Feasibility Study on 'Supervised Drug Consumption' Options in the City of Victoria

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A. EXECUTIVE SUMMARY

1. Introduction

As a result of increased concerns over the prevalence and harmful consequences of drug use in Victoria and the measures concretely proposed in the Victoria Urban Development Agreement, the City of Victoria has initiated considerations towards the establishment of Supervised Consumption Site (SCS) options for high-risk drug users. In order to facilitate the development of a possible SCS initiative in an evidence-based and locally needs-responsive way, this feasibility study was commissioned by the Vancouver Island Health Authority (VIHA) and the City of Victoria, and conducted between June and December 2006. The two core components included: 1) a literature review of the socio-legal contexts, design and operations, and impacts of existing SCS models elsewhere (e.g., in Canada, Australia and Western Europe); and 2) a survey of local key stakeholders' perceptions, views and attitudes with regard to the nature and consequences of drug use in Victoria, existing services and service needs for drug users, and the design, operations and services of possible SCS options. The study is complemented by a brief background review of key characteristics and consequences of street drug use as well as the socio-political context of an SCS initiative in Victoria. The study is concluded by a set of recommendations on the basis of the findings from its various components. This study was jointly funded by VIHA and the City of Victoria, and was conducted by the Centre for Addictions Research of British Columbia, University of Victoria (Principal Investigator: Dr. Benedikt Fischer).

2. Component 1: Literature Review

The review of SCS programs, practices and experiences in Australia, Europe and North America was conducted on the basis of existing peer-reviewed and grey literature published in English and German (available up to the end of 2006); more than 60 studies were consulted. SCS facilities were first established in the 1980s and some 70 or more facilities currently exist in several European countries in addition to the (ongoing) research pilot projects in Sydney, Australia, and Vancouver, Canada.

Many SCS programs originally began as initiatives in violation of existing drug control laws, yet several countries have now adjusted their respective legal frameworks or regulations, or provided for legal exemptions, to have SCS programs operate on a legally sanctioned or more secure basis. Most SCS initiatives are publicly funded or at least supported by public funds, and are typically operated by local service providers; in some instances, regional or local health authorities themselves run the facilities. SCS programs' main objectives are to reduce harms and risks (e.g., overdose, infectious disease transmission, equipment sharing) to drug users' health, to function as a contact and referral point for marginalized drug users, as well as to reduce drug-related public order problems.

Existing SCS programs share many common core operational elements, yet also differ greatly in terms of many aspects of design, operations and services provided. While facilities like the Sydney or Vancouver SCS have a mainly 'medicalized' design and focus principally on actual drug consumption, many of the European facilities are designed more broadly as social and health services or 'contact centres' in which supervised drug consumption constitutes one among many interventions provided. Other services typically included are basic health care, needle exchange, shelter/housing, laundry facilities, food distribution, meeting points, peer groups, as well as addiction, health and social services referrals, etc. A small number of SCS services are offered in mobile form (e.g., bus or van), although potential downsides of these formats, such as capacity limitations and limited uptake due to the fluctuating nature of the service have been described.

While some SCS facilities exclusively target drug injectors (or even only heroin injectors in select instances), an increasing number of European SCS facilities have – generally successfully – expanded their services to target oral drug users (e.g., heroin and crack smokers). Injector and oral user groups are typically accommodated by separate spaces, partly for practical and health reasons and partly to avoid potential problems stemming from the behavioral differences of different drug cultures (e.g., narcotic versus stimulant users). Great variation exists on other operational practices between SCS programs. Some SCS facilities require intensive registration procedures and limit access to local residents, or have restrictions on the number of drug-use or facility entry episodes, whereas others practice more 'low threshold' approaches with very few restrictions. Some facilities are run only by non-medical staff, whereas others have nurses on staff and/or physicians on site or on call. The majority of SCS programs do not allow assisted injection – yet if permitted, assistance is typically provided by other drug users as opposed to staff – and have a defined code of conduct (including the non-tolerance of violence and drug sharing/selling). Differences also exist with regard to facility design (e.g., 'safety' versus 'comfort' priorities or individualized versus social space designs). Several SCS facilities have come up with proactive measures to maintain public order in the facility's periphery (e.g., facility runners or volunteers responsible for cleaning).

A number of research and evaluation studies – albeit most, aside from the Vancouver and Sydney evaluation studies, in the form of reports rather than peer-reviewed literature – have provided insight on utilization dynamics, outcomes and impacts of SCS programs. For example, a variety of important factors influencing drug users' utilization of SCS facilities have been identified, including distance required to travel to use the facility, types of services offered, perceived safety, hygiene and comfort, as well as entry requirements or restrictions. Most SCS facilities operate at full capacity, and hence are well utilized, although some – decentralized – facilities in Europe have been closed or moved due to limited utilization. It has been shown that those utilizing SCS facilities regularly tend to be more marginalized and higher risk users, often characterized by poor health, public injecting, sharing behaviors and unstable housing. Most SCS users surveyed in different jurisdictions are satisfied with SCS services offered.

In terms of key impacts of SCS programs, research to date has shown that: awareness and practices regarding drug use-related risks (e.g., risky or public injecting), as well as health status, improved among SCS users (although actual reductions in infectious disease transmissions have not been shown); all overdose incidents occurring in SCS facilities to date have been successfully managed on or off site without fatalities and SCS programs are associated with reductions in overdose deaths in several jurisdictions; many SCS users receive referrals for health care and/or addiction treatment, with demonstrated uptake for a substantive proportion of referrals made; several indicators suggest that SCS facilities have generally not led to increases in public order problems or drug-related crime. Whereas some studies even document actual local improvements in these areas, some select reports have described phenomena of increased drug dealing or public disorder around SCS facilities, most of which can likely be attributed to capacity and/or facility management problems. Overall, it is recognized as essential for both public order as well as utilization objectives to actively involve and clearly define the role and stance of police vis-à-vis SCS operations. One cost-effectiveness study (Sydney) suggests that SCS initiatives are a 'cost-neutral' operation, yet with the potential for an improved cost-effectiveness ratio on the basis of more efficient operations.

Public opinion and local stakeholder surveys have generally indicated a picture of mixed to slightly supportive attitudes towards SCS interventions, while the important finding is that such attitudes typically became more supportive over time in areas where SCS programs are implemented and their (positive) effects are experienced. Although certainly not without controversy, existing SCS interventions have been assessed to be

feasible, well-utilized by their user target groups and generally accepted by the public, and largely positive in terms of desirable outcomes and effects. Current challenges for SCS programs and practices exist on several fronts and issues, for example, it is not clear how to best integrate services for stimulant users; how to best balance restrictions and 'low threshold' principles; and how to improve the integration or effective referrals between SCS initiatives and other health and treatment services.

3. Component 2: Stakeholder Survey

The stakeholder survey included a sample of 45 social and health service providers, business, community and tourism representatives, political and government representatives, law enforcement representatives; and 23 drug user informants. Participants were invited to partake in the study by way of a one-on-one interview following a semi-structured interview guide. Service providers helped recruit and facilitate contact with drug user informants who were surveyed in the context of small focus groups. The study was approved by the joint VIHA/University of Victoria Human Research Ethics Board. All study participants provided written informed consent, and were assured data confidentiality and protection of their anonymity.

In terms of findings, many stakeholders observed that the visibility of the drug problem in Victoria had increased in recent years, that it is dispersed throughout the Capital Regional District (CRD), yet also concentrated in several downtown locations (often in the proximity of key service providers), and that it typically consists of poly-drug use involving heroin and cocaine injection as well as – increasingly – oral stimulant use (e.g., crack and methamphetamine), prescription drugs, cannabis and alcohol. Stakeholders recognized drug use-related morbidity (e.g., infectious disease transmission) and mortality (e.g., overdose deaths) as key individual harms, yet also identified preeminent harms to the community, including visible drug use, drug use-related erratic behavior and litter (e.g., discarded needles, water bottles), negative impact on business and tourism, and safety concerns. Stakeholders noted that a variety of drug-related services exist, yet that many either do not match existing needs, are not accessible enough or are limited in terms of capacity. At the same time, critical service gaps for drug users were identified, specifically with regard to detoxification, treatment, housing/shelter, basic social and health care, mental health care, as well as specialized services for distinct groups (e.g., Aboriginal, women, and youth).

Stakeholders expressed strong support for the implementation of an SCS intervention in Victoria as a measure to tackle problems associated with street drug use in Victoria, and that such a step needs to be initiated now, as much talk and little tangible action has occurred to date. Most stakeholders recommended the implementation of a decentralized SCS model – e.g., an initiative with at least two or more locations of which at least one should be located in the downtown core, with others elsewhere in the city and/or in surrounding municipalities – to improve the accessibility and utilization of a possible SCS program, yet also to proactively prevent or diffuse a potential concentration of services and to mitigate against any potential negative community impacts. It was strongly emphasized that a possible SCS program should be closely integrated with or linked to essential social, health and addiction services required by the target population – primarily housing/shelter, detoxification and treatment services – and should therefore follow the model of an integrated care or 'contact centre' rather than being a stand-alone facility strictly focusing on 'drug consumption', in order to ensure the possibility of long-term and sustainable beneficial impacts.

Most stakeholders recommended that possible SCS facilities should be embedded into locally existing community-based addiction or health service providers with an established rapport with the target population (e.g., long-term high risk drug users, sex trade workers, and street-entrenched drug users). Mixed views existed on the utility of a

mobile SCS component. In order to maximize the potential positive impact, many stakeholders underscored the importance of a possible SCS program being implemented based on 'low threshold' principles, namely imposing as few barriers as possible on drug users' ability to access and utilize the facility (other than a code of conduct principally focusing on the safety of users and others). In addition, a strong majority of stakeholders stressed that services should be open 24/7/365 or for a maximum number of needs-based hours (e.g., 10am-4am or 2pm-8am) seven days a week. Prospective SCS facilities were recommended to target all drug users (including non-injectors, e.g., oral crack users), although injectors were emphasized as a priority target due to their particular health risks, but potential reasons were cited for keeping different drug cultures separate. There were mixed views on whether an SCS program should allow for assisted use (e.g., assisted injection), whether to set an age limit, or whether to allow non-drug users to access ancillary services offered at an SCS facility.

Stakeholders mostly agreed that it was essential for a possible SCS facility to maintain order and minimize negative impacts on the surrounding community. In this context, it was viewed that the police would need to be an essential partner in the implementation of an SCS program, yet that their role should be transparently defined, and include: preventing the presence of drug dealers from the immediate site periphery; responding to emergencies occurring at any given facility; implementing a protocol agreement to ensure that SCS users would not get 'busted' on their way to/from any SCS; and actively 'referring' users to SCS services, yet generally keeping a distance from an SCS facility. Finally, most stakeholders agreed that the success of a possible SCS program should be measured primarily by its effects on the health and risk behavior of its users as well as its overall impact on order and safety in the community.

4.   Conclusions and Recommendations

Our conclusions need to be preempted by the observation that the operations and potential impacts of SCS facilities are limited by several key extrinsic factors, and need to be assessed against these parameters. For example, the highly compromised health and social situation, the often intensive criminal involvement, or the high morbidity and mortality profile of street drug users centrally originates in the current legal and social conditions under which illicit drug use takes place, and which SCS initiatives cannot change or remedy. Similarly, SCS programs do not have the mandate or capacity to treat or cure their users' addiction – they can at best function as a linkage point to such interventions, yet also only if these services exist in sufficient capacity and quality. Therefore, SCS are by definition interventions which operate with their 'hands tied' to a large degree, and need to be realistically viewed as such.

According to the limited available empirical indicators, the street drug use population in Victoria – estimated to consist of 1,500 to 2,000 injectors alone – also when compared to data from other Canadian cities is characterized by: predominantly cocaine, heroin and other opioid injection; a substantial number of crack smokers and other non-injection users of stimulants or opioids; a large young injector population; a large share of injections occurring in public spaces or in other locales under potentially unsafe conditions; a relatively high – and likely rising – prevalence of infectious disease (e.g., HIV and HCV); a principal reliance on property or petty crime, sex trade or social assistance as main sources for income generation.

Given these indicators as well as the findings from the different components of this feasibility study, we conclude that an SCS intervention should be implemented in Victoria in a locally needs-tailored way on an experimental basis, and that this be done principally in the interest of improving the health and well-being of drug users, as well as public health and safety of the citizens of Victoria [see specific RECOMMENDATIONS below]. However, one

critical caveat is that in the current political reality and climate in Canada, it can be assumed that the federal government in the near future will not entertain the issuing of any further s.56 exemptions under the *Controlled Drugs and Substances Act (CDSA)* for SCS initiatives. It is thus upon the municipal government of Victoria as well as other key local stakeholders to assess and decide whether they are willing to develop and implement a potential SCS intervention despite these conditions, e.g., in a format or approach that does not rely on a federal exemption.

On the basis of the above evidence, we are forwarding the following specific recommendations:

RECOMMENDATIONS:

1. **That** the City of Victoria, the Vancouver Island Health Authority and other local key stakeholders and partners undertake the necessary steps to move forward on the planning and implementing of a Supervised Consumption Site (SCS) initiative in Victoria with the main objective of improving the health and safety of drug users, as well as that of the community at large.

2. **That** expectations towards what an SCS program in Victoria reasonably could and could not achieve be kept realistic and that these expectations and limitations are actively communicated to the public, institutional stakeholders, politicians, the media and other parties of interest.

3. **That** an SCS initiative be conceptualized as a time-limited pilot project with clearly defined and measurable success indicators, the outcomes of which should be independently and rigorously evaluated as the evidence basis of the decision for the continuation, or respective adjustment, of an SCS initiative.

4. **That** the efforts toward an SCS initiative in Victoria ideally go forward under the umbrella of an s.56 exemption under the *CDSA* obtained from the federal government. However, if such an exemption cannot be obtained, that alternative ways are considered for an SCS initiative in Victoria to go forward outside this umbrella while within socially, ethically and legally defensible parameters.

5. **That** the principal objective of an SCS initiative will be to improve the health and well-being, and reduce mortality and morbidity risks and outcomes, among the target population of high-risk drug users, with public order benefits as an equally recognized yet not overarching or exclusive objective.

6. **That** an SCS initiative in Victoria ideally be implemented in a decentralized fashion – featuring at minimum, one facility in the downtown core, as well as one or two additional facilities in other locales in need (e.g., other areas of Victoria or adjacent municipalities). If, for financial reasons, only one fixed SCS facility was possible, this program should be located in downtown Victoria with an accompanying mobile component to service outlying areas. Decentralized SCS program design options are recommended in order to both maximize the accessibility of SCS services for users, and to minimize a concentration of possible negative consequences related to SCS services as well as prevent service duplication in the downtown core.

7. **That** an SCS program, if implemented, be offered in close integration with a range of core additional health and social services required by the target population of an SCS program, specifically detoxification and treatment referrals, basic health care, shelter and housing, and basic social support.

8. **That** as a requirement for the possible success of an SCS intervention, VIHA, the Province of British Columbia, and other relevant entities, ensure the availability of sufficient addiction treatment services – specifically: detoxification, out-patient and residential treatment services, maintenance programs, mental health and addiction co-morbidity care – in the Greater Victoria area, since an SCS is not equipped to provide such services, yet the tangible and sustainable impact of an SCS intervention crucially hinges on whether these interventions are available. In this regard, the potential of an SCS initiative to produce tangible and sustainable outcomes will likely be severely curtailed given the current context of acute gaps in adequate addiction treatment services in the Victoria area.

9. **That** SCS services be operated by either one or a consortium of existing community-based health care providers in Victoria who have an adequate level of trust and can build on an existing rapport with the target population.

10. **That** the specific parameters of an SCS program – e.g., operations and facility design – are developed in active cooperation with key stakeholders and representatives of the drug user target population.

11. **That** given the documented key characteristics of street drug use in Victoria, SCS services be offered to injection drug users as the core target group, yet also be offered to non-injecting risk groups (e.g., crack smokers and other stimulant or opioid non-injectors). It is advised however that consumption facilities for injectors and oral (stimulant) users are spatially separated for reasons of health and practical considerations.

12. **That** an SCS program is organized as a 'low threshold' service model in order to maximize utilization and minimize potential deterrent factors among the target population (and that these specific details are defined in active consultation with stakeholders and the target population). Among other issues, this 'low threshold' framework should materialize through a user-friendly and accessible location, user-oriented staffing and operations, least possible restrictions on specific substances used, repeat visits or residency requirements, and that entry restrictions (e.g., intoxication, youth, pregnant women) are assessed on a case-by-case basis with consideration as to whether greater harm would ensue as a result of being denied access to an SCS facility.

13. **That** SCS services to be offered are categorically open and accessible seven days a week, 365 days a year, and ideally 24 hours a day; if the latter hours have to be restricted for operational or resource reasons, that the number of hours be kept to a maximum and that these hours are set in accordance with the target population's needs.

14. **That** at the same time, an SCS intervention recognizes the equal importance of safety and order inside and outside the facility, in the interest of the health and safety of its users and staff, as much as that of the larger community. In this regard, it is essential that a 'code of conduct' for users of the facility be established and that clear benchmarks and adequate measures for order and safety are established to minimize negative impact on the community, including regular clean up of drug-related litter outside the periphery of an SCS, as well as adequate efforts to avoid possible excessive congregation of SCS users or drug dealers in the immediate vicinity of an SCS.

15. **That** the role of the police in maintaining accessibility to an SCS, as well as the order and safety in and around an SCS for both users, staff and the community is recognized as crucial. Specifically, the police should be included in the development of SCS options from early planning stages onward, commit to clear and consistent operations with regard to an SCS (including a commitment to abstain from 'busting' users), refer users to SCS services where appropriate (yet not in a coercive fashion, e.g., in exchange for non-arrest) and establish an agreement with SCS operators on how to handle possible user congregations and/or the presence of drug dealers in a clearly demarcated area around an SCS facility.

B.   BACKGROUND

This section of the report provides background information relevant for the consideration of Supervised Consumption Site (SCS) options in the specific context of Victoria, BC – namely, key indicators of drug use, mortality- and morbidity-related harms and risks, and drug-related crime indicators are presented. These data, along with preliminary SCS feasibility data collected as part of the I-Track (Phase 2) study, help describe the needs of the population of drug users likely targeted by a possible SCS initiative, and are therefore useful for informing the implementation and planning of such an initiative. In addition, background information regarding the current political climate relevant for SCS programming is presented, as well as a brief history of the efforts towards the development of SCS options in Victoria.

1.   Key Characteristics of Drug Use in Victoria

There are limited available empirical data (e.g., key characteristics and indicators) describing the nature of street drug use in Victoria, and what does exist focuses almost exclusively on injection drug use. There are an estimated 1,500 to 2,000 injection drug users (IDUs) and an estimated 500 to 800 crystal methamphetamine users in Victoria (City of Victoria, 2004; VIHA, 2006). In 2005, the Victoria Cool Aid Society conducted a homeless count and over half of those surveyed reported using street drugs (Victoria Cool Aid Society, 2005). Victoria was one – among a total of seven Canadian cities – site for the I-Track study, a cross-sectional surveillance survey of risk behaviours and prevalence of Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) among IDUs. Victoria specific data from the I-Track study is available from three time periods, namely, the I-Track (Pilot) (n=150) conducted in 2003, the I-Track (Phase 1) (n=254) in 2003, and the I-Track (Phase 2) (n=250) in 2005 (specified as "I-Track (Pilot)", "I-Track (Phase 1)", and "I-Track (Phase 2)" from here on in) (Health Canada, 2006; VIHA, 2006). Another key source of data is the journal article entitled "Missed Opportunities: Injection Drug Use and HIV/AIDS in Victoria, Canada" and the accompanying monograph which surveyed a (non-representative) local sample of 41 IDUs in Victoria in 2002 (Stajduhar et al., 2004; Stajduhar et al., 2002). These data sources generally suggest that 70-75% of the surveyed Victoria IDU population is male and the majority of IDUs are between the ages of 30 and 49, with the female population being younger on average (VIHA, 2006; Stajduhar et al., 2004). In I-Track (Phase 1), the mean age in the Victoria sample was consistent with the average (36.4 years) across all seven sites (Health Canada, 2006). In both the I-Track (Phase 1) and I-Track (Phase 2) studies, approximately 45% of Victoria IDUs reported being 19 years of age or less the first time they injected drugs, suggesting a sizeable young injector population in Victoria (VIHA, 2006). Stajduhar reported that 67.5% of surveyed IDUs in Victoria had injected before age 20 (Stajduhar et al., 2004). Aboriginals are highly overrepresented among IDUs in Victoria, accounting for 15-20% of the respective study samples, yet less than 3% of the population of Victoria (VIHA, 2006; Stajduhar et al., 2004). However, the proportion of surveyed Aboriginals among IDUs in I-Track (Phase 1) was comparatively low in Victoria, for example, compared to Regina reporting a proportion of 87.2% Aboriginal IDUs (Health Canada, 2006). Overall, with respect to socio-demographic indicators, IDUs surveyed in Victoria by the above studies can be characterized as having low levels of education (approximately half having less than a high school education) and a low prevalence of self-sufficient income, with as many as 45% on social assistance in the past six months and as many as 82.5% deriving their main income through drug dealing, panhandling or squeegeeing, involvement in the sex trade or in other criminal activities (Stajduhar et al., 2004). In Stajduhar's study, over 80% of surveyed IDUs in Victoria had unstable housing in the three months prior to the study (Stajduhar et al., 2004). In I-Track (Phase 1), Victoria had the highest proportion

of IDUs (27.2%) living outside of Victoria in the six months before recruitment across all seven sites (average of 22.3% of IDUs reporting living outside of the city of recruitment). In the same study, Victoria had the third highest proportion of IDUs with unstable housing (53.5%), while the average across all seven sites was 40.0% of IDUs reporting unstable housing at the time of recruitment (Health Canada, 2006). It is estimated that IDUs in Victoria spend on average between $700 and $1,400 per week on drugs (Stajduhar et al., 2004)). Stajduhar's study indicated that 47.5% of surveyed IDUs had been in alcohol or drug treatment in the year before the survey and that almost one quarter had tried to access treatment in this same time frame but were unsuccessful, mainly due to long wait times (Stajduhar et al., 2004).

The I-Track (Phase 1) study revealed that in the month prior to the survey, 36.6% of the Victoria IDU sample had injected daily and 14.6% had injected three or more times per week in the past month. Victoria had the highest proportion of daily injectors across all seven I-Track (Phase 1) sites (average of 26.0% of IDUs reporting daily injection; Health Canada, 2006). In I-Track (Phase 1), Victoria had the highest proportion of IDUs (71.5%) who most commonly injected cocaine in the past month (an average of 41.6% IDUs reported that cocaine was the drug they most commonly injected in the past month across all seven sites; Health Canada, 2006). Stajduhar's study found that in the month before the survey, approximately 75% had injected heroin, 70% had injected cocaine and 20% had injected speedballs (a combination of heroin and cocaine) (Stajduhar et al., 2004). In I-Track (Phase 1) and I-Track (Phase 2), over 90% of IDUs in Victoria reported having injected cocaine in the six months before each survey, followed by 60-70% of participants reporting heroin use by injection in the same period. Hence, these data suggest that these two substances (cocaine and heroin) – or combinations thereof, with their well-documented high-level risks for morbidity and mortality – are the primary drugs of choice among Victoria IDUs. After marijuana and alcohol, cocaine was also the most common non-injection drug used among Victoria IDUs in I-Track (Phase 1) and I-Track (Phase 2) (VIHA, 2006). Furthermore, I-Track (Phase 1) also documented that 61.0% of Victoria IDUs reported smoking crack in the past six months, which was similar to the average across all seven sites. Compared to the average across all seven sites in I-Track (Phase 1), a higher local prevalence for the non-injection use of cocaine (56.2% vs. 63.4%), heroin (15.6% vs. 28.0%) and methamphetamine (18.0% vs. 28.0%) in the past six months was found for Victoria IDUs (Health Canada, 2006).

In I-Track (Phase 1) and I-Track (Phase 2), approximately 30% of IDUs in Victoria reported that the street was where they most often injected in the past six months (VIHA, 2006). In I-Track (Phase 1), about half of IDUs across all seven sites reported having injected in a public space at least once in the past six months, and Victoria had the highest proportion of IDUs who had injected in a public space (67.7%). In addition, in I-Track (Phase 1), Victoria had the highest proportion of IDUs (6.7%) who reported injecting in prison at least once in the past six months, compared to 2.7% of IDUs across all seven sites (Health Canada, 2006). In I-Track (Phase 1), Victoria IDUs were asked about the places where they injected most often in the past six months: 45.3% listed their own home, followed by; the street (29.4%); someone else's home (14.3%); a hotel/shelter/squat (7.3%); other locations such as vehicles or public washrooms (3.7%). The above indicators hence suggest that a disproportionate part of injecting activity among Victoria IDUs occurs in public spaces, which is typically associated with elevated risk behaviors for morbidity and mortality. In I-Track (Phase 2), Victoria IDUs were asked to name the municipality in which they most often injected over the past six months: 89.5% listed Victoria, followed by; Esquimalt (5.0%); Saanich (3.6%); Colwood (1.4%); and Langford (0.5%). I-Track (Phase 2) also asked Victoria IDUs to name the neighbourhoods in Victoria in which they most often injected in the past six months: 57.9% listed downtown, followed by; Fernwood (9.6%); Burnside (9.1%); Hillside-Quadra

(5.1%); North Park (4.6%); Vic West (4.1%); Fairfield (3.6%); James Bay (3.0%); Harris Green (2.0%); Rockland (0.5%); and North Jubilee (0.5%).

2.   Mortality- and Morbidity-related Harms and Risks

In 1999, Greater Victoria was one of five health areas in British Columbia with elevated and statistically significant standardized mortality ratios for drug-related deaths (British Columbia Ministry of Health, 1999). The number of illicit drug-induced deaths in the City of Victoria fluctuated between 1997 and 2004, from 17 deaths in 1997 to a high of 31 in 1999, and decreased to a low of 15 in 2004 (BC Coroners Service, 2005). Since 2000, specific statistics have been kept for illicit drug deaths where methamphetamine was present. There has only been one such recorded death in Victoria in 2004 (BC Coroners Service, 2005). The majority of surveyed Victoria IDUs in the Stajduhar study reported either experiencing a non-fatal overdose, having witnessed an overdose or having had friends die of an overdose (Stajduhar et al., 2004).

In terms of infectious disease, the overall number of newly diagnosed HIV positive cases increased from 26 cases in 2000 to 45 in 2004 in the South Island health service delivery area. In 2004, there were 10 newly diagnosed cases of AIDS and 289 newly diagnosed cases of HCV in the South Island health service delivery area (BCCDC, 2004). In 2004, 50% of newly reported HIV infections and 68% of newly reported HCV infections were among IDUs, hence contributing disproportionately – in comparison to average proportions for Canada – especially to HIV incidence (VIHA, 2006). In I-Track (Phase 1) the infection rate (seroprevalence) of HIV among Victoria IDUs was 15.4%, above the average of 13.2% across all seven sites. The infection rate of HCV among Victoria IDUs was 68.5%, which represented the highest rate of all I-Track (Phase 1) sites (Health Canada, 2006). Between I-Track (Phase 1) and I-Track (Phase 2), the respective sample prevalence of HIV decreased from 15.4% to 12.5% but the prevalence of HCV increased from 68.5% to 73.8%. In both I-Track (Phase 1) and I-Track (Phase 2), close to one quarter of those infected with either HCV or HIV were not aware of their infection status (VIHA, 2006). Among the participants surveyed by Stajduhar, 25% self-identified as HIV+ and 53% self-identified as HCV+ (Stajduhar et al., 2004).

In the Victoria I-Track (Pilot), 30.7% of participants reported having shared a needle or syringe in the past 6 months, and 48.0% shared injection equipment such as cotton, filters, cookers or water (Health Canada, 2004). Between I-Track (Phase 1) and I-Track (Phase 2), reported needle or syringe sharing increased from 36.8% to 41.8% in Victoria; women and IDUs under 30 years old – two IDU groups particularly vulnerable for high-risk behaviors – were more likely to share needles or syringes compared to men or IDUs who were 30 years of age or older. HIV+ respondents in the Victoria sample who reported passing needles decreased from 38.8% to 6.7% between I-Track (Phase 1) and I-Track (Phase 2), but there was an increase in receiving needles, from 15.8% to 27.5%, among respondents who were not infected with HIV. HCV+ respondents who passed needles decreased from 37.7% to 31.8% between I-Track (Phase 1) and I-Track (Phase 2), but there was an increase in receiving needles, from 9.6% to 11.5%, among respondents who were not infected with HCV. Between I-Track (Phase 1) and I-Track (Phase 2), there was an increase from 37.5% to 44.8% of Victoria participants who reported sharing used injection equipment, such as water, filters, cookers and spoons (VIHA, 2006). Stajduhar's study found that approximately 65% of participants reported ever sharing needles; 65% had shared spoons; more than 50% had shared cotton; and more than 60% had shared water. Consistent with the I-Track data, women were more likely to share injection equipment compared to men (Stajduhar et al., 2004). Overall, key injection-related risk behaviors thus appear to be occurring at high levels among Victoria IDUs, with increasing trends for some. I-Track (Phase 1) also examined crack use-related risk factors (e.g., for possible HCV transmission or other infections) among

IDUs in Victoria, and among those who had smoked crack in the past six months, 90.8% had shared pipes; 32.0% had burnt their lips; and 73.4% would like safer crack pipes to be supplied (VIHA, 2006).

3. Drug-related Crime Indicators

Data pertaining to drug-related crime suggest that between 1995 and 2004, the rate of total drug offences (e.g., offences contained in the *Controlled Drugs and Substances Act (CDSA)*) reported by the Victoria Police Department (VPD) increased by 35.4% per 100,000 population. Specifically, the rate of total heroin offences decreased by 9%, while the rate of total cocaine offences increased by 71% and the rate of total cannabis offences increased by 18%. In 2004, the last year for which crime statistics are available, there were 30 heroin-, 347 cocaine-, and 998 cannabis-related offences; for all three drugs, the majority of offences were for possession (Statistics Canada, 2005b). In 2002, the rate of 459 drug-related offences (e.g., property crime, break & enter, petty theft) per 100,000 population in Victoria was the third highest among Canadian Metropolitan Areas (CMAs) (Statistics Canada, 2005a). In 2004, the VPD reported 542 drug trafficking-related charges, representing an increase of 73% from 2003. The increase in trafficking-related offences was attributed to targeted drug enforcement in specific areas, such as North Park, Fernwood and Burnside-Gorge (City of Victoria, 2004).

4. Other Preliminary SCS Feasibility Data

The I-Track (Phase 2) study included specific questions relating to attitudes towards and the feasibility of a safe injection site (SIS) among IDUs in Victoria. The proportion of IDUs indicating that they would use an SIS if it was offered was high, with 72.3% responding "yes" when asked whether they would use an SIS. The respondents who indicated a willingness to use an SIS featured the following key characteristics: approximately 40% had injected daily in the past six months (in fact, high-risk injectors – e.g., higher frequency injectors – were more likely to report that they would use an SIS); 21% had injected at least three times per week in the past six months; 76% had injected in the street in the past six months and over 50% reported that they would use an SIS for 75-100% of their injections. Respondents who reported that they would use an SIS offered the following reasons for doing so: safe environment/avoiding police (99%); access to safe equipment (94%); access to health professionals and trained personnel (91%); prevent or treat overdose (86%); referral services such as detox, treatment and recovery (81%); clean, comfortable and warm (12%); to be away from the public (4%); so not alone when injecting (3%); to get off the street (2%); for public safety (2%). The majority of respondents who indicated they would not use an SIS were of the opinion that they could get clean needles elsewhere and had a place to inject or else did not want to be seen or feared being arrested by the police. The following services that could potentially be offered at an SIS were ranked in order of importance according to respondents who would use an SIS: washrooms; nursing staff; urgent detox beds; food; drug counsellors; showers; social workers; crack pipe distribution. Respondents also indicated which distances they would find acceptable traveling distances to get to an SIS: five blocks or less (28.5%); 10 blocks or less (25.7%); more than one kilometer (22.3%); one kilometer or less (20.1%); one block or less (3.4%). More than half of respondents regarded the following possible SIS criteria as unacceptable and hence to be fundamental barriers to their use of an SIS: local residency requirement; required to show identification; onsite video cameras (Carr et al., 2006).

5. Political Context for SCS Options in Victoria

In order to implement a potential SCS program in Victoria, a respective proposal would have to be approved by Health Canada and granted an exemption under section 56 of the *CDSA* as a pilot research project akin to the ongoing *Insite* project in Vancouver. However, as one likely informal condition for consideration, Victoria's scientific research proposal would have to be different from the research project currently underway in Vancouver in order to provide 'added research value'. When Vancouver applied for its s.56 exemption, it was granted on the condition that a 3-year evaluation (2003-2006) be conducted on its impacts on public injection drug use, publicly discarded needles, HIV risk behaviour, use of treatment and other community services, and drug-related crime rates (Wood et al., 2006a). During this period, the results of this evaluation have been published in numerous peer-reviewed articles, and overall concluded positive impacts in the main areas of evaluation (for a comprehensive summary, see Wood et al., 2006a). Former Vancouver mayor Larry Campbell has been quoted as saying "there is no question that the safe injection site is saving lives." Campbell joined former mayors Mike Harcourt (former NDP premier) and Phillip Owen in signing a letter to Prime Minister Stephen Harper, urging him to "allow *Insite* to continue its work" (Mickleburgh, 2006). Health Canada recommended that the Minister of Health renew *Insite*'s original exemption in the fall of 2006 after having reviewed the evidence regarding public health and public order impacts associated with *Insite*. However, in lieu of extending the exemption, Conservative Health Minister Tony Clement on 1 September 2006, granted a 16-month reprieve allowing *Insite* to operate until 31 December 2007, citing the need for more evidence on the impact of *Insite* as the basis for decision-making on future exemptions. Although Minister Clement suggested that no new exemptions for SCS initiatives would be entertained until the additionally requested evidence regarding *Insite* was assembled, federal research funding of the evaluation was cut (Wood et al., 2006a). Given the principal stance of the current Conservative government, alternative – albeit legal – avenues outside of *CDSA* s.56 exemptions might be available for consideration by jurisdictions if seeking to implement supervised drug use options. In the meantime, recently elected Liberal Party leader and official opposition leader Stéphane Dion has criticized the Conservative government's stance vis-à-vis SCS, stating on 26 January 2007, that he believes *Insite* has been a success and would therefore expand supervised injection sites to other communities if his party was elected into government (Fong, 2007). Depending on the outcome of the next federal election – the timing of which is difficult to predict at this time – the federal political context relevant to the potential facilitation and implementation of an SCS initiative in Victoria may thus be subject to change again.

6. History of the Efforts Towards SCS Options in Victoria

In response to growing concerns about the public health and public order problems related to open drug use, combined with pressure from various parts of the community to implement effective measures related to substance use problems in downtown Victoria, the Downtown Health Initiative Action Plan was launched in January 2003, in collaboration between the City of Victoria, the Vancouver Island Health Authority (VIHA) and the Victoria Police Department (VPD). An 'action plan' was created and listed a number of short- and long-term objectives to address addiction and mental health problems in Victoria. In drafting and implementing the action plan, the principles of Vancouver's Four Pillars Approach (e.g., incorporating measures of prevention, treatment, harm reduction and enforcement) were applied and tailored to the local context, resulting in a unique harm reduction strategy for Victoria, which Victoria City council unanimously endorsed in

April 2004. Victoria's harm reduction strategy emphasizes the areas of treatment, prevention, housing and enforcement, and aims to reduce public drug and alcohol consumption as well as to reduce the spread of communicable diseases, minimize adverse medical events (e.g., overdose deaths), and improve public order related to drug use. Supervised consumption sites were proposed as part of the City's comprehensive continuum of harm reduction services under the rubric of prevention (City of Victoria, 2004). In September 2003, a report from the Downtown Service Providers Group entitled, "Serving the Homeless: Social Agencies in the Red Zone" also identified a lack of addictions treatment and support services, including a safe injection site, as one of the primary issues in downtown Victoria (Downtown Service Providers Group, 2003).

In 2004, the City of Victoria, the Government of Canada and the Province of BC established the Victoria Urban Development Agreement (VUDA) to strengthen collaboration between all levels of government towards addressing urban development issues. In April 2005, the community engagement process associated with VUDA began in order to determine the goals and interests of the community through two focus groups sessions vis-à-vis the plan. The second focus group, comprising of community and neighbourhood associations, identified safe injection sites as a means for improving the social environment in the downtown. In October 2005, action tables were formed as an effort to build consensus around priority strategies and actions to be included in the VUDA.   All six action tables mentioned harm reduction and/or mental health issues related to drug use and one table suggested that based on the positive results evident from the implementation of Victoria's Harm Reduction Model, safe injection sites should be set up in the city (Victoria Urban Development Agreement, 2005).

Between the spring and summer of 2005, the City of Victoria and VIHA sponsored a series of harm reduction information sessions to raise awareness and stimulate community dialogue about the different harm reduction strategies Vancouver, Switzerland and Germany have adopted to reduce drug-related harms at both the individual and community levels, including supervised consumption sites (City of Victoria, 2005). In July 2005, a report entitled "Fitting the Pieces Together: Towards an Integrated Harm Reduction Response to Illicit Intravenous Drug Use in Victoria, BC," prepared for the City of Victoria and funded by Health Canada's Drug Strategy Community Initiatives Fund, identified the development of a research proposal for supervised consumption sites as a service priority need (Health Canada, 2005). In July 2006, the City of Victoria and VIHA commissioned a feasibility study to examine Victoria's drug issues and report on stakeholder attitudes regarding supervised drug use options as one among a variety of possible harm reduction strategies (City of Victoria, 2006).

C.   LITERATURE REVIEW: SUPERVISED CONSUMPTION SITES – AN INTERNATIONAL SUMMARY OF CONCEPTS, PRACTICES AND EXPERIENCES[1]

1.   Introduction

The phenomenon of Supervised Consumption Sites (SCS) has been, for two decades, an increasingly prevalent – yet also controversially debated – element of pragmatic interventions aiming to reduce the harms associated with street drug use in Western countries. Initially limited to a few European jurisdictions, available evidence as of 31 December 2006 reveals that SCS or related proposals now exist in several cities on three continents. While numerous SCS exist, they are rather heterogeneous in their histories, design and operations. In addition, few SCS have been systematically documented, and only a couple – principally the Sydney and Vancouver pilots – have undergone rigorous scientific evaluations. The purpose of this review is not to duplicate research studies or reviews on SCS which exist elsewhere (Broadhead et al., 2002; Fischer et al., 2002; Kimber et al., 2003a; Kimber et al., 2005; Hedrich, 2004; Independent Working Group, 2006). Rather, its purpose is to selectively present and concisely summarize key aspects, characteristics and data pertaining to SCS as it will be relevant to developing and recommending options for a possible SCS intervention in the specific locale of Victoria, Canada.

2.   History and Present Landscape

The idea and practice of SCS first appeared in Western Europe in the late 1980s, in the context of local drug policy measures and interventions gradually shifting away from abstinence and enforcement towards acceptance- or health-oriented initiatives, in the midst of intensifying drug-related public health and order crises described primarily by the rise of overdose deaths, the spread of HIV, and the existence of large open drug scenes, which existing measures were unable to effectively curtail (Fischer et al., 2002). In essence, SCS aim to fill a service gap between enforcement, treatment and targeted interventions like needle exchange programs by providing safe, protected and clean environments in which drug users consume their pre-obtained illicit street drugs in the presence of professional staff, thereby reducing various harms associated with street drug use (Kimber et al., 2003a). However, it should be noted that as early as the 1960s and 1970s, unofficial SCS – usually peer-run or operated by drug care agencies or local churches – already existed in some jurisdictions (e.g., the Netherlands, Sydney and Vancouver) where SCS subsequently received official recognition (MSIC Evaluation Committee, 2003; Kerr et al., 2005). Although unofficial SCS typically had short life-spans as city officials or police were quick to shut them down when nuisance surrounding the facilities became problematic (de Jong & Weber, 1999), they likely paved the way for more institutionalized facilities by highlighting the potential for reducing drug-related harm. Importantly, the SCS reviewed in this document are legally sanctioned and therefore differ from illegal shooting galleries which, in most but not all cases, operate for profit and with little regard for the user's health and safety. SCS are also to be distinguished from the supervised drug consumption associated with medical drug prescription programs where pharmaceutical-grade drugs (e.g., medical heroin prescription) are supplied to the client as part of maintenance treatment (Hedrich, 2004).

SCS have been described under a variety of different labels, including 'safer injection facilities (SIF)' (Fischer et al., 2002; Anoro et al. 2003), 'medically supervised injection centre (MSIC)' (MSIC Evaluation Committee, 2003; van Beek, 2003), 'drug

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[1] The authors acknowledge the helpful comments from Dagmar Hedrich and Thomas Kerr on earlier drafts of this review.

consumption rooms (DCR)' (de Jong & Weber, 1999; Kimber et al., 2005; Independent Working Group, 2006), etc. While these different labels generally refer to the same concept, they are an indication of variations in specific details and philosophical and/or operational emphases. For example, SIF are typically limited to drug injectors, whereas SCS may be designed to allow for other forms (e.g., non-injection) of drug use. Similarly, the label 'supervised' often expresses a stronger emphasis on the supervision rather than the safety aspect of drug-related activities within the intervention (and hence it has been criticized by some clients) (Carrier & Lauzon, 2003; Fischer et al., 2004). For the purpose of this review, the term 'SCS' will be used to refer to the facilities falling under the above-mentioned umbrellas for simplicity's and consistency's sake – without intentionally embarking on any value judgments regarding the label or naming issue – as well as that it likely best encompasses the parameters of potential program options to be considered for the specific context of Victoria.

To the best of our knowledge, there are presently over 70 SCS in operation in approximately 40 cities across Switzerland, the Netherlands, Germany, Spain, Australia, Luxembourg and Norway (Hedrich, 2004; Roberts et al., 2004; Independent Working Group, 2006). Most relevant for Canada is the three-year scientific pilot trial of the *Insite* facility initiated in Vancouver in 2003. The *Insite* pilot project – which formally ended in September 2006 – has been allowed to continue for a 16-month period beyond the initial three-year pilot and will be subject to ongoing evaluation. However, the current federal government has recently rejected Health Canada's recommendation to extend the pilot for an additional three and a half years (Wood et al., 2006a). The fate of *Insite* beyond December 2007 remains unclear at this point. Proposals for the establishment of SCS are currently being considered in other major Canadian (e.g., Toronto) and Australian cities, as well as in Austria, France, Portugal, Ireland, and even New York City. It should also be noted that proposals for SCS have been put forward but rejected in Denmark, the Czech Republic and the United Kingdom (Kimber et al., 2003a; Broadhead et al., 2003; Independent Working Group, 2006; Skretting, 2006).

3. Objectives

SCS have been recognized to combine different sets of key and distinct objectives as well as rationales, which are overall linked to both public health and public order concerns associated with street drug use (Stoever, 2002). Depending on the specific context or rationale, these objectives receive different degrees of prioritization. More specifically, SCS predominantly strive to meet the following objectives: 1) by providing a safe and hygienic environment, SCS aim to reduce the risk behaviors related to, and actual incidence of, mortality and morbidity associated with fatal and non-fatal drug overdoses, blood-borne virus transmission (e.g., HIV or HCV) and bacterial infections; 2) as a contact point, SCS target high-risk, difficult to reach drug-using populations with the aim of increasing their involvement with or referral to social, health and treatment services; 3) SCS seek to reduce drug-related public order problems by reducing public drug use, drug-related litter and nuisance (Fischer et al., 2002; Kimber et al., 2003a). Furthermore, in terms of education, SCS are in a good position to convey health-oriented messages to drug users given the amount of interaction between staff and clients relative to users not reached by any services (Broadhead et al., 2002). By promoting safer use practices, teaching personal hygiene, and identifying risk situations, it is assumed that risk behaviours will be reduced beyond the walls of SCS (Stoever, 2002).

Despite these benevolent objectives, some critics believe that the sanctioning or existence of SCS carry a number of detrimental effects, including: condoning or enabling illicit drug use; facilitating the congregation of users and dealers in the vicinity of SCS, also known as the 'honey-pot' effect; and delaying or preventing entry into drug treatment and/or sustaining addiction (Kimber et al., 2003a).

The extent to which SCS differ in their emphasis on either public health or public order depends in large part on the rationale and stakeholder profiles influencing the implementation process of SCS. For instance, the policies surrounding many SCS in Switzerland, Germany and especially the Netherlands have been centered more strongly on public order in response to concerns among local residents, business owners and police relating to large open drug scenes and the nuisance associated with them (Hedrich, 2004; Independent Working Group, 2006; Skretting, 2006). In this context, it has been pointed out that SCS may at times be utilized as vehicles of 'purification' or 'gentrification' of contested urban spaces, in which street drug users and their activities are seen as disturbing elements (Fischer et al., 2004). Conversely, public health concerns, in particular high rates of overdose deaths, advocated by drug users' interest groups and drug care agencies have been reported to more prominently shape SCS in Canada, Spain, Australia, as well as in Norway (Hedrich, 2004; Independent Working Group, 2006; Skretting, 2006). A further related discourse is that of human rights and dignity for illicit drug users, and the role of SCS in providing basic elements of security, safety and protection from death and disease risks as key elements in recognizing the existence and rights of drug users as citizens (Elliot et al., 2002; Skretting, 2006). Finally, other commentators have suggested that SCS may be construed as a pragmatic way to respond to drug-related harms, but more importantly, should be viewed as a component in a long-term policy reform strategy with the ultimate goal of normalizing, de-stigmatizing and decriminalizing the use of currently illicit drugs (de Jong & Weber, 1999).

4. Legal Context

The implementation of SCS has been contentious not only for ideological reasons, but also with regard to legal issues – specifically the legality of SCS, as well as potential liability implications given that drug possession remains illegal, and that staff could potentially incur criminal or civil liability in the event of injury or death of a client. The International Narcotics Control Board (INCB) – the body of the United Nations that ensures compliance with the international drug control conventions of 1961, 1971 and 1988 to which most Western countries, including Canada, are signatories to – strongly asserts that SCS are in violation of these treaties (Elliott et al., 2002; Independent Working Group, 2006). However, various legal assessments have rejected and rebutted this view, either by suggesting that SCS can be construed as distinct measures (e.g., scientific studies or medical interventions) explicitly permitted by the material statutes of the conventions or by claiming that the conventions were designed under fundamentally different circumstances and hence their spirit does not embrace or apply to the specific rationale (e.g., harm reduction) and practices of SCS (Room, 2003; Independent Working Group, 2006). In light of these legal controversies, various interpretations of the conventions have been adopted and generally, three different legal avenues have been utilized to enable the operation of SCS: 1) administrative agreements; 2) regulatory or ministerial exemptions; and 3) amendments to drug laws (Elliot et al., 2002).

Considering specific national examples, local authorities have tolerated SCS in the Netherlands on a 'de facto' basis for many years and in 1996, SCS received official support through the formation of local administrative agreements (e.g., between municipalities, law enforcement and service providers) – there are, however, no explicit legal provisions. The possession of otherwise illicit substances is permitted in the SCS provided that the facilities suit the local drug policy framework agreed upon by the mayor, police and public prosecutor (de Jong & Weber, 1999). The facility in Madrid, Spain is based on a similar arrangement according to local public health regulations (Hedrich, 2004), however, last available evidence indicates that the facility in Barcelona, Spain does not receive any official support and while there is a supposed agreement with the national police, the local police are known to enforce the law against clients of the facility (Anoro et al., 2003).

In Canada, Australia and Norway, the operation of SCS are restricted to time-limited scientific trial studies in which clients and staff may, under specified conditions, be granted an exemption from criminal liability for possession of illegal substances inside the facilities. In Canada, section 56 of the *Controlled Drugs and Substances Act (CDSA)* provides an exemption if it is the Minister of Health's opinion that the trial is "necessary for a medical or scientific purpose or is otherwise in the public interest," and a similar exemption is found in the New South Wales Drug Summit Legislative Response Act 1999 in Australia (Elliot et al., 2002). In 2004, Norway outlined the trial scheme as a health service under the Drug Injection Rooms Act (Skretting, 2006). Utilizing the 'medical study' provision to comply with international treaties means that exemptions are granted on the condition that the health and social impacts of the SCS are rigorously evaluated (Wood et al., 2004a), but rather than becoming institutionalized as formally recognized and permanent interventions, these facilities may be condemned to operate as 'indefinite scientific experiments' in the absence of clearer legal parameters.

Germany and Switzerland have amended their drug laws or applicable legal regulations so that the legal status of SCS no longer rests in a grey or arbitrary area. The first German facilities were informally tolerated by health and law enforcement authorities through multi-agency agreements provided that the selling and sharing of drugs was prohibited. An in-depth legal assessment by the chief prosecutor's office of the state of Hesse had determined in the mid-1990s that SCS were not in violation of drug control legislation (Hedrich, 2004; Roberts et al., 2004). Subsequent amendments to the Narcotic Control Law in 2000 made the facilities legal under strict conditions, such as the requirement that counselling be provided and that the facilities' effectiveness be evaluated (Fischer et al., 2002). In Switzerland, injection rooms were given the status of medical institutions in 1988 and are therefore authorized so long as medical supervision and medical and social services are provided (Hedrich, 2004).

5. Design, Operations and Services

It is important to recognize that SCS as they currently exist are not uniform or homogeneous entities, yet rather vary considerably with regard to numerous aspects, including: design; target groups, drug use and non-drug use-related services, rules, staffing, etc. These particularities are not merely differences in appearance or packaging of SCS – variations in design and service delivery are critical in terms of the responsiveness or tailoring of SCS to local needs, and are subsequently related to service uptake and effectiveness.

A review of documents describing SCS suggests that most facilities provide the following core services: a drug consumption space (injection and/or inhalation); washroom; café or common room (typically offering beverages and light snacks); drug use, health and treatment information; overdose management; provision of sterile drug use equipment and/or needle exchange; counselling and basic medical care (Broadhead et al., 2002; Poschadel et al., 2002; Anoro et al., 2003; Spreyermann & Willen, 2003; Hedrich, 2004; Independent Working Group, 2006; Skretting, 2006). Facilities that are limited to these services are known as 'pure' or specialized facilities (e.g., Sydney, Australia), in contrast to 'comprehensive' or integrated models that are more common throughout Europe, which in addition to the aforementioned services, typically provide a range of social or health services, including: showers, laundry, clothing pools, day-rest or overnight shelter beds, women's-only hours (some facilities target specific populations only, such as women, sex trade workers or illegal immigrants), case management, addiction treatment (e.g., methadone maintenance), recreational activities, parenting skills, mail service, spiritual care, and odd jobs for small remuneration. The rationale underlying integrated facilities is to provide survival-oriented interventions until drug users are ready to seek treatment, and also the recognition that drug use and other needs

cannot be separated (e.g., health and social care), and interact in determining the drug user's health, safety and well-being (Hedrich, 2004). Both specialized and integrated models actively refer clients to outside agencies for services not available onsite, such as, drug treatment, detoxification and rehabilitation, specialized medical care, social assistance, housing, employment and training, and legal aid (Kimber et al., 2001). Specialized facilities are generally smaller in scale, having fewer clients per day but a steadier flow and less staff (four vs. six) than integrated facilities, which operate out of already existing low-threshold facilities (e.g., needle exchange services or drop-in shelters), making the accessibility to services easier. For example, one of Frankfurt's SCS is integrated within a shelter and three others are in close proximity to the main train station (Hedrich, 2004), while the facility in Luxembourg is integrated into an emergency night shelter, also close to the train station (EDDRA, 2005).

A key distinction concerning the specific drug use services that are available relates to the forms of drug use that are being provided for within a given facility. While the original SCS in Europe were limited to injection facilities, spaces for non-injectors (e.g. heroin or crack smoking) have been increasingly established over the past few years in response to the growing prevalence of non-injection drug use in many European jurisdictions and the recognition that this population is in equally strong need of health and social interventions as their injecting peers. Facilities that accommodate non-injectors are most commonly found in the Netherlands where non-injection is more common among street drug users, and increasingly in Germany and Switzerland, however, non-injecting routes of administration are currently not permitted in SCS in Canada, Australia, Norway and Spain (Hedrich, 2004; Skretting, 2006). The Vancouver *Insite* facility put forward a proposal for an inhalation room, and although the room exists, it is not being used since the exemption was not approved (Haydon & Fischer, 2005).

When examining the non-injection arrangements in European SCS, it is important to recognize that considerable heterogeneity exists within the different drug-using population targets or forms of non-injection drug use permitted within the facilities. While some facilities limit their non-injection modes to heroin smoking ('chasing') or cocaine sniffing, others have extended their services to crack or freebase smoking (Independent Working Group, 2006; Shannon et al., 2006). Despite the recognition that crack smoking is prevalent in many locales and users are in need of health interventions as offered by SCS, many facilities made the decision to not allow for crack use within their facilities. Similarly, even though a growing prevalence of crack use has been acknowledged, a recent proposal to pilot SCS in the UK recommended limiting access to injection users only (Independent Working Group, 2006). The rationale for excluding inhalation is typically based on the following reasons: the perception that interaction between different drug cultures (e.g., stimulant and opioid users) can engender problems (e.g., physical or verbal conflicts and/or feelings of discomfort among different drug use type clients due to clashing behavioural profiles) (Poschadel et al., 2002); and the feasibility of designing a well-ventilated room that allows adequate supervision of drug use while, at the same time, does not pose any health risk to staff. Of course, part of the effort to accommodate these different drug-using populations within SCS has occurred by designing separate consumption spaces for injector and inhaler groups (which are often connected to separate entrances/exits into/from the facility). The documented experiences on these co-existing dynamics are mixed. The Zurich facilities – allowing for both injectors and inhalers – report no clashing among different drug cultures, citing peaceful interactions and strong communication (Spreyermann & Willen, 2003). Although one needs to point out that most 'inhalers' in the Zurich population are heroin smokers who are typically considered to be non-marginalized, healthier and more socially integrated than injectors and hence differ considerably from the crack user profiles found in North America. At the same time, data from drug user samples in Germany suggest that the presence of or

discomfort with crack users may figure as one of the main reasons for potential clients not frequenting SCS (Poschadel et al., 2002).

Hours of operation range from three to 24 hours per day (with Madrid being the only facility to operate 24/7). Most European SCS are only open a few hours during the daytime and typically have reduced hours or are closed on the weekends, whereas the Vancouver facility is open 18 hours a day, seven days a week (Anoro et al., 2003; Hedrich, 2004; Independent Working Group, 2006; BC Centre for Excellence in HIV/AIDS, 2004). Cities with numerous SCS usually stagger their hours to maximize the availability of services. The number of spaces for drug consumption ranges from three to 16 for injection and from three to six for non-injection. A small number of SCS in Europe (e.g., Berlin and Hamburg) are provided in mobile form (e.g., a bus or a van), targeting different areas in the city in which they operate, and typically follow a routine plan (Poschadel et al., 2002; Schu et al., 2005). For example, the mobile operation in Barcelona parked in a designated location everyday for four hours but because of physical constraints (e.g., lack of electricity, refrigeration and adequate water supply) health interventions were compromised and the provision of ancillary services, like showers or vaccines was not possible, and therefore it became necessary to move to a fixed site (Anoro et al., 2003).

Staff is most commonly composed of social workers, followed by nurses. Some SCS have doctors on staff, whereas in others, physicians are 'on call' for emergency situations. Most facilities employ drug and alcohol counsellors as well as ex-user or 'peer' staff, and in some cases, students and volunteers. Specifically related to overdose response, naloxone cannot be administered in many European facilities since clinical staff are not always present, and thus 50-70% of emergencies require calls to an ambulance, whereas Vancouver and Sydney administer naloxone onsite and always have a doctor or nurse present allowing for the majority of emergencies to be dealt with onsite (MSIC Evaluation Committee, 2003; Hedrich, 2004; Vancouver Coastal Health, 2005). For instance, between 1 March 2004 and 30 August 2005, only 28% of the 336 overdoses observed at the Vancouver facility required a transfer to a hospital (Kerr et al., 2006b). In Norway, naloxone is available onsite but it is usually only administered once an ambulance arrives (Langass, 2006). Barcelona has a unique program involving take away doses of naloxone for clients who have completed CPR training (Anoro et al., 2003).

Considerable differences exist with regard to the rules and regulations of SCS under operation. Importantly, entry to SCS is in many instances prohibited for: those under 18 years of age (16 in Switzerland); clients accompanied by children; pregnant women (counselling is provided in Zurich); first time users; intoxicated clients (some facilities make case-by-case assessments); clients in substitution treatment (except in Switzerland, Norway and Hamburg). Germany, Switzerland and the Netherlands require clients to be local residents while Spain, Australia, Canada, Luxembourg and Norway have no residency restrictions (Kimber et al., 2005; Hedrich, 2004).

On the inside of SCS, detailed sets of rules apply, most of which are common to all SCS: no violence; no walking around with an uncapped syringe; no drug dealing; drugs must only be consumed in the designated areas; alcohol and tobacco are prohibited (tobacco smoking is permitted in Swiss facilities, except in the injection room); one injection per visit; no sharing of drugs; clients must wash their hands and clean up after themselves (Kimber et al., 2005; Hedrich, 2004). Only Norway, Switzerland and select German facilities permit assisted injection, but only client-to-client. Staff may provide instruction and have assisted in exceptional cases where the client was blind or an amputee (Hedrich, 2004). Some facilities restrict the type of drug, for instance, Norway only permits the use of heroin and only for one dose to be brought inside the facility (Langass, 2006). Some SCS place restrictions on physical injecting sites (eyes, face, neck, groin, abdomen, chest), however, Germany and Norway have no such restrictions but generally advise against such risky practices. Sydney and most facilities in the

Netherlands do not have time limits, but where a limit is imposed it ranges from 15 to 60 minutes. However, most facilities indicated flexibility on this rule, limiting time based on demand (Hedrich, 2004).

Local variations with respect to services, rules and operational priorities also create differences in terms of the design and overall 'atmosphere' under which SCS operate. For instance, the Sydney Medically Supervised Injection Centre has a more formal, clinical atmosphere to facilitate systematic research and data collection requirements. The design involves a unique one-way traffic flow system (van Beek, 2003), through which staff controls access to the three stages common to most facilities. In the waiting room, clients register and eligibility is assessed. Some facilities have strict queuing systems to control access to the consumption room, whereas informal facilities allow clients to move freely between rooms. Non-injection facilities are typically integrated with injection facilities, yet set-up in a separate room. Injection rooms tend to be more clinically furnished with chairs, stainless steel tables, individual consumption 'stalls' (separated by dividers), disposal bins for used equipment, and mirrors facilitating supervision, whereas smoking rooms are well-ventilated, usually furnished more sociably (e.g., with a large table used by a number of people), and are supervised via CCTV or through a large window. A resuscitation room is usually found within or adjacent to the consumption room to manage overdoses, perform other clinical procedures or seclude problematic or distressed clients. The common room or café is where clients 'chill out' and interact with peers until they are ready to leave. Counsellors are usually present to give advice or make referrals (van Beek, 2003; Hedrich, 2004; Independent Working Group, 2006).

The bodies responsible for operating and funding a given facility are largely determined by the political climate or the amount of support from relevant stakeholders, as well as by the legal basis that enables the facility to operate legitimately. In the Netherlands, where local councils authorize SCS, and in Norway and Canada, where the federal government is charged with this task, the facilities are operated by regional health authorities and funded by local or provincial government (Fischer et al., 2002; Skretting, 2006). Swiss facilities are state-run and funded by local governments and non-governmental organizations (NGOs) (de Jong & Weber, 1999). In Germany, federal states partially fund the SCS and have discretion whether or not to issue an operating license, for example to local NGOs or charitable social service agencies, which then run the facility (Hedrich, 2004). In Australia, the Uniting Church holds an operating license on condition that staff composition and services offered allow the facility to operate as a medical pilot institution. The licensing authorities consist of the New South Wales Health Department, which also funds the facility, and the police (Elliot et al., 2002). Comparing the officially sanctioned facility in Madrid to the unsanctioned facility in Barcelona is illustrative of the challenges of operating SCS without any formal or material endorsements. Madrid's facility has a budget nine times larger than the facility in Barcelona, which must consequently rely on private donations, residual funds and volunteers from the NGO that funds the local social and health care program. As a result of organizational strain, the long-term viability of the facility cannot be assured (Anoro et al., 2003).

6.   User Attitudes and Predictors of Utilization

A series of studies in locales where SCS have been considered have explored the (hypothetical) willingness of street drug users to utilize SCS if offered, and which factors would – positively or negatively – influence the uptake of services offered by SCS.

Feasibility studies in Vancouver have found that among a sample of active injection drug users (IDUs) willingness to use SCS was associated with female gender, public injection, sex trade work, difficulty accessing clean needles, frequent cocaine injection, frequent heroin injection, reusing syringes, and requiring help injecting – in other words, many of the factors describing highly risky and harmful drug use practices (Wood et al.,

2003). In Victoria, willingness among IDUs to use SCS increased with frequency of injection (VIHA, 2006). In Montreal, younger IDUs who inject predominantly in public and older IDUs who inject predominantly in private reported a greater willingness to use SCS than their counterparts. Furthermore, having a history of overdose, knowledge about SCS, belief that using SCS would bring relief and empowerment, and comfort with disclosing IDU status were predictive of willingness to use SCS (Green et al., 2004). In Australia, a high proportion of surveyed IDUs were willing to frequent SCS if located near the place of drug purchase (Fry, 2002). Consistent with Canadian studies, those having experienced more non-fatal overdoses, frequent heroin injectors and public injectors reported the greatest degree of willingness, however, males were more willing to use SCS than females (Fry, 1999). In New York City, knowing someone else who would use SCS, having a favourable attitude towards SCS, daily injection, injection with strangers, sharing equipment, and having no fixed address were positively associated with willingness (Broadhead et al., 2003). Willingness to use a safer smoking facility was associated with recent injection drug use, having equipment confiscated or broken by police, crack bingeing, smoking crack in public, borrowing crack pipes, inhalation of brillo or burns due to rushing (Shannon et al., 2006).

In addition, the following reasons for wanting to use SCS have been cited by surveyed street drug users: for safety reasons; to get off the streets; to get help injecting (Kerr et al., 2003a); to obtain sterile equipment; to consume drugs without having to hurry; to avoid police (Wood et al., 2003); to get treatment and health care referrals; to be in the presence of others; to have a clean, comfortable and warm place (VIHA, 2006); to safely dispose of used equipment; to get assistance in case of overdose (Fry, 1999). IDUs consider the following services to be very important features of SCS: needle exchange; flexible hours; confidentiality; accessibility for all ages; capacity for overdose management; provision of information and referrals; proximity to public transport (Fry, 1999); washrooms; nursing staff; urgent detox beds; and food (VIHA, 2006).

However, there are also several important factors which were perceived as potential barriers to or limiting street drug users' willingness to utilize SCS. In Vancouver, hypothetical willingness to use SCS was negatively associated with the imposition of restrictions concerning drug sharing, assisted injection and client registration. Only one in three were willing to use SCS if all three restrictions were imposed, and only 22% were willing if police were stationed outside the facility (Kerr et al., 2003b). Comparatively, pervasive restrictions also deterred IDUs in Australia, but to a lesser extent since most users surveyed stated that they would still use SCS if required to wash hands prior to injecting, if prohibited from assisting others or injecting pills, and if under close supervision. Just over half would use SCS if prohibited from sharing drugs (Fry, 2002). Reasons cited for expected nonattendance included: infrequent injection and/or desire to be drug free (Kerr et al., 2003a); limited hours of operation; too far away; long waiting times (Wood et al., 2003); preference for injecting at home or at a friend's home; privacy concerns (Fry, 2002); fear of police; preference for injecting alone; preference for injecting with friends; and inconvenience (VIHA, 2006). Most IDUs in Victoria said they were unwilling to travel more than five to ten blocks and found rules requiring local residency, showing identification or onsite video cameras to be unacceptable (VIHA, 2006). The one-injection-per-visit rule was a major barrier to willingness to use SCS among frequent cocaine injectors in Vancouver. Focus groups with this population revealed that attendance could be improved if services were offered 24 hours a day, if staff included ex-IDUs and nurses rather than social workers, and if mirrors inside the consumption room were removed. Women sex trade workers expressed a need for a women's-only site with showers (Kerr et al., 2003a).

7. Service Uptake

      In contrast to survey data on hypothetical attitudes and behaviors, ongoing studies of actual facility operations have allowed to empirically describe the characteristics that are associated with SCS service uptake in the – often starkly heterogeneous – population of street drug users.

      While the gender and ethnic composition of the clientele varies according to location, SCS cater in large part to older (e.g., 30 years +) users, having initiated injection drug use before age 20 and with a history of drug use of at least 10 years. Furthermore, clients of SCS are disproportionately described by characteristics of: public injection; intensive drug use; low education; unstable housing and income (many reporting crime and/or social assistance as main source of income); and a history of injection-related health problems, non-fatal overdose or previous incarceration (Wood et al., 2006d; MSIC Evaluation Committee, 2003; Hedrich, 2004). In the European SCS surveyed, between 15 and 50% of clients have never been in treatment, and it is estimated that 60 to 90% of clients are local residents: however, utilization by non-locals increases where drug markets are highly centralized, for example in Frankfurt and Barcelona, attracting users from large geographical areas (Hedrich, 2004). SCS are successful at attracting high-risk populations – clients in Germany are mostly long-term, daily, high-frequency IDUs, (Zurhold et al., 2003) of which, a disproportionate number are inadequately housed and characterized by poor health status (Schmid & Vogt, 2005). Wood and colleagues have shown that the variables that predicted use of the Vancouver injection facility were the risk factors shown to be associated with elevated risk of HIV, namely, younger daily heroin or cocaine injectors who are homeless or living in unstable housing (Wood et al., 2005a).

      Frequent attendance at Sydney's facility has been associated with being a client of KRC (a local health service targeting IDUs, sex workers and at-risk youth), sex trade work, injection of drugs other than amphetamines, public drug use, and homelessness, whereas needing assisted injection was negatively associated with use of the facility (Kimber et al., 2003b). In Vancouver, daily clients were younger than non-daily clients of the facility (Wood et al., 2006d). However, a sample of drug users in Berlin who had never used SCS mentioned a lack of consumer friendliness (e.g., opening hours and regulations) and the high level of social control as the main reasons for non-attendance (Schu et al., 2005). When a non-representative survey of clients of 18 SCS across Germany were asked why they thought fellow drug users did not use SCS, the following reasons were cited: loss of anonymity; fear of police presence; possible wait times; distance to the facility. Clients of this same survey were also asked what they liked best about SCS (selective mentions, and not necessarily in rank order): hygienic environment (48%); opportunity to use calmly and safely and without fear of the police (47%); available medical care and emergency assistance (36%); less need to use in public (31%); use of ancillary services (22.6%); needle exchange program (22%) (Poschadel et al., 2002). In 2001 and 2002, the most frequently reported reasons for not using Sydney's injection facility among IDUs from Kings Cross in a cross-sectional survey was a preference for injecting at home (44% in 2001 and 72% in 2002) or in private (26% and 51%), and that the entry to the facility was too public (18% and 17%) (MSIC Evaluation Committee, 2003). At the Vancouver site, of the 1082 IDU randomly surveyed, the three most common reasons limiting use of the facility were: travel to the facility (12%); limited hours of operation (7%); and waiting times (5%). Suggestions about how Vancouver's injection facility could be improved included: longer hours of operation (53%); access to washroom (51%); and shorter waiting times (46%) (Petrar et al., 2007).

      Compared to treatment or counselling services, drug users perceive SCS as an important source for honest and non-judgmental service delivery (Stoever, 2002), and IDUs are generally supportive of the services (Wood et al., 2004a). When 1082 clients in

Vancouver were asked to rate the overall quality of service, 95% said it was excellent or good compared to 5% rating it as fair or poor. Furthermore, an overwhelming majority reported that staff were always or usually courteous and respectful (97%), trustworthy to provide care (97%), reliable and dependable (96%), and trustworthy to maintain privacy (95%) (Petrar et al., 2007). Clients of German and Swiss SCS expressed satisfaction with the contact with staff and praised their high level of competence in social and legal matters (Hedrich, 2004). For example, the survey of clients of 18 German SCS found that 95% were happy or very happy with services, and that 70% were satisfied with the opening hours (despite many German facilities being open only part of the day) (Poschadel et al., 2002). Approximately 75% of surveyed clients in Sydney report that care is good and relationships with staff are honest and respectful of privacy and confidentiality. The majority of clients rated the facility as a 'good' or 'ok' place to inject. In addition, most clients agreed that the location accommodated them, and while there was less consensus about the opening hours, few reported that they had to wait too long. Most clients in Sydney agreed with the registration process, entry criteria and restrictions on physical injecting sites, however there was less support for rules limiting clients to one injection per visit and not being able to share drugs (MSIC Evaluation Committee, 2003).

Decentralized facilities – as they are sometimes installed for political acceptability (e.g., Hamburg) – may be located away from open drug scenes or drug markets, and can consequently be underused. In fact, a couple of underutilized SCS in Europe have been moved or closed. Conversely, centralized SCS generally operate at capacity, and often cannot keep up with the demand (Hedrich, 2004). Weekly averages of supervised consumptions range from 50 to over 3,000 per facility (Hedrich, 2004; BC Centre for Excellence in HIV/AIDS, 2004). In a survey of facilities operating across the Netherlands, Germany, Switzerland and Spain, the median number of visits per day was 100 (range of 25 to 400) (Kimber et al., 2005). However, the majority of clients in Vancouver are irregular users with one in three clients attending between two and five times a month (Tyndall et al., 2006) and an average usage rate of 11 visits per month (BC Centre for Excellence in HIV/AIDS, 2004). This reflects a similar picture of SCS in Sydney or Madrid, where the majority of clients used the facility only irregularly or occasionally, whereas regular use is more common in Germany and Switzerland with clients visiting an average of several times per week, and highest in the Netherlands where average usage per person is six days per week (Hedrich, 2004). In Berlin, about half of clients used the SCS a few times a week or daily, and approximately 25% of the sample's consumption episodes took place inside one of the facilities (Schu et al., 2005).

Heroin and cocaine are the most commonly used drugs in SCS, and injection is the main mode of administration (Independent Working Group, 2006), with the exception of facilities targeting smokers in the Netherlands (Wolf et al., 2003). The median time spent in the injection room is 20 minutes in Vancouver (Tyndall et al., 2006) and 28 minutes in Sydney (van Beek, 2003). Across Europe, heroin injectors spend about 30 minutes in the injection room, whereas cocaine injectors stay an average of 15 minutes (Hedrich, 2004). Mid-afternoon and early evening tend to be the busiest and utilization peaks following the distribution of welfare cheques in Vancouver (Wood et al., 2004a). Most clients make use of ancillary services offered onsite, depending on availability. Ninety percent of clients surveyed in Berlin reported using ancillary services, however there is no data on the actual uptake of these services (Schu et al., 2005). Advice is often given through informal conversations and therefore not recorded. Only a minority of clients used the consumption room only, as opposed to utilizing any of the other services offered (Kimber et al., 2003a; Hedrich, 2004).

8.   Impacts and Effects

Very few SCS have been systematically evaluated in terms of their impacts and effects, and when this has been done (mostly the comprehensive Sydney and Vancouver pilot studies), the studies have produced unique and pioneering results and evidence for future policy making. However, the studies also face some methodological challenges inherent to the nature of the phenomenon and interventions under study. One key challenge is that it is difficult to isolate and definitively attribute observed effects related to SCS given that: 1) most clients use SCS only for some of their drug use episodes, and continue to engage in high-risk activities outside of the facilities; and 2) the environments surrounding SCS cannot be controlled or kept stable, and so concurrent policy or ecological changes (e.g., increased availability of substitution treatment, changes in police operations or evolving drug use habits) may add difficulty to a rigorous or conclusive evaluation of the effects of SCS (Fischer et al., 2002; MSIC Evaluation Committee, 2003; Roberts et al., 2004; Hedrich, 2004; Hall & Kimber, 2005; Independent Working Group, 2006). As one key example, a sudden but major shortage of heroin occurred during the Sydney evaluation period, influencing key drug use behaviors and harms which made a systematic time-series evaluation of the facility's impact difficult. Generally, largely due to the reasons cited above, most outcomes are reliably best observed at the individual, rather than the population level (Dolan et al., 2000; Hedrich, 2004). There are, on the other hand, major challenges to evaluating SCS by way of – theoretically – more optimal designs or methods. For example, randomized designs are not considered ethical in this instance and hence evaluations need to rely on observational designs and therefore, unknown confounders and selection effects cannot be controlled for. This has considerable implications since SCS tend to attract a select population of individuals at heightened risk and therefore, it is difficult to identify and incorporate adequate controls into the observational design (this also refers to ecological confounders). Another challenge is that pilots tend to be very small and therefore it is difficult to demonstrate population level effects of SCS. Prospective cohort designs would potentially lend themselves to more rigorous evaluations, but are expensive and not feasible in many settings.

i) Overdose

There is limited evidence on the extent to which SCS prevent overdoses from occurring since most available data relates to the incidence of emergencies within SCS and descriptive accounts of their outcome. Most emergencies are heroin-related, followed by epileptic seizures and cocaine-related incidents, and it has been shown that the rate of overdose associated with heroin injection is far greater than the rate of overdose involving the injection of other opiates such as morphine and dilaudid (Kerr et al., 2006b). Generally speaking, injection carries a far greater risk of overdose than does inhalation. Switzerland reports the lowest overdose rate at 0.5 per 1,000 injections, followed by Spain at 1.3 and Vancouver at 1.33. The rate of overdose emergencies ranges from 1.6 to 3.5 in Germany and Sydney reports the highest rate at 7.2 per 1,000 injections (Kimber et al., 2003a; Hedrich, 2004; Kerr et al., 2006b).

It is noteworthy that despite the millions of injections occurring at SCS over the past 20 years, there have been no reported overdose fatalities. For instance, between 1995 and 2001, there have been an estimated 2.1 million consumption episodes in Germany, 5,000 emergencies, and only one death related to anaphylactic shock (Poschadel et al., 2002). Because rapid intervention within SCS is possible, we can assume that morbidity and mortality from overdose is reduced since emergencies are managed earlier and with lower intensity interventions than would otherwise have been necessary (van Beek et al., 2004). Indeed, evidence from Australia indicates that one in

every four heroin overdose that occurs in the community results in a fatality (Darke et al., 2003). A Frankfurt study showed that the likelihood of hospital admission was ten times greater for overdoses occurring in the street compared to overdoses occurring in SCS, and that a lower level of intervention was required (often oxygen alone) (Kimber et al., 2005). Therefore, it is likely that many deaths have been averted as a result of the emergency interventions offered in SCS. It is estimated that SCS might have contributed to the prevention of ten deaths per year in Germany and four in Sydney (MSIC Evaluation Committee, 2003; Hedrich, 2004). An important piece of population level data, a time-series analysis across four German cities between 1993 and 2001 (Saarbrucken, Hamburg, Frankfurt and Hannover), concluded that the operation of SCS was statistically significantly related to the reduction of overdose fatalities in these cities over the period assessed (Poschadel et al., 2002). Overdose deaths declined from 147 in 1991 to 22 in 1997 in Frankfurt – a noticeable decline occurred the year following the establishment of the Frankfurt SCS, while overdose rates remained stable in other parts of Germany (Bollinger et al., 1995 cited in Wood et al., 2004b).

ii) Health and Risk Behaviours

Although some SCS have indicated an improvement or stabilization of their clients' health, there is to date no epidemiological evidence of reduced infectious disease transmission (e.g., incidence) among clients (Fischer et al., 2002). However, a reduction in health risk behaviours (e.g., syringe sharing, public injection) known to increase risk of infectious disease transmission has been associated with the use of SCS – there is a strong relationship between the frequency of visits to SCS and the degree of reduced risk behavior and utilization of other services (Zurhold et al., 2003). For instance, one in five German clients stated they had altered their hygienic behaviours because of increased awareness since attending SCS (Stoever, 2002); 58.9% of a non-representative German sample of clients thought they were receiving better medical care since using SCS and 80% rated their health status as good or very good (a statistically significant improvement over their self-reports compared to before they began utilizing SCS) (Poschadel et al., 2002); clients in Rotterdam and Hamburg reported decreases in public drug use, improved hygiene and consumed less hurriedly since visiting SCS (Zurhold et al., 2001); 75% of 1082 clients surveyed in Vancouver reported that their injecting behavior had changed since using the facility, and of these, 80% said their injections were less rushed at the facility, 71% reported less public injecting and 56% indicated safer syringe disposal (Petrar et al., 2007); and half of clients in Sydney reported that their injection practices had improved since using the facility – over time, a small decrease in the frequency of injection-related problems was observed among clients, specifically, less bruising, scarring and abscesses (MSIC Evaluation Committee, 2003). No instances of syringe sharing have been reported among exclusive users of the Vancouver facility (Wood et al., 2005b), and frequent clients are 70% less likely to share syringes than IDUs who do not attend the facility. Rates of syringe sharing are lower in the Vancouver IDU community than in the past, suggesting that the initiative is having an impact beyond the facility itself (Vancouver Coastal Health, 2005). Potential for the prevention of infectious disease transmission exists, given that one in three clients of Vancouver's facility received safer injecting education, and the factors associated with receiving such education are also risk factors for HIV infection (Wood et al., 2005c).

Concerns that SCS might encourage drug use or delay entry into treatment have not been substantiated. In fact, in Vancouver, community drug use patterns have not worsened as a result of the facility; there have been no measurable negative changes in rates of relapse into injection drug use, stopping injection drug use or seeking treatment (Kerr et al., 2006a). Summarizing existing literature on the impact of SCS on individual drug use patterns, Hunt found that a minority of clients (approximately 16%) have

reported increased drug use since using SCS, while about 22% have reported a decrease (Independent Working Group, 2006).

<u>iii) Public Order</u>

SCS aim to contribute to the improvement of drug use-related local public order problems, as well as expend a considerable amount of efforts on the maintenance of order both inside and outside their facilities. A review of the evidence concerning the impact of SCS on public order suggests a mixed picture, which is further confounded by the fact that very little systematically generated and non-generalizable information is available on this issue (Fischer et al., 2002; Roberts et al., 2004). On the one hand, improvements in public order have been attributed to the opening of SCS in Vancouver and in some European jurisdictions (Poschadel et al., 2002; Wood et al., 2004b; Hedrich, 2004). On the other hand, while Australia has found little or no noticeable change, some European facilities report an increase in public order problems, even to the extent of requiring the closure or relocation of a few SCS in Germany (Poschadel et al., 2002). The systematic evaluation of the Vancouver facility reported several pieces of evidence pointing to positive outcomes regarding public order: the opening of *Insite* resulted in a reduction of public injection, discarded syringes and drug-related litter, and no observed increase in the number of suspected drug dealers in the vicinity of the facility (Wood et al., 2004b). Drug-related crimes have not increased in Vancouver, and even a small reduction in vehicle break-ins and thefts has been observed over the existence of *Insite* (Wood et al., 2006c). In Australia, there is no evidence that the injection facility had any positive or negative impact on rates of acquisitive crime; no increase in drug-related loitering associated with the opening of the facility; and no increase in the proportion of supply offences following the opening of the facility (Freeman et al., 2005). In cross-sectional telephone interviews carried out before and after the opening of the facility in Sydney, local residents and business respondents reported a reduction in public injection and improperly discarded syringes in 2002 compared to 2000. However, it was not possible to attribute these improvements to the facility given the concurrent heroin shortage (MSIC Evaluation Committee, 2003). Drug users in Rotterdam and Hamburg report less public drug use since attending SCS (van der Poel et al., 2003; Zurhold et al., 2001). The evidence relating to whether or not SCS lead to the congregation of drug users or drug-related activities in the immediate vicinity of SCS ('honey-pot effect') is also mixed. A review of European SCS has found that between 63 and 93% of clients are local residents (Hedrich, 2004), and there have been no reports of crowds gathering outside the Hannover site (Stoever, 2002). However, a number of European SCS reported increases in drug dealing around the premises, with several of these also reporting aggressive incidents outside the SCS, increases in petty crime and resentment from local residents (Poschadel et al, 2002; Kimber et al., 2005). Nuisance is more likely when capacity or location of the facility does not meet local needs, and, for example, lengthy wait times for facility use occur. In some instances, these problems may be addressed to a certain degree by an adjustment of service capacity, as well as aided by police cooperation and the active involvement of SCS in local order maintenance (Hedrich, 2004). For example, Sydney and Zurich employ security guards (Kimber et al., 2001), and some German facilities rely on 'facility runners' to prevent congregations or drug dealing outside the premises and help maintain public order (Poschadel et al., 2002). In some instances, clients are called upon to help clean the areas surrounding the SCS, or to keep fellow clients in line (Schu et al., 2005).

iv) Service Referrals

Due to the variation in services offered onsite, caution should be taken when comparing referral rates across SCS. With the exception of Sydney and Vancouver, actual uptake of referrals is not measured, making it difficult to assess whether SCS are effectively increasing contact between clients and service providers. Data from Sydney indicates that 15% of clients are referred to other services – of these, close to 44% are for drug treatment and rehabilitation (1/3 of these referrals made to treatment naïve clients), and 31% are for primary medical care services (van Beek, 2003). One in five written referrals resulted in the client making contact with the agency, and uptake was highest among frequent attendees and for referrals to health services (MSIC Evaluation Committee, 2003). About 10% of visits in Spain result in the provision of additional medical and/or social services, compared to 5% in Switzerland. Over half of German clients have been referred to a drug or social service at least once, but referral rates are lower than Vancouver or Sydney (Hedrich, 2004). Vancouver made over 2,000 referrals in one year, with about 40% to addiction counseling, and one in five regular visitors began a detoxification program (Vancouver Coastal Health, 2005). The likelihood of entering a detoxification program was higher among at least weekly visitors of *Insite* and those who had contact with the onsite addiction counsellors, and the rate of detoxification use increased after people began using the facility (Wood et al., 2006b).

v) Cost-effectiveness

The cost of a particular intervention will vary depending on the chosen operational model. For instance, stand-alone specialized SCS tend to be more expensive than facilities integrated with other existing drug-related services, common throughout Europe (Independent Working Group, 2006). To date, the cost-effectiveness of SCS is difficult to ascertain given that the evidence relating to their impact on the above-mentioned outcome measures is generally sparse, and the fact that only the relatively newer initiatives (e.g., Vancouver and Sydney) provide cost data. Since these SCS were designed as research studies, overhead costs (especially for research data collection) were considerably higher than would be in the more established SCS across Europe, however it is impossible to tell since European facilities typically do not provide cost data. It seems, however, that integrated SCS offer the 'best value for money' (Independent Working Group, 2006).

Specifically drawing on the Sydney example, the set-up costs of the facility were $1,334,041 and the operating costs for the first year were $1,995,784. In the initial year of operation, the cost was $63.01 per client visit and assuming increased uptake and efficiency, it is estimated that the cost per client visit will drop to $37.23 in the second year of operation. Based on current operations, the economic evaluation – based on a cost-of-illness approach examining mortality, morbidity, health and social service cost indicators – suggests a benefit/cost ratio for the facility ranging from 0.72 to 1.20, e.g., concluding the Sydney intervention to be neutral in terms of cost-benefits. However, the evaluators suggest that improved and more efficient operations in the future could increase this range to 1.19 to 1.97, improving the benefit/cost ratio of the intervention (MSIC Evaluation Committee, 2003).

9. Community and Stakeholder Attitudes

Limited data exist with regard to community attitudes and opinions regarding SCS, especially over time. However, support for SCS among community members and stakeholders tends to increase over time as the perceived benefits begin to outweigh any perceived costs or concerns. For instance, in Sydney between 2000 (seven months before

the opening of the facility) and 2002 (17 months after the opening of the facility), the attitudes of representative samples of local residents (n=515/540) and business owners (n=209/207) towards the facility became significantly more positive, although these benefits can only be demonstrated in the short-term. The proportion of residents who agreed with the establishment of the injection site (68% in 2000 vs. 78% in 2002), agreed that the facility reduced the risk of HIV/HCV transmission (87% vs. 92%), and reduced discarded needles (80% vs. 82%) increased, while the proportion of residents who agreed that the facility attracted drug users to the area (65% vs. 55%) decreased. Increasingly, residents disagreed that the site encouraged injection drug use (62% vs. 73%), made law enforcement difficult (55% vs. 63%) or encouraged people to think that it is legal to inject heroin (44% vs. 52%). The proportion of businesses who agreed that the facility reduced public injection increased (67% vs. 72%). In general, businesses and residents wanted the facility to be located in socially suitable areas, namely, away from children, young people and residential areas and located in areas of high drug use (Thein et al., 2005). In 2002, one in three businesses and half of the residents in Kings Cross were not aware of the facility's location, implying that the facility had little or no impact on this population. Furthermore, one in four businesses and one in three residents found no disadvantages with having a medically supervised injection centre (MSIC Evaluation Committee, 2003). However, the community believed that drop-in and ancillary services would attract IDUs from elsewhere in greater number than would health services and therefore, the provision of such services was limited in order to increase acceptability among the community (van Beek, 2003). In Vancouver, close to 50% of 117 surveyed local business people were in favor of the facility, with businesses further away and with higher traffic levels showing less support (BC Centre for Excellence in HIV/AIDS, 2004). A representative general population survey in Ontario asked respondents about their attitudes towards SCS in 2004. A little more than half of the respondents strongly or somewhat supported the concept, with support increasing to about two in three respondents if tangible benefits could be demonstrated (e.g., reduction in overdose deaths or infectious disease transmission; increasing contact with service providers; reducing drug-related neighbourhood problems). Among potential socio-demographic predictors, higher education levels were significantly associated with increased support for SCS (Firestone Cruz et al., 2007).

Through random dialing to residents living in the vicinity of two SCS in Berlin, two representative samples of residents were surveyed by telephone and it was found that both predominantly accepted SCS. A statistically significant positive relationship was found between education level and acceptance of the facility, while being a parent with young children was negatively associated (Schu et al., 2005). Furthermore, residents surveyed in Hamburg viewed SCS as the lesser of two evils compared to public drug use. Residents expect SCS to offer improved addiction services and relieve the drug-related burden on the community. Most agreed that the level of service had improved over the years. However, interviews with the police revealed that they were more ambivalent than residents towards SCS, expressing regret that there was a need for such a facility and suggesting that maintaining the status quo was a worse alternative given drug-related harms (Zurhold et al., 2003). Rotterdam residents attributed the reduction in public nuisance to SCS, and attitudes towards drug users and SCS improved over time (Linssen et al., 2001). Further evidence of community support is the fact that 98% and 94% of all clients of one facility in Hannover reported no negative experiences with local residents or police, respectively (Dolan et al., 2000). Similarly, of IDUs in Kings Cross who reported using the MSIC in 2001 and 2002, 9% reported problems with passers-by, 8% with police and only 3% with local businesses (MSIC Evaluation Committee, 2003). Police report few problems in areas with decentralized SCS except for resistance from select residents. For instance, some Swiss residents expressed strong resistance when SCS were located in residential areas. Generally fewer nuisance problems are reported in cities where a

political consensus or co-operation between police and drug service agencies exists (Hedrich, 2004).

10. Conclusions

Overall, SCS have become an accepted core component in a comprehensive range of intervention strategies – now even enshrined and facilitated by explicit legislative provisions in some jurisdictions – used towards street drug use in a variety of European countries, and exist as experiments in other European cities as well as Canada (Vancouver) and Australia (Sydney). As the above review has illustrated, existing SCS display a considerable range of variation in terms of operations, design, target populations, drug use and other services offered, as well as rules and regulations – all of which respond to and are targeted to substantial variation in local drug user and service profiles and needs. Evidently, it is critical to understand the latter in order to design and deliver potential SCS in an adequately tailored and responsive way that will allow for maximum effectiveness.

In terms of impacts with regard to the objectives of SCS, it is probably aptly summarized that "the evidence on the effectiveness of [SCS] as a means of reducing a range of drug-related harms is promising, but it is less conclusive than supporters of [SCS] might have wished" (Roberts et al., 2004, p.5) (see also Fischer et al., 2002; Hall & Kimber, 2005; Kimber et al., 2005; Independent Working Group, 2006). To date, what appears empirically known from the limited quality evaluation data available is that SCS: reach their target groups and attract street drug users – particularly users who are highly marginalized and characterized by high-risk behaviors – to utilize their services; relocate many injection and non-injection drug use episodes from public spaces into SCS; successfully deal with overdose episodes occurring within the facilities which otherwise would have taken place in less safe environments, and likely reduce overdose fatalities in public spaces; reduce health risk behaviors, including HIV risk behaviours, and improve health status and care among clients; provide other social and health services to users; increase the uptake of certain services, although service uptake and effects of referrals in many instances is uncertain and must be better documented. The evidence on the public order effects of SCS is mixed, with some facilities having clearly contributed to and scientifically demonstrated improvements in this area, whereas others have struggled with issues like user congregations, petty crime, drug dealing and even violence, leading to community resistance and complaints. On the basis of available data, SCS are 'neutral' interventions in terms of their cost-benefit ratio (e.g., not indicating a clear positive or negative value on this metric). However, there have been few cost-benefit evaluations to date, and previous evaluations have suffered from methodological difficulties which resulted in wide estimates around the derived ratios.

What is likely important to consider however, is that expectations put forward towards SCS need to be realistic, as SCS cannot address all the key variables of drug-related harms. For instance, SCS do not change the fact that street drug use is a criminalized activity, thus turning drug users into highly marginalized and vulnerable populations and at the same time forcing drug users to buy their drugs in illicit markets at highly inflated prices (for which they typically need to commit acquisitive crime) and subsequently use substances of unknown quantity and potency. Hence, SCS by design are interventions that are highly constrained in what they can reasonably accomplish. SCS subsequently need to be seen as a valuable part of a multi-piece intervention puzzle aimed at reducing harms and improving health, yet at the same time, it needs to be understood that long-term, fundamental and sustainable improvements to 'the drug problem' need action, changes and reform on other levels. Under current circumstances of dictated reality, it is hence desirable to utilize the opportunities offered by SCS in the optimally beneficial way – and this means to design and deliver them in a locally-tailored

and responsive way in order to maximize their benefits for both users and the community at large within the specific context at hand. While the above review has aimed to outline the many variables and options to be considered for such an effort, a few critical – and largely unresolved – issues have emerged from the literature that require particular attention (Poschadel et al., 2002; Broadhead et al., 2002; Fischer et al., 2002; Stoever, 2002; Spreyermann & Willen, 2003; Roberts et al., 2004; Hedrich, 2004; Independent Working Group, 2006). These selectively include:

- How to best balance between 'low' and 'high' threshold approaches? For instance, to which extent do requirements like user registration or extensive supervision, rules or regulations aid health benefits and safety versus deterring or excluding users in need?
- How to best identify feasible and suitable locations for SCS, which both meet the drug users' needs (e.g., close proximity to drug markets, convenient access, central location), yet at the same time avoid or limit negative impacts to the community?
- With limited resources and space, what services should be offered and when should these be available (e.g., limited opening hours) in order to maximize uptake and benefit for users?
- How are SCS best staffed? Is it necessary to employ costly medical personnel on site, or should facilities be run by less expensive social work or counselling staff, with medical staff on call for emergencies?
- What can be done to optimize the integration of SCS with other social, medical and treatment care, and especially increase follow-through of service uptake?
- What should be done with the population of crack users? While these are among the street drug users in most pronounced need of care, their integration into SCS has proven difficult for several reasons, including the special spatial arrangements required (e.g., separate rooms, ventilation), as well as the potential tensions or discomforts between crack users and other user target (e.g., opioids) populations.
- Should drug users currently in methadone maintenance treatment (MMT) be allowed access into SCS? While the objective of many MMT programs has been to reduce illicit drug use, the counter-argument is that when such use occurs, it should occur as safely as possible.
- What is the appropriate role for law enforcement and other key stakeholders in contributing to the success of SCS? In some jurisdictions, police have acted largely as 'tolerant' referral agents for street drug users utilizing SCS, and instead focused their enforcement on drug markets. However, clients of SCS are still dependent on illicit markets for their drug supply, and so such re-focusing of enforcement may cause problems in that supply may be moved away from SCS. At the same time – where so intended and based on close agency collaboration – police have demonstrated their potential ability to keep SCS and their vicinities safe and workable for both the clients and the communities in which they are located.
- How to best accommodate high-frequency drug users (e.g., cocaine injectors)? Is it feasible to relax rules requiring registration for each drug use episode and can capacity support those users who may prefer to move to and fro between the consumption and common rooms, and if this is the case, should their access between rooms be controlled?

In sum, within their limited potential to reduce specific forms of drug use-related harms, it is essential to bring and adjust local SCS interventions as close as possible to match and respond to local needs, ecological parameters and sensitivities. The following sections of this report are additional components of the efforts to examine and document these key factors empirically.

D. STAKEHOLDER SURVEY OF ATTITUDES, PARAMETERS AND NEEDS REGARDING SCS OPTIONS IN VICTORIA[2]

1. Introduction and Methods

The main consideration for the stakeholder survey component of the feasibility study was to capture a comprehensive and diverse variety of perspectives from different arenas of stakeholders – including those from drug users with different characteristics – relevant for the assessment of the feasibility of Supervised Consumption Site (SCS) options in Victoria, and to allow for basic comparisons across stakeholder groups. The particular stakeholder groups were chosen because their interests, activities or work would be directly affected by a possible SCS initiative, or – in the case of the drug user sample – would be the targeted consumer groups, and each of them hold key information necessary for a locally informed and responsive assessment of the feasibility and specific considerations necessary for a possible SCS initiative in Victoria. Data for the stakeholder survey component were collected from n=45 qualitative one-on-one interviews with individual stakeholders representing various fields of expertise, and five focus group interviews with a total of n=23 drug user informants. The stakeholder groups included: business, tourism, and community representatives; consultants; drug user informants; health care and social service providers; law enforcement representatives; and political representatives (see Appendix 2 for a detailed list).

Participants for the stakeholder survey were recruited by means of targeted recruitment and snowball sampling. Relevant institutions and agencies (or specific individuals with relevant expertise in cases where there was no institutional context) for potential stakeholder participation were identified, and were contacted in writing to solicit their willingness to participate in the study, and were asked to identify a specific key informant representative for the interview. Key informants who had completed a stakeholder interview were asked to recommend other potential participants, who were then subsequently contacted. Focus groups were chosen as an appropriate data collection format for drug user informants in order to make these participants feel as comfortable as possible for the purpose of the data collection exercise. Potential participants for the drug user focus groups were identified and recruited with the help of several health and social service agencies in Victoria. Eligibility criteria for participation in the focus groups required that participants be: 1) a current and regular street drug user, e.g., use illicit opioids, cocaine, or crack on a daily or near daily basis; 2) either an active injector or have an injection history; and 3) 17 years of age or older. The study was approved by the joint VIHA/University of Victoria Human Research Ethics Board.

All stakeholder interviews and focus groups were held between September and December 2006. Stakeholder interviews, as well as focus groups, were conducted by way of a conversation style interview following a semi-structured interview guide. Interviews and focus groups were conducted by the facilitator, with a second member of the study team present for note-taking. All interviews were also audio-taped. Prior to the actual interviews, participants were given a brief introduction regarding the purpose and procedure of the study. Participants then provided informed consent, including the assurance of the protection of their anonymity (if requested) and for purposes of data reporting, confidentiality of the data. Participants were also informed that their participation in the study was voluntary, and that they were free to withdraw from the study at any time. Then, participants were asked to complete a short socio-demographic questionnaire. Beginning with the actual interview, the facilitator would guide the interview through the different questions and topics contained in the semi-structured

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[2] The authors acknowledge the collaboration of Michelle Coghlan and Jo-Anne Stoltz in the implementation of this survey.

interview guide, and elaborate and probe on issues and themes as needed. Individual interviews took 30-45 minutes on average, whereas focus groups took approximately 60-90 minutes. One-on-one interviews were conducted in a closed and private interview room at the University of Victoria or at an alternate private location identified as convenient for the participant (e.g., the participant's office). The five focus groups – the largest of which included seven participants and the smallest of which included four participants – were all conducted in a private room at one of the social or health agencies that had aided in recruiting the focus group participants or at an alternate private location if the necessary space at the agency was not available. Those participants partaking in the stakeholder survey in a non-professional/paid role were compensated with CAN $15 for their participation. If requested, focus group participants were offered referral information with regard to social, health or addiction services.

Immediately following each interview session, the facilitator and recorder jointly documented and recounted the essential information from the interviews – aided by the audio-recording – into a written, textual form following a template for analysis. The textual data for all interviews was first organized into general themes and categories as descriptions and explanations for participants' attitudes were identified. Further thematic analysis then extracted specific themes and sub-topics within which relevant quotes were grouped. The facilitator and recorder compared the data each had independently categorized, and then generated detailed themes. Themes and categories remained tentative until the importance of common and uncommon views and themes were understood, with particular emphasis on understanding variations in opinions and attitudes by each stakeholder group.

In briefly describing the study sample, participants for the one-on-one interviews included eight business, tourism and community representatives, two independent local consultants, eight health care providers, 13 social service providers, four law enforcement representatives, and 10 political representatives. The sample included 27 women and 18 men, and the majority of participants were forty years of age or older. Participants had exposure to drug issues in Victoria either through drug use itself or through the work or mandate of their business or agency, through direct program or service delivery, or indirectly through the planning and coordination of programs or policies concerning drug use, or as part of participant's routine activities (e.g., witnessing open drug use). The majority of participants reported that they worked in downtown Victoria, although the areas served or the locations that participants were responsible for professionally were in some instances located outside downtown, or encompassed the whole CRD. Participants for the five drug user focus groups included 11 men and 12 women, four groups were made up of both men and women, and one group was made up of women only. Four participants were under 30 years of age, five participants were between 31 and 40 years of age, nine participants were between 41 and 50 years of age, and three participants were over 50 years of age. Most drug user participants reported that they currently used cocaine and about half reported that they currently used heroin as their main drugs of choice; three participants reported that they used crack and one participant reported that they used crystal methamphetamine. Eighteen participants reported that they used drugs by injection, eleven reported that they used drugs by smoking them, and four participants reported that they used drugs orally (e.g., swallowing pills or drinking alcohol). Although the majority of drug user participants listed injection as their primary method of drug use, there is some overlap since many participants reported poly drug-use and/or that they used more than one method of drug use. About half of participants reported that they were homeless or that they lived on the street, and four participants reported that they lived in unstable housing situations (e.g., shelter or hostel). Fourteen of the drug user participants reported that they reside in downtown Victoria, and some participants mentioned that they mainly reside in municipalities adjacent to Victoria.

The stakeholder survey component of the report presents findings with regard to perceptions, views and attitudes towards the nature and consequences of drug use in Victoria, and describes the landscape of existing services and service gaps for drug users. The stakeholder survey component also explores the feasibility of implementing possible SCS options in Victoria by presenting the range of views towards the concept of an SCS initiative; and more specifically, the attitudes towards the design, operations, services, rules and requirements and role of the police vis-à-vis possible SCS options; and finally, this section of the report provides an overview of the outcomes that stakeholders believed would be indicative of the success and failure of possible SCS options in Victoria.

2.   Attitudes Towards Drug Use in the Victoria Context

This section presents stakeholders' perceptions of the drug problem in Victoria. Perceptions about the nature of the drug problem, how it has changed over the last several years, and who is typically involved are described. In terms of what drugs are being used, the focus is on the main drugs of choice and methods of use, as well as differences among groups of drug users in Victoria. The discussion then moves towards describing the locations where stakeholders have suggested the drug problem mainly takes place in Victoria. Next, stakeholders' perceptions of the types of harms associated with the drug problem are presented including harms to drug users and to the community. Finally, stakeholders' perceptions about existing services for drug users as well as gaps in services in relation to the local context are presented.

i) Nature of the Drug Problem

When asked to describe the nature of the drug problem, a strong majority of stakeholders agreed that the problem is significant and widespread. Many stressed that the drug problem has increased over the last several years. As a social service provider noted, "*there has been a significant increase in the visibility of homelessness, mental illness, and drug addiction…these three things have definitely increased in the downtown*" (SCS03). Some stakeholders stressed that the main strategy in Victoria is to try to keep the drug problem out of sight, displacing drug users further from the downtown core so as to decrease visibility, but according to many stakeholders, the approach is not working, and instead drug use is increasingly visible. As a health care provider noted, "*the problem is big, there is a lot of use and addiction and it is very visible*" (SCS11). A stakeholder from the business community expressed that "*the nature of the drug problem in Victoria is that there are needles out in front of businesses, there are people sleeping in doorways, there are a large number of break and enters that are essentially drug-related and property crime is drug-related*" (SCS06).

Many stakeholders felt that there has been a shift in the culture of drug use in Victoria, that is, that the people involved, the types of drugs used, and the rules of overall conduct among different groups of users have changed over recent years. For instance, some stakeholders attributed changes in the drug scene to the arrival of crystal methamphetamine in particular – generally, drug users involved with crystal methamphetamine were described as younger, and the drug was thought to be associated with increased aggression and a resulting increase in public fear. An older drug user informant described the behaviour exhibited by younger drug users: "*when I was hooked up, there was honour…it was hard getting a box of these things [needles], let alone dropping a cap [heroin]…the way I was taught, if you were disrespectful enough to yourself and to the community by leaving a cap or a syringe [around], especially something that had fluid in it, somebody would find out within the group…then you'd get a beating from each and every person in the circle…now their [the younger users] attitude is just out to lunch…it's just so out of hand*" (FG04). Other stakeholders agreed that there

"*used to be a code on the street and it's not there anymore*" (FG03). Many stakeholders offered the following comments to describe the nature of the drug problem in Victoria: 'pathetic and prevalent,' 'out of control,' 'it's just going continue to get worse,' and 'it's going to be like Vancouver soon.' As a social service provider described, "*the drug scene is more open now and there are users who openly inject on the street, I believe homelessness is a big part of that, if people had a home or a place to use [drugs], they would choose to use privately, but users are forced out into the open, it's frustrating to not be able to provide all the services that are required, something needs to be done to get a handle on this problem*" (SCS23).

ii) Characteristics of Drug Use

When stakeholders were asked to identify who is typically involved with the drug scene in Victoria, many stressed that a significant proportion of drug users are hidden and that drug use is often defined as problematic only in terms of its public visibility. For example, the majority of stakeholders felt that the drug problem encompassed more than just the small percentage of people seen on the streets in the downtown core. As a health care provider noted, "*it's so much more than that, everybody is out there using, it's youth, physicians, lawyers and everyone in between…there are no boundaries*" (SCS01). While most stakeholders believed that drug use in general traverses many socio-economic and demographic boundaries in Victoria, some groups of people were thought to be more involved in drug use than others, namely because of their visibility on the street. For example, many stakeholders mentioned that Aboriginal people are highly overrepresented in the street drug user population compared to their overall population in Victoria. Although many stakeholders stressed that both men and women are involved in the drug scene, some specifically mentioned that they tended to see more males engaging in public drug use than females, and that female drug users are prone to experience more severe psychotic episodes compared to male drug users. In addition, while many stakeholders agreed that all ages are involved with drug use, some specifically mentioned that street drug users are typically between 30 and 50 years of age. However, some stakeholders, especially those who work with youth, expressed that they were aware of drug users as young as 12 years of age and that youth are becoming increasingly affected by drug use. Other stakeholders believed that drug users tend to have lower education and income levels. Overall, most stakeholders felt that the drug problem is all encompassing and that it typically involves a wide range of people, with varying levels of education and income, and in various social positions.

In discussing who is involved with drug use in Victoria, the majority of stakeholders could only describe those who are the most visible throughout the city. Some stakeholders recounted estimates of approximately 1,500 to 3,000 injection drug users in Victoria. Others estimated that there are about 250 street injection drug users throughout the downtown core, most of whom are homeless, and that there is a smaller, core group of drug users within that who are the most visible. As a law enforcement representative noted, "*there are about 40 to 50 hard core drug users that we deal with on a regular basis, maybe a few more, but these are the ones who are consistently problematic*" (SCS32). In addition, the majority of stakeholders stressed that drug use is prevalent among sex trade workers and also among those who are associated with the sex trade in Victoria. A social service provider commented that "*it's the street [drug] use that everybody notices, but there are people who buy sex workers…they call it drug dates…the sex workers know where to get the drugs because they themselves are drug users, and the date and the woman go together and use drugs*" (SCS03).

Finally, many stakeholders discussed the prevalence of mental health problems among the drug using population in Victoria, although there was some disagreement about the nature of concurrent drug use and mental health problems among drug users.

For instance, some stakeholders stressed that the relationship between mental health and addiction was complex and that it is sometimes difficult to identify those who are most affected. As a social service provider explained, "*what comes first, are they treating their mental health condition with their drug addiction or are the mental health symptoms coming out because of their drug addiction, did they already have the propensity for mental health issues and drugs have triggered that...I'm not sure*" (SCS19).

iii) Types of Drugs Used

When stakeholders were asked what types of drugs are used in Victoria, everyone agreed that many types of drugs are available and commonly used. As a drug user informant noted, "*there's lots of everything...everybody is just doing everything*" (FG01). A health care provider noted that "*a lot of drugs are used in this area...cocaine, crystal meth, crack cocaine, heroin, and ecstasy, marijuana is everywhere, mushrooms are coming back, and there's also some LSD and GHB*" (SCS11). Despite the wide range of drugs available, a strong majority of stakeholders said that cocaine and heroin are the two main drugs of choice in Victoria. In describing which drugs are available, a drug user informant said that "*Victoria is mostly a powder town compared to Vancouver, a rock town...most people here inject powdered cocaine and heroin*" (FG05). Some stakeholders said that crack cocaine use is increasing. For instance, a drug user informant noticed that "*a lot more people are smoking crack these days, when I first came here from Vancouver, not many people knew about crack and it was hard to find, now it's easier to get*" (FG05).

Other stakeholders said that crystal methamphetamine use is increasing, although there was some disagreement about the extent of its use in the area. For instance, a drug user informant commented that "*crystal meth is getting to be quite a lot more than coke or heroin right now and a lot of guys smoke that*" (FG05). However, a political representative noted that "*the most common drugs are cocaine and heroin, crystal meth is out there but the street population won't use it if they have the money to do other things, they know it messes you up*" (SCS38). Furthermore, when drug user informants were asked what their three main drugs of choice were, only one person reported the use of crystal methamphetamine. Some stakeholders felt that the idea that crystal methamphetamine use is increasing was largely perpetuated by the media: "*obviously meth is in the forefront and emphasized by the media and this tends to run in cycles, right now it's meth, but in the early 90s, heroin was a big problem*" (SCS02). Despite diverging opinions about the prevalence of crystal methamphetamine use, many stakeholders mentioned that while cocaine and heroin are the most commonly used drugs used in Victoria, "*crystal meth is a steady contender, especially among youth*" (SCS25).

A number of stakeholders mentioned that marijuana use is common in Victoria, but some drug user informants indicated that marijuana is not as widely available as other types of illicit drugs. As a drug user informant explained, "*if I could find marijuana, I'd be happy, I'd rather buy a thing of weed than powder, there's maybe one guy, and I can't find the guy who sells it*" (FG01). Another drug user informant agreed: "*I would like to be able to walk into [the compassion club] to buy weed, why can't I walk in there to buy weed, I can go [across the street] and buy crack, why make it so hard to buy weed when it's so easy to buy crack*" (FG01). Other types of drugs that stakeholders mentioned are coming onto the drug scene in Victoria include ecstasy, ketamine, mushrooms, LSD, and GHB. Stakeholders thought these types of illicit drugs are popular because they are inexpensive, relatively easy to find, and that the psychoactive effects for some are higher in comparison to other types of drugs. As a law enforcement representative noted, "*GHB is popular for some girls on the street, it only takes a small amount, 2 ml, to get highly intoxicated*" (SCS35). Some stakeholders expressed a similar view about crystal methamphetamine: "*crystal meth is attractive to [youth], it's cheaper...and the effects last longer*" (SCS13). Many stakeholders indicated that prescription drugs (e.g., percocet,

valium, and dilaudid) are also common in Victoria, although one drug user informant expressed reluctance to admit prescription drug use for fear of not being able to obtain them and having to resort to using other types of illicit street drugs. A strong majority of stakeholders agreed that alcohol is also common and that it is one of the most widely used and problematic substances in Victoria. A health care provider noted that "*alcohol is prominent, the ratio is probably two to one in cases that we serve*" (SCS36). A social service provider stressed that "*the number one drug that people struggle with is alcohol, number two is crack cocaine, everything else is insignificant in comparison…but people don't often recognize that alcohol is an issue or a problem*" (SCS41).

All stakeholders agreed that using more than one type of drug and mixing different types of drugs is common among street drug users in Victoria. A social service provider believed that "*some people may have moved away from injection use, they may be on methadone, combined with alcohol, over-the-counter drugs, or prescription drugs, basically whatever they can get at that point in time*" (SCS22). Similarly, as a law enforcement representative noted, "*hard core users use heroin and crystal meth, they're also drinking methadone, they use lots of prescription pills that are either left over from others' prescriptions or stolen…most use a myriad of drugs, not just intravenous drugs, it's a cocktail, it's not just one type*" (SCS35). Many stakeholders stressed that poly-drug use and addictions issues are complex, especially because of the varying levels of drug purity and potency levels in Victoria. A social service provider commented: "*everyone is addicted to everything and the drugs are very mixed…cocaine has a lot of crystal meth in it now, ecstasy too, things are being mixed together… users are ending up with a chemical soup of drugs*" (SCS03). Other stakeholders agreed that different combinations of drugs exist and that drug users often do not know what they are buying or taking. As a health care provider explained, "*cocaine is laced with meth and heroin is laced with methadone and cocaine…people don't always know what they're purchasing, even if it's from the same dealer*" (SCS25). Similarly, a social service provider noted that "*most of the cocaine and ecstasy that people use now contain varying amounts of crystal meth, people who are shooting coke say that it's a different buzz, it's not what they're used to*" (SCS31). Some stakeholders also mentioned that crystal methamphetamine is now being sold in pill form and passed off as ecstasy: "*in town right now, most of the ecstasy is crystal meth and they've just put it in pill form and are selling it as ecstasy*" (SCS02).

Considering preferences in terms of methods of drug use, everyone agreed that methods of use vary according to an individual's drug of choice and that all methods of use are common in Victoria. However, drug use by injection appears to be the primary method of use. As a health care provider noted, "*drugs are usually injected by street-involved drug users, drugs are smoked as well, snorted, just about any method is used*" (SCS08). A social service provider noted that among youth, "*aside from the youth who are [injecting] crystal meth, youth are primarily smoking*" (SCS31). According to most of the stakeholders, the most common methods of use are injection and smoking, although the perception was that injection is more prevalent downtown. As a drug user informant noted, "*mostly injection is what we see downtown, crack smoking too, but mostly injection*" (FG04). Most of the drug user informants interviewed reported that they use all types of methods to consume drugs, for example: "*when it came to coke, I snorted it, I smoked it, and I injected it*" (FG02). While most drug user informants were past and/or present injectors, some noted that they used to inject and now they only smoke, while others said that they only smoke and that they have never injected. Many drug user informants said that "*most of the injectors are also smoking crack*" (FG05). Some drug user informants felt that it is cleaner to inject drugs as opposed to smoking them since "*it's easier to find [needles] than baking soda or pipes, it's cleaner in a way*" (FG01). Some stakeholders expressed that there has been an increase in injection drug use in Victoria over the last several years. As a political representative noted, "*injection drug*

users are the ones who we are focused on the most, or at least they're the most visible part of the problem in terms of how we deal with them in the community" (SCS17).

A few stakeholders mentioned that some types of drugs and methods of use are more common among certain groups of drug users. For example, some described that "*youth tend to use the party drugs and crystal meth, while the old timers are injection drug users, they're heroin users and cocaine users*" (SCS39). Another stakeholder mentioned that within the youth context, "*marijuana and alcohol are most widely used, but if you're downtown, you will see cocaine, crystal meth and heroin*" (SCS29). However, another stakeholder who works with youth noted that "*among youth, heroin is more stable and there is some indication that crystal meth is decreasing…youth who are coming in are reporting this less as their drug of choice*" (SCS14). In addition, a social service provider explained that there are two main groups of drug users: "*there is the downer group which includes those on heroin and alcohol and they typically have safer injection practices than the upper group which includes those on stimulants, cocaine, crystal meth, and ecstasy…these groups don't often mix, they don't often cross over, not when they're really addicted*" (SCS39). One stakeholder described common injection practices among crystal methamphetamine users: "*they share needles, leave needles around, they don't care*" (SCS31). A social service provider said that "*heroin users seem to be more stable, [whereas] coke injectors are unstable and tend to use more [frequently]*" (SCS30). Similarly, a health service provider described a study of Victoria IDU that found a difference between groups of injection drug users who "*use the needle exchange service [at AVI]…they tend to be more regular users, they practice harm reduction and there is a higher prevalence of HIV and HCV, as compared with those who go to Streetlink who are more irregular users, they're people trying to get away from the life, they have injected only once or twice in the last six months*" (SCS30).

iv) Locations of Drug Use

In discussing where drug use activity takes place in Victoria, there was widespread agreement among stakeholders that there is not one concentrated area, but rather that there are pockets of drug use dispersed throughout the city. As a political representative noted, "*one reason people may come here from Vancouver is because they find it unsafe there, they're scared because of the concentration [in Vancouver], but in Victoria, we're all over the place*" (SCS13). When asked to identify specific locations where drug-related activities take place, stakeholders most commonly mentioned areas where services for drug users are located, especially near the following organizations: AIDS Vancouver Island (Blanshard St. & Cormorant St.), Streetlink (Swift St. & Store St.), Mustard Seed (Government St. & Queens Ave.), St. John the Divine (Quadra St. & Mason St.), and Sandy Merriman (Quadra St. & Burdett Ave.). As a drug user informant noted, "*downtown, people inject in the underground [parkades], outside of Streetlink, outside the door here [AVI], they go up to the church too [St. John the Divine]…the cops basically give us those four areas where they aren't going to bust you as long as you are gone by 7am*" (FG05). Other areas that were commonly identified are areas where sex trade activities occur, especially Rock Bay and the southwest corner of Beacon Hill Park. However, a few stakeholders stressed that the sex trade tends to move around in Victoria. A number of stakeholders stated that the intersection of Douglas St. and Yates St. is one of the main areas for drug use, purchase, and distribution. A business owner believed that "*Yates St. is the main street for drug use…it's the worst in the city, everyone knows that drugs are available there and drug use in front of the public is very common*" (SCS43). Some stakeholders mentioned that areas along Store St., especially near Value Village and Capital Iron, are common locations for drug use activity. Some of the other locations that were mentioned include: Douglas St. & Pandora St.; Commercial Alley (also known as heroin alley); both ends of the Johnson St. Bridge; Whale Wall; certain sections

along the Galloping Goose Trail; and Bastion Square. Everyone agreed that many areas feel the effects of drug use: "*shooting up is everywhere, on the grounds of Government House, Centennial Square, every neighbourhood is impacted*" (SCS10).

Most stakeholders agreed that the drug problem is widespread and that it is not limited to downtown Victoria. As a social service provider noted, "*the drug scene is often what people see in the downtown core but it's so much more than that… it's not just the small percentage of people who are seen daily on the street, it's a much larger issue*" (SCS01). Some stakeholders explained that as residents and businesses complain about the visibility of drug use downtown, drug users are displaced to areas just outside the downtown core: "*cops get on the bandwagon and it gets pushed out to North Park and Fernwood*" (SCS21). Similarly, a social service provider thought that some drug users are "*moving out to Oak Bay because there is less hassling there*" (SCS14). Other neighbourhoods outside of the downtown core that were frequently mentioned as hot spots for drug-related activity include: Hillside-Quadra area; Victoria West; the 800 block of Esquimalt Rd.; and the western edge of Fairfield. Some stakeholders mentioned that neighbourhoods in transition and low-cost rental housing complexes are areas where drug-related activities take place. However, many stakeholders stressed that drug use is prevalent in many other areas of Victoria, even in communities commonly thought of as wealthy or immune to such social problems. As a political representative noted, "*people in wealthy communities also use drugs, but we don't see this happening, we don't realize they're addicts because they manage to function every day and they manage to fund their addictions…when they shoot up, they're shooting up in their homes*" (SCS09). Other areas in the greater Victoria area that were frequently mentioned also include: Esquimalt; Saanich, especially the Gorge and Tillicum areas; and the Western Communities including Colwood, Langford, and Sooke.

<u>v) Harms Associated with Drug Use</u>

When stakeholders were asked to describe the key harms associated with the drug problem in Victoria, a variety of harms were mentioned including harms to individual drug users and to the community. For individuals, the most commonly mentioned harms were to drug users' physical health, including increased rates of infectious disease transmission (HIV, Hepatitis C, and Hepatitis B) and overdose deaths. A health care provider noted that "*we're seeing a lot of blood borne pathogens, HIV, Hepatitis B and C, and we know that a large number of those affected are street involved*" (SCS08). A social service provider commented that "*80 to 90 percent of injection drug users have Hepatitis C, and there may be just as many with Hepatitis B*" (SCS12). A social service provider mentioned that "*there is the risk of death from overdose or simply passing out and not waking up*" (SCS16). Many stakeholders referred to unsafe injection practices and the increased risk of injuries, abscesses, and sores, while others referred to the incidence of other health conditions and complications. As a health care provider noted, "*I see a lot of physical injury, abscesses, picking sores, and large scabs*" (SCS02). Another health care provider noted that "*injecting leads to individual trauma…abscesses, wounds, bone infections, heart infections*" (SCS08). Some stakeholders referred to injuries that result from the violence and risks associated with the need to procure drugs, including sexual assault. As a social service provider said, "*people being high and walking the street, there is risk of attack, injuries and violence…there are also risks when users are trying to access drugs, there's violence there, rape, and even death*" (SCS16).

The majority of stakeholders also mentioned a number of harms related to drug users' mental health including depression, self-injury, and psychosis. As a social service provider commented, "*it depends on where they are [in their addiction], but for those further along in the process, their life collapses around it…[drug use] deepens depression and it invokes feelings of suicide*" (SCS36). A social service provider noted that

"*occasional psychosis, especially from withdrawal, sometimes it's difficult to figure out if it's the drug or if it's the mental health issue, but we are aware that 80 to 90 percent [of youth] have concurrent disorders*" (SCS14). Some stakeholders expressed concern about the effects of crystal methamphetamine and on individual users' mental health, while others referred to the harms associated with the uncertain purity of certain street drugs. A health care provider explained that "*[methamphetamine] causes a lot of delusional thought and a lot of mental health issues are being unmasked earlier because of crystal meth use and other stimulant use*" (SCS02).

Many stakeholders felt that the marginalization and stigmatization of drug users by local social and health institutions are significant harms. As a social service provider commented, "*there is huge shame and stigma related to drug use, people can't get housing, they can't get respect of any kind, and they can't get fair treatment in the health care system...all areas of their life [are] affected*" (SCS03). Some stakeholders mentioned the breakdown of family relationships and lack of social support as harms associated with drug use. A social service provider explained that drug addiction "*takes hold over time, relationships and families are affected...family members are worried and anxious...there's no support at home, there's real damage there*" (SCS36). Similarly, a social service provider noted that "*[drug use] has major consequences to the family structure and results in isolation among family members...it affects a person's relationships and sense of community and connections within it*" (SCS04). In addition, some stakeholders mentioned that drug users often have fewer opportunities for employment, and are thus not able to contribute as productive members of society, and overall, have a reduced quality of life.

On a community level, common concerns expressed by the majority of stakeholders included the prevalence of improperly discarded needles, urination, and defecation in public places throughout the city. Some stakeholders expressed concern over needle-stick injuries and others stressed that the prevalence of needles in the street and in parks leads to a growing sense of anxiety and fear in the community. As a social service provider noted, "*people see syringes that have been used and discarded, blue caps that have distilled water in them, and used condoms...people react to it because it's not the kind of environment they want to live in, they either feel fearful or distressed by that happening*" (SCS22). A business owner was concerned that "*people come into the store to use the washroom to use drugs, they discard needles, and they go in there to hide drugs from the police...I find needles in the garbage and the washroom...people don't feel safe to walk around the area*" (SCS43).

While many stakeholders expressed concern about the presence of needles and drug-related litter, there was some disagreement about whether these were real or merely perceived harms. For example, a law enforcement representative noted that "*needles dropped are problematic but I think there is an exaggerated [perception of the] number of needles...what we do see are the blue plastic water bottles...but public perception of what people think they see versus reality is really the largest problem, it's their perception and embellishment, and often perception doesn't match reality*" (SCS32). In addition, many of the stakeholders stressed that downtown residents and those who work in the area are not typically fearful and are more concerned with seeing efforts towards helping drug users as opposed to establishing tough measures to deal with the perceived public disorder issues: "*the downtown residents do not experience harm, they don't feel threatened, they have learned to live with users and they've learned how to be safe around them, they're not scared, they're concerned about users, they believe that helping them would be more economically viable than not helping them*" (SCS28). However, it is important to note that while some stakeholders stressed that many of the harms related to the drug problem are 'perceived harms' as opposed to 'real harms,' this by no means diminishes the significance of 'perceived harms,' given that many stakeholders emphasized that 'perceived harms' can nonetheless have a negative impact on the community's sense of safety and well-being.

Many stakeholders also expressed concerns relating to erratic behaviour or to public disorder problems (e.g., yelling, screaming, and apprehension or manifestations of psychosis) and drug-related crime (e.g., car break-ins, thefts, and violence), brought about by what was seen as increased drug activity in the downtown core. A stakeholder from the business community said: "*whether they are sitting [out in the open] scratching their skin as a result of crystal meth or they're simply flying high on any other substance, they can be very highly animated, or in some cases, they can go into a fetal position and go down*" (SCS37). Similarly, a business owner commented: "*before, people in the area would shoot up behind a tree or a car, they used to hide, now, in the last couple of years, people will shoot up right in front of you…[and] the behaviour after [taking the drug] is screaming and yelling all around the area*" (SCS42). A health care provided noted that "*it's a huge issue for community members…people are shooting up in store fronts or when people are walking down the street with their kids, seeing people openly injecting and the behaviour that comes along with it is very disconcerting*" (SCS23).

Many stakeholders referred to drug-related crime: "*people need to maintain their [drug] habit, it cost up to $300 to $400 per day to maintain the habit and there's only a few ways to make that, break and enter, stealing, dealing drugs, prostitution, these are all harms tied to drug use*" (SCS02). A law enforcement representative referred to the drug-related congregations in certain areas: "*with congregation comes drug use, traffickers come to sell drugs, when there is more than one trafficker it results in conflict such as stabbings, shootings, turf wars, I have already seen this on Cormorant St.*" (SCS34). A business owner referred to seeing a lot of drug dealers downtown and observed that "*selling [drugs] also leads to violence in the area*" (SCS43). Many stakeholders stressed that disorder and crime have a negative effect on residents as well as on the city's image because of increased fear and a decreased sense of personal security when coming to the downtown area. However, a common perception was that different harms are associated with different types of drugs. A law enforcement representative offered the following descriptions: "*with crystal meth [use], it's petty crime, stealing change out of cars and that type of thing, with heroin [use], it's elevated somewhat to robberies, people committing crimes to get money to buy drugs…visible use is the injection drug use, marijuana is out there, it's prevalent but it's a soft drug, and people don't get the same issues, [marijuana users] don't cause problems for people and they don't leave needles around*" (SCS32). A political representative believed that "*crystal meth has increased and that's what is creating violence downtown*" (SCS09).

The majority of stakeholders stressed that drug-related harms have a negative impact on businesses and tourism in Victoria, as many people are fearful and tend to stay away from the downtown core. Some of the business owners interviewed claimed to have experienced a significant decrease in sales over the last few years. As a business owner stressed, "*40 percent of my business has been lost since the needle exchange program moved…the seniors housing unit is located behind the building, they used to be regular customers, but now they are afraid to come to the store*" (SCS42). Another business owner noted that "*there are always people hanging around [outside the store] and this hampers my business…50 percent of my business has been lost in the last few years…people who come in say they want to come more but they can't because they don't feel safe…there is stealing and there is also mental torture for the workers because they are being treated with disrespect*" (SCS43). Considering this, some stakeholders believed that unless Victoria's drug-related problems are addressed, they will have a major impact on the long-term future of Victoria's downtown core and its surrounding areas.

In addition to the above-mentioned individual- and community-level harms, all stakeholders agreed that given the health and social impacts of drug use and the frequent need for individual users to access medical and services, the costs associated with health and social care, as well as the costs to emergency medical services in Victoria, are considerable harms. In addition, given the crime and public disorder problems related to

drug use, stakeholders felt that a considerable amount of criminal justice resources are expended in order to deal with drug users and dealers, including tremendous costs to taxpayers in terms of arrests, legal proceedings, and incarceration. In addition, one stakeholder mentioned that insurance costs rise as more and more people claim break and enters or other drug-related property crimes. Overall, it is important to point out that emphasis on one type of harm versus another depended on stakeholders' perceptions of the nature of the drug problem: some emphasized the welfare of the individual drug users and related public health concerns, while others emphasized public order problems.

vi) Landscape of Existing Services

Stakeholders were asked to identify the landscape of existing social, health and addiction services for drug users, as well as the main gaps in services in Victoria. Most stakeholders listed agencies that provided food and shelter, such as: the Mustard Seed, Streetlink, Sandy Merriman, Salvation Army, and some faith-based organizations. Many stakeholders also referred to primary health care services including hospitals, physicians' offices, and Cool Aid. Most stakeholders mentioned the needle exchange services offered through AVI, VARCS, SOLID, and PEERS. A few stakeholders referred to organizations that assist with syringe clean up and disposal. The majority of stakeholders mentioned programs offered through VIHA, such as: street nursing, drug and alcohol counselling, detoxification and stabilization unit, and the Sobering and Assessment Centre. Many stakeholders referred to youth organizations including the Youth Empowerment Society, YMCA/YWCA, and the Boys and Girls Club. A few stakeholders mentioned some alternative housing programs, some private methadone clinics, and some privately funded rehabilitation programs. Many of the drug user informants interviewed reported using the following services: Sobering and Assessment Centre, Pemberton House, PEERS outreach, street nurses, needle exchange program, and the Mustard Seed.

While a strong majority of stakeholders felt that existing services are helpful, they also said that there are some barriers for drug users in accessing crucial services in Victoria. Some stakeholders mentioned that there are barriers to accessing medical care in Victoria, more specifically, that drug users are treated poorly at hospital emergency departments and that they are often turned away, especially if they are suspected of having mental health problems. A drug user informant explained that "*we see people with huge abscesses who are ready to have their arm amputated but they won't get help because they don't have any rights as a patient… they are treated like second class citizens, if they go to emergency, they are put last in line no matter how serious… and so they leave right away because they aren't getting any medical help, they won't stay for long enough to get a full physical*" (FG04). Another drug user informant noted that "*[going to the hospital is] like going to jail, you get treated like you're a nobody…nobody really goes unless they are dragged there in an ambulance…the clinics are ok but they really aren't set up to do what you need…a downtown hospital is needed*" (FG05). In addition, some stakeholders mentioned that ambulance costs are prohibitive and that the Royal Jubilee Hospital is a half hour walk from downtown, which makes it difficult for some individuals to get there.

Another barrier that most stakeholders mentioned are the long wait times for existing services, including addiction services, such as detoxification and treatment. Many stakeholders stressed that long wait times are a deterrent for drug users because often when they decide to take the first steps towards recovery and access treatment services, there are no beds available for them. A drug user informant explained that "*there are only 10 [detox] beds [in Victoria], and when you're ready to kick [stop using drugs], you need to go now, there are no beds when you are ready, and when the bed is ready, maybe you're not ready to go so you go back to the bottom of the list, by the time there's a bed, you've given up*" (FG05). Other stakeholders agreed that services should be

immediate: "*you walk in the door and you [should be able to] go to detox in 10 minutes*" (FG05). Similarly, a restrictive entry requirement for detoxification, such as the need for clients to have a referral from a physician, was cited as a barrier. As a health care provider noted, "*it used to be self-referral, now people need a doctor's note and they need to show proof of use…it's really difficult for this population to keep appointments, and when the window is open, we really have to take advantage of that opportunity*" (SCS08). In addition, some stakeholders said that some agencies have strict zero-tolerance policies for drugs, which creates barriers for drug users who want to access these services. For example, in discussing rules of various programs, a drug user informant said that sobriety is the main rule that deters drug users from accessing existing services: "*you have to be sober to get into [Streetlink] or you can go to the other one [Sobering and Assessment Centre] where you have to be wasted to get in*" (FG04). Also, some drug user informants expressed that they avoid going to some services because of the clientele that these services attract: "*half the people refuse to go to the services because it's a horror show, only the worst of the worst, and the people who really need it aren't using the service*" (FG04).

In addition, the limited hours of operation for some services, such as the needle exchange program (AVI), was perceived as a barrier for drug users. In terms of location, many stakeholders agreed that since most of the services are located in the downtown core, it is difficult for people living in outlying areas to access services. As a political representative noted, "*services are all downtown and this creates difficulty, especially when people are transient and coming from other places in the region*" (SCS13). In addition, some stakeholders expressed that it is problematic to have all services in the downtown core since it could potentially trigger drug use for non- or past-drug users who would prefer to not come to the area. Finally, some stakeholders mentioned that many of the locally existing drug and alcohol counselling programs are not culturally sensitive and as a result, large segments of the Aboriginal population are not accessing the services. Overall, many stakeholders felt that existing services are not tailored to drug users' needs. A drug user informant commented that "*services are not necessarily helpful, but that's what's there*" (FG03). Many of the drug user informants expressed that "*services should be like a hand up, not a hand out and there are a lot of things that could be done to improve services in the area*" (FG05).

vii) Gaps in Existing Services

All stakeholders agreed that additional and, an expansion of existing services, are needed for drug users in Victoria. Many stakeholders stressed that although many of the needed services are available, there is no continuity between services and there is simply not enough service capacity to meet the demand. As a social service provider noted, "*I have seen it get progressively worse in Victoria, there are less and less services, and the need is much more*" (SCS01). The majority of stakeholders emphasized that the most significant gaps are in the areas of withdrawal management, supportive recovery, and supportive housing. Many stakeholders agreed that there are not enough beds for detoxification and stabilization in Victoria (e.g., only seven beds for detoxification and 20 beds for stabilization). Many also felt that services are needed in order to support people in the early phases of addiction recovery. A law enforcement representative noted that "*if 20 drug addicts came to the hospital or the police station today and wanted to get clean, there is nowhere for us to send them*" (SCS34). Stakeholders also felt that additional outpatient clinics, day treatment programs and residential treatment options are needed in Victoria. In addition to the overall lack of beds and facilities, many stakeholders felt that services also need to be tailored to the needs of specific population groups, such as women, Aboriginal people, and youth. In addition, some stakeholders felt that there is an overall lack of treatment services available specifically for stimulant users. For instance, a

few stakeholders noted that detoxification facilities do not admit people who use crystal methamphetamine or cocaine, or else require that they abstain from use before being admitted because use of these types of drugs is not considered to require medical detoxification. Those who raised the issue of lack of treatment options for stimulant users stressed that it is a significant gap because there are no supports in place for stimulant users and, as a law enforcement representative explained, it is difficult for any type of drug user "*to go through withdrawal symptoms alone*" (SCS35).

Many stakeholders agreed that there are significant gaps in services, especially for those who are marginalized by their drug use and for those who are the most vulnerable. As a social service provider noted, "*there is virtually no help at all for people who are addicted in this region*" (SCS03). A strong majority of stakeholders agreed that a full continuum of services from health care to housing is needed in order to improve service provision for drug users in Victoria and that different points of entry into the system are needed, along with appropriate screening and referral mechanisms to properly assess clients' needs and subsequently refer them to the most appropriate programs. In addition, the majority of stakeholders stressed that "*there is a tremendously inadequate supply of housing in Victoria, and this is the main reason for those who have major problems to get into drugs…this is related to use and recovery, people need to eat and sleep first before they can build self-esteem, confidence and experience recovery*" (SCS36). Many stakeholders stressed that there is a need for a full range of housing options with varying levels of support, especially "*wet housing where someone can actively use and where abstinence is not mandatory because any progress should be viewed as a success, we have to deal with the here and now*" (SCS25). A social service provider referred to the need for transition housing in light of the cycle that people go through when they are released from jail or detoxification services: "*they have managed to deal with their health problems, but they have nowhere to go…there are very little services available, regulations and enforcement of our services basically push people onto the street to deal with their problems, then they self-medicate, there is no housing, no mental health services…they are forced back to live in the same community over and over again*" (SCS05). A law enforcement representative agreed: "*recidivism is prevalent, services are needed to work with users over time and provide them with the services they need to recover*" (SCS34).

A strong majority of stakeholders agreed that despite the increasing demand for services, programs are seriously under-funded and that funding cuts continue to limit the availability of services for drug users in Victoria. A political representative commented that "*there is no funding available for addictions in Victoria, and many organizations face serious funding troubles…their funding is either inadequate or fluctuating and there are serious problems when everyone is competing for the limited funds available*" (SCS11). Many stakeholders felt that funding problems stem from the fact that Victoria is not recognized as a metropolitan area and that service provision in Victoria is complicated by the fact that services for addiction and mental health are located in one municipality, that they are funded and supported by one municipality, yet are mandated to deal with the needs of the entire CRD. As a representative of the business community noted, "*we continually see the dropping off of people with addictions problems by outlying police forces to shelters in the [downtown] core because that's where the services are located…so we have what we consider to be an unrealistic concentration in the core, without the support of the outlying regions…if that problem can't be solved, then this all may be a waste*" (SCS06). Many stakeholders stressed that a coordinated government strategy, involving all three levels of government and health agencies in BC, along with the support of the outlying regions, is required in order to address these problems.

In addition, the majority of stakeholders stressed that more washrooms, showers, garbage cans, safe and accessible storage facilities, and shelter spaces are needed, including shelter space where couples are allowed to sleep together. A few stakeholders

thought that drug education is needed to inform drug users about what drugs they are taking, and that additional equipment such as sharps containers and needle drop boxes are needed in various locations throughout the city. Some stakeholders thought there should be longer opening hours at the needle exchange program and that more fixed sites for needle exchange services are needed. Other stakeholders stressed the need for additional street nurse outreach, especially after the needle exchange program closes and one social service provider said that a drop-in centre that is open at night is needed: "*when I'm in Rock Bay at night, people come up to the car looking for rigs [needles], pipes and condoms, there are no services there at night and this is when most of the activity takes place...a drop-in centre at night is needed*" (SCS31). Overall, stakeholders felt that addictions and mental health issues should not be treated in isolation, that there are currently major gaps in Victoria's systems to deal with these issues, and that a full continuum of health and social services and options for drug users is urgently needed.

3. Attitudes Towards Possible SCS Options

This section of the report presents stakeholders' attitudes and opinions concerning possible SCS options in Victoria. The discussion focuses on stakeholders' levels of support regarding an SCS program with a variety of perspectives presented. Next, stakeholders' opinions regarding the benefits of a possible SCS initiative for individuals and the community are explored. Finally, stakeholders' attitudes regarding the risks or challenges associated with implementing possible SCS options in Victoria are discussed.

i) Support for Possible SCS Options

When asked their opinion generally towards an SCS program, an overwhelming majority of stakeholders were in favour of a possible SCS intervention. Many stakeholders felt that given the harms associated with drug use and the existing gaps in services for drug users, an SCS initiative was perceived as desperately needed in Victoria. Some stakeholders stressed that the current systems and services for drug use and addiction in Victoria are inadequate and that alternative and new approaches, such as SCS options, need to be considered. Some stakeholders felt that an SCS program is long overdue in Victoria, given the fact that the idea of an SCS has been discussed for many years and that many key community groups have already indicated their support for an SCS program in Victoria. As a social service provider noted, "*the downtown service providers including the Open Door, Cool Aid, AVI, the police, the City and other agencies...have been pushing for an SCS for several years and they are on record for their support for harm reduction strategies, including an SCS*" (SCS22). Overall, most stakeholders were very supportive of an SCS program. Many offered positive comments about possible SCS options and stressed that it is a good idea for Victoria.

While support for an SCS program in Victoria is strong, a significant minority of stakeholders stressed that they are in favour of an SCS program only if it is part of an integrated strategy, that is, if it is one option in a continuum of services that encompasses not only drug consumption, but also treatment and support mechanisms. As a service provider noted, "*support services need to be available...unless there are opportunities for detox, treatment, and housing, we are doing nothing...Victoria needs an SCS but we also need the support services*" (SCS15). A political representative believed that "*an SCS with supports to take people to the next stage is crucial, if [drug users] want to make a change, then there would have to be supports there to help them transition to the next stage such as housing or job training*" (SCS10). Another political representative said that as long as an SCS program is supervised with an emphasis on harm reduction, "*then it's worthy of my support, I do not support an SCS without any [positive] outcomes or if it exists just to feed someone's addiction*" (SCS40). Other stakeholders agreed and

expressed concern about the practical implications of SCS options if implemented as a stand-alone intervention (e.g., not complemented by counseling services and treatment referrals). A representative from the business community stated: "*if an SCS were to be implemented on its own, without ensuring that a continuum of services are in place, Victoria would just be sweeping the drug problem under the carpet*" (SCS42).

A small minority of stakeholders felt that they could not state a position at the time of the interview and were reluctant to indicate whether they were for or against an SCS program for various reasons. A political representative felt that more information is needed about how SCS options would be implemented, but indicated support for the philosophy of harm reduction as well as the concept of an SCS. Another stakeholder felt that proposed SCS options are merely band-aid solutions and that there is a strong need for other services before SCS options should be given consideration. A drug user informant shared this view and stressed that other basic services such as life supports are needed: "*I think it's ridiculous to have an SCS when people need housing, shelter, and basic needs first*" (FG04). A service provider who works with youth expressed some concerns over youth and adults mixing in a possible SCS program and said that supports for recovery should take priority over an SCS. Finally, a business representative referred to the evaluation of existing SCS programs and stressed that SCS options may be successful at providing referrals, but the evidence regarding how many drug users have been successfully treated has not been shown to date.

A few stakeholders indicated that they were against the implementation of SCS options, or at least needed to see such an initiative strongly linked with and embedded in other critically needed interventions. A law enforcement representative felt that an SCS "*is not the answer…I would prefer more police resources and stiffer penalties to deal with this issue*" (SCS34). Similarly, a business community representative expressed that an SCS "*won't work…it goes back to the goal of all of this is to improve public safety and to make downtown or our community a better place to live in, the goal is not to promote an SCS*" (SCS06). Two other representatives from the business community said that they were against an SCS program but their comments reveal their potential willingness to support an SCS if it was part of an integrated strategy. As one stakeholder noted, "*I understand it's a safe place, but we could be doing more…there is interest in the business community for the four pillar approach, but we are frustrated because of the promises for more sobering beds, education, and rehabilitation opportunities, we haven't seen these manifest yet*" (SCS44). Similarly, a business owner stated, "*I am against the idea unless it could be guaranteed that follow-up or efforts would be provided to help people stop using drugs*" (SCS42).

ii) Benefits of Possible SCS Options

Regardless of their level of support for possible SCS options, the majority of stakeholders felt that there are many potential benefits of an SCS program for both individuals and the community, such as: reducing health related risks and harms among drug users (e.g., infectious disease transmission, fatal and non-fatal overdoses); connecting drug users with other health and social services; helping to reduce public disorder problems (e.g., open drug use, the prevalence of needles and drug paraphernalia) and drug-related crime (e.g., criminal activity related to the need to procure drugs and violence). Many stakeholders who were in favour of SCS options felt that the most important benefit of an SCS initiative would be to provide drug users with a safe, clean environment in which to consume drugs in order to help them reduce their risks of HIV, Hepatitis C, Hepatitis B, and other physical health problems such as abscesses and bacterial infections. As a drug user informant noted, "*[an SCS] will help keep people off the streets and it will give them somewhere safe to go so they're not ending up picking up used needles in the middle of the night*" (FG04). Another drug user

informant said that "*it's a good idea, it'll be a place to get [needles], people use dirty water, so it would be cleaner and people won't get abscesses, they're horrible and painful*" (FG01). Many stakeholders stressed that an important benefit is that overdose incidents would be handled onsite and that effective and immediate interventions with staff would take place at an SCS. As a health care provider noted, "*it's a safer place for them to inject with clean equipment, users will still have their own [street] drugs, so there's still a risk there, but if there's a risk of overdose or disease, people will be there to help*" (SCS08). Similarly, a drug user informant believed that "*[an SCS] could stop people from doing too much of a drug they don't know the purity of*" (FG04).

Many stakeholders felt that another benefit of SCS options would be the opportunity to connect drug users with other health and social services. Many who were supportive of SCS options felt that such an initiative would be an important point of contact for service providers to build relationships with drug users, especially with those who are not regularly accessing services. As a social service provider noted, "*it's an opportunity to work with everyone that comes through the door, by working with people and wrapping services around them, it will provide opportunities for people to look at other options other than using [drugs]*" (SCS22). A drug user informant expressed that "*it would encourage people to be more health conscious, they [SCS staff] could treat you the right away, I would go more often, I would feel better about going there, there would be rapport with nurses and doctors, you would get a positive reaction, like with the street nurses*" (FG05). Many stakeholders believed that an SCS program would offer a normalizing experience for typically marginalized drug users. A health care provider stressed, "*it's a place where people can come in an orderly fashion, talk to someone at reception who will treat them with respect, sit down in a clean place, be given help if they need it, sit and have a cup of coffee, and be offered other resources...this is a humanizing experience that they may not have had in years and that's the sort of experience they require*" (SCS08). In addition, a few stakeholders mentioned that SCS options would also contribute to a reduction in costs to the health care system, particularly emergency services and hospitalization costs associated with drug-related issues, since health concerns such as abscesses – typically left untreated until an emergency situation requiring hospitalization arises – could be treated earlier, and thus represent cost-savings.

In addition, many stakeholders felt that an SCS program would help to reduce public disorder problems such as open drug use in the community. For instance, a social service provider hoped that an SCS initiative "*will help take an active drug market off the streets, there will be less using outside...the public wants to see people off the streets*" (SCS12). Similarly, a drug user informant noted that "*[an SCS] would help everyone, it would give users a place to go...it keeps users off the street and away from the kids*" (FG03). Another drug user informant said that having "*a place [for drug users] to go would make the businesses happier...it would keep things private, you just go there and do your thing and nobody bothers you...it would cut down on arguing and a lot of bullshit*" (FG05). Many stakeholders felt that an SCS program would help reduce the prevalence of needles and paraphernalia and that there would be less anxiety and fear about health risks in the community. A health care provider believed that an SCS initiative would contribute to "*decreased needles in parks and schools and a decreased subsequent risk of injury from exposure to needles*" (SCS14). In addition, many stakeholders hoped that an SCS program would help reduce criminal activity related to the need to procure drugs and violence in the community. A drug user informant stressed that an SCS would "*save lives, alleys are being locked now and the streets are getting violent*" (FG03).

Overall, even stakeholders who were leaning against the idea of an SCS felt that there would be some potential benefits, they were just skeptical about whether or not the benefits would be realized. As a business community representative noted, "*the real question is if we get an SCS, will it reduce the amount of property crime, make our streets safer, reduce the number of people who are addicted...if all those things are true, why*

would I say no, but no one has been able to convince me of that...the benefit we want is improved public safety in our community, we need that output as a community" (SCS06).

iii) <u>Risks or Challenges of Possible SCS Options</u>

Despite stakeholders' perceptions of the many benefits of possible SCS options, most stakeholders agreed that there are also some risks or challenges associated with possible SCS options in Victoria. The most commonly mentioned risks or challenges included: the difficulty of finding a location for an SCS program given that the perception was that 'not in my backyard syndrome' (NIMBY) attitudes hold strong in Victoria; the possibility that an SCS initiative could contribute to the perception of enabling drug use, especially if treatment is not provided; and the possibility that SCS options could increase public disorder (e.g., screaming, yelling, and discarded needles) and drug-related crime (e.g., drug dealing, theft, and violence) around the possible site(s). Regardless of their level of support, the majority of stakeholders agreed that the most significant challenge would be to ensure its public acceptability in the local environment where it would be situated, recognizing that local tensions exist towards the idea of SCS options, as well as differing perceptions about whether an SCS initiative is the best approach for dealing with Victoria's drug-related problems. As a political representative noted, "*it's always difficult to put a social agency into a neighbourhood, it often needs rezoning and this is difficult for people... NIMBY is strong in neighbourhoods and in other municipalities, so it will be a challenge to find the right place for the SCS*" (SCS13). A social service provider stressed that these types of programs have the "*tendency to concentrate [drug] use, similar to the needle exchange, so finding a location is a challenge...people will agree with the initiative but NIMBY does exist*" (SCS15).

A related risk for many stakeholders, especially those who indicated conditional support and those who were against an SCS program, was the perception that an SCS program would be seen as enabling drug use without providing adequate opportunities for treatment or efforts to deal with the larger problem of addiction. Some stakeholders described the perceptions that exist regarding the idea of an SCS initiative as expressed by the following view from a stakeholder: "*the perception is that it will enable addicts to maintain what is seen as a unhealthy lifestyle choice...people don't believe that the government should allow people to use drugs, [an SCS] is viewed as a solution that doesn't cost very much and it's not going to solve the problem of addiction*" (SCS21). Other stakeholders agreed that if the community believes that nothing is being done to address some of the larger issues, such as the lack of treatment and public disorder issues, the community will be less accepting of an SCS program. A political representative noted that "*there is a risk in not dealing with the health issues in a substantive way, a positive approach is needed, not just doing something that will help make the streets look better or so that people won't have to watch somebody shoot up in a parkade*" (SCS10). Similarly, another political representative stated that "*if [an SCS is] just a site for clients to use [drugs] and leave, it won't deal with the issues of crime, violence and other problems such as homelessness*" (SCS09). A few stakeholders expressed concerns that implementing an SCS program might create the perception that the 'drug problem' has been solved and other, much needed, interventions and programs would risk falling by the wayside.

Another risk seen by many stakeholders was the fear that SCS options would potentially increase – at least locally – public disorder problems (e.g., screaming, yelling, and prevalence of needles on street). As a business owner noted, "*if people use the [SCS] and then go outside, they will be screaming and yelling, unless people can stay there until the drugs wear off*" (SCS42). Some stakeholders believed that there would still be open drug use, regardless of whether an SCS program existed or not: "*people say it will get consumption off the street, but I'm not sure about this, you still see it downtown in*

Vancouver even after Dr. Peter's Centre at St. Paul's, and Insite [were opened]" (SCS15). A business community representative referred to people sleeping in doorways, the prevalence of strewn needles, garbage, and urine and defecation on the streets and suggested that an SCS intervention could amplify these kinds of problems for communities: "*it's unfortunate that that's the case…those types of environments that those services create, we don't want them because it's a cancer that spreads throughout businesses and makes communities unsafe*" (SCS06). Similarly, a law enforcement representative suggested that "*[an SCS] won't cut down on [discarded] needles…I stop people routinely and they have huge amounts of needles on them, it's unbelievable where they leave them and the shape they leave them in…[an SCS] won't cut down on needles because only a small percentage of the population will use the site*" (SCS34).

Some stakeholders expressed concern about the possibility of increased drug-related crime (e.g., drug dealing, theft, and violence) in the vicinity of a possible SCS. A law enforcement representative believed that "*we'll just have more congregation issues like at the needle exchange, dealers will go to the area to sell drugs, and the immediate area around the site will become infested with the drug trade, the sex trade, and there will be stolen property and other crimes*" (SCS34). Others expressed concern about attracting drug dealers and violence to the area of a possible SCS. A business owner stressed that an SCS program "*could attract dealers, lots of dealers hang around outside the needle exchange program, even in front of the door, they're there before and after it opens and there is also violence*" (SCS42). A social service provider cautioned that "*[an SCS] may attract some [drug users] who are too dangerous, those who are predatory for example, those who may get turned away at other services, this will have to be dealt with*" (SCS15). A drug user informant noted that if not effectively prevented, "*a congregation of dealers can create violence…it will probably turn into open vending*" (FG02).

It is important to note however, that stakeholders overall identified many more possible benefits associated with an SCS program than possible risks, challenges or downsides. Many stakeholders, especially those who indicated full support for an SCS initiative, felt that there are no inherent risks with the intervention itself and that there are likely many more benefits to users and to the community if SCS options were implemented in Victoria. As a drug user informant noted, "*I don't see anything negative about it, all I see is it helping…it's riskier to not have it [an SCS]*" (FG01). Attitudes and opinions about the benefits and risks of an SCS were linked to stakeholders' level of support and were split between those concerned primarily with public health and public order. That is, those supportive of the idea saw no prohibitive inherent risks, while those somewhat or categorically opposed saw few or no benefits. Despite overall support for an SCS program, many stakeholders felt that the implementation of possible SCS options is likely to face some opposition in Victoria, not only from political and business groups, but also from the general community. Regardless of their position, the majority of stakeholders felt that a greater understanding of the practical concept, details and implications of SCS options among the general community is required before an SCS program can be effectively implemented and its benefits realized.

4.   Attitudes Towards Design, Operations and Services of Possible SCS Options

In this section, the attitudes and opinions of stakeholders regarding the design, operations and services of possible SCS options are presented. The discussion concentrates on different delivery model options, potential locations and preferences regarding the design for a possible SCS intervention. In terms of operational issues, the focus is on staffing, hours of operation and stakeholders' views are put forward concerning who should run and provide funding for a possible SCS program. The discussion then moves toward the types of services stakeholders would like to see offered in an integrated

SCS service delivery model. Finally, the drug user target groups of possible SCS options are explored.

i) SCS Delivery Model Options

When stakeholders were asked which delivery model they preferred for possible SCS options in Victoria, an overwhelming majority supported a *decentralized* (e.g., two or three smaller facilities in various locations) versus a *centralized* model (e.g., a single larger stand-alone facility, like Vancouver's *Insite*).   Many stakeholders expressed that although a centralized model was perceived to have positive effects in Vancouver, Victoria was seen as a different place with different needs. As a drug user informant commented, "*Victoria is not the same as Vancouver…[the drug problem] is dispersed all over the region and there are pockets of drug use all over town*" (FG02). In discussing the nature of the drug problem, it was mentioned by several stakeholders that despite the perception that problematic drug use is confined to downtown Victoria due primarily to its visibility there, it is widespread throughout the city and even the CRD. Building on this theme, a health care provider suggested that "*a decentralized model is preferred if other municipalities collaborate…if we agree that it's not just a downtown Victoria problem, then two or three sites will increase the availability of the service and help increase access to everyone in need, especially for people in outlying areas who typically remain hidden*" (SCS25). A decentralized SCS model was commonly viewed as having the following benefits: it would help normalize the service; it would help spread the client load; and it would reduce any potential detrimental impacts on any one neighbourhood or business area. As a law enforcement representative commented, "*one [SCS] is problematic because it will create congregations of users and dealers causing a potential for violence*" (SCS34). In addition, according to many of the drug user informants that were interviewed, an important benefit of a decentralized model would be that drug user clients would have a choice over which facility to frequent. For instance, "*non-street involved users might not want to come downtown and others might want to access a site outside of their community for fear of running into someone they know or have a beef with*" (FG01). Many stakeholders emphasized and agreed however, that while there is a definite need for an SCS program downtown, having additional sites outside the downtown core or in other municipalities would prevent the ghettoization of services. As a social service provider explained, "*it's not good to concentrate all services downtown since it creates a volcano of social ills*" (SCS07).

Despite the strong and vocal majority supporting a decentralized SCS model, the interview data did not elicit a clear picture of how this option should be implemented. Stakeholder views were split between either proposing to integrate SCS-like services into existing social or health care settings or institutions (e.g., public health units, emergency rooms, doctor's offices, clinics, non-profit and faith-based organizations) versus the idea of establishing multiple larger and comprehensive stand-alone SCS facilities (e.g., two or three new facilities, like Vancouver's *Insite*, in various locations). Given that the NIMBY issue with regard to SCS options was perceived as holding strong in Victoria, some stakeholders believed that public acceptance of SCS options could be increased by integrating SCS services (e.g., that is by setting up two or three drug consumption spaces) into existing health and social services because the service structures are already in place and locations would not have to be negotiated. Some stakeholders mentioned additional benefits of such an integration. Firstly, the perception was that given that existing local service providers, such as AVI and Cool-Aid, are already connected with other service providers, the referral process to these services – if offering an SCS component – would be smoother. Secondly, these existing organizations have already developed a certain level of trust and rapport with the drug user populations likely targeted by an SCS intervention, which was viewed as a crucial predictor for a heightened

uptake of SCS services. However, in terms of logistics, physical space constraints were viewed as potentially outweighing many of the benefits associated with the idea of integrating SCS services into existing organizations, possibly making for crowded quarters, limited availability of other services and hindering the operation of the original service's mandate. For these reasons, some stakeholder preferred the construction of new and more broadly-oriented SCS facilities that would resemble the European model of a 'contact centre,' described by a health care provider as a "*one-stop shopping where the higher you go in floors, the healthier you get…it's a building with [supervised consumption] services on the first floor and if a client needed counselling or wanted to get away from [the drug scene] they could go to the second floor, and then you'd find detox on the third floor*" (SCS02). Stakeholders who preferred this option stressed that it was important to have the various ancillary SCS services (e.g., counselling, basic health care, treatment referrals and social services) in one place because it would increase their accessibility, and thus the likelihood that clients will access the service and follow through.

The minority of stakeholders who supported a centralized SCS model thought that such a model would be better able to implement the 'contact centre' model where all services are housed under one roof as opposed to a decentralized model which might result in potential redundancy, or local limitation of infrastructure or services provided. According to a political representative, "*one fixed [SCS] site will work better since all services could be in one place and staff could support each other as opposed to smaller sites spread around that might not have sufficient capacity in terms of services and staffing…if there are multiple sites, services will continue to be scattered around and it will be harder to demonstrate its success…I'd rather see one successful site than three unsuccessful sites*" (SCS40). Those who expressed concerns that an SCS program might have a negative impact on the surrounding area were of the opinion that having one facility would at least contain those impacts to the chosen location. Contrary to the opinion of the law enforcement official who supported a decentralized model to diffuse congregations of users and dealers, a business owner commented that "*[an SCS] facility will affect the area, people will hang around outside, so if the sites are everywhere, it will be bad everywhere…there should only be one*" (SCS43).

Another SCS program delivery option that a few stakeholders mentioned was the possibility of having a mobile SCS component[3] (e.g., a van, bus, or mobile home that would travel to different locations on a set schedule) either in addition to or instead of one or more of the fixed facilities. A drug user informant thought that there should be "*a big site downtown and a van to serve Esquimalt, the Western communities and Saanich*" (FG02), while a business owner preferred a van "*since it's not permanent and can reach people in different neighbourhoods*" (SCS42). However, some stakeholders expressed concern that a mobile SCS unit might not be able to meet its clients' needs or deliver adequate services and that it would be more difficult to establish trust due to its fleeting nature. Further concerns relating to possible capacity limitations were expressed by a drug user informant: "*a mobile unit would have long wait times and nobody would wait because when you want to use [drugs], you want to use now*" (FG03).

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[3] A mobile SCS facility has been in operation in Berlin, Germany since 2003. In Barcelona, Spain, SCS service provision began as a mobile unit that operated four hours a day on weekdays but was replaced by a fixed SCS in 2003. Mobile operations have been described as a possible way of managing community concerns and avoiding the costs associated with fixed sites (see Hunt, N. *Paper C: An overview of models of delivery of drug consumption rooms*. Independent Working Group on Drug Consumption Rooms, Joseph Rowntree Foundation, UK: 2006).

ii) Possible SCS Locations

Regardless of the chosen delivery model for a possible SCS intervention, many stakeholders emphasized that it would be difficult to select a location(s) in Victoria that would be accessible for the target population, but that would also not be met by considerable resistance from at least some part of the community. Overall, stakeholders predominantly agreed that if there was only going to be one SCS facility in Victoria it should be located in the downtown core, and furthermore, ideally; in a non-residential area (e.g., commercial or industrial zone); on or near a bus route; far from a school zone; and close to the prevailing places of street drug purchasing in Victoria (given drug users' admitted unwillingness to travel far distances from the location of drug purchase). When asked the maximum distance drug users would be willing to travel to an SCS facility, a drug user informant responded: "*not far…within three minutes of having it [the drugs], you acquire, then you use…I usually hit up the nearest bathroom*" (FG04). On average, drug users reported that they would travel between three and five city blocks to use an SCS facility, however one drug user informant thought that "*if there was a guarantee that [the SCS is] there and it's safe, most people would be willing to travel farther…look how far we go for our dope, I've walked a day for my junk*" (FG02).

Among stakeholders who preferred a decentralized SCS model consisting of multiple facilities (e.g., at least two), the majority believed that at least one of the SCS facilities should be downtown. Specifically, the most commonly suggested downtown locations – also mentioned by stakeholders favouring a centralized model located downtown – were: Cool Aid area (Store St.) or AVI area (Blanshard St. & Cormorant St.); nearby Churches (Quadra St. & Yates St. and Quadra St. & Broughton St.); Douglas St. & Yates St.; lower Government St.; 'the dead zone' (behind the YMCA); Herald St. & Discovery St. More unorthodox propositions for possible SCS locations suggested by stakeholders preferring a centralized model included Victoria Police Headquarters and Centennial Square. With regard to Centennial Square, a political representative said: "*if they won't allow it [an SCS] there beside them at City Hall, how can they ask others to accept it someplace else? It's happening there already, although unsupervised*" (SCS15). Stakeholders who preferred the decentralized model thought that in addition to a downtown location, there should be another facility located outside of the core but still within walking distance to existing services, in areas commonly mentioned, such as Rock Bay Ave., Gorge Rd., Fernwood area, North Park area, Hillside Ave. & Quadra St., Cook St. & Fort St., and the Royal Jubilee Hospital area. These locations were also commonly suggested as the potential location for a centralized SCS model among stakeholders who preferred that service agencies not be concentrated downtown. Many of the stakeholders who supported a decentralized SCS model strongly believed that, aside from Victoria, there is also a need for SCS services in other municipalities adjacent to Victoria, such as, Esquimalt, Saanich, Sooke, Langford, Colwood, View Royal, and Oak Bay.

iii) Preferred SCS Design Options

When stakeholders were asked to describe how a possible SCS facility should be designed in terms of layout and operations, everyone agreed that the design should be based on a medical model or similar to a wellness centre and ideally serve as a portal to other services. Many expressed that it should resemble Vancouver's *Insite* with a one-way traffic flow system where clients would enter through one door, access respective SCS services offered, and leave through another door. The idea is that clients would enter into a waiting room where there would be professionals and/or peers to engage them while they waited to proceed to the actual consumption areas (e.g., injection or inhalation room); some stakeholders mentioned that having staff on hand to chat with drug users would be beneficial given that the opportunity for intervention was perceived to be very

small and because the belief was that drug users might not otherwise attempt to access, or might not know about available services. If they were first-time clients, they would go to a private room, as part of the waiting area, to register and be assessed by a staff member to find out which services would best meet their needs. After clients made use of the consumption facilities, they would then move to a chill-out room where snacks and coffee would be provided and, once again, have the opportunity to consult with staff before leaving. A few people mentioned that it would be good to have separate rooms for clients who needed to be secluded or who wanted to be alone either for their drug-use episodes or afterwards. As a drug user informant said, "*some people get violent after they smash [inject]…they need to be in a separate room by themselves with supervision, and even have a separate exit door to keep them from bothering others*" (FG01). Others preferred the therapeutic community model used at Vancouver's Dr. Peter Centre, described as a more discrete, informal and holistic health care setting with supervised drug use as one among many programs and services.

Reflecting more specifically on interior design options for the drug consumption facilities, most stakeholders liked the idea of having individual stalls with mirrors on the walls that would allow for both privacy and supervision. One drug user informant commented that there should be "*a little cubicle for yourself so everybody's not watching you or grinding you for [stealing] your dope*" (FG01). Another drug user informant liked the idea of having stainless steel furnishings: "*you got your table with stainless steel tubing with a little door and when you're finished you drop your stuff down and it goes to a safe container…you just have to sanitize the table top*" (FG04). Some drug user informants also mentioned that there could be a larger table where people could consume their drugs in a more social and less clinical atmosphere, and health professionals could supervise from a room with a one-way mirror and enter the consumption room to provide appropriate help when needed. Numerous people mentioned that an SCS facility should be clean, well-lit, wheelchair accessible, and that it should be discrete and as low-profile as possible. Some stakeholders also suggested the idea of having a courtyard within the facility's boundaries to reduce the possibility of clients congregating outside and to provide them with a feeling of safety.

iv) Operational Issues for Possible SCS Options

Given that the concept of possible SCS options was primarily viewed as a health intervention by the majority of stakeholders, when asked to describe how an SCS facility should be staffed, it is probably not surprising that the most frequently mentioned type of workers were physical health (e.g., nurses and doctors) and mental health (e.g., psychiatrists or psychologists) professionals with a background or experience in addictions. Stakeholders believed that there should always be a nurse on any given shift and doctors could be on-call or have designated hours. It was stressed that the staff would need to be compassionate, non-judgmental, knowledgeable, and choose to work in this field. As a drug user informant commented, "*nurses should be like the street nurses and not like the ones at Royal Jubilee [Hospital]…they need to be understanding and treat you with dignity*" (FG03). Having drug and alcohol counsellors on staff was the next most commonly mentioned type of worker but it was also recommended that peer counselors be on staff to help make those first crucial connections and help build rapport with clients. The value of experiential counselling was described by a social service provider: "*no one can help someone in an addiction unless they've been there, it's a whole different way of thinking…behaviour and patterns that can only be understood by someone who has been through it*" (SCS03). A drug user informant commented that peer counsellors "*should be strong in their recovery so they won't be triggered [to use drugs again]…they have greater insight*" (FG03). It was also suggested that there should be a role for peer volunteers (e.g., current drug users) and "*there would be a rule that they would have to stay clean*

that day and they'd be there to talk to users and help around" (FG01). However, another drug user informant warned that "*having [drug] users volunteer would be a real hit or miss…street people can understand the complexity of other people's issues, but can't be always be trusted. It's hard to find jobs for these people. It would have to be done on a case-by-case basis and they would have to be supervised closely because there is a lot of trickery and deception going on*" (FG04). Another common theme was that peers should be involved in the planning and consultation process of possible SCS options from the beginning so they will have a sense of ownership and end up keeping order amongst themselves and taking care of problems because they would have stake in the success of the program.

Some stakeholders believed that the role of social workers would be to help link clients to the larger community network of services; act as advocates for income assistance, housing and treatment; and help to set up support mechanisms for clients along the continuum of care. Many also suggested having outreach workers to take SCS clients to detoxification facilities or to other appointments and connect with people who would not use an SCS program. Some people said it would be necessary to have child and youth care workers if youth were permitted to access an SCS facility. The following types of staff were also mentioned: nutritionists; office managers; education professionals; financial advisors; security personnel; religious figures; and someone to teach life skills. Many stakeholders also noted that consistency and continuity of staff is important to build rapport, relationships and trust, and that the quality of the staff is paramount to ensure individualized and client-centered service provision. A few service providers also stressed the importance of having culturally sensitive services and workers who are able to understand and address the specific needs of, for example, the Aboriginal community. In addition, stakeholders were clear in their belief that all staff must be firmly rooted in a harm reduction philosophy towards addiction issues as opposed to abstinence. For instance, a drug user informant expressed that "*people won't go if counselling is about abstinence…it just doesn't work*" (FG02).

The majority of stakeholders believed that an existing community agency that has experience and expertise dealing with the target population and that has a good track record at addressing community concerns should run possible SCS options in Victoria (a few stakeholders spoke about several existing agencies coming together to form a community partnership model). Many stakeholders specifically mentioned that AIDS Vancouver Island and the Victoria Cool Aid Society would be good, natural and well-qualified candidates since they are said to be understanding of their street drug user clients' needs and trusted. Some stakeholders thought VIHA should run SCS programs since it would formally acknowledge an SCS program as a health intervention. Stakeholders favouring a VIHA-run intervention expressed concerns, as one business owner put it, that "*50 to 70% of funding given to non-profits goes to administration instead of programming, so it would be better if it was government-run*" (SCS41). Conversely, a few stakeholders were of the opinion that since VIHA is responsible for so many health care issues, addiction is not given priority and based on past experience, VIHA's bureaucracy is too large and inflexible to respond effectively to emerging street level issues. These stakeholders believed that VIHA would likely be a source of funding for a possible SCS intervention, but should contract the service out to a more responsive community-based agency. Others thought the City of Victoria could also play a role in the operations and implementation of possible SCS options by "*helping to bring in care providers, providing land and dealing with zoning and density issues to make the implementation process smoother*" (SCS33). A couple of stakeholders mentioned that Victoria needed a free standing addictions commission whose sole purpose would be to manage addictions issues and develop effective, collaborative strategies for the whole region, including SCS programs.

In terms of funding for possible SCS options, most stakeholders agreed that there should be a partnership between all levels of government. However, there was some disagreement about whether the City of Victoria should provide ongoing funding, the idea being that it would set a bad precedent since health is a provincial responsibility. In addition, many stakeholders remarked that if the City of Victoria provided funding it would reinforce the perception that the drug problem is only downtown Victoria's problem, rather than acknowledging that drug use is widespread throughout the CRD. Overall, stakeholders agreed that "*you get what you pay for*" (SCS33) and to ensure its success, SCS options would have to be well funded. As a law enforcement representative explained, "*funding decisions will affect the success of the SCS...if the funding is low-end and must rely heavily on volunteers, it'll be patchwork and you will get no results. There needs to be professional staff and they need to be well-paid*" (SCS33).

When stakeholders were asked what the hours of operation for a possible SCS should be, everyone agreed that ideally, SCS programs should be open 24 hours a day, 365 days a year, including weekends and statutory holidays. A political representative made it clear that "*drug use is not a nine to five job*" (SCS10). When probed further, asking which hours were the most crucial, a drug user informant responded: "*I'm serious, there is no compromise here...a junky won't sleep and drug use doesn't stop, there is always someone out there using*" (FG01). Another drug user informant said that "*there are less people using between 10am and 6pm but people are always using and the peak times change all the time, so there is always a need for service*" (FG03). Overall, it seems that if SCS options could not be available 24 hours a day, there was a prevailing view among stakeholders that SCS services should ideally be open from late afternoon (e.g., 3 or 5pm) until early morning (e.g., 6 or 8am).

<u>v) SCS Service Delivery</u>

There was widespread agreement among stakeholders that a possible SCS intervention should adopt an integrated service delivery model that supports clients on all levels of the continuum of services from basic health care to mental health care to housing, with some services offered onsite and others for which referrals would be provided. Some stakeholders mentioned that services should be available on a drop-in basis rather than by appointment. In terms of services offered onsite, the majority of stakeholders frequently mentioned the following: overdose intervention; primary health care (specifically, the treatment of abscesses and sores, first aid, dentistry and the provision of antibiotics and medications); counselling; and safer drug use education. Other stakeholders also suggested that there should be drop-in peer support groups, STI and other disease testing and post-test counselling, anger management training, and a low-threshold methadone maintenance program. Most drug user informants expressed the need for access to storage lockers, washrooms, a bin for clothing exchange, telephones, computers, and a few mentioned that they needed a place to keep their dogs or other pets while using the facility. Although outside the scope of SCS programming, a few stakeholders mentioned that drugs should be provided onsite (by way of medical prescription) because otherwise some of the risks associated with drug use (e.g., the uncertain purity of street drugs and the criminality associated with the need to procure drugs at street-level prices) would not be reduced.

There was considerable debate over whether some of the services to be provided by a possible SCS should be offered onsite or whether referrals should be given instead. For instance, some stakeholders were of the opinion that an SCS program should offer some form of detoxification treatment, whether it was day beds, emergency inpatient detoxification beds or acupuncture detoxification. Supporters of onsite detoxification expressed that the main benefit would be the immediate access for clients who decided they wanted to seek such treatment. A social service provider stressed the importance of

the immediacy of access: "*the window of opportunity is very small…if someone wants to get clean, the service needs to be [available] immediate[ly]*" (SCS36). Others believed that having day beds (sometimes referred to as "daytox") would be a good resource for dealing with highly intoxicated clients who presented themselves at the facility. Rather than turning the client away or allowing the client to consume drugs – two responses that were viewed as potentially putting the client at further risk – the client could be admitted to a day bed where they would be safely monitored. Conversely, some stakeholders did not think it was a good idea to have detoxification services physically located on the premises of an SCS on the grounds that consumption related activities occurring in the same space would make recovery all the more difficult and could rather, act as a trigger for further use. Others thought that it was not realistic to expect that people would want to seek treatment if they were in a place geared towards supervised drug consumption. Instead, it was suggested that referrals and transportation to detoxification services located elsewhere should be provided.

There were also mixed views about whether food, showers, and laundry should be offered as SCS onsite services. There was consensus among stakeholders that snacks and coffee should be provided in the chill-out room, but many people expressed that anything beyond snacks would be appropriate only if there was enough funding and only if it was healthy food. A social service provider commented that "*there is lots of food in Victoria [at existing service agencies], so I would be concerned about diluting the service. If the focus is too broad, there will be less resources to deal with drug use and addiction, which is the priority. We should avoid duplication or potentially taking away from existing services*" (SCS07). Another social service provider mentioned that "*so many drop-ins get bags of donuts, which fills you up but is not healthy…if they are going to provide food [at an SCS], it should be nutritious*" (SCS01). On the other hand, some people thought that the goal of an SCS program would be to act as a main contact point, and therefore food, showers and laundry would be useful for drawing people in and possibly encouraging clients to access other services besides the consumption room. A health care provider commented that "*giving people a chance to clean themselves up and have a bite to eat are part of the normalizing experience, making people feel like they are human beings*" (SCS08). A drug user informant said that "*once people get their feet on the ground, they will be more likely to look for recovery*" (FG02). While some stakeholders agreed that an SCS program should function as a contact point, they expressed concerns that providing food, showers and laundry would hold people up and might have the potential to turn an SCS facility into another drop-in centre, an outcome that many stakeholders viewed as a failure. A political representative mentioned that "*the goal should be to move people out…providing food and laundry might attract a lot of people [not in need of SCS services] that you won't be able to get rid of and might make it difficult for people who really need and want to use the services*" (SCS15). A drug user informant offered an example: "*if you are trying to clean yourself up and someone is really high, flailing all over the place trying to do laundry and not getting it done fast enough and someone is waiting to use the machine…that could cause some friction*" (FG01). Some stakeholders commented that the realities of different types of drug use would determine the services clients would be able to use. For instance, a health care provider thought "*heroin users would be able to make use of services right after shooting whereas crystal meth users would need to wait anywhere between eight and 12 hours to come down [be less intoxicated] before being in a position to use other services*" (SCS02).

Similar arguments for and against the onsite provision of social integration services, such as job training, activities and opportunities for clients to volunteer in the community, were put forward. Again, many stakeholders mentioned that if it was feasible to incorporate these types of services in one location, then it was viewed as a good idea since "*you need to deal with the whole person, not just the addiction*" (SCS08), but overall, these were not viewed as priorities since these services were perceived to exist

elsewhere and it was emphasized that duplication of services should be avoided. Some stakeholders indicated that referrals to these services would be better and that it should be the role of SCS outreach workers to "*link clients with these services, maybe give them a ride to and from, and follow-up with them*" (SCS29). However, many stakeholders believed that the addiction needed to be taken care of before promoting general life skills. As a political representative said, "*it's an unrealistic expectation, it's like putting the cart before the horse…people are not at the right stage to be successful with job training*" (SCS10). Others agreed that job training was unrealistic unless the client had gone through treatment but some thought volunteer opportunities would be great. A health care provider believed that "*people could pick up needles or leaves, or help clean up inside and outside of the facility as progressive steps towards job training…gaining a sense of purpose is very important*" (SCS30).

Overall, stakeholders were of the opinion that an SCS program should have a broader focus than supervised drug consumption alone, as one drug user informant aptly put it: "*it should be so that the SCS is more than just because I want to put something in me*" (FG01). Many stakeholders noted that it was important to provide services in a holistic fashion: "*an individualized, humanistic and client-centered approach is so important because drug use overlaps with everything…not everybody is ready to make changes and so support is needed for each of the stages people find themselves in*" (SCS03). Stakeholders also thought that an SCS program should offer: case management, to again highlight the importance of individually-tailored service delivery; a high level of interagency communication and cooperation to ensure smooth referrals to treatment, housing supports, detoxification, supportive recovery, and family planning; and a healing component. A few stakeholders emphasized that in a decentralized SCS model, each facility might not have all of the same services offered onsite but it would be important that they offer the same referral options in order to streamline the service. Some stakeholders also mentioned that the local context of a given facility would dictate which services were most needed. For instance, a health care provider commented that "*showers would be needed downtown, but maybe not in Oak Bay*" (SCS26).

vi) Target Group of SCS Services

While the majority of stakeholders believed that an SCS would cater mostly to long-term street-involved drug users, or to those who did not have a place to go, other stakeholders thought that "*we shouldn't jump to conclusions about who will be using the facility*" (SCS10), some expressing hope that over time, the shame and stigma associated with addiction could be reduced and that an SCS program would attract a more diverse population of drug users. As one stakeholder commented, "*it's not going to be for the middle-class drug user with a home or the recreational drug user who comes downtown to score drugs, but we shouldn't rule them out*" (SCS11). Other stakeholders described the target population as those most in need or at highest health risk, such as homeless people and sex trade workers, and people who wanted to help themselves.

In terms of the types of drugs or the methods of drug use, the majority believed that SCS options should be open to anyone with an active addiction, regardless of the type of drug or whether the drug was used by injection or inhalation, since as a business representative said, "*Victoria's drug problems are greater than injection drug use alone*" (SCS44), and as a drug user informant said, "*you can't discriminate between different methods of use or types of drugs because people change their habits from injecting to smoking if they can't get a vein or use different drugs if they can't buy their drug of choice*" (FG03). Another drug user informant commented that "*unless the drugs are provided, you can't start excluding some drugs because people are selling bunk dope out there and it's dangerous because you don't know what you're getting*" (FG01). Others commented that if the goal is to get people off drugs or to help anybody at risk, an SCS

facility should be open to all types of users. A drug user informant agreed: "*people say smoking is not as risky, but I've overdosed on a crack pipe...all drug use is risky*" (FG01). Some stakeholders believed smokers would be less likely to use an SCS facility compared to injectors since the perception was that people could smoke drugs, such as crack or crystal methamphetamine, outside with relative ease. As a drug user informant noted, "*smokers can smoke anywhere*" (FG02), and other stakeholders were not sure whether there was much harm associated with smoking, or even how an inhalation facility would be possible given smoking bylaws, but were nonetheless supportive of inhalation if there was a demonstrable need for the service. One service provider said that SCS options might need to include a specialized program for crystal methamphetamine users or those with psychosis because of the uncertainty over how to manage the respective behavioural manifestations. A drug user informant believed that "*there should be no crystal meth whatsoever*" (FG02), however, a peer argued that "*if you say no crystal meth, people will still have to hide...why should one drug be put against another? If you have an addiction you should be able to get help...the younger generation is using meth and that's the most dangerous so it's not fair to exclude anyone...you can't judge or persecute them...anything and everything goes*" (FG02).

Among stakeholders who wanted possible SCS options to be open to both injection and inhalation drug use, there was disagreement over whether capacity for both methods of consumption should be offered at the same facility or at separate facilities. One social service provider commented that "*injectors and inhalers in the same facility would be okay – they are all poly-drug users anyway*" (SCS03). A political representative disagreed saying that "*there has to be capacity to deal with different groups, levels and intensities of drug use*" (SCS40), and a drug user informant noted that "*different drugs have totally different mindsets...each need their own space, cocaine compared to jib [crystal meth] is similar but the two communities tend to collide, so to keep the peace they need separate services*" (FG04). Another drug user informant spoke about the hierarchy within the drug culture as another reason for having injection separate from inhalation: "*people judge you and you think well if I smoke it I'm a little better than the one who shoots it. There's a hierarchy even within one drug and there's definitely an issue of not wanting to sit beside someone shooting crystal meth*" (FG02). A few drug user informants believed that injection and inhalation needed to be kept separate because even the sight of a needle could trigger a relapse into injection drug use for someone who has moved from injection to non-injection drug use.

Some stakeholders, on the other hand, wanted a possible SCS program to be open to injection only. A law enforcement representative said that "*injection drug users should be the highest priority because of the health risks*" (SCS35), and another law enforcement representative specified "*hard core heroin and cocaine injectors as the main priority because of infection risk and behavioural problems*" (SCS33). A social service provider was opposed to inhalation in an SCS because of "*the risk of exposing non-injection drug users to the lifestyle of injection drug users, especially youth*" (SCS14). Another commonly offered reason for not supporting capacity for inhalation drug use was that staff could incur health risks by working in an inhalation facility. A few stakeholders preferred that SCS options only be open to heroin injectors. A law enforcement representative offered his reasoning: "*the staff should never be exposed to people who smoke crack and even those who shoot cocaine because of psychosis...stimulant users are a very volatile population...the police can barely handle them, they are too risky to staff*" (SCS34). A health care provider also agreed that an SCS should only be open to opiate injectors on the grounds that "*it would be a challenge to deal with high-frequency cocaine injectors...they would be there all day wanting to inject every 20 minutes or so*" (SCS02).

5.   Attitudes Towards Rules and Requirements of Possible SCS Options

This section of the report illustrates stakeholders' attitudes towards the rules and requirements that possible SCS options might have. The discussion focuses on the behavioural rules that stakeholders suggested would be needed at a possible SCS. Next, the perspective of drug user informants is offered to describe which rules or requirements would act as significant barriers to accessing a possible SCS program. In addition, the views regarding the issue of whether assisted injection should be permitted are presented. Finally, stakeholders' views concerning the possible entry restrictions that an SCS might have with respect to distinct populations, such as youth, pregnant women, drug users with children, intoxicated clients, and non- and first-time drug users, are explored.

i) Behavioural Rules

When asking stakeholders what kinds of rules or requirements a possible SCS program would need, a social service provider suggested to look at what other facilities had done, and that "*it could be very helpful to find out how Insite has managed to deal with 600 or more people a day and not have the place torn apart*" (SCS01). A common theme expressed by numerous stakeholders was that a balance needed to be struck between keeping staff and other clients safe and not deterring clients from using an SCS program because of an overly rigorous regiment. A health care provider mentioned that "*there must be flexibility and tolerance unless the behaviour is putting the client or others at risk…otherwise you end up missing the people at highest risk*" (SCS11). A drug user informant said that an SCS "*has to be a relaxed environment but at the same time not mayhem for each other*" (FG01). Some stakeholders mentioned that posting a code of conduct on the wall that defined what is acceptable and what is not acceptable would contribute to creating a respectful environment, as a social service provider suggested, "*a kind of informal contract*" (SCS03). The majority of stakeholders mentioned it to be of primary importance that the following rules be in place: no drug dealing inside or around an SCS facility; consumption only permitted in designated areas; no loitering or public disturbance (e.g., yelling or littering) outside an SCS facility; no swearing, violence or intimidation; cleaning up after oneself (especially after using the drug consumption area). Many stakeholders agreed that if someone was behaving inappropriately they should be asked to leave and could be temporarily restricted from an SCS facility, but that there should be no long-term bans.

ii) Potential Barriers to Access

Drug user informants were asked which rules or requirements would be unacceptable to them or deter them from using an SCS. The majority of drug user informants stated that they would not be prepared to wait very long or at all to use an SCS facility. One stakeholder commented that "*there shouldn't be long lines for waiting to get in because we can just go around the corner and then there would be no point to having the facility…when a junky wants their fix, they want to do it now…I wouldn't wait*" (FG01). Others said that they would be displeased if they had to wait a long time to get in and then were rushed out. While most stakeholders hoped that there would not be a maximum amount of time one would be allowed to spend inside an SCS facility, some recommended that there should only be a time limit if it was really busy. A drug user informant disagreed, saying that "*there should be a time limit…I'm not sure how long, but you can't just sit there and use up your entire supply because then other people will have to wait*" (FG03). This same drug user informant went on to say that "*but maybe instead of a time limit, there should be a one-fix [one-injection] rule like in Vancouver…you use once and then you leave but people can come back as many times as they want during*

the day, it keeps people moving" (FG05). However, many drug user informants expressed disagreement with a one-injection-per-visit rule. One person believed that the rule was problematic because "*if you have new dope, you need to test a little bit of it first but that would count as one hit and then you'd have to leave but you would want to use right away and actually get high, so you'd go around the corner and do your full hit*" (FG01). Another drug user informant agreed, saying that "*sometimes you might not shoot enough or you might miss, but you let it wear off for a little before doing another fix, and so for it to be worth your while to go to the facility, you should be able to use as much as you want without having to leave*" (FG01). A different drug user informant said that "*the pattern with crack is that you do your hit and maybe five or 20 minutes later you want another one, so do you get back in line? No, you do your other 20 hits outside, so then what's the point of having an [SCS]? I wouldn't come back if I had to leave after each hit*" (FG03). Drug user informants were also asked their opinion about a rule prohibiting the sharing of drugs onsite. Some thought that if two clients came in together they should be allowed to share as they would on the street, while others disagreed on the grounds that splitting drugs onsite could create the potential for an argument or a fight and therefore, any sharing of drugs should be done before entering an SCS facility.

iii) Assisted Injection

Stakeholders were quite divided on the specific issue of whether assisted injection should be allowed at an SCS facility. Many stakeholders said that it was really difficult to know what to do, and some stakeholders expressed mixed feelings. Of the people who said assisted injection should be permitted, some thought that only staff should be allowed to provide assistance while others believed that drug users known to each other should be able to assist each other. However, the majority of people thought that qualified staff should be the ones to provide the assistance. As a social service provider said, "*assistance should be given on a case-by-case basis with staff assessing whether more harm would result if the client self-injected*" (SCS07). Others mentioned that it should be part of service delivery given that many potential SCS users have physical disabilities, such as paralysis, amputated limbs or blindness. Another social service provider stressed that "*it should be part of the nurse's duty of care...assistance should be provided only if people have legitimate limitations, not simply because they are too high to hold a needle. In that case, they need medical attention*" (SCS04). Some stakeholders pointed out that while they thought that in certain circumstances, it would be necessary for staff to provide assistance, due diligence needed to be taken since there are huge liability issues and staff could potentially suffer psychological damage as a result of having to inject clients. Stakeholders who thought that clients should be allowed to assist each other, also thought that a nurse should supervise and instruct. As one drug user informant suggested, "*it happens on the street all the time, so better inside the SCS than on the streets...peers could be trained on how to inject others safely or there could be designated hitters like the way the VANDU people do it over at Insite*" (FG02). Some people were of the opinion that assisted injection among SCS users would be okay only if they were willing to take legal responsibility if something went wrong. Regardless of whether it was staff or fellow drug users who provided the assistance, many stakeholders stressed that if assisted injection was not permitted, this restriction would act as a significant barrier to accessing the service and would miss many high-risk drug users. As a drug user informant expressed, "*I wouldn't go to the facility because I need to have a doctor [someone who injects another]...a lot of people need help, especially women, and if they don't get it, they end up getting abscesses and blood all over the place because they can't hit their vein...it's disgusting*" (FG01). The stakeholders who were opposed to assisted injection had a range of views, from "*absolutely terrible, this kind of thing should only happen in a hospital setting, otherwise it's just assisted suicide only it takes longer*"

(SCS06), to the idea that "*from a legal point of view, users should take responsibility for their injections since there are too many liability issues and it's too close to encouraging drug use*" (SCS13). A drug user informant said that "*if people can't do it themselves, they shouldn't be doing it*" (FG02).

iv) Local Residency Requirement

The vast majority of stakeholders strongly believed that clients should not be required to be a local (e.g., Victoria) resident in order to gain access to an SCS program, and consequently, should not have to provide a proof of residency. When asked whether there should be a residency requirement, a drug user informant replied: "*hello (emphasis), we are homeless…nobody has ID*" (FG03). Instead, many stakeholders thought that an SCS program should adopt a similar system to the one used at the needle exchange where a code name and a date of birth are used to identify and track clients. Only one stakeholder supported the idea of having a residency requirement saying that "*it is in our interest to have this requirement, at least implicitly, to discourage people from coming in from all over*" (SCS33).

v) Possible SCS Entry Restrictions for Distinct Populations

In terms of entry restrictions with regard to distinct populations, such as youth, pregnant women, drug users with children, intoxicated clients, and non- and first-time drug users, the majority view was that an SCS facility should have an open door policy and turn away as few people as possible. Although the majority conceived an SCS program as a low-threshold intervention with few barriers to access, most stakeholders also acknowledged that there would be a need for specific protocols to deal with each distinct population. In other words, the prevailing view was that, in the interest of harm reduction, these particular populations should not be categorically denied access to an SCS, but that there should be targeted and specialized interventions to address the distinct needs of each population. However, a minority of stakeholders preferred that these distinct populations be denied entry to an SCS given the legal ramifications of permitting such access and the belief that an SCS was not an appropriate environment for some.

Although the majority view was that an SCS facility should be open to youth, there was disagreement over how to define youth and whether there should be an age limit or even a separate site for youth. While some stakeholders believed that an SCS program should be available to any drug-involved person in need of SCS services regardless of their age, others disagreed. A social service provider said that "*to have the SCS open to youth might be difficult to sell, but if a youth is coming in and asking to use the site, it's for a reason…they're not trying to be cool. If they are denied access, their risk will increase and they are the most vulnerable*" (SCS01). A law enforcement representative disagreed, saying "*there should be no minors, or else the whole program is in jeopardy*" (SCS34). Some people mentioned that youth under 16 or 18 should not be allowed to use an SCS. Another common view that many stakeholders expressed, was that there should be a separate youth-specific SCS program since the perception was that youth have different needs and needed to be protected from predatory behaviour. However, definitions of youth among those favouring a separate program for youth, ranged from as low as 13 years to an upper limit of 25 years and some stakeholders suggested that drug-using youth should not be forced to use youth-specific facilities if they were available. On the other hand, a few stakeholders did not see the necessity for separate SCS facilities for youth drug users since the perception was that youth mix with adults on the streets anyways. Among stakeholders who believed that youth should be allowed to use an SCS program, most people stressed that a different strategy would be needed. For example, a

social service provider said that "*a 14 year old should not be turned away, it's a good opportunity to connect with them and support them...intervention services should be ramped up, and there should be a focus on treatment, counselling and getting them out of the life [of drug use]. If we want youth to trust the SCS and get the help they need, we can't be calling child protection services*" (SCS39).

Stakeholders were asked their opinion about whether pregnant women who use drugs should be permitted to access an SCS program. While a few people were completely against this idea, saying that pregnant drug-using women should be immediately hospitalized or forced into detoxification, the vast majority of stakeholders believed that if harm reduction is the goal of an SCS program, pregnant women were especially in need of the service and should not be turned away since the perception was that they would use drugs anyway and thereby increase the risks to themselves and to the fetus. A social service provider commented that "*it's their choice and they need education, family planning, housing, counselling, nonjudgmental treatment and support to help them minimize risks*" (SCS16). Others also mentioned that if the pregnant women were opiate users, they should be referred to a methadone maintenance program.

Stakeholders were also asked what should be done if a prospective SCS client presented themselves to an SCS facility with children in their care. Independent of whether stakeholders believed children should be allowed to enter an SCS facility or not, everybody stressed that the main issue was whether the children are safe. The majority believed that children should not be exposed to drug use since stakeholders were of the opinion that it would perpetuate the notion that drug use was acceptable behaviour. However, many stakeholders did not think it was likely that parents would bring their children to an SCS, but if this were to happen, some stakeholders thought that an SCS should find a way to accommodate and help the family connect with a social worker or a counsellor. A social service provider mentioned that "*it's probably happening at home anyways and there is a lack of affordable child care, so you'll have to allow it on a case-by-case basis and consider whether harm is being reduced or amplified. If the child is in danger, the facility will be obligated to report the situation to the Ministry*" (SCS05). While on the one hand, a few stakeholders strongly believed that child protection services would have to be called since the belief was that children should not be allowed near an SCS facility, on the other hand, a health care provider mentioned that "*the SCS should be seen as a safe place with no threat of arrest...if people fear they will lose their children, they won't come and the children will be in a worse position*" (SCS11).

A strong majority of stakeholders believed that clients who are already severely intoxicated, either by alcohol or any other substance, should be allowed to use an SCS facility if they so desired unless they are violent or putting others at risk. A social service provider commented that "*people who use drugs are rarely using one type of drug and the point of intoxication is the time when health risks are highest, so they should be admitted but monitored closely and if they are too far gone [extremely intoxicated], staff should recommend they wait before consuming again or they should be referred to detox or the sobering centre*" (SCS04). Other stakeholders mentioned that it was important that SCS staff ensure the safety of intoxicated clients and should closely monitor such clients and encourage them to wait inside the facility until they come down before consuming more drugs. Some stakeholders also stressed that it was important that intoxicated clients receive medical advice so they could consume drugs in the most informed way possible. Some drug user informants thought that the issue of intoxicated clients accessing an SCS was a non-issue since they expected that most clients would already be intoxicated to some degree when they came to an SCS facility, as one drug user informant said, "*you probably did a smash [injected] on the way there*" (FG01).

There was also some dissension among stakeholders over whether non-drug users should be allowed to access services offered by a possible SCS facility not associated with consumption. One drug user informant captured the essence of the debate: "*it could be*

risky for a non-user to be around all the drug use because it could be a trigger [to initiate drug use] or they might get curious, but at the same time, everyone should have the right to come in the door and get help…maybe they just want information or counselling" (FG03). Another issue around which no consensus was reached was whether clients should be allowed to consume drugs for the first time inside the facility. Some stakeholders believed that the service should be reserved for people deep into their addiction, and that an SCS was not an appropriate place for first-time users or those experimenting. However, other stakeholders believed that it was the best place for someone to learn how to use safely. As a drug user informant said, "*why not have them do their first one [injection] there if they want to, chances are they are going to do it anyways, so they might as well be shown how to do it safely, but it's not likely going to happen a lot*" (FG01). When asked how staff would keep first-time users away, a health care provider commented that "*you'd never know for sure if it was someone's first time using drugs, but an assessment might help you get a sense of where the person is at…you'd have a discussion with them, talk about their options and try to point them in a better direction*" (SCS30). Despite the disagreement over whether first-time drug users should be allowed entry, the majority of stakeholders did not think that clients should have to demonstrate a history of drug use in order to access an SCS facility, stressing the importance of privacy and anonymity. As a drug user informant said: "*as little information as possible, my life is my business…you shouldn't have to give anything up*" (FG03). Other stakeholders believed that an assessment might be helpful for case workers to understand the client's history of drug use "*so they can deal with different facets of the addiction and figure out how they can best serve the client*" (FG04), but that a client's drug history should not determine whether the client can access an SCS facility.

6.   Attitudes Towards the Role of the Police Regarding Possible SCS Options

Stakeholders were asked to describe their attitudes towards the role the police should play with regard to possible SCS options. Many stakeholders expressed that it is important that the police be involved in all aspects of the planning and implementation process since they were viewed as a key partner with valuable input. Many stakeholders also hoped that the police would be supportive of the initiative and that there would be communication and consultation between the police and SCS staff. The majority of stakeholders thought that the appropriate role of the police would be to provide support for an SCS facility by responding to calls dealing with emergencies but should not have an ongoing visible presence at or in the direct vicinity of an SCS facility. Many stakeholders also believed the police should encourage people who were engaging in public drug use to go to an SCS facility (e.g., play the role of a referral agent) instead of arresting them, yet a few stakeholders emphasized that although referrals should be given, the police should not force or coerce people to go to an SCS as an alternative to arrest. As a social service provider said, "*an SCS should be a place where people choose to go because of the benefits, not because they will avoid arrest*" (SCS03). To increase public acceptance of an SCS, stakeholders believed that a key role for the police would be to maintain public order around the facility. Specifically, many stakeholders thought that police would play a big role in helping to keep dealers away from an SCS and to prevent congregations outside the facility. In other words, a primary role for the police was seen to maintain order and safety for both the community and an SCS, including its clients and staff. A political representative said a police presence would be necessary to ensure that "*the SCS would not become a site for the purchase and distribution of drugs*" (SCS38). Many stakeholders thought that the police would have a hand in educating the public to counter the perception that an SCS program might lead to increased drug-related public order problems and decreased public safety. For instance, a business owner commented that

"*police support for the SCS will help convert the 45% of people who think [an SCS is] a bad idea because those same people believe in the police*" (SCS42).

Many stakeholders also alluded to the concept of a 'bubble zone' (e.g., an area of non-enforcement around the facility) but there were divergent views regarding the concept. Some stakeholders agreed that the police should have a protocol agreement of some kind to ensure that clients would feel safe from arrest when going to and from an SCS facility. A social service provider mentioned that "*when police appear, people go underground…they would be deterred from using the [SCS]*" (SCS31). Also to elucidate the possibility of a deterrent effect, a law enforcement representative stressed that "*we have to be a visible presence to create the perception of safety in the neighbourhood, but we can't overdo it or people won't come to the facility…we need to find a balance but at the same time we can't do anything illegal*" (SCS33). A drug user informant commented that "*I'd only use the SCS if I knew I wouldn't get busted…police should not be allowed within 2 blocks of the site but can be called in for emergencies*" (FG02). Another drug user informant agreed, saying: "*they just shouldn't be there, it's the police presence that makes it unsafe…that's the reason I would use the SCS, to be safe from the cops…the only time they should be there is if someone is getting violent or there are dealers outside*" (FG01). A law enforcement representative disagreed with the idea of a bubble zone, saying: "*we can't create a bubble zone where addicts can do whatever they want with dealers on the edges waiting…a police presence should be there but there should be mutual understanding and respect. We'll support it with a cautious eye, [but] the SCS is not a silver bullet. Obviously we can't arrest people for coming in the door, but we should be an invisible but known presence*" (SCS32). Another law enforcement representative agreed that "*there can't be a buffer zone, if people have warrants, police should be able to enter the site and arrest them just like anywhere else…police will use discretion…we won't storm into the site, but at the same time, people can't commit crimes and hide inside the facility…it should be the staff's responsibility to make them leave if they know there is a warrant out for them*" (SCS35).

7. Indicators of Success and Failure of Possible SCS Options

Stakeholders were asked to describe what outcomes would indicate the success or failure of SCS options if such an intervention were to be implemented and evaluated. The most commonly cited indicators of success were related to health outcomes. For instance, the majority of stakeholders mentioned that a decrease in overdose deaths would be an important indication of the program's success. A social service provider specifically mentioned that "*zero deaths at the facility*" (SCS22) would also demonstrate the intervention's success. The next most frequently mentioned successful outcome was an increased rate of people having recovered from their addictions or having made a positive change and having found the support or assistance they needed to reach their goals. Stakeholders said that the success of an SCS would be reflected in the numbers of people who use the facility, and whether there is an increased rate of referrals to supportive housing, mental health services and addiction treatment and – assuming these services are in place – a successful uptake of these referrals. The majority of stakeholders also mentioned that they hoped SCS options would result in a decreased burden to hospital and emergency services. A large portion of stakeholders also expected to see a decrease in the rates of infectious disease transmission (e.g., HIV, HCV) and any other blood-borne pathogens, or at least a reduction in risk behaviours such as syringe sharing among an SCS program's target population, as a desirable outcome of an SCS initiative. However, a few stakeholders noted that there is no use looking at infectious disease transmission rates as an outcome indicator given the time it would take to observe any significant population-level changes. Many stakeholders also said that an SCS program would be viewed as a success if the physical and emotional health of its clients improved, as a social

service provider hoped "*people would be healthier from their veins to their brains*" (SCS01), while others thought that an SCS program would be successful if it improved the quality of life of both its clients and the larger community. As a political representative commented, "*it's not just about saving lives, it's about turning lives around. It takes a lot longer to measure quality of life, but we need to follow up with people to know where they are and how many people the SCS has helped and whether it's making a difference in the community*" (SCS40).

Many stakeholders mentioned that an SCS initiative would be deemed a success if it had a positive impact on public order, specifically, if there is a reduction in visible drug use and a reduction in publicly discarded needles in the areas where these phenomena are currently present. As a drug user informant said, "*you wouldn't see it in the alleys, all the garbage and paraphernalia lying around, because we would have a place to go. I think people in Victoria would appreciate it if they could walk into a public washroom and not see a bunch of junkies*" (FG01). A number of stakeholders also said that it would be interesting to measure public perception of safety before and after the introduction of SCS options to see whether there is an increase in the community's understanding and support for SCS options, if drug users are viewed as less threatening as a result of having SCS options, and if there are fewer complaints from businesses and the community relating to the manifestations of both drug-related problematic behaviour and open drug use. Some stakeholders also mentioned that a possible SCS intervention would be successful if there is a reduction in the demand for law enforcement resources and time related to drug use and if there is actually less drug-related crime, such as property crime. A few stakeholders noted however, that a reduction in drug-related crime would not be a fair indication of the facility's success unless drugs are provided as part of an SCS program since some clients would still have to resort to illicit activities to fund their drug use habit. Instead, these stakeholders indicated that a successful outcome would be if there is no increase in drug-related crime in the area surrounding an SCS. Some stakeholders also thought assessments of client satisfaction or service quality (e.g., is the staff considered respectful and do they treat clients with dignity? do clients find the services helpful?) by SCS users would indicate the success of an SCS initiative. Finally, a few stakeholders also mentioned that a stabilization or a reduction in drug use patterns would be another successful outcome.

When discussing the outcomes that would be an indication of the program's failure, a few stakeholders expressed that there likely would not be any possible failure scenarios if the initiative is implemented properly, however, the majority expressed that an SCS program would need to be viewed as a failure if there is no improvement or no change in the currently existing drug-related problems (e.g., public drug use, drug-related litter, health risks for drug users and the community). For example, an increase in overdose deaths, an increase in infectious disease transmission, an increase in public drug use or improperly discarded needles, or an increase in morbidity among drug users, or no improvement in any of these areas would likely signify the failure of an SCS initiative. Many stakeholders said that an increase in drug use or addiction would also signal that SCS options have failed in reducing harm and have instead legitimized or enabled the use of drugs. Stakeholders expressed that if an SCS program is not well utilized, this would be a strong indication that the program is a failure. Many stakeholders also mentioned that an SCS program would be a failure if the public did not view it as having a positive effect on public safety, for example, if there are congregations of users and dealers outside an SCS facility, a mess outside the facility, or an increase in community complaints. Other stakeholders mentioned that an SCS would be a failure if it becomes another drop-in centre or a stand-alone service where drug users are not being referred to other services and there is no follow-up. A few people also believed that if there is no decrease in or an increased burden on emergency services and police calls related to street drug use, it would indicate that the SCS program is not a success. A stakeholder

from the business community cautioned that "*there is potential for failure if there is no access to housing, low-income support and mental health services since the SCS cannot be isolated from the broader continuum of care…the SCS is not [the] solution, it may be part of an integrated solution, but it's not the first part or the leading part, so doing this before getting adequate police resources and adequate rehabilitation, detox and housing might be setting it up for failure*" (SCS06). On the other hand, a drug user informant explained, "*even if [the SCS program] didn't get results, the bonus of it all would be that if it was more than just about using, there would still be a place where all the services would be*" (FG04).

E. APPENDICES

1. Recommendations

RECOMMENDATIONS:

1.   **That** the City of Victoria, the Vancouver Island Health Authority and other local key stakeholders and partners undertake the necessary steps to move forward on the planning and implementing of a Supervised Consumption Site (SCS) initiative in Victoria with the main objective of improving the health and safety of drug users, as well as that of the community at large.

2.   **That** expectations towards what an SCS program in Victoria reasonably could and could not achieve be kept realistic and that these expectations and limitations are actively communicated to the public, institutional stakeholders, politicians, the media and other parties of interest.

3.   **That** an SCS initiative be conceptualized as a time-limited pilot project with clearly defined and measurable success indicators, the outcomes of which should be independently and rigorously evaluated as the evidence basis of the decision for the continuation, or respective adjustment, of an SCS initiative.

4.   **That** the efforts toward an SCS initiative in Victoria ideally go forward under the umbrella of an s.56 exemption under the *CDSA* obtained from the federal government. However, if such an exemption cannot be obtained, that alternative ways are considered for an SCS initiative in Victoria to go forward outside this umbrella while within socially, ethically and legally defensible parameters.

5.   **That** the principal objective of an SCS initiative be to improve the health and well-being, and reduce mortality and morbidity risks and outcomes, among the target population of high-risk drug users, with public order benefits as an equally recognized yet not overarching or exclusive objective.

6.   **That** an SCS initiative in Victoria ideally be implemented in a decentralized fashion, e.g., featuring, at minimum, one facility in the downtown core, as well as one or two additional facilities in other locales in need (e.g., other areas of Victoria or adjacent municipalities). If, for financial reasons, only one fixed SCS facility was possible, this program should be located in downtown Victoria with an accompanying mobile component to service outlying areas. Decentralized SCS program design options are recommended in order to both maximize the accessibility of SCS services for users, and to minimize a concentration of possible negative consequences related to SCS services as well as prevent service duplication in the downtown core.

7.   **That** an SCS program, if implemented, will be offered in close integration with a range of core additional health and social services required by the target population of an SCS program, specifically detoxification and treatment referrals, basic health care, shelter and housing, and basic social support.

8. **That** as a requirement for the possible success of an SCS intervention, VIHA, the Province of British Columbia, and other relevant entities, ensure the availability of sufficient addiction treatment services – specifically: detoxification, out-patient and residential treatment services, maintenance programs, mental health and addiction co-morbidity care – in the Greater Victoria area, since an SCS is not equipped to provide such services, yet the tangible and sustainable impact of an SCS intervention crucially hinges on whether these interventions are available. In this regard, the potential of an SCS initiative to produce tangible and sustainable outcomes will likely be severely curtailed within the current context of acute gaps in adequate addiction treatment services in the Victoria area.

9. **That** SCS services be operated by either one or a consortium of existing community-based health care providers in Victoria who have an adequate level of trust and can build on an existing rapport with the target population.

10. **That** the specific parameters of an SCS program – e.g., operations and facility design – are developed in active cooperation with key stakeholders and representatives of the drug user target population.

11. **That** given the documented key characteristics of street drug use in Victoria, SCS services be offered to injection drug users as the core target group, yet also be offered to non-injecting risk groups (e.g., crack smokers and other stimulant or opioid non-injectors). It is advised however that consumption facilities for injectors and oral (stimulant) users are spatially separated for reasons of health and practical considerations.

12. **That** an SCS program is organized as a 'low threshold' service model in order to maximize utilization and minimize potential deterrent factors among the target population (and that these specific details are defined in active consultation with stakeholders and the target population). Among other issues, this 'low threshold' framework should materialize through a user-friendly and accessible location, user-oriented staffing and operations, least possible restrictions on specific substances used, repeat visits or residency requirements, and that entry restrictions (e.g., intoxication, youth, pregnant women) are assessed on a case-by-case basis with consideration as to whether greater harm would ensue as a result of being denied access to an SCS facility.

13. **That** SCS services to be offered are categorically open and accessible seven days a week, 365 days a year, and ideally 24 hours a day; if the latter hours have to be restricted for operational or resource reasons, that the number of hours be kept to a maximum and that these hours are set in accordance with the target population's needs.

14.   **That** at the same time, an SCS intervention recognizes the equal importance of safety and order inside and outside the facility, in the interest of the health and safety of its users and staff, as much as that of the larger community. In this regard, it is essential that a 'code of conduct' for users of the facility be established and that clear benchmarks and adequate measures for order and safety are established to minimize negative impact on the community, including regular clean up of drug-related litter outside the periphery of an SCS, as well as adequate efforts to avoid possible excessive congregation of SCS users or drug dealers in the immediate vicinity of an SCS.

15.   **That** the role of the police in maintaining accessibility to an SCS, as well as the order and safety in and around an SCS for both users, staff and the community is recognized as crucial. Specifically, the police should be included in the development of SCS options from early planning stages onward, commit to clear and consistent operations with regard to an SCS (including a commitment to abstain from 'busting' users), refer users to SCS services where appropriate (yet not in a coercive fashion, e.g., in exchange for non-arrest) and establish an agreement with SCS operators on how to handle possible user congregations and/or the presence of drug dealers in a clearly demarcated area around an SCS facility.

2. Stakeholder Survey Participants' List

Business, Tourism and Community Representatives

Bruce Carter, C.E.O., Greater Victoria Chamber of Commerce
Ken Kelly, General Manager, Downtown Victoria Business Association
Melissa McLean, Senior Vice President, Marketing & Communications, Tourism Victoria
Sandra Meigs, Chair, Downtown Residents Association
Joanne Murray, President, Fernwood Community Association
Theresa Palmer, Owner, Out of Ireland
Bal Sharma, Owner, Mac's Convenience
King Tang, Owner, The Gathering Place

Consultants

Kim Balfour, Balfour Consulting
Dana Carr, Communicable Disease Nurse Consultant, Epidemiology and Disease Control,
        VIHA

Drug User Informants (anonymous)

Drug user informants (n=23) were recruited to participate in small focus groups with the facilitation of the following service provider agencies: AVI, Crystal Meth Victoria Society, PEERS, S.O.L.I.D., and VARCS.

Health Care and Social Service Providers

Ruby Black, Executive Director, Vancouver Island PWA Society
Alan Campbell, Director, Mental Health & Addictions, VIHA
Brad Crewson, Development Coordinator, Pacifica Housing Services
Grant Croswell, Manager, Social Concern Office, St. Vincent de Paul
Michelle Dartnall, Manager, Victoria Youth Addictions Services, VIHA
Karen Dennis, Acting Executive Director, Victoria AIDS Resource & Community Service
        (VARCS)
Anne Drost, Nurse, Cool Aid Community Health Centre
Marilyn Erickson, Outreach & Community Liaison, Vice President, Crystal Meth Victoria
        Society
Kendra Gage, Manager, Hulitan Social Services
Susie Girling, Program Coordinator, Victoria Youth Empowerment Society
Miki Hansen, Executive Director, AIDS Vancouver Island (AVI)
Gordon Harper, Executive Director, Umbrella
Tanya Hooton, Street Nurse, Outreach Health, Epidemiology and Disease Control, VIHA
Becky Hynes, Addictions Support and Intake Worker, Victoria Native Friendship Centre
Tracey Johns, Boys & Girls Club of Greater Victoria
Rev. Canon Dr. Harold Munn, Rector, The Church of St. John the Divine
Jody Paterson, Executive Director, Prostitutes Empowerment Education and Resource
        Society (PEERS)
Jody Pickard, Addictions Counsellor, Mental Health & Addictions Adult Community
        Treatment, VIHA
Carol Romanow, S.O.L.I.D.
Audrey Shaw, Coordinator Epidemiology & Disease Control, VIHA

Law Enforcement Representatives

Const. Rick Anthony, Victoria Police Department
Const. Barrie Cockle, Victoria Police Department
Insp. John Ducker, Victoria Police Department
Sgt. Brian Fox, Victoria Police Department

Political Representatives

Councillor Sonya Chandler, City of Victoria
David Cubberley, Saanich South MLA
Rob Fleming, Victoria-Hillside MLA
Councillor Dean Fortin, City of Victoria & Community Development Officer, Burnside Gorge
      Community Association
Councillor Bea Holland, City of Victoria
Councillor Helen Hughes, City of Victoria
Councillor Pamela Madoff, City of Victoria
Denise Savoie, Victoria MP (NDP)
Councillor Charlayne Thornton-Joe, City of Victoria

* One participant preferred to remain anonymous and is therefore not included in the list of stakeholders and George Lowery preferred to speak as an individual, rather than as a representative of his stakeholder group.

3.   Acknowledgements

4. Reference List

Anoro, M., Ilundain, E., & Santisteban, O. (2003). Barcelona's safer injection facility - EVA: A harm reduction program lacking official support. *Journal of Drug Issues, 33,* 689-712.

BC Centre for Excellence in HIV/AIDS (2004). *Evaluation of the supervised injection site: year one summary*. Vancouver, BC: BC Centre for Excellence in HIV/AIDS.

BC Coroners Service (2005). *Illicit drug deaths - 1997 to 2004*. Burnaby, BC: Ministry of Public Safety and Solicitor General.

BC CDC (2004). *HIV/AIDS Update*. Vancouver, BC: British Columbia Centre for Disease Control STD/AIDS Control.

British Columbia Ministry of Health (1999). *Vital statistics and health status indicators - standardized mortality ratio by local health area drug-induced deaths. British Columbia, 1997-1997*. Victoria, BC: BC Ministry of Health.

Broadhead, R., Borch, C., van Hulst, Y., Farrell, J., Villemez, W., & Altice, F. (2003). Safer injection sites in New York City: A utilization survey of injection drug users. *Journal of Drug Issues, 33,* 733-750.

Broadhead, R., Kerr, T., Grund, J., & Altice, F. (2002). Safer injection facilities in North America: Their place in public policy and health initiatives. *Journal of Drug Issues, 32,* 329-355.

Carr, D., Shaw, A., Walker, E., Choudhri, Y., Pennock, M., Fyfe, M., & Gilbert, M. (2006). *Determining the feasibility and acceptability of a safe injection site among injecting drug users (IDU) in Victoria, British Columbia, Canada.* Victoria, BC: Vancouver Island Health Authority.

Carrier, N. & Lauzon, P. (2003). Se shooter en présence d'intervenants? Les points de vue des consommateurs sur la mise en place éventuelle de lieux d'injection de drogues illicites à Montréal. *Drogues, Santé et Société, 2,* 1-26.

City of Victoria (2004). *Downtown health initiative: Action plan update*. Victoria, BC: Parks, Recreation & Community Development.

City of Victoria (2005). *Residents invited to learn more about harm reduction*. Victoria, BC: Corporate Communications.

City of Victoria (2006). *Notice of news conference: Harm reduction announcement*. Victoria, BC: Corporate Communications.

de Jong, W. & Weber, U. (1999). The professional acceptance of drug use: A closer look at drug consumption rooms in the Netherlands, Germany and Switzerland. *International Journal of Drug Policy, 10,* 99-108.

Darke, S., Mattick, R., & Degenhardt, L. (2003). The ratio of non-fatal to fatal heroin overdose. *Addiction, 98,* 1169-1172.

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

The Downtown Service Providers Group (2003). *Serving the homeless: Social agencies in "the red zone".* Victoria, BC: Downtown Service Providers Group.

Exchange on Drug Demand Reduction Action (EDDRA) (2005). *Programme Information: Abrigado Scene-Contact.* Lisbon: European Monitoring Centre of Drugs and Drug Addiction (EMCDDA).
http://eddra.emcdda.europa.eu/pls/eddra/ShowQuest?Prog_ID=4056

Elliot, R., Malkin, I., & Gold, J. (2002). *Establishing safe injection facilities in Canada: Legal and ethical issues.* Montréal: Canadian HIV/AIDS Legal Network.

Firestone Cruz, M., Patra, J., Fischer, B., Rehm, J., & Kalousek, K. (2007). Public opinion towards supervised injection facilities and heroin-assisted treatment in Ontario, Canada. *International Journal of Drug Policy, 18,* 54-61.

Fischer, B., Rehm, J., Kim, G., & Robins, A. (2002). Safer Injection Facilities (SIFs) for Injection Drug Users (IDUs) in Canada: A review and call for an evidence-focused pilot trial. *Canadian Journal of Public Health, 93,* 336-338.

Fischer, B., Turnbull, S., Poland, B., & Haydon, E. (2004). Drug use, risk and urban order: examining supervised injection sites (SISs) as "Governmentality". *International Journal of Drug Policy, 15,* 357-365.

Fong, P. (2007, January 26). Canada: Dion supports more safe-injection sites. *Globe and Mail.*

Freeman, K., Jones, C., Weatherburn, D., Rutter, S., Spooner, C., & Donnelly, N. (2005). The impact of the Sydney Medically Supervised Injection Centre (MSIC) on crime. *Drug Alcohol Review, 24,* 173-184.

Fry, C. (1999). Establishing safe injecting rooms in Australia: Attitudes of injecting drug users. *Australian and New Zealand Journal of Public Health, 23,* 501-504.

Fry, C. (2002). Injecting drug user attitudes towards rules for supervised injecting rooms: Implications for uptake. *International Journal of Drug Policy, 13,* 471-476.

Green, T., Hankins, C., Palmer, D., Boivin, J. F., & Platt, R. (2004). My place, your place, or a safer place: The intention among Montreal injecting drug users to use supervised injecting facilities. *Canadian Journal of Public Health, 95,* 110-114.

Hall, W. & Kimber, J. (2005). Being realistic about benefits of supervised injecting facilities. *The Lancet, 366,* 271-272.

Haydon, E. & Fischer, B. (2005). Crack use as a public health problem in Canada - Call for an evaluation of 'safer crack use kits'. *Canadian Journal of Public Health, 96,* 185-188.

Health Canada (2004). *I-Track: Enhanced surveillance of risk behaviours among injecting drug users in Canada*. Ottawa: Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention, Health Canada.

Health Canada (2005). *Fitting the pieces together: Toward an integrated harm reduction response to illicit intravenous drug use in Victoria, BC*. Victoria, BC: Health Canada Drug Strategies Initiatives Fund.

Health Canada (2006). *I-Track: Enhanced surveillance of risk behaviours among injection drug users in Canada - Phase I Report*. Ottawa: Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention, Health Canada.

Hedrich, D. (2004). *European report on drug consumption rooms*. Lisbon: European Monitoring Centre on Drugs and Drug Addiction (EMCDDA).

Independent Working Group (2006). *The Report of the Independent Working Group on Drug Consumption Rooms*. United Kingdom: Joseph Rowntree Foundation.

Kerr, T., Wood, E., Palepu, A., Wilson, D., Schechter, M., & Tyndall, M. (2003a). Responding to an explosive HIV epidemic driven by frequent cocaine injection: Is there a role for safe injecting facilities? *Journal of Drug Issues, 33,* 579-608.

Kerr, T., Wood, E., Small, D., Palepu, A., & Tyndall, M. (2003b). Potential use of safer injection facilities among injection drug users in Vancouver's downtown eastside. *Canadian Medical Association Journal, 169,* 759-763.

Kerr, T., Oleson, M., Tyndall, M., Montaner, J., & Wood, E. (2005). A description of a peer-run supervised injection site for injection drug users. *Journal of Urban Health, 82,* 267-275.

Kerr, T., Stoltz, J., Tyndall, M., Li, K., Zhang, R., Montaner, J., & Wood, E. (2006a). Impact of a medically supervised injection facility on community drug use patterns: A before and after study. *British Medical Journal, 332,* 220-222.

Kerr, T., Tyndall, M., Lai, C., Montaner, J., & Wood, E. (2006b). Drug-related overdoses within a medically supervised safer injection facility. *International Journal of Drug Policy, 17,* 436-441.

Kimber, J., Dolan, K., van Beek, I., Hedrich, D., & Zurhold, H. (2003a). Drug consumption facilities: An update since 2000. *Drug and Alcohol Review, 22,* 227-233.

Kimber, J., Dolan, K., & Wodak, A. (2005). Survey of drug consumption rooms: Service delivery and perceived public health and amenity impact. *Drug and Alcohol Review, 24,* 21-24.

Kimber, J., Dolan, K., & Wodak, A. (2001). *International survey of supervised injecting centres (1999-2000)*. Sydney: University of New South Wales.

Kimber, J., MacDonald, M., van Beek, I., Kaldor, J., Weatherburn, D., Lapsley, H., & Mattick, R. (2003b). The Sydney Medically Supervised Injecting Centre: Client characteristics and predictors of frequent attendance during the first 12 months of operation. *Journal of Drug Issues, 33,* 639-648.

Langass, H. (2006). *The injection room in Oslo, Norway: One year report.* Oslo: Alcohol and drug addiction service and harm reduction service.

Linssen, L., de Jong, W., & Wolf, J. (2001). *Gebruiksruimten. Een systematisch overzicht van de voorziening en de effecten ervan.* Utrecht: Trimbos Instituut.

Mickleburgh, M. (2006, August 22). Vancouver Ex-Mayor speaks up for injection site. *Globe and Mail.*

MSIC Evaluation Committee (2003). *Final Report of the Evaluation of the Medically-Supervised Injecting Centre (MSIC).* Sydney: MSIC Evaluation Committee.

Petrar, S., Kerr, T., Tyndall, M., Zhang, R., Montaner, J., & Wood, E. (2007). Injection drug users' perceptions regarding use of a medically supervised safer injection facility. *Addictive Behaviors, 32*, 1088-1093.

Poschadel, S., Höger, R., Schintzler, J., & Schreckenberger, J. (2002). Evaluation der Arbeit Drogenkonsumräume in der Bundesrepublik Deutschland: Endbericht im Auftrag des Bundesministeriums für Gesundheit. In: *Das Bundesministerium für Gesundheit und Soziale Sicherung (Schriftenreihe Bd 149).* Baden-Baden: Nomos-Verlags-Gesellschaft.

Roberts, M., Klein, A., & Trace, M. (2004). *Drug consumption rooms.* United Kingdom: Drugscope and The Beckley Foundation.

Room, R. (2003). Impact and implications of the international drug control treaties on IDU and HIV/AIDS prevention and policy. In J.Rehm, B. Fischer, & E. Haydon (Eds.), *Reducing risks, harms and costs of Injection Drug Use (IDU) and HIV/AIDS.* Ottawa: Health Canada.

Schmid, M. & Vogt, I. (2005). Die Nutzung von Konsumräumen in Frankfurt/Main unter besonderer Berücksichtigung des Konsums von crack. *Suchttherapie, 51*, 233-239.

Schu, M., Tossman, P., Coll, K., & Shuster, A. (2005). *Evaluation der drogenkonsumräume in Berlin: Abschlussbericht.* Berlin: Köln.

Shannon, K., Ishida, T., Morgan, R., Bear, A., Oleson, M., Kerr, T., & Tyndall, M. (2006). Potential community and public health impacts of medically supervised safer smoking facilities for crack cocaine users. *Harm Reduction Journal, 3,* 1-8.

Skretting, A. (2006). The Nordic countries and public drug-injection facilities. *Drugs: Education, Prevention & Policy, 13,* 5-16.

Spreyermann, C. & Willen, C. (2003). Evaluationsbericht offnug der Kontakt – und Anlaufstellen fur risikoärmere Konsumformen. *Ambulante Drogenhilfe Zurich.* Fribourg: Ambulante Drogenhilfe Zurich und Fachstelle für Schadenminderung.

Stajduhar, K., Poffenroth, L., Wong, E. (2002). *Missed opportunities: Putting a face on injection drug use and HIV/AIDS in the Capital Health Region.* Vancouver, BC: Centre for Health Evaluation & Outcome Sciences (CHEOS), Scientific Monograph 10.

Stajduhar, K., Poffenroth, L., Wong, E., Archibald, C., Sutherland, D., & Rekart, M. (2004). Missed opportunities: Injection drug use and HIV/AIDS in Victoria, Canada. *International Journal of Drug Policy, 15,* 171-181.

Statistics Canada (2005a). Trends in drug offences and the role of alcohol and drugs in crime. *Juristat, 24,* 1-24.

Statistics Canada (2005b). *Uniform Crime Reporting Survey – Crime statistics, by detailed offences, annual.* Ottawa: Statistics Canada.

Stoever, H. (2002). Consumption rooms – A middle ground between health and public order concerns. *Journal of Drug Issues, 32,* 597-606.

Thein, H., Kimber, J., Maher, L., MacDonald, M., & Kaldor, J. (2005). Public opinion towards supervised injecting centres and the Sydney Medically Supervised Injecting Centre. *International Journal of Drug Policy, 16,* 275-280.

Tyndall, M., Kerr, T., Zhang, R., King, E., Montaner, J., & Wood, E. (2006). Attendance, drug use patterns and referrals made from North America's first supervised injection facility. *Drug and Alcohol Dependence, 83,* 193-198.

van Beek, I. (2003). The Sydney Medically Supervised Injecting Centre: A clinical model. *Journal of Drug Issues, 33,* 625-638.

van Beek, I., Kimber, J., Dakin, A., & Gilmour, S. (2004). The Sydney Medically Supervised Injecting Centre: Reducing harm associated with heroin overdose. *Critical Public Health, 14,* 391-406.

van der Poel, A., Barendregt, C., & van de Mheen, D. (2003). Drug consumption rooms in Rotterdam: An explorative description. *European Addiction Research, 9,* 94-100.

Vancouver Coastal Health (2005). *Vancouver's supervised injection site.* Vancouver, BC: Vancouver Coastal Health.

Victoria Cool Aid Society (2005). *Homeless count – 2005. Victoria, BC.* Victoria, BC: Cool Aid Society.

Victoria Urban Development Agreement (VUDA) (2005). *Background.* Victoria, BC: Victoria Urban Development Agreement. http://www.victoriaagreement.ca/en/process_background.php

VIHA (2006). *I-TRACK: Enhanced surveillance of risk behaviours and prevalence of HIV and Hepatitis C among people who inject drugs.* Victoria, BC: Epidemiology and Disease Control and Population Health Surveillance Unit, Vancouver Island Health Authority.

Wolf, J., Linssen, L., & de Graff, I. (2003). Drug consumption facilities in the Netherlands. *Journal of Drug Issues, 33,* 649-662.

Wood, E., Kerr, T., Lloyd-Smith, E., Buchner, C., Marsh, D., Montaner, J., & Tyndall, M. (2004a). Methodology for evaluating Insite: Canada's first medically supervised safer injection facility for injection drug users. *Harm Reduction Journal, 1,* 9-14.

Wood, E., Kerr, T., Small, W., Li, K., Marsh, D., Montaner, J., & Tyndall, M. (2004b). Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *Canadian Medical Association Journal, 171,* 731-734.

Wood, E., Tyndall, M., Li, K., Lloyd-Smith, E., Small, W., Montaner, J., & Kerr, T. (2005a). Do supervised injecting facilities attract higher-risk injection drug users? *American Journal of Preventive Medicine, 29,* 126-130.

Wood, E., Tyndall, M., Montaner, J., & Kerr, T. (2006a). Summary of findings from the evaluation of a pilot medically supervised safer injection facility. *Canadian Medical Association Journal, 175,* 1399-1404.

Wood, E., Tyndall, M., Stoltz, J., Small, W., Lloyd-Smith, E., Zhang, C., Montaner, J., & Kerr, T. (2005b). Factors associated with syringe sharing among users of a medically supervised safer injecting facility. *American Journal of Medical Sciences, 1,* 50-54.

Wood, E., Tyndall, M., Stoltz, J., Small, W., Zhang, R., O'Connell, J., Montaner, J., & Kerr, T. (2005c). Safer injecting education for HIV prevention within a medically supervised safer injecting facility. *International Journal of Drug Policy, 16,* 281-284.

Wood, E., Tyndall, M., Zhang, R., Stoltz, J., Lai, C., Montaner, J. & Kerr, T. (2006b). Attendance at supervised injecting facilities and use of detoxification services. *The New England Journal of Medicine, 354,* 2512-2514.

Wood, E., Tyndall, M., Lai, C., Montaner, J., & Kerr, T. (2006c). Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. *Substance Abuse Treatment, Prevention and Policy, 1,* 13-16.

Wood, E., Tyndall, M., Qui, Z., Zhang, R., Montaner, J., & Kerr, T. (2006d). Service uptake and characteristics of injection drug users utilizing North America's first medically supervised safer injecting facility. *American Journal of Public Health, 96,* 770-773.

Wood, E., Kerr, T., Spittal, P., Li, K., Small, W., Tyndall, M., Hogg, R., O'Shaughnessy, M., & Schechter, M. (2003). The potential public health and community impacts of safer injecting facilities: Evidence from a cohort of injection drug users. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 32,* 2-8.

Zurhold, H., Degkwitz, P., Verthein, U., & Haasen, C. (2003). Drug consumption rooms in Hamburg, Germany: Evaluation of the effects on harm reduction and the reduction of public nuisance. *Journal of Drug Issues, 33,* 663-688.

Zurhold, H., Kreutzfeld, N., Degkwitz, P., Verthein, U., & Krausz, M. (2001). *Evaluation des Gesundheitsraumangebots für Drogenkonsumenten in drei europäischen Städten. Abschlussbericht.* Hamburg: Institut für Interdisziplinäre Sucht- und Drogenforschung ISD.