a crime and is therefore bad, ipso facto, drug users are bad and rightly stigmatized" (p. 191). Labeling

people as criminal reduces public concern for and promotes stigma and discrimination against people who use illegal drugs.

The finding of the existence of a culture of stigma in the ED was unexpected, as it was not discussed in the literature. Relations of power, not only between patients and health care providers, but also between health professionals, reinforce the culture of stigma. Patients who use drugs are suspect subjects who are not always trusted to tell the truth. Physicians have a great deal of professional power that allows them to make treatment decisions despite the concerns expressed by nurses. At the same time, older more experienced nurses shape the attitudes of new nurses and can inculcate discriminatory attitudes and practices in their younger less experienced counterparts.

This culture of stigma is further reinforced by the existence of a security policy that focuses on people who use drugs as dangerous and violent. At the same time, other policies that would foster a harm reduction approach to care are absent. At the level of the health authority, there is not only a lack of attention to harm reduction and humane policies for people who use drugs, but the security policy contravenes stated provincial policies on harm reduction. The influence of the broader culture through media messaging, as discussed briefly in one of the interviews, also likely contributes to the culture of discrimination in the ED, as health care is set in and influenced by the larger society. Together these forces work to close the ED to change and to practices that would assist people who use drugs to get the care they need.

In this culture of stigma, the factors discussed above work together to continually reinforce one another in the production and reproduction of stigma.

Consequently, interventions at each of these levels are necessary to create change. With this in mind, I provide a series of recommendations in the following section.

Recommendations

In the health authority and hospital realm of influence, policy has the potential to reduce stigma and discrimination for people who use illegal drugs. The *Mental Health and Substance Use Operating Principles* document acknowledges the stigma experienced by people living with addiction issues and articulates an aim of reducing negative impacts resulting from processes of stigmatization. Explicit goals, actions and measures would enable the enactment of the aims of this policy. The document also discusses developing strategies to increase care provider capacity to support this population, and to increase awareness and understanding among health care providers and members of the public. However, it does not articulate any means to do so. While the literature is far from robust, Livingstone et al.'s (2011) review of interventions to reduce stigma related to substance use disorders show promise for creating change at the care provider level, including educational and contact-based approaches for medical students that facilitate interactions with people living with substance use problems. Communication strategies to change the attitudes of the general public also show some promise.

The goal of the Indigenous Cultural Competency Training is “to improve access to health services and health outcomes for Aboriginal people.” In a clear policy directive, the Ministry of Health has mandated all ministry and health authority staff take this training, meaning it is one of the policies that potentially impacts nurses’ provision of care for Aboriginal people. Ensuring that nurses and nurse leaders are

given the opportunity to complete this training during work time will facilitate the development of culturally competent health care providers and will contribute to the development of an environment of cultural safety for Aboriginal patients seeking care at the ED.

The need for and appropriateness of a robust harm reduction policy that articulates a harm reduction philosophy and approach is obvious. The provision of harm reduction services, including distribution of supplies, education about safer use, and supervised injection is within the legal scope of practice for nurses, and consistent with ethical and professional standards. Clear harm reduction policy would address nurses' concerns about moral conflict, ethical dilemmas and legal and organizational censure. The emphasis on treating people with dignity, respect and compassion in a harm reduction approach would go a long way toward reducing the stigma and discrimination experienced at the site of health care.

The existing security policy produces ethical dilemmas for nurses and often results in stigmatizing experiences and inadequate treatment for people who use illegal drugs. While the need to address safety for patients and staff is important, the discourses of criminalization and violence around possession of illegal drugs and harm reduction supplies heighten concerns about drugs and the people who use them. A review of this policy to change the discourse to one that is less inflamed, and to more accurately reflect the legality of possession of harm reduction supplies, in combination with a clear harm reduction policy as discussed above, will both reduce the harms associated with use of illegal drugs, and reduce stigma and discrimination.

Two respondents in this study called for an opiate withdrawal protocol or policy similar to the existing alcohol withdrawal policy. Methadone and other opiate substitution treatment is an evidence-based approach to both harm reduction and treatment utilized in many countries including Canada. I echo the respondents' call for such a policy.

Stigma is a complex, multilayered problem requiring an equally complex and multilayered set of responses. It is a social process, shaped by existing inequalities including race, class and gender. The creation of stigma and the capacity to resist it is dependent on social, economic and political power-indeed, it is evident in this study that those people who use illegal drugs and who are otherwise marginalized by the forces of structural violence are most impacted by stigma. While education and improved policy have the capacity to contribute to reduced stigma and discrimination at the site of health care, interventions such as advocacy, social action and right-based approaches will be necessary to change the culture of stigma within society.

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Appendix 1: Recruitment Poster



ADVERTISEMENT

Health Care Policy & Provision for People Who Use Illegal Drugs

Are you a nurse who provides emergency department health care for people who use illegal drugs? Would you be interested in participating in a research project to enhance the state of knowledge about your work?

The purpose of this research project is to examine health authority, hospital and emergency department policies and how they impact nurses' delivery of care in the emergency department for people who use illegal drugs. I am interested in interviewing you to explore your experiences, the challenges you face, and the role and impact of VIHA and hospital policies and procedures on your capacity to deliver care. If you agree to voluntarily participate in this research, I will ask you to be part of a one-on-one interview of about 1 hour in length.

My name is River Chandler, and I am a Masters student at the University of Victoria. This research is being conducted under the supervision of Dr. Catherine McGregor at the Faculty of Education at the University of Victoria. You may contact her at 250-721-7823 or at email: cmcgreg@uvic.ca. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca) or the VIHA Research Ethics Office (250-370-8620 or researchethics@viha.ca).

Please feel free to call me with any questions you may have about participating in this research. My phone number is 250-888-9805 and my email address is heyriver@shaw.ca.



Appendix 2: Letter of Invitation**LETTER OF INVITATION TO PARTICIPANTS**

DATE

Dear _____;

I am writing to invite you to participate in research a study entitled *Health Care Provision for People Who Use Illegal Drugs* that I am conducting as part of my MA program in the Faculty of Education at the University of Victoria. You are being asked to participate in this study because you deliver care or supervise nurses who deliver care in the emergency department of Royal Jubilee Hospital (RJH) for people who use illegal drugs.

The purpose of this research project is to examine health authority, hospital and emergency department policies and how they impact nurses' delivery of care in the emergency department. To this end, I wish to speak with nurses and emergency department leadership in RJH emergency department, to discover what you might have to say about delivery of care to this population, the challenges that you face, and the role and impact of policy on your capacity to deliver care.

If you agree to voluntarily participate in this research, I will ask you to be part of a one-on-one interview of about 1 hour in length. The interview will be held away from the worksite and on your personal time. Interview location options are: my private home office, your home, or a private meeting space at the University of Victoria. I prefer to audiotape your interview in order to accurately capture your thoughts, however, if you prefer, I will not use audiotape. When I have completed the transcription of your interview, I will also ask you if you want to review the transcript of your interview. All information you provide will be held in the strictest confidentiality and written summaries of this research will not identify you personally. If you agree to participate in this project, you may withdraw at any point and all interview materials will be destroyed. A consent form with additional details will need to be signed, and I will provide you with a copy.

This research is being conducted under the supervision of Dr. Catherine McGregor at the Faculty of Education at the University of Victoria. You may contact her at 250-721-7823 or at email: cmcgreg@uvic.ca. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Please feel free to call me with any questions you may have about participating in this research. My phone number is 250-888-9805 and my email address is heyriver@shaw.ca.

Thank you for considering this request.

Yours sincerely,

River Chandler
Victoria, BC

Appendix 3: Interview Questions (Nurses)

Interview Questions (Nurses)

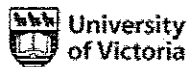
1. Can you tell me about your nursing background? (Education, years of experience, impetus)
2. What drew you to emergency department nursing? How long have you worked in this ED? Other EDs?
3. Can you walk me through what happens when someone who uses illegal drugs comes in to seek care? Is there a protocol?
4. Can you tell me the steps you take to deal with a drug overdose?
5. Can you tell me about your experience delivering care for people who use illegal drugs? Is there anything you find challenging or difficult? Rewarding?
6. In what ways does the environment in which you work affect your ability to respond to those challenges? What helps you to meet those challenges?
7. What do your colleagues say about providing care for this population?
8. What is your understanding of “harm reduction”?
9. What are the main policies that guide your work with people who use illegal drugs? VIHA, hospital, emergency department.
10. Are there emergency department procedures and protocols for people who use illegal drugs?
11. Does your nursing Code of Ethics provide any guidance in the provision of care for people who use illegal drugs? Do you ever experience any ethical or professional conflict in the choices you need to make while providing care for patients who are using illegal drugs?
12. Does the fact that some drug use is criminalized impact attitudes toward or treatment of people who use illegal drugs?
13. Do you think that people who use illegal drugs experience stigma and discrimination in society? In health care? In the emergency department?
14. Is there anything else you would like to tell me about your work with people who use illegal drugs?

Appendix 4: Interview Questions: Manager

Interview Questions (Manager, Assistant Manager, Clinical Care Coordinator)

1. Can you tell me about your nursing background?
2. What drew you to work in your current position (clinical care coordination/management)? Did you work as an ED nurse previously?
3. Can you tell me a bit about the delivery of care in this ED for people who use illegal drugs? What are the challenges and rewards, if any, in this care?
4. In what ways does the environment affect nurses' ability to respond to these challenges? What helps nurses' respond to these challenges?
5. In your supervisory role, what issues do you encounter in the delivery of care for this population?
6. Do people who use illegal drugs come to this ED for other needs (food, rest)?
7. What are the main policies guiding the provision of health care for people who use illegal drugs? VIHA, hospital, emergency department.
8. Are there emergency department procedures and protocols for people who use illegal drugs?
9. Do the nursing Codes of Ethics provide any guidance in the provision of care for people who use illegal drugs? Do nurses in this ED ever experience any ethical or professional conflict in the choices they need to make while providing care for patients who are using illegal drugs?
10. Does the fact that some drug use is criminalized impact attitudes toward or treatment of people who use illegal drugs?
11. Do you think that people who use illegal drugs experience stigma and discrimination in society? In health care? In this hospital emergency department?
12. Is there anything else you would like to tell me about care provision in this ED for people who use illegal drugs?

Appendix 5: Research Ethics Approval



UVic/VIHA Joint Research Ethics Sub-Committee
 Human Research Ethics, University of Victoria
 PO Box 1700, Stn CSC, Victoria BC, V8W 2Y2
 Tel 250-472-4545 Fax 250-721-8960 Web www.research.uvic.ca



Vancouver Island Health Authority, Memorial Pavilion, Kenning Wing
 1952 Bay Street, Victoria BC, V8R 1J8
 Tel 250-370-8261 Fax 250-370-8106 Web www.viha.ca

Certificate of Approval

| | |
|---|---|
| PRINCIPAL INVESTIGATOR: River Chandler | ETHICS PROTOCOL NUMBER: J2013-028 |
| POSITION: Master's Student | ORIGINAL APPROVAL DATE: 28-May-13 |
| DEPARTMENT: EPLS | APPROVED ON: 28-May-13 |
| SUPERVISOR: Dr. Catherine McGregor | APPROVAL EXPIRY DATE: 27-May-14 |
| PROJECT TITLE: Health care policy and provision for people who use illegal drugs | |
| RESEARCH TEAM MEMBERS: Jessica Johnson (Assistance with recruitment, access to relevant policy, VIHA) | |
| DECLARED PROJECT FUNDING: None | |
| CONDITIONS OF APPROVAL | |
| <p>This Certificate of Approval is valid for the above term provided there is no change in the protocol. Extensions or minor amendments may be granted upon receipt of a Request for Annual Renewal or Modification form.</p> <p>Amendments To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.</p> <p>Extensions Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Annual Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol before your expiry date.</p> <p>Project Closures When you have completed all data collection activities and will have no further contact with participants, please notify the UVic/VIHA Joint Research Ethics Sub-Committee by submitting a "Notice of Project Completion" form.</p> | |
| Certification | |
| <p>This certifies that the UVic/VIHA Joint Research Ethics Sub-Committee has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants and the Vancouver Island Health Authority Research Ethics office.</p> | |
| Dr. Rachael Scarth Associate Vice-President, Research | Dr. Louise Costello Acting Co-Chair, Joint UVic/VIHA Sub-committee |

Certificate Issued On: 28-May-13

J2013-028 Chandler, River

Appendix 6: Informed Consent Form



SECTION 3: FREE AND INFORMED CONSENT

Participant Consent Form

Health Care Policy and Provision for People Who Use Illegal Drugs

You are invited to participate in a study entitled “Health Care Policy and Provision for People Who Use Illegal Drugs” to be conducted by River Chandler.

I am a Masters student PhD Student in the Department of Leadership Studies in the Faculty of Education at the University of Victoria. You may contact me if you have further questions by calling 250-888-9805, or emailing heyriver@shaw.ca.

As a graduate student, I am required to conduct research as part of the requirements for a degree in Education (MA). This research is being conducted under the supervision of Dr. Catherine McGregor at the Faculty of Education at the University of Victoria. You may contact her at 250- 721-7823 or at email: cmcgreg@uvic.ca.

Purpose and Objectives

The purpose of this research project is to examine health authority, hospital and emergency department policies and how they impact nurses’ delivery of care in the emergency department for people who use illegal drugs. I am interested in what you might have to say about delivery of care for this population, the challenges that you face, and the role and impact of policy on your capacity to deliver care.

Importance of this Research

This research project aims to provide better understanding of the experiences of nurses in providing care for people who use illegal drugs. It also aims to increase understanding about the role of hospital policies and procedures in the delivery of care for this population, including ways in which policy may foster or reduce experiences of stigma and discrimination for patients.

Very little literature exists that addresses the role of policy in the provision of health care for people who use illegal drugs, and the impact on nurses' capacity to provide care. This study will build on the early work and add to the body of knowledge.

Participants Selection

You are being asked to participate in this study because you provide health care or supervise nurses who provide care in the Royal Jubilee Hospital ED.

What is Involved

If you agree to voluntarily participate in this research, your participation will include an interview of about 1 hour in length. The interview will take place in June or July, 2013, in a private and confidential setting of your choice, at your convenience. The options are a) at my home office b) at your home or c) at an office or meeting room at the University of Victoria. The interview will take place on personal time. While this may create some inconvenience for you, it will further ensure confidentiality. I prefer to audiotape the interview in order to accurately capture your thoughts, however, if you prefer, I will not audiotape but will instead take notes during the interview. I will also ask you if you wish to review the transcript of your interview.

Inconvenience

Participation in this study may cause some inconvenience to you, including taking time from your busy schedule to answer my questions in an interview setting.

Risks

There are no known or anticipated risks to you by participating in this research.

Benefits

The potential benefits of your participation in this research include increasing knowledge about policy and health care in emergency departments for people who use illegal drugs.

Voluntary Participation

Your participation in this research is completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will not be used in any way.

Anonymity

Your personal identity will not be attached to any audio tapes or interview transcripts. When I write up my findings I will not use your personal identity but will provide you with a pseudonym.

Confidentiality

Your confidentiality and the confidentiality of the data you provide are very important to me. Your identity and the data will be protected by the procedures described in the section on Anonymity above to the best of my ability. Given the small sample size, and that it might be possible for co-workers to identify comments originating from a specific participant, there may be some limits to confidentiality. All tapes and interview transcripts will be stored in a locked filing cabinet in a locked office, and all computer data will be password protected. Once this thesis is complete, I will destroy all paper and electronic records and audiotapes. Paper records will be shredded by a BBB accredited shredding company. Electronic records will be deleted and the deleted folder will be emptied. Audiotapes will be unspooled and shredded.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: Thesis, public lectures, journal articles.

Commercial Use of Results

There will be no commercial use of this research.

Disposal of Data

Data from this study will be disposed of in the following ways: audio tapes will be destroyed after the final copy of my thesis is approved by my committee.

Contacts

Individuals that may be contacted regarding this study include myself (250-888-9805, heyriver@shaw.ca) and my supervisor, Catherine McGregor (250- 721-7823, cmcgreg@uvic.ca).

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca), or the VIHA Research Ethics Office (250-370-8620 or researchethics@viha.ca).

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

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix 7: Searching Patients' Belongings, Room, and Person for Weapons and Prohibited Items Policy (Security Policy).



9.0 General Patient Care 9.2 Safety

9.2.BP Searching Patients' Belongings, Room, and Person For Weapons and Prohibited Items Policy

Purpose

There are instances when staff¹ may search a *patients' belongings* and room and *specially-trained staff* may conduct or participate in a *person (body)* search of patients for potentially dangerous items that patients may have brought into *VIHA-operated facilities*. The purpose of this policy and associated procedures is to provide restrictions on the conduct of these searches and a common approach that is respectful of individual liberty and privacy and consistent with Occupational Health and Safety Regulations, the *Canadian Charter of Rights and Freedom*, and the *Human Rights Code of British Columbia*. This policy should be read in conjunction with *Weapons and Prohibited Items in the Workplace Policy, 9.2.6P*.

Scope

This policy applies to all staff and specially-trained staff who are designated to conduct or participate in searches of patient's belongings or rooms or persons in VI HA-operated facilities. This policy does not apply to staff working in patients' homes or in the community.

Policy

Roles In Searching

- 1.1 Programs or services in VIHA-operated facilities must designate, if required, staff to be responsible for seeking *consent* for and searching patients' belongings and rooms for weapons and prohibited items.
- 1.2 Person (body) search processes must be completed by a *team* of specially-trained staff composed of the following :
 - one specially-trained staff member supported by a second specially-trained

staff member and one specially-trained Protection Services Officer (primarily responsible for direct/physical aspects of the person (body) search).

or

- one specially-trained staff member of an *Advanced Team Response* (ATR), who has primary responsibility for the direct/physical aspects of the person (body) search supported by 3 to 5 specially-trained staff who are also ATR members. Staff must take the following action immediately if they observe or are informed of a person acting in a *threatening manner* with a weapon:

- withdraw from the situation calling other staff for assistance if required
- call police (911) and Protection Services (where available)
- inform other staff or others in the vicinity of situation if appropriate
- call the manager/supervisor.

3.4 Staff must not conduct or participate in a person (body) search of a patient unless they have been specially trained to do so.

3.5 Staff must not initiate or continue with a search of patients' belongings or rooms and specially-trained staff must not initiate or continue to participate in a person (body) search of a patient where there is a high *risk* to the safety of staff, the patient, or other person(s) from the patients' behaviour, weapons, or prohibited items until the risk has been mitigated -- that is, until the danger is removed, appropriate safety measures are in place or there is an alternative plan for safely meeting patient care needs.

Consent To Search

3.6 Staff must seek and receive patient consent before conducting a search of a patient's room or belongings.

3.7 Specially-trained staff must seek and receive patient consent before a search of a patient's person (body) is initiated.

3.8 Staff must not seek patient consent to a search of belongings or room and specially-trained staff must not seek patient consent to a person (body) search if that action could increase the risk to the safety of staff, specially-trained staff, the patient, or other person(s).

3.9 Staff and specially-trained staff may search a patient's belongings, room, or person (body) without receiving patient consent only when there is an immediate and serious risk to the safety of the patient, staff, or others.

Criteria For Searching Belongings and Rooms

3.10 Staff may conduct searches of a patient's room and belongings for weapons and prohibited items only if: it is safe to do so and there are *reasonable grounds* to

suspect that a patient is in possession of a weapon or prohibited item and the patient refuses to relinquish the weapon or prohibited item and they have assessed the patient and the situation for potential risks and they have sought and obtained consent to search from the patient and at least two staff members are present and the search is conducted in accordance with the procedures included in this document and program/service-specific procedures and they have completed violence prevention education and training and required, program-or service-specific education and training in searching rooms and belongings

Criteria For Person (Body) Search

Specially-trained staff may conduct or participate in person (body) searches of a patient for weapons and prohibited items only if: it is safe to do so and there are *reasonable grounds* to suspect that a patient is in possession of a weapon or prohibited item and the patient refuses to relinquish the weapon or prohibited item and they have assessed the patient and the situation for potential risks and they have sought and obtained consent to search from the patient and the search is conducted by one specially-trained staff member supported by a second specially-trained staff member and one specially-trained Protection Services Officer (primarily responsible for direct/physical aspects of the person (body) search) **or** by one specially-trained staff member of an Advanced Team Response (ATR), who has primary responsibility for the direct/physical aspects of the person (body) search supported by 3 to 5 specially-trained staff who are also ATR members. the search is conducted in accordance with the procedures included in this document and program/service-specific procedures and they have completed: violence prevention education and training and special training on conducting and participating in person (body) searches and where required, program-or service-specific education.

Required Procedures

Staff and specially-trained staff must follow the procedures in this document (see 5.) for assessing risk, seeking consent to a search, conducting a search, and documenting and reporting information regarding searches for weapons and prohibited items.

Program/service areas that require additional procedures related to searches for weapons or prohibited items must develop such procedures to be consistent with the procedures (see 5.) in this document.

Documentation and Reporting

Staff and specially-trained staff must document the reason for search, the type and manner of search, weapon or prohibited item sought, seeking and/or obtaining patient consent to a search, identity of witness(es) to the search, and whether a

weapon/prohibited item was confiscated, in the health care record and/or patient valuables/belongings record.

3 Principles

VIHA, like other public institutions, has policies that restrict individual liberty in the interests of providing a violence-free environment to protect the safety of all patients, staff, volunteers, and visitors.

VIHA is committed to providing a therapeutic environment that respects and promotes human rights, where individuals are treated with dignity and respect, and free from discrimination and harassment or unreasonable search and seizure, in accordance with the *Canadian Charter of Rights and Freedoms* and BC's *Human Rights Code*.

When these principles legitimately conflict, protecting safety and security of all must prevail.

Required Procedures

In applying this policy to practice, VIHA program/service areas must use the following procedures and, if required, may develop additional program/service-specific procedures that are consistent with and further address the following components.

Risk Assessment

Prior to and throughout any search process, including seeking consent to search, staff and specially-trained staff must assess:
potential risk(s) to both patient and staff safety; this includes the patient's behaviour and possible reaction to a search being proposed or conducted and a weapon/prohibited item being found in the immediate environment to determine availability of other staff/team to assist and to identify potential escape routes and/or means of protection (doors, closets etc.)
capability of the team to safely complete a search

If risk of harm to staff is imminent, call police (911), inform other staff in the vicinity, Protection Service Officers (where available) and manager/supervisor immediately.

See *Weapons and Prohibited Items in the Workplace Policy, 9.2.6P, Procedures, 5.2.1 and 5.2.2*.

Seeking Consent

Staff and specially-trained staff (for person searches) will seek consent from a patient prior to a search of the patient's room, belongings, or person by informing the patient as part of the consent process:

- that weapons and prohibited items are not permitted in VIHA-operated facilities that legal weapons or legal prohibited items must be sent home or relinquished to staff (Protection Services where available) for safekeeping.
- that *illegal* weapons/substances/drugs will be turned over to police (or to Protection Services, where available, until police are arrive)
- that illegal weapons/substances/drugs will be turned over to police without identifying the person from whom they were taken of the reasons for the proposed search of his/her right to ask questions and receive answers regarding the above
- that a patient's refusal to consent to a search may result in the development of an alternative plan for safe care/treatment

5.3 Searching

A systematic search of patients' belongings, room, or person will include:

- begin only after the patient is asked again to voluntarily relinquish the weapons or prohibited items
- be specific to a patient
- be for the sole purpose of discovering weapons or prohibited items
- involve the patient to the greatest extent possible (unless clinical condition or safety of patient/staff does not allow)
- recognize and respect items with *religious, ceremonial, or cultural* significance such as a hunting knife belonging to an Aboriginal person or a kirpan worn by a Sikh
- use a consistent professional approach including a calm, non-judgmental, respectful tone of voice and manner
- be conducted discreetly, least intrusively with the utmost concern for protecting the privacy and dignity of the patient and his/her belongings being searched and the safety of team of staff and specially-trained staff (for person search) involved proceed in a detailed, careful, slow, and systematic way mechanics (for search of belongings or room) be completed by a team of at least two staff with:
 - one staff member conducting the search
 - a second staff member to witness the search process, ensure safety of patient and staff engaged in search process, and to ensure thoroughness of the search or additional staff based on assessed risk
- use a private area (but not isolated/secluded) with a flat surface where belongings are visible to both the staff and the patient

- (for search of belongings or room) may involve Protection Services or police (when appropriate)
- use *parallel-gender* personnel (female/female or male/male) when possible
- involve a staff member who has a good relationship with the patient when possible
- use universal precautions such as wearing gloves/cut resistant (kevlar) gloves or protective clothing
- prevent accidental punctures with sharps by asking first for sharp objects to be relinquished and if found, having the patient remove or handle with care (such as using tongs/cut-resistant (Kevlar) gloves to remove sharps from bags/clothing) and place in cut-resistant container.

For searches of a person (body)

Will be conducted by: one specially-trained staff member supported by a second specially-trained staff member and one specially-trained Protection Services Officer (primarily responsible for direct/physical aspects of the person (body) search) or one specially-trained staff member of an Advanced Team Response (ATR), who has primary responsibility for the direct/physical aspects of the person (body) search supported by 3 to 5 specially-trained staff who are also ATR members.

Team members will witness the search process, ensure safety of patient and staff engaged in search process based on assessed risk, and ensure thoroughness of the search empty pockets from the outside and bottom (never reaching into a pocket), and patting, squeezing, twisting, or crushing clothing. include looking for bulges in bags/pockets/clothing, feeling, or patting down clothing. not include hand-to-skin or hand-under the clothing contact unless it becomes necessary to recover an item during the search of patient

5.4 Documenting and Reporting

Staff/team will report injuries/incidents involving weapons/prohibited items to their manager/supervisor and report/document injuries/incidents as appropriate using the:

Staff Injury Reporting Centre 1. 866. 922.94644

http://www.viha.ca/occ_health/accidents/injury_and_incident_reporting.htm if the incident involves a staff injury or threat of injury.

Patient's health record and the Patient Safety and Learning System, <https://intranet.viha.ca/departments/quality/psls/Pages/default.aspx> if the incident involves a patient or visitor injury or threat or injury, Patient's Valuables/ Belongings Record if a patient's legal weapon/prohibited item has been confiscated

Protection Services should also be notified ProtSvsTeamlr@viha.ca for follow-up documentation on incidents where police have been called.

Definitions

Advanced Team Response (ATR) means the highest level of a Code White Response and consists of a three to five person team response. Team members may be protection service officers or health care providers and must be trained and competent in advanced de-escalation skills and capable of physical containment techniques and strategies. Routine drills and practice sessions are required to ensure staff skills/knowledge are current.

Code White Response means program/site/work area plan to interact with patients or the public to prevent, respond and/or manage violent incidents (Code White). The team responses rely on the principle that personal safety comes first.

Consent means approval or agreement, particularly and especially after thoughtful consideration. Consent may be expressed verbally, nonverbally (through gesture and touch, body language or posture, facial expression and eye contact), in written form or may be implied (inferred from a person's actions and the facts and circumstances of a particular situation).

Illegal Weapons: The possession of firearms and any of the following is prohibited by law:

- a knife or knife-like object with a blade that opens automatically by gravity or centrifugal force or by hand pressure applied to a button, spring or other device in or attached to the handle of the knife (as defined by the *Criminal Code of Canada*) items commonly used as or primarily intended for use as a weapon including *nun chucks* or brass knuckles, clubs/batons
- martial arts devices including throwing stars, nanchuckas, kubatons etc.
- electroshock weapons (e.g., Taser gun) any object that has been improvised or modified to serve or employed as a dangerous weapon as defined in the *Criminal Code of Canada*

Parallel-gender: in the context of a search means a search of a person, room, or belongings conducted by a person of the same gender as the person who is suspected of possessing and refusing to relinquish a weapon or prohibited item. Patient: includes patients, residents, and clients of all ages, not just adults (19 years and older).

Patient Belongings: Patient's personal property including clothes worn on admission.

Person (Body) Search: the search of a patient's body (excluding orifices other than the mouth) and the clothing on the patient's body. A search of a patient's person is a process that includes assessment of hazards and risks, seeking consent

to search, the actual physical search, and follow-up including documentation, reporting, and communication.

Prohibited Items (see also Weapons prohibited by VIHA)

Illegal substances/drugs including but not limited to all psychoactive drugs and their derivatives which are used or distributed in a manner prohibited by the *Controlled Drugs and Substances Act* (e.g., cocaine, opiates, and cannabis that have not been prescribed by a physician) and equipment for using drugs such as pipes, syringes and needles that are not part of a treatment plan.

Legal substances/items brought into a VIHA facility and/or used during care (dependent on clinical circumstances and care requirements). These include: alcohol that is not part of treatment plan; prescribed medications, lighters or fire starters; and syringes and needles except when they are for verifiable personal medical use or are part of the patient's treatment plan.

Note: This list is not exhaustive. Any substance/drug not described above that has mind-altering effects has the potential to contribute to violent behaviour and jeopardize the security of VIHA staff and/or the safety of others.

Reasonable Grounds: is a set of facts or circumstances which would cause a person of ordinary and prudent judgment to believe beyond a mere suspicion. For example, a staff member may have *reasonable grounds* to believe a patient is returning from leave with an illegal drug.

Religious, Ceremonial, or Cultural Items: Examples include sheathed single-edged or curved knives such as: Aboriginal hunting tools or; a Kirpan worn by Sikhs as a symbol of dignity and honour of compassion, kindness and mercy. A kirpan may remain in the possession of a person as per *Canadian Law*, unless assessment of risk indicates the intent to use the kirpan as a weapon. A kirpan is a ceremonial sword or dagger that must be worn by baptised Sikhs at all times; the kirpan is a symbol of dignity and honour, of compassion, kindness and mercy. Sikhs are permitted to wear the kirpan in VIHA-operated facilities unless a risk assessment indicates the intent to use the kirpan as a weapon.

Risk: The possibility of something harmful happening that impacts a person's safety or health.

Risk assessment is a step by step process intended to review a work process, site, or situation to identify potentially hazardous conditions, situations, and conditions that could affect the well-being or safety of staff or any person. Risk assessment is an ongoing process that measures the likelihood (probability) and consequence (magnitude or severity) of exposure; the level of risk (low to high) is determined by analyzing the combined impact of likelihood and consequences.

Search: to examine in order to find a weapon or VIHA prohibited item that may be concealed in a patient's room, belongings, or person. A search is a process that includes assessment of hazards and risks, seeking consent to search, the actual physical search, and follow-up including documentation, reporting, and communication.

Specially-Trained Staff: Staff who have completed violence prevention education and training and VIHA Program/Service training to prepare them to conduct and participate in searches of a patient's person (body and clothing) for weapons and prohibited items.

Staff: health care providers, Protection Service Officers, managers and supervisors employed or contracted by VIHA who have completed violence prevention education and training and, where required, VIHA/program/service-specific training in conducting searches of patient's belongings or room for weapons and prohibited items.

Team: a team of staff (as defined above) working together using violence prevention strategies, to maintain their own and others safety.

Threatening Manner: behaviour that appears to express an intent to inflict harm, injury or pain to another individual. This includes verbal or physically acting out of aggressive or hostile feelings and impulses in a violent or destructive manner.

VIHA-Operated Facilities: Facilities that are owned or operated or funded by the Vancouver Island Health Authority including those associated with VIHA through affiliation agreements.

³ United Sikhs (2011). Kirpan Accommodation in Canada. Feb 2, 2011. Current Kirpan

Violence: Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving a direct or indirect challenge to their safety, well-being or health (Provincial Violence Prevention Curriculum).

Weapon: Anything used, designed to be used or intended for use in causing death or injury to a person or for the purpose of threatening or intimidating a person and, without restricting the generality of the forgoing, includes a firearm (*Criminal Code of Canada*).

Weapons Prohibited by VIHA: Any object or item may be used as a weapon. Staff must take appropriate safety precautions when providing care to patients, in accordance with VIHA's Violence Prevention Curriculum. In addition to illegal weapons, the following are examples of banned, prohibited weapons that may pose risks for patient and staff safety:

- pellet guns, sling shots and catapults

- bows, cross-bows, arrows, darts and box cutters
- explosives or incendiary devices including ammunition, flare guns, fireworks, gas torches, carbon dioxide cartridges or other pressurized gas containers/tanks (except those required for medical care)
- chemical or disabling gases such as mace, pepper or bear spray or caustic material including acids
- objects that could be used to restrain (e.g., ropes, handcuffs, chains)

Program/Service-Specific Procedures/Protocols

Child/Youth and Family Emergency Departments (link)

Mental Health and Addictions (link) Protection Services (link)

References Legislation

Canadian Charter of Rights and Freedoms [http://laws.justice.gc.ca/eng/charter/Human Rights Code of British Columbia](http://laws.justice.gc.ca/eng/charter/Human_Rights_Code_of_British_Columbia)

http://www.bclaws.ca/EPLibraries/bclaws_new/documentUID/freeside/00_9621001

Health Care (Consent) and Care Facility (Admission) Act

http://www.bclaws.ca/EPLibraries/bclaws_new/documentUID/freeside/00_9618101

Firearms Act (Canada) <http://laws-lois.justice.gc.ca/eng/acts/F-11.6/>

Storage, Display, Transportation and Handling of Firearms By Individuals

Regulation (Canada) <http://www.canlii.org/en/ca/laws/regu/sor-98-209/latesUsor-98-209.html>

Freedom of Information and Protection of Privacy Act Province of British Columbia

http://www.bclaws.ca/EPLibraries/bclaws_new/documentUID/freeside/96165_01

Workers Compensation Act (BC):

http://www.bcaws.ca/EPLibraries/bclaws_new/document/D/freeside/96492_00

Occupational Health and Safety Regulation (BC)

http://www2.worksafebc.com/publications/OHS_Regulation/Part3.asp#SectionNumber:3.12

Security Services Act (BC):

Appendix 8: Opiates Policy



Royal Jubilee and Victoria General Hospital
Emergency Departments and Opiates

This handout explains the Vancouver Island Health Authority's (VIHA) Royal Jubilee and Victoria General Hospital Emergency Departments' policy on prescribing opiates for chronic pain.

- **Opiates**—types of pain medication used to treat medium to severe pain. Examples include codeine, hydromorphone, morphine and oxycodone [Percocet].
- **Chronic Pain**—pain that lasts longer than the expected period of healing.
- **Acute pain**—pain that comes on quickly, but lasts a shorter period of time.

Why is this policy needed?

This policy was developed to help achieve the appropriate use, and avoid misuse of opiate medications. It was developed based on guidelines from the BC College of Physicians and Surgeons, American College of Emergency Physicians, and the Canadian Guidelines for Safe and Effective Use of Opiates.

What is the policy?

In general, VIHA's Royal Jubilee and Victoria General Hospital Emergency Departments' do not provide prescriptions or provide opiates to be used outside of the Emergency department. If you have a regular local prescriber or have a prior prescription that cannot be verified, you will not be provided with a renewal prescription.

You and your family or prescribing doctor

Doctors must consider the following when prescribing opiates for non-cancer chronic pain:

- Opiate medications should only be prescribed by one doctor.
- Prescriptions should be based on a thorough first assessment by your family or prescribing doctor. Emergency departments are not able to do this type of assessment.
- Regular follow up is very important to make sure the opiates are helping. This is best done with your regular care provider.



Royal Jubilee and Victoria General Hospital
Emergency Departments and Opiates

You share responsibility for your treatment plan with your family doctor or specialist and therefore you should:

- Make an appointment well before you run out of a medication or if you are using more medication for any reason at all.
- Make sure you have enough medication if either you or your doctor goes on holiday.
- Keep your medications safe to ensure they are not lost or stolen.
- Talk with your doctor about what to do if your pain gets worse for any reason.

The emergency department is not responsible for the above issues and will not refill prescriptions for the above reasons.

Who can help me in the community?

Your General Practitioner is the best resource you can access for your regular prescription. Your General Practitioner can also refer you to the Outpatient Pain Clinic at the Royal Jubilee Hospital.

**If you are struggling with a narcotic addiction contact
BC Mental Health and Addictions Access Information
1-800-661-2121
0900-1600 Monday to Friday**

**For non-emergency health information and services:
HealthLinkBC – health information you can trust 24/7
Tel: 8.1.1 from anywhere in BC.
Tel: 7.1.1 for deaf and hearing impaired assistance (TTY)
Web: www.HealthlinkBC.ca**

Appendix 9: Alcohol Withdrawal Policy



Withdrawal Assessment for CIWA - Ar

(Clinical Institute Withdrawal Assessment for Alcohol Scale Revised)

Page 1 of 2

| | | | | | |
|---|--|--|--|--|--|
| <p>Scoring: Score 0 for normal findings Score 1 for mild symptoms to 7 for severe symptoms Date and time :</p> | Assess and score each parameter as indicated | | | | |
| <p>Nausea And Vomiting 1 mild nausea with no vomiting 4 intermittent nausea, dry heaves 7 constant nausea, frequent dry heaves and vomiting</p> | | | | | |
| <p>Tremor Arms extended, fingers spread apart 1 not visible, but can be felt finger tip to finger tip 4 moderate with arms extended 7 severe, even with arms not extended</p> | | | | | |
| <p>Paroxysmal Sweats Observation 1 barely perceptible sweating, palms moist 4 beads of sweat on forehead 7 drenching sweats</p> | | | | | |
| <p>Anxiety "Do you feel nervous?" Observation 1 mildly anxious 4 moderately anxious, or guarded no anxiety is inferred 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions</p> | | | | | |
| <p>Agitation Observation 1 somewhat more than normal activity 4 moderately fidgety and restless 7 paces back and forth during most of the interview or constantly thrashes about</p> | | | | | |
| <p>Orientation Ask, "What day is this? Where are You? Who am I?" 1 disoriented for date < 2 days 2 disoriented for date > 2 days 3 disoriented for place or time 4 disoriented for place and time</p> | | | | | |

see over to complete

Withdrawal Assessment for CIWA - Ar

(Clinical Institute Withdrawal Assessment for Alcohol Scale Revised)

Page 2 of 2

| | | | | | | |
|---|---|--|--|--|--|--|
| <p>Scoring: Score 0 for normal findings Score 1 for mild symptoms to 7 for severe symptoms Date and time</p> | <p>Assess and score each parameter as indicated</p> | | | | | |
| <p>Tactile Disturbances Ask "Do you have any itching, pins and needles sensations, burning, numbness or feel bugs crawling on or under your skin?" Observation 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p> | | | | | | |
| <p>Visual Disturbances Ask " Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things that you know are not there?" Observation: 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p> | | | | | | |
| <p>Headache, Fullness in Head Ask " How severe is your headache on a scale of 0 – 7?" 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe</p> | | | | | | |
| <p>TOTAL CIWA – Ar SCORE Maximum possible score 60</p> | | | | | | |
| <p>Rater's Initials</p> | | | | | | |



PHYSICIANS PREPARED
ORDERS
SOUTH ISLAND REGION

| | |
|--|---------------------------|
| TITLE | ALCOHOL WITHDRAWAL |
| PHYSICIANS QUALIFIED TO USE ORDERS | ALL |
| * Elder friendly - if patient 75 years or older | |

NOT FOR USE IN THE PRESENCE OF STROKE, HEAD INJURY OR PSYCHOSIS.

1. Electrolytes albumin creatinine
 Ca⁺⁺ INR glucose
 Mg⁺⁺ total bilirubin amylase
2. Repeat electrolytes and _____ in a.m.
3. Bed rest DAT seizure precautions
4. I.V. KCl _____ mmol/L in _____ at _____ mL/h x 48 h.
5. Thiamine 50 mg p.o./I.V. once daily x 3 days
6. Multivitamin suspension 10 mL p.o./NG once daily x 3 days
7. Dimenhydrinate _____ mg p.o./I.V. q6h prn nausea
8. HS sedation _____ (hold if drowsy)
9. Notify MRP if there is an increase of 10 or more points between checks.
10. Diazepam **OR** * Lorazepam (if patient greater than age 65 or has significant underlying liver disease).

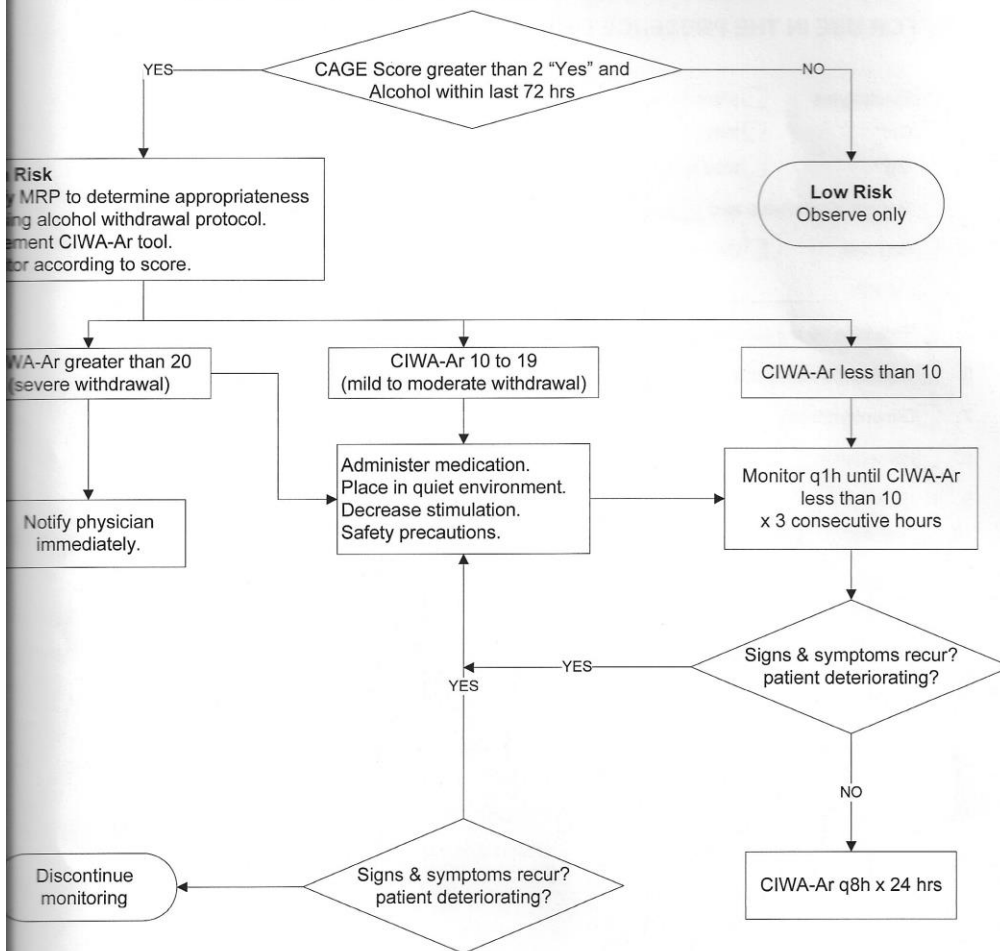
| CIWA – Ar Score | Diazepam | Lorazepam | Reassess |
|-----------------|------------------|---------------------|------------------------------|
| 0 - 9 | No medication | No medication | q1h x 3 then q8h x 24 hrs |
| 10 - 19 | 10 mg po /IV q1h | 2 mg po /sl /IV q1h | q1h until score less than 10 |
| 20 or greater | 20 mg po /IV q1h | 4 mg po /sl /IV q1h | q1h until score less than 10 |

11. Haloperidol 5 mg p.o./I.M. q1h prn for hallucinations (to maximum of 25 mg/24 h).
Notify physician if symptoms not controlled by doses indicated.

_____ DATE

_____ SIGNATURE

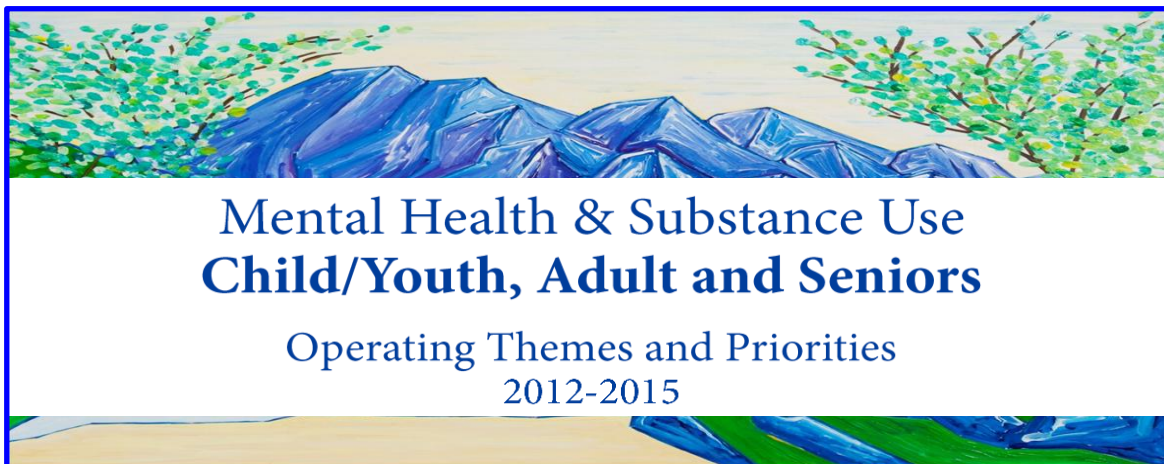
Assessment & Intervention for Alcohol Withdrawal



NOTE:

1. Assess for other contributing causes. eg. Fluid and electrolytes, hypoglycemia, CVA.
2. Notify MRP if there is an increase of 10 or more points between checks.

Appendix 10: MHSU Operating Principles



Artist: Paul Foreman
(participant in VIHA's art capacity program)

The Vancouver Island Health Authority's (VIHA) Mental Health and Substance Use program has three focus areas and priorities for patients, families and health care providers over the next three years:

Improved Access to Care for Patients:

VIHA wants patients to experience clear, transparent access to our programs, as well as smooth transfers between our child, youth, adult and seniors services. Specific priorities include:

- *Ensuring appropriate clinical use of services and effective patient flow:*
 - Implement the Riverview Hospital redevelopment at Seven Oaks, Cowichan Lodge and the Nanaimo Regional General Hospital's Psychiatric Intensive Care unit.
 - Establish a standardized, transparent process to support patients' access to regional and provincial tertiary mental health services.
 - Enhance the capacity of child and youth crisis and stabilization services at Victoria General Hospital.
 - Develop and implement a plan for the recruitment and retention of Pediatric Psychiatrists.

- Develop a plan to address residential treatment needs of youth with complex needs in conjunction with the Ministry of Children and Family Development (MCFD)
- *Strengthening preventive mental health and substance use services:*
 - Collaborate with Divisions of Family Practice to strengthen and standardize the role of community physicians in providing primary mental health and addiction services.
 - Enhance the delivery of multi-level suicide risk management education to VIHA staff, aboriginal communities and community partners.
 - Provide information to adolescents on tobacco cessation, including access to nicotine replacement therapy.
- *Improving mental health and wellness of Aboriginal populations:*
 - Continue to partner with the First Nations' Health Council to identify and implement common and shared priorities.
 - Identify and implement shared educational opportunities between VIHA and First Nation/Aboriginal contracted agencies.
 - Partner with the Ministry of Health on implementing VIHA's Aboriginal Health Plan.
- *Improving mental health and wellness of hard to serve populations:*
 - Develop and implement an integrated service delivery model to engage homeless and street-entrenched individuals with community health services.
 - Develop comprehensive strategies to reach the hard to serve population.
- *Responding to the aging population demographic:*
 - Assess and improve caregiver support strategies, including strengthening community partnerships.
 - Improve the ability to manage complex age-related medical co-morbidities and frailty.
 - Enhance the capacity of residential care facilities to support clients with mental health and addictions disorders.
 - Support evidence-based mental health practices focusing on person-centered program criteria based on cognition and function rather than age.
- *Improving the mental health and wellness of child and youth populations:*
 - Develop processes that identify children and youth who are impacted by parental mental illness and substance use and provide community-based services to respond to these issues in partnership with VIHA's adult Mental Health and Addictions Services (MHAS), MCFD, the Ministry of Education and public health services,

Integrate Services Across the Continuum of Care and Reduce Stigma:

VIHA recognizes mental health and substance use services must work closely together to support seamless transitions when patients move between services as their care needs change. This integration is important both within VIHA MHAS services as well as with family physicians and specialists.

Stigma is experienced by people living with mental health and addictions issues, their family members and among care providers and VIHA aims to reduce the negative impacts that result from stigmatization.

Specific priorities around integration and reducing stigma include:

- *Strengthening the integration of primary care with secondary and tertiary care:*
 - Develop a plan to enhance integration of secondary and tertiary services in the community; for example through the expansion of Assertive Community Treatment teams and collaborative practice initiatives.
 - Support the development the mental health component of the collaborative maternity care clinic in Victoria.
- *Strengthening the integration of services across regions and levels of care:*
 - Define the scope, roles and responsibilities of VIHA's Child, Youth, Adult and Seniors mental health programs, considering function, developmental disabilities and diagnosis.
 - Integrate advance care planning into clinical practice.
- *Improve patients' access to services by reducing mental illness- and addiction-related stigma:*
 - Develop strategies to increase the ability of primary care and direct service providers to support clients with mental health and substance use issues.
 - Improve accountability for clinical effectiveness, efficacy, and flow.
 - Increase awareness and understanding among health care providers and members of the public.
 -

Strengthen Accountability and Quality:

VIHA wants our programs and services and our individual health care providers to follow best practices and the latest standards and approaches. Specific priorities around accountability and quality include:

- *Improving accountability for clinical effectiveness, efficacy, and flow:*
 - Develop and implement an evidence-based accountability framework to support clinical outcome measures in the areas of efficacy, utilization, flow and cultural safety.
 - Explore LEAN approaches for Child, Youth and Family Mental Health and Substance Use Services.
- *Improving the quality and safety of services:*
 - Review the quality of mental health and addictions services in relation to evidence and best practice.
 - Expand and further integrate Trauma Informed Practice Guidelines across Older Adult Mental Health, Child, Youth and Family

Mental Health and Youth and Family Substance Use services in partnership with Adult MHAS.

- *Strengthening internal and external partnerships:*
 - Increase the use of technology to access specialists' expertise.
 - Continue to apply the existing Memorandum of Understanding between Ministry of Children and Family Development and VIHA to collaborative practices, including transitional protocols, integrated planning and training opportunities.
 - Strengthen real-time feedback mechanisms for patients and their families, physicians and staff.

Develop additional strategies to optimize client informed decision making, and engage families as partners.

- *Improving engagement of Mental Health and Addictions staff and physicians:*
 - Identify and implement priorities to improve psychological safety in the workplace.
 - Maximize the use of VIHA's research capacity.
 - Enhance the Centre on Aging and Continuing Health Services (COACH) research partnership.