# Women Who Inject Drugs, Who We Are: The View From Here.

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More importantly, this project could not have been completed without the powerful voice of the women who have experienced IV drug use in their lives. In spite of all that they have survived over the years they have shown us that their spirits are unconquerable. They opened their hearts and minds to the researchers and shared in such a way that it gave life to this undertaking.

AIDS Programs South Saskatchewan (APSS) has been the voice and resource for HIV/AIDS in South Saskatchewan for over 20 years. APSS is knowledge and care based community organization that promotes understanding of HIV/AIDS. The organization is committed to influencing legislators and policy makers on issues related to HIV/AIDS. APSS prides itself on providing resources for professional development in the field of HIV/AIDS and in our support of those at risk of or living with HIV/AIDS.

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## *Preface*

The population of women who inject drugs and who live in Saskatchewan find it difficult to access services that they want or need in the province. Although there are reportedly numerous services available it is difficult to determine what exists. Neither the women nor the service providers seem to be aware of what can be accessed and who is a potential client. In addition, this population of women report that when they do seek help they often meet with negative attitudes from service providers and the community in general because they use IV drugs. Service providers, on the other hand, reported that they want to investigate options that would allow them to facilitate the provision of services to the women.

Relying on research conducted by APSS, other researchers, and on information collected during the present project, APSS has developed a Drug Sensitivity Training Kit and Drug Sensitivity Workshop. The collective voice of the women has been the guiding instrument in this project. The kit and workshop are intended to be a starting point for developing strategies to eliminate gaps in service provision. Furthermore, this information is meant to be a foundation for creating change generating dialogue between service organizations, service providers and the women. During the course of this project the women have clearly identified what they feel and what their experience thus far has been. It is hoped that the service providers and service organizations will embrace this opportunity and review existing policies and procedures in view of what the women have shared.

## INTRODUCTION

Women who use IV drugs are a unique population with distinctive life experiences and concerns that evolve from those experiences. The difficulties they encounter in their daily lives can be complicated by legal issues, poverty, stigmatization, and racism. The apprehension that they often feel when interacting with service organizations or service providers is commonly a natural offshoot of previous negative situations they have met with while accessing or attempting to access services (Abouyanni, et.al., 2000; Farmer & Greenwood, 2001). Consequently, because of these earlier unfavourable interactions, efforts to re-establish connections with the women can be complicated. It is necessary, therefore, to explore means of engaging the women in a way that works for them and allows them to become comfortable with sharing personal information (Ordean, et.al., 2006).

These women are often primary care givers and as such they assume responsibility for the well-being of children in the home. Unfortunately, once a woman has been identified as an IV drug user there is an almost unavoidable stereotyping that takes place (Aalto, Pekuri & Seppa, 2001; Norman, 2001). Society has tended to view these women as bad parents and to complicate this picture laws have made it difficult for them to navigate through the many barriers placed before them (Boyd, 2004).

Community activist, author, and associate professor Dr. Susan Boyd notes that the "medical, legal, and moral regulation of women" who use illegal drugs has increased over time and has become much more prominent since the mid-1980's. "It is assumed that women who use illegal drugs are unfit parents and a danger to the developing fetus" (Boyd, 2004). This pervasive attitude has resulted in increased systemic vigilance designed to expose women who use IV drugs (Boyd, 2004). Within the context of this social environment it is not uncommon for women to try to hide their drug use in order to avoid the resulting stigmatization and the ensuing consequences. These women want to provide what is best for their children but in attempting to do this find that they must struggle against the detrimental image service providers and society in general are inclined to project onto them. Alienation, loss of services, or worse yet child apprehension may all be the fallout after the woman self-identifies as an IV drug user.

Canadian Aboriginal Women can face a somewhat more compounded set of problems than their non-aboriginal counterparts due to the added burden associated with further stereotyping and racism. Marginalization of this population of women has had an impact on service delivery and additionally has been shown to have a negative affect on the provision of health care (Dodgson & Struthers, 2005). Racism is an added factor that service providers need to consider when interacting with aboriginal women who inject drugs. "Coming to terms with gender-based discrimination against First Nations, Métis and Inuit women must be done in tandem with stopping racism from non-Aboriginal Canadians and government institutions" (Status of Women Canada, 2003).

AIDS Programs South Saskatchewan (APSS) has been a resource and voice for HIV/AIDS in South Saskatchewan for over 20 years. The organization is committed to influencing legislators and policy makers on issues related to HIV/AIDS. APSS prides itself on providing resources for professional development in the field of HIV/AIDS and in support of those at risk of or living with HIV/AIDS. Women who use IV drugs are a population that is at risk for contracting HIV/AIDS. This population of women consistently report contending with unsympathetic and judgmental attitudes while trying to access services. The health of the women and their children is compromised when they are not able to access services and this results in increased personal cost to the women and their families and increased cost to society (Boyd, 2004; Boyd, 2007; Ordean, et.al., 2006).

The Women Who Inject Drugs Continuum documents are meant to relay the existing literature about women who inject drugs and to recommend actions that would create positive change for both the women and those who provide services to them. Members of the Harm Reduction Working Group are taking steps to improve outcomes in this area. The current project is one such activity. This project is part of an ongoing attempt to make existing services accessible to this population of women thereby reducing negative impacts on the women, their children and while decreasing the cost to the community.

## Purpose

Over the last number of years APSS has contributed resources to gaining an understanding of the difficulties that women who inject drugs face when they come in contact with service organizations in the city of Regina. To that end, they have actively undertaken research projects that assist the women with defining the obstacles that prevent them from accessing the services they need. The women have participated in numerous focus groups conducted for the purpose of identifying and documenting barriers to obtaining services. APSS is dedicated to helping women relay their concerns to service providers and policy makers.

The purpose of the present project was to find out from women who inject drugs and from service providers where gaps are in services are and to then communicate the results to service providers who come in contact with this population of women. Knowledge translation is designed to take place through presentations (on site, workshops, etc.) and distribution of a training kit.

It is hoped that the training kit and the presentations will be practical and valuable resources for service providers and service organizations and that they will act as catalysts for service providers to review existing policies and procedures with a view towards exploring and meeting the needs of the women who inject drugs. The overriding reason for the present project, however, and the reason that was kept in focus throughout was the necessity of assembling and presenting information that would give the women who inject drugs a voice. It is hoped that this voice can be heard by individual service providers and by the organizations that provide services

In accordance with the purpose of the project the following have been provided:

1) A Drug Sensitivity Training Kit for front line service providers, supervisors, and organizations that may be in contact with women who inject drugs.
2) A report of the research findings.
3) Sensitivity training sessions that will focus on the project research findings particularly in terms of the overlap of and differences between service provider concerns and the concerns of female clients who inject drugs.

## METHOD

### Participants

Focus group questions were developed for the women who inject drugs (Appendix A) and for the service providers (Appendix B). Women who inject drugs were subsequently recruited from within Regina through personal recruitment and posters (Appendix C). Information was subsequently gathered both from the women who inject drugs and from service providers. In both cases the focus group question sheets were distributed at the beginning of groups and participants were informed that they could provide written information if they so chose.

Recruitment posters for women who inject drugs or have had a history of injecting drugs were distributed to organizations in the core area. Women who attended the needle exchange program were also asked whether they would be interested in participating in the research. One hundred and fifteen women accepted. These participants were provided with information regarding the focus groups and given the option of attending these as well.

The voluntary nature of participation was explained to participants and a brief description of the goals and the purpose of the project were provided. It was explained that the information that was collected was anonymous and participants were asked not to provide their names or any other identifying information in order to maintain confidentiality.

A letter of invitation (Appendix D) was sent to 45 Regina and area organizations in order to recruit service providers. Twenty-eight individuals from these organizations attended the focus groups and these formed the service provider participant base.

Five dates were set for focus groups for the women and seven dates for focus groups for the service providers. Focus group sessions for both groups were conducted throughout January and February. Fifty-five women and 28 service providers attended sessions.

### Materials

Women Who Inject Drugs Focus Group Questionnaire (Appendix A): This instrument was developed by the researchers.

Service Provider Focus Group Questionnaire (Appendix B): This instrument was developed by the researchers.

Demographic / Questionnaire Sheet (Appendix E ): This instrument was developed by the researchers. Questions were asked regarding marital status, drug use, encounters with service providers, and drug counselling and treatment.

Information collected from the women was designed to capture the following domains: 1) demographic, 2) drug use, 3) drug counselling or rehabilitation background information 4) exposure to and experiences with service providers and service provider organizations.

Information collected from the service providers was designed to capture the following domains: 1) place of employment and contact information 2) a scale that explores attitudes towards individuals who use drugs 3) questions regarding perceived barriers to working with the women both within organizations and as it is believed the women might experience them 4) information that would be helpful to service providers when working with this population 5) perceived risks for working with this population.

## Design and Procedure

In the Fall of 2006 the second phase of The Women Who Inject Drugs Continuum was launched. This project was developed, in part, in response to the Continuum of Service for Pregnant Women Engaged in Use of Injection Drugs document. That document was prepared by AIDS Programs South Saskatchewan and Native Health Services Regina Qu'Appelle Health Region for the Regina and Area Drug Strategy Harm Reduction Working Group & Public Health Agency of Canada, AIDS Community Action Program.

The history of that project was such that concerns had been raised by the Harm Reduction Working Group Members regarding pregnant women who use injection drugs and the resulting impact on the health of the fetus and the number of addicted babies being born. Through discussion the emphasis turned towards women, their health, their status in society and how these factors impact on generational issues for their families. APSS held a number of focus groups with 45 women who shared their experiences. Through examining this information some service providers started to make subtle changes to their service delivery. This included such things as portraying a different and more tolerant attitude towards the women and taking the services to outreach locations.

Recognizing that there was a need to further explore the barriers that women who inject drugs encounter when attempting to access services APSS applied for and received funding from the Government of Canada's Urban Aboriginal Strategy. Two Training Development Workers (TDW's were subsequently contracted by AIDS Programs South Saskatchewan (APSS) in November of 2006 to develop and implement the second phase of the Women Who Inject Drugs Continuum. The Executive Director of AIDS Programs South Saskatchewan and the TDW's held several meetings during the month of November in order to design the project and develop and/or decide on instruments that would be used. A further purpose of the meetings was to create focus group questions

and to develop recruitment strategies for a series of focus groups for women who inject drugs and for service providers who come in contact with these women.

Focus groups were not recorded as it was felt that the nature of the information being provided was extremely sensitive and recording would inhibit the women and the service providers thereby making it less likely that they would be willing to talk about their experiences and feelings. At the beginning of each focus group the purpose of the research was outlined and the voluntary nature of participation explained. TDW's took notes during each focus group and when both TDW's were present notes were compared to ensure accuracy.

During each of the focus groups questions were discussed in detail. The concerns raised by the groups during the series of focus groups have been organized into themes within each question. Responses to the open-ended questions were categorized and frequencies of responses within category were calculated.

Altogether there were 12 questions posed to service providers. Graphs were run for answers to five of the questions. The items that could be graphed were and service provider comments were included with the graphs. Some of the answers to these items could not be quantified. Consequently, these questions were analyzed for thematic content. A great deal of overlap existed between question one: "What kinds of barriers do you see for working with women who inject drugs (both for the women and the service providers)?" and question five: "If you feel that working with this population may pose risks, what do you see these risks as being?" Because of this the thematic analysis for question one and five were completed together. Four of the questions were answered by less than five people. These were not analyzed as they would not have given an accurate account of the opinions of this group of service providers.

Altogether there were five written questions posed to the women during focus groups. Topics that arose during the group were also addressed. Answers to these questions were analyzed for thematic content and were also incorporated into the "What the Women have to Say" component of the bar chart results.

The analyses represent a snapshot of what these individuals have learned through their experience. Their perspectives reveal what they view as areas that need to be considered in terms of gaps in services for women who inject drugs. Potential implications are explored in the recommendation section.

SPSS 11.5 was used to analyze the Demographic/Information Questionnaire data. Data analysis was primarily descriptive. Descriptive statistics including means, frequencies, standard deviations, and response rates were calculated for appropriate items. When information regarding statistical significance was required, however, independent-samples t-tests were performed to compare each group on selected variables.

## Knowledge Translation Goals

We intend to communicate our findings through the following means:

1) To provide service providers and organizations with an interactive Drug Sensitivity Training Kit as an onsite resource in providing services for women who inject drugs.
2) To use the tools that have been developed as instruments in examining whether there is a need for philosophical changes in policies and ways of thinking when trying to engage these women and if so to help concerned groups generate dialogue around developing and implement suitable policies.

# RESULTS

## Participant Information

During the months of January and February of 2007, 115 women completed the Demographic/Information Questionnaire. Over that same period of time, approximately 55 women attended focus groups at APSS. Of these 38 submitted written comments on the focus group question sheets. Twenty-eight service providers attended focus groups at APSS and 23 of these submitted written comments on their question sheets.

On the Demographic / Information sheet gender was the question most frequently answered (113) and how often the individual had attended drug treatment or counselling was the question least answered (40). Participants in this research were all females. The sample was primarily First Nations (78.3%), single (59%), and 84.3% had children (M = 3.1). They reported a mean of 10.0 years of IV drug use with a preference for injecting two or more drugs (45.6%) and with the primary drug of choice being cocaine (31.2%). Their ages ranged from 16 to 54 (M = 32.7) years.

## Perceptions of Service

The present research has used collaboration between the researchers, the participants, and the service providers in order to identify major areas of concern. The perspectives of the women and the service providers were used to identify gaps in services, to make recommendations, and to develop training resources. There was a great deal of overlap in the views and opinions of two groups indicating that each group has recognized similar needs within the organizations that are providing services and within the community overall. The following areas of concern have been identified:

### *The Women's Perceptions*

During the focus groups with the women several main themes emerged with regard to what they believe is missing in the provision of services that are currently available in Regina. These themes centered primarily around the following issues:

1) Support systems
    - Post drug treatment or counselling
    - Advocate for the women
    - Advocate for children in foster care
2) Education sessions
3) Attitudes

***Support systems***

There is not an organization available that focuses on providing information to the women regarding the availability and intake requirements of the various services available in the Province. Women are not aware of some of the services that do exist and there are other services that they would like to access that are simply not available. There is a gap in service in terms of the provision of service related information.

***Support systems***

- ***post drug treatment or counselling***

Women who complete drug abuse counselling or drug treatment centers have nowhere to go once the program or counselling is complete. There is a gap in service in terms of ongoing support. "I had no support when I got out" was a statement that generated discussion and met with agreement from virtually all of the focus group participants who had been through treatment. The lack of ongoing support left the women vulnerable and set them up to fail.

After leaving treatment the women return to neighbourhoods where "drugs are everywhere" and where "neighbours, family members, and friends are all using". In addition, the women come back to "homes that aren't stable." Given this set of circumstances it would be nearly impossible for the women not to use again. Trying to stay away from drugs would involve avoiding most of their community and family support networks and not interacting with the people around them at a time in their lives when they are most fragile and need support. It simply is unrealistic to expect them to succeed without added support systems.

***Support systems***

- ***advocate for women***

The women have requested a safe place be provided where they can go to network with one another particularly during hours when most services are not available (e.g. weekends and evenings). They also need counselling and advocacy services in such an environment. This need is more pronounced at certain times such as when the women are pregnant, when they are caring for children, and after they return from treatment.

Fear about children and how to keep them surface when the women become pregnant and these fears are justified after they give birth especially if they are alone. "They give people who don't have any support a worse time, testing the baby, testing you, taking the

baby away." The difficulties continue as long as children are with them and there is an ongoing battle that leaves them feeling confused "they get you to sign legal papers and you don't even know what you're signing" and alienated "they don't tell us what's happening."

The service providers are viewed as not being honest at times "The worker gave me the wrong court date and then asked me why I didn't show up". Then she said "It doesn't matter they're in long term care now" and not being forthright with "need to know information." "They take your children; they put them up for adoption, and don't tell you until after the fact."

A woman who wants to go into treatment has to figure out what will happen to her children and how they will be cared for. This can be an obstacle to entering treatment. "I voluntarily gave my kids up to go into treatment. I gave them to my mom. Later she was in a shelter for being abused. I had to go to court to get them back when I got out."

There are many women who have had more than one child apprehended. These women are "devastated by the loss" each time and many turn to drugs to numb the pain that they feel. "Why do they automatically take babies that are born addicted? How can you stay straight after they take your babies?"

***Support systems***

- ***advocate for children***

There is a belief among the women that their children do not have a voice or an advocate to act on their behalf once they are placed in care. Many of the women were not aware of the Children's Advocate and the few who had personal experience with the organization viewed it as ineffective.

During the January 24th focus group following a discussion about the challenges of being an IV drug user while raising children the women were asked the following question: "How many of you feel that the voice of your children is being heard while they are in care?" The great majority of the women agreed that their children were not being heard. There are numerous types of problems that mothers hear about from the children while they are in care. These range from neglect "The foster mother who looked after my son dressed him in the same clothes all the time, no money was spent on looking after him" to emotional abuse "I had one foster mother that told my 10 year old daughter that if she didn't behave she couldn't come and see me."

Many situations involved a lack of regard for basic needs such as food and safety. Withholding food was a form of punishment in some cases and in others it was simply a rule of the house. "Children are told that they can't go into the cupboards for food. They have to wait until it is given to them." In another case, children from one family reported being upset when "they had to wait outside a Bingo hall while the foster mother played." The motivation of foster parents to care for children was viewed as one where the children were just "a way to collect cash" without accountability. "Foster families should be responsible for accounting for the money they get."

When the women try to seek help for their children they say that they are ignored. "During the visit the social worker took notes on everything I said and ignored the ugly things the foster mother said." If a report is taken they contend that it goes nowhere "the children's advocate is not working." When the situations are ignored or mishandled the maltreatment continues. "A lot of abuse happens in care and it happens when no one listens to your children." Finally, there is resentment towards social workers "who are text book taught, have no parenting skills, but tell us how we should be parenting."

***Education Session***

The women have expressed an interest in education regarding drug use and the effects that it has on their "bodies, minds, and spirits". Programs that address the physical implications of "what happens to my body when I use" and the mental factors "how my thinking changes" would provide the women with information they "want and need." Elders are a valuable resource for Aboriginal women to meet "spiritual needs" when they are thinking about changing drug use patterns. An integrated program could offer a holistic approach to reducing drug use or if the women so desires could be a means of support in stopping drug use. This type of education is not currently available. There is a gap in service in providing education and support within these domains.

***Attitudes***

Women will not often share the fact that they use IV drugs because the stakes are too high. "The look on their face changes when they find out that you're an IV drug user." The women feel that once something has been committed to writing it becomes a given. Files are read, passed around, and believed without reservation. Women want service providers to be able to form opinions based on interactions with them as opposed to "what is written in a file." It is imperative to be able to look beyond the paperwork and see that it is "just someone else's opinion, it doesn't mean that it's real" Each woman has to be considered as an individual and not "judged" by those who "can't stop being biased."

Understanding the women who use IV drugs can start with recognizing "That (they) are not failures." "I feel they need to take the time to understand the situation and not jump to conclusions because I was/am an IV drug user." Trying to get children back once they have been apprehended can be immensely distressing when the woman feels that she is fighting a loosing battle based on preconceived notions about who she is within service organizations. "I want to get my girl back. My protection worker doesn't give me a chance. She always puts me down because I used IV drugs." Unfortunately "past problems" sabotage relationships and taint interactions "I think they think that I am dirty."

### *The Service Providers Perceptions Concerning Service Provider Needs*

During the focus groups with the service providers four main themes emerged with regard to their needs. These themes centered primarily around the following issues:

1) Safety
2) Training & education
3) Communication
4) Information

***Safety***

Concerns over safety issues including: who is going to be present in a home when service providers visit, whether there is the potential for exposure to violence when interacting with individuals who use drugs, and concerns over the possibility of coming in contact with blood borne diseases all.

The service providers felt that there were distinct safety concerns that they encountered when working with the women. The possibility of becoming a victim of violence at the hands of a "crazed" client who was using drugs or, more often fearfulness of being victimized by an "other unknown people" that might be with a client were both issues that were brought forward. The risk of contracting illness through exposure to blood was also raised.

Not knowing "who else" might be present was a consideration when providing a service outside an office setting. **"**When you go to a house you never know for sure who is going to be there". "It might not be the client that worries you but someone else." The core area of the city is problematic in terms of gang activity and because of this there were questions with regard to "gangs and personal safety" that couldn't be discounted if a service provider was to interact with a client in a location other than their workplace.

The potential for contracting "blood borne disease" was discussed. Service provider participants from a variety of work locations expressed concern over the threat of "getting jabbed by a needle" and exposure to the "risk of sharps". In the event of being jabbed knowing that you would have to "wait" for a period of time "to find out if you would be ok" turned this into something that could become a source of prolonged stress.

***Training & education***

Training and education were identified as a major obstacle for service providers when attempting to work with this population. "Lack of knowledge" and "little training" provided by agencies constituted barriers that created "an inability to understand or connect" with women who are accessing services. "Specific information on the effects of drugs and how they effect behaviours" was seen as important to have in settings where women who inject drugs are clients.

Understanding drug use and drug effects from "the woman's viewpoint" would "reduce the anxiety" associated with concerns over "personal safety". "Knowing what the women want" and "how they feel" could eliminate some of the mystery that surrounds drug use and could also help to "make the unknown known".

### *Communication*

There is a great deal of confusion surrounding what might be the best way to open avenues of communication when interacting with women who inject drugs. Attempting to make contact can feel "awkward" or "uncomfortable", in part, because there seems to be "no common ground". The "obstacles to communication" appear to be "systemic" as well as personal. "Barriers are not intentionally created. It's just how the system works." Employers do not have programs or training that includes "input from these women" on what would make them "more comfortable when attending an office".

Strategies on "how to better engage the women" need to be implemented. Service providers who are "uncomfortable" when they learn that "someone uses IV drug" and simply "don't know what to say" next can be taught to engage women who reveal their status instead of "retreating" because they don't know what else to do. Opportunities for communication that are lost may not present again for sometime if ever.

## *The Service Providers Perceptions Concerning the Needs of the Women*

During the focus groups with the service providers three main themes emerged with regard to the needs of the women. These themes centered primarily around the following issues:

1) Attitudes
2) Child care concerns
3) Support systems

### *Attitudes*

Service providers have an appreciation for what the women are faced with in terms of attitudes. They know that it can be daunting for them to seek services because of the "labelling that takes place when you are an IV drug user" and for Aboriginal women the "discouragement" that can be associated with "racism." Long-standing societal perceptions that the women are "dirty" or "diseased" contribute to "stigmatization". Faced with the possibility of encountering such negative attitudes the prospect of working up the courage to "come through the door" can seem overwhelming for these women. To compound this problem "There are no advocates for women who inject. No one wants to listen to them."

### *Child care concerns*

Service providers acknowledge that women who are using IV drugs and who have children are often placed in a position where the risks for revealing their use are very real and where being frank and truthful may, at best, result in increased vigilance of their behaviour and at worst lead to the apprehension of their children. "Fear of child apprehension" and discrimination against families occurs when the mother, who is often the primary care giver, uses IV drugs.

"Treatment is geared towards individuals when it should be holistic family treatment." If a woman decides that she wants to get help she does not have the luxury of looking after only her own needs. She needs to weigh the possible cost to her children as well. Part of the problem is due to the fact that "there is a lack of adequate child care for those who are mothers".

***Support systems***

Women are often not able to gain access to a service at the time when it is needed because "waiting lists are long" and "the window of opportunity can be small". For example, if a woman wants help with her addiction at a certain time and cannot begin treatment because she is on a waiting list she may be vulnerable to "someone who comes by with drugs". This lack of being able to receive timely services can result in "the woman creating a crisis because it is the only way to get help".

Moreover, there are gaps in services for women who are trying to stop or who have stopped using drugs. "Drug treatment programs need to be longer than 28 days". As one service provider noted: "if everybody you know and most of your family members use, and if you have used for 10 or 15 years, how can you get better in a month?" Support for women who complete drug programs or counselling needs to be provided after the treatment terminates. "There is no meaningful follow up" once treatment has concluded. As a result "the same people keep going through detox because of the lack of long-term support". What is more, the problems that led to substance use in the first place tend to resurface after a program is completed. For example, "when the mom and children get back together there is a honeymoon phase and then guilt, anger, and resentment surface and there's nowhere to go for help. This can be a set up for failure."

Uncertainty over "what is available for different problems" left focus group participants feeling powerless when it came to referring the women to services that might be able to deal with specific issues. The need for sharing of information on "treatment options and where they (the women) can go for help" would allow the service provider to take much needed action.

***The Service Providers Perceptions Concerning What Would Help Them Work With the Women***

When service providers were asked what would be most helpful to them when working with women who inject drugs four main themes evolved. These themes centered around the following issues:

1) Information regarding experiences of women who inject drugs
2) Drug information
3) Information on strategies to identify and engage the women
4) Knowledge of available resources and services

### *Information regarding experiences of women who inject drugs*

Service providers want more information regarding the women, their lives and the circumstances they live in. "Lack of knowledge about the women and their lives" placed focus group participants in a position where they didn't know how they could help them. Service providers repeatedly expressed a desire to learn more about this population of women and the issues that affect their lives. There was no doubt that a major gap exists in providing necessary information that relates to the women's lives and to their needs. They felt that their knowledge overall about this population of women is limited at best and that this is especially true when it comes to life style in general. "We don't understand the life style because we've never been there."

### *Drug information*

Drug information issues range from a straight forward need for basic knowledge about drugs to more complex issues of ongoing education, sensitivity training, and the individual woman's experience with drugs. Training or information with regard to the types of drugs being used, their short-term and long-term effects and what the person using the drugs might experience would give a knowledge base to service providers who currently have little understanding in these areas. There was a basic lack of information in the workplace about drugs and those who use them and when it came to women there was "not enough knowledge on specific drug issues a woman is experiencing" including "information on drug use, withdrawal, and treatment options".

Any information regarding drugs and drug use that would be provided would need to be periodically updated. This sort of material changes and evolves over time and drug related policies and interventions including "ongoing training and awareness sensitivity" must be revaluated from time to time for relevance and suitability so that they remain practical and useful. The active involvement of employers is critical in bringing drug education and training programs into the workplace. "We need to bring information (on IV drug use) into the agencies perhaps as part of policy. We need to figure out how to keep it on the plate and keep it current."

### *Information on strategies to identify and engage the women*

There is a desire to be involved with more training and education that would allow for better understanding of the women. Front line staff have the most direct influence on establishing constructive relationships with the women but initiatives would have to be developed in order to make this possible. There is a sense that they want to take action to engage the women but "don't quite know what to do".

Having something to talk to the women about and developing strategies that promote interaction could create opportunities for open and honest interactions between the women and the service providers. Handouts, brochures and other "small items" that cover topics of interest such as "where to get and dispose of needles" and "safe injection information" can be easily provided and are informative. These are also items that the

women have expressed an interest in accessing. Recognizing who these women are and when "the best times" are to provide these items would be essential.

"Serious addicts, young women in the sex trade and gang members are flying under the radar. They are not able to access services." If interaction is to take place between the women and the service providers the women must first be identified and then they must be comfortable in discussing their drug use. "The invisible must be made visible". Service providers simply "can't help if they don't know". At the end of the day though, service providers are aware that the women overall "are afraid" that if they admit to IV drug use "there will be consequences".

Aboriginal women face an added obstacle "because of the long history of being badly treated by service organizations including justice, health and social services." This history has led to a situation where "there is no trust." Strategies and perhaps workplace policies for developing and maintaining trust are needed. To that end, an appreciation of who the women are and what their lives involve is essential. Service providers expressed a degree of irritation in terms of not understanding the day to day issues that the women contend with. "We need women who use / don't use now (either) to provide education".

***Knowledge of available resources and services***

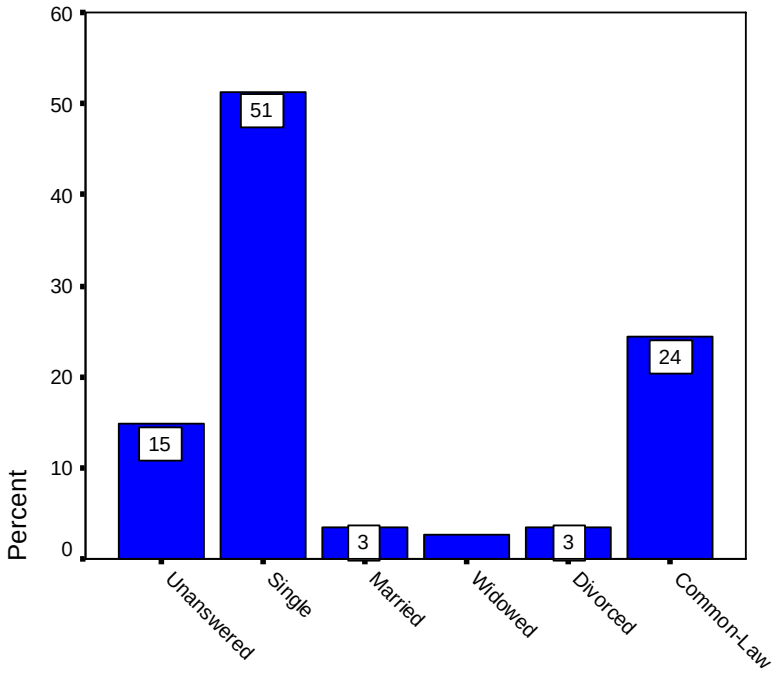
A major gap that exists at this time is the overall lack of knowledge regarding services. Service providers know what is available for women within their organizations the problem, however, is a lack of awareness of what exists outside of their organizations. "Everyone works in isolation; no one knows what the other organizations are doing." They either do not know which other services are available or if they are aware of other services they do not know exactly what they provide.

There is little awareness regarding what is involved in accessing a service or who should be referred. Because they are not aware of what is available within the community they feel helpless frustrated by the "need to know where the resources are for these women and how they can access them." When organizations have not had an opportunity to share information on what each can provide "it can be challenging" to try to figure out "what should be done".

## *Bar Chart Related Information on Women Who Inject Drugs*

The following bar charts depict the results from 15 questions on the demographic/exploratory questionnaire sheet that was completed by the women. Each chart is accompanied by an overview of the results, related literature, and the comments from the women themselves.

**Chart I**
**Marital Status**

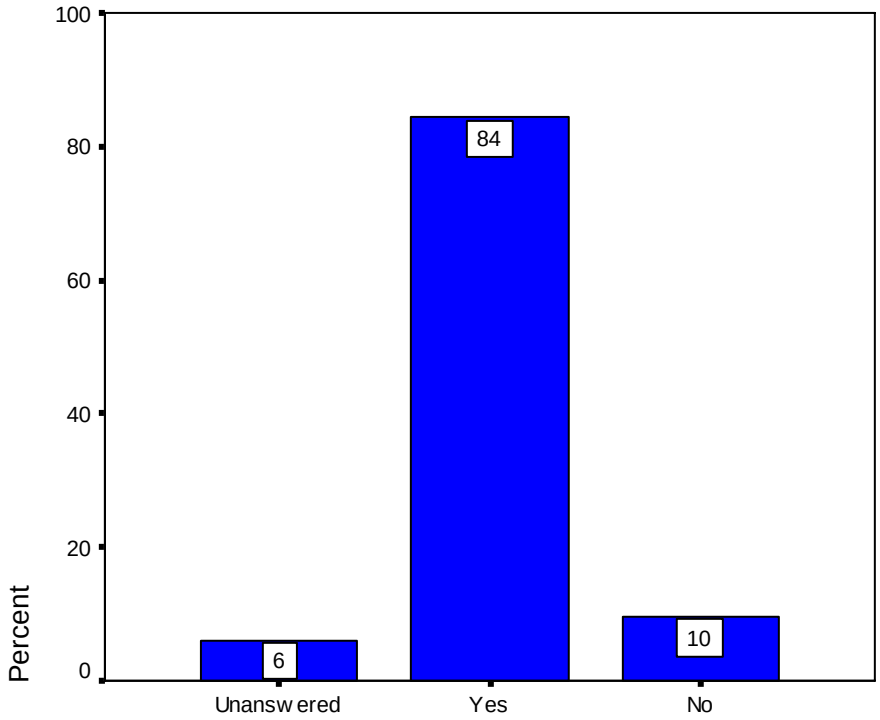



***Overview:***

Ninety-eight of the 115 participants answered the question on marital status. Of these, 57 were single, 28 were living in a common-law relationship, four were married, four divorced, and three were widowed. Most of the women who participated in this research are IV drug users who are single parents and primary care-givers for young children. Most, if not all, live below the poverty line and the majority lack the education or skills that would allow them to seek a better life for themselves and their children.

**NOTES**

**Chart II: Children**
**Do you have children?**




***Overview:***

Of the 115 women who completed the survey 6 % did not answer this question. Of those who did 84% had children. The number of children ranged from none to eight with an average of 3.1 children per woman. Out of 34 participants in the January 24th focus group 29 have had children in care at some time. Most had difficulty in communicating with the social workers involved. The women felt that the workers were constantly pushing them to do something like; life skills, parenting classes, domestic violence, AA, treatment centers, detox centers, and mental health clinics at times when they did not feel prepared to be involved in anything. The women have struggles in their daily lives that make it hard for them to consider committing to programs at any time.

The women expressed tremendous concern regarding the well-being of their children and a nearly constant fear of having their children taken from them. The anxiety they feel in this regard begins during pregnancy and continues as long as they have children living with them. The concern and anxiety can also extend to grandchildren later in life. The women feel as if they need to hide the fact that they are IV drug users in order to maintain custody of the children. They have either personally experienced or know of situations where being truthful about their drug use has resulted in child apprehension.

The women's concerns spanned a many areas and included: negative treatment the women received during their pregnancies, distress over how the women and their babies

are treated during hospitalization for labour and delivery, the threat of child apprehension and, what happens to their children if they are apprehended. The feelings of mistrust and anxiety the women experienced when interacting with service providers was most evident when they interacted with health care providers and representatives of social services. This appears to be because the women have had the most negative interactions with service providers from these two organizations.

Miscommunication, stigmatization, racism, poverty, and alienation are factors that can contribute to a vicious cycle wherein women who inject drugs are unable to gain access to required services. Because of this the potential for compromised health in both mother and baby is increased. Service organizations and service providers need to listen to how the women experience care and look for means of improving the access to and quality of that which is available.

***What the Literature Says:***

"Drugs are one factor amongst many that shape pregnancy and although drug use is a risk, it is a manageable one (Boyd & Marcellus, 2007)."

When women who inject drugs become pregnant it is often difficult for them to seek out the medical care that they require because of the bad experiences many have previously had with medical service providers. It is of tremendous importance, therefore, that the service provider understands that the initial encounter with a woman is critical in engaging her into care. This is an opportunity to establish rapport. "Ask her what she needs and respect her answers" (Ordean, et.al., 2006).

While a great deal of social attention is focused on whether a woman is taking drugs during her pregnancy far less concern is expressed over other factors that play a significant role in the health of the mother and child. Overall health, poverty, and nutrition take a back seat to intense scrutiny of drug use (Boyd, 2004).

When women do seek medical help during pregnancy they may present with concerns about how they are going to be treated and viewed as pregnant intravenous drug users. Behaviour that service providers view as disruptive can often be traced back to bad experiences with the health care system (Ordean, et.al, 2006).

Community responses to women who have children and who use drugs are punitive and judgmental. Criminalization occurs when they are prosecuted and incarcerated rather than being offered treatment. It can be extremely difficult for women to attempt to get help of any sort since disparaging interactions can be a pattern that take place between the women and those in helping professions (Carter, 2002).

Women who have partners who use drugs while the woman is pregnant are less likely to be able to avoid drug use during pregnancy (Tuten & Jones, 2003).

***What The Women Have to Say:***

"I am afraid because they have the power to take your children away from you"

"A lot of it is fear of losing my kids because of using."

"We need reasonable planning to help us get our kids back."

"Jumping through hoops for social services doesn't necessarily mean you will get your kids back."

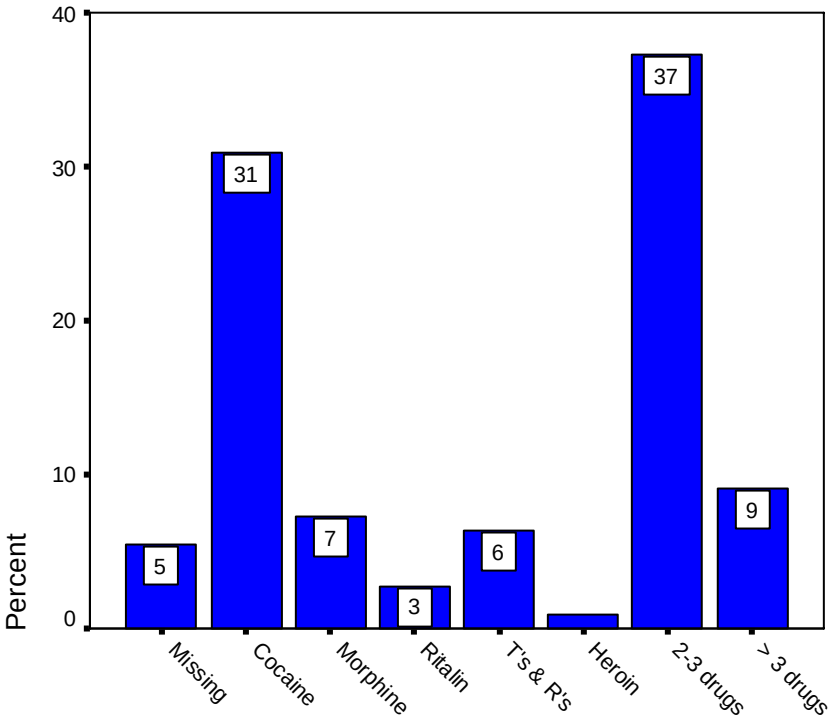
"Service providers need to know what we are going through emotionally"

"When you go in to have a baby…they check your arms."

"We don't have any support once the kids are returned home."

"There are difficulties getting into programs, you have to create a problem in order to get into that program, or to get that support."

**Chart III: Drugs A**
**What drugs do you inject?**



***Overview***

Of the 115 women who completed the survey 5% did not answer this question. Of those who did the majority (37%) inject two to three different drugs. In addition, 9% of the women reported injecting more than three kinds of drugs. Cocaine was listed as the drug that was most often used when only one drug was identified (31%).

Women who participated in this research contend that Drugs are frequently used as a means of escape from the many negative events and feelings that they have in their lives. It also became clear that there can pressure from family and friends who use if an individual stops using. The pressure does not arise so much from being coerced into taking drugs as from being with people who use after you are clean. What is more, the women commonly expressed distress at not having adequate support after they complete drug rehab. In great part, it is because of this lack of support that they can't see alternatives to continued IV drug use.

***What the Literature Says:***

The use of illicit drugs in general is common in Regina and surrounding area. Intravenous drug use has continued to increase over time in the city and that trend continued in 2004 when an increase of 25% was reported. In the same year a more alarming finding with regard to IV drug use was among females 18 and younger who reported an increase of 79% (CCENDU, 2006).

In Canada the prevalence rates of HIV infection among intravenous drug users is unacceptably high and this is particularly true among women and aboriginal people (Canadian HIV/AIDS legal network, 2006).

Cocaine use has increased across Canada (Collin, 2006) and this is the case in Regina as well where between 2002 and 2004 charges for trafficking cocaine rose by nearly 140% (CCENDU, 2006).

The rate of needle exchange has continued to rise in Regina over the last 12 years. Over 1,400,000 needles were exchanged in 2003 and over 1,600,000 in 2004/2005 giving Regina one of the highest rates per capita in Canada for needle exchange (CCENDU, 2006; Prentice, 2004).

***What The Women Have to Say:***

"When they take your babies you just want to get the drugs to forget."

"Make some drugs available at the methadone clinic. For those who suffer depression or a mental illness, they should make those types of drugs available to that individual.

"A lot of us don't have family; you just want to forget about everything."

During the February 14th focus group the women were shown the preliminary results of the data analyses on the demographic and information sheet. The TDW's asked several questions that had arisen from the analyses. The question that arose from Chart III "What drugs do you inject?" was: Many of you have told us that you inject more than one drug. Can you tell us why?

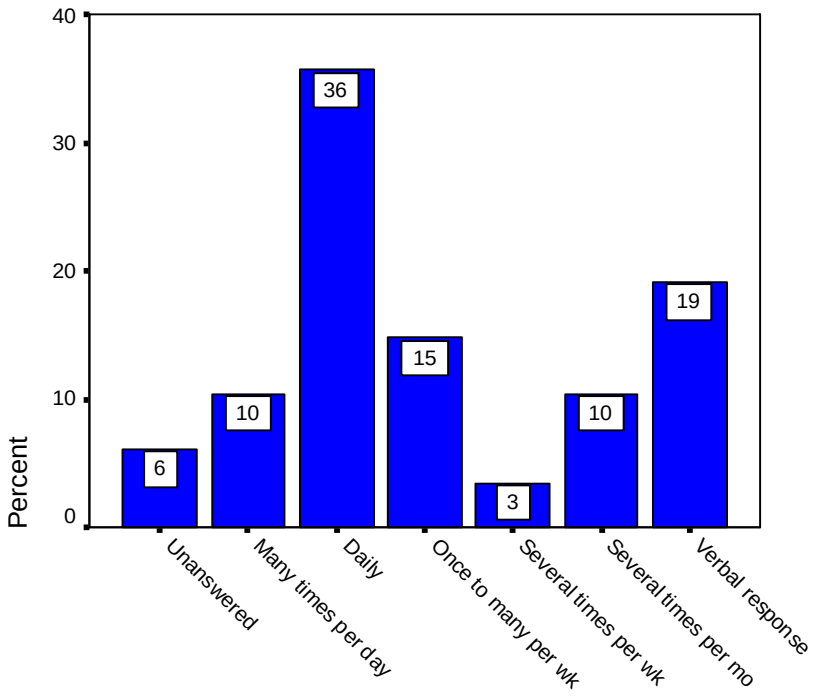
"I inject whatever is available at the time."

"I have gone to the hospital because I was in pain. Because I am an IV drug user I was turned away so I found my own drugs on the street."

"If you want to come down …or if you're too down and you want to go up you use different drugs."

"Whatever I can afford."

**Chart IV: Drugs B**
**How often do you inject?**




***Overview:***

One hundred and eight participants answered this question. Nineteen percent gave a verbal response that could not be quantified such as: "I'm a binge user", "As often as I could or can", "Seldom, "When it's available, "Once in a while" and "All night it would depend". Out of the respondents whose answers could be quantified most (35.7%) inject daily or many times per day (10.4%). Nearly 15% inject once or twice a week. The

minority of women report injecting less often with frequency of use ranging from several times per week (3.5%) to several times per month (10.4%).

The women state that they use IV drugs as a means of escape in their lives. More specifically, they use drugs to numb their emotions and as a reaction to feelings of hopelessness and helplessness. The women maintain that these emotions take place as a response when they encounter racism, unfair treatment, and abuse and child apprehension.

The older women are or the longer they have used drugs the more likely they are to report that they have been treated unfairly because of their drug use. Women who report being treated unfairly report using drugs for a significantly longer ($M = 11.17$ years, $SD = .87$) period of time than women who reported that they were not treated unfairly ($M = 7.2$, $SD = 1.6$; $t\ (81) = 2.22$, $p < .05$). Similarly, women who reported being treated unfairly reported being significantly older ($M = 34.3$, $SD = 1.21$) than women who did not report being treated unfairly ($M = 28.2$, $SD = 2.19$; $t\ (80) = 2.47$, $p < .05$. This finding may be due to the fact that women may be using more services with time and the increased exposure to providers presents more opportunities for negative encounters to take place.

***What the Literature Says:***

Violations for possession and trafficking of narcotics increased 63% in Regina in 2004 (CCENDU, 2006). Regina Addictions Services collected self-report data in 2004 that indicated a 40% increase in cocaine use (CCENDU, 2006).

IV drug use puts women at high risk for exposure to HIV and hepatitis C (Rehm, et.al., 2006). In fact, high prevalence rates of HIV have been noted in IV drug users around the world (Guarinieri, 2004). Newly diagnosed cases of HIV and hepatitis C were up 25% and 10% respectively in 2004 in Regina (CCENDU, 2006).

Complications related to IV drug use such as: pneumonia, lung abscess, endocarditis, and other serious infections (e.g. abscess) may occur if injection practices are not clean (Baciewicz, 2005; Harm Reduction Coalition, 2007). When the dose of cocaine taken is high enough the individual may suffer from convulsions, stroke or heart attack.

The long-term effects can include: depression, psychosis, and respiratory failure (Collin, 2006). IV drug use can also cause scarring of veins making it difficult to get medical treatment that involves injections or drawing blood (Harm Reduction Coalition, 2007).

The cost both financially and personally for cocaine related occurrences is considerable. Addictions Services, in Regina, reported 1,825 situations wherein clients were treated for cocaine use. In addition, drug related diagnoses involving cocaine rose 18% between 2003-2004 and 2004-2005 (CCENDU, 2006).

***What The Women Have to Say:***

There were 41 women who attended the January 31st focus group. The TDW asked how many women when they were little girls wanted to grow up to be addicts. Their responses indicated that they never saw addiction as being where they were going in their lives. The TDW asked how many wanted out of the life that they were in. Thirty-five out of the 41 raised their hands.

When asked how many in the room had children who were using 15 indicated that they did. One woman told the group how her nine year old daughter had watched her inject drugs and how she came to her later with black marker dots drawn all up her forearm. She said "look mommy these are my track marks." She found this extremely upsetting and worried about what this might mean for her daughters future. When the women were asked how many felt that they would not use if they were not living in this area 36 out of 41 indicated that they would not.

Other comments made by the women on the focus group questionnaire and during focus group sessions include:

"Friends, neighbours, everybody is using. It's everywhere, you can't get away from it."

"There are many generations of use. How do you stop it?"

"It's a way to escape from everything."

"Helps with loneliness."

"Wanting to end my life. Hoping the next fix will do it."

"Helps me to cope with what happened in the residential schools."

"To make more friends."

"Numbs the pain of physical, emotional, and verbal abuse."

"Loss of loved ones to death or, children to foster care."

"Suicidal tendencies."

"Feelings of giving up."

During the February 7th focus group the women were told that according to the CCENDU Report the prevalence rate of IV drug use among young women (under 19) was increasing considerably more (79%) than among men (25%). The women were asked why they thought this might be.

Women Who Inject Drugs

"IV drugs are more available"

"Kids get taken away and it's an easy way to forget about it."

"The drugs are better than booze 'cause there's no blackouts."

"We have more stress than men. There is more going on in our lives."

"We need to stay numb working the streets and not think about what we are doing."

"Dealing with issues on a daily basis, like where will I get food from? What will happen to my children?"

"Your partner or spouse is doing it so eventually you decide to do it too."

" Women have more time to themselves."

A way to deal with grief and loneliness."

**Chart V: Unfair or Different Treatment A**
**Do you feel that you have been treated differently by service providers because you are an IV drug user?**

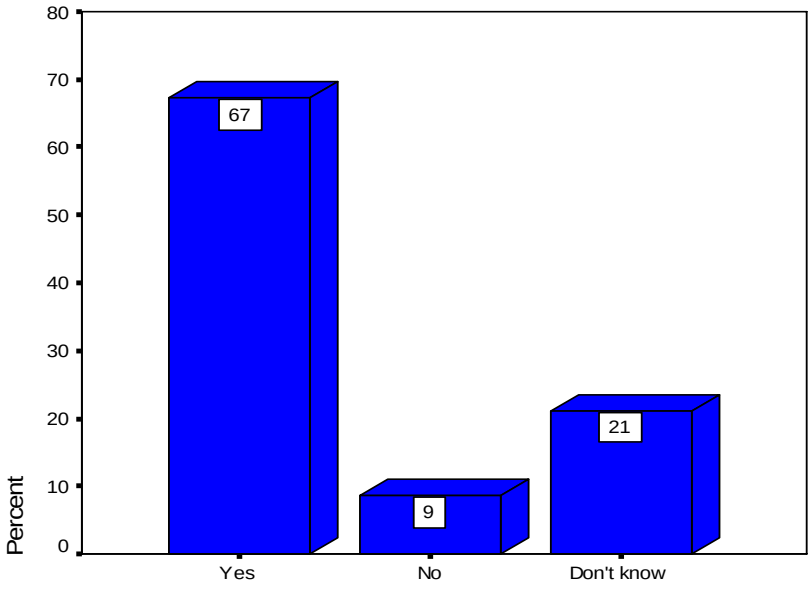
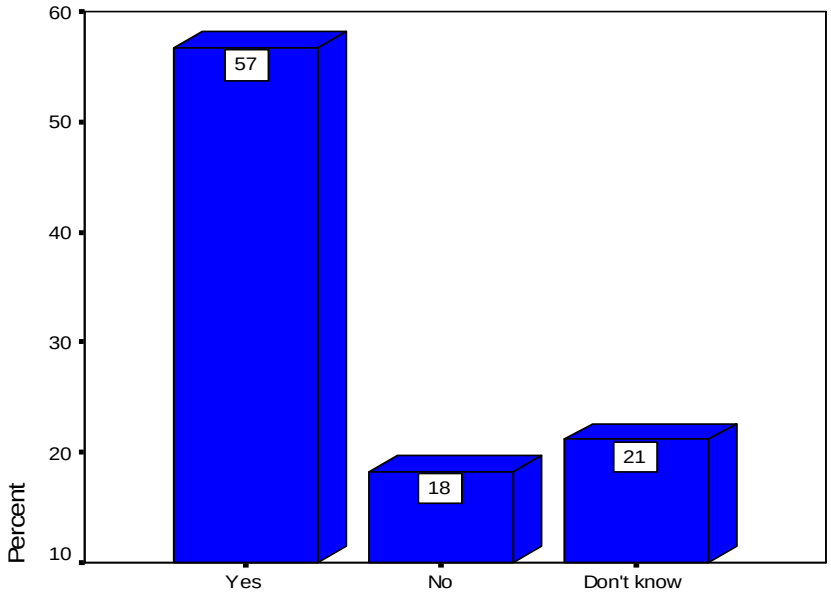


**Chart VI: Unfair or Different Treatment B**
**Do you feel that you have been treated unfairly by any service providers because you are an IV drug user?**




***Overview:***

The vast majority of the participants (78.3%) identified themselves as being First Nations while 12.2% were Métis, and 2.6% were Caucasian. Seven individuals did not identify ethnicity.

Throughout the focus groups a significant number of women raised the issue of racism and put forward the belief that on many occasions they have been treated differently or unfairly simply because they are First Nations or Métis people. They also discussed their belief that once they are recognized as an IV drug user the attitudes of the service providers change markedly and the standard of care they are receiving decreases noticeably. Their observations are consistent with what has been observed in the literature.

***What the Literature Says:***

Drug use is considered a stigmatized condition and previous research indicates that some health care providers have negative attitudes towards drug users (Abouyanni , et.al., 2000; Farmer & Greenwood, 2001) and are less likely to provide them with high-quality care (Skinner, Feather, Freeman & Roche, 2007).

People often view those who use drugs as having little to contribute to the community (Australian Injecting and Illicit Drug Users League, 2007).

The public in general and more specifically government leaders have historically been blinded to the humanity of those who use drugs and are involved in accessing rights as part of a user group (Canadian HIV / AIDS Legal Network, 2005).

There is a common misconception that people who use IV drugs have little value in society and that they are responsible for a vast number of social and medical problems (Friedman, Bolyard, Sandoval, Mateu-Gelabert, Neaigus, 2004).

Attitudes and conversations at work and in social environments can influence the way service providers perceive First Nations people. Perceptions of this culture are influenced by dominant stereotypes which come to be accepted as fact in spite of conflicting evidence (Browne, 2005). This type of interaction can result in misunderstanding and an ongoing lack of communication.

A study conducted in British Columbia in 2001 found that First Nations Women tended to have negative encounters with health care providers that were based on ethnicity. The interactions between the women and the service providers were characterized by racism and discrimination. The result was that there was a continuation of inequality in the care environment that promoted marginalization and disadvantage (Browne & Fiske, 2001).

***What The Women Have to Say:***

The first question on the Women Who Inject Drugs Focus Group Question Sheet was: What do you think service providers need to know about you as a woman who is injecting or who has injected drugs? There were a large number of responses and accordingly they were sorted into like subject matter. Their responses were categorized as: equality and fairness in treatment; personal comments; what they service provider to know about their lives.

***Equality and Fairness in Treatment***

"We are not bad people to treat us with respect or the way they want to be treated."

"That I am human and that I deserve to be treated equally."

"Do not judge. It's hard enough already. Maintain respect."

"I am no less of a woman just because I am a user."

"They need to talk to them one to one."

"They need to be more understanding and listen."

"That I am a person regardless of what I have done in past/present. That I can do what I set out to do in life and that I want to change if given the chance."

***Personal Comments***

"That we are not failures."

"non-drinker."

"That I changed my life around."

"Belief that what I am saying is the truth."

"That we can help ourselves."

"I want them to know that I am a person."

"If the individual is positive with any Hep C or HIV or actually using yet. They need to educate themselves about the disease."

***What They Want Service Provider to Know About Their Lives***

"Most women that do drugs are using some sort of mind altering chemical to escape from all emotional problems. And from my experience, so I didn't have to feel anything.

"I think these service providers need to know what brings on the problem and to give the help that each and every one of us needs."

"They need to know what I am going through and how I feel."

"They need to know about some of the things we go through as intravenous drug users."

"That life is hard for us."

"That I am in need of a steady counselor."

"That some people can stop doing drugs if they really make up their mind to stop using. That forcing a person or anybody to stop using always ends up using again or they don't even stop."

During the course of the series of focus groups for women who inject drugs many examples of unfair treatment were raised. In addition, and more specifically, at the February 14th focus group the women were shown the above charts and asked how they felt that they were treated unfairly or differently. These are some of the responses that were collected:

" Some of them that are aboriginal are even this way…prejudice."

"They need to educate themselves about aboriginal traditions."

"They act like they shouldn't touch you."

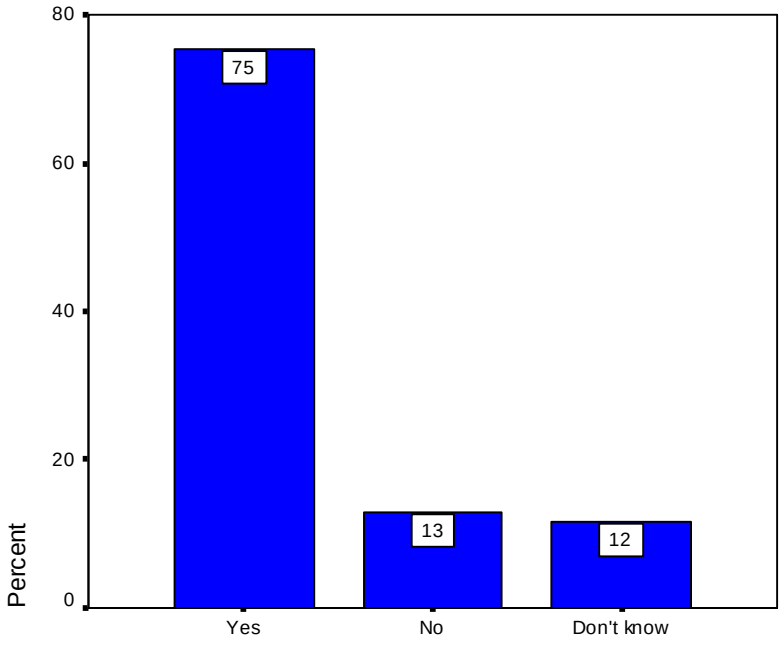
"They judge you."

"Stereotypes."

"Just not to be judgmental."

"When you are talking with them some of the words that come out of their mouths are racist."

**Chart VII: Encounters**
**At some time, I have had an encounter with a service provider that has made me feel: angry, sad, or frightened.**




***Overview:***

Most women come in contact with various service providers throughout the course of any given year. The great majority of women have, at one time or another, come away experiencing a range of negative emotions. They reported feeling angry, sad or frightened, at some time, due to an encounter they had with a service provider. This question was answered by 88 women. Nine did not know if they had experienced such

an encounter, 12 had not and the majority (67) reported that they had felt at least one of these emotions because of an encounter with a service provider.

When shown the above graph at the February 14th focus group the women were asked about each emotion individually. When asked how many felt angry about an encounter 31 out of 36 reported experiencing this emotion. Twenty-one out of 36 reported feeling frightened while 24 out of 36 reported feeling sad.

***What the Literature Says:***

It is not unusual for people who use illicit drugs to experience stigmatization and to be subjected to discrimination. The result is that they are commonly devalued by the rest of the community they are a part of and accordingly experience a sense of alienation. This can contribute to choosing not to access necessary services. Women who inject drugs are especially prone to have this sort of experience. They subsequently do not seek or receive the same sort of treatment as non-drug users. Discrimination has been shown to be associated with poorer physical health while alienation and discrimination predict both poor mental and physical health (Ahern, Stuber & Galea, 2006; Boyd, 2004; Skinner, Feather, Freeman & Roche, 2007).

Individuals who use illicit drugs may avoid seeking treatment from health care providers "due to fear of poor treatment." An added source of anxiety is related to the possibility of authorities being contacted when treatment is sought (Cunningham, Sobell & Chow, 1993; Link, Struening, Rahav, Phelan & Nuttbrock, 1997).

Individuals who use illicit drugs are viewed through a much different lens than are those who do not use these substances. Chronic stress can be the result of stigmatization and discrimination that those who use illegal substances encounter in their daily lives (Minior, Galea, Stuber, Ahern & Ompad, 2003; Young, Stuber, Ahern & Galea, 2005).

The most critical feature of the first encounter with a woman who injects drugs is establishing rapport (Ordean, 2006). If communication breaks down at this point it will be much more difficult to re-establish it in the future.

***What The Women Have to Say:***

During the February 21st focus group the women were again shown the above chart and asked what events had taken place that triggered emotions of fear, anger or sadness.

***Sadness:***

"Telling you that you'll never get your kids back."
"Telling you that you will never amount to anything."
"Feel as if you have no recourse"
"They keep you jumping through hoops and then they don't come through."
"When you go through something emotional they take your last hope from you. Then they expect you to get up and go to work like that."

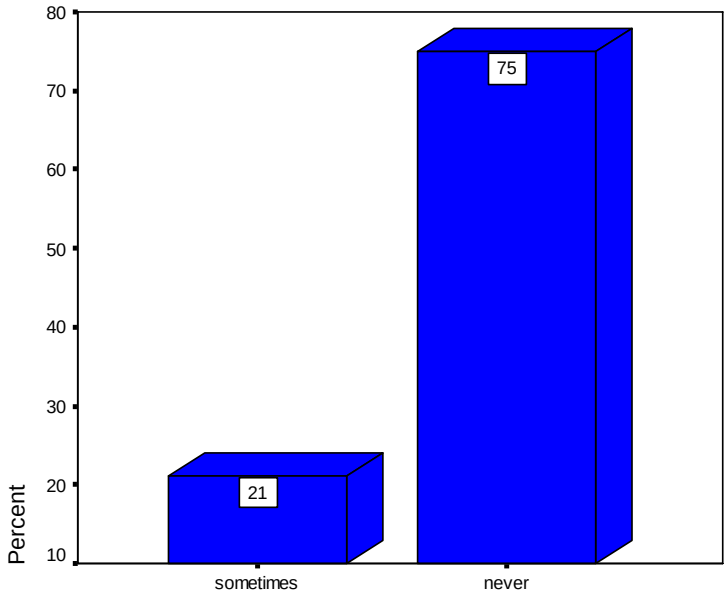
***Fear:***

"Threaten to call the police."
"Say that they will take your kids until they are 18."

***Anger:***

"Their attitude, they're judgmental."
"The way they look at you."
"The way they treat you."
"They treat you badly and they know they are doing it. It's like they're trained that way."
"Instead of trying to help you they preach at you."
"They are supposed to work with you but they work against you."
"They make me mad and I want to strike out at them but I can't so I shoot up or slash my wrists."

**Chart VIII: Needles**
**Do you share needles?**




***Overview:***

Three participants did not answer this question. Of those who did answer 88 reported that they never share needles while 24 said that they sometimes did. None of the respondents indicated that they always shared needles. There were other interesting findings concerning the sharing of needles. Women who reported sometimes sharing needles had significantly more (M = 4.0, SD = 2.3) children than did those who stated

that they never shared needles ($M = 2.9$, $SD = 1.8$; $t(92) = 2.14$, $p < .05$). Although not statistically significant another interesting analysis indicated that women who had attended drug counselling more often were less likely to share needles.

***What the Literature Says:***

A large scale study in Vancouver in 2001 concluded that women who inject drugs in that city have a 40% higher prevalence rate of HIV than men who inject drugs. Moreover, these women are contracting HIV at a faster rate than are the men. Injecting cocaine once or more per day as opposed to less frequently was a predictor of developing HIV (Spittal et.al, 2002).

Sharing needles puts IV drug users at increased risk for contracting HIV, as well as Hepatitis B and C. Those who share needles have been linked in high –risk behaviours and disease transmission by their drug of preference (Wylie, Shah & Jolly, 2006).

For more than 10 years the number of Aboriginal AIDS cases in Canada has continued to increase. In 2002 it was estimated that between 250 and 450 Aboriginal People were newly infected with HIV and that between 3,000 and 4,000 were already living with HIV/AIDS. Estimates are inaccurate because of problems with ethnicity identification on reporting forms and also because Ontario and Quebec did not collect all demographic information on HIV and AIDS. The most common mode of transmission is injection drug use which accounts for approximately two-thirds of new HIV infections (Canadian Aboriginal AIDS Network, 2003).

IV drug use among native populations has increasingly been associated with high-risk for contracting HIV infection. Before 1992 10.3% of diagnosed Aboriginal AIDS cases were attributed to IV drug use. Between 1997 and 2001 this rate had risen to 52.9% (National Native Addictions Partnership Foundation, 2003).

***What The Women Have to Say:***

Twenty-one percent of the women reported that they sometimes share needles. At the February 14th focus group the women were shown the chart and asked why people would sometimes share needles. They provided the following answers:

“Can’t get out of the house to go get needles.”

“Don’t want the neighbours to know so you don’t get the street project.”

“It’s hard to get away from the house.”

“There’s no one to look after the kids while I go.”

**Chart IX: Denied Service A**
**Have you ever been denied medical attention and you believe that it was because of your drug use?**

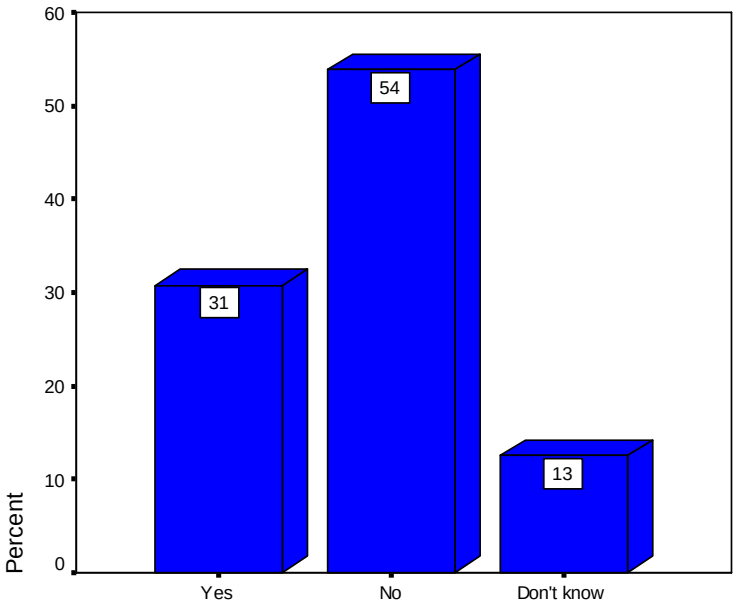
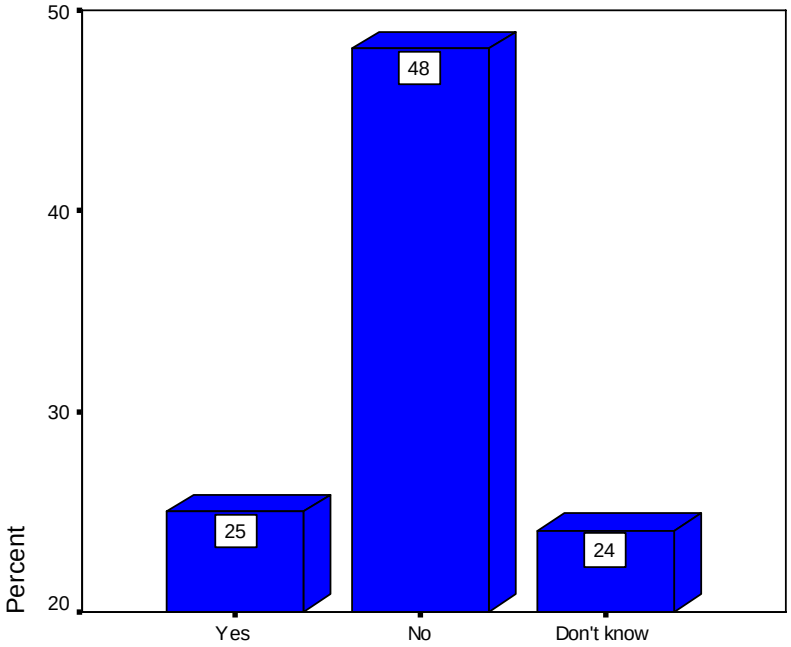



**Chart X: Denied Service B**
**Have you ever been denied any other service and you believe that it was because of your IV drug use?**



***Overview:***

Two of the questions in the research related to the denial of services. Women were asked whether they had been denied medical attention or whether they were denied other services and they felt it was because of drug use. Out of the 115 women 112 answered both questions. With regard to medical attention 30.4% reported that they had been denied this service, 53.1% had not and 13.0% did not know. In terms of the denial of other services 25.2% of women felt that they had been denied another service, 47% had not, and 25.2% did not know.

A considerable number of women report not knowing whether or not they were denied services. This raises an interesting question. Are the women aware of what they are entitled to or what the delivery of the service should look like? Nonetheless, it remains that 1/4 of these women have been denied some type of service at some time that they believe was a direct consequence of their drug use. More alarmingly, nearly 1/3 of the women believe that they have been denied medical attention because of IV drug use.

***What the Literature Says:***

When those who use illegal substances do seek care they are often on the receiving end of further discrimination and, in fact, may find that they do not receive the same standard of care as people who do not use substances (Miller, Sheppard, Colenda & Magen, 2001).

IV drug users are at increased risk for contracting HIV. People who live with HIV or who are suspected of having the virus sometimes do not receive the same medical treatment as those who do not have HIV (Canadian HIV / Aids Legal Network, 2007).

Studies have found that it is not uncommon for nurses to have negative or punitive attitudes towards drug users (Skinner, Feather, Freeman & Roche, 2007).

In Canada it has proven difficult to obtain funding for organizations that promote the voice and involvement of people who use illicit drugs. This is indicative of a larger problem wherein government leaders and concerned citizen groups have had difficulty recognizing the needs of users (Canadian HIV/AIDS Legal Network, 2005).

Law enforcement that is human right-unfriendly reinforces cultural attitudes of discrimination against people who use drugs. This in turn contributes to stigmatization and marginalization wherein these individuals are viewed as criminals who deserve punishment ( Wodak, 2001).

***What The Women Have to Say:***

“How medical service providers act when they know they inject drugs they just stop treating you.”

“You’re pegged as a street person.”

"Hospitals are really bad."

"Once they know, they stop talking to you and they go whisper to each other."

"If they see that you are on methadone you get nothing for pain."

**Chart XI: HIV & HCV Testing**
**Have you been tested for HIV?**

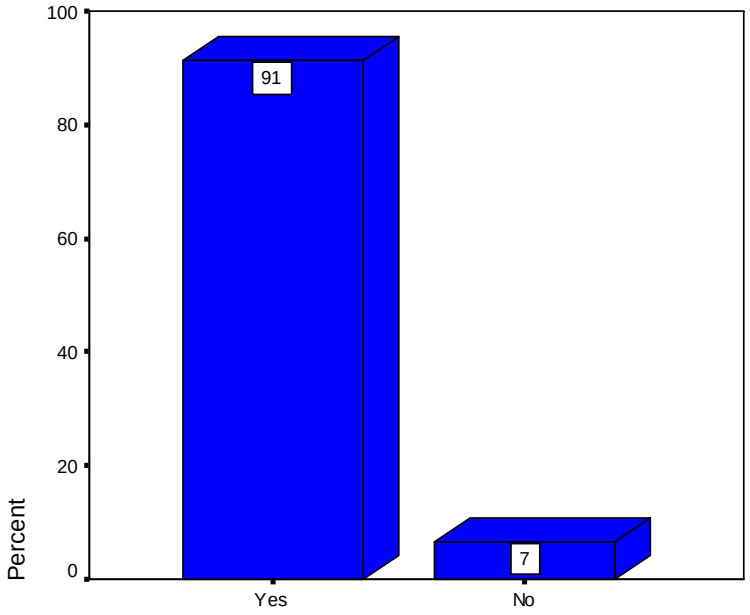
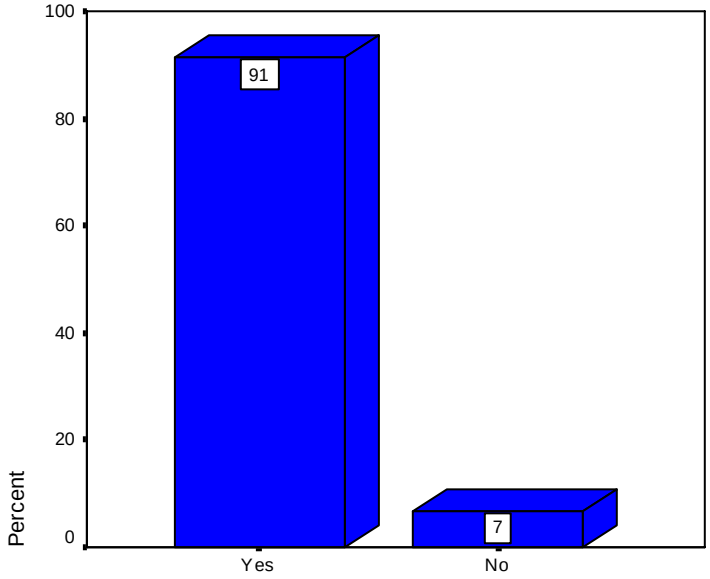



**Chart XII: HIV & HCV Testing**
**Have you been tested for Hep C?**



***Overview:***

Only two of the 115 participants did not answer the questions regarding being tested for HCV and HIV. The vast majority had been tested for both (106 for each). Throughout the focus groups the women showed a great deal of interest in matters related to their health. It was apparent that their concern extended into the area of being tested for both viruses.

***What the Literature Says:***

"People who use drugs represent a significant proportion of people in Canada who contract AIDS" The government must involve this marginalized group in work that is being done in the area of HIV / AIDS if the work is to be meaningful (Canadian HIV / AIDS Legal Network, 2005).

Researchers compared newly acquired HCV statistics in Aboriginal and non-Aboriginal populations in six jurisdictions in Canada. "The overall incidence of HCV infection per 100,000 people age 15 years and older was 18,9% in Aboriginal people and 2.8% in non-Aboriginal people" (Wu, 2007).

"Injection drug use is the main mode of HIV transmission for Aboriginal women" (Canadian Aboriginal AIDS Network, 2003).

Early testing is important in order to prevent spreading of HIV through sexual contact and other risky behaviours. It is also necessary and in order to access early treatment more quickly (Centre for Disease Control and Prevention, 2003).

In 2003 Aboriginal IV drug users in Vancouver were becoming HIV positive at twice the rate that non-aboriginal IDU's were (Craib et.al., 2003).

***What The Women Have to Say:***

During the February 14th focus group the women were shown the above graphs and asked what might prevent the small number of women who had not been tested from getting tested.

"Negative attitudes towards drug users."

"When they know you are an IV drug user they look at you like you're scum."

**Chart XIII: Treatment A**
**Have you ever attended any treatment centers or drug abuse counselling?**

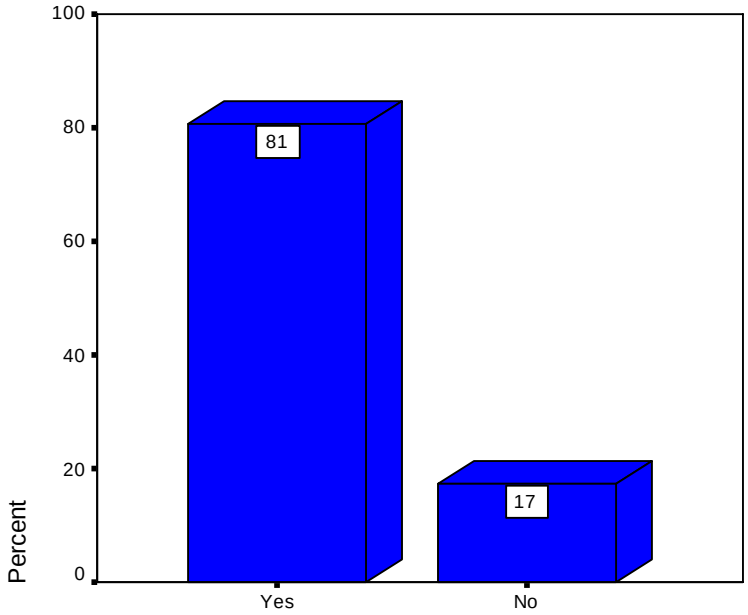



**Chart XIV: Treatment B**
**If yes, was it voluntary or were you forced to go?**

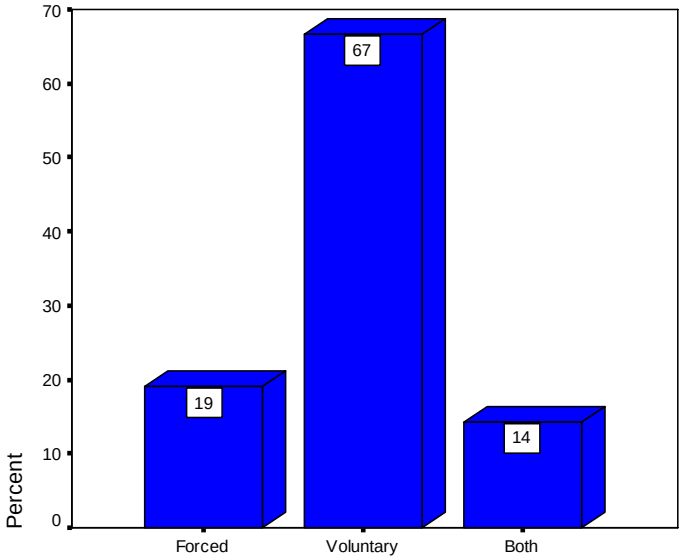


**Chart XV: Treatment C**
**Did you stop using drugs for a period of time after the treatment?**

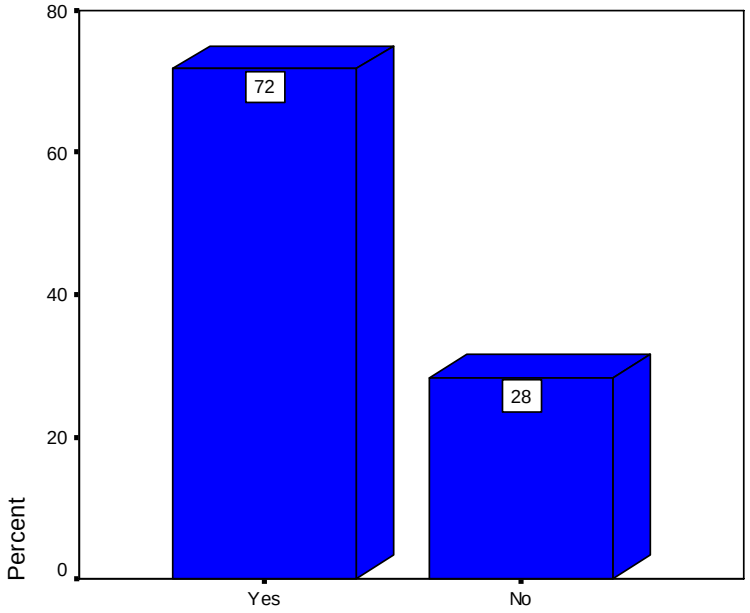
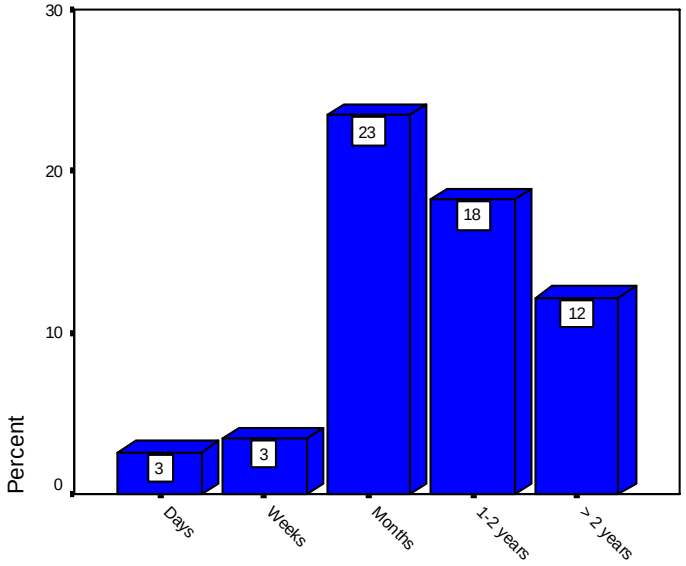



**Chart XVI: Treatment D**
**If you stopped using drugs after treatment, how long did you stop for?**



***Overview:***

Out of the 115 participants 113 answered the question "Have you ever attended any treatment centers or drug abuse counselling? The great majority of the participants had (N = 95) while only 18 had not. The question "If you have attended a treatment centre or drug abuse counselling, how many times have you attended?" was answered by 50 women. Ten answers could not be quantified and included answers such as: "A couple", "Too many", and "Frequently". Out of the answers that could be quantified 80% of the women had attended some sort of treatment one to four times. The remaining 20% attended five to 30 times. When asked "Did you stop using drugs for a period of time after treatment?" 96 women answered the question and of these 70 did stop temporarily. The other 26 resumed using drugs upon completion of treatment. When asked if treatment had been voluntary or forced 92 women answered. Of these 61 had attended voluntarily while 18 were forced and 13 had attended both voluntarily and after being forced into treatment.

***What the Literature Says:***

Regina is one of six locations in Canada with a Drug Treatment Court. The DTC is a therapeutic court that addresses drug addiction as an underlying cause of criminal activity. A participant in the DTC will enter an intensive treatment program that includes an interdisciplinary team of professionals. Successful completion of treatment will be reflected in sentencing (http://www.sasklawcourts.ca/default.asp?pg=pc_div_regina_drug_treatment, 2006).

Forced drug treatment raises questions related to client choices in treatment decisions, civil liberties, ethical responsibilities of legal and health care professionals, and the effectiveness of such programs (Wild et.al, 2001).

People who are awaiting trial are more likely to preserver in attending drug treatment programs. The fact that they attend does not, however, translate into "improvement in the life of the participant". This is most notable in terms of the lack of influence that drug treatment has been reported to have on drug using behaviour (Brochue et.al., 2006).

Approaches to drug treatment that are based on abstinence are limited and may even be counter-productive (Canadian HIV/AIDS Legal Network, 2005).

***What The Women Have to Say:***

"I was forced into treatment when I wasn't ready to be there."

"I started using again after treatment because my friends do it."

"There was no help available for me after treatment."

"At meetings after men prey on women and try to pick them up."

"Women only groups are needed."

"Treatment isn't working because our homes aren't stable."

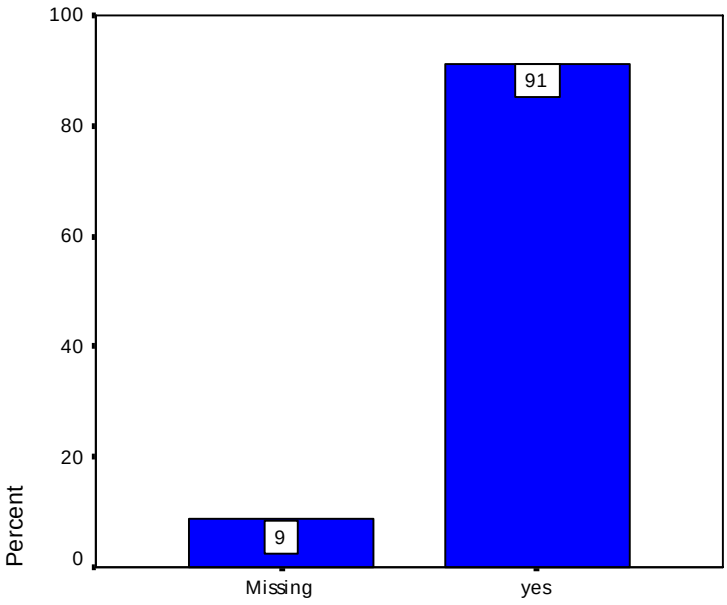
"I had no support when I got out."

"We are sent to treatment centers that don't know how to work with IV drug addictions."

### *Bar Charts Service Providers*

The following bar charts depict the results from focus group questions for service providers that could be quantified. Each chart is accompanied by an overview of the results, and the comments from the service providers.

**Chart XVII: Work With Women**
**Would you be willing to work with women that you knew injected drugs?**




### *Overview:*

Twenty out of 23 service providers answered this question and all 20 who did answer reported that they would be willing to work with this population. None of the service providers indicated that they would not be willing to work with women who inject drugs.

### *Service Provider Comments:*

"I have no apprehension at all."

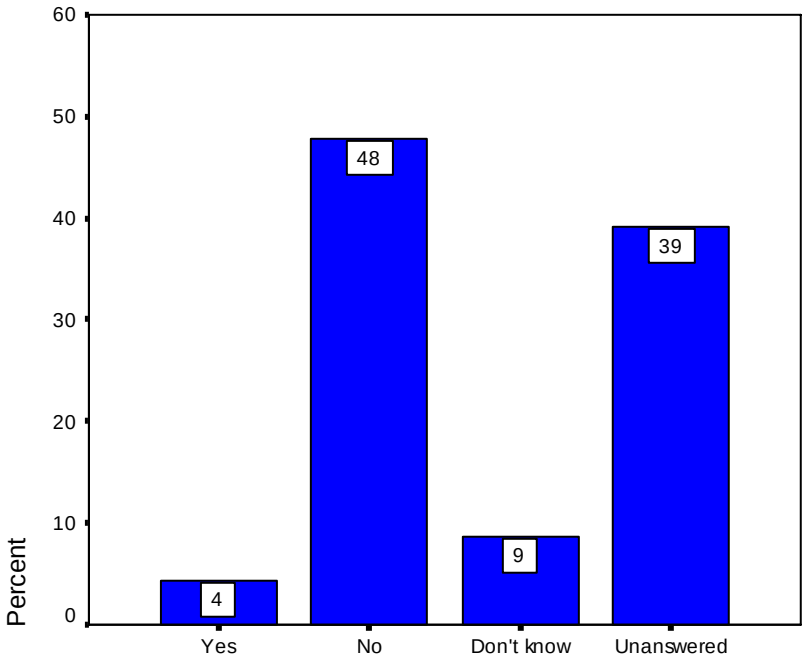
"Everyone needs / deserves help to deal with any addiction."

"Everyone deserves to have respect and access to programs."

"Unavoidable in the world of medicine – it would be good to have lots of info., can be very rewarding."

"(I work in a way) so they can know and feel they are a person."

**Chart XVIII: Policies**
**Does your organization/department have policies for working with women who inject drugs?**




***Overview:***

Fourteen participants answered this question. Out of these 11 reported that their department or organization did not have policies for working with women who inject drugs. One individual answered that this question was not applicable to their organization and nine did not provide any answer. Two did not know whether any such policy existed and only one person identified working in a department or organization where there was any sort of policy for working with people who use IV drugs. During the focus groups departmental policies for working with this population was briefly discussed and comments were made regarding such policies in general.

***Service Provider Comments:***

"Need to encourage harm reduction in policies."

"These women keep falling through the cracks because there are no policies."

"When creating policies some people understand and some don't. Those who look at everything from a strictly philosophical point of view just don't get it."

"The problem with policies is that they are written by people who know nothing about the reality of IV drug use."

"Services don't know how to offer what the women want or need"

"There is a lot of illegal activity associated with IV drug use and we need to see what can bring about changes."

"Policies need to be incorporated that address issues like jobs, homes, and food."

"Long term support is missing."

**Chart XIX: Educational Sessions & Focus Groups**
**Would periodic educational sessions regarding working with women who inject drugs be helpful in your workplace?**

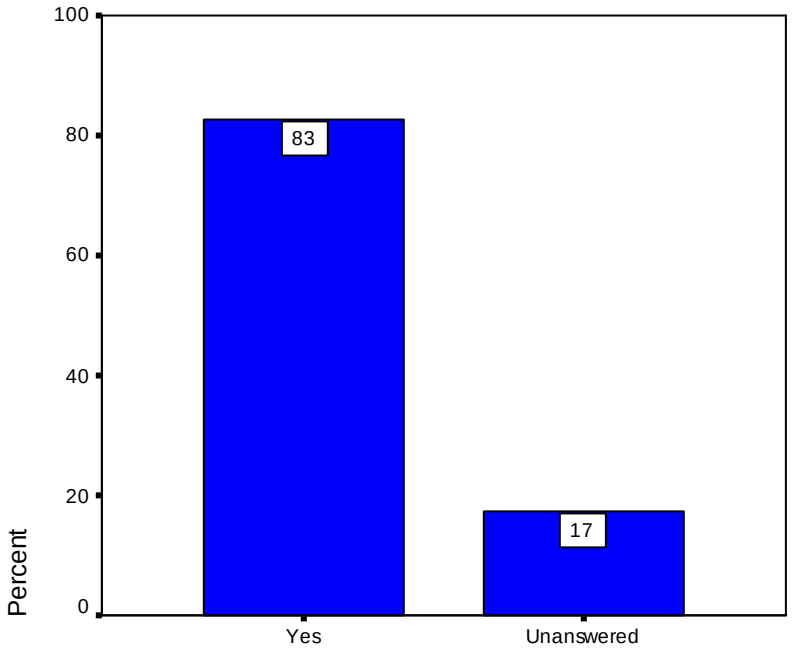
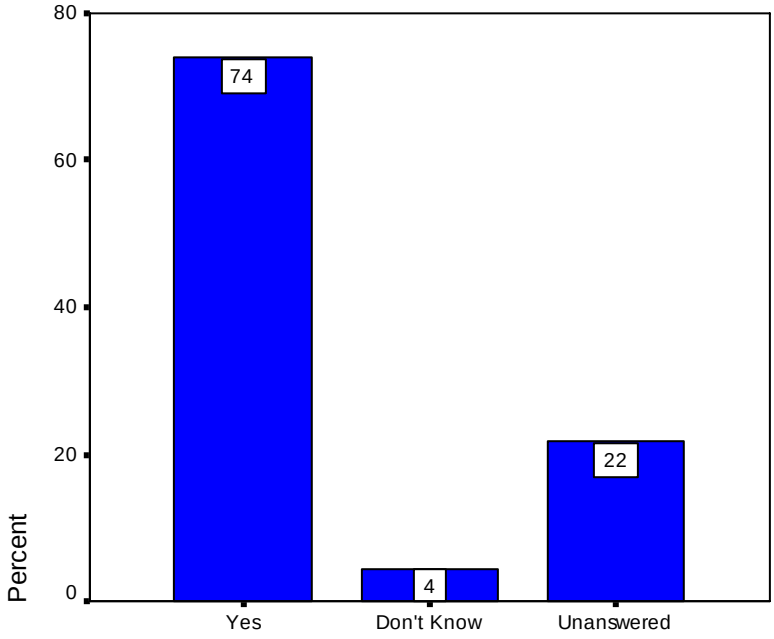


**Chart XX: Educational Sessions & Focus Groups**
**Would periodic focus groups that explore your concerns when working with these clients be helpful?**




***Overview:***

Nineteen of the 23 participants answered the question: Would periodic educational sessions regarding working with women who inject drugs be helpful in your workplace? Of these 19 answered yes and four did not provide an answer. Eighteen out of 23 participants answered the question: Would periodic focus groups that explore your concerns when working with these clients be helpful? Of these 17 answered yes, one answered that they didn't know and five did not provide any answer.

***Service Provider Comments:***

"Where can I get help for this woman?"

"There's a need for presentations to target agencies within the community."

"Education and training are a necessity for working with this population."

"Need to know about street drugs"

"Need to know what services are out there"

"New issues, what's changing and not changing."

"Information on client background – their needs."

"Information on support networks after treatment."

"Information on drug use."

**NOTES**

## RECOMMENDATIONS

**Recommendation 1**

**Provision of information on existing services**

One of the major gaps identified in this study is the lack of awareness concerning services. Both the service providers and the women are confused about whether or not services are available and if they are how to access them. There is a need for an organization that or an individual who can coordinate and provide information regarding existing services. It is recommended that:

- An information coordinator or information coordinating service should be appointed to develop, maintain and disseminate information on available services. This person or organization should frequently update the information and ensure that it is distributed to service organizations as well as to a central location where the women can access it.

- The information must be kept as concise and manageable as possible in order to make it practical.

## NOTES

**Recommendation 2**

**Providing support services for women**

The high rate of return to drug use following treatment or counselling highlights the need for ongoing service provision in this area following completion of a program or therapy. Presently, accessing some services can take a considerable amount of time. If the woman is in crisis she may be able to get help quickly, however, there is nothing available on short notice for ongoing support.

Accordingly, it is recommended that:

- Programs or services that provide the women with support after they have completed drug treatment programs be implemented. Areas that need to be considered in such programs or services:

    - The women feel they have little recourse for the events that take place when they are accessing services. Therefore, an advocate should be appointed who can act on their behalf and assist with problem resolution when there is a dispute with services organizations or service providers.

    - Funding should be provided for a safe place where the women can go to network with each other and receive counselling. This service should be available especially during hours when other services are not available. Women who use drugs should be involved in decision making processes that affect their lives and accordingly must be meaningfully involved in these organizations. Women who inject drugs must be appointed to any governing body or board that oversees this type of service as it is these women who are most qualified to know what they want and need.

**NOTES**

**Recommendation 3**

**Providing education for women who inject drugs**

There has been a dramatic increase in the number of young women who inject drugs in Regina. This rate has increased by nearly triple that of older men or women. This may well represent a trend among younger females that will result in long term consequences to the women and to the community overall. In all likelihood this will result in increased drug related problems in the future including: A) Personal cost to the women such as: 1) health related problems 2) child apprehension 3) legal issues including drug related charges B) Increased cost to tax payers that are related to legal and health issues.

Women have expressed an interest in education regarding drug use and the effects that it has on their bodies, minds, and spirits. The spiritual aspect may be of particular concern to Aboriginal women who often feel that their cultural values and concerns have been ignored within service organizations. This type of education is not currently available. It is recommended that:

- Funding be made available to provide education workshops for women who inject drugs. Implementing such education opportunities will help the women make healthier choices. A plan to promote this recommendation should include:

    - Providing education sessions or workshops on the importance of accessing good health care at all times but particularly during pregnancy.

    - Providing education sessions or workshops on the affects of drugs on the mind and body.

    - Providing sessions or workshops with elders that explore traditional methods of healing the mind, body and spirit.

**NOTES**

**Recommendation 4**

**Providing support for children who are in care**

The women are concerned about the care and treatment of their children once they are apprehended. Many women have been told by their children that they are treated poorly while in care and in some cases there have been claims of abuse or neglect. According to the women these incidents have been conveyed to social workers by the children and/or their mothers. It is not clear, however, whether any investigative or other action has been taken. What is clear is that the women have not been made aware of whether or how the rights of their children are being protected. Given the potential for serious consequences in this regard the following actions should be taken:

- A support system for children who have been apprehended should be made available. It should take into consideration the unique needs of marginalized people who often live below the poverty line and who may be stigmatized because of IV drug use. In addition, it should be culturally sensitive and encompass the implications of racism that may occur in care.

- Someone who can speak on behalf of the children should be made available to meet with them and advocate for them when necessary. Regular meetings with the children should be conducted in order to determine whether or not their needs are being met while they are in care.

**NOTES**

**Recommendation 5**

**Providing education for service providers who work with women who inject drugs**

Many of the needs expressed by service providers can be met through the provision of education sessions, training programs, or workshops. Service providers have concerns regarding safety, communication with the women, and a general lack of information in many areas including: drugs, drug use, and drug treatment.

There is a need for more training and education that would give service providers a better understanding of women who inject drugs from the perspective of the women. Women who inject drugs need to be involved in educating service providers with regard to their personal lives, experiences, drug use, and drug treatment. At this point, the women have not been formally involved in such a process. One of the best remedies for a lack of knowledge about the women is educational sessions that involve input from the women. It is, therefore, recommended that:

- Women be provided with funding and resources that will enable them to develop training sessions for service providers. These sessions could include, but would not be limited to: education on living below the poverty line, the challenges of living in the core area of Regina, drug use from the perspective of a person who uses drugs, supports needed to maintain child custody, legal and health related issues faced by people who use drugs. Policies and procedures within departments could be reviewed following these sessions to determine what could be added, removed or changed to meet specific needs.

- Workshops on safety issues could be conducted. Education concerning blood borne diseases, transmission of these diseases, and prevention strategies should be provided. Ways to avoid contracting blood borne diseases that have been used in other cities or countries could be explored. Policies and procedures should be reviewed to ensure that they are up to date and useful.

- Education sessions on keeping safe when working in the community should be conducted. Policies and procedures should be reviewed to ensure that they are up to date and useful.

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## Appendix A
## WOMEN WHO INJECT DRUGS CONTINUUM 2007 FOCUS GROUP QUESTIONS FOR THE WOMEN

1. What do you think service providers need to know about you as a woman who is injecting or who has injected drugs?

2. What services would you like to see provided for you in Regina that do not already exist?

3. What changes do you think need to be made by existing service organizations in order to meet your needs?

4. What are the barriers that you find when you are trying to access a service in Regina?

5. What are the biggest challenges that you face when dealing with service providers?

## Appendix B

## WOMEN WHO INJECT DRUGS CONTINUUM 2007 FOCUS GROUP QUESTIONS FOR SERVICE PROVIDERS

1) What kinds of barriers do you see for working with women who inject drugs?

2) What kind of information would be most helpful to you when you are working with this population?

3) Would you be willing to work with people that you knew injected drugs?
   Yes □ No □ Don't Know □
   Comments:

4) Do you feel that working with this population poses certain risks?
   Yes □ No □ Don't Know □

   Comments:

5) If you think that working with this population may pose risks, what do you see these risks as being?

6) What policies or procedures would help you to consider working with this group?

7) Would periodic focus groups that explore your concerns when working with these clients be helpful?
Yes □ No □ Don't Know □

Comments:

8) Would periodic education sessions regarding working with women who inject drugs be helpful in your workplace?
Yes □ No □ Don't Know □

Comments:

9) Does your organization/department have policies for working with women who inject drugs?
Yes □ No □ Don't Know □

- Are you familiar with these policies? Yes □ No □
- If you are familiar with these policies, are they useful? Yes □ No □ Don't Know □
- Are there changes you would like to see with regard to these policies? Yes □ No □ Don't Know □

Comment:

**Appendix C**

# Aids Programs South Saskatchewan
# Women Who Inject Drugs Project

We will be holding discussion forums for women who: use drugs, have used drugs, or are affected by drugs and their related issues. This will provide an opportunity for women to network, share ideas and information and to engage in activities, provide feedback and assist in the development and implementation of the project. We will be providing the women with an honorarium for their participation in the discussion forums.

The purpose of the project is:

To develop training tools that will assist service providers who work with women who inject drugs. At the completion of the project the following tools will be provided:

4) A Drug Sensitivity Training Kit for front line service providers, supervisors, and organizations that may be in contact with women who inject drugs.
5) A report of the research findings.

The goals of the project are:

3) To provide service providers and organizations with an interactive Training and Harm Reduction Kit as an onsite resource in providing services for women who inject drugs.
4) To use the tools that are developed to examine whether there is a need for philosophical changes in policies and ways of thinking when trying to engage these women and if so to help concerned groups generate dialogue around developing and implement suitable policies.

In addition, by encouraging women who inject drugs to participate in the development of a Drug Sensitivity Training Kit, it will provide organizations and agencies with insight into how and why these women have come to this point in their lives, and how to work with them. If you are interested or know of anyone who would be interested in this project or if you require more information please contact Keitha Kennedy or Bobbi Stadnyk at APSS – 924-8420.

## Appendix D


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Regina, SK
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Phone: (306) 924-8420

Toll free:
1 (877) 210-7623

Attention: Drug Strategy Workgroup Members, department managers, supervisors, front line workers & other potential participants

Re: Women Who Inject Drugs Continuum

This letter is an invitation to participate in a project that is being funded by AIDS Program South Saskatchewan. The project will be conducted by Keitha Kennedy and Bobbi Stadnyk. Ms. Kennedy has been a consultant in Saskatchewan for several years and has been very active in the area of program development. Ms. Stadnyk is a doctoral candidate at the University of Regina, Department of Psychology, and a Registered Psychologist (provisional) in Saskatchewan.

The purpose of the project is to develop training tools that will assist service providers who work with women who inject drugs. At the completion of the project the following tools will be provided:

6) A Drug Sensitivity Training Kit for front line service providers, supervisors, and organizations that may be in contact with women who inject drugs.
7) A report of the research findings.
8) Sensitivity training sessions that will focus on the project research findings in terms of the overlap of and differences between service provider concerns and the concerns of female clients who inject drugs.

The goals of the project are:

5) To provide service providers and organizations with an interactive Training and Harm Reduction Kit as an onsite resource in providing services for women who inject drugs.
6) To use the tools that are developed to examine whether there is a need for philosophical changes in policies and ways of thinking when trying to engage these women and if so to help concerned groups generate dialogue around developing and implement suitable policies.

We are requesting your assistance in setting up a series of focus groups with front line workers, supervisors, managers, and other interested parties. Ideally, at least two such employees from each organization should attend one of the group sessions. The focus groups will provide a forum where you can discuss concerns and ask questions regarding the project. It will also allow project designers to understand the experiences of service providers who may have the possibility of coming in contact with women who inject drugs. Your input during the meetings will be used in developing and designing the tools that will be contained within the kit. Ultimately this will result in our being able to provide a more meaningful kit for you and your organization.

If you are unable to attend any of the focus groups we ask that if at all possible you provide the name of a contact individual from your organization who might be interested in doing so. In addition, if you feel that organizations other than those identified as target groups would benefit from participation in this project please forward this information to one of the project contacts. Time is a critical factor as all focus groups must take place by the second week of February 2007 and the project must be completed by March 23, 2007. Focus groups will be held on the following dates and times at AIDS Programs South Saskatchewan, 1102 Angus St. Regina:

| | |
|---|---|
| Tues. January 16th, 2007 - 1:30 – 3:30 | Thurs. February 1st – 1:30 – 3:30 |
| Fri. January 19th, 2007 - 1:30 – 3:30 | Tues. February 6th – 1:30 – 3:30 |
| Tues. January 23rd – 1:30 – 3:30 | Thurs. February 8th 1:30 – 3:30 |
| Thurs. January 25th,2007 - 1:30 – 3:30 | |

Please contact AIDS Programs South Saskatchewan by email or by phone (contact provided below) in order to confirm whether or not you, or someone from your organization can attend and if so the date that you would be available.

The target groups and departments that have been selected for participation in this project are:

All Nations Hope

City of Regina Police Service

Corrections and Public Safety

Detox Centre

First Nations University of Canada

Mental Health & Addictions Services
- Addiction Services
- Harm Reduction Methadone Clinic
- Métis Addictions Council of Saskatchewan
- Regina & Area Drug Strategy Work Group

Mobile Crisis

Regina Qu'Appelle Health District
- Mother and Baby Unit
- Emergency Services
- Four Directions Community Centre
- Native Counseling Services
    - Regina General Hospital
    - Pasqua Hospital

Reserves
- Carry The Kettle
- Cowessess
- Day Star
- Fishing Lake First Nations
- Gordon
- Kahkewistahaw
- Kawacatoose
- Little Black Bear

Reserves Con
- Muscowpetung
- Muskowekwan
- Ochapowace
- Okanese
- Pasqua First Nation #79
- Peepeekisis
- Piapot
- Sakimay
- Standing Buffalo
- Star Blanket

Royal Canadian Mounted Police

Saskatchewan Community Resources
- Teen and Young Parents Program

Saskatchewan Department of Justice
:

Saskatchewan Public Health Association

Tribal Councils
- File Hills Qu'Appelle Tribal Council Inc.
- Yorkton Tribal Administration Inc.
- Touchwood Agency Tribal Council Inc.

University of Regina
- Faculty of Social Work

Women's Shelters
- Isabel Johnson Shelter
- Regina Transition House
- SOFIA House
- WISH Safe Haven
- YWCA

For further information please contact:

| | | |
|---|---|---|
| Chris Smith<br>Executive Director, AIDS Program South Saskatchewan<br>924.8420<br>chrissmith@sasktel.net | Keitha Kennedy<br>Training Development Worker<br>924.8420<br>apss@sasktel.net | Bobbi Stadnyk<br>Training Development Worker<br>924.8420<br>545.5355<br>bobbiandozzy@cableregina.com |

Your input into this important project is extremely valuable and your involvement greatly appreciated. Thank you for your kind assistance.

Sincerely,

Chris Smith
Executive Director,
AIDS Programs South Saskatchewan

## Appendix E
## Demographic & Information Questionnaire Sheet

Age: ____ Gender: Male____ Female____

Ethnicity: Caucasian ☐ First Nations ☐ Metis ☐ Asian ☐ African-Canadian ☐ Other ☐

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Common-law ☐

Do you have children: YES____ NO____ If yes, how many? _____

How long have you been an IV drug user? _____

What drugs do you inject? _____

How often do you inject _____

Service provider = (e.g. police, health care personnel, social worker, other service provider)

Do you feel that you have been treated differently than other people by service providers because you are an IV drug user? YES ☐

NO ☐ DON'T KNOW ☐

Do you feel that you have been treated unfairly by any service providers because you are an IV drug user?

YES ☐ NO ☐ DON'T KNOW ☐

If you have been treated unfairly, which service organization was

involved?_____

At some time, I have had an encounter with a service provider that has made me feel : angry, sad ,or frightened

YES ☐ NO ☐ DON'T KNOW ☐

Do you share needles? ALWAYS ☐ SOMETIMES ☐ NEVER ☐

Have you ever been denied medical attention and you believe that it was because of your IV drug use?

YES ☐ NO ☐ DON'T KNOW ☐

Have you ever been denied any other service and you believe that it was because of your IV drug use?

YES ☐ NO ☐ DON'T KNOW ☐

If yes, what services do you feel that you have been denied? _____

Have you been tested for HIV? YES ☐ NO ☐ DON'T KNOW ☐

Have you been tested for Hep C? YES ☐ NO ☐ DON'T KNOW ☐

Have you ever attended any treatment centres or drug abuse counselling? YES ☐ NO ☐

If you have attended a treatment centre or drug abuse counselling, how many times have you attended?_____

If yes, was it voluntary or were you forced to attend? Forced ☐ Voluntary ☐ Both ☐

Did you stop using drugs for a period of time after treatment ? Yes ☐ No ☐

If you stopped using drugs after treatment, what was the longest time that you did not use for? _____