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ORIGINAL ARTICLE

Bridging the gaps: Experiencing and preventing life-threatening heroin overdoses in men in Oslo

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Abstract

The aim of this study was to illuminate and interpret the experiences of professionals and men living with life-threatening heroin overdoses in Oslo. A case study design was chosen for data collection. A phenomenological hermeneutic approach and triangulation was used to analyse the data. The naïve reading involved awareness of the perceived sense of social isolation, which had consequences for how life-threatening heroin overdoses were managed, comprehended and motivated by the men. Professionals also experienced isolation, since they had no specific goals or guidelines for cooperation, and relevant political documents did not address the phenomenon of life-threatening heroin overdoses. Non-participant observation revealed different types of isolated interventions, involving very short interventions by several kinds of actors. The structural analysis identified three themes: The meaning of being rescued, the meaning of longing for communion and the meaning of being confused. A comprehensive understanding of the complexity in experiencing and preventing life-threatening heroin overdoses in men in Oslo indicated that the meaning of these social phenomena could be understood as bridging the gaps between barriers to treatment, interaction and motivation.

Key words: *Heroin abuse, suicidal behaviour, overdose, men, case study, hermeneutics*

Introduction

Worldwide, substance abuse and suicidal behaviour are public health concerns, which seem to be increasing in prevalence (World Health Organisation, 1996; 2007). Illustrating the potentially lethal effect of the combination of these phenomena, research findings point to a relationship between overdoses and the intent to die (Rossow & Lauritzen, 1999; Darke, Ross, Lynskey & Teesson, 2004; Brådvik, Frank, Hulenvik, Medvedeo & Berglund, 2007). The lethal event of a life-threatening overdose may indicate suicidal ideation and intention. Suominen, Isometsä, Haukka and Lönnqvist (2004) revealed this to be particularly relevant for men. Violent deaths (suicide, murder, accidents) associated with poisoning have been shown to contribute increasingly to high mortality (Gjeruldsen, Abdelnoor, Opjordsmoen & Myrvang, 2001). Life-threatening overdose and drug-related death are complex concepts. In this study we use the definition of the European Monitoring Centre

for Drugs and Drug Addiction. The term “overdose death” refers to acute death after the use of illicit drugs, mainly heroin (Reinås, Waal, Buster, Harbo, Noller, Schardt & Müller, 2002).

In Oslo, which represents a Nordic welfare society, a steep increase in the number of overdose deaths among men using illicit drugs occurred during the 1990s. During the period 1992–1997, an out-reach team was established to facilitate psychosocial follow-up and clinical cooperation after initial emergency treatment. Further, cooperation has taken place between Oslo, Amsterdam, Frankfurt and Copenhagen, to compare drug problems and to investigate factors that influence the rate of overdose. Contrary to in other Nordic capitals, drug addicts in Oslo usually inject heroin intravenously, increasing the risk of death (Anker, Asmussen, Kouvonon & Tops, 2006).

The multi-centre project made special recommendations for Oslo, with the aim of making strategic

choices for preventing overdose deaths (Reinås et al., 2002). The final recommendations focused on four areas: (a) structural cooperation between all relevant agencies; (b) a joint and simultaneous intervention with police action and adequate availability of treatment and low threshold facilities, including the dispersal of the open drug scene; (c) coordination of the policy in Oslo with the policies of the surrounding municipalities; and (d) continuous evaluation, improvement and adaptation of the different interventions to changing circumstances.

Until 2004, Oslo had one political body responsible for the health of people abusing substances. Due to structural changes in the Norwegian health care sector, this system was replaced by a system where responsibility was divided between two levels, the state and the municipality. Responsibility for treatment of drug abuse was then transferred to the regional health authorities on behalf of the state. The number of persons receiving medication-assisted rehabilitation in the city increased from 337 in 2000 to 1118 in 2007 (Martin Blindheim, Norwegian Directorate of Health, personal communication), and seizures of heroin by the police were reduced by 52% (National Bureau of Crime Investigation, 2008).

The number of deaths from overdoses of illicit drugs in Oslo is still high. Life-threatening overdoses and suicidal behaviour seriously affect the health and well-being of individuals and significant others, but are still mainly studied in a positivistic and deductive manner. We studied a small number of individuals in depth who had a high-risk for attempting suicide, and professionals engaged with preventive tasks. We aimed to improve and deepen our knowledge and understanding of the meaning of life-threatening overdose, and, thus, we took a hermeneutic and phenomenological paradigm as our point of departure. A holistic understanding of the phenomenon of life-threatening overdose, embedded in an integrated whole, calls for research which tries to contextualize interpretations of the inner-perspective of the individuals in question (Leenaars, 2002; Yin, 2003). The aim of this study was to illuminate and interpret the experiences of professionals and men living with life-threatening heroin overdoses in Oslo. The two research questions were:

- (1) How do men living with injecting heroin construct meaning when narrating experiences of life-threatening overdose?
- (2) How do health and social professionals construct meaning when narrating experiences of prevention of life-threatening overdose?

Method

A case study is a research method which focuses on the circumstances, dynamics and complexity of a single case, or a small number of cases. It is recommended by Yin (2003) to investigate a contemporary and social phenomenon within its real-life context in order to obtain knowledge based on in-depth analysis. Multiple sources of data are employed in order to investigate complex situations and to validate the findings (Bowling, 2002). Thus, the importance of data triangulation is underlined, which also means continuously comparing different findings with findings from other sources in order to contribute to a broader and deeper description and understanding of the case. There were four empirical sources in this study: First, narratives of the experiences of men who had been rescued from life-threatening overdose; second, focus group discussions with health and social professionals who have prevention of overdoses as one of their tasks; third, non-participant observation of the initial care of persons who were experiencing a life-threatening overdose; and fourth, review of relevant official documents, such as laws, political-administrative documents and reports from supervision.

Participants and data collection

In order to examine the lived experiences of men who had taken life-threatening overdoses in Oslo, biographical accounts were collected using a secondary analysis of four in-depth interviews (Biong & Ravndal, 2007). Additional data were collected in cooperation with relevant services. The service providers were given written and oral information. The sampling was purposeful, selecting men with a long career of injecting heroin. These accounts were recorded by staff and sent anonymously to the researcher, in line with instructions from the Regional Committee for Medical Research Ethics, Eastern Norway Regional Health Authority. In total, we analysed accounts from eight men, 23–55 years of age.

In order to investigate professionals' lived experiences, perceptions, attitudes and behaviour with regard to the task of preventing life-threatening overdose, two focus group discussions were carried out. A focus group discussion is a planned discussion among a more or less homogeneous group of people on a subject chosen by the researcher, using the dynamics and interaction within the group in order to reflect on the phenomenon under study (Kitzinger, 1995). The idea is that this method of data collection will shed light on dimensions and understandings that would have been difficult to capture using other

methods. By means of a purposeful selection, nine paramedics, health and social professionals (representing both the state and municipal levels) were recruited with the assistance of the Emergency Service and the Alcohol and Drug Addiction Service. The participants had been engaged for several years in the prevention of life-threatening overdose. The discussions were conducted with the first author (SB) as the moderator, with no additional observer due to the small size of the groups. We tried to organize focus group discussions with representatives from the political-administrative level of Oslo, but this was not possible for practical reasons.

We argue that it is important to investigate the phenomenon of life-threatening overdose without the effect of the researcher (Hammersley & Atkinson, 1983). Thus, non-participant observation is important to supplement other information in the data triangulation. The first author carried out about forty hours of non-participant observation in specific areas in the centre of Oslo. When a life-threatening overdose was identified, the researcher got as close as possible, acting the role of an ordinary member of the public. Eight life-threatening overdoses were identified and observed, all involving men. Several political-administrative documents were retrieved electronically and reviewed to illuminate the findings of the lived experiences and observations. These documents were related to health and social services for persons with substance abuse, strategic choices to reduce life-threatening overdose in Oslo, and structural changes to the system. Seven relevant documents were reviewed, and four were used to analyse social practice.

Data analysis

The text from the accounts of lived experiences and the focus group discussions were analysed using a phenomenological hermeneutic method developed by Lindseth and Norberg (2004). Their point of departure is Ricoeur's philosophy on interpretation of text (Ricoeur, 1976). Ricoeur holds the notion that gaining knowledge and understanding cannot pass directly from one person to another, but is to be constructed through the hierarchical interpretation of text. Such an interpretation integrates explanation and understanding in a dialectic movement rooted in the properties of the text. This movement, the hermeneutic circle, is described as a process, involving first an intuitive guessing of the meaning of the whole, followed by an explanation of the parts and then again a move to a comprehensive understanding of the whole of the text. We found such a phenomenological hermeneutic approach useful when we wanted to analyse and understand how

the meaning of life-threatening overdose was constructed. Lindseth and Norberg's method (2004) emphasizes how to enter the hermeneutic circle, the dialectic movement between understanding and explanation, and between the text as a whole and its parts, in order to get at the meaning of the studied phenomenon. It consists of three different, but interwoven, steps: naïve reading, structural analysis and comprehensive understanding.

The first step in the analysis was carried out by reading and re-reading all the text, in order to grasp an intuitive sense of the whole. Analysing the biographical accounts and the transcribed text from the focus group discussions, the process proceeded with a structural analysis identifying narrative segments (Labov, 1982). Then, these narratives were reflected on against the background of the naïve reading and set in relation to each other and condensed into sub-themes. These sub-themes were analyzed for their similarities and differences and abstracted into themes. Themes were defined as a thread of similar meaning that penetrated one or several sub-themes. With the research questions in mind, we returned to the original texts to interpret the lived experiences in a broader context. Finally, we re-contextualized the different findings by formulating a comprehensive understanding of the meaning of the studied phenomenon, to which all data are related.

Field notes from the non-participant observations describing the events were made directly, and organized in the following pattern: observational, theoretical and personal notes (Taylor & Bogdan, 1998). In the observational notes, efforts were made to be as descriptive as possible. Directly after the event, the observational notes were ordered and systematized. In the theoretical and personal notes, the task was to be as reflexive as possible. This assumed a balance between nearness and distance in the whole process. In the end, the texts from the different notes were interpreted hermeneutically on three levels, inspired by Lindseth and Norberg (2004). In the structural analysis, a meaning unit was defined as a piece of text that conveyed just one meaning. This could be part of a sentence or a paragraph. By this analysis of the empirical data, in the end five themes were constructed: the scene, the actors, the activities, the objects in use, and the time spent.

The political-administrative documents were analysed inspired by a three-step critical discursive analysis approach presented by Fairclough (1992). From a hermeneutic point of view of how to understand what a text means (Ricoeur, 1976), this approach allows for entering the hermeneutic circle, as part of creating meaning and a deeper

understanding of language in use, that is, how text and context interact and thus convey meaning. The texts were carefully read, re-read and reflected upon. Attention was given to an overall understanding of the text. Then, content and patterns were identified by creating meaning units. The meaning units were condensed and organized according to their similarities, differences or variation. However, discourse analysts of this tradition are also concerned with examining the consequences of the use of discourse(s) at a macro level. Therefore, the third step involved a progression from the intuitive interpretation of the discourse practice and the description of the text, to an interpretation of both these in the light of the social practice in which the discourse is embedded (Fairclough, 1992).

Ethics

This study was carried out in line with the principles of the National Committee for Research Ethics in the Social Sciences and the Humanities (National Committees for Research Ethics in Norway, 2007). When carrying out non-participant observation, the researcher’s role could be challenged. As a professional nurse, the first author had to be prepared to intervene directly to save life if necessary. However, in each situation either the ambulance personnel or other persons were already engaged in helping the person in question. The part of the study that included lived experiences identified in the interviews had been approved by the Regional Committee for Medical Research Ethics (Dnr 03143). The committee did not deal with an application for collecting written accounts. As long as this was

carried out anonymously, the committee had no objections (e-mail 7 April 2006).

Findings

The main theme, *bridging the gaps*, was formulated as a comprehensive understanding of the complexity in experiencing and preventing life-threatening heroin overdose in men in Oslo. We found that this complexity was embedded in experiences of isolation. This isolation had consequences for how life-threatening overdose and its prevention were managed, comprehended and motivated when trying to bridge the gaps between barriers to treatment, interaction and motivation. The themes, “being rescued”, “longing for communion”, and “being in confusion” described the forms of isolation in experiencing life-threatening heroin overdose, both as lived experience and in providing services in the context of changes in the Norwegian health care system. The theme of bridging the gaps also relates to the regional health authority’s and municipality’s lack of ability to facilitate structural support for professionals in a goal-oriented organization. Table I illustrates how the comprehensive understanding is supported by the themes, sub-themes and units of meaning.

Naive reading

The process of interpretation started with repeated readings of the different texts. This made it possible to obtain an intuitive sense of the meaning of the texts as a whole. The preliminary understanding involved a sense of isolation.

Table I. Examples from the structural analysis.

Unit of meaning	Condensation (sub-theme)	Theme	Main theme
“I was driven to the emergency clinic, and then to the psychiatric unit. I admitted voluntarily . . . realized that I needed help.”	Aiding a young man experiencing life-threatening overdose concerns <i>identification and recognition of needs</i> .	Being rescued.	Bridging the gaps.
“They asked me how much I was supposed to inject. . . I did not tell them about being abstinent for nine days. I overdosed. . . Luckily, I was invited to stay . . . to recover and talk about what had happened.”	Being open about one’s intentions when injecting in the injecting room concerns the <i>relationship to professionals</i> .	Longing for communion.	
“I was very upset when he was gone. It was the first time I tried to take an overdose. . . I was rescued . . . and taken to the psychiatric hospital, still having . . . intentions to make another try . . .”	A young man using illicit drug, loosing his father, concerns <i>an insecure future</i> .	Being confused.	
“We have to wait, because the out-reach service has other tasks.” . . . “Last year we were contacted in 25 per cent of the cases. We mean that is not good enough.”	Aiding individuals with life-threatening overdose, when governed by different laws and organized at different levels, concerns <i>understanding one’s tasks differently</i> .	Being confused.	

The narratives revealed that the men experienced social isolation in a number of ways over time. They perceived themselves as not being seen and confirmed as individuals. This neglect led to the use of drugs, initially helping them to feel less socially isolated. However, the deteriorating process of addiction over years seemed to lead to a state where they were not able to, or not given the opportunity to, communicate their needs and wants to professionals. This made them feel alone or abandoned. Other types of social isolation included being left out of society, for example, because of homelessness or lack of material resources. They also had symptoms of abstinence. Hunting for the next injection several times a day increased their social isolation, since they could not give priority to relationships. The escalation of social isolation led them to contemplate alternatives to their current situation. Taking an overdose was sometimes seen as a way to end their life.

The transcribed texts from the focus group discussions revealed other forms of isolation. Professionals had different understandings about their tasks in preventing life-threatening overdose. The paramedics described the importance of securing and maintaining vital functions, whereas the social workers emphasized the process of behavioural change in the individual. They were frustrated about not being provided with political goals, guidelines or routines for planned cooperation between different levels and agencies. This gave them a sense of practical and theoretical isolation. One example was how to deal with the legal question of personal autonomy. For example, a person could be rescued from several life-threatening overdoses by the emergency service, but the social service, which is legally in charge, and governed by different legislation, was not informed. Another kind of isolation described by the professionals was caused by focusing mostly on the individual, and not on the group or society that the individual belonged to.

The political documents seemed to reflect a social practice of individualism with regard to the perspective on the problems of drug abuse in people with a long career of addiction. The Oslo City Council (2005) repeatedly stated that people are responsible for their own lives and their choices, indicating that the answers to these problems are to be found within the individual. This document described several important areas regarding services for persons living with substance abuse. However, life-threatening overdoses and their prevention were not specifically mentioned.

The field notes described social isolation in the form of injecting alone, but in public places with other people watching at least some part of the event. Rescuing someone from a life-threatening

overdose was described as involving several actors, in different types of isolated interventions. The description revealed that medical or social follow-up in public places mostly lasted less than fifteen minutes, giving the impression of difficulties in identifying and recognizing needs and wants.

Structural analysis

In the initial part of the structural analysis, the identified meaning units of the narratives, the focus group discussions, the field notes and the documents were condensed into 20 sub-themes. Eleven of them, for example, "identification and recognition of needs", "the preventive content of one's position", and "cooperation between services", referred mainly to the domain of how the initial treatment of life-threatening overdose was experienced and managed. Four of them, "relationship to one's peers", "relationship to professionals", "the autonomy of the person", and "patients legal rights" focused on how the relationship between the person in need of help and the professionals was comprehended. The last five, "feelings and thoughts", "an insecure future", "understanding one's task differently", "lack of goals" and "will-power to act", concerned the motivation for acting out a life-threatening overdose or to engage in preventive follow-up by professionals.

Meaning was constructed across the above sub-themes, and condensed into three themes, involving the meaning of (a) being rescued; (b) longing for communion; and (c) being confused. The findings are presented according to the meanings assigned to the sub-themes by the researchers, and are thus interpretive filters through which subjective experience is conveyed. We have chosen the most relevant quotes to explain the themes.

The meaning of being rescued

The constructed meaning of being rescued concerned the domain of experiencing and managing the practice of care and treatment related to a life-threatening overdose. Lack of medical assessment embedded an experience of social isolation when being left behind. Only three of the eight persons in the sample reported that they were actually taken to the emergency unit or that their mental health status had been assessed: "I was driven to the emergency clinic, and then to the psychiatric unit. I was admitted voluntarily, and I realized that I needed help." One person was referred from the emergency unit to a detoxification unit: "I was there for about a week. My nerves were in shreds". Another one reported that he wanted medical assessment, but did not get it for unknown reasons. However,

individuals who had experienced such events were generally satisfied with the services they had received from the paramedics and out-reach service. Only one of the eight men was taken away by the ambulance. The paramedics seemed to regard their work as complete when the individual's vital functions were stable, with no regard to sex, age or other individual aspects: "The main thing we focus on is to ensure that the patient is breathing" (Focus Group 2). Thus, there was a risk that those who wanted and needed professional follow-up did not receive it.

The Norwegian Board of Health Supervision (2006a), examined the chain of events from when the emergency service is informed that a person is unconscious due to use of alcohol, illicit or prescribed drugs has been observed until the pre-hospital service has dealt with the event. It was found that the emergency service did not always follow the guidelines in the Index (the professional protocol). For several emergency events (10 out of 60), including some in Oslo, the emergency service headquarters did not collect adequate information about the individual's vital functions, nor did they follow up what happened to the person when they were referred to another service. This may indicate a social practice of discrimination against people suffering from addiction. Alternatively, people intoxicated with illicit drugs who were in need of a hospital check-up after being rescued, but who did not want to be taken by ambulance to the hospital, also seemed to present a specific problem, addressed in Focus Group 2: "The police have to be involved if they are not capable of taking care of themselves and if they resist us. We cannot use force".

Another problem in relation to being rescued was addressed in Focus Group 1. Psychological stress in vulnerable individuals, created by repeated action from the police directed at people using drugs, led to isolation and existential thoughts:

People are spread over the whole town and they buy anything, and then they take a dose that they can't tolerate. So there are many people who have an unintended overdose now. But we have also seen that some of them are really desperate, and say 'I can't take any more' and 'Will you let me just die here with you?'

Another kind of stress was also reported in the narratives. This was the social isolation felt when the individual was in a hurry and had to buy heroin from someone other than the usual person. In such situations they could not be sure about the purity, and thus the effects, of the drug. Therefore, the dispersal of the open drug scene, arranged by the police as part of the multi-centre project, and aimed

at preventing overdose deaths, may have had negative effects on care and treatment.

The meaning of longing for communion

The constructed meaning of longing for communion related to how individuals and professionals comprehended their social relationships, and how those relationships affected their experience of life-threatening overdose or the way they dealt with it. Some factors of relevance are the preventive measures that are carried out by the men themselves when buying and injecting drugs, and their knowledge and skills of lifesaving if respiration becomes depressed in their peers. From the narratives we cannot say whether injecting with others is a preferred preventive practice, but the relationship to professionals, for example in the injecting room, served as a safer alternative to injecting alone. However, the safety this room gave led one participant to inject too high a dose after being released from jail and tolerating less heroin:

They asked me how much I was supposed to inject. I told them less than I had intended, and I did not tell them about being abstinent for nine days. I overdosed, but was rescued. I felt very embarrassed afterwards. Luckily, I was invited to stay in the injecting room to recover and talk about what had happened.

The way in which services related to life-threatening overdose could create discrepancies between the event and the person's expectations or needs:

"I wanted the paramedics to take me to a place, but they were in such a hurry that I didn't manage to ask them for more help. I needed help. I had bad toothache and abscesses".

Deteriorating health, confusion about the future, and whether to engage in medication-assisted rehabilitation or not, seemed to affect their relationship to themselves and to others, sometimes also embedded in prospective life-threatening overdoses originating from self-medication or existential conflicts.

The observations of life-threatening overdose in public places revealed different types of relationships. In one type the ordinary public intervened and assisted in getting the person on his feet. In another type, the paramedics intervened medically. The person left the scene afterwards, and only one of eight persons was taken away by ambulance. The last type involved the ambulance service, other out-reach services and/or the police. One focus group

member described the many different actors at the scene (Focus Group 1):

First of all there are the paramedics, then there is the public. The people in the street can be anyone. Often they or the drug addict ring the social centre, the out-reach service, or the low-threshold house. There are very many people involved, if you think about them all.

However, the official report of countrywide supervisions of health and social services for persons using drugs, also including some districts in Oslo, revealed problems with provision of services that fulfil the requirements laid down in the legislation (Norwegian Board of Health Supervision, 2005). A social worker in Focus Group 1 illustrated how relational problems might affect the provision and quality of services, even though many agencies are involved:

We are all sitting in our own corners, and doing our own jobs, and have our duty of confidentiality and things that mean that we don't manage to cooperate with each other.

The many actors involved in cases of life-threatening overdose seemed to operate very quickly and in isolation. The relationship between them is further impaired by legal barriers to what sort of information could be communicated between the services, at least without the permission of the person, possibly reinforcing a social practice of individualism and personal autonomy. In situations assessed as life-threatening, some professionals tried to overcome ethical dilemmas in the prevention of such events, as reported in Focus Group 1:

We first ask the drug addict if it is OK (to send a report of concern to the social service), and if they don't want us to, we say: OK, but we have to, because we are so concerned about you now that we have to do it, even if you won't allow us to.

As a person might be rescued from several life-threatening overdoses during a short period of time, without the knowledge of those legally in charge of preventing such events, the lack of coordination between different levels also seemed to place professionals in ethical dilemmas, as illustrated in Focus Group 2:

We have no written procedures for getting consent, or for informing other bodies. We inform the out-reach service, so that they can come out and take care of them. Then we can make the ambulance available for the next out-call.

The meaning of being confused

The constructed meaning of being confused concerned how different experiences of isolation provided the motivation for life-threatening overdose, or its prevention by professionals. For one of the participants, his experience of confusion after his parents' divorce, followed by his father's premature death, had serious consequences for his actions:

I was very upset when he was gone. It was the first time I tried to take an overdose, I was quite a long way down then, didn't manage to seek help, didn't manage to talk about it. I was rescued by the ambulance, and taken to the psychiatric hospital, still with serious intentions to try again as soon as possible.

In his state of grief, acting out intoxicating himself seemed to motivate a short-term solution of self-medication. In the context of local cultural ideals of masculinity, that is independency and control, his inability to express his psychological needs was so overwhelming that he saw suicide as a solution. The point of his planned suicidal behaviour was to reduce his unmanageable feelings and to adjust to his social realities.

The isolation and confusion experienced in men with heroin abuse and severe health problems seemed to increase the motivation for life-threatening overdose. However, the focus group discussions gave the impression that the physical condition in this group was better. "Feltpleien" is a low threshold, nurse-based service, with mental health nurses and an injecting-room. Men injecting heroin in this facility seemed to be motivated to have safer injection practice and had fewer sores and abscesses. Staff working in the injecting room reported that preventive information seemed to have been understood by the target population: "There has been a change in attitudes, sometimes they even divide the dose" (Focus Group 1). These last words are of special interest, as an important reason for establishing harm reduction facilities was to motivate people to have safer practice (smaller doses and not injecting alone). During the non-participant observations, one woman washed her hands with water from a small paper cup before injecting, expressing a safer practice with regard to the risk of infections and abscesses.

Paramedics reported confusion in mobilizing the out-reach social service to follow up and prevent life-threatening overdoses:

"Far too often we don't manage to get the out-reach service to come when we need it. We have to wait, because the out-reach service has other

tasks, and they assess this as less important” (Focus Group 2).

On the other hand, the Norwegian Board of Health Supervision (2006a) stated that Oslo emergency service headquarters routinely notified the out-reach social service in the case of heroin overdose, but that they did not check whether the out-reach service had actually followed up the case. There seemed to be confusion in agencies at different levels, possibly also affecting the motivation in people in need of medical care if left behind, as the routines of Oslo emergency service headquarters could not be verified by the out-reach service (Focus Group 1):

We should always be contacted when the emergency services are called out to an overdose, and last year we were contacted in 25 per cent of cases. We mean that this is not good enough. What we see, as we still get some reports, is that drug addicts want to talk to us.

In the policy document of the Oslo City Council (2005), which reflects both the Council’s experiences of the structural changes from 2004, and its assessment of the challenges created by this new situation, several important areas were highlighted regarding services for persons with substance abuse. However, this political document lacks descriptions and discussion of the problems associated with life-threatening overdose that Oslo still faces. Furthermore, life-threatening overdose is not mentioned in any other recent and relevant political documents in Oslo, leaving professionals with confusion about the direction of their work. The risk of less motivation in professionals and of poor quality in services seems greater when goals, guidelines and routines are lacking, indicated by a social worker in Focus Group 1: “We have no system for our work with preventing overdoses”.

Comprehensive understanding

The naïve reading and structural analysis revealed experiences of isolation, both among the men who inject heroin in Oslo and among the professionals who provide services for them and who have the task of preventing life-threatening overdoses. This area is characterized by complex relationships, both within the groups involved and between the groups. The complex relationships concern the men and the context in which they live, the men and the professionals who provide care, the different treatment services, the professionals and the administrative

and political levels, and the different treatment services and the administrative and political levels.

A comprehensive understanding of the complexity in experiencing and preventing life-threatening heroin overdoses in men in Oslo indicated that the meaning of these social phenomena could be understood as bridging the gaps between barriers to treatment, interaction and motivation.

Men with psychosocial problems, that is feelings of being isolated, homelessness or lack of material resources, uncontrolled heroin abuse and suicidal behaviour may hide behind a silent mask. Individuals who are at risk of taking a life-threatening overdose do not necessarily express a wish for medical or psychosocial follow-up when they are in a state of crisis. Thus, a serious barrier to treatment for these men is lack of sensitivity in the professionals and continuity of care. Services must be provided appropriately and in cooperation with each other, as part of a continuum of care that meets the different needs of the individual. Since these services are provided in accordance with different laws, and are run by different agencies, ensuring that each individual receives a continuum of care that includes appropriate, individually adapted services presents a challenge. Developing individual plans and facilitating open referral to health and social services in times of crisis could help to bridge the gaps in continuity of care.

A barrier to appropriate interaction between the men and the professionals seems to be a different perception of the reality in which the men live. To men injecting heroin in Oslo, life-threatening overdoses are experienced as a communicative activity and a process of meaning-making in a very difficult life-situation. A holistic and phenomenological attitude towards the individual’s lived experiences is necessary. To bridge the gap between the understanding of reality of the men and the professionals, the professionals need to have an open attitude. They must not act as experts about the individuals’ experiences, but they must maintain an explorative stance.

Regarding motivation, men living with injecting heroin perceived their former and current life as isolated and stressful, creating barriers of ambivalence about the future. A sensitive approach in every encounter may bridge motivational gaps in the men. Professionals perceived their efforts as fragmented, and not as part of a coordinated effort. Barriers such as lack of support and being without political goals and guidelines may directly affect their motivation for facilitating a sensitive approach and providing continuity of care. The professionals seemed to be motivated to bridge the gap between state-run emergency health services and medical and psycho-

social follow-up by the municipality. However, in the present situation, this seems to depend on the single professional.

Discussion

This aim of this study was to illuminate and interpret the experiences of professionals and men living with life-threatening heroin overdoses in Oslo. Bridging the gaps was formulated as a comprehensive understanding of the complexity in experiencing and preventing life-threatening heroin overdose in men in Oslo. We found that this complexity was embedded in experiences of isolation. This isolation had consequences for how life-threatening overdose and its prevention were managed, comprehended and motivated when trying to bridge the gaps between barriers to treatment, interaction and motivation.

Health promotion is the process of enabling people to improve and increase control over their health and facilitating the empowerment of individuals and groups aimed at increasing their ability to alter life conditions (World Health Organisation, 1986). From a health promotion perspective, people who use drugs need to break free from isolation and play an active role in the formulation of policies and practices. We did not find that men injecting heroin or their relatives had been invited to take part in this process. By listening to the needs and wants of those affected, and by having a cultural and gender-sensitive understanding, factors that are important for bridging the gaps in health and social services can be identified (Anker et al., 2006). Additional factors, such as stigmatization and marginalization, and intervention by the police to disperse the open drug scene, seem to have led to a high level of psychological stress. This can make men injecting heroin even more vulnerable, as such stress can lead to a greater risk as part of one's coping with addiction (Wiklund, Lindström & Lindholm, 2006).

Somewhat contradictory to the egalitarian ideology of contemporary Norwegian legislation, free, low-threshold health care services have been developed in Oslo for people using illicit drugs. This service can be seen as a means to ensure individual needs of care and treatment and reinforce equity in health (World Health Organisation, 1998). Despite the lack of political goals and guidelines for preventing life-threatening overdoses, there seems to be ideological and professional capacity in Oslo to bridge the gap between state-run emergency health care and medical and psychosocial follow-up by the municipality. However, ensuring a chain of coordinated measures between state and municipal services requires a firm politically led process to

coordinate legislation. This is necessary, because different acts regulate confidentiality and sharing of information between health and social services.

All the documents analysed in this study, and especially one of the reports from the Norwegian Board of Health Supervision (2006b), stressed the importance of bridging the gaps in treatment by better coordination and cooperation. A person who has long-lasting, complex social and health problems has a statutory right to an individual plan for his care and treatment. Different services are required to cooperate with the plan and to coordinate their efforts, also in the prevention of life-threatening overdose in vulnerable subjects. This study does not verify that this is being done.

External factors that can cause suicide-related stress in men are realities like lack of education, unemployment and low income (Qin, Agerbo & Mortensen, 2003). According to the local norms of masculinity, such phenomena could explain male vulnerability to suicidal behaviour when gender-based social expectations cannot be fulfilled. Risk taking may then function as a signifier of masculinity (Möller-Leimkühler, 2003). Life-threatening overdose may be assessed by the individual as a rational solution to get relief from a reality of isolation, or to communicate problems with relationship to society (Durkheim, 1897/2001; Biong & Ravndal, 2009). A stressful life of addiction might be coped with through heavier drug use and suicidal behaviour, since feelings of being defeated and enclosed in a trap may arise (Williams, 2001). The person may also believe that there is little likelihood that he will be rescued from the trap. However, some additional services were requested by the youngest and oldest participant of this study (23 and 55 years old). They described their sense of isolation and need for help more than the others, indicating a potential effect of age and drug career on life-threatening overdose (Landheim, Bakken & Vaglum, 2006; Ødegård, Amundsen & Kielland, 2007). Medication-assisted rehabilitation, medical treatment for serious physical problems, and access to prompt psychosocial care were addressed. This could indicate inadequate availability of bridging the gaps between realities by insensitivity in professionals, or lack of cooperation between different services.

Professionals seemed to have an unclear understanding of their own tasks and the tasks of other professions. Special attention needs to be paid to the reality that a person could be rescued from several life-threatening overdoses during a short period of time, without the social services or the regular general practitioner being informed. Furthermore, with regard to preventing suicide, Skogman (2006) highlighted the importance of meeting basic physical

needs, such as regular eating and sleeping, as a means of preventing a vulnerable person entering an acute suicidal state of mind. This highlights the need for a phenomenological sensitivity in professionals, also toward the person's language in use (Biong, Karlsson & Svensson, 2008).

Sorjonen (2003), who has studied Swedish students' attitudes to suicidal behaviour, provocatively suggests that some suicides might be viewed as more acceptable than others because the person is judged to have less social value. The thesis concludes that suicide may be more accepted by Swedish students if the victim has low socio-economic status. Even though the results may not be generalized to Oslo, they give a glimpse of some attitudes that conflict with the normative legal discourse and ideals in a Nordic welfare country. However, seen in combination with the conclusions from supervision referred to in this study, and to the very short period of follow-up observed in public places, one might speculate that there may also be hidden, unconscious, negative attitudes in the political, administrative, social or health care systems to people using illicit drugs, whose lifestyle may be said to challenge the morality of the majority. Paphassarang, Philavong, Boupa and Blas (2002) claim that perceived negative attitudes are likely to have a larger impact on individuals who have lower social status than on people with higher status. Negative attitudes may not only make the encounter with social and health systems an unpleasant experience, they may also add to motivational barriers, which in turn may prevent vulnerable people in need from benefiting from general or specialized services. To overcome possible barriers of ambivalence about the future in vulnerable individual, the attitudes of professionals and society in general might be of great importance.

Methodological aspects

This study has some obvious limitations. The samples of individuals who gave biographical accounts and participants in the focus group discussions were biased, as both groups depended on a purposeful sampling. The way that some of the biographical accounts were collected presents a methodological problem, as the subjects' ability to give an authentic voice to their lived experience can be questioned and were written down by staff. The results of this case study cannot be generalized to all young men who inject heroin. The findings should be seen as applicable to a unique situation in a specific context, not establishing truth, but verisimilitude (Bruner, 1986). The design aimed primarily at providing practitioners with a deeper understanding, useful information and insight of a contempor-

ary social phenomenon. For them, this study highlights the necessity of developing a holistic approach to the isolated individual and his needs, and to overcome structural barriers. For decision-makers the study points to the importance of explicitly focusing on life-threatening overdose to reach the public health goal of preventing premature deaths. This study may inspire researchers internationally to investigate a local contemporary phenomenon within its real-life context and from different angles, as the method is suitable when the boundaries between the phenomenon and the context are not clearly evident.

Implications of the study

By law the Norwegian municipalities are responsible for preventing life-threatening overdose. However, there are no explicit political goals or professional guidelines in Oslo to prevent such events. From a health promotion perspective, a recommendation for addressing this problem is to establish a politically led reference group with members from different parts and levels of the system, including members of organizations for drug users and their relatives. The function of this group would be to address, discuss and try to solve legal, structural and professional barriers, and to monitor the establishment and implementation of political goals over time. Measures to prevent life-threatening overdoses in Oslo need to be developed and evaluated.

Conclusions

The constructed meaning of life-threatening heroin overdoses in men in Oslo was interpreted as bridging the gaps between barriers to treatment, interaction and motivation. This living was composed of social isolation. In a state of crisis, individuals do not necessarily express a wish for medical or psychosocial follow-up, so health and social professionals, therefore, must adopt a sensitive approach in every encounter. If hiding behind a still face, medical or psychosocial follow-up are specifically indicated, and the person should not be left behind. For health and social professionals in Oslo, the constructed meaning of preventing life-threatening heroin overdoses was also experiences of isolation. This isolation creates confusion. Bridging the gaps between barriers to treatment, interaction and motivation by reviewing relevant laws, establishing structures for cooperation and facilitating a common understanding of the tasks of preventing life-threatening overdose might ease this confusion. Social workers find the lack of goals and professional guidelines for cooperation most frustrating, while paramedics seem

to be more satisfied, as their life-saving task is clearer. Both parts addressed the need for better practice.

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