VOICES OF ADDICTION - AN ANALYSIS OF THE LIVES OF INDIVIDUALS LIVING WITH DRUG USAGE IN WESTERN CANADA

HANNAH LEIGH FORSTER
Bachelor of Nursing, University of Lethbridge, 2017

A thesis submitted
in partial fulfilment of the requirements for the degree of

MASTER OF ARTS

in

ANTHROPOLOGY

Department of Anthropology
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

VOICES OF ADDICTION - AN ANALYSIS OF THE LIVES OF INDIVIDUALS LIVING WITH DRUG USAGE IN WESTERN CANADA

HANNAH LEIGH FORSTER

Date of Defence: April 17, 2020

Dr. Steven Ferzacca Thesis Supervisor	Associate Professor	Ph.D.
Dr. Gabriel Asselin Thesis Examination Committee Member	Adjunct Assistant Professor	Ph.D.
Dr. Jodie Asselin Thesis Examination Committee Member	Associate Professor	Ph.D.
Dr. Kristine Alexander Thesis Examination Committee Member	Associate Professor	Ph.D.
Dr. James MacKenzie Chair, Thesis Examination Committee	Associate Professor	Ph.D.

DEDICATION

To those fighting every day to simply survive in a world that is so vehemently against you. I pray I did justice to your story, and that I shared your voice in its most authentic form.

ABSTRACT

This research focuses on individuals living with drug usage in a small, western Canadian town amidst the opioid crisis. The opioid crisis has reached a record high in regards to morbidity and mortality. It has become more than a crisis of opioids or narcotics. It is a massive, complex, and multifaceted public health issue which has percolated to the very bedrock of our society. Oral history narratives were collected in order to gain a deeper understanding of the circumstances and experiences which profoundly impacted the lives of these individuals and contributed to their drug usage. Eight life histories were collected at a local harm reduction clinic from 2018 to 2020. Utilizing the methodology of Oral History helped to facilitate meaningful and insightful conversation. This research proved to be valuable in contributing to the discourse surrounding individuals living with drug usage; their stories, their struggles, and their successes.

PREFACE

During the course of this research I had the tremendous opportunity to spend significant amounts of time with individuals currently living with drug usage. I was privileged to get to know them on a personal level, and to hear their most intimate stories. I received their consent for all contributions to this writing. I have used pseudonyms in all instances, and have altered identifiable features from their descriptions. I have changed names and descriptions of geographical places to further maintain anonymity. Despite this, I have attempted to maintain their story in its most authentic state and have refrained from embellishing any quotes, stories, or details.

ACKNOWLEDGEMENTS

A special thanks to Dr. Steven Ferzacca, whose patient guidance and encouragement made this challenge, enjoyable.

Thank you to my parents, Scott and Donna, for their endless support.

And to my love and my heart, Lucas, for holding me up when the emotional toll of this project became too heavy to carry alone.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

ILDU: Individuals living with drug usage

HIV: Human Immunodeficiency Virus

AIDS: Acquired Immune Deficiency Syndrome

CWS: Child Welfare Services

LIST OF JARGON

Meth/Side/Crystal/Jib: Methamphetamine (stimulant, typically smoked or injected)

Soft/Rock: Cocaine (stimulant, typically snorted)

Hard/Crack: Crack Cocaine (stimulant, typically smoked or injected)

Down: Heroin, fentanyl, carfentanil (opioids, depressants, typically consumed orally, smoked, or injected)

Oxy 80s: Oxycodone (opioid, typically consumed orally)

Weed: Marijuana (depressant, typically smoked)

CHAPTER 1: INTRODUCTION

1.1: THE OPIOID CRISIS

The purpose of this research was to gain insight into the lives of individuals living with addiction, and to illuminate the voice of this marginalized population. The goal was to understand some of the barriers this population faces accessing various forms of healthcare, as well as to understand the life events and social constructs which had contributed to their current circumstances. The "opioid crisis" refers to the current and ongoing issue of opioid and narcotic abuse and dependence (Alberta Government, 2020). Historically, the opioid crisis referred to substance abuse within a group of individuals using heroin and morphine, however, it has since expanded to include a variety of substances such as oxycodone, fentanyl, carfentanil, and other Central Nervous System depressants and stimulants (Centers for Disease Control and Prevention, 2020). At face value, the opioid crisis seems to be an issue with chemicals and substances, however through this research, it became apparent that the opioid crisis is a significant social complexity. The opioid crisis is a public health issue which is further complicated by social issues such as economic disparity, homelessness, racial division, and intergenerational trauma.

I conducted research at a local harm-reduction clinic, with the goal of illuminating stories of individuals living with drug usage (ILDU). Through conducting eight oral history interviews I was able to get a first-hand account of not only the daily struggles of these individuals, but also a rich collection of the background, culture, community, identity, and history of this group.

My research focused on the history of public health campaigns aimed at users of various licit and illicit drugs. I conducted these oral histories with drug users who frequent clinics in a small western Canadian town. My aim was to grasp how past and current public health policies and punitive legislation, as well as current healthcare initiatives that directly address addiction framework appears in the life stories and oral histories of ILDU. This research is meant to contribute to the ethnographic and oral history work of licit and illicit drug use. I attempted to understand the complexity of these lives by examining their oral histories of experiences within the healthcare system, addictions treatment, and harm reduction services. Through examining the lives of ILDU I was able to uncover themes of intergenerational trauma, abuse, lasting effects of settler colonialism, numbing emotional pain, inefficacy and inaccessibility of treatment options, incarceration, and perception of self-worth. The most significant element of this research was the stories that were so candidly told, and the life experiences which were shared; the hurt, the pain, the dreams, and the triumphs. I was able to get a sense of who my participants were as people, rather than as a collection of statistics, or a faceless member of a marginalized group. This methodology allowed me to go beyond the surface level of drug usage in the public health sense, and deep into the world and voices of these dynamic individuals.

I begin this thesis with a brief reflection on self-reflexivity, followed by a background of drug abuse and the opioid crisis globally, and more specifically within Canada. I then continue with a discussion of harm reduction within the local setting of Southern Alberta. Interwoven into this conversation of harm reduction are life stories of all eight

of the participants. This section is followed by emerging themes, findings, analysis, and a discussion of the lessons learned through completing this combination of ethnographical and oral history research. This thesis finishes with a final discussion and conclusion. The research process, interview guide, and research challenges are located in the appendices.

1.2: SELF-REFLEXIVITY

I came into this project feeling, at times, like a displaced health sciences researcher. My expertise, previously, was predominantly with disease processes within the healthcare system and treating health issues from a largely physiological approach. This research challenged my understanding of best practice treatment of a public health issue in addition to challenging my understanding of treating the person, rather than the condition. This project forced me to consider individuals in a greater context, beyond quantitative, measurable, and physical data. Conducting oral histories of ILDU challenged my understanding of public health issues, addictions treatment, and harm reduction as a health approach.

Additionally, I found fascinating the lack of danger or fear I felt when being alone, and in close proximity to, when interviewing this population. Due to stereotypes and the general public's perceptions of ILDU, I had a degree of apprehension towards this population. I found it troubling that I seemed to have taken on the very prejudices that I so righteously sought out to dismantle. In the spirit of self-reflexivity, I want to highlight how I was affected by this. I hope that, by doing so, I can continue to become aware of my own biases and stereotypes towards vulnerable populations. Never once did I feel

my safety was threatened when I was interviewing in this facility, nor did I feel disrespected in any way by the clients within my research. It seems that largely, clients treat the staff with a high degree of respect and kindness, even developing close, respectful, therapeutic friendships with them.

Previously, I have been undoubtedly guilty, on my moral high ground, in suspecting that street involved people and ILDU should take control of their own lives, display some initiative, and have the self-discipline to change the trajectory of their life. One of the most beneficial effects of conducting this research was that I was completely challenged on this notion. Through this process, I have become convinced that individuals do not start using intravenous drugs, become homeless, malnourished, prostitutes, criminals, or have their children apprehended of their own volition, but rather, it is largely passed on to them from years of unthinkable abuse, trauma, and pain.

Repeatedly, I found myself struck by the authenticity and willingness of my research participants to divulge their victories as well as their heartbreaks. I was in awe of their perseverance even in the face of tremendous adversity and tragedy. I was amazed by the fight that they had, and the tenacity with which they lived their lives.

I was also humbled, time and time again, by their gentle spirits and kindness. To withstand the hardships that they have endured, and maintain empathy and kindness for others, was inspiring. I was amazed by the community they have formed within the city, and the degree of support they provide to one another. Despite living in extremely

challenging conditions, they continued to display a high degree of mutual respect to one another, and an inspiring network of comradery.

From the pool of incredible lessons, I learned through this project, the most valuable insight I gained was an overwhelming sense of compassion, empathy, and understanding of the life of individuals living with drug usage. The habit of consuming drugs is not a hobby or a pastime, but rather is a method of masking years of unimaginable hurt, neglect, abandonment, abuse, pain, and trauma. The mind-altering effects of many of the opioids and stimulants is a way for these individuals to escape their reality; one which is so inconceivably troubling that most of us cannot even begin to fathom it. The effects that these individuals experience from using illicit drugs is a way for them to process emotions that cannot yet be processed. They use these drugs to find comfort, attachment, companionship, solace, and relief. The feelings and emotions they experience when they feel the sedating or stimulating effects of their drugs is so relieving because, if only for a fleeting moment, it takes the pain away. I found that they use drugs to find a degree of healing within themselves where they have been so deeply scarred they simply cannot by other means.

CHAPTER 2: BACKGROUND

2.1: HISTORY OF DRUG ABUSE

Drug abuse is a significant social and public health issue. Although not initially consumed for the psychoactive effects but as a food source, human species were quickly able to pinpoint the desirable psychological and physiological properties these plants possessed (Saah, 2005). There is evidence of drug usage by primitive civilizations in the third millennium by the Sumerian people, inhabiting present-day Iraq, who cultivated and consumed opium to "enhance joy" (Brownstein, 1993). Psychoactive substances, such as mushrooms, have been used by ancient civilizations in Central Asia for at least 4000 years (Crocq, 2007), and hallucinogenic substances have been used in parts of Africa and South America as elements of religious ceremonies, in order to induce trance-like states, since the 1400s (Crocq, 2007).

While drugs have existed and been utilized in their natural form for thousands of years, the production and consumption of manufactured drugs started just 200 years ago (Musto, 1996). The first time an opioid was isolated from a natural substance was in 1806, when a German scientist, Friedrich Wilhelm Serturner, produced the drug we now call Morphine, named after the god of dreams, Morpheus, (Brownstein, 1993) which is still used today for analgesic effect (Musto, 1996). Following this ground-breaking advancement in drug research, throughout the mid-1800s, heroin and Cocaine were prescribed by physicians for the treatment of mild ailments such as menstrual pain and to assist women in being "suitable home-makers" (Saah, 2005), (Herzberg, 2017). Around this same time era, German psychiatrist, Wilhelm Griesinger, one of the

founders of modern-day psychiatry, recommended opium for treatment of "melancholia", or sadness (Crocq, 2007). Historically, there has also been widespread drug usage by military leaders, who distributed opium as 'morale-boosters' to soldiers. There is documented evidence of this as recently as in the 1970s during the Vietnam War (Hansen et al., 2018) (Herzberg, 2017). According to a recent study, The Department of Defense Survey of Health-Related Behaviours, there is documented to be high rates of illicit drug usage, as well as the nonmedical use of prescription drugs by members of the military to combat fatigue, decrease stress, as a sleep aid, to lessen pain, and to combat boredom (Beckman et al., 2018).

2.2: HUMANS AND DRUG CONSUMPTION

Drug usage by humans has existed for thousands of years, however, the global criminalization of drug usage and consequent persecution of drug users began only a short time ago (Dobkin & Nicosia, 2009). For thousands of years, drug usage was not criminalized for a number of reasons. Historical drug potency was a fraction of that of current drugs', therefore, the physiological effects were also greatly limited (O'Hare, 2007). Due to this, the visibility of drug usage was minimal, as was the scrutinization of drug users. Additionally, for many centuries, humans have existed in communities with support and family structure that remained largely unchanged. With the industrial boom, the rise of capitalism, and larger populations migrating to concentrated urban areas, many scholars argue that individualism became a necessity of survival (Oden, 2013) (Hari, 2015). In some areas, with the shift towards individualism came a breakdown of the nuclear family structure, and a subsequent loss of connection, which

is believed to have partially contributed to the increase in drug usage observed in this period of history (Oden, 2013) (Hari, 2015).

2.3: SHIFT IN THE WINDS

The scientific discovery of the isolation of narcotics from natural substances led to the commercialization for public consumption in the early 1880s (Saah, 2005). As drugs were refined and became more widespread, the mortality rates associated with opioids increased (Saah, 2005). The historical "War on Drugs", as we commonly refer to it, began in the United States of America (USA) in the early 1960s (Dobkin, Nicosia, 2009), however the American national prohibition of narcotics was in place since the Harrison Anti-Narcotic Act of 1914 at the beginning of what is commonly referred to as the "Classic Era of Narcotic Control" (Dobkin & Nicosia, 2009) (Courtwright et al., 1991). Spearheaded by Harry Ainslinger, the commissioner of the newly-created Federal Bureau of Narcotics (FBN), which later became the Drug Enforcement Agency (DEA), drug use of any kind was increasingly criminalized until the eventual War on Drugs was declared. Ainslinger stated that American youth were, "slaves to narcotics, continuing addiction until they deteriorate mentally, become insane, turn to violent crime and murder" (Courtwright et al., 1991, p.17).

Due to reports of an increase in criminal activity throughout the 1960s, American President Richard Nixon declared the infamous War on Drugs in 1971 and proclaimed illicit drug use, "public enemy number one" (Oden, 2013). Publicly endorsed by Nixon, and later President Ronald Reagan, the War on Drugs became a platform on which to ultra-criminalize drug usage by increasing legal consequences such as more frequent

arrests, harsher fines, and lengthier prison sentences (Dobkin & Nicosia, 2009). The increase in criminalization of drug usage, possession, distribution, and drug-related crimes has been criticized for being a way to justify legal harassment, persecution and imprisonment of minority groups throughout the USA, such as people of colour, Gypsies, Hippies, and neutralists (Dobkin & Nicosia, 2009). The War on Drugs has continued for the greater part of 50 years in the United States and other countries, globally.

2.4: CANADA'S WAR ON DRUGS

Under the leadership of Prime Minister Brian Mulroney, the Canadian government adopted its neighbor to the south's drug control initiatives by imposing harsh legal consequences for drug usage (Oden, 2013). Just two days after President Reagan announced the American War on Drugs, Prime Minister Mulroney announced that, "drug abuse has become an epidemic that undermines our economic as well as our social fabric" (Erickson, 1990). Even as recently as 2011 with the passing of The Safe Streets and Communities Act (Government of Canada, 2018), the Canadian government continued to impose strict legislation surrounding drug usage, without evidence to suggest doing so would lead to a decrease in drug-related crime or drug-related deaths (Hari, 2015). In fact, quite contrarily, stricter laws and an increase in penalization for drug-related offenses has been shown to increase drug-related violence (Hari, 2015). Strict imposition of laws intended to protect communities actually further compounds the issue, leading to drug cartels and gangs regulating drugs and, rather than law enforcement. This leads to dramatic increases in drug-related violence, theft, and homicides (Hari, 2015). A suitable comparison is the prohibition of alcohol in the early

1900s in both Canada and the USA. Rather than seeing the expected drop in substance usage and related criminal activity, there was an increase in prohibition-related violence and death due to underground sales, gang/cartel monopolization of price and payment, and lethal confrontations with law enforcement (Dupre & Vencatachellum, 2005). The Safe Streets and Communities Act of 2011 was a bill passed by the Canadian government which implemented mandatory minimum jail sentences for certain sexual offences, marijuana offences, and drug use and trafficking offences (Government of Canada, 2018). The bill was introduced in response to concern regarding an alleged increase in sexual exploitation of immigrants and homeless individuals. The bill was largely criticized for being a "Band-Aid solution" to a greater socio-cultural problem (Hari, 2015). Despite the efforts by the Canadian government throughout the past 50 years, drug usage persists, with a recent notable increase in drug-related deaths since 2013 (Buchanan, 2004). As a nation-wide issue, there has been great attention drawn to current legislation and enforcement that is in place.

The Center for Disease Control and Prevention (CDC) has identified three waves which outlines the historical trajectory of opioid-related fatalities in the past 20 years. The first wave was in the 1990s when a notable increase in physician prescription of narcotics began. The second wave began in 2010, with a spike in heroin overdoses. The third wave, beginning in 2013, is the wave in which we currently find ourselves; the spike of illicit synthetic opioid-related fatalities, predominantly fentanyl (Center for Disease Control and Prevention, 2020).

Canada's current addictions framework includes a four-pillar approach: prevention, enforcement, treatment, and harm reduction (Alberta Government, 2020). Of these four pillars, the first three are generally accepted by the members of the public, however, the last pillar, harm reduction, remains a largely contentious subject.

2.5: HARM REDUCTION MODEL

For hundreds of years, illicit drug use has been publicly criticized by politicians, healthcare professionals, and law enforcement (Roe, 2005). Historically, complete abstinence has been a focus of treatment efforts within public healthcare models, and a zero-tolerance policy had been adopted by law enforcement (Roe, 2005). Harm reduction, as defined by the Canadian Nurses Association, "is a public health approach aimed at reducing the adverse health, social, and economic consequences of at-risk activities such as the use of illicit substances" (Canadian Nurses Association, 2017). Harm reduction aims to minimize deaths and disease transmission by promoting lowest-risk drug practices for individuals currently unable or unwilling to abstain from drug use (Buxton et al., 2013). The World Health Organization (WHO) actively promotes Harm Reduction as a set of initiatives, policies, programs, and services, and encourages countries to increase their efforts in order to mitigate the negative effects of injection/inhalation drug usage (World Health Organization, 2013). The controversial concept of harm reduction began as a movement in the 1980s during the HIV/AIDS crisis amongst intravenous (IV) drug users (Roe, 2005). The focus of public health campaigns shifted from criticizing HIV/AIDS patients for their lifestyles to seeking opportunities to slow the spread of the virus from IV drug users, sex workers, among gay men and into

the general public (Roe, 2005). Initially met with great criticism for being a platform on which to enable drug usage, public health workers have worked tirelessly to gain the public's acceptance of harm reduction initiatives in Canada, by educating the public on the benefits. The Harm Reduction Model was implemented as a crucial component of Canada's public health response to rising rates of infectious diseases and IV drug-use complications. The Harm Reduction Model has been adapted by the Government of Canada, based on research compiled by the Canadian Research Initiative in Substance Misuse (CRISM) which works to reduce risk, improve health, and connect people with other key health and social services (Government of Canada, 2018). Canada's adaptation of the Harm Reduction Model is reflected within the Pillars of the Canadian Drugs and Substances Strategy, which works with provinces and territories to educate the public and regulate access to cannabis (Government of Canada, 2018). It also makes naloxone (Narcan), an opioid-antagonist which reverses the effects of opioid overdose, more accessible. Additionally, this strategy supports frontline harm reduction interventions, advocating for access to supervised consumption sites, and continued research into safer drug use practices. Lastly, Canada's drug and substances strategy, advocates for First Nations addiction and mental health treatment through federally-funded health services and addiction treatment for First Nations, Metis, Inuit (FNMI) communities (Government of Canada, 2018).

Presently, within Western Canada, the opioid crisis has reached a record high in regards to morbidity and mortality (Health Canada, 2019). It has become more than a crisis of opioids or narcotics. It is a massive, complex, and multifaceted public health

issue which has percolated to the very bedrock of our society. The opioid crisis is not isolated to one geographical location, people group, economic bracket, gender, or culture. It is an increasingly worrisome issue within Western Canada. Although prevalent country-wide, opioid-related fatalities and hospitalization rates are highest in British Columbia, Alberta, Yukon, and The Northwest Territories (Belzak & Halverson, 2018). The opioid crisis has been declared a national public health crisis by the Government of Canada (Health Canada, 2019). The opioid crisis is further complicated to by the inappropriate and over-prescription of opioids/narcotics by physicians and nurse practitioners for physical pain (Belzak & Halverson, 2018).

Along with illicit drugs, prescription drugs are being dispensed at an all-time high, increasing over 3000% since the 1980s, with roughly 20 million prescriptions dispensed in the year 2016 (Belzak & Halverson, 2018). Canada consumes the second highest number of opioids in the world, second only to the USA (Belzak & Halverson, 2018). According to the newly-released 2019 Opioid Response Surveillance Report Quarterly, there were over 680 accidental opioid-related fatalities in Alberta in 2018, which equates to 1.9 Albertan fatalities per day from accidental opioid-overdose (Alberta Government, 2019). The issue of drug abuse and overdose exists deep in the roots of Canadian society, even within the local community of Southern Alberta.

CHAPTER 3: HARM REDUCTION IN A PRAIRIE COMMUNITY

Cameron - "It's mostly a story of a lot of loss, and a lot of hurt"

Cameron's story was told to me as I was collecting "illness narratives" (Kleinman 1980) and oral histories of health care from clients who use a Safe Consumption Site (SCS) to reduce the harm involved in drug usage. In 2018, Lethbridge opened its' first Supervised Consumption Site (SCS), where individuals can consume various pre-obtained illicit drugs by intravenous injection, inhalation, nasal inhalation, and orally in a clinic with access to sterile supplies, nurse and paramedic supervision, and overdose prevention and treatment. Although the population of Lethbridge is only marginally over 100 000 residents, its SCS averages 680 visits per day, making it the busiest supervised consumption site, by visit, in North America, even surpassing Vancouver and Toronto, much larger city centres (City of Lethbridge, 2019). The term "visits", all encompasses both new and repeat client uses. It is speculated to be either the most, or second most frequented SCS in the world (Alberta Government, 2020). The Lethbridge SCS was opened in response to the disproportionate rates of drug usage within this small city, and the large number of opioid-related fatalities. Supervised consumption sites serve as a gateway for individuals who use drugs to access healthcare services. Clients have numerous resources available to them such as communicable disease testing, addictions treatment referrals, clean needles and other sterile drug-consumption supplies, and access to take-home Naloxone/Narcan kits. There have been no reported fatalities in SCSs across Canada, to date (Caulkin et al., 2019). SCSs have been shown to decrease the

amount of drug-related paraphernalia discarded in public spheres (syringes, crack pipes etc.), drastically decrease the rates of opioid-related overdoses, and decrease the rate of transmission of communicable diseases, such as HIV and Hepatitis C (Allen et al., 2019). SCSs also increase the rate of enrolment in detox and treatment programs for individuals living with addictions (Allen et al., 2019). The first SCS in North America was opened in Vancouver, Canada in 2003, in a notoriously problematic area; the Downtown East side. SCSs act as the ultimate embodiment of the Harm Reduction Model; reducing harm associated with a certain activity, judgment free, whilst providing opportunities for healthier ways of living when sought out.

I conducted research on individuals living with drug usage, and their experiences accessing harm reduction initiatives and addictions treatment options in Lethbridge, Alberta. Aids Research Community Harm Reduction and Education and Support Society (ARCHES), a local example of the Harm Reduction approach, functions as a not-for-profit service for at-risk ILDU within Southern Alberta. Its focus is on minimizing harm to both the individual as well as to the public through a variety of programs (ARCHES, 2020). The Lethbridge SCS is located within ARCHES. As ARCHES provides a significant number of services to individuals living with drug usage, their facility is a valuable starting point for understanding this public health issue. In collaboration with ARCHES, I conducted research into the lives of individuals living with drug usage in order to more deeply understand the issues faced by this population. These interviews are being archived at ARCHES, with the intent to increase understanding of the issue through public presentations at the completion of my data collection.

This interview took place in the waiting room at the SCS. I was approached by a young man, asking me, “Are you the girl with the Tim Horton’s gift cards?”.

We will call him Cameron.

Cameron is eager to share, regardless of his motives, and divulges candidly and seemingly, honestly. Cameron starts off his story by stating, “Well, it’s mostly a story of a lot of loss, and a lot of hurt”.

Cameron’s mom died early on, from a drug overdose. Cameron rarely saw his Dad growing up, saying that he would just, “come and go”.

He was raised by grandparents. His grandmother was an alcoholic. His grandparents split while he was in their care, “After my grandma and grandpa split things kind of went downhill”.

Cameron started drinking early on, “When I was eight years old”.

He started doing drugs when he was 14 years old; first weed, then cocaine, then on to crack. Cameron worked for the Indian Reservation he lived on for many years. Cameron got suspended for work when he was caught intoxicated at work,

> They put me through detox, which was good. I even completed treatment! But once I got out there was nowhere for me to go. Treatment is good but if you have nowhere to go after you complete it, no home, well you end up back at the shelter! (Participant #4)

Cameron got married and had several kids. When his wife cheated on him, they separated, and he moved in with his father,

> That's when things really started to get bad. My nephew drowned. . . Then right after that, my Dad fell and broke his sternum and died. I got so depressed, I started doing drugs regularly. I started doing 'Oxy 80s'. Drugs was the only way I could manage. (Participant #4)

Cameron lost custody of his children, saying, "I haven't seen them in forever".

Cameron talked extensively about how drugs were an escape for him, saying,

> When I started using again. . . drugs became my home. They gave me something to do and somewhere to go. They numb you. They help you avoid pain. They give me positive thoughts. They help me forget I lost my house, my kids, my job, my family. (Participant #4)

Cameron takes part in the Indigenous Recovery Program at ARCHES, saying, "It is a good program because it gives me a place to shower, store my clothes, they drive you to appointments, they listen and don't judge you, and there is a place to do laundry".

When I asked Cameron about a typical day, he said, "Well, I've been homeless since 2014. . . basically what it looks like is a lot of walking around and trying to find drugs".

As he was leaving Cameron turned to me and said, "Talking about this really helps to get it off my chest. I mean, it sucks, but I actually like to talk about it".

Once again, I was struck by the authenticity and willingness to share, in the face of tremendous adversity and tragedy. Cameron, like so many of the participants, was not raised by his parents, and experienced fractures in his family structure as a result of the lasting effects of settler colonialism.

3.1: LASTING EFFECTS OF SETTLER COLONIALISM

Lethbridge borders the largest First Nation Reservation by land area in Canada, occupying 554.7 square miles. The Kainai Reservation, also known as the Blood Tribe is home to over 12 800 residents (Blood Tribe, 2019). A large population of Indigenous people reside in the surrounding reservations in close proximity to Lethbridge, as well as within the city limits. According to a statistic released by ARCHES, 61% of users of the SCS self-identified as Indigenous. Within my participant sample, seven of the eight self-identified as Indigenous. Because of this, it became apparent that I had to investigate further to uncover the roots of this discrepancy. Indigenous peoples in Canada experience a disproportionate amount of health and economic disparities when contrasted with Euro-Canadian settlers (Cooke et al., 2017). As a result of settler colonization on the Indigenous peoples in Southern Alberta, there has been immense disruptions in family life, family structure, cultural ways and practices, and a tragic loss of language and identify.

In the late 1800s there was a large influx of European immigrants to the Southern Alberta area. These groups of immigrants began to set up settlements on local Indigenous land, and adopt strategies of assimilation that were practiced in other parts of the country (Davidson & Harrison, 2020). Cultural assimilation, residential schools, and other forms of persecution of the Indigenous people became widespread practice. Indigenous people were forbidden from practicing their religion, speaking their languages, or displaying cultural practices. This result of settler colonization caused a

mass destruction of Indigenous communities and culture. Not only did this federal policy wreak havoc on the Indigenous identity, communities and culture, but it also greatly disrupted their method of memory through story-telling. Traditionally, Indigenous history and stories were passed down verbally, from generation to generation. To so severely disrupt the family structure was to deny entire generations of their collective memories. As stated in Volume 6 of the Truth and Reconciliation Commission (TRC),

> One of the most significant harms to come out of the residential schools was the attack on Indigenous memory. The federal government's policy of assimilation sought to break the chain of memory that connected the hearts, minds, and spirits of Aboriginal children to their families, communities, and nations (Truth & Reconciliation Commission, p. 157, 2015).

This tragic break in Indigenous history and memory was not a momentary loss, but rather still affects generations of Indigenous people a hundred years later. These missing pieces created identity crises for many Indigenous children and youth; not knowing where they come from, who their family is, what their ancestry is. This identity crisis was further confounded by tragic accounts of abuse, which are evident in the stories of Indigenous people in the TRC, as well as within the research I conducted.

> Their loss of a sense of collective memory was a loss that directly resulted from the breaking of family ties, the attack on their languages and cultures, and the denial of access to any information about their own unique and special histories. These losses were carried forward to the next generation (Truth and Reconciliation Commission, p. 159).

Results of the impacts of colonization are seen today in Indigenous youth and within Indigenous families. These lasting effects became apparent within the stories and

life histories of the participants in my research. Cameron's story represents all of the injuries of colonialism, marginalization, poverty, and the current consequences of this particular Canadian history of structural violence and nation building. Additionally, Cameron is a living example of how this tragic loss of identity affects generations after the initial insult. Not only was he estranged from his cultural and ancestral identity, but many of the familial and cultural relationships he would have otherwise had, were fractured. I noticed throughout my ethnographical period at ARCHES, that clients of the SCS develop close therapeutic relationships with the staff, perhaps compensating somewhat for the tremendous loss of relationships from the fracture in family structure, as a result of settler colonialism.

Through interviewing individuals living with drug usage and addictions, I have, unsurprisingly, uncovered recurrent themes which are both troubling and emotionally exhausting. The topics discussed included stories of abuse, neglect, and early childhood trauma. Of the eight oral histories compiled, all eight had been abused in some form before reaching adulthood. Seven of the eight participants were raised by individuals other than their biological mother or father. All eight of my participants spoke of either living in deplorable conditions as children, being raised in foster care, or being homeless early on in life.

Another common theme is the use of psychedelic, anaesthetic, opioid, narcotic and other illicit and licit drugs to deter negative emotions, or enhance a euphoric feeling, at least temporarily. As one participant stated, "The only reason I use the drugs

is just to numb my feelings … To take away the pain and the loss, and the grief. Honestly feeling numb is better than feeling most of the time".

Participants in my research also repeatedly stated that they felt that their story was not worth sharing, or that they perceived their existence, and their voice, to be insignificant. It often took great encouragement to convince my participants that their story was valuable to the public in order to attain a greater depth of understanding. I found that my participant's perception of their life distorted their view of the world, and they believed their lifestyle was 'just how life is'. One participant asked me, ""Why would anybody care about a junkie like me?".

Nearing the end of my conversations with ILDU, we would often discuss their treatment experiences (if any). A number of my participants had completed treatment once, if not multiple times. All eight of them, however, had relapsed at one time or another, and were actively using at the time of the interview. My participants expressed concern and dissatisfaction with the current treatment options, as well as the ability to function as a member of society after attaining sobriety. As one participant put it,

> Yeah I got clean. I actually, finally got clean. Ha! I couldn't believe it either, honestly. But then I get out, right? I finished treatment. I got out. And then there was nowhere to go. There was nobody there for me. I was all alone, and sober. And that's the scariest. Sober AND alone! At least when you have 'down' (heroin/fentanyl) or 'side' (Meth) or something you can ignore that void for a while, but I was alone. So I relapsed, you bet I did. And here I am (laughter).

3.2: KLEINMAN ON THE PRAIRIES

Arthur Kleinman, renowned psychiatrist and professor of Medical Anthropology at Harvard University, developed a theory which incorporated culture and the illness experience into a healthcare model, which he dubbed the *Explanatory Model of Illness* (Kleinman, 1980). Kleinman describes medicine as a cultural system comprising of symbolic meanings within social institutions, and patterns of interpersonal interactions (Kleinman, 1980). For many healthcare practitioners and scholars, this theory, which goes beyond the Biomedical Model, is completely foreign. Kleinman's theory goes beyond the realm of physical symptoms and disease process, to include social, cultural, and environmental influences on illness. Although Kleinman does not deny the Biomedical Model, he does interpret health and disease through a more holistic lens (Kleinman, 1980). The Explanatory Model of Illness incorporates individual patterns of illness causation, choices regarding treatment and perceived effectiveness of treatments, social status, interactive settings, and medical institutions (Kleinman, 1980). Regarding these systems as cultural systems greatly benefited my understanding of the illness experience of the participants in this research, which transcends conventional biomedicine. Rather than examining quantitative data of illicit drug use, effectiveness of drug addiction treatments, and relapse rates, I sought to gather significant amounts of qualitative data which illuminated the experience of ILDU within a cultural system of health. By doing so I was able to gain valuable insight into the individual's illness narrative and factors which have contributed to their drug usage. Examining the data

through the lens of Kleinman's Explanatory Model of Illness allowed me to further understand the effects of culture on health, illness, and addiction.

The community of individuals living with drug usage in Southern Alberta is, without a doubt, a cultural system. It is a vast network of communication, comradery, and relationships. Participants within the community of ILDU have formulated dynamic relationships with others in their circles, both helpful and supportive and antagonizing and hateful. Through completing my research at the SCS, I had the opportunity to witness the impressive extent of their communication network. Initially, when I had interviewed one participant, and provided them with the $10 Tim Horton's gift card as a token of my appreciation, word of the gift card spread hastily and effectively to other participants who quickly found me and inquired about the opportunity. This network operates for communication purposes such as informing others about opportunities, safety concerns, drug suppliers, gossip, and news of overdoses. This communication amongst this group proved to be highly useful for the participants in my research, as many of them did not have cellphones, permanent addresses, or other conventional means of transmitting messages.

I was also privileged to observe the variety of dynamic and engaging relationships between clients at the site. Many ILDU have a few very close friends, often referring to them as their 'brothers', or 'sisters', despite no known shared ancestry. These relationships are essential parts of the community, acting as supports for one another, friendships, and a sense of safety. Within the community of ILDU, distinct

friendships and oppositions were blatantly evident. In one particular instance, two individuals were recovering in the 'Chill-Out Room' at the SCS, when another man entered the room, and the first two men got up abruptly with an angry exchange of words. Gang rivalries exist even within small cities in Southern Alberta, and were evident at times by the colours worn by individuals, behavior towards other members, and gang-affiliated signs such as handshakes, tattoos, etc. These behaviors and actions account for the symbolic meaning and interpersonal relationships that Kleinman identified in his Explanatory Model of Illness.

Another reflection of this model was evident in what Kleinman dubbed, "the illness narrative" of the participants. The structure of the interview process of ILDU facilitated conversational flow around addiction, from the participants' perspective. These "illness narratives" were focused on the participant's lives, yet were unavoidably intertwined with the story of their drug usage and addiction. These narratives were a way to understand addiction within the context of suffering, evidenced by the stories of grief, loss, and pain. Kleinman's Explanatory Model allows for an understanding of individual accounts of illness through the lens of chronicity and human suffering, which aligned with a large percentage of the narratives I heard. Participants spoke extensively about their own individual suffering, the struggles of their families, and the plight of their community as a whole. Though I had not intended to so heavily focus on the aspect of suffering within the lives of the participants, I found that addiction and suffering are intrinsically linked.

CHAPTER 4: ILLNESS NARRATIVES AND ORAL HISTORIES

4.1: STORY-TELLING

The illness narratives and oral histories of public health campaigns aimed at addiction that I collected while conducting fieldwork at ARCHES are organized around trauma, tragedy, abuse, encounters with various agents of the state (police, public health, social services) as well as drug addiction. Mark for example describes the family settings in which drug and alcohol can occur.

Mark - "My whole childhood-just screaming and yelling"

One of my first interviews was with a tall, outgoing, middle-aged man with a big smile and a great sense of humor. For the intents and purposes of this thesis I will call him Mark. Mark readily agreed to an interview and frankly shared stories from his life with me in the Chill-Out Room at the SCS, shortly after using. His story is riddled with the all-too familiar themes of childhood abuse, early exposure to substances, family substance abuse, separation from his parents due to parental incarceration, disruptions in family structure, and extensive grief.

Mark began the conversation talking about his parents; his mother was an alcoholic who gave him up because she was unable to take care of him. She died young. His father was in prison for a large portion of his childhood. He spent the majority of his childhood on an First Nation Reservation within Western Canada. He was raised mostly by his grandparents, who also raised some of his siblings and several of his cousins. In a memory of the time spent with his grandparents, Mark recalled,

> My first experience with drugs was actually with my grandparents! We would all pile in the truck and go for a day-out to [town], go load up on painkillers, and cases of wine and Lysol from the hardware store. We'd then take it all back to the reserve and start boot-legging. Was a good business plan, in theory, I guess (Participant #1).

One of Mark's most treasured memories of his grandparents were times of bootlegging on the First Nations Reservation. This family activity was recalled fondly by Mark and labelled as a "family day", and a, "fun outing for all of us kids".

Mark goes on to discuss the abuse between his grandparents and from the hands of his grandparents,

> I can still hear my grandma screaming at my grandpa, 'Go ahead, hit me again! You already gave me two black eyes. See if I care!'. My grandpa was really bad. He really abused my grandma. My father abused my step-mom. I just remember screaming and yelling all the time. My whole childhood-just screaming and yelling. I do have happy memories. They were when nobody was yelling or kicking anybody (Participant #1).

Mark then goes on to discuss growing up on the reserve and some of his early childhood memories. Mark recalled participating at Powwows as a dancer,

> So anyways, I have participated in Powwows for 25 years. . . After the Powwows we would party. We would smoke weed and get drunk and get right stoned. . . The older kids were always drinking. The younger kids were watching the older kids drink. It was normalized I guess. You knew it was going to turn into a party when the women would take a catch basin and turn it upside down. When you do that it becomes a drum. These women would start drumming, then people would start dancing. That's when the party would really start! (Participant #1).

The first time Mark remembers trying alcohol was when he was 12 years old. Growing up with limited figures of authority who were not involved in alcohol or drugs, Mark recalled, "Growing up, I always thought being a man was drinking whatever you can and seeing whoever you can naked".

Mark got married at the age of 18 to a girl from, “She was from an alcoholic family…Fuck I loved her so much. She was my right arm. . . ”.

Mark and his wife had three kids together. Mark graduated from college with a Business Administration diploma, “You probably wouldn’t think that of me, but I did (laughter). Actually, it surprises me too!”.

Afterwards, Mark worked on a reserve before getting his computer certificate from another college. It was when he was on that reserve that he started to use drugs heavily, “There was this painter. Her name was Margie. When I met Margie, I stopped paying attention to my wife. All I wanted was to get high with Margie”.

It was during this time that Mark shattered his ankle, playing recreational basketball, and required extensive surgery. After surgery he was prescribed numerous different types of narcotics and sleeping aids, “Now I have cirrhosis from those pills. I fed those pills to my wife. I got her addicted so she wouldn’t leave the house-so she wouldn’t leave me, I guess” .

Mark started to get involved with selling drugs out of the house he was living in. His ankle pain was still unmanaged by the variety of narcotics prescribed to him by his doctors. He was trading his prescribed drugs for Crack Cocaine (Crack), “One day I was really hurting. So, I tried it. . . Crack made me feel numb. That’s what I like about it. It takes my pain away”.

During this period in Mark’s life, around the time he was 34 years old, his wife cheated on him with her drug-dealer. Mark started to use Crack every day.

> I had day-jobs here and there, of course, but then one day I started just stealing and using and stealing and using. . . The first three years I spent in town I had a car, a job. Then it all slowly disappeared. (Participant #1)

The first time Mark was exposed to Meth was when he moved back to his hometown, “I fell in absolute love with it. I was superman”.

Shortly after his introduction to Meth, Mark started to use fentanyl. For Mark, fentanyl, “It’s like inside, [my head] it’s a fucking party, but on the outside, you’re just nodding off. . . fentanyl is like that Pink Floyd song-*I wish you were here*. . . ‘So you think you can tell, heaven from hell’?”.

Mark recalled this period in his life,

> I fell in love with a girl who liked fentanyl. She’s the one who got me addicted to it. One night. . . We were all partying. . . I nodded off. I don’t know how long I was out, but the room was freezing when I woke up. [She] was stiff and hard when I woke up. She was so cold she was making the whole room cold. She had overdosed. She had pretty black hair. But even her hair looked dead. I still see it every time I close my eyes. (Participant #1)

At this point, Mark was using fentanyl numerous times a day. He has been living on the streets since then, “Sometimes I stay at the shelter, sometimes at a friend’s house, couch-surfing”.

Mark spends a lot of time at parks, McDonalds, the homeless shelter, and ARCHES,

> Then of course, everyone has their own little spot they like to go. I like to sit on that bench overlooking the Westside, by [the museum]. I like to just sit there and look at the stars and watch the sunrise. I love to be high there. I just sit and think Participant #1)

Mark has been to rehab intermittently over the past ten years, “I’ve gone five times, completed it three times. I know it stops me from using, but fentanyl is my best friend”.

Mark talked extensively about the struggles of achieving sobriety, but more so about his inability to cope with the traumatic experiences of his life and the resentment he feels. Mark expressed his frustrations with the community he lives in, stating,

> I think the problem people have with us is not the drugs, they just don’t want to look at us. I mean look at us. . . Do you know the cops will give you a $5000 fine for hanging out under the bridge? They do it because people will phone them and say, ‘Yo, dudes, there’s junkies under the bridge. Get them away. Nobody wants to see that!” (Participant #1)

Mark’s life history is a familiar anthem of grief, hurt, painful life experiences, and ultimately, homelessness and extensive substance abuse throughout the course of his life.

Being raised without the influence of parents, although common in some cultures, is the first step which caused Mark to feel the presence of a fracture of his family structure, and the disconnect from cultural practices. Mark talked fondly of his grandparents in some stories, whilst also reiterating the highly dysfunctional dynamic of their relationship.

Kacey - "God put me through a fucking lot, but he knew I could handle it. I stopped hating him for it".

The next interview I conducted was with an exuberant, outgoing middle-aged woman with long black hair. She had approached me early on in my volunteering time at ARCHES, repeatedly asking me, "Hey girl, you an undercover cop, or what?".

We will call her Kacey.

Kacey grew up within western Canada, "My childhood fucking sucked".

She spoke of her parents in unaffectionate ways,

> They were the kind of people who shouldn't have had kids. . . My parents didn't give a fuck about me. They didn't clean. They didn't care. I just couldn't do anything right. I don't even remember them ever saying they love me. I never got a hug from either of them. My Dad hit us all the time. I don't think he had sex with us, but I don't know. (Participant #2)

Kacey got pregnant when she was in grade ten, at the age of 16 years old. Her parents kicked her out of the house when she was 39 weeks pregnant, ten days before her due date. She was a single mom living in Northern Alberta. She worked as a Personal Care Attendant (PCA), housekeeper, esthetician, and a bartender.

Kacey described herself as a 'high-functioning alcoholic' before she ever got into drugs. Working as a PCA, "As long as my patients didn't know I was drunk, my boss let me drink on the job". She started using illicit drugs at the age of 32 years old when her son moved out,

> This one time I was at the casino and I was a little bit tipsy. I went to the bathroom and my friend asked me if I wanted a Hollywood line [cocaine]. So, I did. And I became totally sober. I was up for 38 days straight. I did it so I could drink more. More lines. More alcohol. That's what I was doing. Then I just stopped drinking. (Participant #2)

Her cocaine habit turned into a more intense variety when she moved,

> I started looking for soft again. Turns out [certain town] is bad though, because I ended up getting hard. So, I started smoking crack. And that is when my addiction started, officially I think. I only would smoke crack once a month, once I was sure I had paid all of my bills. For the next ten or so years I did 700 mg of Morphine a day. Me and my at-the-time husband started with cocaine, then to crack, pills, you name it. (Participant #2)

Eventually Kacey started to deal drugs with her boyfriend. But as she said, “You never know when the boogeyman is coming for you!”.

Kacey was incarcerated for possession, trafficking, and proceeds of crime at this time. When she was released, she started using Meth heavily, “I started smoking meth. It helped me forget… It helps me to forget the pain. It helps me to forget how I’ve fucked up”.

Kacey has never gone to treatment. She is currently a client of the Methadone program. Methadone, an opioid-maintenance drug, helps individuals abstain from dangerous IV drug usage without quitting abruptly. It rewards the pleasure centres of the brain in the same way an opioid does, without the ‘high’ effect.

Kacey is associated with numerous social services and peer-assist programs around the city. Kacey is homeless, “The shelter is horrific. I would rather sleep on a bench or the ground than there”.

Kacey is “Hepatitis C” positive. Kacey spoke of numerous experiences within the healthcare system over the years, “Once they realized I was homeless they started treating me vastly different. It’s not that they don’t like you, but it's more that they don’t know how to treat you”.

Kacey concluded the interview by restating some of the hardships she had faced throughout the course of her life, “I’m still looking for a drug that will help me permanently forget, but unfortunately we haven’t refined things so well yet”.

Kacey is resilient, speaking of her hardships candidly and without shame. She has survived many years as a homeless woman, an outsider to the rest of society. She talked extensively about the importance of helping other individuals living with addictions, as well as talking for the purpose of healing yourself, “I like to talk about it [my life]. The more I talk about it, the better I feel. Once you clam up, you’re absolutely fucked. Humans need to talk to humans”.

Kacey shared her life experiences in an open way, rather than withholding regrets she had or past mistakes. Her life has been a series of daunting tribulations which she overcame and continues to overcome. Kacey put it best when she said, “God put me through a fucking lot, but he knew I could handle it. I stopped hating him for it”.

Jimmy - "I like to keep to myself so nobody can judge me."

The next young man I interviewed was an apprehensive, tall, athletic-looking man. We will call him Jimmy. This interview was short and sweet, lasting roughly ten minutes. We were interrupted when another client burst in midway through the interview and stated, "Yo, Jimmy, we gotta bounce!", and they both abruptly left the facility. Jimmy didn't know his parents growing up. He was raised by his grandparents. He grew up raising horses, calling himself, with a laugh," An Indian cowboy".

Jimmy talked fondly about these years, ranching with his grandparents. He said that his most fond memories of riding horses with his sister, "My sister actually just got off drugs. I'm really proud of her. But her kids are already taken away".

Jimmy lived with his grandparents until junior high school when he moved off the First Nations Reservation, and into town to attend junior high school. Jimmy started drinking when he was 16 years old, and started doing cocaine and crack when he was 22 years old. He was working as a carpenter, but identifies as an artist, "I like to create and work with my hands".

Jimmy was living on a First Nations Reservation in a house with his brothers when he tried drugs for the first time. "My brothers would always be doing drugs, my friends would be using, so I thought, 'I guess I should try it'".

It was during this period that Jimmy started to use "Oxy 80s" and fentanyl. Jimmy was incarcerated for a number of years related to his drug usage. When he emerged, he found the world of drugs to be a changed place, "I came back out and all you could find was Carfentanil, you couldn't even get fentanyl anymore".

When I asked Jimmy about his time in prison he stated, “Yeah, you’re clean, but only because you have to be. The only thing that kept me going was fantasizing about the first hit I was going to get once I got out. Prison doesn’t help a thing (laughter)”. Jimmy has never attended treatment or detox. He has overdosed three times during his ten-years using illicit drugs.

Jimmy avoided eye contact throughout the interview, with a profound sadness about him. Jimmy said, “Most days are sad, but I am happy when I see my family. Drugs make me very happy for a bit, but then it’s just fucking depressing again until your next hit”.

Jimmy shared details of stories when provoked, the conversation full of hesitant pauses, “I find it hard to talk about my life. It’s just sad. I like to keep to myself so nobody can judge me, honestly (laughter)”. It was at this point that the interview came to an abrupt conclusion, when Jimmy and his friend hurriedly gathered their possessions and left the facility.

4.2: THE ADVERSE CHILDHOOD EXPERIENCE

Throughout these narratives, I found myself despaired by the high prevalence of abuse and trauma in the stories of the participants; stories that made me cringe and cry. I found myself musing over how individuals could endure such hardships, and be expected to behaviour as 'normal', law-abiding, conforming members of society. It seems that, largely, as a society we are willing to assist individuals with physical limitations, mental health issues, and other 'medical' ailments, yet the empathy seems to hastily run out for ILDU. A group of researchers based in San Diego, developed the Adverse Childhood Experience (ACE) scoring index that was used to determine the correlation between childhood abuse and household dysfunction, with adverse adult outcomes relating to disease and mortality (Anda et al., 2003). The ACE study identified various household risk factors pertaining to childhood trauma and asked survey participants to identify which were present in their own lives. Scoring indicators on the ACE included physical abuse, sexual abuse, physiological abuse, substance abuse, family member incarceration, household violence, and mental health. When data from over 14 000 respondents was analyzed, it was found that there was a high degree of correlation between respondents who scored highly on the index and individuals who self-identified as experiencing adverse health outcomes such as ischemic heart disease, chronic lung disease, cancer, diabetes, stroke, skeletal fractures, liver disease, and morbid obesity (Anda et al., 2003). Interestingly, these resulting adverse health outcomes have been labelled as being the leading causes of mortality in the United States. The ACE researchers' findings suggest a

strong correlation between childhood abuse and adult disease, as their article stated, “In a strong and cumulative way” (Anda et al., 2003).

The ACE researchers found that high-scoring individuals were seven to ten times more likely to live with substance abuse, alcohol or drugs, later on in life (Anda et al., 2003). Additionally, they found that over two-thirds of individuals living with injection drug usage experienced abuse and trauma within their childhood (Anda et al., 2003). Within the data that I collected, the percentage that experienced abuse and trauma was 100%. This insight into the effects of trauma, abuse, and substances on the developing and fully developed brain shed some light on the otherwise inconceivable rationale for ‘why’ individuals venture down the path of injection/inhalation drug usage.

Dr. Maté describes how individuals who have experienced emotional, physical, sexual, or psychological trauma early on in life have an impaired brain capacity to deal with stressors later on in life, ultimately predisposing them to addictive tenancies as well as Attention Deficit Hyperactive Disorder (ADHD) (Maté, 2008). Dr. Gabor Maté uses the analogy of two seeds; identical for all intents and purposes. The two seeds, although similar in potential and genetic qualities, can have vastly different outcomes depending on the quality of the upbringing of the seeds. The difference lies in the care of the seed; the quality of the soil it was planted in, the diligence with which it was watered, the sunlight it was exposed to, and the care that was taken to ensure that it was provided with the proper nutrients and stimulation. Though neither seed is diseased, per se, if you provide the nearly identical seeds with vastly different circumstances, one will undoubtedly fare better than its counterpart. As Maté stated, “It would be easy to see

how a deprived environment contributed to its weakness and susceptibility" (Maté, 2008, p. 188).

Similarly, to the seed planted in inadequate growing conditions, children who are victims of various forms of abuse early on in life are apt to experience negative effects later on in life. One of the most prevalent themes emerging from the interviews I conducted was the impact of intergenerational trauma. The city which I researched in is in close proximity to the largest First Nation Reservation by land area in Canada, occupying 1436 square kilometres (Blood Tribe, 2019). A large population of Indigenous people reside in the surrounding reservations in close proximity to the clinic. According to a statistic released by ARCHES, 61% of users of the SCS self-identified as Indigenous (ARCHES, 2019). Within my research participants, seven of the eight self-identified as Indigenous. As a result of the effects of colonization on the Indigenous peoples in Southern Alberta, there have been immense disruptions in family life, family structure, cultural ways and practices, and loss of language and identity. Because of these detrimental effects, Indigenous peoples are a vulnerable population within Canada. Results of the impacts of colonization are seen today in Indigenous youth, and became apparent within the stories and life histories of the participants in my research.

Canadian residential schools were legal requirements for Indigenous school-aged children beginning in the year 1930 (Barker et al., 2019). Advertised to the public as a positive initiative, however, behind closed doors they were a method of assimilating Indigenous children into European culture. Children were removed from their homes, placed in boarding schools, and taught non-Indigenous, predominantly Western

European, language, schooling, and culture. (Barker et al., 2019). They did this by suppressing all forms of Indigenous cultural identity; language, spirituality, music, dress, hairstyles, and other traditions. Failure to comply with school requirements resulted in harsh consequences. Schools also often forbade students from remaining in contact with their Indigenous relatives, further disrupting the family and cultural structure of the Indigenous people. In a 2019 study in The Journal of Adolescent Mental Health, the effects of intergenerational trauma on the Indigenous people within Canada was investigated. Researchers described the negative consequences of residential schools as,

> The forcible displacement from ancestral lands, dismantlement of Indigenous governance structures, introduction of disease (e.g. smallpox, influenza), systemic discrimination, assimilative policies, and physical, biological, and cultural genocide. In Canada, one of the most damaging aspects of this relationship was the historical trauma inflicted by the residential school system (RSS) (Barker et al., 2019, p. 249).

These schools were notorious for their intense forms of discipline and abuse; physically, sexually, emotionally, and verbally. Unfortunately, the lasting effects of Canada's residential schools are still seen today; fractures in family structure, high rates of substance abuse, and massive amounts of cultural and language loss. Students at the residential schools were assimilated into "White" society, were, often forcibly, removed from their family setting, experienced a high frequency of stress, abuse, and trauma, and largely lost their cultural identity (Barker et al., 2019). Children in residential schools grew up without and nurturing influence from their parents. They grew up without being exposed to their culture. They endured horrific episodes of abuse.

A group of researchers found that Indigenous individuals who had a parent or grandparent experience residential schools had twice the chance of being apprehended by child welfare systems (CWS) (Barker et al., 2019). This statistical significance speaks to the tremendous lasting effects that residential schools had, and continue to have, on families.

Numerous times throughout the interviews, the lasting effects of being raised on the reservations within Southern Alberta, and some of the issues arising from them were discussed heavily. The First Nations Reservations were initially formed by the Canadian government as a component of the British North American Act, in 1867 (Government of Canada, 2020). Publicly, they were advertised as a way to maintain native lands and retain the Indigenous culture, language, and way of life, however, they were essentially a method of cultural and racial segregation. Compared to the national averages, Canadian First Nations Reservations currently experience disproportionate rates of unemployment, substandard housing situations, substance abuse, crime, and health issues (Crawford et al., 2012). These factors further complicate the health and social disparity faced by the Indigenous people within Canada. The lasting effects of intergenerational trauma are one of the key themes which repeatedly emerged from the narratives I collected. No better example exists of this than through my youngest participant's story.

Billy - "I have no one to run to…But I have drugs to run to"".

The youngest participant in my research was a shy, quiet, young man, who avoided eye contact throughout our interactions, but had the most genuine spirit about him. We will call him Billy. Billy's father died when he was two years old, and his mother struggled with substance abuse and was not in his life. She died young as well. Billy never knew his real family. He has four younger siblings, and a sister, who he has never met. Billy stated that he was in 28 different foster homes before the age of four. Billy recalled a story of his foster parents picking him up from school,

> There would be children with parents. . . the same parents picking them up over and over again. . . and I asked them, 'why do you have the same people picking you up over and over?', and they'd tell me that was their Mommy and Daddy. . . and I'd say, 'Well what the fuck?'. I'd go to preschool, kids would show up with the same parents every time, and. . . every six months or so I'd end up with a new family, and I didn't understand, being as young as I was. (Participant #5)

Billy was not even aware that many children have stability in their parental figures. To him that was a foreign concept. Bouncing around between different foster homes, Billy never understood the concept of having stable childcare providers, stating, "It was confusing. . . at a young age you don't really think about it, but you don't really know what to call them. . . like, 'Who are you?' and they say, 'I'm Dad or Grandpa'…I still don't know my real family".

Billy started using drugs when he was 16 years old. He started smoking meth regularly when he turned 18. Billy has been homeless since he was kicked out of his last foster home, around two years ago. The only positive role model in his life was one

foster home ‘Mom’. Billy recalled his experiences with her, “She put a stop to it [the bouncing around foster homes]. So that was positive. She basically raised me the rest of my life. She claimed me”.

This foster home ‘Mom’ was the one real, positive connection Billy could recall from his childhood. Billy spoke extensively to the degree of loneliness and isolation he felt throughout his life. Being removed from his family, his culture, and any support system, Billy grew up not formulating those healthy attachments. Billy never felt cared for, never had a sense of connection to family or friends, so Billy sought connection to substances, “I have no one to run to. . . But I have drugs to run to”.

Patty - "Sad. Scary. Hurtful. Lonely. Depressed. Waiting to Die"

The next participant I interviewed was an extremely friendly, middle-aged woman. We will call her Patty. Patty grew up on an First Nations Reservation in western Canada. Patty's father was absent, her mother was an alcoholic. She lived with her mother, brother, and grandfather. Her mother was extremely abusive from as early as she can remember. Patty recounted numerous episodes of abuse that continue to haunt her, to this day, "she [her mother] used to put my head in a bucket of water until I almost drowned, then she would pull me back out" .

She also recalled stories of her mother putting her hands in boiling pots of water, hitting her with a cast-iron pan, beating her up, and encouraging her brother to beat her up, as well. Patty told me the story of once, when she was seven years old, her mother made her drive her home from town back to the reserve, because her mother was heavily intoxicated. Patty had to drive the van back home. She was so afraid to drive a car, so her mother gave her a bottle of 'courage', which Patty said, "it was vodka. I got so drunk. I don't know how we got home, but I made it home. . . I was seven years old".

Patty was confiscated by Child Protective Services several times throughout her youth, but often returned back home. Her brother never was taken out of the home. Patty recalled her first day at a particularly abusive foster home,

> They'd give us baths, make us change, and when she [the foster mom] gave me a bath...she took a steel brush and tried to scrub off my brown, trying so hard to wipe my skin. Foster dad came in and he said, 'what are you doing to her? That's her colour!', but she said, 'no I'm trying to get this brown off! She cannot be this colour!' (Participant #6)

In and out of foster homes throughout her childhood, Patty found it virtually impossible to rely on a parental figure, stating, “My whole life was just nothing but being hit and tossed around. Nobody really caring. Nobody to trust.” .

Patty’s mother got suspicious of Patty’s relationship with her Stepfather, and would beat her up when she thought they were getting too close. She also got angry when she suspected that Patty was stealing her grandfather from her. She was beating Patty because of this when her grandfather came in and yelled, “Are you crazy? Are you trying to kill your daughter?” .

Patty’s mom responded with, “She’s bad! She’s not a good girl. Let's get rid of her!”.

Additionally, Patty’s foster mom got suspicious of her relationship with her foster Dad, and she got punished for that. Patty’s mother, an alcoholic, tried to get Patty to drink with her from the time she was a young girl.

Patty worked as a contractor and a house cleaner. Patty said that she tried to be a secretary, but, “I couldn’t be a pencil pusher. I couldn’t stand it!”.

Patty started to use drugs after she received a slipped disc in her back whilst working at a job lifting heavy boxes. She was prescribed numerous narcotics, nothing alleviated the pain. Patty then started to self-medicate by snorting the narcotics, then injecting them. Patty developed a spinal abscess during this time, and required to be airlifted for emergency spinal surgery. Her heart stopped enroute, and she received defibrillation to restart her heart. After this stint in the hospital, Patty started using

Morphine to manage her pain, then fentanyl until it was no longer available, then Carfentanil,

> Next thing you know I wasn't seeing fentanyl that much, people were saying, 'oh, that's heroin' and I'd say, 'That's not heroin', and they'd say, 'Oh well Carfentanil'...You barely see fentanyl around. If I can get it, I'll use it. (Participant #6).

Patty's young daughter was murdered recently. She was found outside a house in a rough part of town. The police officers investigating the case took Patty to confirm the identity of her daughter. When they arrived, Patty just saw two feet sticking out of a blanket,

> And I said 'please God don't let it be her! Please don't let it be her!'. . . Not my baby! Not my baby girl'. Every time I close my eyes I see her. Her eyes were open. (Participant #6)

Patty also recently lost her son to an apparent heroin overdose. Patty has been homeless for the past year. Patty currently sleeps on the sidewalk. Patty avoids the homeless shelter. When I asked Patty what her experiences living on the street was like, she responded, "It is cold. I don't like it. I don't like this kind of life. I want my own life. I want to move forward with my life".

Patty is currently trying to wean herself down to injecting Carfentanil only three times a day. She wants to go to detox and treatment, stating, "I am ready. I want to go".

Patty is currently working with programs within the city to make that a reality. Patty is also attempting to work out housing options for herself through a local program, *Home Base*.

When I asked Patty about resources in the community that would be helpful to individuals such as herself, she responded by saying,

> Well it would help first of all if they would stop calling us down. I have been called every name in the book. I've had kids throw beer bottles at us. . . pellets shot at us, paintball guns. . . they've beaten me up. . . hit me all over. (Participant #6)

When we were concluding the interview, Patty commented that, "It is the hardest thing I've ever had to do. It's awful (crying). I miss my daughter a lot. I think about my grandchildren. When I just want to die I think about them. Don't want to abandon them".

Patty is the matriarch of her family, but also of the family of ILDU in her community. Throughout the interview she refers to the young drug users as her "children". She said they affectionately call her "Mom".

Patty's resilience in the face of some extreme tribulations moves me throughout our interview. She has endured horrific events throughout her life, yet she holds her head up high, has a huge smile, is kind-hearted, and a sympathetic listener. It is evident throughout our conversations that she cares deeply about the community of drug users around her. She cares about their wellbeing and is extremely proud of them when they make positive steps towards a different lifestyle, "When I talk to them, it helps me. I'm actually helping people. I do it from the kindness of my heart".

Patty is also extremely emotional throughout our interview. Recalling memories surrounding such heavy topics such as trauma, grief, and abuse brings back waves of suppressed emotions. At one point throughout our interview, Patty said, "I am very

emotional. I am hurt. Things are crashing down, everything falling down. I just want to die at times. I want it to end".

Patty's story is another account of the disturbing ramifications of intergenerational trauma, resulting fracture in family structure and subsequent familiar themes of substance abuse, domestic violence, foster care issues, and marginalization of vulnerable populations. Her story is also a testament to the lack of support in place to assist individuals desperately trying to escape the vicious cycle that is drug usage.

Kirsten - "You do what you 'gotta do to survive around here. If that means stealing or whoring, you do it".

I next interviewed a young, solemn looking woman. She appeared to be in a rush, but sought me out, sat down, and indicated that she wanted to talk to me. We will call her Kirsten. Kirsten was raised on an First Nations Reservation in Western Canada. Her father was sexually and physically abusive. She was sexually abused repeatedly by her uncles. Kirsten spoke about this,

> Everybody wants a piece of the pretty little Indian girl. I grew up confused about what was normal. I mean you'd go to school and other people didn't have those scary stories that you did, that you lived every day. I thought it was normal. Turns out your family trying to fuck you every chance they get isn't too normal. So yeah, fuck, yeah, I was fucked up. . . early on I'm pretty sure. (Participant #7).

Her mother was not involved In her life. She believes that her mother struggled with substance abuse also, "I never knew my mom. Heard she was a junkie too. Runs in the family, I guess".

Kirsten was raised intermittently by her grandparents, who, "came and went. They were usually drunk every time I saw them. They're those ones drinking the "Toilet Bowl Punch", we call it (laughter). . . That's Lysol, man".

Her aunt also raised her for a number of years throughout her life. She speaks of her aunt with affection, "She actually gave a shit about me. She was like the mama of the Res' [First Nations Reservation]'".

Kirsten talks extensively about growing up as a young woman on the reserve, and some of the difficulties associated with that. She talks about her boyfriend in grade seven, "We were in love. He's actually dead now. Crazy, man".

Kirsten became heavily involved in alcohol and drugs as a young woman, “I didn’t fall into the wrong crowd, I was the wrong crowd (laughter). I was always the life of the party”.

The first time Kirsten tried drugs, to the best of her recollection, was, “Sometime in high school” .

Growing up, Kirsten always wanted to be a rodeo princess. She graduated from high school, attempted to find work, but was unsuccessful, “I worked here and there, but mostly was just looking to score [find drugs] at this point”.

Kirsten was incarcerated shortly before her 22nd birthday, “Got thrown in there due to a big misunderstanding. I had drugs on me that weren’t mine and they said they were all mine. Was in there for 18 months”.

Other than prison, Kirsten has never been to detox or treatment, “I don’t even want to think about that now. It will happen, but it can’t, yet. I just can’t. First thing is I’m just trying to survive” .

Kirsten’s big brown eyes dart back and forth across the room throughout the course of our interview, as if anxiously expecting someone. Kirsten states she doesn’t attend any programs or access any resources within the city, currently. She states she is, “technically homeless” right now, “sometimes I can score a place to sleep here and there, depending on who I show my tits to (laughter)” .

Kirsten alludes to her involvement in prostitution to support herself throughout the interview, “You do what you ‘gotta do to survive around here. If that means stealing

or whoring, you do it. Anybody would do that to stay alive. . . .if you want to stay alive I guess".

Kirsten hurriedly concluded the interview when her friend entered the room. She gave me a warm smile, shook my hand, gathered her numerous bags and purses, and hurried out of the facility. I was struck by the vulnerability of this woman who just shared some of the troubling events of her life with me. I was also taken aback by our close age proximity and the astounding differences in our upbringing and subsequent life circumstances. I left the facility that day feeling saddened and defeated.

Ronnie – "All I really know is pain. That is what life consists of to me"

My last interview was with a pleasant, high-energy young woman. We will call her Ronnie. Ronnie was raised in a city in Western Canada. She never knew her father. She was raised by her mother until she, along with her siblings, were placed in foster care. Her mother was an alcoholic, "and I think, thinking back, she was on more drugs than me even".

Ronnie spent the majority of her childhood in the foster care system, "Some people were really nice. Most of them do it just for the money…"

From the time she was a young girl she was physically, sexually, and emotionally abused by both her foster care parents and her biological mother. She endured painful episodes of abuse and torment, specifically at the hands of her mother,

> She was a nasty lady. I don't think it was very normal, if I think about other people's moms -moms who love them and stuff. It's like my mom just took out all her anger at me. It's like she hated me for being alive. (Participant #8).

Ronnie mentioned that her mother had been through a lot of hurt in her life as well, in speculating about what made her mother so violent. Ronnie recalled one particularly disturbing memory,

> That mean old lady would hit me until I cried and then she would start laughing. She thought it was funny that I was a little bitch, I was just a kid though, right? She'd say, "My parents used to hit me way harder than this!" And I'd be crying. . . what kind of mother thinks that's funny? I still hate her when I think about that day. (Participant #8)

Ronnie recalled a heartbreaking memory from one particular set of foster parents,

> The lady would leave. . . I would be playing, me and some of the other kids. That's when the dad would come and say he wanted to play too. That meant he

> wanted to *play*. He would take us into his room, tell us that we had to keep this play a secret. . . he didn't hit me, but he did worse things. . . Now I know, thinking back, he was a fucking perv' [pervert], man. (Participant #8)

Ronnie worked as a house cleaner and a cocktail waitress for a number of years, "I had jobs here and there. Mostly just waiting to turn out like my piece-of-shit mom (laughter)".

Ronnie gave birth to one child as a teenager, and another one later in her 20s, "I remember that first time holding my babies. . . so innocent (crying)".

Both of her children were raised by foster care, "I want to get clean just to see them again. The only reason I want to get clean is to look them in the eye and be able, you know. . . to be worthy of respect, right?".

Ronnie states she has been to detox and treatment twice before,

> Yeah, I got clean. I actually, finally got clean, ha! I couldn't believe it either, honestly. But then I get out [of treatment], right? I finished treatment. I got out. And then there was nowhere to go. There was nobody there for me. I was all alone, and sober. And that's the scariest- sober and alone! At least when you have down or side or something you can ignore that void for a while, but I was alone. So, I relapsed, you bet I did. And here I am (laughter). (Participant #8)

Ronnie had an abusive partner recently, and is currently living in a shelter for battered women. She mentioned she may be at risk for being evicted, "They don't like it when you're always fucked up. Like when you're just happy with where you're at. They'll probably boot me back to the shelter at some point, I'm guessing".

When I asked Ronnie, what brings her joy in life, she stated, "I don't know about joy. . . all I really know is pain. That is what life consists of to me".

4.3: EMERGING THEMES

One of the purposes of this research was to take an in-depth look into the lives of ILDU in an effort to understand some of the barriers which have hindered their access to healthcare, drug detox and treatment, and social services. As a vulnerable population, it was again reaffirmed that this population faces barriers to healthcare and addictions treatment. Through compiling and comparing several oral history narratives, I noticed numerous recurrent issues, as identified by my participants.

Through interviewing ILDU and addictions I have uncovered recurrent themes of abuse, neglect, intergenerational trauma, parental substance use, fractured family structure, childhood trauma, extensive grief, cultural isolation, and incarceration. The themes uncovered, although troubling, are not surprising. The stories told by my participants were unbelievably rich, yet often incredibly heartbreaking. Of the eight oral histories compiled, all eight had been abused in some form before reaching adulthood. Seven of the eight participants were raised by individuals other than their biological parents. Six of the eight reported experimenting with drugs before the age of 16. All eight of my participants alluded to either living in deplorable conditions as children, or being raised in foster care. All eight reported being homeless or street involved at some point throughout the course of their life, seven were at the time of the interviews.

Table 1

Self-Reported Demographics of Participants

	Raised by Non-Parents	Incarcerated	Abused	Parental Substance Use	Homeless	Attended Detox/T(x)	Identified self as Indigenous
Participant #1	✓		✓	✓	✓	✓	✓
Participant #2	✓	✓	✓	✓	✓		
Participant #3	✓	✓	✓	✓	✓		✓
Participant #4	✓		✓	✓	✓	✓	✓
Participant #5	✓		✓	✓	✓		✓
Participant #6	✓		✓	✓	✓		✓
Participant #7	✓	✓	✓	✓	✓		✓
Participant #8	✓		✓	✓		✓	✓

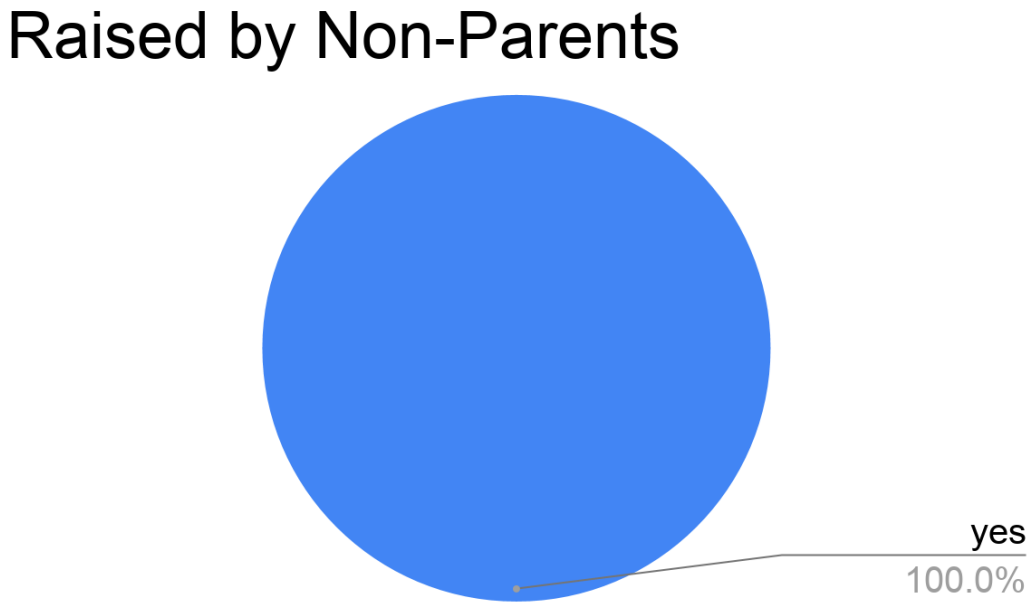

Figure 1.0: Percentage of participants raised by people other than their biological mother or father

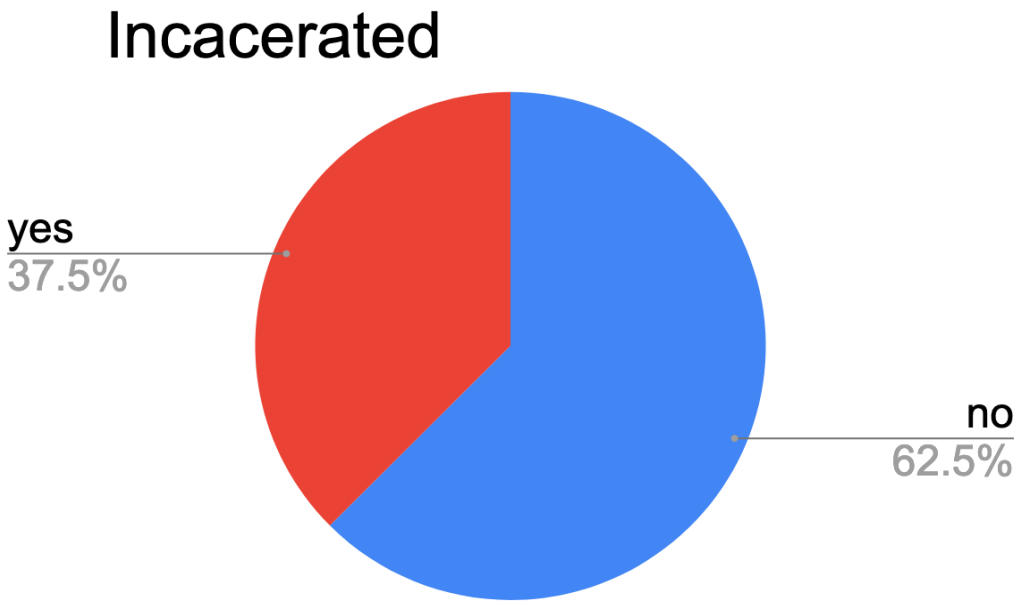

Figure 1.1: Percentage of participants previously incarcerated

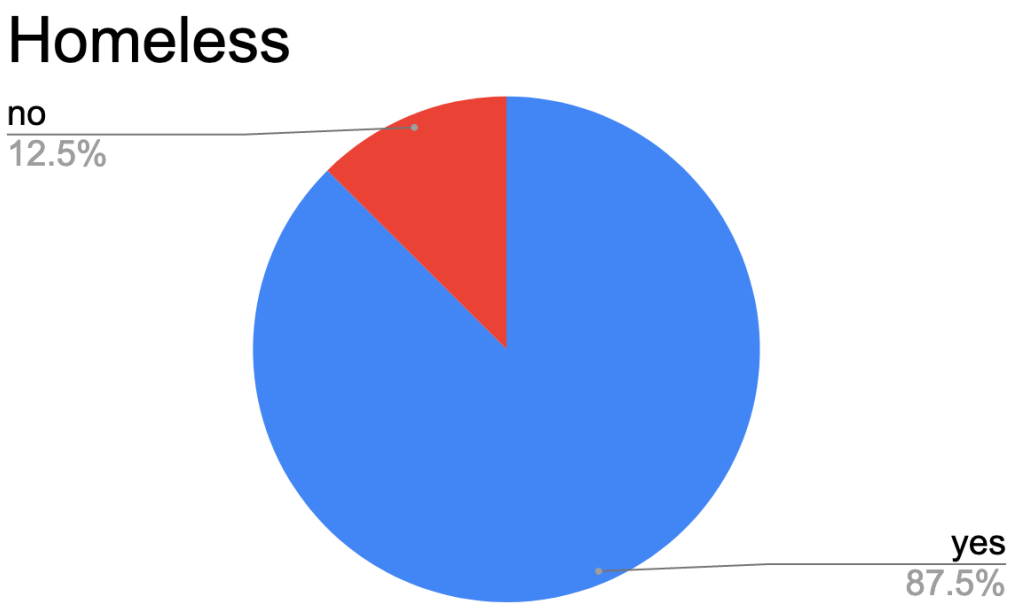

Figure 1.2: Percentage of participants who identified as homeless or street involved

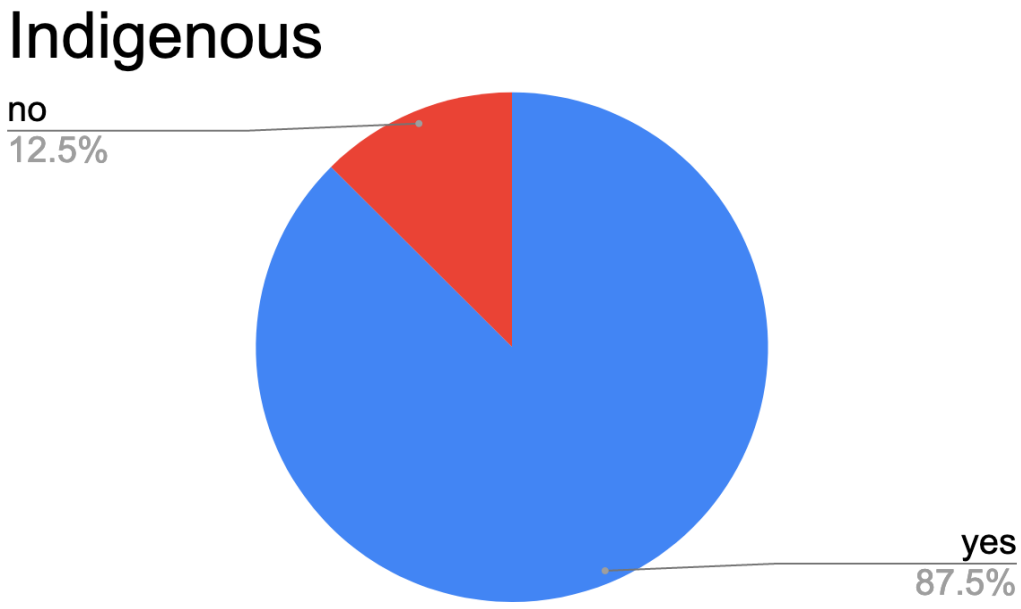

Figure 1.3: Percentage of participants who self-identified as Indigenous

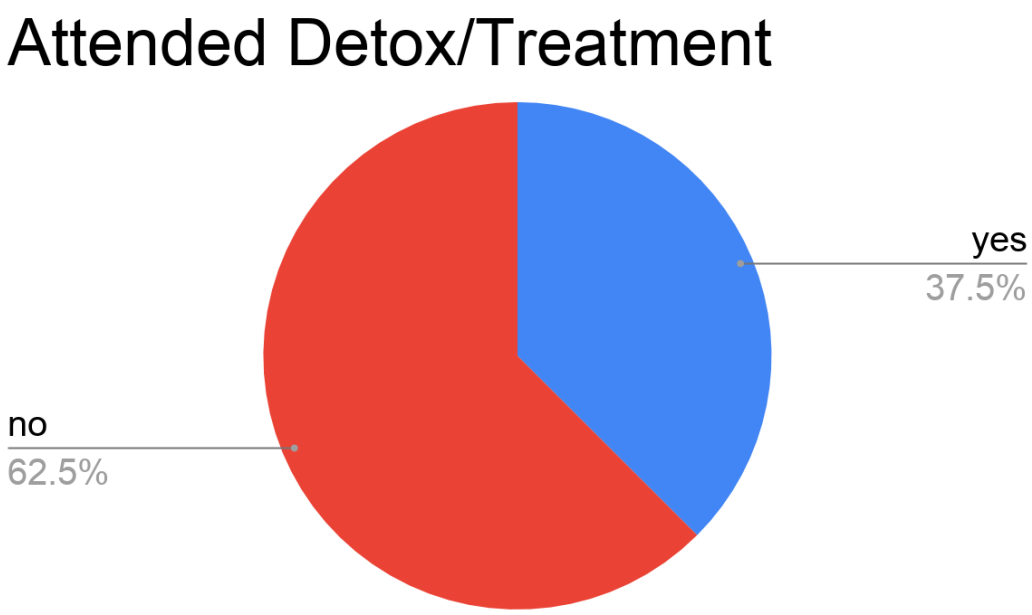

Figure 1.4: Percentage of participants who previously attended detox/treatment

4.4: INCARCERATION

Numerous times the participants in my research disclosed their time incarcerated for drug-related offences. Of my eight participants, three shared they spent time in prison at one point throughout their life. Numerous shared that their parents, one or both, had been incarcerated at some point throughout their lives. All eight of them shared some degree of distrust in the police and other law enforcement. Many of them had experienced the challenges of not only being incarcerated, but detoxing within prison. Additionally, once they were released from prison, some participants described the challenges associated with learning to live in society as a newly, often unwillingly, sober ex-convict. Reintegration into society after being released from prison with adequate support in place would be challenging, never mind being isolated without

proper supports in place. Many of our participants relapsed back to familiar crowds, old friends, and drug-usage shortly after being released.

There are numerous barriers to successful reintegration into society after incarceration, such as widespread homelessness, inadequate treatment programs, limited career opportunities, and lack of support (Eliason et al., 2009). These barriers, combined with struggling with an addiction, lead to an extremely difficult reintegration for the individual. When these individuals are released, they are often ill-equipped to face the challenges of obtaining sobriety, even if they do possess the desire to do so (Eliason et al., 2009).

4.5: HOMELESSNESS

A significant portion of my research participants (seven out of eight), belonged to the demographic of homeless or street involved. All eight of them had been homeless or street involved at some point in their life. Although drug usage does not cause homelessness and financial marginality or vice versa, they are intrinsically linked. Engaging in a daily activity such as injection or inhalation drug usage makes it extremely difficult for these individuals to maintain jobs. The mind-altering, sedating, and potentially hallucinogenic effects of these drugs also result in a loss of anonymity in public. The nature of routinely consuming illicit substances makes it insurmountably difficult to avoid a criminal record, which further excludes these individuals from success in the workforce. They are social pariahs: a visible minority, engaging in an illegal, highly-criticized activity, disrupting society. These social issues are perpetuated by the marginalization of these groups, and the overwhelmingly negative perception of this

population by the community. This is painstakingly demonstrated in reports generated by institutions such as the Alberta government in the recently released Socio-Economic Review of the Supervised Consumption Sites. In this report, which was a subjective survey-style report, stakeholders and community members repeatedly reported that they believed they were suffering negative consequences as a result of the implementation of SCSs throughout the province. (Alberta Government, 2020). In response to a survey, citizens voiced concerns regarding destruction of property, a perceived decrease in public safety, a perceived increase in crime surrounding the sites, a perceived lack of policing in the area, and a perceived increase of incorrectly-disposed drug-related paraphernalia in the area (Alberta Government, 2020). Numerous stakeholders and business-owners reported lost revenue and business as a result of the SCSs being placed near their businesses, along with a decrease in property value. This report, which was widely utilized as a criticism of SCSs around the province, perpetuated the negative stereotype of ILDU by highlighting negative perceptions of community members, whilst minimizing imperial efficacy of these sites.

4.6: GENERATIONAL ABUSE

The effects of childhood abuse early on to child's brain development have been heavily studied. In his 2008 publication, I*n the Realm of Hungry Ghosts*, medical doctor and clinical psychologist, Dr. Gabor Maté describes the lasting effects of childhood trauma on the adult brain, specifically in regards to susceptibility to addictions.

In order to understand ILDU, it is crucial to understand the detrimental effects that childhood abuse, intergenerational trauma, and other external influences have on

the human brain. The brain has a potential capacity which far surpasses all other mammals. Within the uterus, the fetal human brain grows at an astounding rate of over 250 000 nerve cells per minute (Ackerman, 1992). The most significant brain development occurs, however, after birth, within the first three years of human life. The brain of a child is the most malleable up until the age of three, when the rate of growth and neural connections drops off dramatically (Ackerman, 1992). During this first crucial period of development the child brain is highly susceptible to stimulation in all forms; positive, absence, and unfortunately, negative. In the early stages of human brain development, the brain is in a constant state of formulating connections between neurons. These connections are what compose a child's ability to speech, emotional regulation, physical dexterity, and physiological state. Children who have been exposed to traumatic experiences or have endured various forms of abuse; physical, psychological, emotional, or sexual have an impaired ability to construct this neural network. Children who are exposed to trauma or stressors in the early years of life are predisposed to addictive tendencies as well as Attention Deficit Hyperactive Disorder (ADHD) (Maté, 2008). Childhood trauma is not only disadvantageous to an individual's psychological state, but will irreversibly disrupt the neural pathways of their brain. This disruption leads to a lower threshold for stress hormones, such as Cortisol, to be released, leading to a perpetually stressed child (Dube et al. 2003).

Another predictor of a healthy adult brain is the degree of attachment the child received to a nurturing parental figure throughout the crucial years of development. A vital building block of the pliable child brain is this nurturing bond. Without it, the child's

brain neurotransmitters misfire leaving the child at risk for unhealthy attachments, or an inability to form attachments. A brain without attachment will search for any connection it can to fill the void (Maté, 2008). This is where opioids, narcotics, and other mind-altering substances play a role. These Central Nervous System (CNS) depressants reward the pleasure centres in the brain which are left unstimulated by the child's lack of maternal/paternal attachment," When circumstances do not allow the infant and young child to experience consistently secure interactions, or worse, expose him to many painfully stressing ones, maldevelopment often results" (Maté, 2008).

Disruptions in healthy attachments often manifest later on, such as in adult life, as problematic behaviour, addictive tendencies, and immature emotional status. These stresses leave the individuals susceptible to the mind-altering substances of chemicals. As Dr. Maté stated,

> The presence of consistent parental contact in infancy is one factor in the normal development of the brain's neurotransmitter systems; the absence of it makes the child more vulnerable to "needing" drugs of abuse later on to supplement what her own brain is lacking. (Maté, 2008, p.189).

According to Dube and fellow researchers, a healthy brain is one that has an ability to relate to its surroundings in a positive way, identify shifts in emotional statuses, and react accordingly (Dube et al., 2003).

Children who suffer from forms of abuse and trauma have their brain development sabotaged. The detrimental lasting effects of this often manifest later on in adulthood as problematic behavior.

4.7: PERCEPTION OF WORTH

Participants in this research also repeatedly stated that they felt that their story was not worth sharing, or that they perceived their existence, and their voice, to be insignificant. It often took great encouragement to convince my participants that their story was valuable to the public in order to obtain a greater depth of understanding. Some of the participants in this research held a perception of themselves which made them feel helpless. Many of them believed their life was “just how life is”. One individual asked me, “Why would anybody care about a junkie like me?”.

This negative perception of self-worth is further amplified by the interactions these individuals have had with members of the community, law enforcement, and within healthcare.

When the rhetoric surrounding ILDU is so overwhelmingly negative in public spheres, it is understandable that these individuals would have feelings of being unwanted, marginalized, or worse, forgotten.

A 2019 study published in The Journal of Substance Abuse Treatment studied the effects of perceived worth and self-esteem in ILDU. These researchers surveyed 387 adults who entered into an opioid-managed withdrawal program, by using the newly developed Brief Opioid Stigma Scale (BOSS) (Anderson et al., 2019). The BOSS is a three-part scale which assesses perceived OUD stereotype awareness, stereotype agreement,

and self-esteem decrement (Anderson et al., 2019). Participants were given numerous statements surrounding their own perceptions of their addictions, public perceptions of addictions, and perceived stigma. Researchers found that 56-78% of participants believed that the public held negative stereotypes of ILDU, which is statistically consistent with the reported national perception (Anderson et al., 2019). They also found that a large percentage of participants (27-65%) experienced diminished self-respect due to stereotypes of ILDU (Anderson et al., 2019). A smaller percentage, (17-44%) of participants actually agreed with stereotypes towards ILDU (Anderson et. al, 2019). What these researchers discovered, through using the BOSS, was that ILDU were aware of, and felt the impacts of, negative perceptions towards them from the general public. Additionally, a number of them also felt that these negative perceptions, in turn, affected their own perceptions of self, and their self-esteem (Anderson et al., 2019). This research provides insight into the judgment and negative perceptions ILDU experience from the general public in regards to addictions. This issue complicates and further marginalizes this population and makes it increasingly difficult for these individuals to access resources.

4.8: NUMBING THE PAIN

Another common theme is the use of psychedelic, anesthetic, opioid, narcotic and other illicit and licit drugs to deter negative emotions, or enhance a euphoric feeling, at least temporarily. As one participant stated, “The only reason I use the drugs is just to numb my feelings. . . To take away the pain and the loss, and the grief. Honestly, feeling numb is better than feeling most of the time”.

This concept of using drugs as a coping mechanism was highly prevalent in all eight of the interviews. The mind-altering effects of the substances was a way for these individuals to escape their reality. Typically, these individuals had endured one, if not numerous, highly traumatic events which left them vulnerable to the euphoric feeling that opioids and stimulants provide. Many of them had watched as parental figures in their life had used drugs and alcohol in similar ways to cope with negative emotions and experiences, and had in turn, learned that was an effective method of coping. Many of my participants in this research had limited positive memories from their past. To these participants, drug usage was their main source of comfort and satisfaction in their lives. Rather than suffer the tremendous weight of these negative memories and experiences, these individuals opted to dull the feelings by way of chemicals.

Despite our understanding of the rationale for drug usage, society seems to continually demonize this population for their response to unthinkable life situations and historical trauma. Unfortunately, rather than addressing the detrimental effects of certain social and cultural constructs, continued marginalization of vulnerable populations, and negative perceptions of this population, society seems to condemn ILDU for their lifestyle “choices”.

4.9: TREATMENT OPTIONS

Towards the end of my conversations with ILDU, we would often discuss their detox and treatment experiences, if any. Three of my participants had completed treatment once, one of them completed it numerous times. All eight of them, however, were actively using at the time of the interview. My participants expressed concern and

dissatisfaction with the current treatment options, as well as the ability to function as a member of society after attaining sobriety. As one participant put it,

> Yeah, I got clean. I actually, finally got clean, ha! I couldn't believe it either, honestly. But then I get out, right? I finished treatment. I got out. And then there was nowhere to go. There was nobody there for me. I was all alone, and sober. And that's the scariest - sober and alone! At least when you have "down" or "side" or something you can ignore that void for a while, but I was alone. So, I relapsed, you bet I did. And here I am (laughter).

The healthcare system is a pivotal step in the addiction treatment paradigm, however, increasingly healthcare professionals and healthcare programs do not have the capacity to deal with the growing demand related to drug addiction in our communities (Allen et al., 2014)(Hewitt & Vinjte, 1991). Not only is drug addiction a great burden on the healthcare system financially, but the current healthcare model often does not provide holistic care for drug users (Allen et al., 2014). Patients who are repeatedly admitted to the hospital with overdose or drug usage-related complications, are sobered up, treated, and then discharged without proper supports in place. They often return to their home situations where they continue to use. The healthcare system treats addiction mainly from an abstinence-focused approach. Often, due to financial restrictions, the healthcare system -- hospitals, clinics, physicians, nurses, and other healthcare components-- is unable to treat ILDU effectively. In Alberta, the perpetually inadequate funding for the significant demand of detox and treatment facilities results in drug users unable to access resources in a prompt manner. There is currently a 27 day wait for individuals living in Southern Alberta to receive an appointment for outpatient addictions treatment (Alberta Government, 2019). For an inpatient addictions treatment

bed the wait time is currently six to twelve weeks (Alberta Government, 2020). The issue with these wait times is that individuals attempting to give up drug usage are in a precarious position when they make the call to seek detox, treatment, or addictions counselling services. Detoxing from years of opioid use takes a tremendous amount of courage, but also, takes an incredible toll on the human body. This daunting first step should be facilitated by timely, accessible, and affordable inpatient and outpatient treatment programs.

An insufficient number of treatment beds is a continuing problem within the province of Alberta, largely due to financial restrictions (Government of Alberta, 2019). Additionally, insufficient funding for current harm reduction services already in place within the community makes it difficult for these services to provide the wide array of programs and supports needed by clients. The increasing demand on these social services, combined with limited new funding to support new initiatives, leads to a situation within Alberta wherein the demand is going up, and the capacity is either unchanging or not increasing proportionally to the demand.

CHAPTER 5: REFLECTION

5.1 THE THREE GROUPS

Within this oral history collection, it became evident how these individuals viewed themselves, specifically in regards to their health. Through analyzing their oral histories, it became evident that definite themes were emerging. Through this analysis, I separated the participants into three distinct groups. Some individuals spoke to the notion of not seeing their addiction as problematic, some saw it as problematic but were not ready for change, while others saw it as completely problematic and were noticeably upset with themselves for continuing with usage.

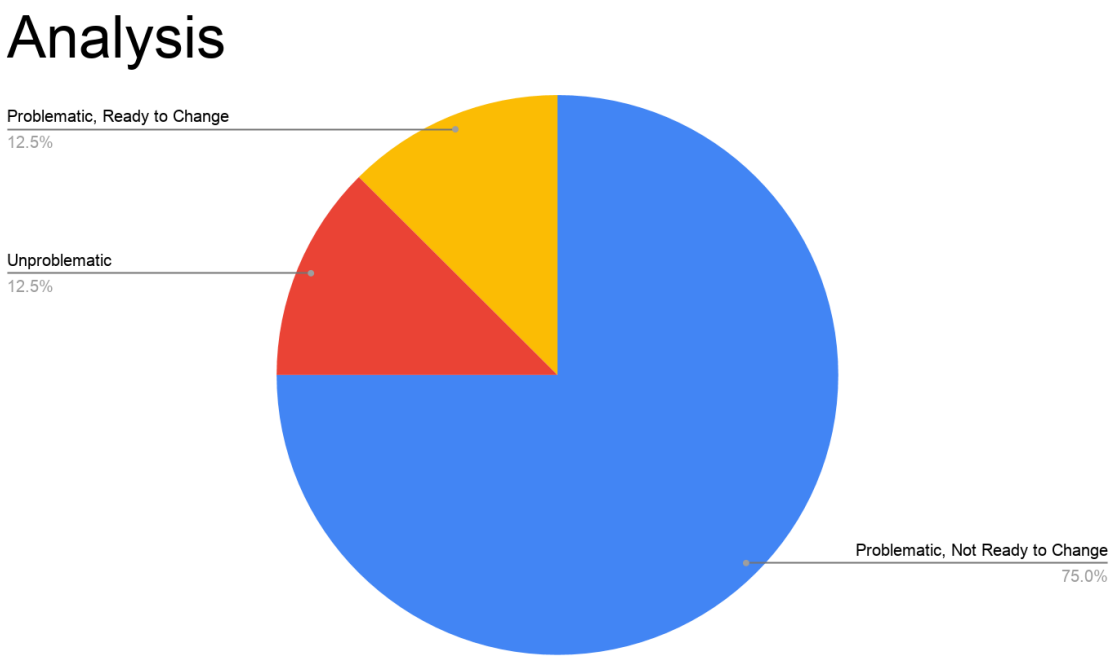

Figure 2.0: Participant's Perception of their Addiction

The first group, not seeing their addiction as problematic, had a way of feigned confidence about them. I identified one participant as belonging to this group (n=1). This participant, extremely outgoing and seemingly positive, had been a longstanding stimulant user. They did not believe, or did not disclose to me that they believed, their drug usage was problematic. Perhaps due to the hardships she had experienced throughout the course of their life, or the insuperable odds stacked against her since she was born, but she did not perceive her usage as an issue. This participant had been through seemingly unbearable events all throughout her life, yet had a positivity and confidence about her.

The second group, seeing their addiction as problematic but not ready to change, would be the majority of participants (n=6). This group was uncomfortable with their drug usage, however, due to an inability to heal from traumatic life experiences, seemingly impossible current circumstances, or the daunting feasibility of obtaining sobriety, felt trapped in their usage. This group often became emotional when we talked about detox and treatment options. Three participants of this group had even completed detox and treatment before, one participant several times, but due to intrinsic or extrinsic factors, relapsed.

The third group (n=1), believed their usage was extremely problematic and were attempting to escape it. This participant was taking concrete steps to limit their usage, with the ultimate outlined goal of reduction, cessation, detox, and treatment. This participant was extremely emotional throughout the course of our interview, but specifically when talking about struggles and successes with treatment options. This

third group is the most receptive to discussions on detox and treatment options, and the group which would have the most success within addiction treatment programs.

The purpose of identifying these three distinct groups within the pool of participants is so that we can develop more appropriate and individualized treatment options for clients currently accessing addiction and harm reduction programs.

There will always be individuals within the demographic of drug users who are not currently willing to discuss cessation, reduction, opioid-maintenance programs, or changing their habits. This is the group that requires harm reduction interventions the most. This is the group of ILDU that will benefit from take-home Naloxone kits, sterile drug consumption supplies, wound care, infectious disease testing and treatment, and overdose prevention and treatment services. This is an extremely vulnerable group that needs a high degree of support, while they live with their drug usage. Although they may not be receptive to treatment options at this time, providing ongoing care, and maintaining points of contact with this group is essential. I will use the analogy of a lifesaver buoy being tossed off the side of a lifeboat to a drowning child who cannot swim, amidst a violent ocean storm. The drowning child can grab onto the buoy to stay afloat, until they can get reeled into the boat to safety. Harm reduction services act as this lifesaver buoy; providing a lifeline to individuals to keep them from drowning until more long-term solutions can be reached. Harm reduction is the lifeline that draws these individuals in, providing them with access to lifesaving services that would otherwise remain inaccessible. Without this pivotal step, the child will undoubtedly drown. Teaching the drowning child to swim at this point, is unrealistic, and infeasible.

There is also the group of ILDU that is dissatisfied with their current situation, but cannot yet make significant changes to their lifestyle. This second group needs the ongoing supports of harm reduction, in order to avoid further complications caused by their usage. This is also a key time to provide education to these clients, as they are more likely open to discussing their usage with addiction treatment specialists. This is the time to start having open discussions with clients about their goals and the support they need. This group needs ongoing multidisciplinary support from healthcare, social services, and the community. This group of drug users is analogous to the child who gets pulled into the lifeboat amidst the violent storm. Left in the stormy water for too long with nothing but a buoy, the child will eventually drown. But lifted up into the lifeboat, the child has a fighting chance. The child is still in a dangerous lifeboat amidst the stormy seas, but her chances of survival have just multiplied, exponentially.

The third group, the individuals who perceive their addiction as problematic and are attempting to make serious changes, are the group that is the most receptive to addiction treatment options. This is the group that should be targeted to ensure that they receive appropriate and timely interventions. This group is likely ready to make changes in their lifestyle, given a sufficient amount of support and care. This group will likely be open to making significant life changes, however, the practicality of this is dismal if points of contact and support are not provided to them when they are a member of the first and second group. This group is like the child who is rescued by the lifesaving buoy, pulled into the lifeboat, given a lifejacket, and taught how to swim. The child is best equipped to avoid drowning when the correct education, supports, and

resources are in place. Maintaining positive relationships with clients while they are living with their drug usage is one of the strongest predictors of successful recovery when they are ready to make a change. These individuals need high levels of support throughout their addiction journey, so that if and when the time comes to give up their usage, they are already connected with appropriate resources. This is the reason addiction treatment efforts cannot solely be focused on the goal of abstinence. If lifesaving interventions are not provided to these individuals, many will never get the opportunity to change. You will not have success teaching a drowned child how to swim.

The addiction journey is just that, a journey. Individuals can move from group to group, depending on where they are at in their life. Drug users are a vulnerable population for a reason. They need support and care from healthcare services, addictions treatment, harm reduction services, and the community. Caring for these individuals throughout their journey of usage to potential recovery is an ongoing process. It can be time-consuming, costly, and tiring for frontline staff, taxpayers, and communities. It is also a basic human right.

5.2: BEYOND THE PAIN

Beyond the aforementioned themes of pain, grief, abuse, hurt, and the resulting situations that many of the participants found themselves in, I also uncovered some surprising themes; reoccurring stories of strength, resilience, community, and heart wrenching episodes of raw humanity. I heard stories of individual struggles and loss, coupled with tremendous accounts of strength in the face of adversity. These individuals

are not just a sad story. The participants in this research are dynamic, social creatures, with both heartbreaking and inspiring stories to share.

ILDU live an extremely social life. They are involved in 'normal' everyday activities of daily living. They work, play, love, have family, friends, they have moments of crippling sadness, and moments of joyful triumph. This social component of drug usage is at the epicentre of the community around them, yet is a concept which is often neglected within the literature surrounding ILDU. To these individuals, clinics such as ARCHES are not merely a place to consume safely, but are a social sphere where meaningful relationships are built, lived experiences shared, and profound exchanges take place. This social component of drug usage was a theme which surprised me. It was a concept which I had not considered, prior to my ethnographical period at ARCHES, yet it is a crucial piece of the puzzle to when one is attempting to validate clinics, such as ARCHES. Harm reduction clinics such as ARCHES, are a place where the social exchanges between ILDU, harm reduction specialists, healthcare professionals, and the public can occur.

CHAPTER SIX: CONCLUSION

This research is relevant because it targets a large vulnerable population, ILDU. This population is often marginalized within society. This research is valuable because it is pertinent to a local crisis which is taking a significant toll on the healthcare and legal system. Additionally, this research sheds light on the experience of the drug user on a personal level in order to further understand the road that led him or her to addiction, as well as some of the historical factors which may have contributed to his or her current circumstance, such as intergenerational trauma and settler colonialism. Research by the *Canadian Alcohol and Drug Use Monitoring Survey (CADUMS)* published that 46.4% of Albertans self-reported use of one or more illicit drugs in their lifetime, and 2.2% of Albertans reported experiencing harm as a result of their drug habits (Embil & Laupland, 2012). These statistics testify to the need for more research into drug usage within Alberta, and a deeper insight into the social problems related to it. This research is significant because there are limited resources available to drug users, our publicly-funded addictions and healthcare system is overburdened by the associated complications and costs , and because of the numerous opioid-related deaths occurring in our community. Lastly, this research is significant because it gives a voice to a population that, up until this point, has remained largely unreached. The subject of the degree of responsibility to assist individuals who use drugs is highly controversial and heavily debated within media, political, and social discourse. This research was initiated to document individual's life experiences and contribute to the public discourse on

addiction, directly from their perspective. My ultimate goal with this research is that it will give this population a voice in the discussion on addictions.

My research was an effective way to understand some of the resources available to drug users, as heard first-hand. It was useful to document which community resources these individuals were accessing, and how they felt they were impacted, positively or negatively. In addition to this, I was hoping to identify some of the areas where drug users felt that gaps exist within our system: areas where additional resources are needed, but currently unavailable. Particularly within the last two years, Western Canada has seen an increase in programs available to drug users, including but not limited to SCSs, needle exchange programs, detox centres/beds, and other harm reduction initiatives. Although some of these programs are available to drug users, there is still a great need for further prevention, education, and treatment, as evidenced by the 687 Albertans that lost their lives at the hands of opioid in the year 2018. This research was a useful way to gain insight into the resources and programs available, and the degree to which they are currently being accessed by the research population. Additionally, I sought to uncover how these addictions treatment programs and harm reduction initiatives are being perceived by individuals who use drugs.

This research is significant for a variety of reasons. At the most fundamental level, I hope that this collection of oral histories will allow researchers and the public alike to appreciate the struggles and hear the life stories of ILDU in the community. It is important that we, as members of society, seek to understand the challenges that vulnerable populations in our community face, in order to more effectively assist them. I

believe that the most important concept which will emerge from this research is the stories that are told, and the lives that are being shared. By partaking in the interview process of this population, I found I was able to develop a deeper understanding of this vulnerable population and became further equipped to educate the general public of the issues they face.

> "It is impossible to understand addiction without asking what relief the addict finds, or hopes to find, in the drug or the addictive behaviour."
>
> -Dr. Gabor Maté

REFERENCES

Ackerman, S. *Discovering the Brain*. Washington (DC): National Academies Press (US); 1992. 6, The Development and Shaping of the Brain. Available from: https://fentanyl.ncbi.nlm.nih.gov/books/NBK234146/

Alberta Government. 2019. Alberta Opioid Surveillance Report Quarterly. Retrieved online on November 4, 2019 from https://fentanyl.alberta.ca/opioid-reports.aspx.

Alberta Health Services. (2018). Drug Safe. Retrieved online on October 5, 2018 from, https://fentanyl.albertahealthservices.ca/info/Page16025.aspx#savemesteps

Alberta Government, 2020. Impact: A socio-economic review of supervised consumption sites in Alberta . Retrieved online on March 20, 2020, from https://open.alberta.ca/publications/9781460147054

Allen, M. A., Jewers, FENTANYL., & Mcdonald, J. S. (2014). A Framework for the Treatment of Pain and Addiction in the Emergency Department. *Journal of Emergency Nursing,40*(6), 552-559. doi:10.1016/j.jen.2013.12.020

Allmark, P. J., Chambers, E., Clarke, A., Thompson, A., & Tod, E. (2017). *Research Ethics Review,5*(2), 48-54. doi:10.18411/a-2017-023

Anda, R., Edwards, A., Felitti, V., Koss, M., Marks, J., Nordenberg, D., Spitz, A., Williamson, D. (2003). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 1998. 14*(4),

Anderson, B., Bailey, G., Grivel, M., Lawrence, FENTANYL., Opler, M., Stein, M., Wong, L. Yang. (2019). A new brief opioid stigma scale to assess perceived public attitudes and internalized stigma: Evidence for construct validity, *Journal of Substance Abuse Treatment 99,* 44-51,

ARCHES. Who We Are/What We Do. Accessed on September 7, 2018 from https://fentanyl.lethbridgearches.com

Back, S. E., Payne, R. L., Wahlquist, A., Carter, R. E., Stroud, Z., Haynes, L., Ling, J. (2011). Comparative Profiles of Men and Women with Opioid Dependence: Results from a National Multisite Effectiveness Trial. *The American Journal of Drug and Alcohol Abuse*, *37*(5), 313–323. http://doi.org/10.3109/00952990.2011.596982

Barker, B., DeBeck, K., Dong, FENTANYL., Hayashi, K., Kerr, T., Lagimodiere, L., Milloy, J., Tourangea, M., Shoveller, J. (2019). Intergenerational Trauma: The Relationship Between Residential Schools and the Child Welfare System Among Young People Who Use Drugs in Vancouver, Canada. *Journal of Adolescent Health, 65*(2), 248-254. Doi: 10.1016/j.jadohealth.2019.01.022

Beckman, R., Cefalu, M., Collins, R., Doyle, M., Engel, C., Hawes-Dawson, J., Kress, A. Meadows, S., Ramchand, R., Sontag-Padilla, L., Williams, K. (2018). 2015 Department of Defense Health Related Behaviors Survey (HRBS). *Rand health quarterly*, *8*(2), 5.

Belzerk, L. Halverson, A. (2018). The opioid crisis in Canada: A national perspective. *Health Promotion Chronic Disease Prevention Canada 38*(6): 224–233.

doi: 10.24095/hpcdp.38.6.02.

Blood Tribe. (2019). Information. Retrieved Online on September 9, 2019, from fentanyl.bloodtribe.org

Bray, R., Brown, J., Hourani, L., Lance, M., Marsden, M., Olmsted, K., Pemberton M., Witt, M., Weimer, B., Scheffler, S. Department of Defense Survey of Health-Related Behaviors among Active Duty Military Personnel. Research Triangle Park, NC: RTI International; 2012. Retrieved online on November 2, 2019 from http://fentanyl.tricare.mil/2008HealthBehaviors.pdf

Brownstein, M. (1993). A brief history of opiates, opioid peptides, and opioid receptors. *Proceedings Of The National Academy Of Sciences*, *90*(12), 5391-5393. doi: 10.1073/pnas.90.12.5391

Buchanan, J. (2004). Tackling Problem Drug Use: A New Conceptual Framework. *Social work in Mental Health, 2*(2), 117-138. Retrieved online on September 12, 2018, from fentanyl.blackwell-synergy.com

Buxton, J., Campbell, J., Kuo, M., Tzemis, D. (2013). A cross-sectional study of public attitudes towards safer drug use practices in British Columbia, Canada. *Substance Abuse Treatment, Prevention, and Policy, 8*(40), 1-9. Retrieved online on November 21, 2018 from http://fentanyl.substanceabusepolicy.com/content/8/1/40 .

Canada Drug Rehab. Waiting List For Alberta Drug Rehab Centers. Retrieved September 13, 2018, from https://fentanyl.drugrehab.ca/waiting-list-for-alberta.html

Canadian Harm Reduction Network | To act and not be acted upon is the essence of joy. –

Alain. (2018). Retrieved from http://canadianharmreduction.com

Canadian Harm Reduction Policy Project – CRISM Prairies. (2018). Retrieved from https://crismprairies.ca/charpp/

Canadian Nurses Association. (2017). Harm Reduction & Illicit Substance Use, Implications for Nursing. Retrieved online on October 21, 2018 from https://fentanyl.cna-aiic.ca/-/media/cna/page-content/pdf-en/harm-reduction-and-illicit-substance-use-implications-for-nursing

Caulkins, J. P., Pardo, B., and Kilmer, B. (2019) Supervised consumption sites: a nuanced assessment of the causal evidence. *Addiction*, 114: 2109– 2115. https://doi-org.ezproxy.uleth.ca/10.1111/add.14747.

Cooke, M., Maltby, A., Wilk, P. (2017). Residential schools and the effects on Indigenous health and well-being in Canada - A scoping review. *Public Health Reviews. 38.* 10.1186/s40985-017-0055-6.

Courtwright, D., Gerstein, D., & Harwood, FENTANYL. (1991). *Treating Drug Problems 2*, 1-62. Washington (DC): National Academies Press.

Crawford, D., Hartshorn, K., Whitbeck, L. (2012). Correlates of Homeless Episodes Among Indigenous People. *American Journal of Community Psychology 49,* 156–167 https://doi.org/10.1007/s10464-011-9446-x

Crocq, M. (2007). Historical and cultural aspects of man's relationship with addictive drugs. *Dialogues in Clinical Neuroscience, 9*(4), 355-360. Retrieved online on October 14 from https://fentanyl.ncbi.nlm.nih.gov/pmc/articles/PMC3202501/ .

Darke, S., Larney, S., and Farrell, M. (2017) Yes, people can die from opiate withdrawal.

Addiction, 112: 199–200. doi: 10.1111/add.13512.

Davidson, R., Harrison, R. (2020). Alberta. Retrieved online on May 1, 2020 from https://fentanyl.britannica.com/place/Alberta-province/History

Dobkin, C., Nicosia, N. (2009). The War on Drugs: Methamphetamine, Public Health, and Crime. *American Economic Review,99*(1), 324-349. doi:10.1257/aer.99.1.324

Drug Rehab Services. (2018). Waiting list for Alberta drug rehab centers. Retrieved online on October 2, 2018 from, https://fentanyl.drugrehab.ca/waiting-list-for-alberta.html .

Dupre, R., Vencatachellum, D. (2005). Canadians and Prohibition: An Analysis of the 1898 Referendum. Retrieved online on September 9, 2019, from www.web.hec.ca/articles/Vencatachellum

Eliason, M., Freudenberg, N., Van Olphen, J.(2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment Prevention Policy* 4, 10 https://doi.org/10.1186/1747-597X-4-10

Embil, J., Laupland, K. (2012). Reducing the adverse impact of injection drug use in Canada. *Canadian Journal of Disease and Medical Microbiology, 23*(3), 106-107. Retrieved online on November 21, 2018, from http://dx.doi.org/10.1155/2012/297530

Erickson, P. (1990) Past, current, and future directions in Canadian drug policy. *The International Journal of the Addictions 25*, 247-66.

Gallahue, P., Saucier, R., & Barrett, D. (2018). Partners in Crime: International Funding for Drug Control and Gross Violations of Human Rights. Retrieved from

https://fentanyl.hri.global/files/2012/06/22/EXEC_summary_web.pdf

Gelder, C. L. (2016). Measuring the development of fetal brain anatomy using MRI. *Archives of Disease in Childhood, 101* doi:http://dx.doi.org.ezproxy.uleth.ca/10.1136/archdischild-2016-310863.115

Government of Canada. (2018). Safe Streets and Communities Act. Retrieved online on November 6, 2018 from https://laws-lois.justice.gc.ca/eng/annualstatutes/2012_1/page-1.html

Government of Canada. (2018). Health Canada and the Public Health Agency of Canada's (PHAC) Research Ethics Board. Retrieved online on October 1, 2018 from, fentanylttps://fentanyl.canada.ca/en/health-canada/services/science-research/science-advice-decision-making/research-ethics-board.html

Government of Canada. (2020) Indian Reservations. Retrieved online on March 5, 2020 From https://fentanyl.bac-lac.gc.ca/eng/discover/aboriginal-heritage/first-nations/indian-reserves/Pages/indian-reserves-western-canada.aspx

Hammersley, Richard. (2017). How and Why Addiction is socially constructed. 10.13140/RG.2.2.17828.48008.

Hansen, H., Mendoza, S., Rivera, A. (2018) Re-racialization of Addiction and the Redistribution of Blame in the White Opioid Epidemic. *Medical Anthropology Quarterly 00*(0), 1-21. doi: 10.1111/maq.12449.

Hari, Johann. (2015). *Chasing the scream: the first and last days of the war on drugs*. New York: Bloomsbury.

Health Canada. Harm Reduction: Canadian Drugs and Substances Strategy. (2018).

Retrieved online on August 30, 2019, from https://fentanyl.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/harm-reduction.html

Heather, N. (1998). A conceptual framework for explaining drug addiction. Retrieved October 10, 2018, from https://fentanyl.ncbi.nlm.nih.gov/pubmed/9584962

Herzberg, D. (2017). Entitled to Addiction?: Pharmaceuticals, Race, and America's First Drug War. *Bulletin Of The History Of Medicine*, *91*(3), 586-623. doi: 10.1353/bhm.2017.0061

Hewitt, D. S., & Vinjte, G. S. (1991). Injection Drug Use Among Addictions Treatment Clients in Alberta: Implications for the Spread of AIDS. *Canadian Journal of Public Health,3*, 205-207. Retrieved September 12, 2018, from https://wwwjstor.org/stable/41990050 .

Järvinen, M. and Ravn, S. (2011), From recreational to regular drug use: qualitative interviews with young clubbers. Sociology of Health & Illness, 33: 554-569. doi:10.1111/j.1467-9566.2010.01303.x

Jensen, E. L. (1993). State Efforts to Construct a Social Problem: The 1986 war on drugs in Canada. *Canadian Journal of Sociology,*453-462. Retrieved September 10, 2018, from https://ac-els-cdn-com.ezproxy.uleth.ca/S0955395918301257/1-s2.0-S0955395918301257-main.pdf?_tid=05d8359b-3d84-4f18-9234-

Klaue, K. (2018). United Nations Office on Drugs and Crime. Retrieved October 16, 2018, from https://fentanyl.unodc.org/unodc/en/data/bulletin

Kleinman, A. (1980) *Patients and Healers in the Context of Culture.* Berkeley. University of

California Press.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, *88*(2), 251-258. Retrieved from http://in.bgu.ac.il/en/fohs/communityhealth/Family/Documents/ShlavB/culture%20illness%20and%20care.pdf

Legislative Services Branch. (2018, September 07). Consolidated federal laws of Canada, Safe Streets and Communities Act. Retrieved September 12, 2018, from http://laws-lois.justice.gc.ca/eng/annualstatutes/2012_1/

Lock, M., Schepher-Hughes, N. (1987). The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly 1*(1), 6-41. Retrieved online on October 5, 2018 from, fentanyl.jstor.org/stable/648769

LoBianco, T. (2016, March 24). Report: Nixon's war on drugs targeted black people. Retrieved September 13, 2018, from https://fentanyl.cnn.com/2016/03/23/politics/john-ehrlichman-richard-nixon-drug-war-blacks-hippie/index.html

Macalester College. (2018). Retrieved November 1, 2019, from https://fentanyl.macalester.edu/history/facultystaff/amysullivan/

Mcauley, A., Aucott, L., & Matheson, C. (2015). Exploring the life-saving potential of naloxone: A systematic review and descriptive meta-analysis of take home naloxone (THN) programmes for opioid users. *International Journal of Drug Policy,26*(12), 1183-1188. doi:10.1016/j.drugpo.2015.09.011

Mcdonald, R., & Strang, J. (2016). Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria. *Addiction,111*(7), 1177-1187. doi:10.1111/add.13326

McGowan, C. R., Harris, M., Platt, L., Hope, V., & Rhodes, T. (2018, May 12). fentanyl self-testing outside supervised injection settings to prevent opioid overdose: Do we know enough to promote it? Retrieved September 12, 2018, from https://fentanyl.sciencedirect.com/science/article/pii/S0955395918301257

Musto, D. (1996). *Pathways of addiction: Drug Abuse Research in Historical Perspective* (1st ed.). Washington, D.C.: National Academy Press.

National Institute on Drug Abuse. (2018, March). Opioids and Substances of Misuse. Retrieved September, 2018, from https://fentanyl.drugabuse.gov/drugs-abuse/opioids

O'Brien, C., Oster, M., & Morden, E. (2013). *Substance use disorders in the U.S. Armed Forces*(1st ed., pp. 1-388). Washington (DC): Institute of Medicine of the National Academies.

Oden, R. (2013). Emerging from the Haze of America's War on Drugs and Examining Canada's New Half-Baked Laws. *Fordham International Law Journal,36*(1), 198-222. Retrieved September 12, 2018, from https://news.law.fordham.edu/filj/publications/volume-41-online/

O'Hare, P. (2007). Merseyside, the first harm reduction conferences, and the early history of harm reduction. International Journal of Drug Policy, 18(1), 141-144. doi: 10.1016/j.drugpo.2007.01.003

O'Rourke, A., White, R., Park, J. (2019). Acceptability of safe drug consumption spaces among people who inject drugs in rural West Virginia. *Harm Reduction Journal* 16, 51 (2019). https://doi.org/10.1186/s12954-019-0320-8

Pijl, E. M., Bourque, S., Martens, M., & Cherniwchan, A. (2017). Take-Home Naloxone Kit Distribution: A Pilot Project Involving People Who Use Drugs and Who are Newly Released from a Correctional Facility. *Canadian Journal of Criminology and Criminal Justice,59*(7), 559-571. doi:10.3138/cjccj.2017.0001.R2

Potier, C., Laprevote, V., Arbour, F. D., Cottencin, O., & Rolland, B. (2014). Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence,145*, 48-68. Retrieved October 11, 2018, from https://ac.els-cdn.com/S0376871614018754/1-s2.0-S0376871614018754-main.pdf?_tid=016406bf-2c81-4456-bdda-47e8c412820b&acdnat=1539803910_2f3a5594e5eaa8547b24198e31eee555

Ravitz, J. (2018). Inside the secret lives of functioning heroin addicts. Retrieved from https://fentanyl.cnn.com/2018/02/27/health/functioning-heroin-addicts/index.html

Roe, G. (2005). Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction. *Critical Public Health*, *15*(3), 243-250. doi: 10.1080/09581590500372188

Saah, T. (2005). The evolutionary origins and significance of drug addiction. *Harm Reduction Journal*, *2*(8), 1-7. doi: 10.1186/1477-7517-2-8

Shanmugam, P. K. (2006). The Influence of Social Factors in Drug Addiction–A Mini

Review of Work by Miller & Carroll (2006). *Journal of Alcoholism & Drug Dependence,05*(04). doi:10.4172/2329-6488.1000272

Shaw, A., Lazarus, L., Pantalone, T., Leblanc, S., Lin, D., Stanley, D., Tyndall, M. (2015). Risk environments facing potential users of a supervised injection site in Ottawa, Canada. *Harm Reduction Journal,12*(1). doi:10.1186/s12954-015-0083-9

Strang, J. (2015). Death matters: Understanding heroin/opiate overdose risk and testing potential to prevent deaths. *Addiction,110*, 27-35. doi:10.1111/add.12904

Tzemis, D., Campbell, J., Kuo, M., & Buxton, J. (2013). A cross-sectional study of public attitudes towards safer drug use practices in British Columbia, Canada. *Substance Abuse Treatment, Prevention, And Policy*, *8*(1), 40. doi: 10.1186/1747-597x-8-40

United Nations. (1961). Drug prevention, treatment, and care. Retrieved on November 1, 2018 from https://fentanyl.unodc.org/unodc/en/drug-prevention-and-treatment/publications.html

Webster, P. (2014). Canada opposes harm reduction policies for drug users. *Canadian Medical Association Journal*, *186*(4), 256-256. doi: 10.1503/cmaj.109-4714

Welp, E. A., Bosman, I. , Langendam, M. FENTANYL., Totté, M. , Maes, R. A. and Van Ameijden, E. J. (2003), Amount of self-reported illicit drug use compared to quantitative hair test results in community-recruited young drug users in Amsterdam. Addiction, 98: 987-994. doi:10.1046/j.1360-0443.2003.00421.x

Zames, R. (1992) "Recent trends in Canadian drug policy: The decline and resurgence of prohibitionism." doi:121: 239-67.

APPENDIX A: RESEARCH PROCESS

This qualitative research project was intended to investigate the lives of ILDU in an effort to understand their experiences within our society, within addictions treatment, harm reduction initiatives, and healthcare. This research was designed to highlight the voices of this vulnerable population, in an effort to comprehensively understand the issues that they face. By using oral history as a methodology, I was able to uncover meaningful, unique, and personal data which would be difficult to achieve by quantitative means. In collaboration with ARCHES, I conducted research into the lives of ILDU in order to more deeply understand the issues faced by this population. These interviews are to be archived at ARCHES, with the intent to increase public knowledge and understanding of the issue facing clients of the site through dissemination through public presentations.

Ethical approval was obtained from the University of Lethbridge Human Subject Research Committee (HSRC) Research and Ethics Board on March 9, 2019. After ethical approval was received, I began the volunteering phase at the site I was hoping to ultimately data collect at. Firstly, I began volunteering, without soliciting individuals for interviews, but familiarizing myself with the site, processes, protocols, layout, staff, and clients. Additionally, this period allowed the staff and clients to become familiar with my presence at the site on a regular basis.

Due to the sensitive nature of this research, it was paramount that I maintain a high degree of confidentiality and anonymity for my participants. For both the safety and well-being of my participants, I used pseudonyms throughout my thesis writing,

altered physical descriptions, and omitted any obvious identifying features. I kept the audio recordings and interview transcripts in locked files in a discreet location in my office at the University of Lethbridge.

The next period in my research process allowed me to build rapport with the clients and staff, which is an essential part of the research process when conducting qualitative interviews, particularly within a vulnerable population, such as this. Once I had been at the site for over two months, I informed clients that I was conducting oral history interviews, and that participation was encouraged, if they felt so inclined. Additionally, I informed staff so that they could refer clients to me, if the clients had expressed interest in doing so. I utilized a snowball sampling method for recruiting participants. This strategy proved to work well as the clients at the site have an extensive network of communication amongst themselves, that proved to be highly effective. Once I completed my first interview, I quickly received numerous requests for interviews. My goal was to find eight participants, and, fortunately, I did receive over eight requests, but due to the time constraints I had, I capped the number of interviews to eight.

The interview process consisted of an allotted one-hour time slot for a semi-structured interview. I brought pre-outlined research questions, but would adapt to conversational flow, as appropriate. Interview time ranged from ten minutes to two hours, depending on the participant, situation, and conversational flow. I used a semi-structured interview method, in doing so, favouring conversational flow over order and sequence of the predetermined interview guide.

As a symbol of my gratitude to my participants for their contribution to my oral history narrative collection, participants were offered a $10 Tim Horton's gift card. It was agreed upon at the start of the interview, after consent was received, that compensation would be received at the conclusion of the interview. All eight of my participants accepted the compensation.

Research Challenges

I initially, and perhaps somewhat naively, chose oral history as a methodology in the hopes that I would uncover meaningful qualitative data which could potentially contribute to the public discourse surrounding addiction in a small, conservative Western Canadian town. Oral history, due to the highly personal and organic nature of the discussion, produces incredibly rich, insightful data which is nearly impossible to achieve through quantitative means, specifically when dealing with vulnerable populations. Great care must be taken when studying vulnerable populations, such as individuals living with addiction, as not to take advantage of their position, their experiences, or the inevitable power-dynamic between researcher and participant. Oral history, despite all of the tremendous strengths it possesses as a methodology, requires a certain degree of commitment and structural rigor that proved to be challenging in certain aspects for myself.

Some challenges of using oral history as a methodology for individuals living with addiction include the time commitment required for an oral history interview to take place. To commit to an hour, or two-hour long process is quite often infeasible for this population. Additionally, the structured format of the interview process challenges the

participant's routines, as one participant coined it, "my life of chaos". A different individual expressed interest in participating in an interview with me, but when I tried to arrange a time which would work for him, he stated with a laugh, "Well, my life is a complete fucking disaster right now, but maybe on a different day, like once I'm fixed? (laughter)"

Another issue I encountered was the issue of informed consent and the legal barrier of participants signing a legal and ethical agreement when they are incapacitated to any degree, due to the influence of drugs and/or alcohol. As one individual put it, "Yeah, I'll chat with you, but is it okay if I'm stoned?". To deny them the opportunity to participate in this collection of life histories, under the pretense that they must be sober, is to deny them agency. It would be inappropriate for myself, as a researcher, to identify participants whom I deemed capacitated by my own moral compass, and to interview solely those clients. Rather, it was decided that if the participant felt inclined, and was able to sign the consent, that their story would be recorded, and their consent considered to be "valid" for the purpose of this research.

Another challenge faced was the fact that individuals living with addiction are classified as a vulnerable population, and are at a high risk for emotional trauma, Post Traumatic Stress Disorder (PTSD), and other reciprocal negative emotions in response to participating in interviews pertaining to sensitive subject matter (WHO, 2019). The discussed subject matter of the interviews can be not only challenging for the participant, but for the researchers as well. Examples of challenging topics which were frequently discussed included stories of physical, emotional, and sexual abuse,

abandonment, grief, suicides, violent behavior, crime and death. To mitigate these risks, I had attached a list of resources available to clients if they felt they needed professional assistance after the interviews.

Oral history is a challenging methodology for this population as it is the admission of involvement in an activity which is illegal, and criminally prosecuted in Canada, currently. It was often difficult for individuals to discuss such subject matter due to fear of persecution by law enforcement. Because of the sensitive nature of the interviews, the research participants belonging to a vulnerable population, and the required trust for meaningful conversation to ensue, extensive rapport-building became a crucial part of my fieldwork process prior to the commencement of the interviews at the SCS. I spent two months intermittently volunteering at the SCS prior to beginning my recruitment for interviews in an effort to familiarize myself with the facility as well as to build rapport with the staff and clients. This process allowed me to interact with the clients and staff without pressure of interview participation, to familiarize myself to clients, and for them to conclude that I was not, in fact, “an undercover cop”.

It also became challenging for me to foster an environment that was comfortable for both the participants and myself. In the facility I researched at, there were limited private areas, therefore, most of my interviews took place in public spaces. Although these public spaces were often sufficient, some interviews had frequent interruptions which caused disruptions in conversational flow due to the lack of privacy. As one participant put it, “Can we go someplace more private? People keep interrupting. Showing no respect”.

A few participants asked to conduct the interview with other clients present, so I did oblige. Several of the interviews took place in the "Chill-Out Room", which is a post-consumption space where clients can recover prior to exiting the facility. Clients are not required to use this room after consumption, but many do take the opportunity to play music, sketch, talk with staff and other clients, and lounge on comfortable furniture. The Chill-Out Room has a one-way flow of traffic through two doors, serving as a type of hallway. This meant that there was extensive foot traffic through the space I conducted several of the interviews in. This busy space created several challenges for myself as the interviewer such as the noise level, the fear of discussing private subject matter with limited confidentiality, and the distractions. It was indicated to me by one of the staff members that perhaps conducting interviews in the Chill-Out-Room was more preferable to clients as it was a familiar space that the clients felt safe in.

One research challenge that I came across, which caught me by surprise, was the degree of connection between participants and myself. There was one individual involved in my research process who began to cross professional boundaries with me, and began to solicit personal favors from me. They had my personal cell phone number, in an effort to be accessible for setting up an interview, however this quickly developed into a non-therapeutic relationship. They began to frequently call and text me to ask me to drive them to various places, pick up their medications, stay at my house, and borrow money. I found myself struggling daily to maintain boundaries with this individual who had attached them self to me. It was difficult due to the fact that I desperately wanted to assist them with their life, however, I knew that by doing the favours that this

individual asked, I would quickly be compromising my integrity as a researcher, and the therapeutic nature of our relationship. Sadly, I was forced to end our relationship, and encouraged this individual to get assistance from trained professionals. This particular episode, which happened early on in the research process, was deeply troubling to me. Although it was incredibly insightful, it was a challenging position to be in.

Although logistically and emotionally challenging at times, giving this population an opportunity to share their stories was made a priority and facilitated in any way I could manage.

APPENDIX B: INTERVIEW GUIDE

The following is the interview guide that I used with all of my participants:

1. Describe your childhood. Describe your adolescence. Describe your early adult years.
2. Tell me about your family.
3. Tell me about your home growing up.
4. Tell me about your community.
5. Tell me about your friends.
6. Tell me about the first time you used drugs of any kind.
7. Tell me how it made you feel. When was the next time you used drugs?
8. How do you currently feel about your drug use?
9. What services do you currently utilize in the community? What services have you used in the past?
10. Would you re-visit any of these services? Why, or why not?
11. Have you ever been to detox or treatment? If so, what worked for you?
12. What are some factors which have affected your drug use?
13. What do you value most in your life? What brings you joy?