FRAMEWORK FOR REACTION

FRAMEWORK FOR REACTION: THE POLITICS OF EVALUATING NORTH AMERICA'S FIRST SAFE INJECTION SITE

By

SUSAN JOAN STERLING, B.A., B.S.W.

A Thesis

Submitted to the School of Graduate Studies

in Partial Fulfilment of the Requirements

for the Degree

Master of Social Work

McMaster University

© Copyright by Susan Joan Sterling, August 2005

MASTER OF SOCIAL WORK (2005)

McMaster University
Hamilton, Ontario

TITLE: Framework for Reaction: the politics of evaluating North America's first safe injection site

AUTHOR: Susan Joan Sterling, B.A., B.S.W. (McMaster University)

SUPERVISOR: Dr. Donna Baines

NUMBER OF PAGES: v, 66

ABSTRACT

Program evaluation is inherently political, and the evaluation of a state-sponsored injection site for drug users especially so. Stakeholder analysis is one element of a comprehensive evaluation, one that usually takes place after the program has been in operation for some time. In the case of the City of Vancouver's decision to establish such a site, it was clear that there was already stakeholder opinion prior to the opening of the site. This study examines pre- and post-trial stakeholder opinion by reviewing media and other accounts of the pre-trial public debate, and by interviewing six major stakeholders eight months into the trial. Special attention was given to the issue of how to include the voice of a marginalized population in a stakeholder analysis, and four principles were proposed as a means to guide the stakeholder analysis piece of the initial evaluation of this highly controversial initiative.

ACKNOWLEDGMENTS

Researching and writing this thesis has been a great privilege; it has also been one of the most difficult things I have ever done. I do not believe I could have successfully completed it without the direction and support I received from my űber-advisor, Dr. Donna Baines. On the home front, the encouragement, support and prayers of my father, sister and friend Mal were lifesaving. Thank you all!

TABLE OF CONTENTS

Introduction 1

Literature Review 6

Methodology 18

Findings 21
- Overview of respondents' views and positions
- Critique and analysis
- Implications for the stakeholder approach to an evaluation of Insite

Conclusion 45

Bibliography 48

Appendix A 60

Appendix B 61

Appendix C 63

Ethics Certificate 66

Introduction

On May 15, 2001, Vancouver City Council voted unanimously to adopt a multi-faceted strategy aimed at addressing the drug problems of its Downtown Eastside (DTES) neighbourhood (*A Dialogue on the Prevention of Problematic Drug Use,* 2004). The details of this strategy were presented in an 84-page document entitled "A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver" (MacPherson, 2001). The four pillars that the city committed to focus on are prevention, treatment, enforcement, and harm reduction. This paper will focus on Insite, the safe injection site (SIS) that was created under the harm reduction pillar.

Harm reduction is a newer approach to the negative outcomes related to injection drug use, most notably the high rate of HIV and Hepatitis C transmission (Erickson, Riley, Cheung and O'Hare, 1997). Its focus is on reducing the impact that intravenous drug use[1] has on both the user and on the community (MacPherson, 2001), rather than on attempting to reduce or prohibit use. A significant amount of controversy usually erupts whenever a harm reduction approach is considered. Some worry that any harm reduction initiatives (such as a

[1] 'intravenous drug use' as used throughout this paper refers to the injection of illicit drugs, usually heroin or cocaine

needle exchange or condom distribution) signals that deviant, anti-social behaviour is approved of and will be facilitated. Some groups fear that unwanted activities will not be discouraged, and that individuals from outside the neighbourhood will be drawn to the operation, increasing unwanted activities and criminal behaviour.

The proposal to consider establishing a SIS ignited a stream of controversy in Vancouver as some local businesses and a significant portion of the Chinatown community (Chinatown borders the DTES) argued that establishing such a site would only increase their community's already significant problems. These parties waged demonstrations, issued press releases and circulated petitions. The parties that were in favour of the site (Vancouver City Council, the Vancouver Police Department, Vancouver's public health authority, and the grassroots user organisation known as VANDU - Vancouver Area Network of Drug Users) also issued press releases, and VANDU staged demonstrations as well. Nevertheless, on September 22, 2004, Insite, North America's first safe injection site, opened its doors. Interestingly, the site is not officially known as a 'safe' injection site, which is how such sites are usually referred to, but rather has been designated a 'supervised' injection site.

The federal, provincial and municipal representatives involved in the development of the site have been careful to describe the initiative as a pilot project only. The media release crafted for the opening of the site stated that

> "the goal . . . is to assess whether the SIS . . will reduce the harm associated with injection drug use to individuals and the community.

> Researchers will examine if it reduces overdoses, improves the health of injection drug users, increases their appropriate use of health and social services, and reduces the health, social, legal and incarceration costs associated with serious addiction "("Insite – North America's first official supervised injection site". Retrieved July 5, 2004 from http://www.vch.ca/sis/).

Nobody has declared that the site is here to stay; it appears to be understood that the outcome of the evaluation will determine if the site remains open.

A draft copy of the evaluation proposal for the SIS obtained by this researcher states that the intention of the evaluators is to "focus on three specific areas: process, outcome, and cost-benefit" (BC Centre for Excellence in HIV/AIDS, 2003, p.2). The outcome measure will be to identify impacts of the SIS on "public health, client health, neighbourhood environments, and crime" (BC Centre for Excellence in HIV/AIDS, 2003, p.3). The process measure will utilise "Focus groups with clients and SIS staff . . . to evaluate client and staff satisfaction indicators, and targeted community surveying will be used to assess community attitudes"(BC Centre for Excellence in HIV/AIDS, 2003, p.3).

As comprehensive as this approach appears to be, when an evaluation strategy is developed for an extremely controversial initiative such as Insite that falls into the category of "never-been-done-in-these-parts-before", it is necessary to expand the traditional understanding of the program evaluation process. The public debate that took place prior to the opening on September 22, 2003 was unique. People on each side of the issue were arguing for/against something – a SIS in Canada – that none of them had ever experienced. They could only argue from what was available to them - - their fears, belief systems, life experiences. A

review of media accounts in the four years leading up to opening day at Insite is revealing. It seems that nobody was on the fence. It was almost as if, in the absence of real knowledge (since there was as yet no evidence to inform whether or not a Canadian SIS would/would not work), everyone felt more free than usual to speak their minds (Wild, 2002; Mulgrew, 1999; Moore, 2000).

This 'pre-trial' public perspective is an overlooked, valuable piece of the evaluation process, and needs to be collected and compared to post-trial public perspective. In the absence of experience, people will only support what fits with their world view. Even if Insite is a success from, say, a public health perspective, should the general public believe that there was no benefit to them, at the end of the three-year trial period the same controversy may erupt again. And public opinion, this time informed by experience, could put an end to a promising and progressive step in the struggle to address a complicated urban issue.

In order to obtain a post-trial public perspective, this researcher spent three weeks in Vancouver, visiting the Downtown Eastside on several occasions to conduct open-ended interviews with various individuals. These individuals had identified themselves throughout the period of the pre-trial media reportage as belonging to a group that had a strong interest in the outcome of the trial: they had either been strongly in favour of the establishment of a SIS or strongly against. The SIS had been in operation for eight months at the time of this visit, and although it appeared to this researcher to be producing desirable outcomes (thus allowing the various stakeholders to re-form their opinions with real information),

the strong feelings and beliefs held by these individuals did not appear to have been relieved, and the reality of the thing, now eight months old, appears to have actually added further layers of complexity to an already complex and controversial issue.

Literature Review: Setting the Context

Two main bodies of literature will be examined in this section: harm reduction, and the political nature of program evaluation. As well, a number of media reports will be discussed that present the nature of the debate surrounding the SIS as it occurred in the city of Vancouver prior to the establishment of the site.

Harm Reduction

Harm reduction is a term that is increasingly gaining currency in the drug policy debate. It is a newer perspective in the armoury of responses to illicit drug use, the more traditional methods being the criminalization of drug use, enforcement, treatment, and prevention. While there is a tendency to think of harm reduction as referring to the practice of reducing the physical harm accruing to an individual who uses illicit drugs, this paper will engage the more comprehensive definition employed by the City of Vancouver: reduction of all harm – physical, emotional, social, economic – that occurs to the individual and to the community (MacPherson, 2001).

As well as being a key component in Vancouver's plan, Canada is giving an increasing amount of air time to the concept of harm reduction. In 1987 the federal government announced the creation of 'Canada's Drug Strategy', and published the first document outlining the Strategy in 1991 (Riley, 1998). This thin (four page) pamphlet informs the reader that by reading it "You will learn all

about what Canada is doing to reduce the harm caused by problem drug use" (Government of Canada, 1991, p.1). Although the words *harm* and *reduction* are used in the same sentence, the 'strategy' turns out to consist of prevention, treatment and rehabilitation, research and information collection, and enforcement and control. In 1998 the second edition of the Strategy document was produced and it was much the same; again the words *harm* and *reduction* in the same sentence: "The long-term goal of Canada's drug strategy is to reduce the harm associated with alcohol and other drugs to individuals, families, and communities" (Government of Canada, 1998, p. 4). However, this second document also goes on to state that this 'reduction' of 'harm' will be accomplished by pursuing five goals that appear to have little to do with the concept, namely: increasing education around the risks associated with illicit drug use; reducing drug deaths by reducing drug use; enhancing prevention and treatment options; and reducing supply. The fifth goal, "reduce the costs of substance abuse to Canadian society", which sounds like a reference to harm reduction, has no further commentary attached it, no information pertaining as to how the goal will be operationalized, something that the first four goals do. (Government of Canada, 1998, p. 4). The remainder of the document is an attempt to reassure the reader that Canada is in step with the international community; that is, the arm of the international community that proposes to criminalize all drug use, and focus on enforcement as it pertains to use and to trafficking.

The initiative *Canada's Drug Strategy* actually went into decline in the late 1990s, with budgets and departments disappearing (incredibly, the Policy and Research Unit of the Canadian Centre on Substance Abuse was closed in 1996) (Riley, 1999). It didn't entirely go away, and in 2000 it was renewed, this time with different areas of focus (for example, Injection Drug Use, Seniors, Youth) and a collection of studies and reports, rather than a single declarative-style document. In 2001 the public information provided by the Strategy (now in the form of a website) released a document entitled "Reducing the Harm associated with injection drug use in Canada" that it described as a

> "federal/provincial/territorial response to a significant number of recent, well-researched papers and consultations recommending action to reduce the harm associated with injection drug use in Canada. It is intended to provide a framework for multi-level strategies and action plans to reduce the harm associated with injection drug use in Canada and to promote a new level of co-ordinated action and collaboration among various sectors and jurisdictions in adopting policies and practices to address injection drug use and the associated harms"(Health Canada, 2001, *Executive Summary*).

This new direction taken by the *Strategy* appears to reflect a move away from the traditional law and order focus to a more nuanced understanding of the harm reduction approach. Unfortunately, that same year another Canadian governing body revealed that, despite the implied application of the report, 95% of the Drug Strategy budget is still dedicated to attempting to reduce the supply of illicit drugs (Auditor General of Canada, 2001).

The harm reduction literature is a new field for North American researchers and academics – the earliest writings are from Europe, particularly

Holland and Germany, where harm reduction initiatives, including safe injection sites, have been a familiar activity for some time. The literature coming out of Canada and the US developed in the context of the American-influenced 'war on drugs' style of approach to the problem of illicit drug use. This approach is essentially a prohibitionist one, premised on the belief that a nation's social ills are caused by drug use, and the manner by which this is to be mitigated is to eliminate all use by reducing demand and reducing supply by way of the criminal justice system.

Nevertheless, there are North American studies reporting similar findings to those of Europe (and those of Australasia, also ahead of North America in terms of harm reduction initiatives). For example, needle exchanges and Methadone maintenance programs, two of the more familiar harm reduction practices, have repeatedly been shown to reduce the transmission of blood-borne illnesses (Gold 2003; Watkins et al 2003; Loxley, 2000). The literature also report that there does not appear to have been a rise in drug use since these practices were established (World Health Organization, 2005; International Federation of Red Cross and Red Crescent Societies, 2003), which has been the fear of those in the just-say-no camp (The Partnership for a Drug-Free America; the Just Say No Foundation – Nancy Reagan was an honorary chair of this organization).

More recently, the North American literature has been addressing the social aspects of harm reduction. Increasingly it is recognised that the target populations of harm reduction initiatives tend to be members of the most

oppressed and marginalized groups: street youth; injection drug users; sex-trade workers (Watkin et al, 2003). A significant portion of this literature, particularly coming from Canadian and U.S. authors, are treatises suggesting that much of the suffering of these individuals is the result of the fallout that occurs whenever a nation engages in an American-style war on drugs (Alexander, 1990; Csiernik and Rowe, 2003; Erickson et al, 1997; Giffen et al, 1991; Gray, 2000). These writers urge that harm reduction be seen as a means of changing a nation's perspective on how it views and treats social problems. These writers suggest that, in addition to improving physical health outcomes, a comprehensive harm reduction approach can effectively address homelessness, chronic drug addiction, high crime rates, even urban decay. In fact there is evidence from Europe that these issues can be impacted in this way (Wild, 2002; Erickson et. al., 1997; Kerr and Palepu, 2001). Even in the face of such reported success, considerable literature exists exploring our reluctance to establish harm reduction initiatives in our own personal neighbourhoods (Malatesta et.al., 2000; Malowaniec and Rowe, 2003). People reportedly fear that such activities will invite drug trafficking, increase property crime, and 'send the wrong message' to their children (Gerlach & Schneider, 2002; Byrne 2001; Dolan and Wodak 1996).

Since the more controversial harm reduction initiatives such as safe injection sites and legalised heroin prescription have only been operating in Canada for an extremely short time, there is, as yet, no significant body of literature commenting on related social outcomes. This is one gap in the literature

that only time can address; it will be interesting to see if there are similar outcomes to those reported in Europe and Australia; namely, that the more controversial initiatives mentioned above have enabled an extremely marginalized population to connect with health and social service providers in a way that they would not otherwise (Dolan et. al., 2000; Riley, 2003; Watkin et. al., 2003).

Politics of Evaluation

Business organisations that operate for-profit have been evaluating their effectiveness in one way or another for as long as there has been a product to sell and a profit to make (Scriven, 1991). Interest in evaluating organisational effectiveness is said to date back to the Industrial Revolution, and came into its own towards the end of the nineteenth century and the beginning of the twentieth. Today, the science and practice of evaluating for-profit concerns occupies much of a business' time and money (Boone and Bowen, 1999; Judge, 1994).

Human service organisations were not far behind in the move to evaluate organisational effectiveness. This accelerated around the time of the Great Depression, as governments in Canada and the US greatly expanded their efforts to "salvage the . . . economy" (Fitzpatrick et. al., 2004, p. 33) by initiating various social and income programs at both the federal and provincial/state levels. Alongside these programs, agencies and governmental departments were formed to oversee and measure progress (Fitzpatrick et. al., 2004; Muller-Clemm and Barnes, 1997).

Interest in the evaluation of non-business organisations and programs continued to develop and refine, and by the 1970s had become, in the US first and then Canada, a discipline unto itself. The Canadian Evaluation Society was founded in 1981, and began publishing the peer-reviewed *Canadian Journal of Program Evaluation* in 1986. Since that time other evaluation-related journals and periodicals have been established, as well as undergraduate and graduate-level texts.

At first these writings focused primarily on technique, but even from the start there has been discussion of the political nature of evaluation. As early as 1973 American Carol Weiss, considered to be one of the more influential writers publishing on evaluation, pointed out that the resolution of social problems has been left to the political arena (Weiss, 1973). Thomas Cook, also a founding member of the new profession, commented in Chelimsky and Shadish's 1997 evaluation textbook that the past 25 years of the profession has taught its members, among other things, that politicians are primarily interested in re-election rather than the output of an evaluation exercise, except when that output can be used to enhance one's chances at the polls (Cook, 1997). Dr. Jonathan Morell, when he was co-Editor-in-Chief of the journal *Evaluation and Program Planning*, was greatly interested in the political processes of evaluation, and made an observation in 1979 concerning the weak relationship between the exercise of evaluation of social programs and the actions of governing authorities that was so trenchant it is reproduced here in full:

> The reason for the weak and indirect relationship is that political dynamics allow only those solutions which are based on single-cause models. Any research which indicates the need for solutions based on multiple-cause models will be disregarded. In this case, research is irrelevant not in the sense that it cannot point to better solutions, but in the sense that it will not be called upon to do so (Morell, 1979, p. 99).

Other writings on the political nature of program evaluation – especially of social programs – are of a similar nature: they question the applicability of their methodologies and techniques, as well as the appropriateness of the subject of study – the individual as he/she is served by an organisation (See also Rossi, 1972; Berk and Rossi, 1977; Weiss, 1970; Goodwin and Tu, 1975; Palumbo, 1987; Patton, 1997).

Since these evaluation pioneers examined and discussed the meta-issues of the political nature of evaluation, techniques have continued to evolve, with one style in particular gaining prominence: the stakeholder approach (also known as the participatory evaluation approach). Minkler and Wallerstein point out that for many human service organisations, particularly those engaged in providing controversial services, the stakeholder approach tends to be the evaluation design of choice (Minkler and Wallerstein, 2003). Participatory approaches - involving stakeholders in the design, implementation and analysis of the evaluation strategy - was formerly seen as contrary to the rigor necessary to produce an accurate measure of an organisation's effectiveness (O'Brecht, 1992). However, this approach has been used for many years as the means of assessing aid development projects overseas (Vernooy et al., 2003), and has been gaining ground in the West as the human service organisation community adopts it. The

bulk of the literature concerning the participatory approach was written in the 1980s (Alex, 1995), but there has been a re-examination of it recently and a corresponding refinement and examination of its principles (Fine, Thayer & Coghlan, 2003).

There is also a literature, albeit a smaller one, on the political dynamics of this particular approach to evaluation. The most well-defined is a body that examines the impact of power relations among and between the various stakeholder groups, recognising that in many, perhaps most evaluations situations, one of the primary stakeholder groups – the service users – often belong to a marginalized population (Gregory, 2000; Rebien, 1996; Guba and Lincoln, 1989; Ledwith, 1997; Oakley, 1991; Patton, 1997; Pawson and Tilley, 1997; McHardy, 2003). Another major theme focuses on the recognition that the evaluation exercise itself, initiated as it tends to be by non-marginalized, 'professional' middle-class individuals, has the tendency to underscore an Us-Them tension, regardless of the degree of buy-in to a participatory approach (VanderPlaat 1997; Higgit et al 2003; Petras and Porpora, 1993). While many authors have examined in depth the problem of power relations in stakeholder evaluation, less has been written to suggest practical ways to overcome this tension (Gregory, 2000).

A second tension is peculiar to the client stakeholder group discussed in this study, the injection drug users from the inner-city neighbourhood that has been called Canada's poorest postal code. Not only is this group unquestionably marginalized, and therefore subject to the power relations issues described in the

preceding literature, but, frankly, they frighten those who are not able to identify with them. There is some literature that looks at the issue of the popular image of certain groups, primarily that of adolescents (or "superpredators", as John Dilulio refers to them in his book *Body Count,* warning America about youth, drugs and moral poverty) (Bennett, Dilulio and Walters, 1996). These writings, in particular the ones that look at involving youth in evaluation of youth-serving programs, suggest that the popular image of a marginalized group presents an additional issue for the evaluation team to be aware of (London, Zimmerman & Erbstein, 2003; Acland 1995; Barron 2000; Cohen 1972; Giroux 1996; Schissel 1997). It is critical that this hurdle be overcome, as numerous studies indicate that in a stakeholder approach to evaluation, if all stakeholder groups are not given equal voice, the strongest group will dominate the evaluation and render it essentially unusable (Morris 2002; Brandon 1998; Greene 1988; O'Brecht 1992).

Media Reportage

Understandably, there was a high degree of controversy as the city of Vancouver considered the pros and cons of establishing a SIS as a means of countering the serious problems surrounding drug use in the city's Downtown Eastside. The controversy was proceeded by public inquiries: in 1994 British Columbia's former chief coroner, Dr. Roy Cain, led a provincial inquiry "which recommended that the heroin issue be dealt with from a health perspective rather than a criminal perspective" (Western Economic Diversification Canada, n.d., p. 5). In 1997 public health officials in Vancouver declared an HIV/AIDS epidemic

(Health Canada, 1997), and the B.C. Minister of Health requested help from the federal Minister of Health. After two years of meetings between all three levels of government and various federal departments, in March 2000 Vancouver entered into an Urban Development Agreement. Called *The Vancouver Agreement*, its stated purpose was that "Canada, British Columbia and Vancouver wish to co-operate in promoting and supporting sustainable economic, social and community development of the city of Vancouver, focusing initially on the area known as the Downtown Eastside" (DTES Revitalisation, Vancouver Agreement, n.d., p.5).

The 1990s also saw Vancouver play host to drug policy experts from Europe to observe the 'drug scene' of the DTES. It was reported that some of them were shocked by what they saw, and one expert was quoted as saying "You are still in denial. You don't seem to realise that these people are not just going to go away" (Middleton, G., as cited in Gold, 2003).

In July 2000, the Vancouver Area Network of Drug Users (VANDU) organised a demonstration in the city's Oppenheimer Park, designed to alert the community and municipal government to the crisis that they felt was being caused by official inaction: thousands of people were dying in British Columbia every year from the unsafe use of injected drugs. Half of those so affected were from Vancouver, primarily the DTES (Wild, 2002). VANDU members also staged a demonstration the same year at City Hall, pleading that council do something, anything, to push back the tide of deaths from HIV/AIDS, Hepatitis C infections, and drug overdoses (Wild, 2002).

The City of Vancouver issued in 2001 a document, *Framework for Action,* that promised to address the problems of the DTES. One proposal was to establish a SIS. While applauded by VANDU, AIDS organisations and others, local businesses and a significant portion of the Chinatown community (Chinatown borders the DTES) argued that establishing such a site would only increase their community's already significant problems. These parties waged demonstrations, issued press releases and circulated petitions. (Wild, 2002). The parties that were in favour of the site (Vancouver City Council, the Vancouver Police Department, Vancouver's public health authority, and the grassroots user organisation VANDU (Vancouver Area Network of Drug Users) also issued press releases, and VANDU staged demonstrations as well (Wild, 2002). Other members of the DTES community made known to the city their frustration with the city's apparent inability to make a dent in the housing, health, public safety, employment and social problems of their community (Dempsey, 2004).

Methodology

Research Design

The design of this research study is qualitative in nature, employing elements of an interpretive approach and a critical approach. In general, a qualitative approach is chosen when the researcher is interested in exploring a situation "in which reality is socially constructed, complex, and everchanging" (Glesne and Peshkin, 1992, p.6). Furthermore, a qualitative design allows for the identification of shared threads in respondent interviews (Sherman and Reid, 1994).

This qualitative approach is expressed in the present study by two perspectives: the interpretive position and the critical position. The interpretive position considers how people make sense of their personal experiences and the world around them (Neuman, 1997). This perspective was chosen because the contention of the stakeholder method of evaluation is that each person affected by the outcome of a particular activity will have a different, and therefore valuable, perspective on that activity (Morris, 2002). Each participant's individual experience of the SIS has meaning for a stakeholder evaluation.

While the interpretive position seeks to understand these interactions of meaning, the critical position attempts to uncover the structural inequalities that underlie these interactions (Neuman, 1997). A primary declared focus of Insite is the service user, of which there are many – a peak of 701 visits in one day (April

2004)! The staff, governance and funding numbers are much smaller. Is this creating an imbalance in influence? Will the final formal evaluation be a disproportionate reflection of stakeholder involvement? A critical position will examine the experiences of each stakeholder with a view to exposing possible structural inequities.

Sampling Design

Purposive sampling was used as stakeholder evaluation, by definition, includes only those who have a stake in the outcome of the activity being evaluated. Purposive sampling allows the researcher to select only those participants who possess certain characteristics (Berg, 2004), which in this study translates into:

- service user
- street nurse
- police officer
- local businessperson/resident
- Drug Policy Co-ordinator, City of Vancouver
- Project Co-ordinator, VANDU

Each of these persons is considered, by both the researcher and by their own personal opinion, to be affected in a direct way by the operation of the SIS. The researcher located these participants through newspaper and media stories, professional contacts and personal referrals. Participants were contacted by phone and/or email and were asked to consider participating.

Data Collection

Data were collected by engaging participants in open-ended interviews. Ethics approval for this study was obtained in advance from the McMaster University Ethics Board, and participants consented in writing at the time of the interviews. Participants had also been sent this information one month prior to the interviews.

These interviews were based on a set of 20 questions, open-ended, that were presented to the respondents one-on-one with the interviewer, at a location and time chosen by the respondent. This format was chosen in order to guide the subject matter of the interview, while at the same time allowing for spontaneity in reflection and interaction between interviewer and participant, an egalitarian, non-exploitative practice recommended by Kirby and McKenna in their book Methods from the Margins (1989). For example, two such questions were:

- What meaning does the Downtown Eastside have for you?
- What has it been like since the supervised injection site opened?

Interviews were audio-taped with the participant's consent. See Appendix A for complete list of interview questions.

Findings

The research findings will be examined in three parts: overview of respondents' views and positions; critique and analysis; and implications for the stakeholder approach to an evaluation of Insite. To reiterate, the following individuals were interviewed, and their data form the main substance of this chapter: an injection drug user (cocaine and heroin) who uses the SIS, a street nurse from the DTES, a police officer responsible for the SIS policing plan, a representative of the local business community who has also resided in the DTES since 1991, the Drug Policy Co-ordinator for the City of Vancouver, and the Project Co-ordinator for VANDU, the drug user group.

Overview of respondents' views and positions

The most obvious thread shared by every respondent was how strongly they felt about the issues under discussion. While they had been purposively selected for this study because of their history as spokespersons for their various interests, it was apparent that neither time nor the opening of the SIS had weakened their opinions. Equally strong was their shared belief that they each had something important to say, they wanted to be heard, and while some of them expressed fatigue about the whole business, none of them seemed to be ready to give in yet. VANDU's Project Co-ordinator felt that their input into the design of the SIS had not been invited. As she put it "and suddenly all these suits showed up from Health Canada and came down and worked on the details. Why the hell didn't we have some say in how that

fucking place was designed?" (Tape I). The business community representative/resident said that "not a soul that I know who works in businesses or lives down here has ever been surveyed, ever" (Tape I). She went on to say that they (she is, or was back then, part of a local business association) made so much noise to City Hall during the time the SIS was under discussion that arrangements were made for them to give their input. They gave their input, and then were disappointed to find that it apparently had not been taken into account. Her comment: "I get so tired of being patted on the head and told to go away" (Tape I). Feeling strongly about being heard appears to be a universal theme wherever stakeholder input is sought (Whitmore, 2001). Interestingly, this aforementioned business person, whose association had been portrayed by the media as being anti-SIS and anti-addict, said that she believes that the addicts should also be asked for their input, because "they're the ones that know" (Tape I).

This business person was the first individual interviewed, and all I knew about her and her positions on the issues was what I saw or read in the media. She had been very reluctant to speak with me when she heard what I was studying. In fact she was my second choice; my first choice was the president of another neighbourhood business association. I contacted this person first by telephone and then by email, and she would not agree to be interviewed. When I shared with her via email the difficulty I was having in getting a representative of the business community to meet with me, she emailed back, "well that should tell you something." Therefore I was fully expecting to hear the business person/resident

express grave concerns about how the SIS will make non-users want to become addicts; it will 'send the wrong message' to our children, all the usual rhetoric that surrounds the Just Say No/War on Drugs mentality. I was sure I would then go on to discover that the other respondents would either be in the same camp - the police officer was my bet - or in the extreme opposite camp, pro-SIS and pro-Harm Reduction.

I was mistaken. There were certainly well-defined camps, but they did not appear to be the same camps that the media portray - War on Drugs vs. Harm Reduction. Nobody, not the business person, not the police officer, *not one* respondent said they thought that a SIS was a bad idea. The police officer said that the VPD supports the SIS, the needle exchanges, the whole Four Pillars drug policy. He reported that there had been some initial concern, but it was not of a 'philosophical' nature, that is, that the police were anti-addict or anti-Harm Reduction; it was actually a logistics thing: the VPD had been, at the very same time the SIS was preparing to open, experiencing a significant level of cutbacks, yet were asked to put together an 'enforcement plan' for the SIS and the DTES. He commented that he was aware that the media had portrayed that the VPD "doesn't care about drug users, the department doesn't care about the people on the DTES . . . that we're constantly getting in the way of health initiatives" (Tape V). He was clearly bothered by this, yet at the same time somewhat resigned: "Public opinion is not going to change because you know, it doesn't sell newspapers or create good conflict and so I've certainly accepted that" (Tape V). He and his department were

still smarting from the way the media had portrayed the VPD's handling of the missing women issue (61 prostitutes had gone missing from the DTES over a 20-year period; at least 27 ended up as microscopic bits of DNA on Robert Pickton's pig farm on the outskirts of Vancouver). The police representative observed

> the VPD have made lots of headlines around the missing women, so you have this image that the VPD are now horrible and they do all these awful things. There's certainly a lot more to it than the police department didn't do its job, perhaps we didn't on some levels, but the image that's been portrayed and keeps being harped upon is entirely different than what the reality is in many ways (Tape V).

The business person was also not against the SIS; she seemed to 'get' that there were no easy answers and the problem was not going to go away. Her concern, reported by the media as being shared by all local businesses, including the Chinatown area, was that more and more singularly dedicated services were appearing in the DTES - those whose sole purpose was to serve the addict - and now here they have a SIS:

> what I see is an area that has been designed to be, it's an area that the City of Vancouver, the province and the feds have purposely placed resources for the poor, the addicted, the disenfranchised, it's a resource for them. It's exactly a ghetto and it's been designed intentionally and that's where you have the SIS and that's where you have all the health resource centres for the Methadone Clinic, that's where you have all of that. If you want to provide drug injection sites, if you want to provide needles, if you want to provide Methadone to people, do it in every healthcare unit in this province, preferably in the country. Don't do it in one neighbourhood of a city in one province, because they're here from everywhere, from Montreal to Boston (Tape I).

VANDU's Project Co-ordinator also felt there should be more sites, that

> it's impossible for that small of a place to impact the neighbourhood, because there are 4,700 addicts and they thought they would be looking at 500 a day but they've had 700, like it's growing and growing, the number of users a day" (Tape II).

The business person also felt that Insite was too small for the size of the problem, and the man who had used the site to inject his heroin agreed there should be more than just the one:

> we're missing half the people out there, half the people are rock smokers, so if they would have opened up an inhalation room in the back, we would have got almost all the population right in this area, hopefully they can open up more SIS because someone's not going to walk down from the Astoria Hotel to use the SIS, they're just gonna use the alley, it's just too far (Tape IV).

The street nurse (who is also co-chair of the Harm Reduction Action Society) thought that the idea of supervised injection sites and harm reduction in general were "great" (Tape VI). She did not comment on how many she thought there should be, or in what parts of the city they should be located.

Finally, the Drug Policy Co-ordinator for the City had some interesting commentary that may answer the concerns of those who were troubled by the decision to only open one site for the pilot: *It's political.* He said, "I think it's the art of dealing with the fact that this is the first injection site in North America, Health Canada is just going crazy trying to worry about it" (Tape VII). He indicated that because it was a pilot project there needed to be certain well-defined limits. In response to my sharing that some of the other respondents felt that Insite was

designed by "suits from Health Canada" (Tape II) and unnecessarily complicated, he said

> See, the first one, it's also a Cadillac version, I mean it's expensive, it's big, shiny, they don't all need to be like that. In Europe they're often just a room off the side of another service. Here, this is sort of the flagship, this is the injection room, the whole point of it is to be a high volume site (Tape VII).

If the pilot of a new initiative started life already loaded with political consideration, the evaluation will certainly not be free of it, and will likely by that time (end of 2006) require a set of very skilled operators and wise policymakers, able to sort out the role that evaluation should play in policymaking (Palumbo, 1987).

In an effort to ascertain what, if any, difference that the actual operation of the SIS had made to their strong opinions (it had been in operation for eight months at the time of the interviews), the question "What has it been like for you since Insite opened?" was asked of each interviewee. All but one felt there had been significant change.

The Project Co-ordinator for VANDU noted that users had shifted much of their injection drug use to the safety of the SIS

> There was terrible problems because people were injecting everywhere. When I walk and I always look up the alleys to see and the lowest number of people I ever saw injecting was six and the most I ever saw injecting was 17 and that's one block. Now when I go up that alley and look down that alley, there's no-one injecting now (Tape I).

The injection drug user who had been using the site for the past five months or so noted an improvement in neighborhood safety and aesthetics

> Well there's less people in the alleys shooting up and so obviously there would be less garbage in the alleys, less rigs, and I haven't been on the alley patrol but they (alley patrol) even noticed that there's less people. I remember them saying that there's less demand for the alley patrol to hand out rigs because a lot of people were already using the SIS and the numbers show that (Tape IV).

The VPD officer first made the comment that there had been no increase in crime since the site began operating, then went on to observe that both real and perceived notions of personal safety had been impacted: "the old people just felt they couldn't go outside and that's changed since we implemented it in the fall. The SIS certainly had an impact on, I would say, street disorder, we got less people in the lanes" (Tape V).

The street nurse also commented on the reduction in public drug use, then commented on what she saw in terms of health benefits for injection drug users

> You see way less drug use in the lanes, you know, way, way less. I mean, it's just, had you come a year ago it would have been, like, it was a nightmare walking around at night in the lanes and in the pouring rain and they're using water from the spouts to put in their rig to shake it. I mean, a lot of the nurses came back in here (the Team office) they say, you know, Welfare Wednesday used to be like a big bad time outside, and it's, and people say it's way calmer, and then (the SIS) will just encourage them to stay clean (Tape VI).

The Drug Policy Co-ordinator for the City was also in agreement about the impact of the SIS on the problem of public drug use

> Well there is an evaluation attached to it that we haven't reported out yet, but anecdotally, I mean, everyone will say that there's much fewer people injecting outside in the back alleys. The back alley behind the Carnegie Centre across the street from the SIS, that's in

> Chinatown, was a major injecting locality for 12-13 years. Discarded needles, so much less in Chinatown and much less in the back alley behind the SIS, which was the other major injecting site, because the drug scene was centred at Main and Hastings. Anecdotally, it's very well used, 700 injections occurring inside the injection site per day are 700 injections that aren't occurring somewhere else (Tape VII).

The business person/resident was the only interviewee who reported that the SIS had made no difference. However unlike the other respondents, she was referring to the impact it had/didn't have on her *personally*, and intimated here, as she did at other times, that the problem was that there was only one site, and that additional sites might make the difference

> I do not think that the number of people that they're allowing to use the site to do their injection makes any difference to the amount of people that are shooting up in my lane. There's no difference here, two blocks away, yup. And I've even, when I've been frustrated, even said to the addicts in the lane, why don't you go to the drug injection site? **Interviewer:** And what do they say? **Business person/resident:** Nothing. It's a rhetorical question, you know. I mean, it's me being frustrated that they're still in my way and I can't get into my parking because they're there, that's all, but no difference (Tape I).

One last anecdote highlights the changing perception of Insite: I toured the SIS, and I asked the person giving the tour (a 'consultant', employed by Vancouver Coastal Health, who was on staff there) if he had seen any changes. He said that the Chinatown community, who had previously been strongly opposed to the establishment of the site, had "done a 180° turn", and were currently undertaking a letter-writing campaign, asking that the SIS be open 24 hours a day (at the time of my visit, the hours were from 10:00 in the morning to 4:00 am the following day).

The respondents were all aware that the primary focus of my study concerned evaluation, that I was interested in developing a set of principles that would be useful in the design of an evaluation strategy for Insite, principles that would be founded on the perspective of the stakeholder. They were aware that their perspectives were being sought as they had been identified, both by the media and by their own admission, as being primary stakeholders. As I posed the question "What should the evaluators do to get the information that will tell them whether or not the project has been successful?" there were two types of response: those who had no reservations stating their preferences about what they thought an evaluation should include, and those who suddenly became hesitant, saying that they were not the experts, were "not professional evaluators" (street nurse, Tape VI), or "Oh, God, I know who the evaluators are" (police officer, Tape V). This hesitancy is likely part of all the tippy-toeing that certain parties feel they need to engage in - those with a more official connection or capacity. But when encouraged, all respondents gave an answer, an answer that was fairly comprehensive, that they had clearly thought through. This suggests that not only are stakeholders a source of evaluation data in terms of measuring "the degree to which (they) are at least minimally satisfied with the organisation" (Bowditch and Buono, 2001, p. 304), but should perhaps be further 'mined' for their ideas about how to go about collecting these data. What questions should be asked? Who should be asking them? This further step is in agreement with the most recent incarnation of the stakeholder approach to evaluation, only a decade

old, known as Empowerment Evaluation (Fetterman and Wandersman, 2005). The respondents' ideas about evaluation design are discussed below:

The VANDU Project Co-ordinator's first concern was that the scope of the evaluation was too small

> I'd like to see that, my biggest fear is that the evaluation is going to be, I guess, if you really have a captured little herd of people and you know that they're using the site constantly, you could look at the changes in their lives and that's valid. I think what would be really interesting, particularly with the politics in the neighbourhood, is there really less shit in the alleys and stuff?

She also had an interesting observation about possible unintended uses of the site

> The other thing though, they need to be clear about what people are coming in for. If I was homeless and I knew that someone would let me sleep in a really peaceful and lovely atmosphere in this chill room (a room in the SIS to which clients move after they've injected), I would pretend I was shooting dope so I could go into the chill room. So I don't know how much of that shit is going on because that's the other thing, you got this over-the-top kind of luxury place and it's just out of place. That's the kind of awareness I would like to see them really examine.

Finally, she had some thoughts on employee suitability and safety

> I guess they should measure some of this stuff I'm talking about with employee attitude so that we can start to say what are they, what are we looking for in an employee in a place like that, and how is it that they stay safe? What is the best practice for staying safe? 'Cause it ain't fucking calling the police, I'll tell you that (Tape II).

The individual who was using the site for some of his injections understood the value of surveying community stakeholders

> They should be asking the people that are using this site: Is the site working? What do you like about the site and what don't you like? I think they should talk to the surrounding areas like the business community, because they got a stake in it. The people that were opposed to it before, maybe see how they react now to it, maybe their attitudes have changed (Tape IV).

The VPD officer (after some encouragement), proposed a fairly comprehensive set of ideas

> Well, theoretically, I think they should look at everything from drug use, talk to a proper randomised study group of users, talk to the people that don't use the site and ask them why, and not have an ideologically-based, let's say, analysis, saying the reasons are that the police are around, when the reality is: then why are hundreds and hundreds of people going there daily if the police are somehow getting in the way of this, but are the other issues involved with that? They still get street-level disorder, needle pick-up, there's a whole range of things. You know, I'm not a researcher (Tape V).

The street nurse, at first, also spoke in broad terms

> I think you need an actual evaluation of the running of the site, you need to look at the staff that are working at the site, you need to look at the consumers. You have to look at job retention, you have to look at any operational practice, you want to get feedback from the clients and from the community. Do a cost-benefit study, look at community impact, you know, are there less needles, less people injecting in the street. Yeah I'm not a professional evaluator so... (Tape VI).

After some encouragement she went on to speak more specifically in terms of health measures, community outcomes, and long-range client outcomes

> I would say, has this had an impact on needle sharing? On using clean injection equipment? HIV rates, Hep C rates? Blood pathogen transmission? Has it had an impact on the relationship between the drug user and the community? You know, the guy who runs his business down the street, does he find it easier to manage without a lot of chaos? Do customers feel comfortable going to his shop without having a lot of users injecting on the front door step? Has, how many people have gone into detox programs, Methadone programs, treatment, how many have quit using as a result of the site, how many have been able to get referrals to other health services, housing referrals, how many lives have become stabilised? And that's just a few things (Tape VI).

The Drug Policy Co-ordinator was concerned about drug user and public perceptions

> Well, I think obviously the health piece is important. I think they need to look at drug user perceptions, both of those who use the site and those who don't. I think we need to talk to a group of users who don't use the site and find out why, is it too far away, whatever reasons you don't use the site. I think an evaluation should look at public attitude, like for instance through the press. I guess you could look at press stories about the site over time, like before, after, so you could get some sort of sense of the public's attitude towards it (Tape VII).

The business person/resident had the most to say about the exercise of evaluation; it was clear she had been thinking about this issue for some time

> Well, the first thing that should be done, and this is what seems to be missing in evaluations of programs down here, is look at what the mandate was. What was the original mandate? Why are we spending taxpayers' money at the outset? How was this sold? What was this sold as? There's going to be less addicts on the street? Or fewer people dying of overdoses? What is it that caused that money to be invested in that program? Now, did that program achieve that? You know, it just drives me crazy because I keep saying, you know, the needle exchange for one thing. It was set up to prevent the spread of AIDS. It (AIDS) went wild. Why didn't we do something else the first year after operation when AIDS was going through the roof? Maybe at that time it would have occurred to us, it should be widespread or something different done, but instead we keep pouring more money and more money and more money.

She felt very strongly about what seemed to her to be the endless amounts of money being channeled into programs for the DTES

> In private industry, you can't afford that. If we set aside a certain amount of money in an annual budget to do something, if it doesn't achieve that goal, we're not going to double it next year. I can assure you and yet, from a government point of view, that happens over and over down here. I get so mad about the evaluation. The evaluations are full of shit. They say, I mean I talked to them and they say, well you should see the pride in the face of these people. And I'm saying,

> is that why we spend money? There's tons, there's so much money being spent down here. Nobody, you will never find a soul who's had an inventory from the federal, the provincial . . . The civil government is different. You'll find out sort of, there's lots of programs that don't sort of sit on the radar of money that's being spent down here. Provincially they cannot tell you how much money is being poured into this area. Federally, no idea, not a clue. So here's all this money, no evaluation of the proper evaluation like this is the mandate, did we achieve it? To me, that's an evaluation. The rest is all 'feel good, wasn't that great, let's go out to dinner' (Tape I).

Analysis and Critique

Two additional themes emerged from the research. They will be discussed under the following headings: My Stake is Bigger than Yours; and I Need to Lie Down Now.

My Stake is Bigger than Yours

One of the primary purposes of this research was to examine the issues around the voice of the marginalized person who has been invited to participate, as a stakeholder, in a project evaluation. The literature suggests, and correctly, that special care and effort must be made to ensure that the voice of the marginalized individual - the homeless, the street-involved drug addict, the survival sex-worker - is heard when a stakeholder approach to program evaluation is sought (Chambers, 1999; Fetterman and Wandersman, 2005; Mertens, 1999; see also House and Howe's principles for 'Deliberative Democratic Evaluation', 2000). This need for special care and effort has been addressed by the literature, and excellent tools have been developed that allow engagement of marginalized populations; how to elicit their voice in ways that will be heard and utilized

(Arnold et. al., 1991; Evans and Fisher, 1999; Fetterman et. al., 1996). Other literature exists that provide some excellent tools for how to engage this population, how to elicit their 'voice' and record it for posterity (Arnold et al, 1991; Evans and Fisher, 1999; Fetterman et al, 1996). These bodies of literature suggest that

1) The more power held by the stakeholder, the greater their 'voice' in the discussion; therefore

2) the street-involved drug addict - the least powerful stakeholder among those interviewed for this study - his/her voice, while solicited for feedback about the SIS, will not be given as much weight, or respect, as the voices of the other stakeholders. There were concerns at the time of the public debate that of all the various 'special interest' groups that were saying their piece, the business community had the potential, in terms of financial resources and so on, to torpedo the SIS (Wild, 2002; Moore, 2000)..

The debate did not end up this way, of course, and the first of this research's observations is that the ratio of (apparent) power to who gets heard, is not as linear as the literature suggest. Many opinions may be solicited, but there doesn't seem to be any simple formula for determining who will be 'heard'. When a controversial initiative is torpedoed, what really happened? Often the media will place the blame on the naysayers who complained and complained and just wouldn't go away, but is that really who had the last say? The aforementioned local business community in the DTES appeared, in the media, to be very strong

and powerful and vocal. Yet each interview, particularly the ones with the VPD officer and the business person, seemed to suggest that there is an additional mechanism operating when the public enter such a debate: it may not be the loudest or the most powerful who get to be 'heard'. The business woman in particular had some very rational and important points to make (contrary to how the media presented her association), as did the VPD officer. What struck me after those two interviews was that it did not appear that *their* voices were being heard. Why would that be? What is that additional mechanism, and who, or what, is operating it?

I Need to Lie Down Now

A second theme that emerged was the impact that culture had on interviewees' responses. Culture, in a general sense, has been discussed in the literature in terms of the need for the listener to be aware of and respectful of difference issues such as class, gender, ethnic origin (Belenky et al, 1986; Finch, 1991; Yee & Dumbrill, 2003). However there is missing from the literature a discussion of the impact that listening through the filter of culture has on the interviewer/evaluator. As well, the literature tend to portray culture as somewhat one-dimensional: the interviewees are Asian, or lesbian, or poor. The reality is that each stakeholder comes to their interview fully loaded: she may be a poor Asian lesbian who is also blind, a new mother, and an identical twin. Each of these variables will flavour their answers to the interviewer's questions. They are not just talking about the SIS and harm reduction; they are telling you about how

all of the things that make them who they are interface with the SIS, which to them is only a further layer of who they are. The VANDU project coordinator, a non-user, explains how she was 'primed' for political action by two of her life realities:

> The drug users have a hard time with it and I know that my incredible gift is to be able to have an understanding of it, partly because I was on welfare and I've been treated, I have a child with a disability and you have what is called parent as patient. So somehow, if you stand with your child, you are going to experience what they experience. If you stand with a drug addict, you are going to experience what they experience (Tape II).

Thus primed, she reported that the penny dropped for her when, some years back:

> right out here in the alley (below her apartment's windows), a woman overdosed and 20-something children were standing on those stairs down there looking over and watched the entire interaction. I didn't see it. Once the woman went down, people all started yelling and we called 911 but in the meantime, my kid's dad was visiting and we and my six-year-old went over to the firehall to tell the firemen, would they please come and revive her. In the meantime, (my kid's dad) went down and did mouth-to-mouth and another person was doing it and . . .when the (EMS) pulled up the (paramedic) looks at my six-year-old son and me standing there, and we had been part of saving this woman's life, and he goes "get him out of here", as if there was something pornographic or unacceptable. When they saw her sit up, because Narcan has this miraculous effect, she sits up and then there's this cut-off, because if we had been able to revive her ourselves we would have been saying "oh, you really scared us", and it was the intimacy of seeing someone die, that lives. When someone said look, we should organise drug users, I met with Melissa in 1995, way before VANDU started (Tape I).

None of us bring pure, unadulterated, reasoned logic to any discussion. The business person saw things through the eyes of business and of her home

neighbourhood. The police officer and street nurse very obviously saw the issues through the cultural lens of their professional mandates. The VANDU Project Co-ordinator and the business person both remarked that they had read studies (not just media accounts) about the issues, but even a dry scholarly work will be processed through a multi-layered cultural filter.

In addition to trying to avoid making the mistake of culturally pigeon-holing stakeholder responses, the evaluator/researcher/interviewer needs to be aware of the impact that this mosaic of information will have on his or her abilities as a researcher. Each respondent was so clearly their own person, with their own world view, that this interviewer quite literally began having headaches as the interviews went on. I grew up in Quebec, and at one time I was able to speak a passable French. This research experience felt similar to when I would switch between French and English: both entirely different languages, with different structures and inflections and nuances. Switching back and forth was exhausting. I am not aware of any literature on the impact of listening to so much information presented in so many different (cultural) 'languages'. The temptation to simplify and discard potentially valuable pieces of stakeholder feedback is great. It must be recognised and addressed.

Implications for Evaluation

Evaluation time is always an anxious time for a social or health service initiative. Overtly, the goal of an evaluation is to identify ways in which the program can be made more responsive to client need (Bernstein et al, 2002).

Covertly, many fear (and some may hope) that the result will be a shutting down of the whole operation. The evaluation of Insite is in that most anxiety-producing position: it is being evaluated as a three-year pilot, not as a program of longstanding history. Even if the evaluation team produces many valuable recommendations, if the powers-that-be decide to pull the plug, it may never be known if it could have really become something.

Public opinion has an impact on these powers-that-be, although it is not always clear to what degree, nor is it clear just whose opinion presses which button. For this reason it is vitally important that a broad range of opinions be solicited by the evaluation, and in a fairly comprehensive way. In the case of Insite that would mean assigning equal weight to the stakeholder analysis element (or 'process', as it is referred to in the draft evaluation proposal) of the evaluation, equal to that given to the outcome and cost-benefit elements, and comparing this element (what I call the post-trial public perspective) with the pre-trial public perspective. It would also mean giving equal weight to each voice captured by the stakeholder analysis, being careful to correct for possible power imbalances and marginalization issues.

The discussion of the implications for evaluation of such a variety of opinions will begin with a look at the question, *How does one include the voice of major stakeholders without drowning out the voice of service users?* It will conclude with a proposal of four principles that should guide the stakeholder

analysis piece of the initial evaluation of North America's first supervised injection site.

How does one include the voice of 'major' stakeholders (such as the local Public Health authority or the local police department) without drowning out the voice of the service users? It can be done, but in a very planned way. Funders, evaluators, and major stakeholders must be encouraged to accept the voice of the service user, a most power-less and marginalized population, as an absolutely critical voice. As the concept of stakeholder analysis evolves from measures of stakeholder satisfaction to participatory evaluation to empowerment evaluation, some fear that any call to include the voice of the marginalized in a program evaluation has become only about respecting people's right to be heard, and not about good "science". This fear is greatly misplaced, and care must be taken to educate around the "scientific" value of soliciting feedback from this population, whether or not they use the service.

Once it is accepted that the voice of the marginalized will be solicited, valued, and central, there needs to be something said here about the voice of the non-marginalized. It is usually assumed that these individuals - members of the VPD, the health care professions, the local business associations - will encounter no problems in terms of being heard. In fact some of the literature (see House and Howe's "Deliberative Democratic Evaluation") is careful to warn that the so-called 'major stakeholders' do not need any help in being heard. Indeed, they are the ones that could bring to life Dorothy Rowe's proclamation that "In the final

analysis, power is the right to have your definition of reality prevail over other people's definition of reality" (Rowe, 1989, p. 16).

However as was discussed earlier, it is more complicated than that. Some who may be seen by the public, the project funders and the media as major stakeholders may have quite a different opinion about the 'heardness' of their voices, and may not participate as fully or as openly in a stakeholder analysis as might be expected. The VPD officer, trying to point out that his organisation is in fact supportive of harm reduction initiatives, said

> you'll see some of the research, the recent research that shows, in my view, that bias (against police) around. You will scarcely see a whisper of, that part of the reason why (the) SIS has been such a success is precisely because of the police department (Tape V).

The business person had similar concerns, fearing an exclusive focus on service providers

> There was a community meeting about evaluation and we (her business association) gave a lot of ideas, but when I had a look at the draft evaluation, it wasn't like. . . let's have a look at what their terms are and what they think. Well I'd be really interested to see who they survey when they do their evaluation because it seems to me that they're going to be talking to the service people. **The people who work there?** Not just work there but all the agencies and everybody that's involved . . . so people who have a stake in here based on their own job. **If that's the only people they talk to. . .** now I've had this discussion with Heddy Fry, our Liberal MLA, and said to her, you can't evaluate like that because it's conflict of interest. Well she almost flew across the table and almost had her hands around my throat and said how dare I! And I said Heddy, this is their job, of course they want to continue to make $ 100,000 a year, of course they do, and she was just livid that I would think that these caring people would put that in the way of being, of doing a proper evaluation but I'm saying look, your whole evaluators, your whole people that you are serving are all people whose business it is to do these jobs. Where do you think their perspective is going to be?

Keeping the more marginal voices central to the evaluation exercise while still attending to the voices of the more powerful stakeholders requires an awareness of the many ways power is distributed in society. Age, gender, sexual orientation, income, physical ability, there is an almost endless list of variables to which we assign power and importance. Joan McHardy used the metaphor of the waltz in her discussion of the need for a careful and sensitive negotiation of participation within and between stakeholder groups where there are issues of exclusion (McHardy, 2003). Partners in a dance must negotiate their places, their rhythm, their steps. It will not happen naturally – the aforementioned power imbalances will see to that – and it is the evaluator's job to ensure that differing interests are negotiated and resolved.

Four Principles for Stakeholder Analysis

It is perhaps somewhat naïve to think that it is possible to articulate a checklist of tasks that, once completed, will ensure that each stakeholder group has been properly heard from. Evaluation is inherently political, and the evaluation of a pilot of a controversial initiative, absolutely political. A more useful course would be to inform the stakeholder analysis piece of the Insite evaluation by structuring it in terms of certain *principles.* I propose in this last section, four principles that would allow evaluators to collect the stakeholder data they need in a balanced way, with a heightened awareness of the various levels of meaning that each stakeholder brings to the table.

Principle One: Recognise that in cases such as this, where the initiative being evaluated has no Canadian precedent, that stakeholders' *pre-trial* opinions will rarely be based on experience, but on what they have learned from the media, other individuals, and their own articulation of what constitutes 'common sense'. Media reports recording the pre-trial debate reported comments that ran generally thus: "common sense will tell you that to open up a safe injection site will send the message that it's OK to do drugs" or "common sense will tell you that this War on Drugs is only making things worse, we've got to try something that works." Pre-trial opinions such as were heard in Vancouver will likely be unique to that place and time, now that Insite has been in operation for almost two years. Any other Canadian city that undertakes to examine the possibility of establishing a SIS will have a Canadian reference point, and it will be interesting to see if the range of public opinion/outcry is different.

Principle Two: Recognise that harm reduction initiatives are often located right at the epicentre of the problem, and no-one is going to go away. Therefore, 'lesser' stakeholders *must* be heard from. They were around long before the initiative began, and this permanence has some power - there is always the chance that they could torpedo it, occupy it, or otherwise significantly impact it. VANDU's project co-ordinator was aware of the power of that marginalized population:

> There's this principle . . .that the public expression of pain is subversive, and it's what's absolutely never allowed, is the public expression of pain. The reason VANDU is a powerful group is we take the voice of users and begin to have it in the newspaper and

> have it on the TV. Because VANDU has 1,340 people signed up, and if we make a call and organise ourselves in such a way, we will have 100 people somewhere and that's the point. What can you do when you are a completely marginalized human being who has no value to anyone? You can be a fucking problem, watch me (Tape III).

Principle Three: Recognise that stakeholders' *post-trial* opinions will be based on how the outcomes have impacted their particular agenda. They are unlikely to change their personal values, even in the face of what might seem to some to be incontrovertible evidence that a certain action or program is fulfilling its promise. For example, the Chinese community are now in favour of the SIS, but not necessarily because they have come to sympathise with the plight of the marginalized drug user. Rather, it is likely because their particular agenda – to have drug users concealed from public view - is being fulfilled.

Principle Four: Recognise that the politically delicate nature of such an evaluation has the potential to interfere with a balanced stakeholder analysis. Vancouver's Drug Policy Co-ordinator, as well as VANDU's Project Co-ordinator, made reference to the high levels of anxiety being experienced by the funders, the feds, the province, the City, even the nurses on staff:

> (There is a) squeamishness on the part of health care workers about being in a place where they know that someone, that the purpose of the place is for people, with an illicit substance they just purchased in an illegal way outside, to come in and use. They're being foolish, in my opinion, to think they would ever be charged. It really is a charge, and it's absolutely never used, it has a very, very poor chance of standing up in court. The opinions of prosecutors was that it would never be used, so I found the drama around people's own personal lack of commitment to saving lives (ridiculous), and their fear around losing their RN status, or being arrested is what they would always say (Tape III).

This squeamishness, or political tension, is not just internally generated. As soon as the site received the necessary exemptions from Health Canada, U.S. Drug Czar John Walters proclaimed "It's immoral to allow people to suffer and die from a disease we know how to treat," he told the press. "There are no safe-injection sites," he continued, calling the policy "a lie" and "state-sponsored personal suicide" (Follman, 2003).

As well, the International Narcotics Control Board (an independent United Nations organisation that monitors international drug use) criticised Insite in its annual report released March 3, 2004 - not quite six months after the site had begun operating. The report observed that Insite allows people to "inject drugs acquired on the illicit market with impunity". The report went on to state that the existence of the site means that Canada is violating international drug treaties to which it is a signatory partner. (CBC News Online, 2003). The body of literature on effective evaluation design continues to grow, with the most recent additions giving increasing attention to the impact that systemic inequalities have on the notion of stakeholder participation in project evaluation. It is being recognized that the traditional style of stakeholder analysis often silenced some groups while giving advantage to others. Power imbalances are a fact of life and may never be corrected. Therefore it is imperative that when an evaluation strategy is sought for a project whose 'customers' are unquestionably marginalized, and the nature of which is controversial, the strategy chosen does not ignore these political realities but actually includes them in the design.

Conclusion

Canada has been moving away from the U.S.-inspired 'War on Drugs' approach to the problems generated by illicit drug use for some time now. Although arousing the ire of United States of America, as well as that of the United Nations, it appears that this trend will continue. Shortly after this study's interviews were completed, Vancouver initiated yet another trial of a highly controversial initiative – the NAOMI trials. NAOMI (North American Opiate Medication Initiative) will be giving clean, pharmaceutical-grade heroin to selected chronically relapsing addicts for one year, and compare this group to a group receiving Methadone. This initiative is based, like the SIS, on the experiences and outcomes of drug policy research in Europe.

This trend is the trend of harm reduction, reducing the harms, to the individual and to the community, of illicit drug use. These new initiatives have been carefully planned and founded on sound scientific research. Nevertheless, great public controversy arose when it first became apparent that the City of Vancouver was considering establishing a safe injection site right in the epicentre of its most troubled neighbourhood – the Downtown Eastside. This public display of beliefs about personal drug use was unique in that there was no actual experience to inform it. It revealed, in a stark way, the nature of public opinion, public debate, and personal values and beliefs.

This study considered the aforementioned public debate a source of data, an important component of the evaluation exercise that will take place at the end of the three year pilot. This study collected further public opinion data in the form of interviews of persons – stakeholders – who had identified themselves as spokespersons in the pre-trial public debate. Although mid-trial (rather than post-trial), information was sought concerning if, and in what way, public opinion had shifted now that the safe injection site was a reality, having been in operation for eight months at the time of the interviews.

The data show less of a shift than I, and others, had anticipated. However, it was clear that these major stakeholders continued to feel strongly about the concept of harm reduction and about the site. It seemed that the reality of Insite did not inform or reshape their strongly held beliefs.

These two pieces of data, the pre-trial and post-trial public perspectives, need to be recognised by evaluation experts as a necessary and critical element of the stakeholder analysis piece of the evaluation exercise. Each stakeholder spoke from a very complex location, informed by such layers as social/economic/political power, life experiences, and personal agendas. Of particular interest was the examination of the voice of the most marginalized stakeholder – the drug user. The drug user most affected by the site was not the white-collar middle-class professional who indulges in cocaine, but rather the street-level addict, poor and underhoused. There can surely be no question that

their voice is crucial, yet how to include it, how to protect it from being crowded out by the voices of the other stakeholders?

It is understandable that VANDU has played a significant part in ensuring that the voice of the drug user is solicited and respected. However, not all users are thus organised, and there remains a need for the evaluation team to ensure that the politically delicate nature of this particular evaluation exercise does not interfere with a fair and equitable stakeholder analysis. There would be no Insite if there were nobody to use it, and while the voice of the street-level addict may not wield the same power as that of a client who pays for a service, it would be a poor piece of research if this voice was not carefully sought and considered.

Bibliography

Acland, Charles R. (1995) *Youth, Murder, Spectacle: The Cultural Politics of "Youth in Crisis"*. Boulder: Westview Press.

Alex, J. P. S. (1995). *Understanding the Dynamics of Stakeholder Participation in Evaluation Research.* Unpublished master's thesis, University of British Columbia, Vancouver, British Columbia.

Alexander, B. K. (1990). *Peaceful Measures: Canada's Way Out of the 'War on Drugs'.* Toronto: University of Toronto Press.

Arnold, R., Burke, B., James, C., Martin, D., & Thomas, B. (1991). *Educating for a Change*. Toronto: Between the Lines.

Auditor General of Canada (2001). Illicit Drugs: The Federal Government's Role. *Report of the Auditor General of Canada.* Ottawa.

BC Centre for Excellence in HIV/AIDS. (2003). *Vancouver Supervised Injection Site Evaluation Proposal.* p.2.

Barron, C. L. (2000). *Giving youth a voice : a basis for rethinking adolescent violence.* Halifax, N.S.: Fernwood Publishing.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). *Women's Ways of Knowing: the development of self, voice and mind.* New York: Basic Books, Inc.

Bennett, W. J., DiLulio, J. J., & Walters , J. P. (1996) *Body Count: moral poverty . . . and how to win America's war against crime and drugs.* New York: Simon & Schuster.

Berg, B. (2004). *Qualitative Research Methods for the Social Sciences.* Boston: Pearson, Allyn & Bacon.

Berk, R. A. & Rossi, P. H. (1977). Doing good or doing worse: Evaluation research politically reexamined. *Evaluation Studies Review Annual,* Vol. 2, pp 77-90.

Bernstein, D.J., Whisett, M.D., & Mohan, R. (2002). Addressing Sponsor and Stakeholder Needs in the Evaluation Authorizing Environment: trends and implications. *New Directions for Evaluation.* (95) Fall 2002.

Boone, L. E. & Bowen, D. D. (1987). (Eds.). *The Great Writings in Management and Organizational Behaviour.* New York: Random House.

Brandon, P. R. (1998). Stakeholder Participation for the Purpose of Helping Ensure Evaluation Validity: bridging the gap between collaborative and non-collaborative evaluations. *American Journal of Evaluation.* (19). pp.325-337.

Byrne, A. (2001). *Injecting Room up and running in Sydney.* Retrieved July 10, 2005 from http://www.drugpolicy.org/library/sydney_injection.cfm

CBC News Online staff (2003). *Vancouver's safe injection site a concern: UN.* Retrieved April 4, 2005, from http://www.cbc.ca/stories/2004/03/02/canada/un_injection040302

Chambers, R. (1999). *Whose Reality Counts? Putting the first last.* London: Intermediate Technology Publications.

Cohen, Stanley. (1972) *Folk Devils and Moral Panics: the creation of the Mods and Rockers.* London: MacGibbon and Kee.

Cook, T. D. (1997). Lessons Learned in Evaluation Over the Past 25 Years. In E. Chelimsky and W. R. Shadish (Eds.), *Evaluation for the 21st Century: a handbook.* (pp.30-52). Thousand Oaks, CA: Sage Publications.

Csiernik, R., & Rowe, W. S. (Eds.). (2003). *Responding to the Oppression of Addiction: Canadian social work perspectives.* Toronto: Canadian Scholars' Press, Inc.

Dempsey, O. (2004). The Cost of Forgetting: lessons from Canada's "worst" Neighbourhood. Retrieved August 23, 2005, from http://www.canadiandimension.mb.ca/v38/v38_5od.htm

A Dialogue on the Prevention of Problematic Drug Use. (February 2004). *A Summary of Proceedings from the Symposium "Visioning A Future For Prevention: A Local Perspective".* City of Vancouver, British Columbia.

Dolan, K. & Wodak,A. (1996). Final Report on injecting rooms in Switzerland. Retrieved July 10, 2005 from http://www.lindesmith.org/library/dolan2.cfm

Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D., & Trautmann, F. (2000). Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia. *Harm Reduction Digest 10, Drug and Alcohol Review. 19, pp. 337-346.*

DTES Revitalization. (n.d.). *Vancouver Agreement.* Retrieved September 3, 2004 from:http://www.city.vancouver.bc.ca/commsvcs/planning/dtes/pdf/va.pdf

Erickson, P.G., Riley, D.M., Cheung, Y.W., & O'Hare, P.A. (Eds.). (1997). *Harm Reduction: a New direction for drug policies and programs.* Toronto: University of Toronto Press.

Evans, C. & Fisher, M. (1999). Collaborative evaluation with service users: moving towards user-controlled research. In I. Shaw & J. Lishman (Eds.). *Evaluation and Social Work Practice.* London: Sage.

Fetterman, D. M., Kaftarian, A. J. & Wandersman, A. (Eds.). (1996). *Empowerment Evaluation: knowledge and tools for self-assessment and accountability.* Newbury Park, CA: Sage.

Finch, J. (1991). Feminist Research and Social Policy. In M. McLean & D. Groves (Eds.). *Women's Issues in Social Policy* (pp. 194-204). London: Routledge.

Fine, A. H., Thayer, C. E. & Coghlan, A. (2003). *Program Evaluation Practice in the Nonprofit Sector.* Washington, D.C.:Innovation Network, Inc.

Fitzpatrick, J. L., Sanders, J. R., & Worthen, B. R. (2004). *Program Evaluation: Alternative Approaches and Practical Guidelines.* Boston: Pearson Education Inc.

Follman, M. (2003). *Canada's safe haven for junkies.* Retrieved August 31, 2005, from http://archive.salon.com/news/feature/2003/09/08/vancouver/index_np.html

Gerlach, R. & Schneider, W. (2002). *Consumption and Injecting Room (CIR) at INDRO, Münster, Germany: Annual Report 2002 (English Version).* Retrieved July 5, 2005, from http://www.indro-online.de/cir.htm

Giffen, P.J., Endicott, S. & Lambert, S. (1991). *Panic and Indifference : the politics of Canada's drug laws.* Ottawa : Canadian Centre on Substance Abuse.

Giroux, Henry A. (1996). *Fugitive Cultures: Race, Violence and Youth.* New York: Routledge

Glesne, C. & Peshkin, A. (1992). *Becoming Qualitative Researchers: an introduction.* White Plains, NY: Longman.

Gold, F. (2003). Supervised Injection Facilities. *Canadian Nurse, 99 (2).*

Goodwin, L. & Tu, J. (1975). The social psychological basis for public acceptance of the social security system: The role for social research in public policy formation. *American Psychologist* (30). pp 875-883.

Government of Canada (1991). *Canada's Drug Strategy.* Ottawa.

Government of Canada (1998). *Canada's Drug Strategy.* Ottawa.

Graham, J. R., Swift, K. & Delaney, R. (Eds.). (2002). *Canadian Social Policy: an introduction.* Toronto: Prentice Hall.

Gray, M. (2000). *Drug Crazy: how we got into this mess and how we can get out.* New York: Routledge.

Greene, J. G. (1988). Stakeholder participation and utilization in program evaluation. *Evaluation Review,* (12), pp.91-116.

Gregory. A. (2000). Problematizing Participation: A Critical Review of Approaches to Participation in Evaluation Theory. *Evaluation* (6)2, 179-199. Retrieved June 15, 2005 from http://evi.sagepub.com.libaccess.lib.mcmaster.ca/

Guba, E. G. & Lincoln, Y. S. (1989). *Fourth Generation Evaluation.* Newbury Park, CA: Sage Publications.

Health Canada. (1997). *Federal government responds to the HIV/AIDS crisis among injection drug users in Vancouver.* Retrieved June 15, 2004 from http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/1997/1997_aids_nr_e.html

Health Canada (2001). *Reducing the Harm associated with injection drug use in Canada.* Retrieved July 9, 2005 from http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogues/injection/index_e.html

Higgitt, N., Wingert, S., Ristock, J., Brown, M., Ballantyne, M., Caett, S., et. al. (2003). *Voices from the Margins: experiences of street-involved youth in Winnipeg.* Winnipeg: Winnipeg Inner-City Research Alliance.

House, E. & Howe, R. (2000). Deliberative Democratic Evaluation. *New Directions for Evaluation.* 85, pp.3-12.

"Insite - North America's first official supervised injection site" Retrieved July 5, 2004 from http://www.vch.ca/sis/

International Federation of Red Cross and Red Crescent Societies. (2003). *Spreading the light of science - Guidelines on harm reduction related to injecting drug use.* Retrieved July 30, 2005 from http://www.ifrc.org/docs/pubs/health/hivaids/harm_reduction.pdf

Judge, W. Q. Jr. (1994). Correlates of Organizational Effectiveness: A Multilevel Analysis of a Multidimensional Outcome. *Journal of Business Ethics,* (13)1, pp 1-10.

Kerr, T.& Palepu, A. (2001). Safe injection facilities in Canada: is it time? *Canadian Medical Association Journal,* 165(4), 436-441.

Kirby, S. & McKenna, K. (1989). *Experience/Research/Social Change: Methods from the Margins.* Toronto: Garamond Press.

Ledwith, M. (1997). *Participating in Transformation: Towards a working model* of community empowerment. Birmingham: Venture Press.

London, J. K., Zimmerman, K., & Erbstein, N. (2003). Youth-led research and evaluation: tools for youth, organizational and community development. *New Directions for Evaluation.* (98).

Loxley, W. (2000). Doing the possible: harm reduction, injecting drug use and blood borne viral infections in Australia. *International Journal of Drug Policy.* 11(6), pp. 407-416.

MacPherson, D. (2001). *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver.* City of Vancouver, British Columbia.

Malatesta, D., Kubler, D., Joye, D., & Hausser, D. (2000). Between public health and public order: Harm reduction facilities and neighborhood problems. In J.P. Moatti, Y. Souteyrand, A. Prieur, & P. Aggleton (Eds.). *AIDS in Europe: new challenges for the social sciences* (pp. 178-188). New York: Routledge.

Malowaniec, L. & Rowe, W. S. (2003). Social Workers and Safer Injecting Rooms: We accept them the way they are. In Csiernik, R. & Rowe, W. S. (Eds.). *Responding to the Oppression of Addiction: Canadian Social Work Perspectives* (pp. 37-52). Toronto: Canadian Scholars' Press Inc.

McHardy, J. (2002). New partnerships require new approaches to participatory program evaluations: Planning for the future. *The Canadian Journal of Program Evaluation.* 17(2). pp.89-102.

McHardy, J. (2003). Negotiating Participation in Participatory Program Evaluation: The Dance of Collaboration. Retrieved May 10, 2004 from http://www.evaluationcanada.ca/distribution/20030601_mchardy_joan.pdf

Mertens, D.M. (1999). Inclusive Evaluation: Complications of transformative theory for evaluation. *American Journal of Evaluation.* 20(1), pp.1-14.

Minkler, M. & Wallerstein, N. (Eds.) (2003). *Community-Based Participatory Research for Health.* California: Jossey-Bass.

Moore, Dene (2000). Vancouver group angry over drug problem. *The Canadian Press,* retrieved June 14, 2005 from http://www.canoe.ca/Health0008/10_drugs.html

Morell, J. A. (1979). *Program Evaluation in Social Research.* New York: Pergamon Press.

Morris, D. B. (2002). The Inclusion of Stakeholders in Evaluation: Benefits and Drawbacks. *The Canadian Journal of Evaluation.* (17)2, pp. 49-58.

Mulgrew, I. (1999). City staff want to change the way we deal with drugs. *The Vancouver Sun:* Vancouver, British Columbia.

Muller-Clemm, W.J. & Barnes, M.P. (1997). A historical perspective on federal program evaluation in Canada. *The Canadian Journal of Program Evaluation.* (12)1, 47-70.

Neuman, L. (1977). Social Research Methods: Qualitative and Quantitative Approaches. Boston: Allyn & Bacon.

Oakley, P. (1991). *Projects with People.* Geneva: International Labour Organization.

O'Brecht, M. (1992). Stakeholder Pressures and Organizational Structure. *Canadian Journal of Program Evaluation.* (7) 2.

Palumbo. D. J. (1987). Politics and Evaluation. In *The Politics of Evaluation.* Dennis J. Palumbo (Ed.). Newbury Park, CA: Sage Publications, Inc.

Patton, M. Q. (1997). *Utilization-Focused Evaluation: The New Century Text.* Thousand Oaks, CA: Sage Publications.

Pawson, R. & Tilley, N. (1997). *Realistic Evaluation.* London: Sage.

Petras, E. M. & Porpora, D. V. (1993). Participatory Research: three models and an analysis. *American Sociologist,* (24)1.

Rebien, C. C. (1996). Participatory Evaluation of Development Assistance: Dealing with power and facilitative learning. *Evaluation* 2(2), pp.151-172.

Riley, D. (1998) Drugs and Drug Policy in Canada: a brief review and commentary. Retrieved August 2, 2005 from http://www.cfdp.ca/sen1841.htm

Riley, D. (2003). *An overview of harm reduction programs and policies around the world.* Ottawa: Health Canada.

Rossi, P. H. (1972). Boobytraps and pitfalls in the evaluation of social action programs. In C. H. Weiss (Ed). *Evaluating Action Programs: Readings in social action research.* Pp.224-235. Boston: Allyn & Bacon.

Rowe, D. (1989). Foreward, in J. Masson. *Against Therapy.* London: Collins.

Schissel, Bernard. (1997). *Blaming Children: Youth Crime, Moral Panics and the Politics of Hate.* Halifax: Fernwood Publishing.

Scriven, M. (1991). *Evaluation Thesaurus.* CA: Sage Publications.

Sherman, E. & Reid, W. J. (Eds.) (1994). *Qualitative Research in Social Work.* New York: Columbia University.

VanderPlaat, M. (1997). Emancipatory politics, critical evaluation and governmental policy. *The Canadian Journal of Program Evaluation.* (12)2 pp.143-162.

Vernooy, R., Qiu, S. & and Jianchu, X. (Eds.). (2003). *Voices for Change: Participatory Monitoring and Evaluation in China.* Ottawa: International Development Research Centre.

Watkin, J. , Rowe, W. S. & Csiernik, R. (2003). Prevention As Controversy: Harm Reduction Approaches. In R. Csiernik and W. S. Rowe (Eds.). *Responding to the Oppression of Addiction: Canadian Social Work Perspectives*. Toronto: Canadian Scholars' Press.

Weiss, C. H. (1973). Where Politics and Evaluation Research Meet. In D. J. Palumbo (Ed.). *The Politics of Program Evaluation.* pp. 47-70.

Weiss, C. H. (1970). The politicization of evaluation research. *Journal of Social Issues* (26). Pp.57-68.

Western Economic Diversification Canada. (2004). *Vancouver Agreement: A Governance Case Study.* Retrieved September 3, 2004 from http://www.wd.gc.ca/rpts/audit/va/default_e.asp

Whitmore, E. (2001). 'People Listened To What We Had To Say': Reflections on an Emancipatory Qualitative Evaluation. In I. Shaw & N. Gould (Eds.). *Qualitative Research in Social Work.* London: Sage.

Wild, N. (Producer). (2002). *FIX: The Story of an Addicted City* (Documentary Film). (Available from Canada Wild Productions, 1818 Grant Street, Vancouver, British Columbia. V5L 2Y8).

World Health Organization, (2005). *Status Paper on Prisons, Drugs, and Harm Reduction.* Retrieved July 30, 2005 from http://www.euro.who.int/document/e85877.pdf

Yee, J. Y. & Dumbrill, G. C. (2003). Whiteout: Looking for race in Canadian Social Work Practice. In A. Al-Krenawi & J. R.Graham (Eds.), *Multi-cultural Social Work in Canada-Working with Diverse Ethno-Racial Communities.* Toronto: Oxford University Press.

Appendix A

INTERVIEW GUIDELINES

- What is your role in this organisation? How long have you been involved? In what capacities?
- How did you come to be identified as a public spokesperson?
- What do you see when you look at the Downtown Eastside?
- What meaning does the Downtown Eastside have for you?
- Would you call it a problem?
- Was there a time when it wasn't a problem? What was it like then?
- What happened to change it into a problem?
- What has been done to address the problem?
- What has been the result?
- What do you think about the idea of safe injection sites?
- What do you think about the idea of a harm reduction approach?
- What do you think would work to fix the problem?
- How do you see that playing out?
- What has it been like for you since Insite opened?
- What has it been like for the Downtown Eastside since Insite opened?
- What do you think the Downtown Eastside will be like 2 years from now, when Insite will have been operating for 3 years?
- What should the evaluators do to get the information that will tell them whether or not the project has been successful?
- Who should be performing the evaluation?
- What do you think would happen if other cities in Canada got a program like Insite?
- Are your views shared by the rest of your community?

Appendix B

LETTER OF INFORMATION

Project Title: Framework for Reaction: the politics of evaluating North America's first safe injection site

Student Investigator: Susan Sterling, MSW student, School of Social Work at McMaster University, Hamilton, Ontario
Contact: (519) 645-0324 or sterlisj@mcmaster.ca
Faculty Supervisor: Dr. Donna Baines, Faculty of Social Work, McMaster University, Hamilton, Ontario
Contact Number: (905) 525-9140 ext. 23703 or bainesd@mcmaster.ca

PURPOSE OF THE STUDY

This project is a research study, intended to produce a set of principles that would be useful in the design of an evaluation strategy for Insite. The hallmark of these principles will be that they are founded on the perspectives of different stakeholders, especially those of the service users.

PROCEDURES

The researcher will interview, privately, relevant key stakeholders who have identified themselves as public spokespersons with an interest in the outcome of the Insite project. Interviews will be audio-taped and later transcribed. Interviews will last an hour or more, depending on the participant's willingness to answer questions. The interview will be conducted at a place of the research participant's choice. Researcher will ask such questions as:

- What do you see when you look at the Downtown Eastside?
- What has it been like since Insite began operating?
- What kind of information will tell the evaluators whether or not the project has been successful?

Participants are free to decline to answer any question.

POTENTIAL RISKS/DISCOMFORTS

There are no anticipated risks or discomforts. Participants are free to decline to answer any question they feel would make them uncomfortable or to withdraw entirely from the study with no reprisals.

POTENTIAL BENEFITS

Participants will receive no direct benefits (such as payment) from taking part in this study, apart from knowing that their experience and knowledge are being valued.
An indirect benefit is the opportunity to participate in the development of a set of principles that may by used to develop an evaluation strategy for the Insite project.
Participants may request a free copy of the research findings at the conclusion of the study.

CONFIDENTIALITY

Any information that is obtained in connection with this study that identifies participants by name will be kept strictly confidential, unless the participant is willing to have his/her name associated with the information. To protect confidentiality, audio tapes will be stored in a locked file cabinet in a temporary home office during the research period in Vancouver. Upon the researcher's return to Ontario, tapes and transcripts will be stored in a locked file cabinet in the researcher's home office. Tapes will be destroyed after 3 years, and transcripts will be destroyed after 10 years.

PARTICIPATION AND WITHDRAWAL

Participants can choose whether or not to be in this study. Participants can turn off the tape recorder at any point or decline to answer any questions. Participants may withdraw at any time from participation in the study without reprisal.

RIGHTS

Participants do not waive any legal claims, rights or remedies because of their participation in this research study. This study has been reviewed and has received ethics clearance through the McMaster Research Ethics Board (MREB). Questions about this study can be directed to either the student investigator (Susan Sterling), or to Susan's faculty supervisor (Dr. Donna Baines). Questions regarding the rights of the research participant can also be directed to:

MREB Secretariat
McMaster University
1280 Main St. West, GH-306
Hamilton, ON L8S 4L9

Telephone: (905)525-9140 ext. 23142

e-mail: srebsec@mcmaster.ca
Fax: (905)540-8019

Appendix C

CONSENT TO PARTICIPATE IN RESEARCH

Project Title: Framework for Reaction: the politics of evaluating North America's first safe injection site

You are being asked to take part in a research project conducted by Susan Sterling, MSW student at the School of Social Work at McMaster University in Hamilton, Ontario. If you have any questions or concerns about the research, please feel free to contact Susan at (519)645-0324 or e-mail her at sterlisj@mcmaster.ca. You may also contact her faculty supervisor Dr. Donna Baines at (905)525-9140, ext. 23703 or e-mail at bainesd@mcmaster.ca.

PURPOSE OF THE STUDY

This project is a research study, intended to produce a set of principles that would be useful in the design of an evaluation strategy for Insite. The hallmark of these principles will be that they are founded on the perspectives of different stakeholders, especially those of the service users.

PROCEDURES

The researcher will interview, privately, relevant key stakeholders who have identified themselves as public spokespersons with an interest in the outcome of the Insite project. Interviews will be audio-taped and later transcribed. Interviews will last an hour or more, depending on the participant's willingness to answer questions. The interview will be conducted at a place of the research participant's choice. Researcher will ask such questions as:

- What do you see when you look at the Downtown Eastside?
- What has it been like since Insite began operating?
- What kind of information will tell the evaluators whether or not the project has been successful?

Participants are free to decline to answer any question, to turn the tape recorder off at any point or to stop the interview entirely with no reprisals.

POTENTIAL RISKS/DISCOMFORTS

There are no anticipated risks or discomforts. Participants are free to decline to answer any question they feel would make them uncomfortable or to withdraw from the study entirely at any point in time with no reprisals.

POTENTIAL BENEFITS

Participants will receive no direct benefits (such as payment) from taking part in this study, apart from knowing that their experience and knowledge are being valued. An indirect benefit is the opportunity to participate in the development of a set of principles that may by used to develop an evaluation strategy for the Insite project.
Participants may request a free copy of the research findings at the conclusion of the study.

CONFIDENTIALITY

Any information that is obtained in connection with this study that identifies participants by name will be kept strictly confidential, unless the participant is willing to have his/her name associated with the information. To protect confidentiality, audio tapes will be stored in a locked file cabinet in a temporary home office during the research period in Vancouver. Upon the researcher's return to Ontario, tapes and transcripts will be stored in a locked file cabinet in the researcher's home office. Tapes will be destroyed after 3 years, and transcripts will be destroyed after 10 years.

PARTICIPATION AND WITHDRAWAL

You can choose whether or not to be in this study. You may refuse to answer any question you don't want to answer, and still remain in the study. You may also withdraw altogether at any time, without reprisal.

RIGHTS

You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and has received ethics clearance through the McMaster Research Ethics Board (MREB). Questions about this study can be directed to either the student investigator (Susan Sterling), or to Susan's faculty supervisor (Dr. Donna Baines). If you have questions regarding your rights as a research participant, contact:

MREB Secretariat
McMaster University
1280 Main St. West, GH-306
Hamilton, ON L8S 4L9

Telephone: (905)525-9140 ext. 23142
e-mail: srebsec@mcmaster.ca
Fax: (905)540-8019

SIGNATURE OF RESEARCH PARTICPANT

I understand the information that has been provided to me about the study "Framework for Reaction: the politics of evaluating North America's first safe injection site". I agree to participate in this study. I have been given a copy of this form.

____

Participant

____

Date

McMaster University Research Ethics Board (MREB)
c/o Office of Research Services, MREB Secretariat, GH 306K, x 23142, e-mail: ethicsoffice@mcmaster.ca
CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH

APPLICATION STATUS: NEW: ☒ RENEWAL ☐ ADDENDUM ☐ REB# **2004 054**

TITLE OF RESEARCH PROJECT: **Framework for Reaction: the Politics of Evaluating North America's First Safe Injection Site**

	NAME	DEPT./ADDRESS	# EXT	E - MAIL
Faculty Investigator(s)/Supervisor(s)	D. Baines	Social Work	23703	bainesd
Student Investigator(s)	S. Sterling	Social Work	519-645-0324	booler@sympatico.ca

The application in support of the above research project has been reviewed by the MREB to ensure compliance with the Tri-Council Polic Statement and the McMaster University Policies and Guidelines for Research Involving Human Participants. The following ethics certification is provided by the MREB:

☐ **The application protocol is approved as presented without questions or requests for modification.**
X **The application protocol is approved as revised without questions or requests for modification.**
☐ **The application protocol is approved subject to clarification and/or modifications as appended or identified below.**

COMMENTS & CONDITIONS:

Reporting Frequency:	Annual Date:	Other:
DATE: May 10, 2004	Dr. D. Maurer, Chair, REB: Daphne Maurer	

3370 31