Safe Injection Facilities

Proposal for a Vancouver Pilot Project

Prepared by Thomas Kerr
for the Harm Reduction Action Society
November 2000

The Harm Reduction Action Society would like to thank the following individuals for their contributions to the creation of this document:

Kim Balfour..... Balfour Consulting Group
Deborah Graham ..... AIDS Vancouver
Andrew Johnson ..... AIDS Vancouver
Dr. Anita Palepu ..... Centre for Health Evaluation and Outcomes Science
Dr. Michael O'Shaughnessy..... BC Centre for Excellence in HIV/AIDS
Dr. Martin Schechter ..... BC Centre for Excellence in HIV/AIDS
Irene Goldstone..... BC Centre for Excellence in HIV/AIDS
Dr. Mark Tyndall..... BC Centre for Excellence in HIV/AIDS
Ann Livingston..... Vancouver Area Network of Drug Users
Jo-Anne Sargent ..... University of Victoria, Faculty of Education
Ray and Nicola Hall..... From Grief to Action
Rob and Susie Ruttan ..... From Grief to Action
Werner Schneider ..... City of Frankfurt (Frankfurt, Germany)
Josch Steinmetz..... Druckraum Niddastr. 49 (Frankfurt, Germany)
Wolfgang Barth ..... Drogennotdienst (Frankfurt, Germany)
Michael Hallstein ..... Deputy Chief of Police (Frankfurt, Germany)
Mark Haden..... Addiction Services, Ministry for Children and Families
Ian Malkin..... University of Melbourne, Faculty of Law
Kylie Hutchinson..... Community Solutions Planning and Evaluation
Judith Thompson ..... Dr. Peter Centre
Dr. Robert Broadhead ..... University of Connecticut, Department of Sociology

Thomas Kerr, a health researcher and doctoral student at the University of Victoria, is coordinator of practice standards and research at the Dr. Peter Centre.

CONTENTS

EXECUTIVE SUMMARY

British Columbia is in the midst of a public health crisis involving injection drug users. Soaring rates of disease and death and the associated health and legal costs serve as distressing indicators of drug-related harm within our province (Fischer, Rehm, & Blitz-Miller, 2000).

Health authorities estimate that 400 of the 15,000 British Columbians who inject drugs will die of drug-related overdoses this year, approximately 400 will contract HIV, and many more will acquire hepatitis A, B, or C, tuberculosis, or any of a variety of sexually transmitted diseases. The estimated annual cost of injection drug use in British Columbia is more than $207 million (Single et al., 1998). The cost of providing medical care for an injection drug user with HIV/AIDS is currently about $139,000 (Hanvelt et al., 1999). Crime, incarceration, and public nuisance are other serious problems associated with injection drug use. Clearly, there is need for urgent action.

Despite provincial funding for drug and alcohol services in British Columbia, government reviews indicate repeatedly that the current level of service delivery is inadequate (Cain, 1994; Lower Mainland Municipal Association, 2000; Millar, 1996; Ministry for Children and Families, 1998; Parry, 1997; Vancouver Coalition for Crime Prevention and Drug Treatment, 1999; Whynot, 1996). A 1998 review of alcohol and drug services in Vancouver by the Ministry for Children and Families concluded that there are major problems with existing service delivery, particularly in terms of accessibility, scope, and the number of services available. The report states:

> The impact of the lack of adequate resources cannot be overstated. The simple fact is: there is not enough of anything, there are waiting lists for everything and we are chronically under-serving many. There is not only a need for more of the same, but new and innovative approaches need to be developed to attend to emerging trends and issues (p. 4).

While the scope of problems resulting from illicit drug use in British Columbia is disturbing, evidence from Europe provides reason for optimism. Several European cities have been successful in reducing drug-related problems similar to those experienced locally (MacPherson, 1999). Recently, the City of Vancouver adopted the “four-pillar approach” employed in European countries to address problems of drug use. This

approach coordinates and balances the "four pillars" of enforcement, prevention, treatment, and harm reduction. Critical to the success of harm reduction is a comprehensive strategy of low, medium, and high threshold services for drug users, which include safe injection facilities, methadone maintenance, detox beds, and drug treatment.

Safe injection facilities are controlled health care settings where drug users inject drugs under supervision and receive health care, counselling, and referral to health and social services, including drug treatment. Evidence from Europe indicates that safe injection facilities provide a cost-effective means of engaging the most marginalized and at-risk drug users and of addressing the following objectives:

- Improving the overall health of drug users, including reducing the incidence of overdose and disease transmission;
- Reducing public nuisance associated with drug use, such as crime, discarded needles, and public drug use;
- Increasing appropriate use of health and social services by drug users;
- Reducing health, social, legal, and incarceration costs associated with drug use.

Evidence also indicates that safe injection facilities contribute to the activities associated with the three pillars of treatment, enforcement, and prevention. For example, in Frankfurt alone, hundreds of clients are referred directly from safe injection facilities to drug treatment each year (MacPherson, 1999), and the total number of drug users in detox, abstinence-based treatments, and methadone programs has increased since safe injection facilities were implemented (Schneider, personal communication, November 16, 2000). By bringing drug users indoors, off the streets, and ultimately out of the drug market, safe injection facilities also help free up police to arrest dealers rather than street level users. Safe injection facilities also contribute greatly to prevention efforts, as primary activities include the promotion of safe sex and injecting practices within a population at high risk for contracting and spreading disease. Safe injection facilities also serve as ideal locations for the trial of new and innovative health promotion initiatives.

Claims that safe injection facilities promote drug use and increase the number of drug users locally are unfounded and contrary to existing evidence. In municipalities where safe injection facilities have been implemented, the total number of people using

drugs has decreased, with the biggest impact occurring in the open/public drug scene. As mentioned previously, rather than promoting drug use, safe injection facilities have also contributed to an increased number of drug users entering various forms of drug treatment.

The Harm Reduction Action Society is advocating for a comprehensive response to the drug problem in British Columbia. The Society maintains that safe injection facilities are a necessary component of a more effective strategy, and that any remaining questions concerning the effectiveness of safe injection facilities in British Columbia can best be answered through trial and rigorous evaluation. To this end, the Harm Reduction Action Society is proposing the implementation of an 18-month pilot of two safe injection facilities in Vancouver. Based on local demographics and advice from local and European experts, the Society believes that two safe injection facilities should be opened simultaneously in order to manage the anticipated demand for these innovative services.

The proposed safe injection facility model will offer a range of services, including:

- Primary health assessment and care, health education, and referral to health services;
- Provision of sterile injection equipment, supervision of injections, and needle exchange;
- Psychosocial assessment, counselling, and referral to social services;
- Peer-based education, counselling, and support;
- Access to nutritious snacks.

Safe injection facilities will be staffed each day by a team of five health care professionals. The facilities will be open for eight hours a day, seven days a week. In addition, four eight-hour shifts per month will be added to allow for 24-hour care on cheque issue day ("welfare Wednesday") and the day following. Evidence suggests that a high number of overdoses and injuries occur during this time.

An expert advisory committee is being established to advise the Harm Reduction Action Society on issues of research and evaluation. Evaluations will examine the design and delivery of services, target population reach, service quality, achievement of intended results (outcomes), and cost-effectiveness of the safe injection facilities.

The precise legal status of safe injection facilities in Canada is unclear. There are four different legal options available under which a pilot of safe injection facilities could proceed. The first two involve using existing mechanisms to gain exemption from current laws, a third involves forming administrative agreements, and the fourth involves amending the Controlled Drugs and Substances Act. A safe injection facility pilot would not violate any of the international conventions to which Canada is a signatory. In fact, several states signatory to these conventions have incorporated safe injection facilities into their continuum of health services.

Put simply, while effective health interventions for injection drug users exist and have been successfully implemented elsewhere, little is being locally to address the public health crisis among injection drug users. The Canada Health Act reminds us that Canadians can achieve better health through "collective action against the social, environmental and occupational causes of disease." Consistent with this declaration, the Harm Reduction Action Society urges the different levels of government, health professionals, community organizations, and concerned individuals to work together in implementing an 18-month pilot of two safe injection facilities for injection drug users.

INTRODUCTION

In March 2000, more than 3,000 individuals attended a harm reduction symposium held in Vancouver, titled "Keeping the Door Open: Health Addictions and Social Justice." Out of this event grew the Harm Reduction Action Society. Incorporated under the Society Act of British Columbia on May 4, 2000, the Harm Reduction Action Society's mission is "to take harm reduction measures to save lives."

Harm reduction has been defined as a "policy or program directed towards decreasing the adverse health, social, and economic consequences of drug use without requiring abstinence from drug use" (Canadian Centre on Substance Abuse). While harm reduction approaches do not preclude abstinence as a worthwhile goal, they question the long established notion that abstinence is the only acceptable drug policy or program outcome. Comprehensive harm reduction models include "low threshold" services designed to reach those who are unwilling or unable to abstain from drug use.

The mission of the Harm Reduction Action Society is supported by seven strategic purposes:

- To improve the quality of life for people who use drugs illicitly, and for their families, their friends and their communities;
- To provide harm reduction, health promotion, and other health care services;
- To empower people who use drugs illicitly to live healthy, productive lives;
- To reduce harm associated with the prohibition of drugs;
- To change the laws regarding the prohibition of drugs;
- To promote public education and encourage activities that eliminate negative stereotyping of people who use drugs illicitly;
- To develop networks and coalitions of informed people who will work to ensure public policies and practices are favourable to people who use drugs illicitly.

The membership of the Harm Reduction Action Society is made up of people with a wide range of interests and backgrounds, and includes health care professionals, researchers and administrators, community health activists, allied community organizations, health care facilities, former and current drug users, their friends and families, user group representatives, and concerned citizens.

The Harm Reduction Action Society recognized from the outset that new and innovative harm reduction action would be initiated within existing services and evolving policy frameworks. The policy framework currently being discussed in Vancouver is the so-called “four-pillar approach” (City of Vancouver, 2000). This approach emphasizes prevention, treatment, enforcement, and harm reduction. A review of harm reduction strategies reveals that services of various types have been implemented successfully in other jurisdictions. Low threshold harm reduction services commonly offered in parts of Europe include:

- Needle exchange
- Low threshold methadone
- Heroin maintenance
- Peer-based education
- Resource centres
- Contact cafés
- Safe injection facilities
- Emergency shelters
- Street outreach

Vancouver currently offers a number of these harm reduction services, and a number of others are in the proposal or development stage. Millions of needles are exchanged in Vancouver each year at fixed sites and mobile outreach, by both the Vancouver/Richmond Health Board and the Downtown Eastside Youth Activities Society (DEYAS). Access to methadone has been improved in recent years, and a heroin maintenance trial, NAOMI , has recently been proposed (Schechter & O’Shaughnessy, 2000). Fledgling peer-based programs are being developed by the Vancouver Area Network of Drug Users (VANDU), including the user-run VANDU Health Network. The Vancouver/Richmond Health Board, with funding from Health Canada, is waiting to open a resource centre, and the BC Centre for Disease Control’s street nurse and other programs provide outreach services. The Portland Hotel Society and the Dr. Peter Centre have developed innovative housing and residential projects with health care services built

in. The Harm Reduction Action Society has specifically chosen to develop services that are conspicuously absent in the Vancouver context.

Towards a Safe Injection Facility Pilot

The goal of the Society's first major initiative is to establish an 18-month pilot of two safe injection facilities. Safe injection facilities would serve as venues where drug users could inject drugs safely under medical supervision and have access to key health and social services. A pilot format would allow for a rigorous scientific evaluation of the efficacy and outcomes of this specific harm reduction service in the Vancouver context. Research partners include the BC Centre for Excellence in HIV/AIDS and the Centre for Health Evaluation and Outcome Sciences at St. Paul's Hospital.

The specific objectives of this initiative are derived from outcomes associated with safe injection facilities in other jurisdictions:

- To reduce overdoses and transmission of diseases (e.g., HIV/AIDS, hepatitis B, hepatitis C) associated with injection drug use;
- To reduce other injection-related harms (e.g., abscesses, endocarditis);
- To bring marginalized drug users into contact with appropriate services (e.g., methadone maintenance, drug treatment) that can help restore health and social well-being;
- To reduce harms associated with illicit drug use (e.g., crime, discarded needles, public drug use) that affect communities;
- To reduce unnecessary health, social, and legal care costs associated with drug use.

The purpose of this proposal is to articulate the outstanding need for safe injection facilities in Vancouver and to describe a comprehensive safe injection facility program designed specifically to address local needs.

STATEMENT OF NEED

An estimated 15,000 British Columbians inject illicit drugs (Millar, 1998). This estimate is likely conservative as it fails to include hundreds, perhaps thousands, of occasional users. Injection drug use is associated with an array of severe health and social consequences for drug users, their families, and their communities. Rates of disease, death, and the accompanying costs are distressing indicators of drug-related harm experienced within our society (Fischer, Rehm, & Blitz-Miller, 2000). Over the past decade, problems resulting from injection drug use have grown exponentially.

In 1998, there were 529 deaths from drug-induced causes in British Columbia (Vital Statistics, 2000); 412 of these deaths resulted from drug overdoses. Sixty percent of drug-induced deaths in 1998 occurred in the 25 to 44 age category, accounting for one death in five in this group.

HIV/AIDS is easily transmitted through activities and behaviours associated with injection drug use, most notably needle sharing and unprotected sex. There is a 23-30% prevalence rate of HIV infection among injection drug users (IDUs) in Vancouver (Fischer et al., 2000), and more than 400 new seroconversions will likely occur this year. Hepatitis C, a blood-borne viral hepatitis, is also transmitted easily through needle sharing, and to a lesser extent through unprotected sex (McLean, 2000). An estimated 88% of injection drug users in Vancouver have hepatitis C (McLean, 2000).

British Columbia has the highest per capita illicit drug-related costs among Canadian provinces (Canadian Centre for Substance Abuse, 1992). The estimated cost of illicit drug use in BC was more than $207 million per year in 1992 (Single et al., 1992). This figure does not take into account transfer payments for income assistance or costs associated with drug-related crimes.

Expert opinion repeatedly suggests that there is no single solution to the problems related to illicit injection drug use. A balanced and comprehensive approach that combines both enforcement and health-based strategies is key. Considerable resources are currently directed towards drug-related law enforcement. About 82% of the total direct cost associated with illicit drug use in Canada is accounted for by law enforcement; however, only 16% of the cost goes towards the provision of health care, and a mere 8%

is spent on prevention and research (Fischer et al., 2000). Substance use disorders are not unlike other complex chronic disorders marked by relapse and remissions. Addiction is caused by a combination of genetic, biological and environmental factors, and the related effects can be reversed by treatment and social support (Millar, 1998). Recent studies of cost-effectiveness confirm that considerable economic savings are gained from health-based approaches to drug addiction. A Rand study, for example, found that every dollar spent on health-based approaches yielded seven dollars in social and health savings.

Many cities throughout the world witnessed a rise in illicit drug use during the 1980s and 1990s. In response, municipalities in Germany, the Netherlands, and Switzerland developed balanced, comprehensive programs that combine enforcement, harm reduction strategies, prevention initiatives and education. These programs have been highly effective in reducing the problems associated with illicit drug use. In contrast, the United States has opted for an almost exclusively enforcement-based approach which has resulted in massive annual drug-related costs and a record number of non-rehabilitated drug users in prisons (Brochu, 1995).

Twenty years have elapsed since the first safe injection facilities opened in Europe, and they remain an integral part of effective harm reduction strategies employed there. Evidence indicates that safe injection facilities are associated with an array of positive health and social outcomes, including:

- Less drug use;
- Fewer drug-related overdoses;
- Reduced disease transmission;
- Less public nuisance associated with drug use;
- Less drug-related crime;
- More users referred to drug treatment and other health services.

Experience indicates that safe injection facilities are uniquely effective in sustaining contact with the most marginalized and chaotic users who inject drugs in public places. It is this type of user who is at greatest risk for disease and death, and who is least ready to engage directly in traditional abstinence-based health services. There is no evidence to suggest that safe injection facilities attract young, first-time users.

In light of the outstanding problems and needs in British Columbia, it is clear that safe injection facilities could be an integral part of a more comprehensive and effective drug strategy.

THE VANCOUVER CONTEXT

While an estimated 10-20% of the 15,000 IDUs in British Columbia live in Vancouver's Downtown Eastside, other Vancouver neighbourhoods and Lower Mainland communities such as Burnaby, New Westminster, and Surrey are experiencing increased prevalence of HIV/AIDS, hepatitis B, hepatitis C, and other problems associated with injection drug use. This is counter to the popular assumption that problems of drug use occur exclusively in Vancouver's Downtown Eastside (Bognar, Legare, & Ross, 1998). According to one local user, "[t]here is a Downtown Eastside in every community [with] areas of easy access to drugs, coupled with poverty, violence and social dysfunction" (cited in Bognar, Legare, & Ross, 1998, p. 5). While the scope of the open drug scene in the Downtown Eastside is unparalleled in Canada, open scenes, such as those in Surrey, are emerging in satellite municipalities throughout the Lower Mainland and the rest of the province.

Drug Overdoses and Drug-Induced Deaths

Among Canadian provinces, British Columbia has the highest number of drug-induced deaths per capita (4.7 per 100,000 population). Drug-induced deaths in BC have increased dramatically in the last twelve years, rising sharply from 39 in 1988 to 412 in 1998. There were 202 overdose deaths in the first nine months of 2000 (BC Coroner's Office, 2000).

In 1993, deaths due to illicit drugs reached epidemic proportions in BC (Millar, 1998), with illicit drugs becoming the leading cause of death among adults 30 to 49 years of age (Cain, 1994). The Chief Coroner's report of 1993 suggested that the sharp rise in accidental overdose deaths could be attributed to unpredictable shifts in heroin purity and the increased tendency among IDUs to combine drugs (particularly heroin and alcohol).

In the 1999 Vancouver Injection Drug Users Study, the 10% mortality rate among the study's participants was accounted for primarily by drug-induced deaths, and 15% of the study's participants reported at least one non-fatal overdose in the previous six-month period.

HIV/AIDS, Hepatitis C and Other Diseases

Risk behaviours among injection drug users are common and are associated with the spread of diseases such as HIV/AIDS and hepatitis C. These behaviours include, but are not limited to, the sharing of needles and other injection equipment (e.g., filters, spoons, cookers) and unprotected sex (including unprotected commercial sex). The increasing use of cocaine has contributed to an escalation in risk behaviour, since many cocaine users inject frequently—often up to twenty times per day.

Prior to 1993, injection drug users accounted for less than 3% of new HIV infections in Canada. In 1993-94, for the first time, IDUs outnumbered men who have sex with men among those testing newly positive for HIV. In BC today, IDUs account for 38% of new HIV infections (Fischer et al., 2000), and there will likely be more than 400 new seroconversions in 2000.

The groups now considered most at risk for HIV infection include First Nations peoples (composing 17% of new infections), women who inject drugs (80% of whom work in the sex trade), persons living with mental illness, persons injecting cocaine, street youth, and homeless persons (Parry, 1997). According to the Point Project (cited in Millar, 1998), other factors most commonly associated with HIV infection among IDUs are unstable housing, cocaine use, frequent injecting, history of sexual abuse, and depression.

Hepatitis C is a blood-borne viral hepatitis transmitted easily through needle sharing, and less easily through unprotected sex (McLean, 2000). Recently, more than half of all hepatitis C cases reported in Canada were in British Columbia (Millar, 1998). This is attributed primarily to a higher rate of injection drug use in BC compared to other parts of the country. For the last four years, approximately 2,000 new cases of hepatitis C have been reported annually in Greater Vancouver. Injection drug use currently accounts for an estimated 80% of new cases of hepatitis C. According to the 1998 VIDUS project, 88% of injection drug users in Vancouver have hepatitis C (cited in McLean, 2000).

While HIV/AIDS and hepatitis C are the diseases most frequently associated with injection drug use, many other diseases and medical conditions often result from injection

drug use and accompanying behaviours. For example, hepatitis B is an infectious disease that peaked in incidence in 1995 in part because of injection drug use, and although immunization programs have been effective in reducing the incidence of hepatitis B, this disease will remain a problem for years to come (Millar, 1998). Tuberculosis, syphilis, and hepatitis A also occur at epidemic rates within the IDU population. In 1998, the VIDUS project reported a 38% prevalence rate of tuberculosis among Vancouver injection drug users. Other medical conditions common among drug users are severe abscesses, endocarditis, and septicemia, which require hospitalization for treatment.

Drug-Affected Newborns

Often neglected in discussions about injection drug use are drug-affected newborns. According to the Provincial Health Officer (1997), in British Columbia, more than 150 babies are born with impairments from injection drug use each year. This figure represents a six-fold increase over the past decade. According to Dr. Elizabeth Whynot (1996), short-term or long-term consequences of fetal exposure occur in 30% of babies born to mothers in the Downtown Eastside.

Many of these babies face a lifetime of disability. According to the Provincial Health Officer (1997), they “have high rates of congenital anomalies and Sudden Infant Death Syndrome. As children they may be developmentally delayed, in school they may suffer from learning disabilities and behavioural problems” (p. 2). In hospital settings, these babies fall into two diagnostic categories: noxious influences affecting fetus and drug withdrawal syndrome in newborn. In 1996, the drugs involved were primarily cocaine (38%) and heroin (25%). According to the BC Task Force into Illicit Narcotic Overdoses in British Columbia (1994), drug-affected babies represent a public health issue with broad significance.

The Economic Costs of Illicit Drug Use

It is evident that injection drug use leads to an array of health, legal, and social consequences that have an immense impact on the economy of British Columbia. In fact, BC’s annual per capita drug-related costs ($60) are higher than those of any other

Canadian province (Canadian Centre for Substance Abuse, 1992). According to Single et al. (1992), illicit drugs cost the BC economy more than $207 million per year. This figure does not take into account transfer payments for income assistance or the costs associated with a number of drug-related crimes (such as property crimes). The cost of income assistance alone may be as high as $67 million annually (Millar, 1998). One Ontario study (cited in Millar, 1998) found the annual costs for an untreated opiate user to be as high as $33,761 per year ($29,164 for law enforcement and $4,597 for health care).

Costs to the Health Care System

Currently, the consequences of illicit drug use place great strain on health resources. Care for individual IDUs with incurable diseases such as HIV/AIDS and hepatitis C may continue beyond twenty years. The average age of persons newly diagnosed with HIV in 1998 was 23 (Bognar, Legare, & Ross, 1998).

Treatment costs for HIV/AIDS in British Columbia in 1999-2000 are projected to be $72.3 million (Hanvelt et al., 1999). In the long term, local estimates of the lifetime expense of medical treatment for an IDU living with HIV/AIDS is $134,559 (Hanvelt et al., 1999). Estimates for the cost of lost productivity are $471,650 per individual. Therefore, if only five to seven of every 100 HIV infections were prevented each year, the long-term saving for that one year alone would be approximately $3 million for treatment and $38 million for lost productivity.

In a report to the Vancouver Medical Health Officer, Dr. Elizabeth Whynot (1996) lists the major impacts of injection drug use on the Vancouver health system:

- Increasing incidence and prevalence of symptomatic infectious diseases, including HIV/AIDS, hepatitis A, B, and C, skin and blood-borne infections, and endocarditis;
- High frequency of drug overdoses resulting in significant morbidity and mortality;
- Increased hospital and emergency service utilization: treatment for HIV-related disease, septicemia, and endocarditis; emergency room visits; ambulance responses (including approximately 2,048 ambulance responses to drug overdoses in the Downtown Eastside in 1998);

- Fetal exposures with both short-term and long-term consequences (an estimated 30% of infants born to mothers living in the Downtown Eastside live with effects of fetal exposure to illicit drugs);
- Increasing pressure on all community-level outreach, nursing, and medical services;
- Increasing need for community-level hospice palliative care;
- Worsening consequences of associated conditions such as mental illness.

In a 1996 report, the City of Vancouver stated that in 1992 an estimated 30,799 in-patient hospital days were attributed to drug and alcohol problems (primary and secondary diagnoses). At a base rate of $873 per day (for in-patient beds), the total cost of these drug-related hospitalizations was approximately $27 million. In 1999, 1,002 injection drug users accounted for 9,483 in-patient days at St. Paul's Hospital (St. Paul's Hospital, 2000).

Drug-Related Crime

The relationship between illicit drug use and crime is complex and difficult to assess. While it is generally accepted that people using drugs commit many crimes, a large portion of these crimes do not directly involve drugs and therefore are not recorded as "drug offences." Furthermore, while many writers have attempted to reduce to a simple formula the causal role drug use plays in crime (e.g., users commit crimes to get money to buy drugs to feed their habit), comprehensive reviews indicate that there is currently no viable singular explanation (Brochu, 1995).

In discussing the relationship between drug use and crime, Brochu (1995) noted that 80% of offenders within the correctional system reported using illicit drugs during their lifetime, and 30-50% of prison inmates showed signs of illicit drug dependence. Approximately 50-75% of these offenders showed traces of drugs in their urine at the time of arrest, and almost 30% reported being under the influence of illicit drugs when committing the crime for which they had been arrested. There are approximately 131,000 people incarcerated in Canada (Correctional Services of Canada, 1999), and another 113,000 are in non-custodial care such as full or day parole or statutory release (City of Vancouver, 1998).

Easier to assess are the crime statistics directly involving drugs. The Vancouver Police Department (McLean, 2000) reported the following illicit drug-related offences for 1998 (adults only):

Drug	Number of Offences
Cocaine	1,178
Heroin	328
Marijuana	313
Total	**1,819**

It is important to note that these statistics are for Vancouver only, and do not include drug offences involving other common illicit drugs such as amphetamines or methamphetamine (speed).

In 1998, Single et al. reported an estimated 56,000 charges attributable to violations of drug laws in Canada. Given this figure and the various crimes related to but not directly involving violations of drug laws, it is fair to assume that the statistics cited by the Vancouver Police Department capture only a fraction of the crimes committed in Vancouver that are associated with drug use.

RESPONDING TO THE CRISIS

> *It is ethically wrong to continue to tolerate complacently the tragic gap that exists between what can and should be done in terms of comprehensive care for drug users and what is actually being done to meet these persons' basic needs (Roy; cited in Canadian HIV/AIDS Legal Network, 1999).*

Policy

The goal of Canada's Drug Strategy is to "reduce the harm associated with alcohol and other drugs to families and communities" (Government of Canada, 1998, p. 4). The Strategy states that because "substance abuse is primarily a health issue rather than an enforcement issue, harm reduction is considered to be a realistic, pragmatic, and humane approach as opposed to attempting solely to reduce the use of drugs" (p. 4). The two primary harm reduction initiatives listed in the Strategy are needle exchange and methadone maintenance. While these programs are unquestionably efficacious, experts agree that a more comprehensive harm reduction approach with increased accessibility to the most marginalized drug users is needed (CCSA, 1992; National AIDS Strategy, Health Canada, 1997; Single, 1999; Strathdee et al., 1997).

Support for a more comprehensive approach has also come from the Canadian Senate, which in April 2000 adopted a motion to form a Special Senate Committee on drug policy (cited in Canadian Foundation for Drug Policy, 2000). The Committee's mandate includes plans to "develop a national harm reduction policy in order to lessen the negative impact of illegal drugs in Canada [and to] study harm reduction models adopted by other countries and determine if there is a need to implement them wholly or partially in Canada" (2nd Session, 36th Parliament, Volume 138, Issue 47, p. 1).

The position of the Department of Justice is that "[t]he criminal law should be employed to deal only with that conduct for which other means of social control are inadequate or inappropriate, and which interfere with individual rights and freedoms only to the extent necessary for the attainment of its purpose" (Gilmour, 1995, p. 11).

In 1998, in response to the hepatitis C epidemic among IDUs, Health Canada's Laboratory for Disease Control recommended that "hepatitis C prevention programs should adhere to the harm reduction model as a health promotion strategy" (p. 3).

At the provincial level, the British Columbia Ministry for Children and Families is responsible for issues of drug use and addiction. According to the Ministry's "strategic purposes," the priorities for addiction services include "[supporting] the education and harm reduction strategies to prevent the spread of HIV and other related infectious diseases" (Ministry for Children and Families, 2000, p. 1).

In response to the increasing prevalence of HIV infection, hepatitis C, and drug-induced overdoses, the Vancouver/Richmond Health Board declared a public health emergency in the Downtown Eastside in 1997. A report commissioned by the Medical Health Officers of the four Lower Mainland health regions stated: "there can be no progress made on the epidemic of HIV and communicable disease in injection drug users until the underlying epidemic of addictions and injection drug use are addressed" (Bognar, Legare, & Ross, 1998, p. v).

The Vancouver HIV/AIDS Care Coordinating Committee (1999) has expressed the following opinion:

> In light of limited government resources and the cumulative future benefits of prevention, governments need to ensure that effective prevention programs are not under-funded today. Effective programs must address the broad needs of those people who are most likely to contract or transmit the virus. Prevention programs among those most at risk can be controversial; nonetheless, primary prevention can preserve health, save lives and reduce the avoidable human and financial burden of HIV disease in the future (p. 16).

The Vancouver Agreement, a five-year initiative developed by all three levels of government, is a coordinated strategy to support sustainable economic, social, and community development in Vancouver. The Agreement will focus initially on the Downtown Eastside. In its proposed strategy for community health and safety, the following objectives have been identified:

- Reduce the need for emergency and crisis interventions;
- Improve access to hospital care;
- Reduce the spread of HIV/AIDS and other infectious diseases;

- Reduce preventable deaths;
- Increase the proportion of residents receiving regular primary care;
- Reduce preventable deaths related to substance misuse;
- Reduce the incidence of communicable diseases associated with injection drug use.

In order to fulfil these objectives, the Vancouver Agreement commits to developing a comprehensive substance misuse strategy consisting of a continuum of services with innovative approaches to reducing harm. In Europe, this "four-pillar" approach that integrates prevention, enforcement, treatment, and harm reduction has been highly successful and over time has gained wide public support. Critical to its success has been a balance between public health and public order. According to Vancouver City Drug Policy Coordinator Donald MacPherson:

> In Vancouver, the public discussion regarding drug use must move beyond the traditionally polarized debate on harm reduction approaches vs. abstinence based approaches. It is clear from the European context that it is necessary to move forward on all fronts in order to have a significant impact on the number of individuals using drugs and on our inner city neighbourhoods. Efforts must be made to mediate this debate and move toward an acceptance of a broad range of services for drug users who wish to exit the drug scene and for those who are not ready to do so. The true objective of our strategies must be to reduce harm to our children, families, and communities caused by drugs (City of Vancouver, cited in Vancouver Coalition for Crime Prevention and Drug Treatment, 1999, p. 2).

More so than with tobacco or alcohol, the costs associated with illicit drug use are "largely avoidable" (Single et al., 1996, p. 9). These costs have even prompted groups with conservative interests, such as *The Economist* magazine and the Fraser Institute, to call for the decriminalization of drugs and health-based, rather than enforcement-based, approaches to drug addiction. In an article on drug use, *The Economist* cited a Rand study, which found that every dollar spent on health-based solutions to the drug problem yielded a seven dollar saving in costs to society.

Action

Efforts to address the drug problem in British Columbia have been largely ineffective. While some have emphasized that current prohibitionist laws and enforcement strategies have exacerbated the drug problem (Brochu, 1995; Oscapella, 1995), others have highlighted the lack of comprehensive services for drug users as the problem warranting greatest attention (Millar, 1995; Whynot, 1996). Regardless, the lack of effective action is evident, and has led to conclusions that the current situation involving drug users is comparable to the blood tragedy of the 1980s (Skirrow, 1999; cited in Canadian HIV/AIDS Legal Network, 1999). Put simply, British Columbia is in the midst of a public health crisis, and while effective health interventions for IDUs exist and have been successfully implemented elsewhere, little is being done locally. According to the Canada Health Act, all citizens of Canada are entitled to universal access to health care, including Canadian citizens who inject drugs.

A number of government documents and policies call for comprehensive harm reduction strategies to deal with the drug problem. While experts agree that a health-based approach to injection drug use is needed, the majority of federal, provincial, and municipal funding for drug-related issues is being spent on enforcement. In addition, a considerable sum is spent on providing hospital and emergency services for IDUs. This money is not specifically allocated for the care of IDUs, but rather comes out of a more general public health budget. Remaining money for drug-related issues is allocated to treatment and prevention programs. At present, no comprehensive plans exist to specifically address the unique health needs of IDUs. Experience in Europe convincingly suggests that even the most marginalized IDUs can be engaged in health care if services are designed specifically to meet their needs.

Currently, the Ministry for Children and Families provides funding for the following drug-related services: sobering services for adults (police referral only); detoxification services for adults and youth; support recovery residential services for adults (with limited space for youth); day treatment programs; outpatient counselling services; and prevention services such as education and needle exchange (Parry, 1997). In addition, limited resources have been allocated to fund housing projects, such as the

Portland Hotel Society, for individuals at risk for declining health due to drug use, mental illness, and HIV/AIDS. Programs that could be considered within the category of harm reduction are few. The most notable are needle exchanges and methadone programs operating throughout the province. However, various government and academic reports have indicated a need for increased availability of these two programs.

Despite provincial funding for drug and alcohol services in British Columbia, government reviews indicate repeatedly that the current level of service delivery is inadequate (Cain, 1994; Millar, 1996; Ministry for Children and Families, 1998; Parry, 1997; Vancouver Coalition for Crime Prevention and Drug Treatment, 1999; Whynot, 1996). A 1998 review of alcohol and drug services in Vancouver by the Ministry for Children and Families concluded that there are major problems with existing service delivery, particularly in terms of accessibility, scope, and the number of services available. The report states:

> The impact of the lack of adequate resources cannot be overstated. The simple fact is: there is not enough of anything, there are waiting lists for everything and we are chronically under-serving many. There is not only a need for more of the same, but new and innovative approaches need to be developed to attend to emerging trends and issues (p. 4).

The report also states that there are significant problems of accessibility for the most vulnerable populations who have no point of entry into the current system of care. This concern is echoed in an article by Schechter et al. (1999; cited in Fischer et al., 2000) who described the access to health care for drug users as “woefully inadequate” and “diminish[ing] even further since 1995.” Fischer et al. (2000) observed that while there was a steady decrease in IDU-related harm in Europe during the 1990s following the implementation of broad harm reduction prevention measures, the opposite trend has been observed in Canada: limited harm reduction programming and an increase in IDU-related harm during the 1990s.

The Impact of Enforcement

To date, enforcement initiatives have failed to adequately address the drug problem in British Columbia, and several experts have presented compelling arguments

suggesting the current emphasis on enforcement has made the problem of drugs worse (Brochu, 1995; Fischer et al., 2000; Oscapella, 1998; Puder, 1998). The prohibitionist response produces a black market, which results in increased crime, violence, and corruption, and destabilizes countries and economic markets. While numerous government reports have called for a comprehensive harm reduction strategy to deal with the drug problem, little concrete action has occurred.

Clearly, enforcement of drug laws at the street level—arresting chronic users for possession—is an expensive and not terribly effective use of a vital public resource. In Vancouver, 15% of all enforcement costs are used to address substance use, and another $25 million is spent on incarceration (Kwan, 2000). In a 1995 report on illicit drug overdoses, the Chief Coroner of British Columbia argued that the "so-called 'War on Drugs' which is conducted by the Justice System can only be regarded as an expensive failure" (p. 6).

Drug addiction is not easily modified through negative reinforcement strategies and other deterrents such as imprisonment. In fact, most IDUs continue to use drugs while in jail and are then released without having been rehabilitated in any meaningful way. It is also obvious that many IDUs often continue to use drugs despite extreme adverse health consequences.

Several major reports have concluded that prohibitionist laws and current enforcement tactics exacerbate drug problems and hinder efforts to reduce the spread of disease. Examples include Brochu's (1995) report titled "Estimating the Costs of Drug-Related Crime" and the Canadian Centre on Substance Abuse and Canadian Public Health Association's report "HIV/AIDS and Injection Drug Use: A National Plan" (1997). In its work titled "Injection Drug Use and HIV/AIDS" (1999), the Canadian HIV/AIDS Legal Network concluded the following:

> The criminal approach to drug use has several effects on drug users, health-care professionals, and society at large, and may increase rather than decrease harms from drug use:
>
> - Because drugs can only be purchased on the underground market, they are of unknown strength and composition, which may result in overdoses or other harm to the drug user.

- Fear of criminal penalties and the high price of drugs cause users to consume drugs in more efficient ways, such as by injection, that contribute to the transmission of HIV and hepatitis.
- Because sterile injection equipment is not always available, drug users may have to share needles and equipment, which further contributes to the spread of infections.
- Significant resources are spent on law enforcement, money that could instead be spent on prevention and the expansion of treatment facilities for drug users.

> The most pronounced effect, however, is to push drug users to the margins of society. This makes it difficult to reach them with educational messages that might improve their health and reduce the risk of further spread of disease; makes users afraid to go to health or social services; may make service providers shy away from providing essential education on safer use of drugs, for fear of being seen to condone use; and fosters anti-drug attitudes toward the user, directing action toward punishment of the "offender" rather than fostering understanding and assistance (p. 3).

While many problems result from street-level enforcement of drug laws, it is clear the police can play an important role by managing the "supply side" of the drug problem and directing drug users to health services. In Europe, police forces have worked in coordination with health service providers in achieving mutual goals. By focusing on non-using dealers and organized crime, the police in Holland, Switzerland, and Germany now play an effective role in managing the drug problem.

THE EUROPEAN EXPERIENCE

Holland, Switzerland, and Germany have developed innovative and effective strategies to address problems associated with drug use. Typically, these strategies involve coordinated efforts among health care providers, police, and the judicial system, and there is a large body of evidence suggesting these more comprehensive approaches have been highly successful.

The Dutch have had more than twenty years of experience with their policy of "normalization" which prioritizes social integration over drug use. In essence, normalization involves containing and managing the consumption and abuse of illicit drugs rather than trying to eliminate them entirely (Parliament of New South Wales, 1998). Efforts in the Netherlands aim to protect the health of drug users, and programming gives priority to the young, vulnerable, and most marginalized drug users. Health authorities manage the care and rehabilitation of drug users while the police focus on managing the supply side of the drug problem.

Following large increases in consumption of illicit drugs in the 1980s and the development of open drug scenes, Switzerland and Germany both developed a "four-pillar" approach to managing problems associated with drug use. The four pillars are prevention, harm reduction, treatment, and law enforcement. Key to the success of this approach has been the high level of coordination among the four elements. Prevention initiatives have an educational, health promotion focus aimed at those who do not use drugs (including children) and those who use drugs only occasionally. Street-level harm reduction services are provided for those who continue to use drugs, and abstinence-based treatments and other complementary programs are available for those wanting to exit the drug scene (MacPherson, 1999). Enforcement strategies have been developed both to assist with health initiatives and to tackle organized crime. The police have generally shifted their focus from arresting users to identifying and charging those involved in the supply side of the drug problem, such as suppliers and non-addicted dealers.

A critical component of the four-pillar approach has been the creation of many street-level low threshold services. According to MacPherson (1999), threshold "refers to the eligibility criteria for entrance into programs and the state of readiness of individuals

to participate and meet the demands of the various programs" (p. 4). Switzerland has developed a range of low threshold harm reduction services to bring as many drug users as possible into contact with health services. The two primary goals are improved public health and increased public order (MacPherson, 1999, p. 5). Low threshold programs include easy access to methadone, shelter beds for drug users, needle exchange, outreach worker programs, employment programs, and methadone treatment in prisons (MacPherson, 1999). An important component of harm reduction strategies in European countries has been the development of several safe injection facilities where IDUs can inject their drugs safely and receive food, medical care, sterile syringes, and referral to health and social services.

Safe Injection Facilities

There are currently 42 safe injection facilities (sometimes referred to as health rooms, safe injection sites, or drug consumption rooms) in Germany, the Netherlands, and Switzerland. Spain has recently passed legislation to establish its first injecting facility in Madrid this year (Drug Policy Expert Committee, 2000). Following on the European experience, Australia plans to open one site in the fall of 2000 and six other sites in three cities the next year (Drug Policy Expert Committee, 2000; ABC News, 2000). Although motives for establishing safe injection facilities vary, the primary goals have been the prevention of drug-related disease and death, the reduction of drug-related harm within communities and neighbourhoods, and the reintegration of drug users within mainstream society. Safe injection facilities are also simply meant to provide an alternative public space in which to inject drugs (Broadhead et al, 2000). Typically, safe injection facilities achieve these goals by:

- Supervising injections to ensure safety and quick response to overdose;
- Collecting used syringes and providing sterile injecting equipment and condoms;
- Providing information on safe injecting practices;
- Providing counselling and referral to detox and various forms of treatment;
- Providing food and basic primary medical care;

- Maintaining and improving contact with marginalized users and facilitating reintegration.

While needle exchanges and outreach services work effectively with drug users in public spaces, there is no evidence to suggest that these services promote reductions in public drug use. Safe injection facilities provide an alternative to using drugs in public, while reducing health and other risks, such as robbery, assault, and arrest by police, associated with public injecting. When forced to inject in public, users often inject in a hurried fashion, which increases the risk of mistakes while preparing and injecting drugs. This pressure can also lead to a tendency to use non-sterile water and equipment and to reuse injecting equipment, especially since cleaning of equipment is a time-consuming process and possession of injection equipment can result in arrest. An Australian study also found that overdoses were more common among persons who were alone when using drugs (McGregor et al., 1999). Safe injection facilities reduce this risk by supervising injections.

Compared to needle exchange and outreach programs, safe injection facilities typically offer a more direct approach to the prevention of drug-related problems and the use of medical, drug treatment, and other health care services. Within safe injection facilities, staff are able to engage directly with drug users in a safe setting after users have injected. According to Broadhead et al. (2000), "this is when drug users are most likely to be at least temporarily at ease and available to reflect and interact…. [S]taff are, therefore, seen as more favorably positioned than needle exchange and outreach workers to engage drug users in a help-seeking relationship, to discuss health concerns they may have, to provide them with immediate medical and other interventions if desired, or to make referrals" (p. 4).

There is general agreement that safe injection facilities are most effective when supported by a comprehensive drug strategy that includes other harm reduction and abstinence-based approaches, enforcement, and coordinated drug policy. Despite some initial opposition, there is now widespread public support for safe injection facilities in Europe. These facilities, along with the associated cost savings and increased public order, are apparently preferable to the open drug scenes that preceded them.

Safe Injection Facility Models

Despite the variety of safe injection facility models, most share some common attributes. Most are fairly small, simple operations consisting of a common waiting area (where food, beverages, and complementary programs such as medical care, needle exchange, and recreation are available), and an injection room. Most, if not all, safe injection facilities have established systems for referral to detox, treatment, and other services. Some safe injection facilities operate as independent entities, while others are attached to or contained within other facilities or services such as methadone clinics and treatment facilities. Staffing levels vary slightly, with a typical facility having three to five staff members on shift at any one time. Although staff members have diverse backgrounds (usually either social work or nursing), they typically undertake the same duties. Hours of operation range from four hours per day to fifteen hours per day. In some instances these hours are spread out over set intervals (e.g., noon to 2:00 p.m. and 5:00 to 7:00 p.m.). Facilities also vary in the number of days per week they operate.

Safe injection facilities generally have strict entrance requirements and rules. In some jurisdictions, entrance is restricted to individuals 18 years of age and older who are local residents. Clients also typically participate in a brief intake interview in which a staff member collects information (e.g., age, drug of choice, participation in drug treatment) and outlines the rules of the facility. At many sites, clients are also required to sign a form prior to admission, attesting to their age and residency. Most sites have explicit rules prohibiting dealing, violence, and the sharing of drugs. Some facilities call the police when a dealer enters or loiters outside. Others temporarily ban clients who are found injecting or purchasing drugs immediately outside the facility.

Once a client has entered a facility, he or she can seek admission to the injection room. Entrance to the injection room is controlled by facility staff, and the number of clients allowed to be in the injection room at any one time is restricted, usually to between seven and fifteen. There is often a brief waiting period before a space becomes available and the client is granted admission. Clients will often wait in the common area, talking with staff members, eating, or receiving medical attention or referrals. Clients are required to wash their hands before entering the injection room, and are then provided

with sterile injecting equipment. Some safe injection facilities only admit clients who inject drugs, while others also accept those who smoke crack cocaine. In some facilities, clients sit at tables, while in others, clients sit in individual cubicles along stainless steel counters. At least one staff member is present in the injection room to provide and collect injecting equipment and supervise the injections. Most facilities limit the amount of time spent in the injection room to 15 or 20 minutes and do not allow other clients or staff members to assist individuals with injections. After injecting, clients are generally encouraged to spend some time in the common area before leaving the facility. Typically, when an overdose does occur, a staff member will call for assistance and then begin resuscitating the individual. Facilities vary in how they respond to overdoses, with some facilities using oxygen only (as in Switzerland), while others will occasionally use Naxolone (Narcan) to revive those who do not recover within a set time. If a client is not easily revived, an ambulance will be called (most facilities have direct lines to ambulance services). To date, there has never been a fatal overdose in any of the 42 safe injection facilities in operation.

Aside from the commonalities described, there are also substantial differences in the physical layout and operation of safe injection facilities. Complete descriptions of each site are beyond the scope of this document; however, four models are described in detail in Appendix 1.

Evaluation of Safe Injection Facilities

While only a limited amount of formal research on safe injection facilities has been completed, many facilities have collected data and completed informal program evaluations. The goals of a safe injection facility typically include: reducing the rates of drug-related death, disease transmission and illness; increasing the number of social and health care referrals provided to drug users; reducing public drug use and associated public nuisance; and reducing drug-related crime. While direct empirical evidence of these outcomes is limited, findings from various sources suggest that safe injection facilities are making substantial gains towards these goals.

Demographics of Safe Injection Facility Clients

Most safe injection facilities collect demographic data from their clients. In a review of this information, the Lindesmith Center (1999) concluded that safe injection facilities provide an effective means of contacting the most marginalized drug users (p. 2). There is a 40% rate of homelessness among clients using safe injection facilities in Rotterdam; in Frankfurt the rate is slightly higher, and records confirm low income levels (Kemmesies, 1995). Roughly 73% of clients attending the facility in Bern also had a history of incarceration (Dolan & Wodak, 1996).

According to the Parliament of New South Wales report (1998), safe injection facilities in Germany, the Netherlands, and Switzerland attract predominantly male clients who are older than the average local drug injector. Clients of European facilities also tend to be longtime illicit drug users. Data from Frankfurt reveal that while most of these users began injecting drugs at age 18, some were as young as 12 when they started using hard drugs. The vast majority of clients in Frankfurt and Rotterdam are also polysubstance users (i.e., users who mix heroin, cocaine, and alcohol, for example) (Kemmesies, 1995; Parliament of New South Wales, 1998). Data collected in various jurisdictions, including British Columbia, suggest that longtime polysubstance users are at high risk for drug-induced overdose (BC Vital Statistics, 2000; Parliament of New South Wales, 1998). This risk can increase when an IDU has just been released from jail and drug tolerance is low.

Information on overdose and disease rates suggests that individuals using safe injection facilities are generally in poor health or at risk for declining health. In Frankfurt, 95% of clients were found to have hepatitis C, and 25% had HIV/AIDS (Kemmesies, 1995). Participants in the Frankfurt study also reported high rates of depression (42%), abscesses (30%), and diseases of the liver (53%), heart (23%), stomach/bowel (33%), and lung (31%). Less than half of these conditions were being treated at the time of data collection. As well, 65% of those interviewed reported having experienced a non-fatal overdose, and 23% reported having a non-fatal overdose in the last four weeks. More than half of these overdoses occurred in public settings. Data collected at Drogennotdienst site (Frankfurt) indicated that 35% of the clients had never had contact with drug help

services prior to using the safe injection facility (Barth, personal communication, November 15, 2000).

Drug users from various jurisdictions have given fairly consistent explanations for attending safe injection facilities. In Switzerland, the main reasons given were to inject in peace (86%) and to obtain injecting equipment (33%). A study by Kemmesies (1995) found that 66% of clients in Frankfurt used safe injection facilities in order to consume drugs without having to hurry and to avoid "prosecution stress" (p. 26). When drug users in an open scene were asked why they were not frequenting safe injection facilities, 64% said the hours of operation were too limited, 45% said the waiting time was too long, and 30% said the facility was too far away (Kemmesies, 1995). When asked about how to improve the safe injection facility service, 84% suggested establishing more facilities and extending the hours of operation. When asked what would prevent them from using drugs in public, 45% said they would likely stop if more safe injection facility services were offered.

Health Benefits

By providing medical supervision, on-site resuscitation, prompt emergency response, and education on safe injecting practice, safe injection facilities can reduce risks associated with drug-induced overdose. Several cities have witnessed substantial reductions in overdose deaths following the establishment of safe injection facilities. For example, in Frankfurt the number of overdose deaths has declined from 147 in 1991 to 22 in 1997 (Lindesmith, 1999). While this improvement can be attributed in part to other harm reduction services already in existence, the data show a substantial decline in the overdose rate in the year following the establishment of safe injection facilities. These reductions occurred while overdose rates remained stable in other parts of Germany. Similarly, Switzerland witnessed a decline in drug-related deaths, from 419 in 1992 to 209 in 1998 (Drug Policy Expert Committee, 2000). While non-fatal overdoses do occur in safe injection facilities, a report by Integrative Drogenhilfe (1998) suggests they tend to occur with less frequency than in open drug scenes (cited in Lindesmith, 1999). The rate of overdose in safe injection facilities varies, but most sources report a figure close to one

overdose for every 500 injections. Three facilities in Switzerland, however, reported a much lower rate of only 22 overdoses per 68, 000 injections (approximately one overdose per every 3,100 injections). Evidence from the Integrative Drogenhilfe report indicates that overdoses in facilities in Frankfurt are ten times less likely to require hospitalization than those occurring on the streets. To date, there has never been a death in a safe injection facility anywhere.

Safe injection facilities also help take the strain off emergency response services, and provide a safer venue for ambulance personnel to work in. One evaluation of the drug help system in Frankfurt found that 85% of all "emergency situations" (e.g., overdoses, aggressive behaviour) involving drug users occurred in safe injection facilities (Schneider, 2000). Of these, 96% were handled within the facility and less than 3% resulted in a transfer to hospital.

Much of the high rate of HIV and hepatitis C infection among IDUs can be attributed to needle sharing and unprotected sex. The provision of sterile injecting equipment, condoms, and education within safe injection facilities likely results in reductions in disease transmission. While studies have demonstrated such outcomes for similar services (e.g., needle exchanges), currently there is only limited evidence confirming this effect for safe injection facilities. For example, Nickolai (cited in Lindesmith, 1999) noted that autopsy results in Frankfurt showed significant declines in the number of drug users dying with HIV/AIDS (from 65% in 1984 to 12-15% in 1994) following Frankfurt's introduction of a comprehensive harm reduction strategy that included safe injection facilities. A Swiss report concluded that a 10% reduction in the prevalence of HIV among drug users was due to a marked decline in needle sharing behaviour which was in part attributed to the existence of safe injection facilities.

In 1996, Haemmig (cited in Lindesmith, 1999) reported positive outcomes associated with educational programming in safe injection facilities. Clients in Switzerland reported substantial increases in safe injecting and safe sex practices. Data collected in Arnhem (1996) indicate that clients took fewer health risks following the establishment of safe injection facilities (cited in Lindesmith, 1999). In Bern, facility staff assisted clients in switching from 2 mm syringes to 1 mm syringes (cited in Lindesmith,

1999), which may reduce the risks of vein damage and disease transmission. Staff in Bern also found that reuse of injecting equipment among clients decreased significantly from 1990 to 1995.

Prior to the establishment of safe injection facilities, evidence from Germany and Switzerland indicated that health services were reaching only a small portion of drug users. Safe injection facilities were established, in part, as a way of contacting the most marginalized drug users. In Switzerland, research findings (cited in MacPherson, 1999) suggested that medium and high threshold services (e.g., abstinence-based treatment, methadone clinics, out-patient drug counselling) reached only 20% of drug users. Following the introduction of a harm reduction strategy that included safe injection facilities, 50% of drug users were registered in methadone maintenance, 15% were in abstinence-based treatment, and the remaining 35% were in regular contact with harm reduction services (MacPherson, 1999). In Frankfurt, while much had improved following the first phase of the harm reduction strategy in the early 1990s, there were still problems associated with public drug use, and research indicated that a greater number of drug users could be reached (MacPherson, 1999). This led to the opening of the first four of five safe injection facilities in Frankfurt. Since that time, more than 85% of drug users have been found to be in regular contact with health services (Parliament of New South Wales, 1998). Interviews with 138 drug users in safe injection facilities and the open drug scene in Frankfurt revealed that, on average, users had approximately 5 contacts with "drug-aid" services each week. Of those drug users interviewed, 75% had contact with needle exchange, 64% had contact with safe injection facilities, and 56% had attended contact cafés (low threshold services where users can access food, beverages, and other services). These data confirm expert opinion that low threshold services extend the "contact field" of health services.

Safe injection facilities also act as gateways to other systems of care and treatment. Data collected at La Strada (Frankfurt) indicate how safe injection facilities often play this critical role. In 1997, 194 La Strada clients asked for referral to detoxification services and 64 were successful in completing the detoxification process, despite having to wait 2 to 6 weeks for services (MacPherson, 1999). La Strada

employees work closely with their clients and support them in maintaining their commitment to detoxification during the waiting period. In the same year, 93 La Strada clients were referred to treatment, resulting in 34 admissions to treatment programs (MacPherson, 1999). Waiting time for treatment spaces is approximately six months. Another 94 clients asked for referrals to methadone programs, and 36 of these people were successful in gaining entry. In total, in 1997 there were 134 successful referrals from La Strada to medium and high threshold services.

Social Benefits

The establishment of safe injection facilities is also associated with reductions in drug-related public nuisance and criminal activity. In Arnhem, there were significant declines in public drug use following the establishment of safe injection facilities (cited in Lindesmith, 1999). Similar changes were noted in Frankfurt, where the number of public drug users dropped from approximately 800 in 1992 to 150 in 1993. Public complaints about drug use also dropped significantly during this period. It should be noted that these effects are attributable to Frankfurt's comprehensive harm reduction strategy which includes safe injection facilities among many other services. Kemmesies (1995) found that while 50% of drug users interviewed in the Frankfurt open drug scene reported injecting in public every day of the week, only 14% of drug users interviewed in safe injection facilities reported doing so during the previous week. The same study found that while 25% of drug users who did not regularly attend safe injection facilities reported visiting the open drug scene out of boredom, only 2% of those who did attend cited this as a reason for going to the open drug scene. Safe injection facilities also incorporate syringe exchanges within their structure, leading Haemmig (1996) and others to report decreases in the number of discarded syringes found on city streets where safe injection facilities are located.

The existence of safe injection facilities is also associated with reductions in criminal activity. The most compelling evidence comes from Frankfurt. While the reported reductions can be attributed to Frankfurt's comprehensive harm reduction approach, many of the more substantial decreases in crime occurred following the

establishment of safe injection facilities. The Frankfurt police (cited in Lindesmith, 1999) reported the following decreases from 1991 to 1997: cases of street robbery declined from 1,761 to 1,407; car break-ins declined from 28,672 to 19,495; heroin offences declined from 1,109 to 631; heroin trafficking charges declined from 1,211 to 220. As well, legal proceedings dropped 20% from 1995 to 1996.

There are likely many cost benefits associated with the existence of safe injection facilities as well. Most obvious may be reductions in health care costs. For example, in a one-year period, clients were treated in three safe injection facilities in Switzerland for more than 3,000 abscesses (Dolan & Wodak, 1996). If left untreated, many of these clients would have been hospitalized for up to two weeks in order to receive intravenous antibiotic treatments. In British Columbia, the cost of an acute care bed for fourteen days amounts to more than $9,000. As well, because staff are able to manage more than half of all overdoses occurring in safe injection facilities, substantial savings in emergency services likely result. Given estimates of approximately $130,000 for treating one IDU with HIV/AIDS (over a lifetime), safe injection facilities also likely contribute to savings through disease prevention initiatives. Reports from Switzerland also indicate that the creation of safe injection facilities has led to reductions in money spent on recovering discarded needles (cited in Lindesmith, 1999).

Additional benefits associated with safe injection facilities relate to policing efforts and the cost of criminal proceedings. Following the implementation of a harm reduction strategy in Frankfurt, police were free to focus their efforts on arresting drug dealers and addressing the supply side of the drug problem. It is also very likely that reductions in drug-related criminal proceedings have led to savings related to reductions in court time and incarceration. Finally, safe injection facilities may also assist in taking customers out of the drug market, which in turn may affect the supply side of the drug problem.

PROPOSED PROGRAM MODEL

With soaring rates of disease and death among drug users, British Columbia is in the midst of a public health crisis, and there is an urgent need for action. While the scope of problems resulting from illicit drug use in British Columbia is disturbing, evidence from the European context provides reason for optimism. It is clear that several European cities have had success in reducing drug-related problems similar to those in British Columbia. Critical to each success story has been a comprehensive harm reduction strategy that includes low, medium, and high threshold services for drug users, such as safe injection facilities, methadone maintenance, detox beds, and drug treatment. The research indicates that cities with high concentrations of drug users and open drug scenes stand to benefit most from the establishment of safe injection facilities (Dolan & Wodak, 1996; Parliament of New South Wales, 1999). To this end, the Harm Reduction Action Society is proposing the implementation and rigorous evaluation of two safe injection facilities in Vancouver.

Overview

The proposed safe injection facilities will be similar to models developed in Europe. The physical layout will be simple, and will include: an open waiting area with access to food; medical and counselling consult rooms; needle exchange; washrooms; a staff and equipment room; and an injection room. The facility will be designed to accommodate up to 35 drug users at a time who inject cocaine or heroin. Only those 18 years of age or older will be admitted. Services will include primary health care, provision of food and beverages, a needle exchange (for registered participants), a referral system, peer-facilitated education and support, counselling, supervision of injections, and resuscitation in the event of overdose.

Governance

The Harm Reduction Action Society is governed by an elected board of directors. The board is responsible for developing the Society's mission and values, determining and assessing organizational outcomes, and delegating day to day operational responsibilities to an executive director or project manager. The Carver model provides one clearly articulated framework for guiding the board of directors in its work (Carver Governance, 2000, p. 4).

Service Philosophy

Acceptance

Critical to the success of any safe injection facility is an "acceptance-oriented" approach to service delivery (German Federal Commissioner for Drugs, 1999). This approach emphasizes accepting drug users and their health, social circumstance, and lifestyle, while suspending judgements and actions derived from individual systems of values. This principle is integral to the success of low threshold programming.

Health Promotion

Health promotion involves encouraging personal control and responsibility in health matters. Therefore, while service providers will offer health options to participants in a manner that promotes self-directed care, ultimately IDUs themselves will decide their readiness to participate in health services and programs. The concept of self-care is closely linked to the aforementioned principles. In promoting this concept, safe injection facility staff will work with participants in a manner that maximizes autonomy, choice, and capacity for self-care.

Participant Involvement

Two final key principles are user-involvement and participant-driven programming. Current and former drug users along with others will be involved in governance and the delivery of various safe injection facility services. For example, drug users will be responsible for peer-based counselling and education initiatives within the safe injection facilities, and will be invited to participate in community-based research projects. The participants attending safe injection facilities will be encouraged to become involved in decision-making processes concerning operational and programming issues. Participation will be facilitated through a variety of structures and formats, including weekly community meetings.

Participant Care Issues

The provision of service to IDUs is uniquely complicated and challenging. Data from local studies indicate that this population struggles with a complex array of social, physical, and mental health problems. While safe injection facilities can attend to some of these problems in-house, many of the needs of participants will be addressed by other services.

Referrals

In order to promote comprehensive treatment, safe injection facilities will be equipped to provide referral to relevant services. While staff with psychosocial backgrounds will be responsible for spearheading the development of the referral system, all staff members will be trained to provide appropriate referrals.

A growing number of street youth are now using illicit drugs (Bognar, Legare, & Ross, 1998). While youth as young as 14 are able to consent to medical treatment, only individuals 18 years of age and over will be permitted to use safe injection facilities during the pilot period. In order to promote effective care of youth using drugs, safe injection facility staff will refer youth to specialized youth services (e.g., DEYAS, Watari, Nexus, Options, Ministry for Children and Families services). Because youth using illicit

drugs are deemed to be a "high risk" group, youth seeking entrance to safe injection facilities will be offered direct, assisted referral to youth services. Presently, in Vancouver, there is a range of specialty services for youth, including non-residential treatment, day treatment centres, programs for street youth, and youth-specific recovery homes (Bognar, Legare, & Ross, 1998).

Drug of Choice

A number of drug users in British Columbia are smoking "crack" (i.e., rock cocaine). However, local informants suggest that this trend has already peaked and that many users are returning to injectable cocaine. A recent survey completed by the BCCDC Street Nurse Program found that 72% of drug users in the Downtown Eastside are still injecting drugs (Gold et al., 2000). During the pilot period, crack users will not be permitted to smoke drugs within the facility. Staff will collect data concerning the needs of crack users and will incorporate these findings and recommendations in final evaluations.

While concerns may be raised about the different health and behavioural challenges of cocaine and heroin users, European models have demonstrated that these groups can be served successfully within the same facility. A review of safe injection facilities in Europe found that only one facility elected to provide separate injection rooms for cocaine and heroin users. The overwhelming majority of safe injection facilities allow these two groups to inject in the same space. For the purposes of this pilot, heroin and cocaine users will be permitted to inject in the same room.

Behavioural Issues

There are many behavioural challenges associated with the injection drug using population. Specifically, cocaine-induced psychosis, aggressive behaviours, theft, drug sharing, and drug dealing will need to be addressed. Clearly articulated rules, behaviour management techniques, and conferencing techniques (Moore & McDonald, 1999) will

be used to foster safety, inclusion, and adherence to facility rules. All efforts will be made to ensure that access to service is maintained rather than interrupted.

Clients may arrive at safe injection facilities severely intoxicated. This is a serious concern, especially if the individual is a heroin user under the influence of central nervous system depressants (e.g., alcohol, benzodiazepines). In these instances, staff will assess the risk of overdose and, when appropriate, encourage clients to use parts of the facility other than the injection room. Intoxicated clients will also be encouraged to make use of other appropriate services (e.g., detox, sobering centres). Individuals at high risk for overdose will not be permitted to use the injection room.

Operational Issues

Hours of Operation

Safe injection facilities will be open for a minimum of eight hours per day, seven days a week. Because evidence suggests a high number of overdoses occur on cheque issue day ("welfare Wednesday") and the day following, services will be offered 24 hours a day over these two days.

Capacity

The safe injection facility will accommodate a maximum of 35 participants at any time. This will make for a 7:1 participant to staff ratio. However, following the model employed at La Strada (Frankfurt), facility staff will determine on a moment to moment basis how many people should be allowed in the facility. To quote one source, "sometimes one visitor is too much and sometimes thirty-five is okay" (Steinmetz, personal communication, September 17, 2000). When the room is running at full capacity, those seeking entrance will be asked to return in 10 to 15 minutes. Those inside who have already made full use of the facility will be encouraged to leave to allow for turnover.

Staffing Model

The proposed staffing model has been developed specifically for the 18-month pilot period. Until the program has been fully evaluated, the staffing model should be conservative, taking into full consideration optimal standards of practice and participant safety. Staff will have appropriate professional and first aid training. Individuals with experience in the IDU community will be encouraged to apply. Salaries will be based on standards described within relevant local collective agreements. The staffing model is based on 7.2 hours per day, 7 days per week, with four additional 8-hour shifts per month:

	FTE (per site)
Registered Nurses	3.2
Counsellor	1.6
Social Services Worker	1.6
Physical Site Coordinator	1.6
Administration	0.5
Project Manager	0.5

The proposed staffing model has been selected to ensure that all necessary areas of expertise and competence are covered. There will be five staff members on shift at all times, including two registered nurses, one counsellor, one social services worker, and one physical site coordinator. As well, a half-time administration position will be included to cover additional administrative duties. It is recommended that a full-time project manager (0.5 FTE per safe injection facility) be hired to coordinate the establishment of the safe injection facilities.

The registered nurses will assume responsibility for primary health care, assessment, and referral. As well, nurses will assume a leadership role in the event of an overdose or injury.

The counsellor will be responsible for coordinating psychosocial assessment and referral, and will coach the rest of the team in managing difficult behaviour. The counsellor will also assume a leadership role when a participant expresses suicidal ideation or intent to harm others.

The social services worker will assist in coordinating peer facilitated programming and activities, and will coordinate the development of a referral database of social resources and supports.

The physical site coordinator will manage the physical site, including its maintenance and security, as well as the ordering and receipt of supplies.

Intake and Registration

Upon arrival, new participants will be asked to provide information about themselves (e.g., age, address, drug of choice, participation in substitute therapies). This information will be compiled in a computerized database, and lists of registered participants will be posted regularly for staff reference. As well, participants will be asked to sign forms agreeing to abide by the rules of the facility and verifying that they are 18 years of age or older. All client information will be protected in accordance with the Freedom of Information and Protection of Privacy Act.

Security

Adequate security measures will be in place to ensure participant and staff safety and to prevent theft. At least two staff members will be designated at all times to provide security in and around the facility. When a participant becomes agitated or threatening, he or she will be approached by two staff members who will try to contain and calm the participant. If the participant becomes increasingly agitated or violent, the police will be called to deal with the situation. All participants present in the facility will be informed that the police have been called and are on their way. Staff will also work with police to ensure that people (including dealers) do not loiter or linger around the facility.

Overdose Management

A coordinated overdose management protocol will be developed in partnership with Emergency Health Services. In the event of an overdose, two staff members (including at least one nurse) will attend, and move the individual to the middle of the

room. If the individual is not breathing independently or if their respiration is unusually shallow or slow, the staff will initiate assisted breathing as necessary and call Emergency Health Services. A more detailed protocol will be developed in consultation with Emergency Health Services.

Program Design

The safe injection facility program has been designed to achieve health and community outcomes, and is modelled on successful safe injection facilities in other jurisdictions. Input from drug users, service providers, and the community has been instrumental in tailoring the program to meet local needs.

Safe Injection Facility Logic Model

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
Resources consumed by the program	**What the program does to fulfill its objectives**	**Direct products of program activities**	**Benefits derived from program activities**
• Funding • Staff and volunteers • Staff and volunteer time • Facilities and equipment • Supplies **Constraints on the program:** • Current drug laws • Municipal regulations and by-laws • Public opinion • Funders' requirements	• Room for safe injection of drugs • Needle exchange • Education in safe injection and safe sex • Access to primary health care • Access to counselling • Referral to health and social services • Provision of food and beverages • Peer/social support opportunities • Volunteer opportunities	• Number of injection drug users served • Number of supervised injections • Number of needles exchanged • Number of participants receiving education in safe injection/safe sex • Number of condoms distributed • Utilization of on-site primary health care • Utilization of on-site counselling services • Number of referrals to health/social services • Amount of food and beverages consumed • Number of participants in peer/social support activities • Number of participants in volunteer activities	**Participants:** • Increased knowledge of safe injection/safe sex • Increased clean needle usage • Increased condom usage • Increased knowledge of health/social services • Increased opportunities for peer/social support • Increased overall health status **Community:** • Decreased overdoses and overdose deaths • Reduced rates of HIV and hepatitis C • Reduced drug-related hospitalizations • Reduced public drug use and public complaints • Reduced drug-related criminal activity • Reduced drug-related law enforcement and incarceration

Supervised Injections

The injection rooms will be a major component of safe injection facilities. Entrance to the injection room will be controlled by staff members. Staff will monitor the number of people in the room at any time, and allow participants in (one by one) as a space becomes available. The injection rooms will serve a maximum of eight participants at any time. One staff person will be present in the room at all times, and will be responsible for supervising injections, responding to overdoses, and collecting used injecting kits. Staff will rotate supervision duties every 20 minutes.

Participants will be required to wash their hands upon entry and will then be given an injection kit and sterile needles. Participants will supply their own drugs and will not be permitted to share or sell drugs in the safe injection facilities. Staff will provide coaching on safe injection practice to participants in the injection room. Based on estimations from other safe injection facilities, injections will take 10 to 15 minutes on average, and participants will be given up to 30 minutes to complete their injections.

Health Care

Nurses on site will provide primary health care in the facility's consult room. Based on local experience, this care will most often involve treating abscesses, cuts and abrasions, providing first aid, making primary diagnoses (e.g., cellulitis) and offering referrals to health services such as detox and treatment. As well, nurses and other staff will provide information on safe sex and injection practices. While the staffing model does not include physician services, safe injection facilities will seek the services of consulting physicians (including one psychiatrist) who will work on a sessional basis. Ideally, a general practitioner and psychiatrist will be available to participants one day of the week. A small scale needle exchange will be provided to registered participants. Appropriate quotas will be determined in consultation with local needle exchange operators and the Vancouver/Richmond Health Board. Non-registered participants seeking sterile syringes from safe injection facilities will be directed to the local needle exchange operator.

Counselling

Counselling and referral services will be provided on site and will be coordinated by a counsellor on staff. As well, all staff members will receive training in basic crisis counselling, suicide risk assessment, and referrals to local agencies and services. Counselling and referral services will be provided on a formal basis in the consult room, and on an informal basis throughout the safe injection facility. Because many participants attending the safe injection facility may have difficulty following through on referrals, an "assisted referral" system will be implemented. This system will involve staff or volunteers escorting "high need" participants to other agencies or services.

Food and Beverages

Food and beverages will be provided on site in recognition of the generally poor nutritional status of drug users. This service will complement the provision of other health and educational programs on site. As in other safe injection facilities, the food served will be in the form of highly nutritious light snacks (e.g., fruit, muffins, juices) rather than full meals. Staff, volunteers, and participants will provide this service. A small serving area within the safe injection facility will be used to serve food.

Peer Support

Peer-facilitated education, support, and counselling will also be offered within the safe injection facility. Ideally these services will be offered in coordination with user-based groups such as the VANDU Health Network. Education will be offered in a variety of formats including one to one and group discussions, workshops, information sheets and booklets. Topics will include overdose prevention and management, safe injection and sex practices, life skills, and health and social support.

Key Partnerships

The success of safe injection facilities is contingent upon the existence of key partnerships with other service agencies, the police, emergency health services, and the

community. In European municipalities, safe injection facilities perform important referral functions for street-level drug users. Therefore, before safe injection facilities are opened, a registry of agencies and services relevant to IDUs will be developed. Facility staff will work closely with local operators to ensure that appropriate information is shared and effective systems of referral are in place. Ideally, facility participants will have immediate access to a number of reserved treatment and detox beds.

Efforts will be made to develop effective partnerships with local police and emergency services. The police, ambulance, and other emergency service staff will be consulted on a variety of operational issues prior to implementation of the safe injection facilities. For example, the project manager will work to obtain direct lines to police and ambulances to ensure prompt response from these critical services. As well, staff will work with police to foster optimal working agreements that address problems of dealers on or near the safe injection facility and police intervention in the facility.

Safe injection facilities will pursue coordinated needle exchange under the guidance and support of local operators and authorities to ensure appropriate provision and disposal of syringes. Facility staff will also seek close working relations with the BCCDC Street Nurse Program and local consulting physicians as a means of maximizing medical care capacity.

To secure and maintain community awareness and support, some safe injection facilities in Europe have organized days when the local community can come and visit the facilities. Because the concept of safe injection facilities is new to the general public in British Columbia, similar initiatives that build community relations will be undertaken.

Physical Layout and Design

The simplest and most practical approach to establishing a safe injection facility would involve modifying an existing structure to include the necessary components of a safe injection facility. At present, a site has not been secured. A schematic design (Appendix 2) is provided for conceptual purposes only.

Accessibility and Visibility

Accessibility to and visibility within safe injection facilities must be maximized in order to accommodate persons with disabilities, including those with mobility and cognitive challenges. As well, individuals who are under the influence of illicit drugs must be able to navigate entry to and movement within the facilities.

Another concern is access to the safe injection facilities and the injection rooms by ambulance personnel. Doors and hallways must be large enough to comfortably accommodate stretchers. The facilities must also be appropriately lit. Indirect bright lighting should be used throughout in order to maximize visibility while reducing undesirable glare.

In order to ensure accessibility and visibility, building specifications will be designed in accordance with the British Columbia Building Code (Section 3.7) and the Canadian Standards Association's Barrier Free Design Standard document.

Safety and Security

Entrance to the facility and other participant sensitive areas must be controlled. The main entrance should be designed to permit casual observation by staff and should be electronically controlled so that flow of participants and unwanted visitors can be monitored. Entrance to injection rooms should also be electronically controlled by staff in the injection room and the adjacent staff area. Exit buttons should be placed on the inside of all electronically controlled areas to permit easy exit by participants.

The design and layout should also minimize problems such as opportunistic thefts and physical confrontations. All areas of the site should be visible and accessible to at least one staff person. As well, areas containing confidential records, valuable equipment, and money should be secured and accessible to staff only.

Functional and Spatial Components

The following spatial specifications are based on a gross area of 1000 sq. ft. or 92m² (including walls). This is a recommended minimum spatial requirement for safe injection facilities. This space has been designed to accommodate 35 participants.

Space	**Area**	
	m²	**sq. ft.**
Total waiting area	52.50	570.60
Wheelchair accessible washroom	3.83	41.68
Consult room 1	4.50	48.93
Consult room 2	4.79	52.04
Staff and equipment area	13.29	144.50
Injection room	13.09	142.25
Total area	**92.00**	**1000.00**

Waiting Area/Lounge (52.5m²)

The proposed waiting area/lounge is a large, open, rectangular space with a wheelchair-accessible washroom, serving area, and storage closet. The space should be highly accessible and visible to staff located in the staff and equipment area. The proposed space is designed to accommodate participants who are eating, waiting for access to the injection room, or seeking other services (e.g., primary health care, referrals). The space should also be appropriate for group meetings and educational workshops. There should be enough seating at the tables for at least 20 people. Additional lounge seating (e.g., sofas) should be provided for another 6 to 10 individuals. The wheelchair-accessible washroom is located within the waiting area next to the round tables.

The proposed serving area will include a refrigerator, microwave ovens and a counter space. This small serving area will be used primarily for serving snack food and beverages, and storing minimal dishware. Most food supplies will be stored in the staff and equipment area. A large sink will be located beside the serving area so participants

can wash their hands upon entry or before eating. A storage closet will be adjacent to the serving area. This will allow for easy access to cleaning supplies and equipment.

Consult Room 1 (4.5m²) and Consult Room 2 (4.79m²)

The proposed consult rooms are small, closed, secured spaces that are to be used for medical consults, counselling, and administration. Consult Room 1 is accessible from the waiting area, and Consult Room 2 is accessible by way of the waiting area and the staff and equipment room. Both rooms are designed to hold a maximum of two to three persons at a time. Included are sinks so that health care personnel can wash their hands before and after physical examinations. The rooms will have a large window (two feet square with blinds) to ensure safety and allow for monitoring by other staff. Blinds will be used as necessary to ensure privacy. Locked cupboards will be located on the walls to allow for storage of medical supplies.

Staff and Equipment Room (12.4m²)

The proposed staff and equipment room is a closed, secured space that is accessible to staff only. Included is a staff washroom, sink, refrigerator, and several secure floor and wall cupboards for storage. The space is accessible to staff by doors located in the consult, waiting, and injection rooms. This multipurpose space will be used for: storage of equipment, supplies and medical records; needle exchange; participant registration; controlling access to the injection room; and dispensing and collecting of injection kits. The front and injection room side of the staff and equipment area will have open counters (approx. 1.5 metres in length). The front counter will be used as a space to register participants, and the side counter will be used to dispense and collect injection kits. These open counters will also allow for easy visual monitoring of the waiting area and the injection room. The staff seated at the front counter will also control the flow into the injection room.

Injection Room (14.6m²)

The proposed injection room is a closed, secured space used for injecting drugs. The space is accessible to staff and participants by way of the waiting area, and to staff by way of the staff and equipment room. Access to the room will be controlled by an electronic locking system located within the staff and equipment area. A release button will be located on the inside to ensure easy exit by participants. The injection room will accommodate eight participants and will be monitored by a staff person at all times. Stainless steel counters will line the perimeter of the room. The counters will be divided into eight individual cubicles (approx. 2.5 to 3 feet in width) that will include lights and mirrors to promote safe injection practice. Counters are located around the perimeter to increase privacy and maximize the space available in the middle of the room for management of overdoses. The space will also include a sink for hand washing, and chair for one staff person.

LEGAL ISSUES

The precise legal status of safe injection facilities in Canada is unclear. Currently, there are no precedents or documents that specifically address legal issues related to their operation. A survey of the relevant laws suggests that one legal concern for safe injection facility operators may be civil liability. Because drug use is not a criminal offence in and of itself, criminal charges would only arise in the form of possession or trafficking offences, or criminal negligence. While technically possible, in practice it is unlikely that safe injection facilities would face these types of charges. Furthermore, there are defences available to safe injection facility operators facing prosecution for these offences. The Canadian HIV/AIDS Legal Network's 1999 document titled "Injection Drug Use and HIV/AIDS: Legal and Ethical Issues" addresses many issues relevant to the operation of safe injection facilities. Much of the information presented here was obtained from this document. Information from other sources is referenced accordingly.

Possession

The Controlled Drug and Substances Act (CDSA), implemented in 1997, prohibits the unauthorized possession, manufacture, cultivation, trafficking, export and import of specific substances listed in appended schedules. Listed substances include cannabis, heroin, methadone, cocaine and coca leaf, barbiturates, and amphetamines, as well as an array of other controlled substances. Under the CDSA, it is also an offence to possess, traffic, import, etc., not only drugs, but also:

> any thing that contains or has on it a controlled substance and that is used or intended or designed for use (a) in producing the substance or (b) in introducing the substance into a human body (CDSA, section 2, cited in Canadian HIV/AIDS Legal Network, 1999).

It follows then that possession of injecting equipment (e.g., syringes) could result in charges under the CDSA. Penalties for offences under the CDSA vary considerably. For example, possession of heroin or cocaine carries a penalty of imprisonment for up to seven years, while possession of a small amount of marijuana can result in six months in jail and/or a $1,000 fine (Canadian HIV/AIDS Legal Network, 1999).

While the most common form of possession (i.e., possessing illicit drugs on one's person) is an unlikely cause for concern for safe injection facility staff, other forms of possession, if given a most conservative reading, could be problematic. "Constructive possession" occurs when "a person 'knowingly' has the drug in the actual possession or custody of another person, or has the drug in any place, whether or not that place belongs to or is occupied by him, for the use of or benefit of himself or of another person" (p. 34). Another relevant form of possession is "joint possession." When "one of two or more persons, with the knowledge and consent of the rest, has anything in his custody or possession, it shall be deemed to be in the custody and possession of each and all of them" (p. 34).

While these descriptions appear to suggest that safe injection facility staff could be criminally liable for possession (given the presence of illicit drugs in their place of work), a conviction for constructive or joint possession is contingent on proof that the staff had a measure of control over the drug. Given that safe injection facility participants would be responsible for obtaining, holding, and administering their drugs (without assistance from staff), it is unlikely that safe injection facility operators would be found to have such control.

A charge of possession could also arise if a facility were found to be storing drug paraphernalia that contained residue of illicit drugs (e.g., used syringes). While this charge is possible, it would constitute a highly unusual application of the CDSA, as there are many facilities and services throughout Canada collecting used syringes and none has been charged with possession.

Trafficking

According to the CDSA, trafficking involves selling, administering, giving, transferring, transporting or delivering an illegal substance. An individual may also be found guilty of these offences for offering to do any of these things. As mentioned earlier, any object used to introduce an illegal drug into the body is also considered a controlled substance. Because safe injection facility staff will provide equipment, they could be perceived as assisting in administration. However, a charge resulting from the provision

of sterile syringes would constitute a highly unusual departure from standard enforcement practice.

Criminal Negligence

> According to the Canadian HIV/AIDS Legal Network (1999) document:
>
> Prosecutors could also conceivably bring charges of criminal negligence causing death or bodily harm against those working in health-care or treatment facilities if prosecutors were of the opinion that, by tolerating or facilitating drug possession on the premises, the facility caused or contributed to someone (e.g., resident, staff, volunteers, visitors) being injured (p. 35).

A person could be considered negligent if he or she, in departing from a legal duty, demonstrates "wanton or reckless disregard for the lives or safety of others" (Criminal Code, section 219; cited in Canadian HIV/AIDS Legal Network, 1999, p. 35). Prosecution in this case would require proof beyond a reasonable doubt that the accused did not fulfill a legal duty. Because safe injection facility staff would have a duty to ensure the well-being of participants, staff, and visitors, it could be argued that "facilitating the use of drugs or perhaps tolerating it constitutes a breach of a legal duty" (Canadian HIV/AIDS Legal Network, 1999, p. 35). Also required to establish this offence is proof that the accused did something that was a "marked departure from the standard of behaviour expected of a reasonably prudent person in the circumstances" (p. 36). While there are no established standards for safe injection facilities in Canada, standards of practice have been established in Europe. As well, various health care services in Canada have established standards for dealing with many of the more challenging circumstances that might arise in a safe injection facility (e.g., drug overdoses). Collectively these standards would define "standards of behaviour of a reasonably prudent person."

Professional Discipline and Civil Liability

There are varying opinions concerning the issues of professional obligations and discipline. According to the Canadian HIV/AIDS Legal Network (1999), individual staff

members working in safe injection facilities may be at risk for disciplinary action from their respective professional bodies. However, given the benefits and reductions in harm associated with safe injection facilities, others believe that facility staff would be fulfilling their professional ethical obligations. As well, it should pointed out that the work of safe injection facility staff would merely involve an extension of the many harm reduction practices of nurses working in the Downtown Eastside in street outreach or in home or clinical care capacities.

As in the case of criminal negligence, safe injection facility staff could face civil liability if a participant, visitor, or staff member suffered harm as a result of drug use in a safe injection facility. Civil lawsuits may be directed against either individual staff members or the facility. None has arisen in the European context.

The Defence of Necessity of Treatment

> In avoiding criminal or civil liability, an individual or facility may claim that:
>
> The use of drugs was a necessity for the treatment of the patient and/or that, in the circumstances, it would be negligent to prohibit possession of a controlled substance by a patient, as this might interfere with essential medical treatment (p. 36).

This argument may be especially compelling in the case of safe injection facilities, as evidence suggests IDUs are at much greater risk for acquiring life threatening diseases or death from drug-related overdose when injecting outside of safe injection facilities. Furthermore, the Canada Health Act provides for universal access to health care for all citizens. If criminal law and professional codes do, in fact, limit or constrain the provision of health care to drug users, it could be argued that these structures wrongly deny this population an essential right.

International Law

Canada, like many other countries, is a signatory to various international covenants pertaining to illicit drugs. The most notable are: the Single Convention on Narcotic Drugs (1961), the Convention on Psychotropic Substances (1971), and the

relevant portions of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988). Many assume these conventions require that signatories adopt a criminal prohibitionist approach to dealing with problems of drug use. In fact, these conventions contain provisions allowing for the use of a range of health-based approaches, including harm reduction measures.

In his review titled "International Covenants Prohibiting Drug Activities," Gilmour (1995) argues that harm reduction policies can be accommodated within the various international conventions. As an example, Gilmour cites Article 4c of the Single Convention (1961) which states that parties "shall take such legislative and administrative measures as may be necessary…subject to the provisions of this Convention, to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs" (p. 2). Therefore, the use and possession of drugs for medical or scientific purposes is permitted by this convention.

It could be argued that Canada would, in providing harm reduction services, be fulfilling its international obligations as described by the three conventions, as they uniformly advocate the "treatment, education, aftercare, rehabilitation and social reintegration" of drug users (Swiss Institute of Comparative Law, 2000, p. 1). Furthermore, the conventions require signatories to "take all practical measures" for the benefit of drug users. While these measures are not specified, the conventions state that signatories may resort to such measures in place of or in addition to prosecution and punishment when criminal offences are committed by drug users. In practice, there are now a number of states, signatory to the three conventions, which have incorporated safe injection facilities in their continuum of health services. According to the Swiss Institute of Comparative Law, this "is not a legal question at all, in the sense that medical experts, social workers, and health policy makers are much better equipped than lawyers to provide reasonable responses" (2000, p. 2).

Legal Options Permitting A Safe Injection Facilities Pilot

There are four different available legal options under which a pilot of safe injection facilities in Canada could proceed. The first two involve gaining exemptions from current laws, a third involves forming administrative agreements, and the fourth involves amending the CDSA.

According to the Canadian HIV/AIDS Legal Network (1999), there are two forms of exemption from current laws that could be sought to allow for a safe injection facilities pilot. Under Health Canada's Special Access Program, safe injection facilities could "arrange access to specific drugs under existing legislation, so that drugs that would otherwise be illegal can be allowed or even administered to patients" (p. 36). A second option involves appealing to the Minister of Health for exemption as permitted by section 56 of the CDSA. In this situation, provisions could be applied to exempt safe injection facilities from criminal penalties for offences such as possession.

A third option involves an administrative agreement between relevant authorities, including health authorities, local government, public prosecutors, and the police. Such an agreement would be similar to those used in Britain (regarding needle exchanges) and in the Netherlands (regarding various drug offences). As part of these administrative arrangements, the police typically agree not to enter facilities except in extreme circumstances. While safe injection facility staff and the police do maintain informal communication, the police avoid making unnecessary visits to the facility. The agreements can also extend to include public prosecutors who could agree to refrain from prosecuting individuals committing specified drug-related offences within safe injection facilities. This option has the advantage of being quickly instituted.

The fourth and most time-intensive option would involve amending the CDSA. First, the CDSA could be amended to bring it more in line with international conventions, and thus allow for the use of illegal drugs in medical settings. Second, current laws could be changed to exempt service providers from prosecution related to tolerating use within facilities. Third, drug laws could be amended to exempt drug users from prosecution

when they are receiving care or treatment. And fourth, drug laws could be changed so that used syringes containing residue of illicit drugs are no longer listed as controlled substances.

EVALUATION

The Harm Reduction Action Society's proposed 18-month pilot of two safe injection facilities will require rigorous internal and external evaluation in order to assess the efficacy of the facilities and promote excellence in service provision. It is recommended that two sites be opened simultaneously for 18 months to allow for optimal evaluation. Two sites will ensure an adequately representative sample, and allow for a variety of comparisons, particularly in terms of operational differences.

Evaluation Objectives

The purpose of the evaluation is to examine the process, service quality, reach, results or outcomes, and cost effectiveness of the safe injection facility. The evaluation will answer the following questions:

1. How well are the safe injection facility services designed and delivered? (process)
2. How satisfied are participants with the safe injection facility services? (service quality)
3. To what extent does the safe injection facility serve its target population? (reach)
4. Has the safe injection facility achieved its intended results for participants and the community? (outcomes)
5. Has the safe injection facility achieved its intended results at a reasonable cost? (cost effectiveness)

Advisory Committee

The Harm Reduction Action Society has established an advisory committee consisting of experts in relevant areas of research and evaluation who can advise the Society in matters related to research and evaluation. The key partners include the BC Centre for Excellence in HIV/AIDS and the Centre for Health Evaluation and Outcomes Science. The advisory committee will contribute to the development of both evaluation components and recommend an external evaluating body to the Harm Reduction Action Society board of directors. Current members of the advisory committee include:

Dr. Anita Palepu	The Centre for Health Evaluation and Outcomes Science
Dr. Mark Tyndall	The BC Centre for Excellence in HIV/AIDS
Dr. Bob Hogg	The BC Centre for Excellence in HIV/AIDS
Dr. Patricia Spittal	The BC Centre for Excellence in HIV/AIDS
Dr. Robert Broadhead	The University of Connecticut, Dept. of Sociology

Methodology

Evaluations will be conducted internally and externally. The advisory committee and project manager will develop the methodology employed for the internal evaluation, while the methodology used for the external evaluation will be determined by the external evaluating body. The project manager will oversee the implementation of the internal evaluation and will coordinate the interface between the external evaluation and the safe injection facilities. Final proposals for both evaluations will be submitted for external ethical review.

Evaluations will include quantitative and qualitative methods, and, where appropriate, evaluators will employ community-based research approaches to allow for community input and evaluation. Data will be collected using existing data sources, as well as through specifically designed collection instruments (e.g., questionnaires, structured interviews, medical examinations). Baseline data will be collected to allow for prospective comparisons.

FUTURE DIRECTIONS

Experience from overseas indicates that safe injection facilities are effective. Arguably, this form of low threshold service is critical to the success of any four-pillar approach to problems of drug use. Only experience will prove whether this type of service is appropriate to the Vancouver context. What is required then is action to secure a trial of safe injection facilities, in which rigorous evaluation is a key component.

The Harm Reduction Action Society has examined the feasibility of this initiative, and is now calling on all three levels of government to support the implementation and evaluation of safe injection facilities in Vancouver. The Harm Reduction Action Society is prepared to operate these services, and is interested in engaging in dialogue to that end. The City of Vancouver has released a policy document inviting discussion of safe injection facilities. Given this development and the extent of drug-related problems in Vancouver, the time to act is now. In the absence of concrete action, drug users and their communities will continue to suffer.

REFERENCES

ABC News Online. (2000). Brack vows to push ahead with heroin injecting rooms. [online]. Available: http://www.abc.net.au/news/1999/10/item19991029101142_1.htm. (July 21, 2000)

Bognar, C., Legare, J., & Ross, S. (1998). Injection drug use and the epidemic of HIV in the Lower Mainland: Final report. Vancouver: Lower Mainland Working Group on Communicable Diseases.

British Columbia Ministry of Health and Ministry Responsible for Seniors. Drug-affected babies. In A report on the health of British Columbians: Provincial Health Officer's Annual Report. (1997). [online]. Available: http://www.health.gov.bc.ca/pho/ar/1997/report/97_ch8c.html. (August 16, 2000)

British Columbia Task Force into Illicit Narcotic Overdose Deaths in British Columbia. (1994). Report of the Task Force into Illicit Narcotic Deaths in British Columbia. Victoria, BC: Ministry of Health.

British Columbia Vital Statistics Agency. (2000). Annual Reports (1998). [online]. Available: http://www.hlth.gov.bc.ca/vs/. (August 12, 2000).

Broadhead, R., Altice, R., & Kerr, T. (2000). Unpublished paper.

Brochu, S. Estimating the costs of drug-related crime. (1995). [online]. Available: http://www.ccsa.ca/brochu.htm. (August 14, 2000)

Cain, J. V. (1994). The Cain report. British Columbia Task Force into Illicit Narcotic Overdose Deaths in British Columbia. Report of the Task Force into Illicit Narcotic Deaths in British Columbia. Victoria, BC: Ministry of Health.

Canadian Centre on Substance Abuse National Working Group on Policy. Harm reduction: Concepts and practice – a policy discussion paper. [online]. Available: http://www.ccsa.ca/wgharm.htm. (August 9, 2000)

Canadian Foundation for Drug Policy. Special Senate Committee on drug policy. [online]. Available: http://www.cfdp.ca. (August, 9, 2000).

Canadian HIV/AIDS Legal Network. (1999). Injection drug use and HIV/AIDS: Legal and ethical issues. Montreal: Canadian HIV/AIDS Legal Network.

City of Vancouver. (2000). [online]. Available: http://www.city.vancouver.bc.ca/commsvcs/planning/dtes. (May 11, 2000).

Correctional Services of Canada. Forum on corrections research. [online]. Available: http://www.csc-scc.gc.ca/text/prgrm/corr_e.shtml. (September, 11, 2000).

Cottier, B., & Sychold, M. (2000). Use of narcotic drugs in public injection rooms under public international law. [online]. Available: http://www.drugtext.org/articles/useroomavis.htm. (July 20, 2000)

Dolan, K. & Wodak, A. (1996). Final report on injecting rooms in Switzerland. The Lindesmith Center – Drug Policy Foundation (unpublished). [online]. Available: http://www.lindesmith.org/library/dolan2.html (June 24, 2000)

Drug Policy Expert Committee. (2000). Drugs: Responding to the issues, engaging the community. Melbourne: Government of Victoria.

Drug Policy Expert Committee. (2000). Heroin: Facing the issues. Melbourne: Government of Victoria.

Drug strategies in the Lower Mainland. (2000). [online]. Available: http://www.city.vancouver.bc.ca/greaterdot/gv2000/episode9.htm. (August 9, 2000)

Fischer, B., Rehm, J., & Blitz-Miller, T. (2000). Injection drug use and preventive measures: A comparison of Canadian and Western European jurisdictions over time. Canadian Medical Association Journal, 162 (12), 1709-1713.

German Federal Commissioner for Drugs. (1999, November). Guidelines for the operation and use of consumption rooms. Symposium conducted at the Consumption Rooms as a Professional Service in Addictions-health: International Conference for the Development of Guidelines, Hannover: Germany.

Gilmour, G. The international covenants “prohibiting” drug activities. Paper submitted to Canada’s Senate Standing Committee on Legal and Constitutional Affairs, December 14, 1995. [online]. Available: http://www.cfdp.ca/gilmour.html. (August 15, 2000)

Gold, F., Cruz, B., James, E., Wrath, K, Astin, C., & Brunt, C. (2000). An overdose survey in the Downtown Eastside. Vancouver: AIDS Prevention Street Nurse Program, BCCDC.

Guidelines for the operation and use of consumption rooms. (1999). Consumption rooms as a professional service in addictions-health: International conference for the development of guidelines, November 18-19.

Hanvelt, R., Copley, T., Schneider, D. & Meagher, N. (1999). The economic costs and resource impacts of HIV/AIDS in British Columbia. (NHRDP Project No. 6610-2372-AIDS).

Health Canada. (1998). Canada's drug strategy. (Catalogue No. H39-440/1998E). Ottawa: Minister of Public Works and Government Services Canada.

Health Canada. (1999). Hepatitis C – prevention and control: A public health consensus. Canada Communicable Disease Report, 25S2. [online]. Available: http://www.hc-sc.gc.ca/hpb/lcdc/publicat/ccdr/99vol25/25s2/index.html. (August 15, 2000)

Joint Select Committee into Safe Injecting Rooms. (1998). Report on the establishment or trial of safe injecting rooms. Sydney: Parliament of New South Wales.

Kemmesies, U. (1999). The open drug scene and the safe injection room offers in Frankfurt am Main 1995: Final report. [online]. Available: http://www.muenster.net/~indro/injection_room.htm. (July 20, 2000). (Original German version published INDRO 1995)

Kwan, J. (2000). [Vancouver Agreement on substance misuse pilot]. Unpublished data.

Lindesmith Center. (1999). TLC research brief: Safer injection rooms. [online]. Available: http://www.lindesmith.org/cites_sources/cites.html. (July 7, 2000)

Lindesmith Center. (1999). Research summary: Safe injection rooms. [online] Available: http://www.lindesmith.org/cites_sources/brief17.html. (July 7, 2000)

Lower Mainland Municipal Association. (2000). Towards a Lower Mainland crime and drug misuse prevention strategy: Needs assessment and identification of issues. Abbotsford, BC: Dandurand, Chin & Associates.

MacPherson, D. (1999). Comprehensive systems of care for drug users in Switzerland and Frankfurt, Germany. A report from the 10th international conference on the reduction of drug related harm and a tour of harm reduction services in Frankfurt, Germany. Vancouver: Social Planning Department.

McGregor, C., Darke, S., Ali, R., & Christie, P. (1998). Experience of non-fatal overdose among heroin users in Adelaide, Australia: Circumstances and risk perceptions. Addiction, 93(5), 701-711.

McLean, M. (2000). Vancouver drug epidemiology and drug crime statistics 2000. Canadian Community Epidemiology Network on Drug Use (draft, June 21, 2000).

Millar, J. S. (1998). HIV, hepatitis, and injection drug use in British Columbia – Pay now or pay later? Victoria: Office of the Provincial Health Officer.

Ministry for Children and Families. (1998). Report on the status of the implementation of the recommendations of: The review of alcohol and drug services in Vancouver. Victoria: Ministry for Children and Families.

Ministry for Children and Families. Addiction services: Our mission and mandate. [online]. Available: http://www.cfdp.ca. (September 18, 2000)

National Task Force on HIV, AIDS and Injection Drug Use. (1997). HIV/AIDS and injection drug use: A national action plan. Ottawa: Canadian Centre on Substance Abuse and the Canadian Public Health Association. [online]. Available: http:// www.ccsa.ca/plweb-cgi/fastweb.exe?getdoc+view1+GENERAL+210+16 ++HIV. (August 9, 2000)

Oscapella, E. (1995). How Canadian laws and policies on "illegal" drugs contribute to the spread of HIV infection and hepatitis B and C. [online]. Canadian Foundation for Drug Policy. Available: http://www.cfdp.ca. (August 13, 2000)

Parry, Penny. (1997). "Something to eat, a place to sleep and someone who gives a damn": HIV/AIDS and injection drug use in the DTES. Final project report to the DTES community, Minister of Health, and Vancouver/Richmond Health Board.

Schechter, M.T., & O'Shaughnessy, M.V. (2000, March). The NAOMI trial: A clinical trial of heroin. Paper presented at Keeping the Door Open: Health, Addictions, and Social Justice, Vancouver, BC

Single, E. (1999). A harm reduction framework for drug policy in British Columbia. Penultimate draft of a discussion paper prepared for the British Columbia Harm Reduction Working Group.

Single, E. (1999). The economic implications of injection drug use. Conference on injection drug use, Montreal, March. [online]. Available: http://www.ccsa.ca/iduecon.htm. (August 9, 2000)

Single, E., Robson, L., Xie, X., & Rehm, J. (1996). The costs of substance abuse in Canada. [online]. Available: http://www.ccsa.ca/costhigh.htm. (August 14, 2000)

St. Paul's Hospital. (2000). [Flagged intravenous drug use cases by month – Apr 1/95 to Mar 31/00].Unpublished raw data.

Strathdee, S.A., Patrick, D.M., Currie, S., Cornelisse, P.G.A., Reckart, M.L., Montaner, J.S.G., Schechter, M.T., & O'Shaughnessy, M.V. (1997). Needle exchange is not enough: Lessons learned from the Vancouver Injection Drug Use Study. AIDS, 11(8), F59-65.

Swiss Institute of Comparative Law. (2000). Use of narcotic drugs in public injection rooms under Public International Law. [online] Available: http://www.drugtext.org/articles/useroomavis.htm (July 20, 2000).

The Vancouver Agreement. (2000). [online]. Available: http://www.city.vancouver.bc.ca/commsvcs/planning/dtes/vcragree.htm. (May 11, 2000)

Vancouver Coalition for Crime Prevention and Drug Treatment. (1999). Discussion paper: Building partnerships to revitalize the Downtown Eastside. Vancouver: City of Vancouver.

Vancouver HIV/AIDS Care Coordinating Committee. Background to strategic plan 1999-2000. Vancouver: The Vancouver HIV/AIDS Care Coordinating Committee.

Whynot, E. (1996). Health impact of injection drug use and HIV in Vancouver. Vancouver: Vancouver Health Board.

APPENDIX 1: SAFE INJECTION FACILITY MODELS

Most of the information below was obtained from the report on the Establishment of or Trial of Safe Injecting Rooms by the Joint Select Committee into Safe Injection Rooms (Parliament of New South Wales, 1998). Information from other sources is referenced accordingly.

Switzerland

Government sanctioned safe injection facilities have been in operation in Switzerland since 1986. There are presently 13 legal safe injection facilities in Switzerland. They are located in Basel, Bern, and Zurich. Most sites are open for seven hours per day and approximately one hundred people visit daily.

Legal Issues in Switzerland

The law addressing illicit drug use in Switzerland is the 1951 Federal Law on Narcotic Drugs. Although under this law use of illicit drugs is prohibited, it constitutes only a minor offence. A panel of judges was formed to examine whether or not safe injection facilities could operate free from prosecution under Swiss law. They concluded that Article 19a provided the basis for legal operation of safe injection facilities:

1. Anyone who, illegally and intentionally, consumes narcotics or who commits a violation of section 19 in order to consume them, is liable to be arrested or fined.
2. In less serious cases, the competent authority may suspend the sentence or decide not to impose a penalty. A reprimand may be given.
3. Criminal proceedings need not be pursued where the person who has committed the offence is already as a result of having consumed narcotics, undergoing treatment under the care of a doctor or where he or she agrees to do so. Criminal proceedings will be commenced if he or she withdraws from treatment.
4. Where the person who has committed the offence is dependent on narcotic drugs, the judge may order him or her to be sent to a treatment centre. Section 44 of the Swiss penal code is applicable in such a case (Parliament of New South Wales, 1998, p. 67).

The judges decided that safe injection facilities should be categorized as a "medical treatment" and therefore exempted from police intervention. In 1991, this position was further supported by the Federal Government's intensified commitment to reducing drug-related problems. Specifically, the Swiss government developed a policy consisting of four strategic pillars: prevention, therapy, harm reduction, and law enforcement. The policy also emphasizes consensus, cooperation, pragmatism, evidence, and innovation.

Spitalstrasse 36, Basel

The Spitalstrasse 36 injection room was built in 1995. The facility is open seven days a week, and the injection room is open four hours per day: Sunday to Tuesday, 5:00 to 9:00 p.m.; and Wednesday to Saturday, 11:00 a.m. to 3:00 p.m. Officially, only Swiss residents are permitted entry, although some flexibility is exercised. Staff use informal questioning before entry is permitted. There are a variety of rules, many of which are common to drug treatment facilities. Breaking the rules can result in being barred from the facility for a period of time.

The common area of Spitalstrasse 36 consists of an open sitting and recreation area that includes a cafeteria run by staff and clients. There is one room in which to inject drugs. Smokers are no longer allowed to use the injection room. Clients line up for access to 10 available spaces in the injection room. The waiting time is usually between 5 and 30 minutes and most clients are prepared to wait. There are a number of small tables where clients sit, prepare, and inject their drugs. Staff place free injection equipment (e.g., syringe, spoon, candle, and sterile water) at each table. Clients typically complete their injection within 10 minutes. There are more than 100 injections per day, and over 1,500 syringes are exchanged daily. One staff member is present in the injection room at all times to monitor but not assist with injections. A minimum of three staff members are on shift at all times. There are seven medically trained staff members in total, three of whom are relief workers. In the event of an overdose, the staff person in the injection room calls for assistance. Staff then administer oxygen through a face mask and resuscitation bag until the client regains the ability to breathe without assistance. If a client is unable to

breathe independently within 10 minutes, an ambulance is called. Naloxone (Narcan) is not administered by safe injection facility staff to revive clients in any of the safe injection facilities in Switzerland.

Spitalstrasse 36 offers primary medical care, including psychiatric and STD services. Information on safe injection and sex practices is also provided, as is referral to drug treatment and other health and social services. Approximately 80 condoms are distributed each day. Staff at Spitalstrasse 36 have direct lines to ambulance and other emergency services, and police enter the facility only if called by staff or if they believe a wanted criminal is on the premises.

The Centre, Bern

The Centre in Bern is located in a basement near the main square and is run by a non-profit organization. There are 9.7 full-time staff members, with an additional 1.8 staff employed specifically for the needle and syringe exchange program. Staff maintain strict control over behaviour, and access can be denied for up to a week for breaches of rules. Passes are not required for admission. On Mondays, only women are allowed into the Centre.

The facility in Bern includes a sitting/recreation area with a cafeteria. Simple meals such as soup, bread, fruit, and tea are served by staff and clients, and clients receive a small payment for cooking one night of the week for a group of 20 to 25 clients. The Centre also has shower and laundry facilities.

The injection room in Bern is for IDUs only. Smoking of drugs is not allowed. The injection room has three tables at which up to 12 clients can sit. Staff attend the injection room at 15 minute intervals, and replenish injection kits (e.g., syringe, ascorbic acid, cotton wool, alcohol swabs and filters) as needed. The facility provides the first syringe free, and additional syringes are provided at a modest price. While staff do not assist with injections, clients are permitted to assist one another. The facility distributes approximately 15,000 syringes each month.

The Netherlands

Several safe injection facilities operate in Rotterdam, Arnhem, and Maastricht. Facility models in the Netherlands vary considerably from city to city, with some operating as non-profit organizations, and others operating under private and government funding. Throughout the Netherlands, the police have played a critical role in the planning and supervision of these facilities.

Legal Issues in The Netherlands

The Dutch approach to drug policy is described in a document prepared by the Dutch Ministry of Health, Welfare and Sport (cited in Parliament of New South Wales, 1998). It states:

> The main aim of drug policy in the Netherlands is to protect the health of individual clients, the people around them and society as a whole. Priority is given to vulnerable groups, and to young people in particular. Policy also aims to restrict both the demand for and supply of drugs. Active policies on care and prevention are being pursued to reduce demand for drugs, while a war is being waged on organised crime in an attempt to curb supply. A third aim is to tackle drug-related nuisance and to maintain public order. The Netherlands now has twenty years' experience of working with these policies on drugs (Drug Policy in the Netherlands, 1997, p. 1).

The Opium Act outlines the regulations pertaining to illicit drugs. Under the Act, possession is an offence, while use of drugs is not. Anyone found to be in possession of less than 0.5 grams will likely not be prosecuted, although police will confiscate the drugs and consult a care facility. The Arnhem police currently use a point system instead of charging drug users for every offence. Points accrue with each offence, and eventually drug users may be required to serve detention in a prison or clinic. Importing and exporting of drugs are the most serious offences.

Stichting Gelders Centrum Voor Verslavungszorg, Arnhem

The Stiching Gelders Centrum Voor Verslavungszorg is government funded, and is located next to a methadone clinic in an industrial district that also encompasses the

major prostitution area. The facility operates from 9:00 a.m. to 10:00 p.m., Monday to Friday, and 2:00 to 10:00 p.m. on weekends.

A staff person located in a small office inside the front door controls entry to this safe injection facility. Clients must apply to be approved to use these rooms, and access is limited to residents of Arnhem. Beyond the entrance is a large open sitting and recreation area with access to a cafeteria (10 metres by 8 metres) where food and beverages are served. The facility has one room for injecting and one room for smoking drugs. Separate rooms were established to better deal with the unique behavioural problems associated with cocaine use. Each room is simple and small (2 metres by 3 metres), and is located behind a counter where a staff person sits. The rooms accommodate eight people at a time. The doors of the rooms have one metre square windows through which staff observe clients. Access is controlled by a booking system.

The facility in Arnhem provides information on drug use to assist local police in crime prevention. As well, police often consult with clients in the Centre on matters relating to drug trafficking and crime.

Germany

The first safe injection facilities in Germany opened in Bonn and Bremen in 1987 as practical responses to increasingly high levels of public drug use (Drug Policy Expert Committee, 2000). Since 1994, additional facilities have been established in Frankfurt, Hanover, Hamburg, and Saarbrucken. There are 13 safe injection facilities in operation at the present time.

During the 1980s and 1990s, an open drug scene flourished in Frankfurt, mainly in one park near the Frankfurt banking and business district. In 1991, an estimated 6,000 people visited the park each day to buy drugs, and more than 1,000 people were injecting or dealing drugs there at any given time. Approximately 20 ambulances attended the park each day to deal with overdoses.

Following the launch of a new harm reduction program in the early 1990s, four safe injection facilities opened from 1994 to 1995. While the new program was

successful, research indicated that more could be done, as many users were not being contacted by existing services (MacPherson, 1999).

Legal Issues in Germany

Drug issues fall under the Federal Narcotic Act. The day to day application of the Act is up to the individual Länder (states). Consequently, divergent approaches are taken throughout the country. Article 29(10) of the Federal Narcotics Act makes it an offence to:

- provide information concerning unauthorized use or acquisition of narcotic drugs;
- provide unauthorized narcotic drugs, either publicly or in self-interest; or
- provide third parties with such an opportunity or concede or incite such persons to unauthorized use of narcotic drugs. (However, the provision of sterile disposable syringes for drug addicts is not to be understood as provision of opportunity for use) (Parliament of New South Wales, 1998, p. 72).

While the German Federal Narcotics Act may appear to preclude the legal operation of safe injection facilities, the statement concerning the provision of syringes emphasizes the socio-political rather than the criminal-political aspect of public policy. In the German context, the provision of "opportunity" is seen as requiring more than the provision of a possibility. According to the Parliament of New South Wales (1998) report:

> the distinction turns on the degree of active involvement: opportunity means making available conditions over and above what may have been possible. In other words, if a drug user has drugs and is going to use them, making available the facilities of an injecting room is not seen as providing that person with an opportunity to do something that he or she otherwise wouldn't do (p. 73).

In March 2000 the German Upper House (the Bundesrat) passed amendments to Betäubungsmittelgesetz to fully permit the operation of safe injection facilities (Drug Policy Expert Committee, 2000). Under these amendments, safe injection facilities can operate legally if they meet minimum requirements, including:

- medical counselling;
- monitoring of compliance with the obligations laid down in the Federal Narcotics Act;
- documentation and evaluation of operations;

- measures being taken to prevent criminal offences in safe injection facilities; and
- maintenance of a register of people using the safe injection facility.

La Strada, Frankfurt

La Strada is located 500 metres from where the open drug scene was once most active. The facility is run by the national non-profit AIDS organization AIDS-Hilfe. La Strada is open Mondays and Wednesdays from 3:00 to 7:30 p.m., Tuesdays and Fridays from 9:30 a.m. to 2:30 p.m., and Thursdays from 11:00 a.m. to 2:00 p.m. The service includes an overnight emergency shelter (for fourteen men and nine women), six day beds for people in crisis, a café, meals on two days of the week, AIDS education, a referral service, and an outreach program focused on crack users (MacPherson, 1999).

The injection room is fifteen feet square and has seven tables for users (MacPherson, 1999). Prior to entry, staff collect information about the user and then provide a small sterile injecting kit. Only one user is permitted at a table at one time, and 20 to 30 minutes is given to complete injections. Clients are encouraged to spend time in the café following the injection. A staff person is present in the injection room at all times, and is trained to revive clients who overdose. The staff manage approximately 50% of the overdoses and ambulance services handle the remaining 50% (MacPherson, 1999). There are approximately 150 injections per day at La Strada, and over one million injections have been supervised since the site opened (MacPherson, 1999). The staff at La Strada work closely with police to maintain order within and around the site, and police are called immediately if a dealer enters the facility. According to MacPherson (1999), staff at La Strada and police “work hand in hand to keep the use of drugs as low key and out of sight as possible” (p. 14).

APPENDIX 2: PHYSICAL LAYOUT FOR PROPOSED SAFE INJECTION FACILITY