

# In Memory of Steve who died on February 26, 2008

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# **LEARNING FROM EACH OTHER:**

Enhancing Community-Based Harm Reduction Programs and Practices in Canada **Executive Summary** 

## Purpose of the Project

The aim of this project is to document and disseminate information on innovative and useful ways that harm reduction programs and practices are being offered in some of Canada's small to mid-sized cities, and some of the more effective ways that challenges to them have been overcome. We believe that this information will help service organizations and people who use drugs to learn from each other new ways to address some of the difficulties and obstacles that they continue to face in this country.

### **Methods**

A National Advisory Committee was established to guide the project: a Harm Reduction Symposium was held, to get further direction; is to harm reduction programs and services and focus groups with people with illegal drug-use experience were conducted in Whitehorse YT, Victoria BC, Edmonton AB, Winnipeg MB, Rouyn-Noranda QC, Ottawa ON, Québec QC, Halifax NS, and St. John's NL.

### Focus Group Summary

Focus group participants expressed a desire for **treatment for problematic substance use.** Programs must be available when requested. Treatment must be varied, flexible and tailored to their needs, goals, culture and drugs of choice. Counselling and support must be available for as long as needed, to address the issues underlying problematic substance use. They cited difficulties in getting into treatment, such as long waiting lists, and the need for more treatment and detox programs. Participants stated that **methadone maintenance programs** help some, but not all, to stay off illegal opiates. They favour the increased availability of low-threshold methadone programs. Treatment for the use of non-opiate drugs must also be available to people on methadone, as well as alternatives to methadone. Additional physicians must be trained to prescribe methadone. Ready access to methadone in prisons is needed. They also want to see additional treatment options for people who use cocaine, especially some type of drug substitution.

Focus group participants were keen to be involved in program development, implementation, delivery and evaluation. "Nothing about us without us" was a pervasive theme. Many, compelled by a sense of altruism, have long been involved in providing outreach on their own. They stated that user or peer involvement improves program credibility, products and output. It also can give peers a sense of empowerment, belonging and purpose; build their self-esteem and self-confidence, and enhance their life skills and employability. They recognized the importance of educating others, especially youth, on the realities of drug use and want to be a part of this. They said that systemic barriers such as restrictive policies within organizations and exclusionary practices must be addressed and that their expertise and commitment should be better utilized. They want training and mentoring for specific tasks, such as public speaking and writing funding proposals, and support at the same level as staff.

1 A Key Messages Report is available at www.cdnaids.ca/learning\_from\_each\_other or at www.canadianharmreduction.com/project



Focus group participants reported that **needle and injection equipment distribution** works best in a community-based, non-judgmental environment. Using peers for outreach and secondary distribution is essential to reach people who do not typically access services. Services must provide longer hours of operation, home deliveries and ALL equipment required for safer use. There must be no limit on the number of needles which can be obtained in a given contact. Needle distribution must be put in place in rural and remote areas, as well as in prisons. **Safer crack use kits** must be universally available, and **safe drug consumption sites** are a necessity.

Focus group participants reported that **drop-in centres and shelters** were most effective when staffed with cheerful, caring workers who provide a welcoming and non-judgmental space for people who use drugs. Staff are often seen as surrogate family. The availability of on-site health professionals at shelters is also encouraged to provide both on-the-spot service for people who use drugs and to provide health care workers with an opportunity to gain insight into the lived realities of people who use drugs. The practice of closing shelters first thing in the morning and of barring people who use drugs or have pets from shelters and drop-in centres must be eased. More drop-in centres and shelters and additional staffing are required.

Regarding **education**, **awareness and information dissemination**, focus group participants expressed strong interest in educating people about the realities of substance use through public speaking and delivering prevention education to youth in schools, and that these messages must be delivered using a harm reduction approach. As well, police need to be educated about harm reduction. Disseminating information about services and about HIV, hepatitis C and other possible consequences of substance use must be increased and other means of dissemination must be developed and utilized.

Focus group participants appreciated health professionals and service providers who were caring, interested, non-judgmental and positive, and who provided services unconditionally. Those who had had personal experience with substance use or who had been immersed in an environment frequented by people who use drugs were often viewed as the most helpful and effective. Opportunities for clientele to make direct contact with health professionals help break down barriers to care, enhance external referrals, and lower the resistance of professionals to serve a marginalized clientele. Overall, participants sensed the need for greater emphasis on harm reduction in the training of all health professionals. They experienced most doctors as reluctant to provide pain medication to people who use drugs and recommended training that focused on the specific pain management issues of people who use drugs. They found care to be inconsistent from one healthcare professional to the next and recommended that physicians and other healthcare professionals develop expertise in caring for people who use drugs. They pointed out that the attitudes of healthcare professionals are often a barrier to obtaining services and equipment from pharmacies and hospitals. Finally, they expect health professionals and service providers to work from a harm reduction perspective, providing clients with options regarding their substance use, and celebrating their successes instead of punishing them for their failures.

**Outreach services** were appreciated by focus group participants. Outreach workers, especially peers, are able to develop trusting relationships with a highly cautious client group. Outreach teams could further strengthen their efforts by providing a broader range of information, extending their hours, and serving at locations where people use. Outreach to people in prisons and hospitals is essential, as people are particularly lonely and isolated in these situations. In general, more outreach workers and vans are required.

Focus group participants expressed frustration at the federal government's **omission of harm reduction** from its National Anti-Drug Strategy. They call on the government to view substance use as a health and social issue rather than a criminal one. They emphasized that harm reduction works. It meets people where they are at, without judging them or their use of drugs, helps people to connect with services, including treatment, and focuses on their health and safety and that of

"Open your arms, open your heart, open your mind, you know, like that's harm reduction."

- focus group

### **Site Visit Summary**

#### Whitehorse YT

- No Fixed Address Outreach Van – a coalition model that works
- Blood Ties Four Directions
   Centre a HIV/hepatitis
   C service organization
   that embraces harm
   reduction

#### Victoria BC

- Society of Living Intravenous Drugusers – "People helping people"
- Prostitutes Empowerment Education Resource
   Society – by and for sex workers
- The Canadian National Coalition Pilot Addictions Treatment Model Specifically for Sex Workers
- Vancouver Island Compassion Society – safer access to cannabis for medical purposes

#### **Edmonton AB**

- Alberta's Non-Prescription Needle Use Initiative
   a provincial network
- Boyle Street Community
   Services a community
   centre, not a social service
- Streetworks outreach with a smile
- Alberta Addicts Who Educate and Advocate Responsibly – a provincial drug users' network

### Winnipeg MB

- Sage House a welcoming space for street-involved women
- SOS a unique solvent users' group
- Biindigen North End Schools Safer Corridors Project
- Kali Shiva AIDS
   Services / Sunshine
   House a welcoming
   space for street involved people living
   with HIV/AIDS
- Nine Circles Community
   Health Centre –
   integrating Aboriginal
   cultures into its services

### Rouyn-Noranda QC

- Abitibi-Témiscamingue HIV/AIDS Regional Clinic
   an award-winning multidisciplinary approach
- Arrimage Jeunesse youth outreach in a small town

the community. They are aware that extensive research on the effectiveness of harm reduction measures has been conducted and published internationally. They suggested an alternative to current **drug policy**, such as the regulation and taxation of drugs, which would have a positive impact on the lives of people who use drugs as well as to society in general by reducing illegal activities, eliminating the need to run underground safe houses, reducing violence and increasing health and public safety.

### Challenges for harm reduction programs and practices

Marginalization and discrimination afflict people who use drugs and pose challenges to providing services for them. Some policies infringe on human rights and drive users underground and out of reach. Some programs discriminate against youth, refusing them service even though they may legitimately require it. Racism and homelessness are also prevalent and need to be addressed. Health care for people who use drugs is not available in a manner that is effective and respectful of their situation. Continuity of care and services for people who are in and out of prison is non existent or highly inadequate. Without adequate government support and funding, workable solutions to these issues are unlikely.

**Peer involvement** is hindered by agency reluctance to engage drug users to provide services and by challenges to user group organizing.

**Rural and remote** areas face challenges in maintaining privacy and confidentiality, and in providing services to cover vast territories.

The **sustainability** of programs and services is often compromised by a lack of sustained funding and a tendency towards project-based funding with no assurance of continuity. Services fluctuate and agencies experience high staff turnover, often leaving clients without the services they have come to rely on.

Harm reduction programs face **threats and challenges** which can affect community buy-in. Improper disposal of syringes can be a lightning rod. While a legitimate concern, this is sometimes used as a "red herring" to de-legitimize harm reduction. Harm reduction messages must be constantly repeated in order to get through to those opposing them. "Not in my back yard" actions by neighbourhood groups make it difficult for programs and services. Innovative, community-based models of methadone maintenance treatment feel pressured to conform to more conservative medical models. Community-based hepatitis C treatment for people who use drugs works, but it is not universally available. Police opposition to programs sometimes borders on political repression and is not being addressed.

# Lessons Learned - What Works Well to Address Challenges and Needs

Community buy-in strategies can include: establishing a broad coalition of community members, service organisations, researchers and potential partner organisations; ensuring that logistics are well worked out before launching a program; courting the media and educating them about what you are doing and why, before a program is launched; establishing good working relationships with key police staff and politicians; anticipating community concerns and addressing them in advance; holding community consultations prior to moving into a neighbourhood; performing periodical community clean-ups and public information forums; celebrating agency and community champions; and organizing community-building events.

Community members with drug-use experience have a right to be involved in making decisions that affect their lives. Capitalize on their experiential understanding and street smarts. Include them in program planning, delivery and evaluation. They can be advocates within their own community, and, as spokespersons to the broader community, they can help counter the

misinformation about drugs and the people who use them. Through involvement they will develop commitment to the program. Support the development of user groups. Along with providing mutual support, they can provide invaluable assistance.

Adopting a harm reduction approach means that everyone is treated as equals, in a person-centred, respectful and non-judgmental manner. The harm reduction approach is as much a means of relationship building, getting people connected with programs and services, assisting them in taking better care of themselves and discovering new options and opportunities, and making positive changes to improve their quality of life and well-being as it is about safer drug use. Dignity and respect are basic needs, along with food, shelter and the other social determinants of health. Harm reduction can be explained as a public health or health promotion priority, which may work to face down opposition.

**Patience and perseverance** are required when developing and implementing harm reduction programs and practices. Often a community's fears are worse than the reality and, after services have been open for a while, the fears subside. Identify your allies and support them. Be strategic and creative. Think outside the box. Celebrate successes, even small ones. DON'T GIVE UP!

**Enhanced human resources** can be attained through the use of volunteers and peers. This can increase the scope of programs and develop a cadre of supporters and spokespeople. Seek out and hire staff with experiential knowledge. Pair seasoned workers and volunteers with new ones, to ensure support, continuity and appropriate work performance. Provide practice guidelines for outreach workers and hold monthly information and support meetings for them. Employ a multidisciplinary approach and ensure that all collaborating disciplines buy into harm reduction. Celebrate and support dedicated staff and volunteers.

**Enhanced harm reduction programs and services** can be achieved by providing a welcoming, non-judgmental space and staff and making services as accessible as possible; offering services such as food, clothing, medical care, personal and social support, activities and referrals; delivering services close to where prospective clients are; collaborating with other agencies to ensure continuity of service; accommodating the needs of active drug users; and employing mobile outreach vans and secondary distribution to reach rural and remote areas.

**Involvement in community-based research** is an excellent approach and can contribute to the body of evidence on the efficacy of harm reduction programs and practices. Be selective in the research you get involved in and ensure that it will be used in a way which benefits both the clients and the program. The collection of data on the use of services and on the clientele will prove invaluable when **applying for funding**, evaluating programs, and adapting to changing trends.

Be an advocate!

#### Ottawa ON

- Oasis a multidisciplinary approach to outreach and drop-in services
- Lessons learned from Ottawa Public Health's Safer Crack Use Initiative
- Methadone Case
   Managers in Ontario –
   one person at a time

#### Québec QC

- Point de repères community-based needle distribution and more
- Prostitute Intervention
   Project of Québec outreach and awareness in
   the community

#### **Halifax NS**

- Mainline Needle
   Exchange a community-based needle distribution service
- Direction 180 a community-based low threshold methadone maintenance program
- Phoenix Youth Centre a shelter for youth that has incorporated harm reduction

#### St. John's NL.

- Tommy Sexton Centre integrated HIV/AIDS services, transitional housing, emergency shelter, and needle distribution
- Street Reach street outreach for youth



# **INTRODUCTION**

The Canadian Harm Reduction Network (CHRN) and the Canadian AIDS Society (CAS) conducted a symposium, a series of site visits of various harm reduction programs and services, as well as focus groups with people who use drugs and/or the services, to document programs and practices, and to see what works well and what does not in the context of providing services to people who use illegal drugs.

"The heroes are the people who knew that anything was possible and believed in the philosophy of harm reduction. They are the ones who pushed the envelope and challenged the status quo, calling to attention the human side of drug use. The most important thing we can learn from them is that looking at anyone can be like looking in a mirror; though the glass is shattered, we can still see our own image in the fragments."

Don Young,
 Superior Points,
 Thunder Bay, ON

This document presents the results of these consultations, in the hopes of enriching the practice of harm reduction in Canada. There are many creative and innovative activities going on in cities all across Canada, and we are bringing some of these forward so that people who use or have used drugs, frontline service providers, administrators, program developers, researchers, public servants and advocates can all learn from each other. We encourage you to contact the people identified in this document to find out more and to further your networking efforts.

We also hope that you will get a sense of the people behind all of this work. Our country is a better, more compassionate place because of their passion, dedication and commitment.

Most importantly, we hope that you will come to better understand the harm reduction approach to service delivery and the life-affirming impact it can have on people's lives.

# **CONTEXT FOR THIS PROJECT**

People who use illegal drugs face multiple and complex issues that may have a significant impact on their health and well-being. An important public health concern is the spread of HIV/AIDS and hepatitis C through injection drug use. In Canada, about 17% of HIV cases to date are attributed to injection drug use. It is encouraging to see that new HIV infections among people who inject drugs have decreased from 19% of new infections in 2002 to 14% in 2005.

Nevertheless, an estimated 350 to 650 people still got HIV through injection drug use in 2005, which is unacceptably high.<sup>2</sup> Hepatitis C, an infectious disease that attacks the liver, affects about 240,000 Canadians, with approximately 5000 new infections per year.<sup>3</sup> It is estimated that about 70% of those infected are current or former injection drug users. Evidence reveals that there may also be an association between sharing a crack pipe and the transmission of HCV infection.<sup>4</sup>

These important public health issues affect every community. However, they are often of lesser immediate concern to people who use illegal drugs than are other health, wellness and safety problems. Primary concerns often include: "cotton fever" (sepsis), "chalk lung" from injecting pills, serious abscesses, homelessness, hunger, chronic pain and tuberculosis, the risks from drugs of unknown strength and purity, the consequences of imperfect drug use practices and, of course, overdose and death. Most homeless people who use drugs also experience mental health issues such as depression or post-traumatic stress disorder, as well as a range of physical illnesses. There are other obstacles as well: lack of housing, employment, education and training, lack of access to acceptable drug treatment programs, an inadequate diet, and, above all, lack of fair and equitable treatment and respect.

"A big piece of the excitement is around the changes of the people. As you know, when people start feeling that they have some value and they're important, a lot of things change in their lives, and so we've seen lots of life changes."

Marliss Taylor,
 Streetworks,
 Edmonton, AB

<sup>&</sup>lt;sup>2</sup> Public Health Agency of Canada. HIV/AIDS Epi Updates. November 2007. Available online at http://www.phac-aspc.gc.ca/aids-sida/publication/index.html.

<sup>&</sup>lt;sup>3</sup> Health Canada. Reducing the Harm Associated with Injection Drug Use in Canada. 2001. ISBN 0-662-3078-6. Cat. No. H39-589/2001E. Available at www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/injection/index\_e.html

<sup>&</sup>lt;sup>4</sup> Fischer, B. HCV virus transmission among oral crack users: viral detection on crack paraphernalia. European Journal of Gastroenterology and Hepatology. In Press.

<sup>&</sup>lt;sup>5</sup> Vicky Stergiopoulos and Nathan Herrmann, Canadian Journal of Psychiatry, July 2003, v. 48: 374-380.

"I just started to believe in myself when someone else believed in me, and that was the difference... And friendship. People helping each other."

- focus group

Despite the harshness of this reality, the use of illegal drugs does not diminish, nor does the plight of the people who use them. Just about everyone who uses illegal substances is stigmatized, especially those who inject drugs, smoke crack cocaine or sniff solvents, pregnant women and mothers<sup>6</sup>, poor people, youth, and Aboriginal people. As a result of stigma, not only are they unable to access services available to other citizens, their rights are violated also. They cannot get jobs and they have difficulty obtaining or keeping housing.

This bleak picture enforces why harm reduction must be about much more than HIV and hepatitis C, and why its interventions must reach beyond the obvious ones. The best known harm reduction strategies include needle distribution<sup>7</sup>, methadone maintenance and outreach<sup>8,9</sup>, especially when offered by community members.<sup>10, 11</sup> These strategies are implemented in different ways, depending on the context in which they operate, human and financial resources, the level of community support, and socio-political restrictions.

Other harm reduction strategies have also been implemented, though they are not broadly practiced in Canada. These include, but are not limited to, crack pipe distribution, user empowerment projects, safer drug use sites, heroin prescription, and social justice projects. Some organizations have developed or adapted innovative harm reduction approaches, programs and materials, for example, overdose prevention programs or survival guides produced by and for drug users. These would be of enormous benefit to people in other communities, if they were aware of them.

The aim of this project was to identify, document and disseminate information on some of the more innovative and useful ways that harm reduction programs and practices are being offered and some of the more effective solutions to overcoming the challenges to offering harm reduction. We believe that this information will help service organizations and people who use drugs to learn from each other and to discover new ways to address some of the difficulties and obstacles they continue to face in this country.

<sup>&</sup>lt;sup>6</sup> Angela Pirisi. Family physicians learn to address alcohol use during pregnancy: Cross Current,s Autumn 2003.

<sup>&</sup>lt;sup>7</sup> Reducing the Harm Associated with Injection Drug Use in Canada. Report of the Federal/Provincial/Territorial Advisory Committee on Population Health, 2001.

<sup>&</sup>lt;sup>8</sup> Fischer, B. (2000) Prescriptions, power and politics: The turbulent history of methadone maintenance in Canada. Journal of Public Health Policy 21(2): 187-210.

<sup>&</sup>lt;sup>9</sup> Brands, J., Brands, B., and Marsh, D. (2000). The expansion of methadone prescribing in Ontario. 1996-8-98. Addiction Research 8 (5): 485-496.

<sup>&</sup>lt;sup>10</sup> Marlatt. A.G., Blume. A.W., Parks, G.A. (2001) Integrating Harm Reduction Therapy and Traditional Substance Abuse Treatment. Journal of Psychoactive Drugs, 33 (1)

# **SUMMARY OF THE PROJECT**

### BACKGROUND

Frontline practitioners, advocates of harm reduction and people who use drugs identified, at three separate meetings between 2002 and 2005, <sup>11</sup> that there are few resources documenting how various agencies in Canadian cities are providing harm reduction support and services. A survey on harm reduction materials conducted by CAS in 2003 also revealed the same dearth of information. Attendees and respondents further noted that opportunities to share information amongst agencies and people who do harm reduction work are rare. The occasional conferences which take place in Canada and elsewhere are costly to attend, and often beyond the budget of frontline agencies, the ones who would most benefit from new information, networking and information sharing.

### PROJECT GOAL AND OBJECTIVES

While the largest cities in Canada, Vancouver, Toronto and Montréal, were quick to develop harm reduction responses to issues surrounding drug use, the harm reduction activities of smaller cities have been less visible. This project aimed to identify the efforts of smaller communities and to help them succeed by enabling them to serve as resources for one another.

The Canadian Harm Reduction Network and the Canadian AIDS Society received funding from Health Canada's Drug Strategy Community Initiatives Fund to:

 document innovative models of harm reduction programming and services in medium-sized cities in Canada;

<sup>&</sup>lt;sup>11</sup> In an information gathering workshop held by the Canadian Harm Reduction Network (CHRN) at the First Canadian Harm Reduction Conference in Toronto, in 2002, in a full-day satellite which the CHRN held at the Canadian AIDS Society (CAS)'s Skills Building Symposium in Calgary in 2003, as well as at the Forum on Crack Cocaine hosted by Health Canada in Ottawa in 2005



- promote the awareness and employment of a greater range of effective models of harm reduction programming and services to community-based organizations, people who use drugs, policy makers and the general public in Canada;
- integrate the perspectives of people who use drugs, community workers and policy makers into the development and implementation of harm reduction programming and services; and
- explore the extent to which harm reduction, treatment, prevention and
  enforcement systems are interacting to serve the best interests of people who use
  illegal drugs and of communities.

### **METHODS**

### **Definition of Harm Reduction**

Harm reduction is much more than handing out new injection equipment or safer crack use kits. It is both a goal of service delivery and the philosophy that underpins it. It is an approach to policies and programs for people who use drugs which is directed towards decreasing the adverse health, social and economic consequences of drug use and drug distribution to the individual user and the community. Although abstinence may be the goal for some people whose substance use has become problematic, it is not a requirement for obtaining services and treatment. Practicing harm reduction also ensures that services are provided without discrimination, prejudice or negative judgement and that the quality of those services will not be compromised because of discrimination, prejudice or negative judgement.

Harm reduction embraces a number of **principles**:

**Pragmatism:** Harm reduction accepts that some use of mind-altering substances is inevitable and that some level of drug use is normal in a society. It acknowledges that, while carrying risks, drug use also provides the user with benefits that must be taken into account if drug using behaviour is to be understood. From a community perspective, containment and amelioration of drug-related harms may be a more pragmatic or feasible option than efforts to eliminate drug use entirely.

**Humanistic Values:** The decision to use drugs is personal. No moralistic judgement is made either to condemn or to support use of drugs, regardless of level of use or mode of intake. The dignity and rights of the person who uses drugs are respected, including the right to care and treatment. Harm reduction appreciates that all life is precious.

**Hierarchy of Goals:** The immediate goal of harm reduction programs is to engage individuals, groups or communities by addressing their basic, most pressing needs, usually the determinants of health, before offering services of secondary assistance,

such as needle distribution services. The hierarchy then progresses to tackling issues which society has chosen to criminalize, demonize or ignore, that is, the use of drugs. This can be achieved through advocacy by and for users, health entitlements and rights, access to services, drug policy and reforms, etc.

**Focus on Harms:** The fact or extent of a person's drug use is of secondary importance to the risk of harms resulting from use. The effort is to mitigate these harms. The harms addressed can be related to health, social, economic or many other factors affecting the individual, the community and society as a whole. Therefore, the first priority is to decrease the negative consequences of drug use to the user and to others, as opposed to focussing on decreasing the drug use itself.

**Expert-Centred Approach:** Harm reduction holds that the relationship between people who provide services and people who use drugs is a partnership in which the expertise of the client is given credence. In this sense, it is "bottom-up", rather than "top-down". It also recognizes that professionals in various service areas and the people who use drugs have complementary areas of expertise and must work together in a climate of mutual respect.

**Structural Perspective:** Harm reduction is not merely about the health and well-being of individuals, though that may come first, but also of the family, the community of people whose lives are organized around drug use, and of the broader community. The needs of these varying constituencies must all be addressed. In this way, harm reduction responds to the principles of public health.

Grounding in the Ethical Values of Social Justice: Harm reduction asserts that no one should be denied service or access to service merely because they are using a drug, legal or illegal.

Appreciation of the True Nature of Drug Dependency: Harm reduction maintains that what we call addiction is a recurring behaviour and that, to manage it, the individual may need long-term support. It does not rule out abstinence as a goal, nor does it rule out return to some level of use in the long term. Use or non-use of drugs may be permanent or episodic. In this light, lapse from abstinence is not seen as a failure. In harm reduction, success is measured in terms of health and the quality of life for the individual, the family and the community, not in terms of achieving total and unrelenting abstinence.

**Holistic View of Health:** Harm reduction addresses issues of individual and public health, as well as the key determinants of health, <sup>12</sup> such as income and social status, social support networks, education and literacy, employment and working conditions, social and physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture.

 $<sup>^{12}</sup>$  This list of determinants of health was obtained on the Public Health Agency of Canada's website at http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/#determinants.

## **National Advisory Committee**

A National Advisory Committee was established to guide the project. It consisted of twelve members, including people who use drugs, representatives from AIDS service organizations and/or hepatitis C organizations who work in the area of harm reduction, representatives from community-based harm reduction organizations and agencies, the Project Consultant from the Canadian AIDS Society (CAS), and a representative from the Canadian Harm Reduction Network (CHRN). Each of the five geographical regions in Canada was represented (Pacific/Yukon, Prairies/NWT/Nunavut, Ontario, Québec and Atlantic). The committee was cochaired by the representatives from the CHRN and CAS.

A call for nominations was issued in October 2006 and members were selected by the co-chairs based on the following criteria:

- experience with, or expertise in, the delivery of community-based harm reduction programs;
- ability to reflect community/individual needs on a national level;
- ability to communicate and consult widely with their stakeholders;
- ability to network with the community;
- commitment to the goals of this project; and
- agreement to abide by the Terms of Reference.<sup>13</sup>

### Selection of Cities and Sites

With a view to collecting information on innovative harm reduction programs and practices, a tour of Canadian medium-sized cities was planned to conduct focus groups with people who use harm reduction services and/or illegal drugs, as well as site visits of select organizations. Medium-sized cities were defined as cities other than Vancouver, Toronto and Montréal.

The National Advisory Committee selected cities that would represent a wide cross-section of populations (e.g., women, youth, Aboriginal peoples, street-involved individuals, etc.), drugs of choice, drug use patterns and harm reduction programs and services. Selection of cities was also based on practical considerations, such as travel costs and access

<sup>&</sup>lt;sup>13</sup> The Terms of Reference are available at www.canadianharmreduction.com/project.

to frontline people in selected cities, to assist in recruiting focus group participants and coordinating site visits. There is innovative and interesting harm reduction work going on in other cities, and we hope that this project will encourage communities to communicate with people in other cities to share their knowledge and experiences.

The selection of specific organizations was also based on advice from the National Advisory Committee. An effort was made to represent a vast array of services and practices. Time and budget allowed for two or three site visits per city, which does not capture every organization offering harm reduction programs and services.

Representatives from all of the selected organizations in each city were invited to participate in a Harm Reduction Symposium, prior to the cross-country tour, and were interviewed on-site during the site visits. Documentation on each organization and relevant resources were collected and incorporated into this document.

The final selection of cities to visit included: Whitehorse, YT; Victoria, BC; Edmonton, AB; Winnipeg, MB; Rouyn-Noranda, QC; Ottawa, ON; Québec, QC; Halifax, NS; and, St. John's, NL. The harm reduction programs and services we visited are included in the Summary of Site Visits.

## Harm Reduction Symposium in Winnipeg

From March 30 to April 1, 2007, the CAS and the CHRN jointly hosted a national symposium on harm reduction. In addition to providing an opportunity for much needed networking, its objectives were to:

- showcase and document innovative and effective harm reduction programs and practices in selected cities and examine how they are integrated in the full spectrum of treatment, prevention and enforcement activities; and,
- 2) identify how the information garnered in this project would be most usefully delivered to people who are currently offering harm reduction programs or who wish to develop harm reduction programs in their community.

At the symposium, each representative presented the harm reduction work that is taking place in their organization and city. This information has also been incorporated into this report. To guide their presentations, the representatives were asked to describe their program or practice and to respond to the following questions:

- What are the distinctive features of your program or practice?
- How do people (users, practitioners) respond to it and feel about it?
- What works best about it? Are there any evaluation results to be shared?











- What hurdles/barriers needed to be overcome to launch and maintain the program? What/who made a difference in overcoming these barriers?
- Whose support was needed in going forward? How was it obtained? What made a difference in getting "buy in" from the key players?
- Who are the "heroes" / the real leaders in getting this program (or harm reduction in general) to happen? What makes them "heroes" and what can we learn from them?
- What barriers are still preventing progress?
- If you had to do it over again, what would you do differently?

They also participated in a series of exercises to help guide the deliverables for this project, as well as future activities needed to enhance harm reduction efforts in Canada. The complete report is available at www.cdnaids.ca/learning\_from\_each\_other or at www.canadianharmreduction.com/project.

# **Focus Groups**

In each city, representatives from selected organizations assisted with the recruitment of participants for the focus groups. Network sampling was used, which means that people were recruited through word of mouth or by service providers. All of the focus group participants were former or current drug users.

Participants were given an honorarium and sometimes bus tickets, for a total value of \$30 per participant. Snacks and refreshments were also provided.

A member of the community who is known to the participants introduced the facilitators. The two project leaders facilitated the discussions, which lasted about one and a half hours. The consent form was read to the participants before they signed it, to ensure they understood the purpose of the focus group and how the information would be used. The presence of the photojournalist was also explained, and the consent form for the photographs was also read and signed. The focus group participants were later asked to fill out a short demographics survey to obtain general and anonymous information, and then were asked the following set of questions in the flow of the conversation:

- 1) Can you introduce yourself (you can use a different name if you like) and tell us what brought you here today?
- 2) Which harm reduction services have you used in this city (needle exchange program, crack kit distribution, peer support groups, methadone, other...)?
- 3) How did you hear about it?
- 4) What has your experience been with this program or service?

- 5) What information or service do you wish you had? What's missing?
- 6) Have you ever been involved in the planning, implementation or operations of a harm reduction program? If so, how was that experience? (user groups, volunteering, peer employment, delivery of services...)
- 7) Have the harm reduction programs made an impact on your life? If so, how?
- 8) What do you need to say to end this discussion?
- 9) Is there anything you want to ask us about?

Each focus group discussion was recorded and transcribed. The text was analyzed using Atlas.ti and the demographic data compiled using SPSS Statistical package. The results of the focus group discussions are presented in order of importance, based on how often the topics came up.

### Website

A website was developed to present all the information relevant to this project, including all key documents, photographs and travel logs. Please visit: www.canadianharmreduction.com/project. All of the documents are also available at www.cdnaids.ca/learning\_from\_each\_other.







# **FOCUS GROUP SUMMARY**

# WHOM WE TALKED TO

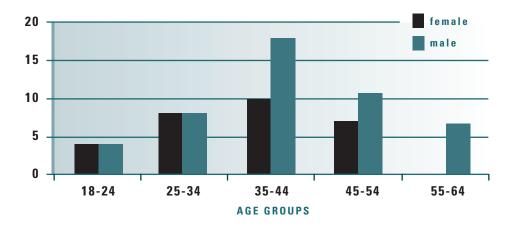
# GEOGRAPHIC LOCATION, GENDER AND AGE OF PARTICIPANTS

In total, 80 people from nine cities across Canada participated in the focus groups, for an average of eight or nine participants per group in each city. More than half of the participants (50) were men. The ages of the participants varied greatly: 10% aged 18-24; 20% aged 25-34; 35% aged 35-44; 22.5% aged 45-54; and 8.8% aged 55-64. Some people did not indicate their age on the questionnaire.





Figure 1. Age and Gender Distribution of Focus Group Participants



Participants came from nine of the thirteen provinces and territories, and 62.5% of them resided in urban centres, while 13.8% resided in suburban areas and 15% in rural or remote areas.

### ETHNOCULTURAL BACKGROUND

People were asked to indicate the ethnocultural group they identified with. Answers varied greatly – 15 participants identified as white, 14 as Quebecois, 11 as Canadian, 9 as Aboriginal, 5 as Metis, and the others indicated a variety of identities related to religion, language or lifestyle, or did not identify with any particular group. Sixteen people did not answer this question.

### DRUG USE

When asked about drug use, 63.8% were currently using illegal drugs, while 26.2% were on methadone maintenance, and 10% were former users of illegal drugs. The number of drugs used per person ranged from zero to nine for an average of two. The most popular drugs reported were: cocaine (used by 48.5% of those who reported drug use in the last month), marijuana (42.4%), and crack cocaine (30.3%). Of interest are the 30% of former users who reported using one or two drugs in the last month, and the 71% of people on methadone maintenance who reported using one to eight drugs in the last month.

# HIV/AIDS AND HEPATITIS C

Fifteen participants (or 18.8%) were living with HIV/AIDS, while 53.8% had been diagnosed with hepatitis C. The advances in HIV treatment since 1996 have dramatically improved people's life expectancy and quality of life. However, there is

still no cure and living with the disease has many challenges. The stigma associated with HIV/AIDS and hepatitis C still poses some concerns around disclosure as well. While many AIDS service organizations (ASOs) embrace harm reduction, participants did speak of situations where they felt ASOs discriminated against them because they use drugs.

Treatment for hepatitis C lasts about 6 months to one year, with very unpleasant side effects, including what feels like a severe case of the flu, and depression. Treatment is successful in about 50% to 85% of cases, if people manage to complete it. For people who use drugs, there are many barriers to accessing treatment. Insistence on abstinence from drug use is the major one. Some physicians, however, are starting to offer treatment to people who are still actively using.

### **EDUCATION**

The majority (53.8%) of participants had at least a high school education, while 20% had technical training, and 6.2% had a university education, either at the undergraduate or graduate level.

### FOOD SECURITY AND HOUSING

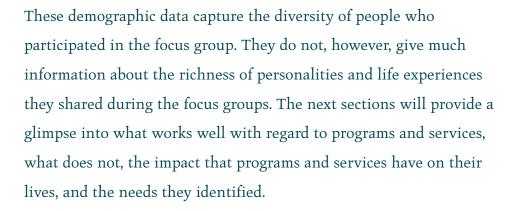
To get a sense of their financial situation, focus group participants were asked if there were times in the past year when they worried that they would not have enough food in their household before there was money to buy more. While 51.2% of participants never or sometimes worried about not having enough food, another 33.7% often or always worried, and 13.8% encountered this concern at the end of the month.

Finally, while most participants (71.2%) were housed, 17.5% were homeless. Another 6.2% of participants were "hidden homeless" who spent the majority of nights couch surfing. Another 3.8% had spent the majority of their nights in a hospital or institution in the last month.

Most of the discussions about housing during the focus groups dealt with the need for more housing, specifically the need for more shelters where people who use drugs, including alcohol, are welcome and perhaps supported with harm reduction services. Discussions also focussed on the need for housing for people with pets and for people in recovery.

## WHAT THEY SAID







The following sections have been arranged in order of importance, according to how much of the focus group discussions were spent on specific topics. Discussions regarding drug treatment, counselling and methadone maintenance programs arose most often, followed by peer involvement in the harm reduction services and programs; needle, injection equipment and safer crack use kits distribution; drop-in centres and shelters; health professionals and service providers; education, awareness and information dissemination; outreach services, and harm reduction and drug policy. Quotes are only included to illustrate the topics identified and do not represent every discussion on the topic.

### 1. Treatment and Counselling

Treatment and counselling for substance use came up most often in the focus group discussions. In this context, treatment and counselling refers to support services aimed at assisting people with managing their problematic substance use through support groups and programs, and one-to-one or group counselling. It does not include drug substitution programs, such as methadone maintenance programs, which will be discussed later in the document.

# What works and unique solutions for treatment and counselling

NON-JUDGMENTAL AND RESPECTFUL COUNSELLING AND PEER SUPPORT

Counselling and support were the most frequently reported methods that helped people get their drug use under control, whether it is to reduce the amount or the number of drugs they use, or to be completely abstinent. Peer support groups such as

Narcotics Anonymous were mentioned in this context. Some preferred one-to-one counselling, while others sought help from a variety of sources. Only one person in the focus groups mentioned having the means to pay for private counselling.

Participants also indicated they found it helpful if counsellors were attentive, willing to listen, and available when needed. Treating people with dignity and respect is clearly beneficial, and the reputation of a specific service or worker spreads through word of mouth. A low-threshold approach, such as a group home recovery house or methadone maintenance program that tolerates the use of some substances, such as cannabis, also helps some people.

### Here are some excerpts:

"I... talk to the counsellors or whoever's there and I find they're very helpful. They practically stop what they're doing. If you've got something on your mind and you want to get it out, they're very good. They have a willing ear to listen."

"I didn't use today, and I haven't used since probably about three weeks, which is a miracle for me. I was following through groups and stuff, NA... And that's why I got through... I found a ... one-on-one counsellor that I could sit down [with] and just throw everything on the table and say, 'Look, this is what I've been doing since I was thirteen years old. I'm 40 now.' "



### PROVIDING SERVICES ON DEMAND

Unfortunately, access to detoxification and treatment services can be difficult, often requiring repeated attempts to receive service due to high demand. It appeared that sometimes help is provided only when someone gets irate. Some people shared the desperate and innovative measures they used to get the help they needed, which included threatening to hurt themselves, getting drunk so that they could be admitted to alcohol treatment programs, pretending to have a mental illness, and even finding volunteers to wean them off of drugs. Such stories speak loudly to the need for more detox and treatment services which address the needs of street-drug users. In addition, recognizing that a person's readiness to change is often key to treatment success, help needs to be immediately available when people who use drugs seek it.

"You know what I had to do? ... I had just lost my boyfriend of four years and my father had just died, and I'm trying to come off all these drugs. And no one would help me. And we drove to [Health Sciences] and I said, 'I am not walking outside that door until you put me on some methadone and help me come off drugs, or I'll slice my throat right in your doorway.' That's the only way I got help."

"I was in there a few times. The detox...
I've been in hospital.
I have counsellors.
Different programs,
NA, and everything
I could find to try
to help."

#### ART THERAPY

A few respondents suggested that art therapy as part of drug treatment would be helpful for them.

"I used coke and morphine. I went to therapy to get out of it and I am doing well so far. I don't use anymore. I no longer shoot up."

### **KEEPING BUSY**

Some people had successfully managed to get their problematic substance use under control. Others shared their strategies to manage their drug use, which included staying busy, finding interesting activities to do, reducing drug use and connecting with nature through activities such as gardening. Regardless of the strategy used, the most important factor in a person's successful management of their drug use was their readiness to change.

"Well, there's one sure thing... If somebody's going to quit, they got to want to quit. You can lead a horse to water but you can't make him drink."

# What does not work for treatment and counselling

### WAITING LISTS AND WAITING PERIODS

By far the most frequent barrier to accessing treatment and counselling reported by the focus group participants was the waiting time it took to get into a program, indicating the need for more treatment services or timely intake procedures. Waiting weeks for admission into a program, or even hours for emergency service, did not work and often resulted in a missed opportunity. Some even stated that the waiting list may result in suicides. Here are some examples of what was said:

"You're looking for help now, someone has to be there to provide it."

"It's not just a question of being ready, it's a question of fuck, you want to quit, you want to quit already. It's because you are sick of doing what you are doing. It's because you are on the verge of shooting yourself with a bullet. But two weeks or three weeks is a long time... I am convinced that there are a lot of people who finally committed suicide and they could have been saved."



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# LIMITED TREATMENT OPTIONS FOR PEOPLE WHO USE DRUGS OTHER THAN ALCOHOL

The focus group participants pointed out that people who have a problem with alcohol have more options and opportunities for treatment than do people who have a problem with the use of other drugs.

Developing this theme, it was also noted that the 12 Step approach is not for everyone, though there are few or no alternatives to it. Though some found 12 Step programs were helpful, others had negative experiences with them or were not drawn to them. One approach clearly does not suit all people.

"I don't like the idea of faith-based treatments and they can also have a problem. Like the 12-step program and stuff like that, I kind of don't like that approach. And it seems like most treatment centres seem to revolve around some sort of modified 12 Step Program."

"And when the speakers from AA come into the hospital every night at 8:00, and it doesn't matter if you're an opiate user, stimulant, whatever your drug of choice is, solvents, they expect you to go to the meetings. But, as I said, it's only AA meetings. And now I myself, have been to one and been told because I was a drug user that I didn't belong there. Meanwhile, it's all a drug. But you feel... like I cried my eyes out at that time. What was I supposed to do?"

# DENIAL OF ADMISSION INTO DETOX AND DISMISSAL FROM TREATMENT SERVICES

Some focus group participants also reported not being able to get into detox or treatment centres when they were high, which seemed counterintuitive to them.

Similarly, some people resented getting kicked out of treatment programs for behaviours they were working on changing and that were associated with their drug use:

"About two years ago I was thrown out of therapy. I had been there for about two months, and I did two things that I was not supposed to do and I took the initiative to tell them that I had done those things. I was honest throughout my process. I was really motivated and I was doing well. Well, they threw me out of the therapy house because I had done one more thing that I was not supposed to do, and they are all behaviours that go with my use, things I have to change."

"I noticed that some of the alcoholics they get to come under... they're out for one week and they're back the next week. When it comes to drug users, if we have a hard time in there, they won't let us come back."

"So, because I didn't have an alcohol problem, and I was on so much drugs, they didn't want to take me. So they sent me back down to [the hospital]. And then I came back here, and they saw me. I got in... And the doctors were so disgusted I was there. They couldn't believe I got in, because I had a drug problem."

### POOR TREATMENT BY HEALTH PROFESSIONALS

People who did get into detox reported various experiences, from being well cared for to, more often, being subjected to the negative attitudes of the health professionals:

"If you're on drugs, they send you right to the medical unit. They give you about three days of just sleeping, eating, sleeping, eating. They give you... sleeping pills... and once you go through about a three-day period, they send you off to a normal range where you can't even stand up and fend for yourself. And these guys don't watch on the range, because you're just a junkie, or a drug addict, crack addict, whatever."

### THE NUMBER OF DAYS IN DETOX IS INSUFFICIENT

It was also pointed out that the number of days a person may remain in detox is insufficient, and that there is no care after release from treatment programs.

### OTHER BARRIERS TO TREATMENT

One person mentioned that life insurance policies may be cancelled if treatment is sought. One person had no one to babysit. One felt that treatment is like jail, with all the rules. Another was afraid to fail.

"I have never gone through detox, I have never gone to treatment... I will never go. I don't feel like experiencing disappointment. Disappointment is hard. It's worse than using drugs. A disappointment, you are not proud of yourself. Whatever pride you had about yourself, you don't have it at all anymore."

### EXPOSURE TO TRIGGERS

Even when some people decide to abstain from drug use, they are faced with many challenges. For some, exposure to the drug scene in their immediate environment is difficult to avoid.

Talking about drug use in the context of a therapy group, or a focus group, could even trigger cravings. Similarly, even being a peer who helps others with their problematic substance use could cause relapse.

"You're actually shopping... but then you run into buddy in the store. It's like, ah, this is defeating the purpose... I even bought my dope when I'm buying my groceries. I've got a buddy in the grocery store."

"I'm jonesing like a son of a bitch. I'm pouring sweat and everything just talking about it."

"I was once at a rehab... and one of the counsellors was an ex-user and about six months after, he was out on the street... he wanted to buy [a piece] from me and I wouldn't sell it to him..."

### CRAVINGS FOR THE NEEDLE, NOT JUST THE DRUG

For some, the cravings they battle are not just for the drugs, but for the needle itself.

"What I'm thinking too is the poke down. It's the needle thing... sometimes I know I'm going to waste my money, I just do it for the poke. I can't fool my mind and say I'm going to put water in. I mean I've got to put a drug in it."

### LOSS OF IMPORTANT RELATIONSHIPS IF NOT ABSTINENT

For some, not remaining abstinent or not completing treatment may come with a high price, for example, losing important relationships with partners or children:

Female Respondent: "It's okay. If you get cleaned on this, you can try to get [your children] back."

Female Respondent: "Well, I can have them back if I complete Stonehenge."

Male Respondent: "That's something to look forward to. That's a goal."

# Needs regarding treatment and counselling

### ONGOING COUNSELLING AND SUPPORT POST TREATMENT

One powerful theme that came out of the focus groups was the need for continued counselling and support and for long-term recovery facilities, beyond detoxification and treatment programs. Some also needed a place to go when they are struggling to maintain abstinence.

Female Respondent: "Long-term recovery facilities. By long-term, I mean at least one to three years so that people can turn their lives around, get a trade, get some counselling and then go and rehabilitate into whatever life that they can make."

Female Respondent: "Until they get stable."

Male Respondent: "And the ability to support themselves."

Female Respondent: "Yeah. It doesn't happen in weeks. It's many, many years."

Male Respondent: "Another thing that... detox... go into detox in the middle of the night. Even if you don't want any, say if you're not using and you feel like using and you don't find, and you can spend the night there."

"This guy here, I started seeing him almost a month ago, and that's when I came off the drugs. And I'm telling you, there [have] been days I've been with him and I'm jonesing so bad and I want a hit so bad. And now it's starting to be like... a negative thing. But he supports me so much, it drives me nuts. There's no leverage at all. I want to get high so bad, and I know if I just do it once, I'm going to lose him. And I don't want to lose him."

"I think that maybe some of these programs you can have things for people to do every day all day. Because I found when I had nothing to do, then I'm like, 'Okay, I'm just going to get drunk.' I need something to do every day. I need a routine."

"I can get by just about everything... if I'm low on food, if I need a crack pipe, or condoms or anything, clean clothes... I pretty well heard it from word of mouth that I can find it. The only thing is, is if you want to straighten out or something, there's a problem there."

#### **ACTIVITIES TO STAY BUSY**

Since some people found that staying busy and having some responsibilities helped them manage their drug use, there is a need for more activities, leisure counselling, life skills support, and a more meaningful life. Many participants expressed the need for a routine, for things to do to fill in a void or reduce boredom, and for help to identify what makes them happy. The need for life skills training in prison was also mentioned.

"We need some kind of program that'll help people who are trying to abstain actually realize what the thing is that makes them happy. Because I have no idea and that's why I'm a user."

### MORE TREATMENT AND DETOXIFICATION FACILITIES

The long waiting lists and the difficulties experienced getting into treatment, as identified by the participants, pointed to a need for more treatment facilities.

One group in particular that was frustrated by the lack of drug treatment services noted that the hospital in their city had many empty beds. They would like to see these vacant hospital wings used for drug treatment and staffed by additional personnel specializing in the field. They also thought that there should be hospitals that specialize in treating problematic substance use.

In St. John's, there was a lot of discussion around the need for more medically assisted detoxification, rather than a place to simply sleep it off. In Victoria, rapid detox was mentioned, as was increasing the availability of Buprenorphine as an alternative to methadone or to help people transition off methadone. Some participants also called for peer support during detox, in addition to the medical services.

"We need some medical detox really bad.... Like it's too bad there's places they can't go just to be reduced [tapered off] instead of having to change the drug."

"I'd like to see more peer support in the detoxification process, not just a medical approach. I mean I remember sitting in detox absolutely alone."

### MORE COUNSELLING AND COUNSELLORS

The focus group participants identified the need for more counsellors and more counselling to help them with their problematic substance use and underlying factors that contribute to it.

#### DIFFERENT PROGRAMS TO MEET DIFFERENT NEEDS

Programs also have to be tailored to meet the different needs of individuals or groups based on their culture, age or gender. A few people suggested treatment services for stimulant users that were similar to methadone programs for opiate users. They wanted to see more research conducted to address problematic crack cocaine use. Some participants wanted to see more programs offered in safe localities, away from their high-risk environments, where they would have sufficient time to heal. Others said that connecting with nature would be helpful.

"I think there needs to be more individual programs. Like everyone needs to be looked at differently. [...] Everybody's different, everybody reacts to things different. We really need a one-on-one contact."

"A secure environment... a place where people can get clean long enough. They could go to a place where they've got low risk impact or they can stay in a healing place. It could be a cabin out in the country."

### OTHER SUGGESTIONS

Finally, one person mentioned that treatment programs need to be critically evaluated, especially when people are kicked out or do not successfully complete them. Privacy was another concern, especially in small towns. Participants did not want to be seen walking into a facility with a big "Recovery Centre" sign above the main entrance and were not inclined to go to it. One group described a successful women's centre that deals with issues related to violence and substance use. Participants would like to see something similar for men.

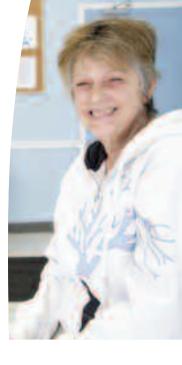
### 2. METHADONE MAINTENANCE PROGRAMS

# What works and unique solutions for methadone maintenance programs

### ADVANTAGES OF METHADONE

The focus group participants discussed the advantages and disadvantages of methadone. Being on methadone had allowed some of the participants to get their lives back on track and had given them some time to think about things other than getting the next fix. Methadone was also helping some people stay off of street drugs. Obtaining carry privileges for their methadone, which enables them to take home a few doses at a time, was appreciated, especially in bad weather, as it meant not having to go to the pharmacy or clinic every day.

"Yeah, I know lots of people that are on methadone that don't have any desire to use... crack or anything."



"I find that like this program that they have downstairs, low threshold, so people when they come you can pee dirty and still get your methadone or what have you, but to keep you clean, that's on your own. You know what I mean. It's not because you need to be clean."

#### LOW-THRESHOLD PROGRAM PROVIDES WIDER ACCESS

Some focus group participants appreciated the low-threshold methadone maintenance programs that enabled them to obtain methadone even if their urine tests showed that they were still using drugs. They mentioned that it was up to each individual to abstain, if they chose to. One participant described programs that mandate withdrawal from methadone in response to a positive urine test as sadistic.

"Methadone has been... I've had a few attempts at that and... the different programs have changed the rigid standards they had as to where, you know, a dirty urine analysis test and... I mean it was two tests and it was mandatory withdrawal... 30-day mandatory withdrawal and I was on 210 ml. So I went to --- and they put me up to 210 again. It's sadistic."

### CANNABIS AS A SUBSTITUTION TREATMENT, OVER METHADONE

A few participants found cannabis helped them stay off opiates and would prefer to see cannabis distributed rather than methadone. They considered cannabis safer and easier to wean off of than methadone. One person found methadone to be a trigger, since it is used by active heroin users when there is no heroin available.

"[I]f I had a choice now to do it all again, I would pick marijuana over methadone for detox... I think it's safer and I think it's easier to transition off of. It might take a bit longer, but you don't have to detox from marijuana."

"I was scared to go on methadone [...] It was like a trigger to keep using. Because when I used heroin, there was a lot of mixing around with methadone when you didn't have heroin. And so I was concerned it was going to keep me in the crowd... I also felt that the benefits of marijuana would be better for my health than the benefits of methadone. So I smoked marijuana continuously for two years as a form of my detox. And it worked. Now, I don't smoke marijuana at all."

# What does not work with methadone maintenance programs

### DISADVANTAGES OF METHADONE

People reported that their ability to function was challenged by the long-lasting effects and potency of methadone and that methadone is very difficult to wean off of. Being on methadone also prevented some individuals from getting treatment for their other addictions. Others were concerned that carry privileges had become harder to obtain because of recent methadone-related deaths. Some would not consider using methadone, believing it simply replaces one addiction with another.

A few participants recounted having difficulties getting into methadone programs because of stringent eligibility criteria and waiting lists. One participant was concerned that so many people are now on methadone and questioned whether this is a positive thing. Another participant mentioned that pharmacists were reconsidering whether they should offer methadone and needle distribution because of the amount of shoplifting they are experiencing.

"I can smoke crack and do coke and when I'm done, five minutes later, I'm back to normal. Now, you get me wired on methadone and... it takes forever to get off, yeah.

And plus I'm screwed the rest of the day... It's long lasting. Yeah, and I'm not into that."

"And compared to before, it's really difficult to get some. When I was recently about to get some methadone, well the two doctors told me that it takes six months of closed therapy, otherwise you can't get any."

"Well, I would like to get into the methadone program and I was told that there was a two or three-week waiting period. But two, three weeks is a long time to wait."

#### SUSPECTED MISUSE OF METHADONE

In a few cities, the focus group participants reported that some people had been put on methadone when their drug of abuse was cocaine, for which methadone has no effect. They believed that some methadone clinics were profit-driven and benefited from putting more people on methadone, regardless of whether it was helpful for them. One participant reported that a friend wanted to wean off of methadone, while the clinic was conspiring to keep him on methadone for profits.

"I had a friend on methadone and I don't know which clinic he's going to, but he said that he felt that they were conspiring to keep him on methadone and that he wanted to accelerate his... weaning off... But they wanted him on it."

Male Respondent: "It boils down to money. That's what it boils down to."

"Like I know guys that are on speed in Calgary, guys that are smoking crack. They've never done an opiate and they're being prescribed methadone."

### DIFFERENCES IN PRACTICES AMONG PRESCRIBING PHYSICIANS

A few participants explained that methadone dosing and eligibility practices varied depending upon the physician and city, even in the same province.

"I was up to a ridiculous dose at one point. I was at 290, and when I came to ---, they were quite surprised. Their idea of harm reduction apparently was something totally different than how they were running things in ---. So that was a bit of a shock because of how quickly they wanted to change things around."



"I was having a hard time getting on methadone too. This was when I first heard about it... And he said, 'Go down to --- and check yourself in to see the psychiatrist.' I was down for four hours waiting to see him... And you know what he said to me? He turned me away. He said, 'You're on drugs. I can't help you.' A month later, I was seeing Dr. --- and I was on methadone."

### LOSS OF CONFIDENCE IN METHADONE PROGRAM

A few participants had lost faith in methadone programs, having noticed people on methadone were still using other drugs. One person wondered why so many people are now on methadone.

# POOR TREATMENT BY HEALTH PROFESSIONALS IN HOSPITAL AND CLINICS

Obtaining pain management care in the hospital was a challenge for some participants, when it was known that they were on methadone. They also commented on the negative attitudes of the health care professionals toward them because they were on methadone.

"And you do not get any pain management, because they think you're a drug addict...

And they'd treat you like garbage."

"Another thing was talking about getting off methadone. Coming down off methadone. The doctor said to me, 'I don't know what to do. I'm thinking maybe we should just leave you on your pain medication and bring you off your methadone.' And the nurse turned around and said, 'Yeah, right. But you'll be back.' In other words, 'You're going to fuck up.' That was totally uncalled for."

"I went to jail last November... What they done, just put me in segregation for five days. And I went through hell for like five months."

#### ISSUES WITH METHADONE IN PRISONS

One participant shared a chilling story about being put in segregation in prison, with no access to methodone.

### CHALLENGE OF DAILY PICK-UP OF METHADONE

In some clinics, people lost their carry privileges if they had a positive urine test. Participants resented having to go to the clinic every day to obtain their dose.

"I don't need to be walking a mile and a half to dose for my methadone every day because I have dirty urine. Because they said I've got dirty urine, I've got to walk downtown, take my dose at the pharmacy... That's worse than we treat cattle. Cattle, we put them in a trailer and we take them to the vet."

## Impact of methadone maintenance programs

### IMPROVED QUALITY OF LIFE

Some of the participants on methadone mentioned that it was making a difference by improving their health, which assisted them in putting their life in order. In certain cases, it brought with it stability and a routine. Others felt that methadone had even saved their life.

"Methadone is the first real outreach program that's come here, to actually make a difference."

"I find that with the methadone [it's] the only thing that helped me because it put that much time, like three years now between me and the drug. I'm not saying I've been clean the whole time, but 99% of the time I have been clean, and then I had counselling."

## Needs regarding methadone maintenance programs

MORE HEALTH CARE PROFESSIONALS QUALIFIED FOR METHADONE; MORE LOW-THRESHOLD PROGRAMS; PRIVACY

Some needs regarding methadone programs were expressed by the focus group participants: more health care professionals qualified to prescribe methadone; more low-threshold programs; and more discretion in terms of the clinics' locations and signage.

## **Drug substitution**

### CANNABIS AS DRUG SUBSTITUTION

Some participants found that using cannabis helped them stay away from other drugs. One person said that a youth shelter he used to stay at was tolerant of cannabis use. As previously mentioned, some people would also like to see cannabis used instead of methadone to help get off opiates.

"[C]annabis keeps me free of chasing cocaine these days. I'm a past ID user of cocaine, but cannabis works fine for me now and I use it every day."

"When I was living out there, I was living in a [youth shelter]... I came back home and then I got in trouble with my parents when I started hanging around with all the crack people, and then I started using drugs again. Got in trouble with the law... Now I just want to smoke marijuana and get back in the house."

"[I]t's also some sort of stability, routine in my every day kind of thing, otherwise I can go days without leaving my apartment or there's nothing which I really have to go out for, so it sort of forced me to complete one task a day."



#### NO DRUG SUBSTITUTION FOR CRACK COCAINE

A few participants wished that a drug substitution program would be developed for people who use crack cocaine.

"I wish we had something for crack addicts like they do for people that do the opium, the methadone. I really think there's a need for that."

#### PRESCRIPTION PILLS AS DRUG SUBSTITUTION

Other participants reported using pharmaceutical drugs to end street drugs use.

"And I've used a lot of doctors... like pill medication to come off the harder stuff."

"I have a doctor who is trading off my heroin for [prescription] opiates."



A few participants would like to see opium prescribed.

Male Respondent: "It'd be far better to prescribe the opium. Sounds like you people need to go into the medical college and educate the doctors."

Male Respondent: "Oh, absolutely. Yes. Because they don't understand. Humans are in pain... daily."

### 3. PEER INVOLVEMENT

Peer involvement refers to the participation of people with drug-use experience in the conceptualization, development, implementation and delivery of services offered to them and their peers. Many of the focus group participants were involved in the delivery of services as volunteers, or as members of programs or agencies. Many others had started their own separate initiatives. Some spoke in schools or at public events, sharing their stories in the hope of preventing others from going down the same path they did.

## What works and unique solutions for peer involvement

#### PEER LEADERSHIP

While some participants were members of various groups or involved with agencies, others demonstrated impressive leadership skills and levels of community engagement working independently. They participated as volunteers in outreach, on boards of directors, for user newspapers, and in support groups, coalitions and user groups. Some were strong advocates for their peers and communities.



#### **ALTRUISM**

One theme that surfaced in every focus group was the altruism participants expressed. Much peer work is driven by altruism, and many participants displayed a genuine commitment to helping others, as they understood what it was like to need help. They also wanted to make things better for the next generation. Altruism is also a way of bringing meaning to the lives of many of these people.

"Yeah, I would be very interested actually to help out. We all have a genuine concern, that's why we're here."

To give back to their community, peers got involved in many ways. Some patrolled parks and areas near schools, picking up used needles and injection equipment, and properly disposing of them. Some got involved in user groups and some in the advocacy efforts needed for the development of programs. Some prepared hygiene and injection equipment kits for the outreach vans. Some distributed injecting equipment and crack stems after hours, or helped others wean off of opiates. One person mentioned a belief in strength in numbers, stating that the more people help each other, the stronger they will get.

"We are trying somehow to give back a bit of what we got."

"I tell myself that if we can continue like this, I think we are heading in the right direction. The more we are to help each other, the stronger we will get, [and] the better chance we have at succeeding, the more chances we put in our favour. And I hope wholeheartedly that it will continue like this."

### PEER DISTRIBUTION

One phenomenon that is taking place in all of the cities visited is peer distribution, where people who use drugs take it upon themselves to distribute new needles and other supplies to their peers. This "secondary distribution" is essential to fill in service gaps, by making equipment available after hours, and to reach people who are not coming to the needle distribution services or other programs.

#### **EMPOWERMENT**

A core belief and value<sup>14</sup> of the CAS and of the CHRN is empowering people who use drugs. People have the right to be directly involved in all decisions that affect their lives and in the organizations that serve their needs. We have a duty to see that the resources are available and accessible for them to do so. The focus group participants expressed the importance of being involved in every aspect of programs and services.

"You know going to those houses, the crack houses, or the cocaine houses... They have their problems and we have our problems. I don't condemn them for their problems, their crack cocaine problems. I help them out if they need money or... If they need their pipes I'll give them the pipe or whatever, help them with smokes... because I know how it is."

 $<sup>^{14}</sup>$  For the Canadian AIDS Society's Core Beliefs and Values, visit www.cdnaids.ca.

"But how else are you going to learn anything about the community and everything else if you don't ask the people who are using the services?"

"Nothing about us, without us." 15

"[T]his is really good for bringing people together... from different walks of life, from solvency to opiate use, to stimulants. And sometimes there tends to be a tendency to say 'there's us and then there's them'. So really, if we're going to bring it together, we've got to get beyond that ourselves, so that way we have a better, stronger voice to say, 'Look, it's addiction. And we want to help ourselves."

### **USER GROUPS**

Across the country, many people who use drugs have mobilized to form user groups. User groups enable people to network and to speak up in unity about their needs, their rights and their struggles. This creates for them a stronger voice and empowers them to help themselves and others and to confront the stigma that society has imposed on them. User groups also bring together people with a variety of drug use experience and help them overcome the prejudices they may have against each other.

"We're not going to change anything without speaking up."

#### TRAINING PEERS TO EDUCATE OTHERS

The focus group participants said they would like training on how to educate others and how to speak in high schools to do prevention with youth. They felt that education was a priority and that this could be done by sharing their experiences and expertise and openly speaking about the realities of drug use. For their efforts, they would like to receive honoraria as well.

### PEER SUPPORT

The importance of peer support was expressed in several of the focus groups, whether through support groups, a buddy system, visits in hospitals or prisons, and during recovery.



<sup>&</sup>lt;sup>15</sup> In reference to the Canadian HIV/AIDS Legal Network's publication "Nothing About Us Without Us: Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical and Human Rights Imperative." Available at http://www.aidslaw.ca/publications/.

#### OTHER WAYS OF GETTING INVOLVED

For some, simply taking the initiative of picking up and safely disposing of discarded needles and injection equipment in their community was a way to be involved. Peers also reached out to people who did not access the available services. One person was developing a website for street-involved people. People were very resourceful at doing what they could with no funding.

"We have been running the group for three years. We never received any funding. We did it all with volunteers. Point de repères supplied the room and it's a great space to welcome everyone. The rest is up to us volunteers."

## What does not work for peer involvement

#### EXISTING POLICIES MAY LIMIT PEER ACTIVITIES AND INVOLVEMENT

In some cases, peer involvement was hindered by policies. For example, some peers wanted to distribute injection equipment with their car, but were told they could not, since they did not have the proper sharps containers for safe disposal. In another instance, someone wanted to volunteer, but the training period was too long and onerous, and the screening was too strict.

"I would like to do more, but some of the organizations make it difficult to have peer training or peer support... you've got to go through a year of training before you can even get in the door to do anything, you know, so some of them are strictly screened. So you can't get in and do your volunteer work. I do a little bit, but I feel that I can do more. I feel I have something to offer, but there's a strict policy."

### CHALLENGES OF STARTING A USER GROUP

People in one city wanted to start a user group and were encountering challenges. The facility they were working out of was near a police station, keeping potential participants at bay. Some personal problems limited the amount of time they could devote to form the group as well. Not being able to obtain funding was another important obstacle.

Male Respondent: "Places like VANDU, well, they've been around for a while... they can go to different organizations and they know who they are and have money donated for them to go to the conferences and whatnot.[Here], try and go to people and say, 'This is who we are and this is what we're doing.' And they're like... 'Go away.'"

Male Respondent: "Or they think it's some kind of scam you kind of pull on them just to get money for yourself for drugs basically."









#### OTHER CHALLENGES OF PEER INVOLVEMENT

Getting involved does not necessarily mean that a person's struggle with problematic substance use will go away. Nor will people who want to get involved and do more in their community necessarily be welcomed to do so. Helping other people who use drugs might be a trigger for some and could result in relapse. Peer involvement in programs and services can be problematic if the peers don't receive proper mentoring, training or support. One focus group told of the deterioration in quality of service provided by an organization after peers became involved.

"I got my high school education... post-secondary education... and I'd do talks in conferences in Halifax, in Ottawa about drugs, about Hep C, about HIV, and it still didn't deter me [from using]."

Male Respondent: "When we first got there, there was an outstanding team of workers. It was probably one of the top five best-managed organizations in Canada. Now, if you go see them, you have to do a 180 because it is now one of the worst. They have changed inside and out."

Female Respondent: "... if there were some people with diplomas, they are no longer there. Clients are now managing the place."

Male Respondent: "If we talk about quality, they have lost some."

# Impact of peer involvement

ATTENDING CONFERENCES PROVIDES USERS WITH OPPORTUNITIES FOR NETWORKING, LEADERSHIP, A SENSE OF BELONGING AND CONTRIBUTING, AND LIFE-SKILLS EXPERIENCE

International and Canadian provincial harm reduction conferences routinely set aside time for user meetings and provide the logistical and financial support to ensure participation. People who have taken part in these meetings tell of the great opportunities they had for networking and of the strong sense they had of being part of a community. We met several people who had attended the meeting of users at the International Harm Reduction Conference, held in Vancouver, in 2006, including some who were involved in the planning of that meeting. Through this meeting, and the ones held at conferences in some of the provinces, people who use drugs are becoming cognizant of their worth and have developed a clearer vision of why the creation of a strong voice for users nationally is contingent on their organizing locally. They also received some insight on and how to go about forming user groups in their communities. Clearly, being involved can have a significant impact on the lives of people who use drugs.

"... people are starting to listen to me. You know, before it was like in one ear and out the other. Nobody really gave too much as far as being a drug addict. But something evolved... and... the networking was phenomenal for me."

# INVOLVEMENT BRINGS SELF-ESTEEM, SELF-HELP, A PURPOSE, ALTRUISM, EMPOWERMENT, CREDIBILITY AND LEARNING

Getting involved gave some people a sense that they were truly being heard, enhanced their self-esteem, gave them goals to strive for, and helped them manage their substance use. By being involved, they felt they could help others and perhaps prevent youth from going down the same path that they had followed. Participants reported that they became very useful and could contribute more when people trusted them. Talking about their situations became easier with time and encouraged some to get more deeply involved. People felt they learned a lot from their peers, especially those who had also "been there".

"So this is a way to raise my self-esteem, right, being part of something."

"You're going to get something from helping someone else."

## Needs regarding peer involvement

## GETTING PAID FOR WORK THEY DO

With regards to their need for involvement, participants mentioned that getting paid for some of the work they do would be beneficial.

# ACCESS TO SCHOOLS AND PUBLIC SPEAKING OPPORTUNITIES TO SHARE STORIES AND INFORM YOUTH

They would also like more opportunities to get into schools to speak with youth about their experiences and to raise awareness of the general public about the issues related to drug use.

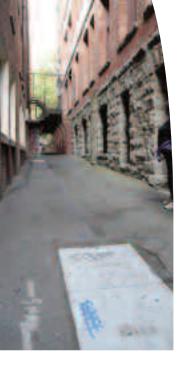
#### TRAINING IN OPIATE OVERDOSE PREVENTION

In Edmonton, some of the focus group participants had been trained to administer Narcan to prevent overdose deaths. They greatly supported this pilot project and wanted to see it continue. When focus group participants in another city heard about this, they said they would like to see something similar in their city.

#### ASSISTANCE WITH AND TRAINING FOR PROPOSAL WRITING

One participant brought up the importance of obtaining support and training to write proposals for funding.

"And it's been really beneficial. Like I've done a lot of public speaking in the last vear since I really got involved with the user groups and started them off and... it's really been good for the self-esteem and it's given me a goal to shoot for. It was the main thing that got me straight, and I think that's great, and it was that people listen to me now. Yeah, if I can prevent even one kid [from going] through what I did for 30 years, then I am a success, right?"



#### PEER SUPPORT FOR PEOPLE IN DETOX CENTRES

The need to involve peers to provide personal support to people going through detox was identified.

#### FUNDING TO ORGANIZE AND RUN USER GROUPS

People would also like to see financial support for starting up user groups.

### 4. Needle and injection equipment distribution

# What works and unique solutions for needle and injection equipment distribution

### PEER DISTRIBUTION (SECONDARY DISTRIBUTION)

Focus group participants in every city reported distributing needles and injection equipment to their peers. They saw this "secondary distribution" as a way of helping each other and of filling in service gaps. Peer distribution provided around-the-clock care, as well as privacy for people who were not accessing services. Some peers even brought clean equipment to people during their hospital stays. Some shared information about better injection techniques and other things they had learned from service providers. Some dealers also distributed clean equipment to their clients, and some peers had developed good relationships with police. People who use drugs find out about each other through word of mouth. They know whom they can trust.

"I used to tell people back then, if you need [injection equipment], knock on my door, knock on my window, I don't care, any hour in 24... And I would give them out."

"I allowed people to use my home to safely use drugs. I would say, 'Hey, here's one. If you want to do another hit, give it back, I'll give you another one.' Sort of educate people myself about what's safer."

"For some, they are shy. They are too shy or I don't know what. There was one guy, for a whole year I went and got him his needles. I would go and get mine and I would grab a pack for him."

# COMMUNITY-BASED NEEDLE DISTRIBUTION PROGRAMS VERSUS PHARMACIES

People who use injection drugs can obtain injection equipment from needle exchange programs, which are sometimes located in community-based organizations, in community health centres or in pharmacies. Some participants mentioned that they prefer community-based organizations to pharmacies, as they felt they experienced less judgement. Although some pharmacies provide a good service, some charge for

the needles, and cost is a barrier for many. For these reasons, people preferred going to a place where they could obtain the equipment at no cost.

"I prefer coming here to get my equipment rather than the pharmacy. At the pharmacy it seems like sometimes they look at you funny and they have prejudices. Here there are less prejudices, you feel more comfortable."

"I guess the attitudes changed in the early '80s quite quickly with a lot of pharmacists and I got to know at least two in Ottawa that, if you didn't have money to buy syringes, they would give you syringes. And this is just the late '80s. And the Site, I guess it just opened on Somerset, I'm not sure. But I only started using the Site when I became aware of the needle exchange thing, which was cheaper than buying them or going to these two drug stores and asking for a bag for free."

# NON-JUDGMENTAL ENVIRONMENT; NO LIMIT ON NUMBER OF NEEDLES AND EQUIPMENT

People appreciated the non-judgmental environment of community-based needle exchange programs. Friendly staff helped cheer them up. They also appreciated being able to obtain as much equipment as they needed in one visit, which made it likely that they always have on hand what they needed for safer use.

"What I love about Point de repères is that we are not judged. We are always truly welcome with good spirit. And if we get there and we are not in a good mood, it cheers us up. They are not afraid to give, you know, when we ask for more so that we don't run out... It is possible to get a sufficient quantity so as not to run out. I appreciate that a lot because I am not always able to get there."

#### SERVICES AVAILABLE WHEN AND WHERE NEEDED

Focus group participants were quick to point out that needle distribution programs are very helpful, and that it is important for the services to be available when they need them. Hours of operation are therefore an important factor for them. They also appreciated the fact that these services exist at all. Recalling a time when it was not easy to get what they needed, some participants disclosed how they used to obtain needles.

"Back in the '70s in Vancouver you could not get syringes anywhere, and I used to have to sharpen them with pencils with match book covers. And yeah, we shared them, cleaned them once, pass them, clean them twice, pass them around. That's how it was. I was very lucky, all I got was hep B out there. But then I left before the AIDS thing blew up... And when I started again, it was easy to access syringes. You could walk into the drug store and ask for a bag and... if you found the right drug store, it was no questions asked."

"I was stealing them for my habit, throw-aways you know, we'd get them from the hospital all the time... But now you can actually walk in and even if you don't have one to turn in, you can get a half a dozen or 15 units."

"Safeway... you can go into Safeway and buy them now, and sometimes in an emergency I'll go get one. It's like \$3.50 or something for ten."

"The only way you can get a fresh needle in prison is if you are on insulin and when the guy is not looking, you've got to sneak your hand in the box... and walk out of the office. That's the only way it works."

#### ABILITY TO PURCHASE NEEDLES AS AN OPTION

A few participants did appreciate that there are some places outside of needle exchange programs where they could purchase needles, if they needed them. Some participants bought needles, as there were no needle distribution services in their area.

## POLICY FOR PHARMACIES TO GIVE OUT INJECTION EQUIPMENT

In the region of Abitibi-Témiscamingue, in northern Québec, a policy has been developed that has made it mandatory for pharmacies to distribute clean injection equipment and to provide people with as many kits as they request. This has made a difference for the people using the services.

"It's like before that [policy] paper came out, at the pharmacy, sometimes we had problems getting a kit. Now, they give us as many as we ask for."

### SAFE INJECTION SITE

Some focus group participants had the opportunity to try the safe injection site in Vancouver and reported on its benefits: injection equipment distribution, supervised injection, safe disposal, and access to a nurse.

#### HOME DELIVERY

Home delivery of injection equipment through an outreach van in some cities is very much appreciated.

# What does not work with needle and injection equipment distribution

#### VARIABLE REACTION OF HOSPITAL AND PHARMACY STAFF

Even though hospitals and pharmacies participate in the distribution of clean injection equipment, reactions of the staff to the requests of people who use injection drugs vary.

"They refused me [at the hospital]. 'You are not allowed to have any.' 'No problem, I will go get some at the pharmacy.'"

"The pharmacies stay as is. She sees me come in. I say I want one, she knows, she knows me, she gives me one. I come in, I want two, they give me two. But when you go to the hospital around midnight... Sometimes it depends on the nurse that you get. When she is tired, she grumbles a bit. Sometimes she gives you a dirty look and she complains. 'You can wait, and I don't want to hear you ring the bell twice or three

times.' And they get on our case a little. Once I was sent away. The woman said, 'Come back later, I am busy.' Come back later, that's a good one. I don't have time to wait. I was tired of living like this at one point."

#### POLICIES THAT HINDER PEER DISTRIBUTION

Some policies hinder peer distribution. One group was told that they could not distribute injection equipment without proper sharps containers to collect used needles. Another group was told they could not duplicate services, so they could not operate when other services were open.

"We want to actually go to certain neighbourhoods and hand out clean syringes, but we were told we couldn't. We were going to do it out of our car... in the van they have the proper boxes where they're sealed in tight, you know."

"SOLID only does two routes a week, though... Right now we have a Sunday afternoon slot... and a Wednesday evening slot. One of the reasons about that is we're not to duplicate services. When other services are open, we're not to duplicate that."

#### DISADVANTAGES OF PEER DISTRIBUTION

Peer distribution is not without its disadvantages. Some people use the opportunity to sell new needles, and some suspect that people even sell used ones. User groups who take on peer distribution have a difficult time finding a place to rent for a fixed site.

#### DISADVANTAGE OF ONE-FOR-ONE EXCHANGE

Recognizing that it may not be wise for some people to carry used equipment even to an exchange program, most programs no longer insist on people returning used needles to obtain new ones. Instead, they educate users on safe disposal through other means. The one-for-one exchange requirement made for some tense situations between service providers and service users who frequently came with no or few needles and needed a sufficient supply. Insisting on one-for-one exchange may have lead to more sharing of needles and, hence, more transmission of infectious diseases.

"[B]ack in those days, they realized that one-for-one was actually tantamount to making the spread of diseases even more [prevalent] as people were sharing... [They] had to clean their needles several times instead of giving you a whole package."





# CHALLENGES OF NEEDLE DISTRIBUTION IN HOSPITAL EMERGENCY ROOMS

There are challenges associated with providing needle distribution through hospital emergency rooms. Emergency rooms tend to be busy, which deters some from wanting to access them for needles. Staff may be disinterested or disinclined to see the need for new needles as an emergency and resent having to deal with this.

#### LACK OF NEEDLE DISTRIBUTION SERVICES

Some AIDS service organizations provide needle distribution, and some don't. The provision of needles, however, doesn't indicate that the quality of service will be acceptable. One focus group had this to say about one particular AIDS service organization that poorly treats people who use drugs.

"Don't try to obtain new [injection] equipment there. They will not give it to you. You will get thrown out with a kick in the ass. They say they supply, but I have never seen anyone get a needle there or bring in a container of used needles."

In Ottawa, participants reported that there were now fewer needle distribution services than before, requiring them to plan more.

"It [needle distribution service] is still hard to find sometimes too... I used to be able to get them there, not anymore. Now, there are fewer places to get them. Unless you actually plan your day, [...] organize your day to get to the site van as it's driving around on the hours it's available, you've kind of got to have supplies on hand all the time. That's why I carry a few extras."

Not having access to needle distribution services can lead to reuse of needles, and perhaps increased sharing of needles.

"I know some people who inject and, you know, they don't have needle exchange sometimes. They use the same needle for such a long time."

Given that clean injection equipment is not available in Canadian prisons, some former inmates disclosed some of the unique solutions that people resort to in prison, such as stealing needles from the medical office.

#### CONFLICTING POLICIES AT SHELTERS

One person reported that shelters provided clean injection equipment, but kicked people out when they found out they used drugs.

"Well, I've been at every woman's shelter that's here... But when they find out that you are a needle user, I got kicked out when I was there. You know what I mean? So they're giving me needles to go use, but then they turn around and kick me out."



#### CHALLENGES WITH SAFE DISPOSAL

One group reported that safe disposal containers don't come with the clean injection equipment kits and that they have to find places to safely dispose of their used needles – at the pharmacy, or in the washrooms at the hospital. Another person reported that an employer found used needles in the garbage and was not sure how to handle the situation, and he did not want to pay for a sharps container.

"He didn't want to pay for this box. He didn't want anybody to get in trouble and the personnel didn't want to be identified, so it's like they just pretended it didn't ... exist..."

## DRUG USERS' BEHAVIOURS THAT JEOPARDIZE PROGRAMS

One group told us pharmacies in their community report lots of shoplifting, so they are considering ending methadone dispensing, as well as needle distribution.

#### NEEDLE DISTRIBUTION AS A TRIGGER

Finally, one participant had mixed feelings about needle distribution.

## Impact of needle and injection equipment distribution

#### DISEASE PREVENTION AND IMPROVED HEALTH

The most frequently reported impacts of needle and injection equipment distribution were disease prevention and improved health, and the cost effectiveness of preventing HIV/AIDS and hepatitis C. People mentioned their appreciation for having access to safe and clean injection equipment and safer crack use kits. Some people report that they walk away from risky situations and never share equipment, an indication that harm reduction messages are sinking in. Before the availability of needle distribution services, people report that they commonly shared equipment. In prisons where there is an absence of equipment distribution services, a few former inmates reported using unsafe drug paraphernalia and resorting to stealing injection supplies from the office. Participants attributed not having HIV or hepatitis, and getting fewer infections, to the availability of needle distribution services. Harm reduction services have been a good influence on some participants' behaviour.

"Oasis saved my ass. It's there when I need it... It's good to have clean needles and clean stems other than having to look for a pop can, or whatever it is, to use."

"I know for myself, needles are more accessible. Before... my immune system was weak so I used to catch infections all the time. I used the same needle for a long time. I was always at the hospital on antibiotics. So I decided to change needles more often and have less infections."

"[W]ith the needles,
I think it's a Catch 22.
When you are using
it, it's worth it, it's
there, but when
you're not, ...you
see it, it's a trigger."



"If I had prompt access to free needle exchanges when I was actively using just prior to catching HIV, I would not be HIV positive as of right now. If I was given the knowledge early on and access to harm reduction strategies, there is a good chance that I would not be HIV positive. And just my costs alone to the health care system since I've been positive are probably several hundred thousand dollars minimum."

# ACCESS TO COUNSELLING AND SUPPORT, FOOD, GUIDANCE ONCE OUT OF PRISON, AND MORE

Focus group participants appreciated the other services, such as counselling and support, food, and guidance, they could access at the community-based needle distribution programs. This was particularly important for people just out of prison. In this situation, staff often became their surrogate family.

"I come to Point de repères to get clean equipment. I also come... when I have problems, something on my chest that I need to talk about, I come and see the staff. They help me a lot."

"I inject and I come here for the needle exchange, the injection kits, the pharmacy and the food."

"As a junkie, it's here that I find the best services and I think that's important...

Especially with regard to detention, it's important that they get even more involved.

Because it really helped me when I got out. They guided me and anyway, I raise my hat to them."

### COST SAVINGS FOR PEOPLE WHO USE DRUGS

Providing new injection equipment for free makes a difference.

"Cost. Believe it or not, the expense. If you've got five dollars or four dollars, you're buying a bag of fix, guess what? ... It might be the difference between getting well and just being there, just functioning better... but getting well, because if you're functioning you're still able to get better."

"It removes the shame. Sitting around the corner trying to find a needle. It's the stigma."

#### DECREASES THE LEVEL OF SHAME

Having access to needle distribution services removes the shame for some people.

## Needs regarding needle distribution and peer distribution

### SAFE INJECTION FACILITIES

In many of the focus groups, people identified the need for a safe injection facility (SIF). They liked the idea of being able to inject in a safe, clean and well-lighted place with no questions asked and no judgement. They felt that SIFs would reduce the number of overdoses, as well as the number of discarded needles in public places. They also felt that SIFs would be beneficial for police. While there is some public support for SIFs, participants realized that much work needs to be done to bring more people onside. That said, some people were already looking into getting SIFs in their cities. A few people reported that they would not use SIFs, as they need assistance to inject, and the SIF in Vancouver does not allow this. However, they felt that SIFs would still be a valuable source of knowledge and services.

"A safe injection place, that would be a dream. It's funny to have such a dream, but it is a dream. It's a place where a person is safe. He does not have to worry about doing what he has to do and about being judged. Stop judging us. Sometimes we really need to be doing what we are doing."

"Yeah. I don't think I'd use one... Because I have the hardest time hitting myself...
I need somebody to hit me... I might go there to learn..."

"I have to go inject in a public park. And if I go in a public park, I get arrested by the police. If I go in an indoor parking [lot] I get arrested by the police. There is no place where I am allowed to inject. And I leave my needles on the ground because I panic. Well, I don't do that but there are a lot of people who will do that. They are paranoid, they do their hit of powder [cocaine]. So then they will get paranoid, and they will throw their needle on the ground. If there was a legal injection site, there wouldn't be any of that. We are talking about harm reduction here..."

"I would personally rather be inside... Honestly I never do it alone because I think it's really dumb. Because I've saved two people's life..."

### LONGER OPERATING HOURS - PEER DISTRIBUTION TO FILL GAPS

Many respondents spoke of the need for longer operating hours for needle distribution services. Ideally, they would like services 24 hours a day, seven days a week.

"[W]hen you're doing cocaine, if you need a needle, you need it now."

"Our services... I think they are pretty good. But they just started doing it on the weekends, where before that it was just Monday to Friday and on the weekends there's nothing. Well, people use drugs on weekends, and they need clean syringes on weekends also."







Winnipeg: "We don't have the amounts of drug users on the street as the bigger cities, per se, do, of course. But we still have them and I still think it's important that in certain areas where there is a higher rate that we should have some drop off boxes, so that the needles aren't thrown on the street or wherever. But we don't have them."

Edmonton: "They say there are so many people down at the river bank, well why don't they start putting [drop-off boxes] down by the river. People will use them."

#### MORE DROP-OFFS AND WAYS TO DISPOSE OF USED NEEDLES

Participants also identified the need for more places to safely dispose of used injection equipment, especially in strategic locations where people tend to use.

Similarly a need was expressed for more protocols guiding businesses on how to properly dispose of used needles when they find them.

# OTHER NEEDS REGARDING NEEDLE AND INJECTION EQUIPMENT DISTRIBUTION

A few participants spoke of the need for needle and injection equipment distribution in prison, the need to distribute ALL equipment required for injection, the need for various kit sizes with a different number of needles and equipment to accommodate various needs (distributing kits over distributing the supplies in bulk is a common debate) and the need for privacy.

## Crack kit distribution

Some of the cities visited were providing safer crack use kits, but most were not. Focus groups participants had comments with regard to safer crack use kit distribution.

## POLICIES THAT HINDER DISTRIBUTION

In Winnipeg, some participants felt that current policy limitations hinder the distribution of safer crack use kits. They reported that the outreach van would not do a home delivery specifically for crack kits. The kits could only be obtained from the van if one knew to ask.

Male Respondent: "I had them to my place to pick up one of those yellow [sharps] containers. I was kind of surprised because I seen the pipes but he didn't offer, like he usually would kind of thing..."

Female Respondent: "Yes, if I'm mistaken, I could be wrong, but if you're on the street you can get a crack pipe kit. But when you have a home delivery, you can't get a crack pipe kit."

### DESIRE FOR SAFER CRACK USE KITS

Many participants in cities where there were no safer crack use kits would like to have access to them. One participant was actively involved in trying to get them in his city.

"Well here in Rouyn, if they could give out pyrex pipes, that would be alright."

St. John's: "...they don't give out crack pipes and there's no harm reduction there. Eventually I'm sure it'll come on the table."

Edmonton: "I use crack, smoke pot and I think about all the other drugs I've used. I'm still involved with trying to get the crack kits and everything else. It hasn't happened yet. It's definitely slow."

# APPRECIATION FOR THE SAFER CRACK USE KITS AND THEIR CONTENTS

In Ottawa, where municipal funding for the safer crack use kits has been discontinued, focus group participants reported their appreciation for the kits. Some community groups have kept the distribution going despite the city's lack of funding.

"I mean, the crack kits, I think they're phenomenal. I love them."

"It's good to have clean needles and clean stems other than having to look for a pop can or whatever it is to use."

## OTHER COMMENTS REGARDING SAFER CRACK USE KITS

Some people report that they are distributing safer crack use kits to their peers, just as they do with needles. One participant mentioned that the police are adding to the stigma of people who use drugs with their attitude towards crack kit distribution. Another mentioned that seeing the kits triggers her to use. One participant identified the need for a safe place to smoke crack.

### 5. Drop-In Centres and Shelters

# What works and unique solutions for drop-in centres and shelters

#### WELCOMING SPACES TO BE WITH PEERS

Focus group participants appreciated drop-in centres as welcoming spaces where they could be amongst "their own", relax, warm up, eat, socialize, watch TV, and get support. They could also obtain help seeking employment and sometimes get health care from an on-site nurse or physician. Spending time in a drop-in eased some of their daily stresses.

"Yeah, places like that and you drop in, [they're] likely to ease you with all your problems or if there's something bothering you... at Sunshine House you can eat, relax, watch TV, whatever. They have about 20 people would stop there all the time. Great place."















"It's talking."

"...the boys and the girls working with Streetworks are very aware of what's happening with us and everything. They are concerned."

### QUALITIES OF PERSONNEL AT DROP-IN CENTRES AND SHELTERS

Participants appreciated staff who were non-judgmental, helpful, caring, willing to listen, and supportive. Personnel were responsible for creating a welcoming atmosphere in drop-in centres or shelters.

"People there actually have faith and they don't judge who I am. I can have a fuck-up going on for five days, then you come back and they don't change... they're always still the same... It's a beautiful place. I love it there."

"She helped me, you know. Again I've had problems with drugs and alcohol and she just cares about me. She's there. She wants to hear how I feel. A lot of times they don't care about you."

"I go to Blood Ties myself, talk to the counsellors or whoever's there and I find they're very helpful. They practically stop what they're doing. If you've got something on your mind and you want to get it out, they're very good, they have a willing ear to listen."

Female Respondent: "I go to the Phoenix Drop-In Centre. They really help me. They're really good people... Just support. When I go in there freaking out if I don't use, they stay with me for an hour, until I feel better, until they know that I'm in a better state. I've had some really good experiences."

# INFORMATION DISSEMINATION THROUGH WORD OF MOUTH OR REFERRALS

People often found out about drop-in centres and other services through word of mouth or referrals at shelters.

#### SHELTERS THAT WELCOME PEOPLE WHO USE DRUGS

The shelter at the Tommy Sexton Centre in St. John's welcomed people whether they used drugs or not. Although they do not allow drug use on site, they do provide new injection equipment and do not kick people out for using.

"This is an awesome shelter, you know? I can go out and get high and not worry about having to come home. Like a bed to sleep in. I don't have to stay on the street."

# PROFESSIONALS' EXPOSURE TO DROP-IN CENTRES' PATRONS IS BENEFICIAL

Participants felt that health care and other professionals benefited from visiting a drop-in centre and meeting its clients. It allowed them the opportunity to understand the needs and realities of these people and led to improved attitudes toward them.

"We also have a doctor. She comes here... It helps to have a doctor come out and treat us. She probably understands what you're going through... She actually listens to people."

"Well, ... the attitude with people that are coming here, [...]when they come down here, I know after a while, after they've been here for a week or two, their attitudes completely turn around."

### UNIQUE SOLUTIONS

People were resourceful at finding ways to provide services. One drop-in centre had worked out an arrangement with a local caterer to obtain leftover food to hand out. One person in one focus group was working at establishing a more user-friendly shelter, which would not require that people leave first thing in the morning and would offer some life skills training and support and assist patrons in finding permanent housing.

# What does not work with drop-in centres and shelters

### DISCRIMINATION AGAINST PEOPLE WHO USE DRUGS

Not all drop-in centres and shelters are welcoming to people who use drugs. Focus group participants reported incidents of discrimination, negative attitudes and maltreatment from staff. People were kicked out or banned from these establishments for their drug use. These situations sometimes depended on which staff was on duty at the time.

"I've been to a lot of drop-in centres throughout Canada and the United States. They'll feed you, they'll let you wash your clothes, let you have a shower, but they'll treat you like utter crap."

## CHALLENGING POLICIES

Some policies of the drop-in centres and shelters were challenging. People lose their beds if they don't show up two nights in a row. They are also required to leave the shelter first thing in the morning, when drop-in centres are usually still closed. As a result, they have nowhere to go and are left to wander the streets. Some clients are even forced to resort to unusual measures, like feigning mental illness, to ensure they have a place to stay.



"There is still a lot of judgement. I am banned from there because they found some needles in my things."





Most shelters also have a policy of not accepting pets. This discourages many people who use drugs and are pet owners from staying there.

"I don't agree with the part in the morning at six o'clock when you get booted out, because then in winter time, it's cold out."

#### CONCERNS REGARDING ANONYMITY AND CONFIDENTIALITY

Some people stayed away from drop-in centres, as they did not want to be associated with them, especially if they were linked to HIV/AIDS services. Sometimes the practices at the centres have kept people away because they did not ensure confidentiality.

"I don't go to --- anymore because you have to go to the front desk and then they want to know what you want from the back. And I said, 'Well, I need supplies.' And they said, 'Well, what kind of supplies?' I said, 'I need needles.'... There's other people around me and I don't need everybody to know what I need, what I'm doing."

#### OTHER FACTORS THAT KEEP PEOPLE AWAY

Sometimes the locations proved problematic and kept people away, especially if there happened to be a police station next door.

# Impact of drop-in centres and shelters

#### **ALLEVIATION OF TROUBLES**

Some people reported that going to drop-in centres alleviated their troubles.

"Sometimes I feel bad or hung over or something and come to a place like... Sunshine House... sometimes I just felt better. I felt okay."

#### THE PROVISION OF FOOD

For some, the food provided at drop-in centres made an important difference.

Moderator (F): "You were saying that you would be a lot skinnier?"

Male Respondent: "Oh for sure. I have gotten a lot of food here in three, four, five years. It's been a long time."

#### **DETERS CRIMINAL ACTIVITY**

Services available from drop-in centres deterred some from criminal activity.

"Instead of stealing... they are there to help us."

#### SURROGATE FAMILY

The theme of finding a surrogate family at various services surfaced in many of the focus groups.

"Socially, for me, having Our Place to hang out with every day... makes me feel part of a family. I don't have any direct family here in B.C... and having the drop-in centres... is really helpful for me. Every day I enjoy waking and look forward to go getting a coffee and talking with my friends at Our Place and the other drop-in centres around town."

## Needs regarding drop-in centres and shelters

### MORE DROP-IN CENTRES, AND FOR VARIOUS CLIENTELE

People identified the need for more drop-in centres and for more positive places in which to spend time. Centres that cater to different client groups, such as men or older individuals, were also mentioned.

#### MORE PERSONNEL AT DROP-IN CENTRES AND FOR OUTREACH

Focus group participants also identified the need for more staff at drop-in centres.

#### DROP-IN CENTRES WHERE CONSUMPTION IS ALLOWED

A few respondents would like to see drop-in centres where the use of drugs is allowed, similar to a safe injection centre.

#### IMPROVEMENT OF SHELTERS

Some people called for improvements in existing shelters, including more and better space and additional amenities.

### SHELTERS THAT ACCEPT PETS

Participants with pets would like to see more shelters that accept pets, in addition to accepting people who use drugs.

"I think there needs to be more places that accept dogs. It's a really big problem. There's not really very many shelters that take people with dogs... For a lot of people animals are their family."

"When I have nothing to do, I come here to talk... and it's good... that there are organizations like that and it would be good if there were more... There could be some for older people, ... for those who are more seriously affected."







## LEGAL SQUATS

One participant proposed the idea of having a legal squat where people could stay.

"Yes, about legal squats. That would be interesting... I know that there are some in Europe. But that would be great if we could squat there and we would not be hassled by the police. It would help a lot because a lot of people cannot go to the shelter... because there is still a lot of judgement."

### 6. HEALTH PROFESSIONALS AND SERVICE PROVIDERS

## What works with health professionals and service providers

NON-JUDGMENTAL, CARING SERVICE FROM HEALTH PROFESSIONALS AND SERVICE PROVIDERS

The focus group participants appreciated health professionals and service providers that were caring, interested, non-judgmental cheerful, positive and giving. Health professionals who will not give up on them were also important. They found that health professionals and service providers who are immersed in the street/drug-use environment better understood their realities and needs, and had fewer prejudices.

"Often the staff, the problem with the organizations is that the staff has no idea of the problem and their view is biased and from there they pass judgement. I think that is the biggest problem. And Point de repères is a good reference. And they are immersed in the environment [...] Personally, I think it is the best organization."

Male Respondent: "When I show up for my medication, I show up early in the morning. When I show up in the morning and people are down, that kind of dictates the day from that point on to a certain point. But if you come in and everybody is all chipper and stuff like that, even if you were down, the staff brings you up a little bit."

Male Respondent: "And... I think a lot of people don't really understand how much they do affect other people's moods, their moods. That's important to me."

#### SERVICE PROVIDERS WITH PERSONAL EXPERIENCE WITH DRUG USE

A few participants mentioned that it helps if the health professionals or service providers have some personal experience with drug use.

### HOLISTIC/NATURAL APPROACH

One person appreciated the natural approach of a naturopath, steering her away from pills.

# What does not work with health professionals and service providers

#### POOR TREATMENT AT HOSPITAL

Many focus group participants reported that they had experienced poor treatment at hospitals. They reported being ignored, pushed aside, and judged. They also had difficulty being admitted into detox. Some had received inappropriate comments. Of concern are those who put their health at risk by not accessing health care altogether, even when it is needed, in order to avoid being subjected to humiliation from health professionals.

"And when you are a person who injects, go and get needles at the hospital. What a trip! 'Before I touch the woman with AIDS...' A month ago they released me... it was all infected and everything... 'Send me the AIDS case, let's go, she is ready to leave.' They left all of the tubes and everything."

"And I got a really big sore on my leg. The last time I used, that's where I used. And like he's been saying to me, 'Go to the hospital, go to the hospital.' But I'd rather take a month for it to heal on its own, or let my leg fall off, than go to a doctor... because they, you know, you go in, they treat you like shit."

#### DIFFICULTY OBTAINING HELP IN PAIN MANAGEMENT

Another common theme was people's difficulty in obtaining proper treatment for pain. Some people resorted to obtaining drugs illegally to ease their pain.

"I remember one time... I crawled into the hospital... I had wicked back pain.
I couldn't walk... They said, 'Oh, ... you were on drugs. On your record here, you
OD'd one time. And we can't give you no pain medication.' I said, 'What?' So I called
up my friend. He gave me a bunch of heroin. Man, I can't stand it. I went into the
bathroom, fixed up some heroin, 'See you guys later,' and I walked right out of the
hospital... it was ridiculous."

"I went in to have surgery on my head again. And these guys said, 'Oh, he's on methadone.

He doesn't need no painkillers.'"

### LACK OF INFORMATION ABOUT DRUG USE PRACTICES AND HARMS

Some participants felt that health professionals and service providers did not have enough information about drug use and the associated harms.

"I think all persons... should learn more about how we are using... because I went to a doctor once because I inhaled a Brillo and I went to the hospital and the nurse said, 'What happened?' 'I inhaled Brillo down my throat.' 'What is Brillo?'... They don't even know." [Note: brillo or crushed screens are used in the construction of crack pipes.]

#### COMMUNICATION BARRIERS

Sometimes health professionals used language that people did not understand, which created fear, confusion and barriers to good treatment.

"No, they use these big long words on me. I don't know what they're talking about half the time. I get mad and I walk out... They should use little words for me, so I can understand what they're talking about. They use these big long words. They should bring me a dictionary... I talked to her about that hepatitis C... They give me these long words and I start crying. I think I'm dying when I go to the doctor's office."

# Impact of health professionals and service providers

# IMPROVED HEALTH AND WELL-BEING OF CLIENTS, INCLUDING SAVED LIVES

Health professionals that adopted a harm reduction approach to care had a very positive impact on some of the focus group participants. Offering people options and focusing on the small successes went a long way to improving their health and well-being. Harm reduction messages may take time to make an impact, but after a while, they do sink in. A harm reduction approach may also reduce the negative consequences of drug use, such as losing one's housing. Ultimately, some service providers' interventions were even able to save lives.

"[W]hen I came here I was a mess. I was 95 pounds. I could barely speak. I couldn't walk properly. And the Cree clinic here is really good... I found that in the important times, it didn't matter when I used. They focus on the times I don't use. You stop beating yourself up and straighten up and that was my first step toward harm reduction."

#### SERVICE USERS FEEL VALUED

Health professionals who developed a good rapport with their clients made them feel valued.

"I think because of the rapport they feel like where no one is sub-human. The longer society turns their back to us they will always be part of the problem."

#### CLIENTS DEVELOP A SENSE OF FAMILY AND FEEL SUPPORTED

For some, service providers became their surrogate family.

"All my family is far away and I don't go back to my family, because my family judges me because I am a junkie, they fear me and all that. And for me, my family is here, at Point de repères. And when things are not going well, I come here and the girls take the time to listen to me."

"I have known Point de repères since '91, and it's in 2002, they could see that I was not feeling well, and they forced me to go to the hospital and all that. And that is when they told us we had HIV. So if it had not been for them, we would not have gone to the hospital and we would be gone. Because he had 2

CD4 and I only had 80.

We were not very

strong."

## Needs regarding health professionals and service providers

### MORE EDUCATION ON HARM REDUCTION APPROACH

Focus group participants said that both healthcare professionals and the general public need more education on harm reduction. They felt they were not getting proper care because current health practitioners are not sufficiently educated in how to treat people who use illicit drugs. They also pointed out that additional health professionals who understand the realities of their lives, as well as people with broader expertise in methadone maintenance, need to be recruited. Some participants said they needed more time to develop trusting relationships with their physician than current constraints permit.

"We need more doctors who understand what the addict is going through, never mind the book bullshit basically... Like one doctor we did have was addicted or used to be addicted. He knew exactly what it was like."

"It would be nice if the medical system would wake up and educate people in a different way, I guess. I don't know what it's going to take to get better services... I can't myself anyway go to a doctor and just disclose everything right off. It takes a few months, and by that time, that doctor's moved on... So I never really get the harm reduction part of the medical services that I require."

## 7. Education, Awareness and Information Dissemination

# What works and unique solutions for education, awareness and information dissemination

#### REFERRALS MADE BY SERVICES

People reported finding out about the services they needed through referrals while they were at shelters, drop-in centres or hospitals, as well as through word of mouth. That said, they identified the need for better information dissemination about available services.

#### SPEAKING IN SCHOOLS AND IN COMMUNITIES

Many focus group participants expressed the importance of speaking in schools or in communities about the realities of drug use. Some participants are already doing this, while others have not been able to gain access to schools.









#### EXPOSING PEOPLE TO THE REALITY OF PEOPLE WHO USE DRUGS

Exposing people to the realities of drug use and street life seemed to help change their attitudes and raise their awareness. It can be tricky to do while still respecting people's privacy and dignity.

"Well, I was going to say... the attitude with people that are coming here, regardless of whether it's people who work with Streetworks or... whatever, when they come down here, I know after a while, after they've been here for a week or two, their attitudes completely turn around."

"I took them out for Hard Night Out... I had to show them around, get them to where the people were using. I showed them the people who are using the crack cocaine a lot. But I didn't want to bring her around. I know how it is like people who go through stuff like that when you're high. I know how it is when you're high. You don't like people approaching you like that when you're high."

"It's not so much preaching the abstinence part of it, but also the harm reduction part. And if you are going to use, this is where to go. And that's the thing, because I realized we're not going to prevent everybody from using, but we can get people that are going to use to use safely and slow down the spread of HIV, Hep C, and overdoses."

### HARM REDUCTION MESSAGING

Some participants mentioned the importance of including harm reduction messages in the overall information about drug use, as this acknowledges the reality of drug use and contributes to disease and overdose prevention. One participant shared his experience that revealed that harm reduction messages are being absorbed into the drug-use culture.

Male Respondent: "But like observationally... I find that... this network of people that I know that use it, like they're pretty savvy about things like that."

MODERATOR (F): "So it's becoming part of the common culture, if you want... to not share equipment and stuff like that?"

Male Respondent: "Yeah. And you've got to educate them, exactly, like you're saying there. Like I've seen a couple of generations of... people younger than me. And I see changes."

### DISSEMINATING INFORMATION THROUGH A VARIETY OF WAYS

Participants suggested disseminating information through a variety of means, including pamphlets, word of mouth, and even through the radio.

# What does not work for education, awareness and information dissemination

# LIMITATIONS ON ACCESS TO SCHOOLS BY PEER EDUCATORS AND ON WHAT CAN BE DISCUSSED IN SCHOOLS

Although many participants felt that it was important that they speak to youth in schools and share their stories to help prevent problematic drug use, they mentioned that getting into schools was at times difficult or impossible. They were sometimes instructed on what they could, or could not, discuss with the youth, which often undermined the message.

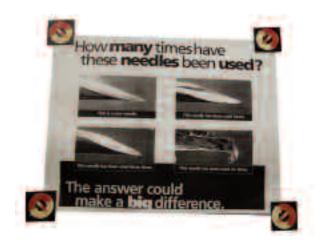
MODERATOR (M): "Can you talk about sex and drugs?"

Male Respondent: "Yes. It depends on where you go..."

MODERATOR (M): "Can you talk about harm reduction in the schools?"

Male Respondent: "Not really, unless it's kind of to make allusions to it. But you got to work it in..."

"Schools... we're not allowed to even speak because it's such a touchy thing... They can't even take condoms into the school. You know, if you're not even going to talk about condoms, are they going to talk about drugs? ... But I think that's one thing that needs to happen, because that's a big harm reduction tool, the people in this room. We've been there, we've done that, right. [...] We got to tell them the truth."



#### RELUCTANCE TO DISSEMINATE/POST INFORMATION

One participant wanted to put up a poster at a pharmacy on the risks of sharing cocaine snorting straws and hepatitis, but the pharmacy did not put it up.

"There's not enough education... I brought a poster down to the pharmacy and he didn't even put it up; about snorting and getting hepatitis."





## Needs regarding education, awareness and dissemination

INFORMATION DISSEMINATION ABOUT HIV, HEPATITIS C AND OTHER CONSEQUENCES OF DRUG USE TO BOTH THE GENERAL PUBLIC AND PEOPLE WHO USE DRUGS

Participants said that information dissemination regarding the risks of injection drug use must be increased. However, they also recognized that at times people sometimes find it difficult, if not impossible, to make healthy choices, even when they know about the risks of unsafe drug use. They also noted that people need to be informed about the risks of sharing straws for snorting cocaine and that there are some barriers to disseminating this information. The need for more harm reduction information in prison was also identified.

"More knowledge of consequences... If I knew back then what I know now, I wouldn't have suffered like I did half as much, about hep C, about AIDS, about sticking needles in my arm, about leaving scars in my arm."

"Hepatitis, you know you always hear about blood transfusion and needles. But [most] people in Newfoundland, I was told, are getting this from sharing straws. And that is definitely not advertised. I told some teenagers the other day and they did not know that."

# MORE COMPREHENSIVE, STREET-LEVEL EDUCATION AND AWARENESS FOR HEALTH PROFESSIONALS

The focus group participants identified the need to educate health professionals on how drugs are used and the harms related to their use. They would like health professionals to have more exposure to the realities of drug use and not rely exclusively on books, so that they would be better equipped to listen to and assist their patients. Participants also mentioned that it takes time to build a trusting relationship with a health professional before they will disclose their issues related to drug use.

# MORE EDUCATION AND PREVENTION INFORMATION ON DRUG USE FOR YOUTH

The need to educate youth about drug use was discussed in most focus groups. The participants wanted the youth to learn the truth about drug use, instead of propaganda. They mentioned the importance of speaking in schools, and of the messaging. Despite varying views about the "Scared Straight" program currently running in schools, the well-being of youth regarding drug use was clearly very important to them.

"Why not throw money towards education and prevention programs in the schools and have people that are living through these various different stages in life, whether it's being an addict, whether it's being HIV positive, whether it's being hep C positive ... share our experiences with the kids that are coming up in society."

Male Respondent: "Yeah, they tried a similar program, I think it was called "Scared Straight." And go back and look at that and how many people were scared straight? Not enough. Not many...

Male Respondent: "It worked for my son."

Male Respondent: "One out a hundred."

### HIV/AIDS EDUCATION FOR YOUTH

The focus group participants identified the importance of educating the general public, as well as youth, on HIV/AIDS. They discussed the need to inform people about the fact that HIV/AIDS is not the death sentence it once was, and that people are now living much longer, with a good quality of life. They mentioned the need to educate children of parents living with HIV/AIDS about the disease to ease some of the stigma. At the same time, they said it is also important to speak to youth about the prevention of HIV/AIDS and the realities and challenges of living with HIV/AIDS.

"I was a speaker/coordinator in --- for a number of years. And we went into schools all the time. It depends on how you portray your stories. You're sharing the emotional attachment to HIV, all the hardships that came along with it, the negative effects of the pills, the side effects. You're sharing all that with the crowd.[...] But it's all these little things with, in my case, with HIV and medications and the emotional bullshit that I went through... years of isolation when I first found out there was no services at all. There was no agencies... you know, these are little stories that I pick on, that I portray when I talk. That's why... there are positive messages that kids need to hear."

# INFORMATION DISSEMINATION TO PEOPLE WHO USE DRUGS REGARDING AVAILABLE HARM REDUCTION SERVICES

Some focus group participants pointed out the need to promote awareness about the various harm reduction services that already exist.

"It's not so much preaching abstinence, it's ways to get services if you are going to use. And that's something that I find is really lacking. People talk to people on the street and they don't know about these places. Then there's not enough information on it." "It's not the death sentence that it was and it's not the walking corpse look stereotype from 1981. You know what I mean? That's got to be brought out. And... something that I've always thought there's a missing approach is explaining to children of parents who are HIV positive... to send a message to younger people that mommies and daddies have HIV. hepatitis C and that mommy is not going to drop dead tomorrow."

#### EDUCATING POLICE ABOUT HARM REDUCTION

Some participants would like to see police better educated about harm reduction and the in-depth realities of drug use and dependence. It was mentioned that many police officers accept the fact that people will use drugs and that some seem to know that harm reduction is a good thing. However, they need to understand the importance of harm reduction's role in the context of addressing problematic substance use.

"Well the police, for one, they should also get a program to inform them. Because they don't know what it's like, they have no idea... In their mind, we shoot a needle in our arm and that's all they know. They really don't know more than that. If they knew a bit more and they knew what we do, why we do it..."

"A cop on TV the other night was saying, 'How do I explain to my child who's in high school that my employer employs me to arrest people that do drugs. And my employer has a van that runs around giving people supplies?' And there's a policeman saying, 'How do I explain that?' He should know how!"

"Yeah, compassion, yeah. We really need it because there's a lot of people going through it. If they know one, 'Hey, you need some help, you come see me. I'll help you through, whatever.' I've been there."

# OTHER NEEDS RELATED TO EDUCATION, AWARENESS, AND INFORMATION DISSEMINATION

Other identified needs included: a drug users resource centre; training on how to speak in schools; education to raise awareness about and understanding of people who use drugs, especially pregnant women who use; education to address stigma and encourage compassion; dissemination of relevant information, including bad date lists, to sex workers everywhere; life skills training for inmates to prepare them to reintegrate into society; and support networks for families and people affected by people who use drugs.

"We do need an open heart, open mind, open arms for these young women who are pregnant and using, instead of scaring them off into a corner with a pipe or whatever the hell they're doing, you know, because... the pressure will make you want to use more. So there's got to be more understanding. Like, come on, it's an illness. It's not that you're doing it because you're an asshole. No, no, no. Me, of all people. I never thought I would go through a pregnancy like that. I just said to myself, you know, I'm intelligent. I never, ever thought I would..."



### 8. Outreach Services

## What works and unique solutions for outreach services

#### PEER OUTREACH

Peers are in a unique position to do outreach with people who do not access services. Sometimes they fill in service gaps by distributing food, new injection equipment and information. In addition, they sometimes volunteer to help out existing outreach services.

"One of the street guides is going to start walking around with food."

"The street guides are a great thing because they reach a clientele that does not always come to Point de repères."

### **OUTREACH WORKERS AS SUPPORT**

Participants often expressed the importance of the support they receive from outreach workers, which ranged from moral support, accompaniment and a listening ear. One participant sought and received assistance with his hepatitis C treatment injections from outreach workers at a drop-in centre, as doing it himself was a trigger for him.

"So I use the girls at --- to inject... so that it doesn't trigger me with the needle. And just as a moral support. They come with me when I go to see the psychiatrist and go see the liver specialist."

#### HOME DELIVERY BRINGS SERVICES TO THE PEOPLE

Home deliveries were greatly appreciated as a way of getting services to the people who needed them.

"With outreach van. With outreach workers. They'll bring it to you... They will do that.

Although they're not mandated to do so, they will do it because they understand. People are fucked up and they don't want to go out. So what happens? Magic happens."

"Bring the services to them because a lot of people won't come."

#### GOOD EXPERIENCES WITH THE OUTREACH VAN

People who had used the services of an outreach van appreciated that they showed up at the time they said they would, and that the workers had a good rapport with them.











#### STREET GUIDES - BY PEERS FOR PEERS

One program in Québec City trains peers to be "street guides" (peer helpers). This program was created by peers for peers and is working well, according to participants in the program. They developed resources to provide information on services, including wound care and safe injection, among others. A similar program is being developed for sex workers.

Moderator: "And how did you get involved in that?"

Female Respondent: "Well it's been a year and a half now. We came here. We went through some training and we got involved. And now, we have been involved for a year and a half. We got our diplomas. Yes, we are making babies, the little booklets."

Female Respondent: "Well we each have a project. I have my project... My project is on youth... that come to Québec. [It] help[s] them find a place to inject, equipment, places to sleep, all that. This is the project I want to start."

#### **OUTREACH IN PRISONS**

Outreach in prisons, which was made possible through partnerships with Corrections Canada, was considered effective and worthwhile.

### What does not work with outreach services

#### LIMITATIONS OF OUTREACH SERVICES

While discussing outreach services, a few limitations were mentioned. Outreach workers cannot be everywhere, nor can outreach vans, and some people feel they have to chase them around. Outreach services may not be available every day, and there may be only one van to cover a whole city. One person felt that outreach workers were simply feeding an addiction and not really providing access to essential services such as housing and food.

"So in a way it was good that they're trying to be going around and get you to get clean... and... at the same time they're still not giving you any help. They're just helping me feed my addiction even more. You know the stuff is clean... but that doesn't put a roof over my head or food in my gut."

"I mean there's one van to cover one city. And not only that, they have their spots where they stay and sit for 20 minutes or... Well, they're usually out of the way. But on Main Street and things like that, they sit for 20 minutes so the people who use in those neighbourhoods, they would know that the van is there and they can go there to get them, whatever. But to cover a city and you only have one van... and then like I said, again, on Sundays there's really nothing. So that's the part that bugs me. People need clean syringes all the time."

# DIFFERENCES IN PRACTICE WITH RESPECT TO SAFER CRACK USE KITS FROM OUTREACH VANS

Not all outreach vans were handing out safer crack use kits, and there were differences in how the kits were distributed, depending on the city. In Winnipeg, for example, people reported that the outreach van does not do home visits in response to requests for safer crack use kits. People have to know to ask for one because the outreach workers will not volunteer that they have any.

#### FEAR OF APPROACHING OUTREACH VAN

Some people are too shy or ashamed to approach the outreach van.

Female Respondent: "I remember I was like that and I was scared to just to walk up to the needle van and, you know."

Male Respondent: "There's a lot of shame."

## Impact of outreach services

#### VERY IMPORTANT UNCONDITIONAL SUPPORT – SAVES LIVES

Sometimes the unconditional support of outreach workers can mean the difference between life and death. Simple things can do it, like letting them know you believe in them, or visiting them when they are hospitalized.

"In 2002, I turned 50 and my goal for the year was to die. And I ended up in the [the intensive care unit] and [an outreach worker]... came over when I came to after three days. And she gave me a slap in the head, she did, she gave me a slap on the head. I said 'Why d'you have to do that?' She said, 'That's the only thing that you deserve.' She gave enough belief to give it one more try. I'd just failed so many times trying to quit. And she got me over to a long-term care facility. For three years I was in and out of God. And it gave me back my spirituality. It gave me back my mind. It gave me back my physical health. And without [her] there to begin with, I would... When I came to I was angry... Now I've got a purpose."

visit me a couple of times when I was in treatment so it was just, you know, very supportive... So just having people from the community that I knew come out and say hello. It was a lot, it was great. It kept me... you know, I was suicidal and stuff, having something... But just having the staff from here show up, you know, was very beneficial."

"They come and



## Needs regarding outreach services

# BETTER INFORMATION DISSEMINATION REGARDING OUTREACH SERVICES

The need for more effective or concerted information dissemination about outreach services was identified.

"They should have more people, instead of going to the van, just have a couple of vans driving around. Because on the weekends and Sundays, everybody wants to use on Sundays. I don't think people are going to relax on Sundays. When they have money in their pocket, do you think they're going to stay at home and sleep in their bed?"

# MORE PERSONNEL, MORE OUTREACH VANS, LONGER OPERATING HOURS

The focus group participants also stated more outreach workers and vans were needed in order to extend hours and days of operation.

## OUTREACH SERVICES THAT GO WHERE THE PEOPLE ARE USING

Outreach services need to go where people are using.

"Services that go out to the people. Go out to the riverbank [an area where homeless people encamp]."

#### MORE OUTREACH IN PRISONS

More outreach is needed in prison.

"As a junkie, this is where I find the best services and I find that important. If they were not here, I don't know where I would be now and I probably would have used an old needle or something. Especially with detention, it's important that they get involved even more. Because it helped me a lot when I got out, they guided me, and well, my hat's off to them!"



### 9. HARM REDUCTION AND DRUG POLICY

Some focus group participants discussed the current drug policy in Canada and the importance of including harm reduction as an approach to address problematic substance use.

# Frustration about harm reduction being eliminated from federal strategy to address problematic substance use

A few participants were frustrated with the current government's approach regarding problematic substance use. They did not appreciate the omission of harm reduction in Canada's National Anti-Drug Strategy.

"As far as I know, we are under the World Health Act here in Canada, yet we follow the [Americans] so closely. It's a farce, as far as I'm concerned, but a lot of the governments are trying to do it... in the budget. Cut the safe injection sites. Cut funding for needle exchanges. Cut funding for this."

"I was on a conference call this morning where a lady who represented the Canadian CCSA or whatever... She said that they get their funding from the government, but yet they are not allowed to even mention the word "harm reduction" when they're speaking to a government official. Well, come on, people, wake up and smell the coffee! I mean, Starbucks is not going away, and neither is addiction. So get with it."

# Harm reduction important as part of continuum between abstinence and use

One participant summarized his view about the importance of including harm reduction as part of a continuum between abstinence and use.

"[S]ociety has to start offering an alternative to the two choices that are given. It's "abstinence" or "user". And in the middle are these programs for harm reduction...

Society thinks that given enough time, they will be able to educate everybody into abstinence... [I am] old enough to decide for myself what I want to do with the rest of my life, and at this point I'm not going to be abstinent ever, except by my choice when I choose not to use. Nothing they're going to threaten me with is going to change [that]. Harm reduction is very, very important as an alternative."



## Questions regarding whether more research is necessary

At the time the focus group discussions were held, many media reports focussed on the government's reluctance to continue to fund harm reduction programs such as Insite, Vancouver's safe injection site. The government was calling for more scientific evidence about its effectiveness. Some participants were frustrated with this, given that so much research had been conducted and published internationally.

"Addiction is not going to go away. People are open-minded and that's good to an extent. We need to get people to start thinking [of it] as a social issue. So, if you look at Europe, where they've got... we've got a NAOMI Study here in Vancouver, for pharmaceutical heroin, right? It works all over Europe. They spent 10 million dollars on that study... And are West Coast Canadian addicts that much different than somebody in Europe?"

# Call for viewing drug use as a social issue – enforcement does not work

Some participants also felt that law enforcement was not the way to address problematic substance use and called for it to be viewed as a social issue.

"I see it as a social issue. You know, whereas, mandatory sentencing, that's great, you're going to give me two years for selling a piece of crack, but the guy I got from, you're never going to get him and when you do, he walks out the door. So I look at it as enforcement, enforcement doesn't work, right?... We've been trying to cure alcoholism for how many years? 80 years? Have we succeeded? No. How are we going to cure addiction?"

# Mixed messages regarding alcohol and street drugs under prohibitionist approach

Some participants felt that the current prohibitionist approach to drug use was sending mixed messages regarding the use of alcohol, as opposed to the use of illegal drugs.

Female Respondent: "You can go out Friday night and have a beer and you can be the worst ignorant son of a bitch when you're drunk, but you know what, it's OK."

Male Respondent: "But I go out and do a hit of blow, 'Oh, he's a fuckin' drug addict."

# Proposed alternatives to current policy: legalization of all drugs, with education and regulation

Some participants felt that drug use issues would be better addressed by legalizing and regulating all drugs, and providing education around their use and potential harms. This alternative approach would also eliminate the profit motive for crime, though some felt that criminals would simply find other sources of revenue. Participants also suggested that regulation would improve drug quality and assist users in identifying drugs, which would enable them to make informed choices, resulting in safer use.

"[T]he best harm reduction that we're going to see, if we do see it in our lifetime, will be the legalization and the dispensation of all drugs legally. Then you're going to have no profit motive with the crime, with the criminals. You're going to see no gangs trying to take over projects where poor people live. And people will be free to make the choices in an intelligent way, with facts... not with anecdotal information or propaganda. Drugs don't kill. Ignorance does."

Impact of end of prohibition on lives of people who use drugs – no need to support habit by illegal means, to forfeit children to children's aid, no need to run safe houses; improved personal safety

Finally, some participants stated that the end of prohibition would create a number of positive changes in their lives. Among those mentioned were: that they might be able to keep their children; that they would no longer have to support their drug use through illegal means; that they would no longer have to create safer-use environments in their own homes, so that their peers could use drugs in a manner which would reduce the possibility of harm; and that their personal safety would no longer be compromised by putting themselves in dangerous situations to obtain drugs.

Moderator (F): "[...] if the drug laws were to change, how would that change your life, like your particular life?"

Male Respondent: "I wouldn't have got arrested last night. I wouldn't be going to jail.

I mean, yeah, it would change my life because I'm supporting my habit by illegal means.

So there."

Female Respondent: "I would have my children."

Male Respondent: "I wouldn't have to run safe houses like I have for the last 17 years."

"It's not so much the drug itself, obviously, but also the getting and the using of it — the people and the places it takes you to get the drug. That's the whole lifestyle aspect of it, and that's really what brings you down to your bottom."

"I believe anybody over the age of 21 should be allowed to do whatever drug they choose to do. And if the people are educated then they can look at literature to support their choice."



# **SUMMARY OF SITE VISITS**



# 1. WHITEHORSE, YUKON TERRITORIES

#### HARM REDUCTION CLIMATE IN WHITEHORSE

The story of the harm reduction in Whitehorse is inspiring. People in Whitehorse seem generally receptive to harm reduction programs, thanks to the efforts of the Substance Abuse Prevention Coalition described below. At the same time, initiatives such as the Safer Community and Neighbourhoods (SCAN) legislation suggest that there is still a struggle to find ways to address the complex activities related to substance use in the community.

The challenges Whitehorse faces include limited financial and human resources and difficulty attracting skilled people with knowledge and expertise in the field of harm reduction. Agencies have developed a coalition model to work around these issues. Multi-agency coalitions in Whitehorse have enabled the community to operate an outreach van service and, more recently, a safer crack kit program.

Working with the Aboriginal communities also has its challenges.

"There is still not a whole lot of understanding about harm reduction among the elders... it's been really seen as the way to go to get the elders on board in terms of understanding, and that will have a big impact. It's a slow process and there are lots of other things we need from our elders. We are trying to get our elders to help with the healing and the alcohol, and a lot of the elders are raising their children's children because their children are a lost generation. It's so tough."

- Patricia Bacon, Executive Director, Blood Ties Four Direction Centre

#### SAFER COMMUNITIES AND NEIGHBOURHOODS LEGISLATION

In November 2006, the Yukon government's Justice Minister Marian Horne announced the implementation of the Safer Communities and Neighbourhoods (SCAN) legislation, part of the Yukon Substance Abuse Action Plan, designed to provide Yukon citizens with a safe and confidential method to deal with specific illegal activities.

The legislation allows citizens to call the SCAN office when they suspect that activities such as producing, selling or using illegal drugs, sex work, solvent use or the unlawful sale and consumption of alcohol are taking place in their neighbourhood. Complaints trigger an investigation by the SCAN team of law enforcement personnel, and suspect dwellings are marked with vivid lime green signs. "Remedies" can result in closing down the house and providing alternative housing and support for children, as well as support and treatment for the house dwellers. As of June 2007, the SCAN office had received 96 complaints on 75 different properties. As a result, there were nine evictions, one official warning, and seven properties had ceased activity voluntarily. There are some concerns, however, about the constitutionality of this legislation and one lawyer is looking into this. As well, people who use drugs are being driven underground and hence are more difficult to reach with essential services. 16

Although the SCAN legislation suggests a hostile climate for harm reduction in Whitehorse, this is not so. The Outreach Van, known for its harm reduction programs of needle exchange and safer crack kit distribution, is widely accepted and supported by community volunteers, small business owners, and several non-for-profit organizations. Furthermore, the introduction of the Safer Crack Kit program in Whitehorse in December 2005, met with no resistance either from the media, local politicians, or the public. The territorial government, however, does not financially support crack kit distribution. Cost of this service has been picked up by the Rotary Club. Generally speaking, harm reduction programs are allowed to run in Whitehorse uninterrupted by local politicians, police, or public. However, the SCAN legislation did serve as a painful reminder that there is still much work to be done in Whitehorse concerning advocacy for people who use drugs.

<sup>&</sup>lt;sup>16</sup> For more information, visit http://www.gov.yk.ca/news/2006/06-233.html and http://www.gov.yk.ca/news/2007/07-184.html.





# NO FIXED ADDRESS OUTREACH VAN – A COALITION MODEL THAT WORKS

## History

In the early 1990s, a group of people from a diverse cross section of the community — Blood Ties Four Directions, Yukon Family Services Association, Yukon College, an outreach worker and a nurse from Kwanlin Dun Health Centre — came together to write yet another report about substance use in Whitehorse. They decided it was time to take action and the Substance Abuse Prevention Coalition was born. The "SAPC" undertook a number of initiatives including the production of pamphlets targeting students and water distribution programs for alcohol-related events.

"The van is a big one. Big one. Angel network."

focus group

In 2000, an outreach van program was proposed to address some of the needs of the community. A brainstorm took place. Yukon College owned an old ambulance that they donated to the initiative; Yukon Family Services, Blood Ties and Kwanlin Dun offered staff in the capacity of outreach workers to run the van; a concerned community member offered to make sandwiches, and is still making them five years later; and a number of community businesses donated gas, coffee, and donuts. Two months later, the No Fixed Address Outreach Van program, offering needle exchange, hygiene supplies, hot coffee and soup three nights per week, was launched.







"Very nice to see that we have that option to help with the van. It goes to the communities and everything. That's very important, I think."

- focus group

### **Operation**

Today, the outreach van has expanded its service and programs to six nights per week and operates under the aegis of Many Rivers Counselling and Support Services, Blood Ties Four Directions Centre, Kwanlin Dun Health Centre and Kaushee's Women's Transition Home. However, in the early days of the van program, it was entirely run by the SAPC. Even today, although no longer under the auspices of the SAPC, the van is not owned by any one organization. Four organizations share ownership of the program, which has ensured continuity of service, even though some organizations have lost funding. In the early days of the van operation, the coalition was an effective way of uniting agencies, individuals and community members to address a problem within the community. The Coalition is operated entirely by volunteers whose actions are determined by terms of reference. Membership is open and people can join and bring their ideas.

One benefit of the coalition model has been that members learn from one another and from their shared experiences. They then bring this knowledge back to their own communities and agencies. This has allowed information about harm reduction to be disseminated across a wide and diverse section of the community and has helped to gain support for controversial issues such as the safer crack kit program.

A challenge for the Coalition has been the difficulty funders have in understanding the organization's structure and their reluctance to fund a coalition. Therefore, whenever funds from the territorial or federal government are available, one of the organizations from the coalition will apply for the funding, then channel those funds to the outreach van program.

It was also a challenge for the Coalition to develop policies and procedures for the van program that worked for all the participating agencies. The Coalition built into the policy manual (one of the first of its kind in Canada) a caveat that agency policies supersede van policies if and when contradictions in program policies arise.

During the first five years of the outreach van program, the Coalition was responsible for the vision, roles and responsibilities with regard to all operations of the outreach van. The day-to-day operations did sometimes get confusing, given the number of partners as well as serious time demands. A van coordinator was hired under contract to help with the van operations.

After about five years of two, and sometimes three, nights per week of van service, with no decrease in demand for service, the Coalition lobbied the Yukon government to become a funding partner for the van. They signed on in the fall of 2006, and in February 2007, the van services expanded to six nights per week. Due to the greatly expanded program and the desire of the territorial government to work with one organization, rather than a coalition, ownership of the van program transferred from the coalition to four key service delivery partners: Many Rivers, which holds the

contract with the government and provides counsellors; Blood Ties Four Directions Centre, which works under subcontract with Many Rivers and provides health educators and harm reduction specialists; Kwanlin Dun Health Centre, which provides nursing staff; and Kaushee's Place Transition Home, which provides crisis counsellors.

#### **Services**

The van offers: new injection equipment; food and beverages, including hot soup in the winter months; safer crack use kits; clothing, especially mitts, hats and socks; hygiene supplies; condoms and lube; support; and referrals. Staff from four agencies shares the shifts and include nursing staff, staff for health education, counsellors, and crisis counsellors.

Over the years, the number of people the van serves has steadily increased as the van has gained the trust of people who use drugs. While in the first year they served about 11 or 12 people an evening, the van now serves 70 to 90. The program still relies on volunteers to make sandwiches, prepare the hygiene, injection equipment kits and safer crack use kits, and to donate socks, collected through the local CBC radio's annual winter sock drive. With the introduction of the Safer Crack Kit program, new clients came to the van, which meant an opportunity to provide outreach and education to a new cohort of people who use drugs.

The territorial government supports all of the services provided on the van, except the ever-controversial safer crack use kits. Therefore, funding for the purchase of crack kits has been secured elsewhere.

To date, there are few or no harm reduction programs in the rural Yukon communities. Needle exchange services are available; however, there is a lot of reluctance to use these services as the concern about confidentiality and anonymity remains high among those who live in rural communities. The van does not reach the rural and outlying communities.

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#### SAFER CRACK KIT PROGRAM - GETTING COMMUNITY BUY-IN

Offering safer crack use kits has been a challenge for many cities across Canada. Whitehorse developed a creative way to offer this service, which included obtaining community buy-in.

The Coalition proposed the idea of offering safer crack use kits about two years ago, recognizing many people in the community were smoking this drug. Since the outreach van was already operating, it seemed like a good place to offer the kits. Blood Ties Four Directions also wanted to have a safer crack use kit program offered on-site, through their needle exchange. Both programs were launched in December 2005, after an eight-month process.

#### The Process

#### **BUY-IN**

The Coalition wanted to launch this program right and get buy-in from the community, media and police. First, the Coalition members had to be brought on board. Members representing government departments did not have the authority to vote on the issue and had to take it back to their managers for final say. In the end, many of the members who were government representatives had to abstain from voting on the launch of this program. This process took about three to five months, with a meeting every two weeks. Eventually, there were enough NGO coalition members and private citizens to carry the vote.

At the time, there was no police member on the Coalition, though there had been a representative from the RCMP on the Coalition in the past. Informal discussions about the safer crack kits were thus broached with the RCMP. While they would not directly support the program, they indicated they would not interfere, and have not to date.

During the negotiations, the outreach van's patrons were asking for the safer crack use kits and wanted to know when the program would be implemented. The van workers had to explain that there were politics involved.

## **Proactive Media Campaign**

The Coalition also wanted the media on board. Yukoners are very progressive, and harm reduction, overall, is well accepted. Nevertheless, the Coalition developed a proactive media strategy. They released a story to the media about the safer crack use kits in advance of the launch. It was a progressive story which was well received. There

were no letters to the editor, no rants, no raves. They also prepared media kits for all of the NGOs that were involved in the Coalition, so that they could respond to the media once the program was announced. In December 2005, the program had a successful launch. Their foresight had pre-empted any fearful reaction from the community.

## Logistics and Supply

Once there was agreement to launch the program, the Coalition had to deal with logistics, such as kit contents and best practices for distribution of the safer crack use kits, so a sub-committee was struck to address those issues. Furthermore, a protocol was developed for dealing with youth and new clients accessing the van for crack kits.

Once the program was up and running, the biggest issue to deal with was the supply of equipment for the kits. The outreach van was operating two nights a week at that time, and the initial demand for the kits, through both the outreach van and the needle exchange program at Blood Ties, increased more and sooner than expected. Both the Coalition and Blood Ties had serious difficulties obtaining brass screens for the kits and they ran out of them by mid January 2006. The only supplier in town was the person who ran the local head shop (where paraphernalia is sold), and he did not want to order the screens because he did not want to be associated with 'crack heads'. Since the best practices guidelines stated that workers would only hand out complete kits, this caused an interruption in the program. They also ran out of lip balm.

#### **Lessons Learned**

For the first four months, there were constant interruptions in supply, which caused friction with clients. Patricia Bacon has a suggestion for those looking at implementing such a program: "Ensure your supply problems are well worked out and anticipate three times the demand that you think you are going to have." Supply problems were resolved by March 2006, and there have been no interruptions in the program since.

## Status of the Program

Blood Ties has been able to track data on safer crack kits through their in-house harm reduction program. They now have a year's worth of data. They had expected to see some new clientele when the program was launched, and indeed they have. They are also seeing a big difference in the clientele. The safer crack use kit program has overtaken the needle exchange program with 62% of clients accessing the fixed site program at Blood Ties solely for safer crack use kits. They are also seeing more women – 77% of people using only the needle exchange program are men and 23% are women, whereas for the safer crack use kit program, 66% are men and 34% are women. Blood Ties is now looking at how accessible, barrier-free and progressive these programs are for women.

As for ethnicity, 41% of the syringe-only population are from First Nations, while 74% of the safer crack use kit program clients are from First Nations. The safer crack use kit clients are also younger than the needle exchange clients by four to seven years. It is speculated that the van program's data is similar to that of the fixed site; however, the van is unable to keep and track statistics in the same way that the Blood Ties in-house harm reduction program does.

Despite the demand among younger individuals, the territorial government has an issue with serving people under the age of 18. The Coalition has developed some practice guidelines to address this. The programs will not discriminate based on age, so it is only an ongoing issue for the funders. As Patricia Bacon states:

"What do we say – because you're 17, you don't have a right to comprehensive health, but if you are over the age of 18 you do? You know, it's crazy. So we don't discriminate based on age, but it is an issue with funders and it hasn't fully gone away in the sense that we recognize our vulnerability because they won't fund that aspect of the program. And it's a big part of the program. We need to make sure that we have other NGOs and other sources of funding to help us ensure that the crack kit program isn't interrupted."

Funding for the safer crack use kit program is currently provided by the Rotary Club. This year, the Kwanlin Dun First Nations Health Centre had some year-end money, so they purchased \$2,000 worth of crack kits – half for the van, half for Blood Ties. Funding remains a concern.

"I go to Blood Ties myself, talk to the counsellors or whoever's there and I find they're very helpful. They practically stop what they're doing. If you've got something on your mind and you want to get it out, they're very good, they have a willing ear to listen."

– focus aroup





#### **BLOOD TIES FOUR DIRECTIONS CENTRE**

The Blood Ties Four Directions Centre provides support and education about HIV/AIDS and hepatitis C for individuals, families, agencies and communities. Blood Ties is a member organization of the Canadian AIDS Society. They provide a drop-in centre, a street clinic, individual and family support, needle and injection equipment distribution, and safer crack use kit distribution. They are also a partner in the operation of the No Fixed Address Outreach Van.

Blood Ties is a very welcoming centre with a drop-in area where people can relax, chat and use a computer. They have an in-house area that offers needle and injection equipment, safer crack use kits, as well as hygiene kits which include shampoo, soap, a toothbrush, a razor, and pads and tampons for women. From January 1 to December 31, 2006, they had 707 unique clients accessing their services, 62% of whom requested safer crack use kits.

They keep a database to document the number of people they serve and the supplies they distribute. When a client comes in, they use the client's date of birth as a unique identifier. They also collect information on gender and ethnicity. The database allows Blood Ties to invoke a complete client history. While the outreach van keeps some statistics, mostly counts, details about individuals are not recorded.

It is interesting to note that the on-site needle distribution and crack kit distribution services are still just as busy, despite the fact that the outreach van increased its services from three to six nights a week a few months ago.

Other services Blood Ties offers include: scheduled visits by a naturopath and a nurse, food programs and client drop-offs and pick-ups for various appointments.

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# 2. VICTORIA, BRITISH COLUMBIA

# Society Of Living Intravenous Drugusers - "People Helping People"

The Society of Living Intravenous Drugusers (SOLID) is operated by and for people who use or have used drugs. It provides education, harm reduction services, peer support and outreach with empathy and understanding. Their services include needle and injection equipment distribution, food distribution, information and education about safer and more responsible use, peer-to-peer interaction and a support group. They also work with agencies in the city to assist people who use illicit drugs. Subscribing to the principal of "Nothing about us, without us" SOLID advocates for the involvement of people who use drugs in program planning and delivery, educates agencies on the realities of working with people who use drugs, and addresses issues of stigmatization. SOLID is also the voice of experience at community meetings where issues that affect the lives of people who use drugs are being discussed and deliberated. The organization is run by people with drug use experience and continues to operate despite severe financial challenges.

SOLID has a good relationship with the police. They have a policy of establishing a safety zone or "bubble zone" within a one-block radius of locations where they hold a meeting or any group activity, or where their outreach van (RIG X) is parked. Within the bubble, members of SOLID agree not to use, make plans to use or discuss sales or purchases of drugs.

The two RIG X vans are property of members, who use them to provide services. Some services are also delivered by bicycle.







"When I found out I had hep C, SOLID... was a really big thing... I felt like I really had peer support."

- focus group

## **Challenges and Barriers**

As a drug user group, SOLID has experienced great difficulty in obtaining funding. Funding was finally obtained and an office space is now available. They resist being part of an organization such as an AIDS service organization as they feel, rightly, that the needs of people who use drugs are distinct, largely because of the illegality of drugs and level of stigma and discrimination which drug users experience. For similar reasons, it is also a challenge for people who use drugs to come forward and be in the public eye, attend meetings or be spokespersons on behalf of SOLID.

There are also policies that impose limitations on the services SOLID is able to provide. For example, as one member describes:

"[The] SOLID [van] only does two routes a week, though. We have to make that clear. Right now we have a Sunday afternoon slot... and a Wednesday evening slot. One of the reasons about that is we're not to duplicate services. When other services are open, we're not to duplicate that."

SOLID overcomes its challenges with perseverance and the dedication of its members, and by capitalizing on the community and agency support that does exist. Involvement in SOLID provides its members with the satisfaction that comes from helping and supporting their peers, knowing that they are contributing to the prevention of diseases, such as hepatitis C and HIV, and supporting the rights of people who use drugs.

#### **Needs**

SOLID members would like to see funding made available for the operation of drug user groups across the country and for the establishment of provincial and national users' groups.

One of the focus group participants recently died. He was homeless. His death highlights the impact that the lack of housing, support and other services has on the poor, marginalized and criminalized people in the Victoria area, and elsewhere in Canada.

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# PROSTITUTES EMPOWERMENT EDUCATION RESOURCE SOCIETY – BY AND FOR SEX WORKERS

The Prostitutes Empowerment Education Resource Society (PEERS) is an organization of sex workers for sex workers. PEERS' programs and services are offered by PEERS staff members, most of whom are sex workers, who use their life experience in the sex industry to know where and how to connect with and relate to other sex workers. PEERS serves both outdoor and indoor sex workers and has specific outreach programs targeted to each group. Through an outreach van operating seven nights a week, they distribute injection equipment, clothing, food and beverages, and bad date lists, and provide support and referrals. PEERS has offices in Victoria, Vancouver and Prince George.

The PEERS site in Victoria provides support, resources and programs for past and current sex workers, male or female, as well as help with housing and training, volunteer opportunities, advocacy, and public education on sexual exploitation and the issues of adult sex work. There is an inviting and open drop-in area, painted in bright colours, where people can hang out, have a coffee and snacks, and socialize. Street nurses, counsellors, medical doctors and a psychiatrist are available on schedule to provide care as needed.











"I belong to...a program called PEERS... if someone needs to have someone listen to them or stick with them or whatever, whatever they need... just company."

- focus group

## **Elements Program**

The PEERS Elements Program is a multi-phase program designed for those wanting to transition from the sex trade to more mainstream employment or education. The program assists participants in removing barriers to leaving sex work and provides support in finding safe housing, recovery from addictions, budgeting, self care and developing healthy relationships. Other elements include training and education in life skills, job readiness (through career exploration), computers, workplace standards and expectations, résumé preparation and interview skills, as well as health and lifestyle change information and support, and volunteer placements. Personality assessments are also conducted using approaches such as the Myers-Briggs Type Indicator.

The program also offers parenting information and support, and childcare top-up as needed.

PEERS staff provides support to participants throughout this program and offers incentives for good attendance.

Recreational activities are also organized for participants.

# PEERS Owns Its Building

One unique feature of PEERS is that it owns its own building. This provides much needed stability and sustainability for a not-for-profit organization. The purchase of the building was made possible by generous donations from private donors.

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# THE CANADIAN NATIONAL COALITION PILOT ADDICTIONS TREATMENT MODEL SPECIFICALLY FOR SEX WORKERS

Traditional drug treatment programs have often failed to work for sex workers, as they focused only on drug use issues and ignored factors directly related to working in the sex industry. In response to this shortcoming, the Canadian National Coalition of Experiential Women (CNCEW) obtained funding from the federal government for a pilot addictions treatment/relapse prevention program for sex workers to be situated in an existing residential treatment facility in British Columbia. This innovative model is the first of its kind in Canada and was designed by sex workers to address the complex relationship between addiction and sex work. The model embraces a harm reduction approach to treatment.

"PEERS. I love PEERS."

- focus group

CNCEW found a treatment centre in Kelowna, BC to house the program. Lauren Casey, Executive Officer, CNCEW, explains:

"We wanted to be in a centre that used a harm reduction approach, that didn't have the 'You have to have 30 days clean before you can get in; if you're caught using, you're kicked out.'... They have the whole continuum on site, they have detox on site, they have 28 residential beds. They were very open and excited about piloting this model."

The program began operations in May 2007 and has now become a part of the PEERS Elements program.

# VANCOUVER ISLAND COMPASSION SOCIETY - SAFER ACCESS TO CANNABIS FOR MEDICAL PURPOSES

The Vancouver Island Compassion Society (The VICS) is a registered non-profit society which provides a safe source of cannabis to people throughout and beyond Vancouver Island. It has been operating since 1999.

Although compassion clubs remain illegal in Canada, some court decisions have acknowledged they provide a valuable community service. Not all compassion clubs are created equal, and the VICS operates as a community-based non-profit society, with a Board of Directors and a membership to which it is accountable. Members have a vote and a voice in the operations of the organization.

In collaboration with the British Columbia Compassion Club Society in Vancouver, the VICS has produced the "Guidelines for Community-Based Distribution of Medical Cannabis". Clubs throughout Canada can voluntarily adhere to these guidelines, which set standards of service in the absence of an official regulatory system.

# Reducing the Harms of Obtaining Cannabis for Medical Purposes

#### SAFE ENVIRONMENT, SAFE PRODUCT

In the context of harm reduction, the use of cannabis is rarely mentioned. The VICS has been included in this report to illustrate its role in providing cannabis for medical purposes, while reducing the harms associated with obtaining cannabis from street dealers. "The VICS provides a safe environment..., which we test... other contaminants", says Philippe Lucas, Founder and Director. They offer a selection of cannabis strains and work with their members to find the strain most suitable to alleviate their symptoms. To obtain a membership to the VICS, one must provide a letter of support from a physician or health care practitioner specifying the need for cannabis for a medical reason.

"I also felt that the benefits of marijuana would be better for my health than the benefits of methadone. So I smoked marijuana continuously for two years as a form of my detox. And it worked. Now, I don't smoke marijuana at all."

- focus group





#### ALTERNATIVES TO SMOKING

To provide options to their members and to reduce potential harms to lung health, the VICS offers alternatives to smoking cannabis, such as cookies, oil and tinctures, along with information on how to use cannabis and other cannabis-based products safely and effectively. They also promote the use of vaporizers. These devices heat cannabis below the point of combustion and vaporize the oils found in it that contain the active compounds called cannabinoids. This provides medical users with the benefits of inhalation – quick effect, ease of dosing – while virtually eliminating the harms of smoke by-products. The VICS has a vaporizer on-site for its members to try and see if this is an option for them.

## Cannabis as a Harm Reduction Approach to Drug Use

The focus group discussion introduced the concept of using cannabis as a means to get off of other drugs, in addition to addressing its medical benefits, which include: alleviating nausea and vomiting; stimulating appetite; relieving muscle pain and spasms; reducing the frequency of seizures; lowering intraocular pressure, in the case of glaucoma; and relieving various other types of pain. Please consult the Drug Substitution section, in Section 2 focused on Methadone Programs, in the Focus Group Summary.

#### Other Services Offered at the VICS

The VICS pursues other aspects of harm reduction, including minimizing financial difficulties from purchasing a therapeutic product that is not covered by health insurance. They do their best to provide cannabis to members at the lowest price possible and have a donation program to assist those who cannot afford enough cannabis for their medical needs.

The VICS offers a resource board with community information and job opportunities. They have an annual food drive, an ongoing clothing exchange bin and an annual cold weather coat and blanket drive. They have a small library of books that their members are free to use, and they provide referrals to other services and information on cannabis and various medical conditions.

Perhaps the most beneficial aspect of membership in the VICS is the creation of social capital that comes from annual social events and occasional volunteer opportunities.





"I am a crack addict and I do find, every now and then I go smoke a little bit of weed, and that does help me."

- focus group

# Relationships with the Community

The VICS has worked at establishing good relationships with its neighbours. They consulted them before moving into the neighbourhood and, to address their neighbours' concerns, maintain a strict policy of not allowing cannabis use around the building. They have built a good relationship with local police and also adhere to a strict zero-tolerance policy of not allowing their members to sell their cannabis to anyone. Failure to comply with this policy results in loss of membership.

The VICS provides information sessions for health care organizations and performs outreach to inform them about their services. As a result, they have obtained the support of hundreds of local physicians. They even host nursing students from the University of Victoria who come to the VICS to do practicums for four months as part of their university training.

The VICS is also involved in ongoing research investigating the therapeutic properties of raw cannabis and other cannabis-based therapies.

## Constitutional Challenge in the BC Supreme Court

In order to ensure the quality of the cannabis they provide to their members, the VICS established its own production facility in 2003. In 2004, the facility was raided and two people face charges of illegal production and trafficking of cannabis. The case is before the BC Supreme Court and is challenging the constitutionality of the federal medical cannabis program for failing to provide an adequate and accessible supply of cannabis for medical purposes. The VICS is also challenging the restrictions that currently exist on licenses to produce cannabis for medical purposes, which stipulate that a designated grower can produce cannabis only for one authorized person. The case is ongoing and a decision should be rendered by the end of 2008.

"Medicinal cannabis keeps me free of chasing cocaine these days. I'm a past IV user of cocaine, but cannabis works fine for me now and I use it every day."

- focus group

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### **USEFUL RESOURCES**

- City of Victoria's website lists of social services and housing and accommodations: http://www.victoria.ca/residents/profiles\_rsrcs\_sclsrv.shtml
- City of Victoria's Harm Reduction Approach: http://www.victoria.ca/cityhall/pdfs/departments\_comdev\_hrmrdc\_bckgrn.pdf



Learning from Each Other: Enhancing Community-Based Harm Reduction Programs and Practices in Canada



# 3. EDMONTON, ALBERTA

#### HOMELESSNESS IN EDMONTON

Alberta is experiencing a major economic boom. As a result, the rich have been getting richer, the poor have been getting poorer, and the marginalized are being pushed even closer to the edge.

The cost of housing has escalated to unprecedented levels, in many cases more than doubling over one year. A small apartment will rent for about \$800 to \$1,000, on average. A room in a rooming house rents for about \$350 to \$400 a month. Considering that welfare provides \$402 for a single employable person, many people find they are unable to afford housing, in addition to food, clothing and other necessities. Furthermore, many rooming houses have shut down, and the ones that remain don't have vacancies. Some people live in the river valley illegally in tents, and park rangers fine them and shoe them away. Higher rents have also meant that even more working families, seniors on fixed incomes and people with disabilities can no longer afford housing. This is putting a burden on shelters.

Gentrification and the influx of new people are causing tensions. The demand on shelters has escalated:

"Now what's happening is that our shelters are filling up with people from other parts of Canada and abroad who have come for jobs [and] either they didn't get a job, or they get a job but they haven't got their housing. And the people that typically stayed there who were the absolutely homeless, they are displaced out of there now and so Boyle Street has the Parkland Outreach which was started with the park rangers here in the city."

- Marliss Taylor, Program Manager, Streetworks





Everywhere, Edmonton is being gentrified, with predictable results. Boyle Street Community Services, which provides community support for people in poverty, anticipates conflicts over the next few years as six high-rise condos are built near their building.

Fortunately, the mayor of Edmonton is very concerned about the impact of redevelopment on people living in poverty; however, finding workable solutions is challenging. The Premier of Alberta, along with the mayors, has pledged to end homelessness within a decade. The province will be setting up a special secretariat to coordinate social housing programs. It remains to be seen what impact these programs will have on addressing homelessness, and if the goal is attainable.

However, simply building new apartments and condos will not resolve the situation for the chronically homeless, many of whom are also affected by mental illness and problematic substance use.

For people who are street-involved in Edmonton, it is becoming increasingly difficult to have access to even the most basic of facilities, a public washroom. One can be fined for urinating in a public place. Yet, there are no public washrooms to speak of, and private washrooms, such as those in restaurants, are off limits. Moreover, public space is being privatized. As Hope Hunter, Director of Boyle Street Community Services, puts it:

"There is no such thing as public property. Public property is the street or the sidewalk, and you have to be moving on them. And if you don't move, you can be charged – \$500 fine for jaywalking, \$500 fine for spitting or urinating in public, \$286 fine for trespassing."

The "Guardian Angels" are currently out on the streets of Calgary and are apparently coming to Edmonton. Established in New York in 1979, during one of the city's highest crime periods, the Guardian Angels are a "citizen patrol" organization whose aim is to clean up the neighbourhood. They may come across as being helpful, but a modus operandi is to target certain people and move them out of a neighbourhood. Often a subject of controversy, they are viewed by some as vigilantes with little accountability and oversight. They can be identified by their red berets and red jackets or white t-shirts emblazoned with the Guardian Angels logo. Their jackets say "Outreach" but they are definitely not outreach workers.

### STREET SCENE IN EDMONTON

In Edmonton, crack cocaine has gained popularity in the last few years. Distribution of safer crack use kits was introduced at the end of 2007. Talwin and Ritalin (Ts & Rs) used to be very popular, but morphine has been the drug of choice for the past several years. Morphine users have added crack to their list of drugs used and those who injected cocaine have switched to crack in large numbers. Prescription drug abuse continues to be high. It is predicted that Alberta's adoption of electronic health records may decrease the number of prescription-based addictions, but it may also lead to an increase in the use of other drugs, such as heroin.

"Drug tourism" is a unique and long-time aspect of the Edmonton drug scene. People employed in northern communities, for example, work for three weeks, then have a week or two off, during which they come to Edmonton to party with drugs and alcohol, and then go back north. With the burgeoning number of people attracted to work in Northern Alberta by oil sands development, drug tourism has increased radically.

Despite, or perhaps because of, the prosperity, there is a sense of despair and hopelessness in the air. The major issues for street- involved people are poverty, racism and hopelessness, along with dislocation. Here are some statements from community workers:

"I've only been on the van for a couple of weeks and there is a greater sense, it's almost an overwhelming sense... of desperation and hopelessness than when I [was on the van] before, about four years ago."

- Geoffrey, Outreach Worker, Streetworks

"I'd say the major issues in our community are poverty, racism and hopelessness. And poverty and racism reap the hopelessness. Our clientele is predominantly Aboriginal and Aboriginal people in this country continue to be the biggest underclass we have. I think what many people don't appreciate is the racism experienced by Aboriginal people when you are at the bottom of the heap, no matter who comes, and that you live with that for life."

- Hope Hunter, Director, Boyle Street Community Services

There has also been an increase in gang-related violence. Gang culture prescribes that youth fulfill a "jumping in" rite of passage, which is achieved by committing a random act of violence.

### HISTORY OF HARM REDUCTION IN EDMONTON

There has been a gradual shift from a moral and criminal approach to substance abuse to seeing it as a health and social issue. There has even been a campaign to educate people to obtain drugs from people they know, and to never use alone.

A recent survey in Edmonton showed that 47% of Edmontonians were in favour of a supervised injection facility. <sup>18</sup> Alderman Michael Fair thinks the city would be receptive to one. While the city would not fund such a facility, it could donate a building. Alderman Fair, however, has recently resigned his seat on the City Council.





<sup>&</sup>lt;sup>18</sup> See http://www.edmontonsun.com/News/Edmonton/2007/05/30/4221097.html

#### Alberta's Non-Prescription Needle Use Initiative

# History of the Non-Prescription Needle Use Initiative

The Non-Prescription Needle Use (NPNU) Initiative began in 1995, as a three-year project when the government called together the needle exchange programs from Edmonton, Calgary, Red Deer and Grande Prairie. Despite initial suspicion of the government's intentions, assembling these groups had several positive outcomes. Agencies realized that people who use their services move a lot between cities, especially through the Edmonton-Calgary corridor.

They became aware that the same drug trends were happening simultaneously in each city. They were also able to identify the issues they were dealing with that went beyond those addressed by just distributing needles. In fact, they realized there were so many issues that they were just setting people up to fail. So, they expanded the mandate of the group and the number of representatives invited to the table. The Initiative is now a shared responsibility among many departments, levels of government and community agencies. Each participant is responsible for communicating, to people within their organization and professional network, information identified by the NPNU Consortium as a priority in furthering the health of non-prescription needle users and for promoting, where appropriate, the implementation of suitable interventions.

The NPNU Consortium is a 39 member, multi-sectoral committee that meets once a year to oversee and monitor a provincial NPNU Action Plan. The purpose of the NPNU Consortium is to reduce the harms associated with non-prescription needle use as they relate to blood-borne pathogens, such as HIV and Hepatitis. Alberta Health and Wellness facilitates the NPNU Project, but is not solely responsible for implementing the action plan

A smaller steering committee (16 to 18 members) meets quarterly to oversee the implementation of the action plan and to ensure that the policies, programs, themes and issues that are identified by the larger Consortium are addressed by appropriate agencies throughout the year.

Harm reduction programmers (field staff of harm reduction programs with needle exchange) meet quarterly to identify emergent issues for the consortium, steering committee and task groups and to share resources, information and strategies, and to better coordinate data collection methodologies.

The Opioid Dependency Treatment (ODT) Coordinating Committee meets approximately four times a year to provide central leadership for the delivery of ODT services in the province. This committee ensures that key issues relating to the delivery of ODT services are addressed and monitored. These issues relate to service availability, access and acceptability; quality of care; and system level support. The Coordinating Committee is co-chaired by the College of Physicians and Surgeons of Alberta and the Alberta Alcohol and Drug Abuse Commission and reports annually to the Consortium.

Consortium participants head seven task groups that address priority themes including: addictions; prison; public awareness; Aboriginal people; surveillance; mental health; and professional and community development. The task groups and harm reduction programmers identify issues from the field or the frontline, propose strategies to address the issues, and present recommendations to the Consortium for ratification. Recommendations that pertain to provincial government departments are forwarded for consideration to appropriate Ministries through the Minister of Alberta Health and Wellness. Recommendations for other organizations, agencies, and associations are forwarded by the NPNU Consortium Chair. A status report on the outcome of the recommendations is prepared by Alberta Health and Wellness and presented to the Consortium at the next meeting. This process acts as the "report card" to ensure that the issues are addressed.

The ongoing work of the task groups and harm reduction programmers is supported throughout the year by the steering committee, an NPNU consultant, and an Alberta Health and Wellness NPNU project team leader.

This project is responsible for many joint initiatives, including: the Alberta Harm Reduction Conference; a harm reduction instructional video (Pieces to the Puzzle); training for pharmacists (including an accredited distance course), social workers, addiction workers and emergency personnel; a prison video; enhanced addiction services; expanded methadone maintenance; a crack kit study; and the provincial drug users network.

#### Comments on the NPNU Consortium:

"Having that provincial perspective and the provincial sharing has been huge... I look at where we are now compared to where we were ten years ago, the difference is huge and a lot of things have changed. The NPNU might be a model to consider in each province."

- Marliss Taylor, Program Manager, Streetworks

# BOYLE STREET COMMUNITY SERVICES – A COMMUNITY CENTRE, NOT A SOCIAL SERVICE

Boyle Street Community Services has existed in Edmonton for about 35 years. It started off as an outreach and liaison initiative to address the service needs of newcomers to the city, particularly Aboriginal people from rural communities, and to help them find the services they needed.

Its vision is: "All people growing healthier through involvement in strong, accepting, and respectful communities." Its mission is to build and provide community support for people in poverty.

The guiding practice principle of the programming offered by Boyle Street is this: "All behaviour is functional because it is intended to meet a need." This, along with their close engagement with their community, creates the foundation for their harm reduction projects. "We are a community centre, not a social service agency... In a community centre, everybody is working together to make [the community] a better place for everybody," says Hope Hunter. In this context, harm reduction is approached from a "What-do-you—need-to-be-safe?" perspective.

Programs at the Boyle Street Community Services include: adult outreach, a housing registry, mental health services, youth services, winter warming, youth housing, a receiving home for apprehended children, and a high school for street-involved youth. Streetworks, the Adult Learning Centre, and Children's Services are housed in the same building.

# Children's Services in Same Building

The idea of housing Children's Services in the same building as the Boyle Street Community Services was conceived in order to address the challenges the Boyle Street staff had experienced when working with young people whose children were apprehended by Children's Services. This co-location project is brand new. A unit of the Child Welfare Agency workers moved in just last year, and they work hand-in-hand with Boyle Street staff. The goal of this partnership is two-fold: to introduce harm reduction thinking into the Child Welfare Agency, and to allow Boyle Street staff and the Child Welfare Agency to work together in the best interests of the clients. There have been challenges for both groups, but proximity and collaboration have resulted in improved services for children and families.

"When we have a child who is at risk, one of the first questions the urban aboriginal staff will ask is 'Who is your auntie?' And so they will start to figure out in the genealogy where... this child live[s] and who is related and based on that, who could take this kid home."

Hope Hunter, Director,
 Boyle Street Community
 Services





"One of the things that we are working on right now is looking at a project around pregnant women. [A] number of them are not able to access or are unwilling to access health care so our idea is... to have a team where we have a community member and a nurse as team leaders, of equal status, and then work with the group of probably... four part-time women that have had babies while street-involved that have 'been there, done that'. They can do a lot of the prenatal stuff with some supports outside of there. They can do a lot of the initial stuff and do the urine testing, ...being support people, going with them [clients] to appointments, doing all of that instead of a scary nurse, or worse, a scary Children's Services person." – Marliss Taylor, Program Manager, Streetworks

Before this initiative, there was a lot of "snatch and run" and a lot of tragedy for families, especially single mothers, who were deprived of their children, often forever, with no support or grief counselling. Often they would have more babies as a way to cope with the loss.

"This [approach] is trying to be kinder and gentler and trying to work with families and do the support pieces that people need right from the time of becoming pregnant," says Marliss Taylor of Streetworks. "There is a woman yesterday that came and she is newly pregnant and living in the river valley. She is going to come [in]. We have a doctor that comes a half day a week so she will come tomorrow and will see her and we'll certainly take her under our wing, which will be so perfect for this group too... in terms of going and checking on her. She wants a good healthy pregnancy. She just quit her crack, she quit injecting, she's been through detox and treatment, but it's pretty hard to stay clean, I would imagine, here. She's had three previous terminations so this one she wants to keep.... She has not had Child Welfare involved up to this point because she has terminated each time, so if we can get her a place, maybe she can keep the baby."

# **Outreach Programs**

Boyle Street Community Services also has outreach programs in various parts of the city. As gentrification happens, and parts of the city develop into trendy business and residential areas, a shift in thinking is taking place. Hope Hunter, Director of Boyle Street Community services explains the welcome phenomenon:

"A group of people were very concerned by the increased number of panhandlers in [a new shopping] area. And most of them were our clients who had left the inner-city because it was getting too dangerous and not very lucrative, and they moved to this nice shopping area because it was safer and more lucrative. And the business com-

munity was very concerned and wanted to get rid of them and wanted to get them all back downtown where they belonged. And so we became involved with them and started an outreach program based on the same kind of model we work on downtown. And the impact has been, over the probably five years now that we've been having these discussions, [that] we have seen... a shift in that community from the thinking of "get those people out of here and get them back downtown" to their slogan now is, "we are a caring community". So what they are trying to do now is to address root causes of homelessness. And they're advocating... and actually this winter they opened up a warming centre in this business district for people who are homeless; and there is a group also very interested in trying to create housing. A group of businessmen have gotten together and they've started "damage deposit" programs so they can help people actually access housing on the open market."

## **Working with Aboriginal Communities**

Boyle Street Community Services serves a predominantly Aboriginal community, and many members of their staff are Aboriginal as well. Because of this, they have learned a lot about the impact of racism and the challenges of understanding other cultures, even within their agency. They have developed an appreciation of what it means for Aboriginal people, with their distinct and unique culture, drawn from ancient traditions as well as contemporary experiences, to live in an urban society very different from their own.

A key aspect of urban Aboriginal culture is the importance of family. What counts as family, however, can include an extended network of community members who are granted the status of "relations" and who are awarded familial loyalty and respect.

The belief that "it takes a whole community to raise a child" is also very present among the Aboriginal peoples in Edmonton.

There are aspects of Aboriginal culture that do not translate well into the urban environment because the traditions require pure earth, sobriety, access to elders, and respect for traditional protocols. In the city, the earth is impure, many people use substances, elders are not always nearby, and many people are not familiar with, or have lost touch with, their cultural roots.

Within the culture, the concept of respect is strong and pervasive. Respect must be both earned and given. Speaking ill of someone to a third party, for example, is seen as lateral violence, hence disrespectful. People have been shunned for disrespecting others, among other reasons. Some Aboriginal people have come to the city because they had been shunned by their community.

In Edmonton, there are also people from various Aboriginal tribes with differing beliefs and codes, and they cannot all be lumped into one culture. This convergence has resulted in a melding of some of the diversity, as well as in considerable inner conflict. "I think a lot of people here are struggling to create a definition for self and where [they] fit," says Hope Hunter. Many are also dealing with a great sense of loss, both historical and current.

These considerations all come into play when developing programs and services for people in Edmonton.

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#### STREETWORKS - OUTREACH WITH A SMILE

## History

Because of their reputation for their outreach work, Boyle Street Community Services was approached by a sexually transmitted diseases physician from Alberta Health when new populations started showing up with HIV. A strategic committee was formed, which included the addictions agency, the police, public health and a number of community organizations. The committee designed Streetworks, which is now a program of the Boyle Street Community Services.

## Mission and Objectives

Streetworks is a community-based HIV/AIDS prevention program which targets street-involved injection drug users, sex trade workers and their social networks. Its mission is to "provide or enhance the skills, knowledge, resources and support that street-involved injection drug users and sex trade workers need to live safe and healthier lives."

Its objectives are to:

- Increase the knowledge and understanding about hepatitis B and C, HIV and other health issues that affect street-involved people.
- Assist the target population in maintaining or improving their own health.
- Provide service users with the skills, knowledge, resources and support needed to remain safer and healthier.
- Assist and act as advocates, improving accessibility to supports and services as needed, as well as decrease barriers in the community.
- Create trusting relationships with members of the target group and give positive feedback in order to build self-worth.
- Increase the knowledge and understanding among organizations, community agencies, and individuals around the target population and harm reduction.
- Provide clean needles, alcohol wipes, clean water, condoms, lubrication, vitamins and first aid supplies, if necessary.

"The attitude with people that are coming here, regardless of whether it's people who work with Streetworks... or whatever, when they come down here, I know after a while, after they've been here for a week or two, their attitudes completely turn around."

- focus group





### **Operations**

Streetworks is a collaborative program jointly governed by a council of agencies which includes HIV Edmonton, Boyle McCauley Health Centre, Boyle Street Community Services, Capital Health Regional Public Health, Alberta Alcohol and Drug Commission (AADAC), Catholic Social Services, the University of Alberta Northern HIV Clinic, the Prostitution Action and Awareness Foundation, the Centre for Health Promotion Studies, and Edmonton Police Services. The Council acts as a board of directors. HIV Edmonton is presently the Chair of the Council. Boyle Street Community Services is the banking agency.

Streetworks is funded through the Alberta Community Council on HIV, with additional monies from Capital Health. This funding is renewable every three years. Streetworks has also received project and research funding, donations and other grants. The program is not incorporated.

Streetworks is housed within Boyle Street Community Services and has another site at the Boyle McCauley Health Centre. There are satellite needle exchange sites at the Sexually Transmitted Disease Clinic, HIV Edmonton, the George Spady Centre, and the Eastwood Public Health Centre.

Streetworks provides full needle exchange services, referrals, advocacy and education; houses a street clinic at the Boyle Street site; does research and evaluation; has an active and innovative 'natural helper" (peer) program, and much more. They operate an outreach van five evenings per week, and staff members go out on foot outreach during the day.

Streetworks staffs their two main sites, as well as the outreach van. The other sites provide their own staff, but work within the Streetworks philosophy.

The program has five positions: a program manager, 2.4 registered nurses and three outreach workers. There is also "associate staff", which includes research assistants from the Centre for Health Promotion Studies, University of Alberta, and a physician who holds a medical clinic a half day per week. The program also is involved in the training of students from the Faculties of Nursing, Medicine, Law, Social Work and Pharmacy. They exchange 600,000 to 800,000 needles a year.

### **Program Components**

People often think that Streetworks is only about needles. In many ways, however, the needles and condoms are a means of getting people connected with the larger program. Staff can then assist them in taking better care of themselves, discovering new options and opportunities and making positive changes.

In order to fulfill its objectives, Streetworks is very broad-based and comprehensive. The following is a synopsis of its services:

**Nursing Services:** Nurses on the team provide health assessments, including HIV and hepatitis testing and screening for tuberculosis; immunizations for hepatitis B, pneumonia (pneumovax) and the flu; health education and advice; and minor treatments and emergency care. They also follow women through their pregnancies and check on the chronically ill. Many people who come to the program are not needle users or sex trade workers, but people who simply want to see a nurse.

**Business Program:** The program staff attempts to work with area businesses such as gas stations, sex shops, pharmacies, hotels, convenience stores, etc., to keep their establishments safer and healthier.

**Ride-alongs:** Once a month, in an effort to become known and trusted, physicians, nurses, social workers, outreach workers, and others from selected agencies, go out in the outreach van to provide services directly to people who otherwise have difficulty accessing services. Getting to know a worker from an agency through the van makes it easier for the clients to go to these agencies for services.

**Referrals:** The Streetworks staff makes a large number of referrals to physicians, treatment centers, detoxes, legal services, social services, methadone clinics, STD clinics, safe houses, mental health services, housing services, and others, in order to help people make positive changes in their lives. Staff will often accompany clients to the places of referral as well.

Supplies: Streetworks provides individuals involved in drug use or the sex trade with the tools they may need to remain safer and healthier. These include needles, alcohol wipes, elastics, condoms, lubrication, tourniquets, vitamins, pregnancy test kits, Health-for-Two coupons, feminine hygiene products, first aid and general health supplies, water, food and clothing, Bad Date Sheets, and other items as available. Streetworks also supplies some agencies and businesses with sharps containers. They have recently added safer inhalation kits to their distribution items.

Health Education: Streetworks staff provides information to agencies, groups and individuals on a wide range of topics, including HIV/AIDS, hepatitis, harm reduction, universal precautions, safer injection drug use, sexual health and the Streetworks program itself. As well, Streetworks develops culturally appropriate resource material for its target groups. Many of the booklets or videos, prepared in collaboration with community members, have earned international attention, including: The Vein Care Book; Street First Aid; The Germ Book; The STD Book; Uptown, Downtown: The Drug Handbook; and the Clean Points video.

"We supply the needles to Eastwood, which normally you would think, 'Well, why are you supplying needles to public health.' On the other hand, it gives us a whole lot more control on how to roll it out... So it works in our favour to do it that way."

Marliss Taylor, Program
 Manager, Streetworks



Staff members serve on committees at the regional, provincial and national level.

Prison Program: Streetworks works to assist individuals involved with the criminal justice system, helping them stay safer and healthier while incarcerated and after release. Staff members sit on many committees which address the issue of blood-borne pathogens and incarceration, at both the local and provincial level.

**Research and Evaluation:** Streetworks has an ongoing research partnership with the Centre for Health Promotion Studies at the University of Alberta and has participated in many studies which enhance the knowledge of the practices and social networks of people who use drugs, the strengths they display, and the challenges they encounter. Annual evaluations and maintaining statistical records are routine.

**Advocacy:** Staff advocates for clients when the need arises. This may take the form of accompanying someone to an appointment or working with agencies to help them become more effective in meeting the needs of street-involved individuals.

## Outreach Van

Because of the availability of placement students and ride-alongs, it is possible for Streetworks to operate the outreach van five nights a week, from 8:30 pm to 12:30 am, staffed with a Streetworks staff member and one of the above-mentioned "passengers". Streetworks is exploring ways to operate the van on a sixth night and has recently started doing some outreach at 6 am. In the long term, Streetworks would like to expand the outreach services to mid-morning, mid-afternoon, early evening and overnight.

The van workers have a cell phone and people can call for deliveries if they are outside the van's route. Part of the van workers' duties includes providing information and education around safer injecting practices and safer sex.

In addition to injection equipment and safer sex supplies, the outreach van provides granola bars, water and juice, if available. These items are usually donated, but Streetworks does buy them when they are able. They are unable to provide cookers, nor do they distribute safer crack use kits. They are also unable to supply clothing, so they refer people to services that do.

The van is not identified by any logo. However, clients recognize it due to its very distinctive colour. Streetworks new van, which has no name, does have a unique red and black diagonal stripe and a logo on the back. They thank the Edmonton Police Foundation for contributing to its purchase.

"We actually started doing some morning outreach because as some of the workers were driving in, they noticed some of the [sex] workers out in the street already in the morning, so we've done our second week of doing outreach in the morning and it's been quite popular."

– Geoffrey Villebrun, Outreach Worker The Streetworks van is designated as a neutral zone. If police want to question people or talk to them, they have to wait until they are done their business with the van.

Streetworks is working on developing partnerships with local businesses, such as taverns, to get permission to enter and inform their clientele that the outreach van is available to them. Van staff do not often go into rooming houses because of safety concerns.

There are big yellow drop-off boxes around the city where people can dispose of their used needles and injection equipment. According to the outreach staff, they are well used. This has reduced the need to do community clean-ups.

# Natural Helpers Initiative

The concept of natural helpers is ingrained in the philosophy of all Boyle Street's programs and services, including Streetworks. It acknowledges and builds on the mutual support and sense of community that occur naturally amongst marginalized people. The Natural Helper Initiative taps into and benefits from this already existing resource of "people who help others" and explores how they take care of each.

Streetworks staff has noted that many street-involved people take care of each other rather than accessing mainstream services. For example, people who do not use drugs or work in the sex trade go to the outreach van to obtain supplies for friends or family. They also recognize that people do the best they can to help others with what they have. With this in mind, Streetworks provides "natural helpers" with information and education to keep them safer and healthier and to better equip them to help the hidden individuals and groups they are in contact with. The idea of cultivating and supporting natural helpers goes beyond peer education and employment in recognizing and strengthening health work done at a grassroots level, in the community and by the community.

"[B]ecause I'm a nurse I see it from a health perspective, but I've seen all kinds of natural-born nurses and doctors and lawyers and social workers within our community members. You've seen them in your own communities probably. How can we work with that?", asks Marliss Taylor of Streetworks. She adds: "So what you don't want to do is formalize it too, too much in a way because this is a whole system that works in spite of us, and yet there are some parts that you can pull out of that. So we've tried to do things sort of on an individual basis... And then we do it a little more formally, and some of that is the resource development that we've done in getting people together sharing expertise of the street and the nurses and coming together with some sort of teaching tool."



"I just want them
to be as safe and
healthy as they can
be and I encourage
that. And to get
away from this idea
that because I am
a nurse, I am the
only one that
knows about health.
Because a lot of
people know about
health, out there on
the street. They are
doing it every day."

Marliss Taylor,
 Program Director,
 Streetworks

"In my first month here, Donnie came and he said, 'You got to come and see ---, her face is green, she got burned on Friday.' OK, so I grabbed my bag and I went with him to this rooming house. We got to the rooming house. In there, I was met by a group of people... And I got swept into this room and one of them had slapped vitamin E cream on the burn, one had put Vaseline, one had put rubbing alcohol and another had found antibiotics rolling around in a drawer, so they gave it to her. She had burned her face. She had gotten hit with a hot pot on Friday, and this was Monday. But they were all in there and they were all trying to help her. In my apartment, I don't know my neighbours and I don't know that they would try that hard to help me. So from a nursing perspective, for me a lot of it is around health... The people who run the York Hotel downtown here are lay social workers. I don't care what anyone says. They are watching out for the people who are living in that hotel, they know who's off their medication, they know when they need to phone somebody. There is all of this going on in the community. What we want to do is capitalize on it in terms of the overall gains to the community."

Streetworks also works with natural helpers to create resources (see Useful Resources). Streetworks staff and some current or former drug users will come to the table as equals to decide what resources need to be developed, what needs to go in a particular resource booklet and how to say it. Everyone brings their real-life knowledge, which is respected. The nurses, of course, often bring medical knowledge, but they learned very quickly that what they are taught in school doesn't always fit, and that information from the street can be more practical and effective.

"When we did the germ book, [...] because people tell stories here a lot, it's a very common form of communication. We have it in story form. On this one, Angel saw one of her regulars drive by and she goes running in her stilettos, she falls, bang, hits the sidewalk, gets a road rash, and Lucky, the main character, comes along and finds her; so when they were creating this book, [the nurse] Jen was going, 'Well OK, he needs to take her to the Easy Lay Hotel and they can wash it with soap and water.' And they were going 'Jennifer, there's no soap in the bathroom at the hotel, what are you thinking?' That's not going to work. So everybody negotiated to come up with a response, something that is going to be helpful to people."

- Marliss Taylor, Program Director, Streetworks

Currently, three natural helpers have been hired to assist with the overdose prevention project (see below). They each work one or two days a week. They do public speaking, peer education, community outreach and education, and needle exchange, and are provided with opportunities for personal skills building.

## **Overdose Prevention Project**

Streetworks' Overdose Prevention Project is the only one of its kind in Canada. Funded by Health Canada's Drug Strategy Community Initiative Fund, this three-year pilot project was created to address the issue of overdose from within the affected community.

The project consists of three parts:

- The development of "Uptown and Downtown: The Drug Handbook" a resource about drugs;
- A community overdose awareness campaign "Don't Drink and Fix"; "Don't Fix Alone"; and
- A research project that taught 50 community members how to administer emergency resuscitation (cardio-pulmonary resuscitation or CPR), and naloxone (Narcan) to people who had overdosed.

Naloxone (Narcan) is used to reverse opiate overdose. It has conventionally been administered by medical personnel (doctors, nurses, paramedics) in emergency situations. About ten years ago, activists in Chicago developed a program to train drug users to administer naloxone and to provide them with a personal supply of it. The program exists now in a number of American cities and has proven to be quite successful.

Two physicians prescribed Narcan for Streetworks. With project funding, Streetworks purchased the naloxone through their partners in Chicago, where it costs about \$2.50/vial, compared to purchasing it locally at \$89.00/vial.

The project terminated March 31, 2007 and efforts are being made to extend the program. According to Marliss Taylor, the successful project did more than just save lives:

"A big piece of the excitement is around the changes of the people. As you know, when people start feeling that they have some value and they're important, a lot of things change in their lives, and so we've seen lots of life changes...One of the people that [Lisa] trained [used to] overdose two times a week, at least once, if not more. She trained him and it was like, 'I don't think so, Lisa, I don't know why you are doing this. I'm not so sure that's a good idea.' He has not overdosed in the past year and a half. He is out there, he is walking around. Actually he and someone were chatting with me yesterday and they said, 'Did you ever think that we'd be like this now?' I said, 'You know, I got to be honest, 'No. I didn't think that I would see you this far.' They are both part of the users' net-

work [See AAWEAR and "As It Is"]. They both have been trained in naloxone. They have both been included and involved in things, and for them, they are bright-eyed and bushy-tailed for the first time that I have ever seen."

Current project evaluation has shown that the naloxone was used by 18% of the participants. Typically in the US, they expect that 10% of the participants will use it in the first year.

The people involved in this project would like others who work with people who use opiates to know about this program, in the hope that it will be offered elsewhere. They have even been approached by a pharmacy that would like its staff to be trained in overdose prevention.

### **Hurdles and Successes**

It has been a challenge for Streetworks to get all the partners on the council of agencies to the same point of awareness and to feel equal. Using a common language was a stumbling block, and buy-in from the whole of Boyle Street Community services was also a challenge. Once program delivery began, Boyle Street Community Services was a little fearful of the unknown and hesitant. Not everyone supported it, regardless of whether or not the Executive Director did. The Streetworks service model was also contrary to that of some partnering organizations.

Alcoholics Anonymous or abstinence-based programs, especially the Aboriginal groups, were resistant at first. They also tended to be more conservative, which made working with them a challenge.

What made a difference was a Health Minister who wanted to see this program implemented, and the AADAC manager who supports needle exchange. Making fiscal, rather than moral, arguments to support the program also helped. Educating the editorial boards of the city newspapers so that Streetworks got good press, and eroticising safer sex classes for staff helped bring people on board. Protocols were also put in place for needle-stick injuries and hepatitis B shots were provided for staff.

The program has been successful due to the availability of a significant amount of high quality supervision, hiring staff who are keen on the program, a strategic-thinking manager who would not take no for an answer, people who laid the ground work before the program opened, a dedicated program manager, productive brainstorms, Aboriginal organizations that attracted resources, a host organization willing to take a risk and try anything, caring about the individual, and accepting incremental successes as a measure of accomplishment. It also

"Streetworks and Street Youth... that's my support."

- focus group

helped that some senior staff in the police department and in treatment organizations were advocates for the program.

As well, Streetworks has benefited from long-term staff who are committed to the program and the population they serve and non-profit managers who empathize with the population and who can articulate the importance of offering dignity and respect, appreciating small gains, and seeing the person rather than the system.

The people involved in implementing Streetworks have learned that "Where there is a will, there is a way — you just need to know who to play with and who to threaten." They have learned, too, that people are more important than systems and that basic needs, including dignity and respect, are fundamental. Harm reduction is the fall back of health promotion.

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focus group

# AAWEAR – ALBERTA ADDICTS WHO EDUCATE AND ADVOCATE RESPONSIBLY

# **History of AAWEAR**

Typically, drug user groups are created by people who have been hit hard by their own circumstances. HIV, hepatitis C, stigma and poverty played a role in these circumstances. Consequently, they feel they have the right to be involved in activities that can affect their health and well-being, to be able to make decisions about their lives and their health, and to share their unique expertise and experiences.

AAWEAR is a provincial drug users' network. It was created after needs assessments in Medicine Hat, Lethbridge, Calgary, Grande Prairie, Edmonton and Red Deer identified that users wanted a group where they would feel supported and a safe place to talk about drug use and related issues. They got some start-up funding through the federal hepatitis C program. Calgary and Edmonton showed the most interest, so focus groups were organized and in September 2005, two groups were formed: Grateful or Dead, in Calgary; and As It Is, in Edmonton. They're under the supervision of a provincial coordinator and local community leaders.

The provincial users' network in Alberta meets four times a year. One of those times is at the annual Alberta Harm Reduction Conference, which is the best time for everyone to get together.

Some issues that have been brought up include: methadone availability; the need for harm reduction housing, including housing for people pre- and post-treatment; and the need for a safe injection site and safer crack use kits.

AAWEAR hopes to continue meeting in a supported and supportive manner, and to encourage other locations to begin groups. They want to be involved in the evolution of a national network.

AAWEAR currently holds two seats on the NPNU Consortium and will be co-hosting Alberta's 10th Annual Harm Reduction Conference in 2009.

## Edmonton Users Group - As It Is

User groups, such as As It Is, provide a safe, non-judgmental place where people can come together and be themselves. There is power in numbers, and a group such as this one gives people a voice. It also helps in dealing with the stigma experienced by people who use or have used drugs.

The Edmonton user group meets once a month to share a meal and discuss various issues, concerns and current events that affect the community. They are considering meeting twice a month. The rules of conduct and the agenda are set by the people attending. As It Is does advocacy, education and information dissemination; provides support and fellowship; and organizes social events. They invite family members and staff to community clean-ups three times a year to help them in picking up any litter caused by injecting drugs.

"At the last meeting, we had 60 people.
That was in Calgary.
Past and present users. They bring concerns that they have and I bring a lot of them to the Addictions Task Group and the NPNU which I sit on."

Rosemary Fayant,
 President of AAWEAR

There are some challenges with regard to boundaries when a person who runs a peer group is also an employee of the organization that houses it. Marliss Taylor explains the situation:

"[Rosie] is a staff member here and so her group, when they have a great idea, she needs to lead the charge against her own people, which is funny. It's worked so far. We've managed to do it well so far."

Some of the members of As It Is were involved in the development of the resources for the natural helpers. They had never been on a committee or in a working group before. Now, some of them are involved in the users' network and mentor newcomers. Some members have also expressed the desire to be trained for public speaking.

Barriers prevent some people from attending the group's meetings: the meetings are currently during the daytime, which does not work for everyone. The group is looking at how it could be more accessible.

Despite exhausting funds at the end of March 2007, members of the group plan to keep going. Currently, few women attend, except for the facilitator. Many of the women that did come have dropped out for health reasons, because they have moved away, or because they work and cannot make weekday meetings. Some women have children, which makes attendance even more difficult.

According to Rosemary Fayant, who runs the Edmonton group, the organization has had a significant impact:

"Some of our guys have really stabilized. There was one fellow who used to overdose twice a day and sometimes three times a week. He hasn't overdosed in almost 18 months. He's had stable housing for a year. We have another fellow who was living in shelters. He's got a place. And it's just, they said it's because of the group and being recognized that they're human beings and they're not 'less-than'. We're people's fathers, brothers, mothers, sisters and we're worthwhile human beings. And that's what a lot of our guys have said they get from our group, that they're made to feel worthwhile again."

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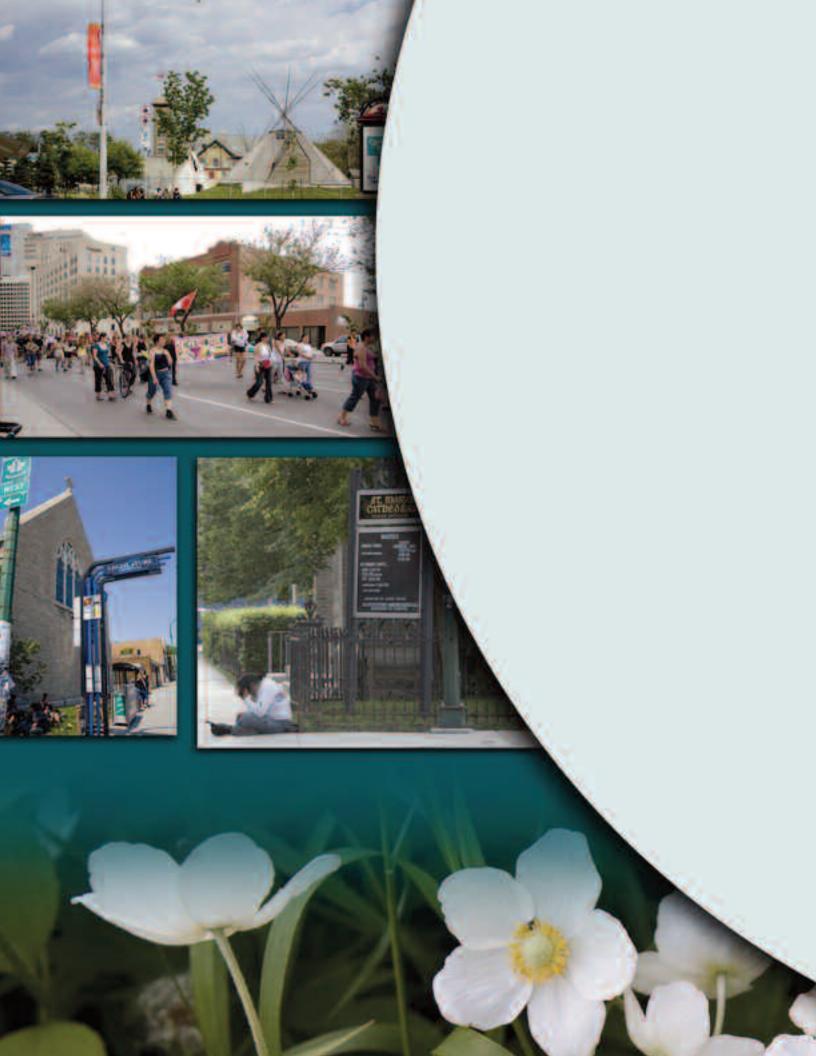
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# **USEFUL RESOURCES**

# AVAILABLE FROM STREETWORKS

- Vein Care Handbook: a booklet on how to stay safer and healthier if you use injection drugs
- GERMS: How To Stay
   Healthy on the Street: a
   booklet that explains
   germs, how you can
   catch them and how
   you can get rid of them
- Street First Aid: 'Cause you just never know': a first aid booklet written by people who live on the streets
- Uptown, Downtown: the Drug Handbook: a booklet providing safe advice on drugs from the street
- Pamphlet on Overdose Prevention: Prevent Going Down! Don't Run... Call 9-1-1



# 4. WINNIPEG, MANITOBA

# SAGE HOUSE - A WELCOMING SPACE FOR STREET-INVOLVED WOMEN

Sage House is a street women's health outreach and resource centre. It is a program of Mount Carmel Clinic, Canada's oldest community health centre. The program is a good fit for the clinic, since they both focus on population health and community development. However, Sage House was not always embraced by the clinic:

"We used to be at that little tiny old house under the ... bridge, where nobody could see us and nobody was supposed to hear about us. We felt that we were Mount Carmel's dirty little secret. We don't feel that way now. Mount Carmel poured a lot of money into renovating this building and having us move here. We did a lot of fundraising for it and they've made sure that the building is paid for and we are not going to lose it. We feel that we are on solid footing. As long as the health system is on solid footing and community health centres are on solid footing, then we feel like we will be okay."

- Gloria Enns, Program Manager, Sage House

Sage House moved into its new building in July 2006. It is now closer to downtown in an area that is a sex trade workers' stroll, which is convenient for the women who need the services. Fortunately, the move did not result in the loss of clients.







## **USEFUL RESOURCES**

- Mount Carmel Clinic's website: www.mountcarmel.ca
- Video "Trying to Exit": about sex work, made by participants, 20 minutes, won the Kaiser Award – Available from Sage House

#### **Services**

The goal of Sage House is to improve the health and safety of street-involved women and transgender people living as women. It provides a variety of services on-site, through street outreach and in programs offered with partner agencies. It offers a welcoming, safe environment, where women are encouraged to explore their choices and support each other. Meals, laundry, toilet and bathing facilities are available, and the main floor is wheelchair accessible.

The house serves mainly adult women; youth must be referred to Child and Family Services.

The drop-in operates from Monday to Friday. People can come in, watch TV, have a rest, and eat. There is always food on hand, and the women can cook for themselves on days when dinner is not served. Food is donated by Winnipeg Harvest; Sage House also purchases some food. Sage House also works with the Elizabeth Fry Society, which provides services for women who are in conflict with the law.

There are two staff on hand when the drop-in is open, and a nurse is available onsite during drop-in hours.

Services include: nursing care; testing for HIV, hepatitis A, B and C, STIs and TB; health education; pregnancy testing; condoms and safer-sex supplies; counselling and support; referrals to other services; advocacy; laundry; bathroom; kitchen; someone to talk to; volunteer opportunities; bingo; art therapy; clothing; dinner on Tuesday and Friday; a Sobriety Support Group; a Solvent Users Group; Biindigen Outreach Project (see page 114); and a monthly newsletter. Sage House provides shampoo, conditioner, towels and even changes of clothes, so people can wear pyjamas while they are doing their laundry. There is a backyard where women can have picnics and barbecues, and smoke.

Sage House has a counsellor who does individual counselling. As well, the outreach workers have a room in the house where they can hold private discussions with women as needed. Sage House also offers a program called Dream Makers for women who are further along in their healing journey and want to give back to the community through peer support work. A doctor's office is just a short walk away from the house.

Funding for Sage House comes mostly from the Winnipeg Regional Health Authority. As part of cost recovery, the house also rents its garage to auto mechanics.

# Harm Reduction at Sage House

Sage House is part of the Manitoba Harm Reduction Network and houses its coordinator, who is one of their outreach workers. The Network distributes sterile injection equipment on-site. Although they do not distribute safer crack use kits, they do refer women to Street Connections and their outreach van, which do.

Their harm reduction approach is reflected in all the work they do. It shows in the way they approach teenagers and others on the street and in the way they help women find alternatives to working on the streets near schools (see p. 114). It's also obvious through their breakfast and drop-in services, their offers of transportation to ceremonies with elders, and their relationships with elders.

# Challenges of Pregnant Women Who Are Using Drugs

Providing services to women who are pregnant and using drugs poses a challenge of balancing the provision of care with legal obligations. Sage House encourages pregnant women to cut back on their drug use and to get into a treatment program, if possible. They do their best to steer the women toward less harmful drugs. They must also let the women know that their name and their situation is being passed along to Child and Family Services, as they try to prepare them for the possibility that their child will be apprehended.

"For them to actually stop using because they are pregnant, it may not happen. But then, we really have to work with them around preparing for their child to be apprehended and preparing for working with the child welfare, so that they can have visits and contact. It's heart-wrenching every time. It's never easy. It will never get easy for a woman to give up her child." — Gloria Enns, Program Manager, Sage House

"I think harm
reduction is in
everything that we
do. It's how we
approach community,
it's how we approach
women who are
pregnant when
they are using. It's
everything. It's not
just whether we give
out more needles."

– Gloria Enns, Program Manager, Sage House

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# SOS - A UNIQUE SOLVENT SUPPORT GROUP

Solvent users in Winnipeg are typically homeless. About 95% of them are Aboriginal, and 98% are living in shelters or under bridges. They are highly stigmatized, even by other drug users.

The SOS Solvent Support Group is the only program run by Sage House (see page 109), that welcomes men as well. It appears to be the only solvent users' support group in Canada. Its purpose is to build a strong sense of self within its members, and a stronger sense of community. It helps them move from a pre-contemplative to a contemplative stance in their struggle with their solvent use, and provides them with the skills and support to achieve or maintain sobriety.

Meetings are held once a week at the Mount Carmel Clinic. Participants do not have to be sober to attend. They just have to express the desire to quit using. The group comprises of 24 to 35 participants, on average, with two facilitators. As in similar groups, the meetings are run by the participants, not by staff. Members determine the rules of operation and the meeting agenda and monitor each others' behaviour.

# Challenges

Solvent users likely experience more stigma and discrimination in the health care setting than other people who use drugs. It is a challenge to overcome the stereotyping that people apply to them. They are easily identified because of the lingering odour of the solvents they use, and staff at many agencies fear them, perceiving them to be aggressive and dangerous. As a result, they receive poor health care and limited support and resources, if any. Part of the SOS Group's purpose is to support the members to self-advocate, to get their needs met.

It has also been a challenge to advocate for agencies to provide services for solvent users. As Andrea Baigrie, the group's main facilitator, explains, "It's getting people to get past [how solvent users smell] to see the people for who they are." Finding treatment is another difficulty. Current treatment programs tend to be too short and are not solvent-specific.

Sage House trained a few peers as support workers and mentors to help recruit participants for SOS. They are currently working on producing a solvent use prevention video which features the SOS group.

"I sniff a lot and I get help from [Sunshine House] and Sage House and Nine Circles."

- focus group

"...the solvent groups happening at Mount Carmel Clinic... what we do there, every Friday at 2:00 or 3:00 we have a group there at the Mount Carmel Clinic. We go there... It's pretty good."

- focus group

### Harm Reduction for Solvent Users

In the context of solvent use, harm reduction goes beyond talking about disease prevention. It is about decreasing the substance use to reduce the harms caused by it.

# **Impact of SOS**

"When somebody from our community dies, we have a vigil... And there was a really unfortunate and horrible death of one of the solvent-using women, and almost her whole group came to that vigil. ... I was so impressed by ... the way that they celebrated this young woman's life, the stories they told about her that really brought her humanity to light... She wasn't just a street person or just a solvent user, she was somebody who, on welfare pay day, went to the cheap movie cinema, and she was somebody who sang songs while she was walking on the street. And these are the kind of things that they remembered. I'm saying this because not that you don't believe that solvent users are human, but a lot of the population doesn't. And when they're treated like sub-humans and they're treated like scum to be taken off the street, to be swept away and to be put out of sight and out of mind, sometimes it can lead to people acting like that. And I think the Solvent Use Support Group has led to a sense of community where they see themselves as taking care of each other."

- Gloria Enns, Program Manager, Sage House

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"Through SOS, participants have learned to gain a voice and that they have the right to be here. They collectively responded to a [Winnipeg Free Press] newspaper [article which called] them 'high and hopeless' by stating that 'they may be high, but they're not hopeless', that they have value and that they belong in society and they should be valued for that."

Andrea Baigrie,
 Main Facilitator, SOS

# BIINDIGEN NORTH END SCHOOLS SAFER CORRIDORS PROJECT

"Working together for safer streets and communities by building a network of welcoming resources for street-involved women."

"Biindigen" means "you are welcome here" in Ojibway. The Biindigen North End Schools Safer Corridor Project is funded through Crime Prevention and Neighbourhoods Alive, and is also a program of the Mount Carmel Clinic.

The goal of the Biindigen Outreach Project is both to provide more places where women will be welcome and to provide options to working on the streets near the schools when children are traveling to and from school. The project's objectives are to:

- increase safety of children traveling to and from school by reducing the visible sex trade;
- provide support and services to help women exit the sex trade;
- support and listen to residents to promote community safety; and
- work with community organizations to build a positive network of supports for women.

Outreach staff offer alternatives to women on the street working in the sex trade. They remind women that services are available to them, and seek their cooperation in being off the streets during the times that children are walking to and from school. They also train and support parents monitoring school areas before and after school.

CONTACT

Biindigen Outreach Tel: 204.791.6235

# KALI SHIVA AIDS SERVICES – SUNSHINE HOUSE – A WELCOMING SPACE FOR STREET-INVOLVED PEOPLE LIVING WITH HIV/AIDS

Kali Shiva AIDS Services runs Sunshine House, a drop-in and support program for people living with or at risk for HIV infection. Established in 1998, the drop-in is one of the few places locally that allows homeless and transient people a place to rest for up to eight hours. Initially, Kali Shiva had partnered with a number of groups to start Sunshine House as a separate entity, but eventually they took full responsibility for its management.

Until fairly recently, Kali Shiva did not receive operating funding. In the beginning, it took on most of the responsibility for human resources and paying the rent, while other organizations covered utilities. It was quite an innovative start.

Kali Shiva received capital monies in August 2005 from the Winnipeg Housing and Homelessness Initiative. Kali Shiva now has a permanent home. In April 2007, the Homelessness Initiative approved extended operational funding until December 2007. However, this funding was not renewed.

The drop-in is open Monday, Thursday, Friday and Saturday, to both men and women. It provides basic support services, such as meals, laundry, clothing, showers, emergency food boxes and harm reduction supplies. In addition, Kali Shiva operates an HIV program for positive women on Tuesdays and Wednesdays. They also have storage space for people's belongings

Food is donated by Winnipeg Harvest, which distributes to all the food banks and community kitchens in Winnipeg.

Safe Injection supplies come from Street Connections. People can help themselves to what they want. Kali Shiva requests only that their clients record what they take on a sheet located near the injection equipment, so there is a tally of the items distributed. To reduce the likelihood that people inject in the bathroom, ties and cottons are available in common areas. Kali Shiva also provides small sandwich bags for solvent users to put their rags in.

The drop-in usually welcomes 30 to 60 people daily, with only two staff on duty at a time to monitor the three floors. They have nine employees, with seven recruited from the target population.

"Sometimes I feel bad or hung over or something and come to a place like... Sunshine House... sometimes I just felt better. I felt okay."

focus group

"Yeah, places like that and you drop in, they're likely to ease you with all your problems or if there's something bothering you [...] Sunshine House [...] they sit around Sundays sometimes... you can eat, relax, watch TV, whatever, they have about 20 people would stop there all the time. Great place."

- focus group

CONTACTION CONTACTION

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# NINE CIRCLES COMMUNITY HEALTH CENTRE – INTEGRATING ABORIGINAL CULTURES INTO ITS SERVICES

### Mission and Vision

Nine Circles Community Health Centre is a community-based, non-profit centre that: supports HIV and STI prevention through testing, education, and treatment; provides coordinated medical and social supports for those living with and affected by HIV; and promotes sexual and personal harm reduction to those, at risk. It offers a variety of services, including: counselling, Aboriginal/cultural support, advocacy, social work, primary medical care, STI drop-in clinic, social networking opportunities, health promotion and education, and outreach.

Nine Circle's vision is one of client-centred care that: reduces rates of infection for HIV and STIs; improves quality of life for those living with and affected by HIV/AIDS; and reduces the stigma and discrimination associated with sexuality and sexual health, resulting in the overall improved health of the community.

Nine Circles is a not-for-profit organization with a board of directors. They obtain funding from various sources, although their main source is the Winnipeg Regional Health Authority. Nine Circles seeks to support the highest quality of life, general health and sexual health of people living with HIV through the provision of excellent primary care and treatment. This includes primary care, HIV-related treatment and care, on-going case management and linking clients with resources both within and outside of Nine Circles.

The Centre's spacious lobby is decorated with artwork of a First Nations theme. The Centre serves many Aboriginal people. The concept of Nine Circles reflects that everybody moves in various different circles throughout their life and that when we interact with other people, their circles overlap with ours. The circles also represent the integrated model adhered to by Nine Circles, showing that health is comprised of different components: physical, mental, social, and spiritual.

### **Services**

Services include counselling, health services, advocacy, education, prevention, social support and referrals.

The spiritual centre of the clinic is its Round Room. The room features a mural painted by an Aboriginal artist and is used for Aboriginal ceremonies, pipe ceremonies, sharing and drumming circles. It is a quiet, contemplative place where people can go if they are in crisis, they are tired, and need a peaceful place to rest. A ventilation system is in place for smudges and pipe ceremonies, which

are the only times when tobacco can be burned there. Nine Circles has an Aboriginal cultural advisor who provides one-to-one support and facilitates group activities such as drumming.

The boardroom is used for various meetings, such as the journal group, and as a waiting room for the food bank on Thursdays. A client room is open from 8:30 am to 5 pm and provides computers and a space to hang out. A multipurpose room hosts social events, the art therapy group, the STI clinic, life skills training, the food bank, volunteer appreciation days, and staff meetings.

The weekly food bank serves people living with HIV/AIDS. Attendance varies depending on needs experienced by the clients. The food bank can serve as few as ten people, and as many as 40, on a given Thursday. They distribute boxes filled with food items provided by Winnipeg Harvest which, at times, are supplemented with frozen meat and cold cuts purchased with funds raised by Gio's Cares, a local GLBT organization, to ensure that the food bank provides adequate protein sources.

One staff member is in charge of the food bank, while a number of volunteers assist with preparing and distributing the food boxes. The program also has volunteer drivers who deliver food boxes to people with restricted mobility. The food bank also considers the special needs of the clients. For example, many of them may need to take medications with milk, liquids, food, or may not have facilities to cook or store food.

## Harm Reduction at Nine Circles

Nine Circles practices harm reduction at all points of service delivery and distributes needles, condoms, and lubricant. Currently, a counselling student hosted by Nine Circles is working on implementing an addictions support group for Nine Circles clients. Nine Circles also provides extensive treatment and prevention information with the support of the Canadian AIDS Treatment Information Exchange (CATIE). The Winnipeg Regional Health Authority's program, Street Connections, is located in the same building as Nine Circles. They supply sterile injection equipment, condoms, lubricant, safer crack use kits, information, and sexual health supplies on-site and through their outreach van.

### Outreach

Since the end of the last fiscal year, Nine Circles has five outreach workers, who work essentially in the gay community. They are often the clinic's first point of contact for clients living with HIV, who historically have trouble making their appointments and have other issues preventing them from accessing care. People are also referred to Nine Circles through the clinic's nurses and doctors.







Everyone on the food bank delivery list is referred to outreach, so that workers can identify the barriers that are preventing clients from coming directly to them. The Health Sciences Centre also refers hard-to-reach clients to Nine Circles for outreach. Outreach workers work with clients to assess their barriers to care and develop plans along with the clients to address these barriers. This often includes providing one-to-one support and referring clients to a variety of community resources and Nine Circles services. Outreach workers often work in partnership with the Client Advocate and Long-Term Social Support Coordinator.

Outreach workers also conduct health promotion activities: HIV education seminars, coordinating special events such as Winnipeg's World AIDS Day event, Sexual Health Awareness Week, and Pride. In one health promotion partnership with the Winnipeg Regional Health Authority, a Nine Circles outreach worker accompanied public health nurses to local bathhouses to provide additional outreach support to bathhouse clients, including information about Nine Circles' Wednesday STI drop-in clinic. While the nurses set up testing clinics in two rooms of the bathhouse, the outreach worker circulates among the clients, provides them with information, and refers them to the clinics. The team has developed good relationships with the bathhouse owners, staff and clients.

Nine Circles is part of the GLBT Health Promotion Coalition to raise awareness of health issues of the GLBT community, including a syphilis awareness campaign.

The proximity of Nine Circles to a police station limits its accessibility for people who use drugs.

CONTACT NFORMATION

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# **USEFUL RESOURCE**

 Manitoba Harm Reduction Network Margaret Bryans Coordinator Tel: 204.228.8114

Email: harmreductionmb@yahoo.ca

Website: www.harmreductionnetwork.mb.ca



# 5. ROUYN-NORANDA, QUÉBEC

### HARM REDUCTION IN ABITIBI-TÉMISCAMINGUE

Abitibi-Témiscamingue is a region in northern Québec, about seven hours by car from Montréal. There are around 145,000 residents, spread over six cities with populations ranging from 10,000 to 40,000. Rouyn-Noranda is one of those cities, and has a population of about 40,000.

Although injection drug use was taking place in this region in the mid-1980s, people who used drugs had no voice and no leader at the regional level to address the issues they faced. That all changed in 1985, with the arrival of Pauline Clermont, a nurse at the Agence de la santé et des services sociaux de l'Abitibi-Témiscamingue (Abitibi-Témiscamingue Health and Social Services Agency). Injection drug use is an issue dear to her heart. When she joined the public health unit, she addressed the broader health services issues related to injection drug use with a harm reduction approach, even when it fell outside of the public health mandate.

Mme. Clermont studied the epidemiological data for the region, as well as the services that had been developed there. Estimates revealed that there were about 200 people in the region who injected drugs, and that about 50% of them were infected with Hepatitis C. Observations from a sero-prevalence study of regional inhabitants who inject drugs (SurvUDI) showed that 7% of them were HIV-positive, compared to 17.5% in Montréal and 10% in Québec City. Nevertheless, the prevalence was important enough to justify the development of a clinic of integrated services in the region. Some needle distribution was available there, but the survey revealed that in spite of this, people in the region shared needles more frequently than users elsewhere. They were also less frequently tested for HIV and hepatitis C than were users in other regions.

Risk factors for injection drug use in street-involved youth included: being a minor (3 times more likely to move to injection drug use); having recently been homeless (2.5 times); having recently used heroin (2.5 times); having used cocaine (2 times); having been sexually assaulted (2 times); and having injection drug-using friends (girls, 4.6 times; boys, 1.4 times).

From this information, it was determined that a continuum of actions based on harm reduction principles was needed, from the distribution of injection equipment to preventive clinical practices, including vaccination against hepatitis A and B, testing for HIV and HCV, safer sex education and condom distribution, and safer injection education, as well as the improvement of living conditions.

Three projects were then initiated in Abitibi-Témiscamingue by the public health authorities: the Access to Injection Equipment Project; the Programme Travail de rue (Street Work Program); and prevention projects targeted at people who inject drugs. These projects were all guided by the basic principles of community development. The first of these principles, stakeholder involvement, ensures that those most intimately concerned are at the table. It was a challenge in the early 1990s to get people who inject drugs to participate; however, over a one-month period, they did manage to consult 20 people who injected drugs. As a result, the first program to be established provided access to injection equipment.

Program planners took the time to define a common vision and to negotiate the objectives. If this had not been done, they may have lost sight of why they were doing this work. It also allowed them to determine where they were heading.

The planners listened to the needs and concerns identified by the stakeholders and learned about their experiences and knowledge. They combined experiential knowledge with theoretical models and created programs to respond to the needs of the region. They worked with the community on concrete actions, while respecting their pace. This was a long process that required political action aimed at decision makers and the mobilization of allies to work with them.

They were not afraid to advocate for funding and met with MPs and local politicians to get them on board:

"So that they may understand our reality, and that they may continue to advocate on our behalf, and that they know that in our region, well, there are not just elite basketball players or piano players, that there are all kinds of people and that everyone has a right to services."

- Pauline Clermont, Nurse, Agence de la santé et des services sociaux de l'Abitibi-Témiscamingue

Leadership on these issues has really come from the regional public health unit. They have developed training tools and, for the last 10 to 12 years, have been offering harm reduction training to correctional services personnel, substance use workers, nurses, and police through a project in prisons. As well, the outreach workers periodically meet with police to inform them about the harm reduction approach. According to Mme. Clermont, training is ongoing, since people move and change employment.

# Needle Exchange, Support Services and Information on AIDS Program

The Abitibi-Témiscamingue region now offers access to injection equipment 24 hours a day, seven days a week. How is this done?

The objective of the Programme d'échange de seringues, services d'aide et d'information sur le sida (Programme ESSAIS – Needle Exchange, Support Services and Information on AIDS (NESSIA) Program) is to prevent the transmission of infections, especially HIV and hepatitis C, by making available injection equipment and information on its use, through 35 access sites, including private pharmacies, which are the principal collaborators. Public health buys the kits, sends them to pharmacies, and the pharmacists hand them out at the prescription counter. The kits contain four of each of the following items: Securicups, water vials, alcohol swabs, and needles (syringes), as well as condoms. Emergency nurses distribute injection equipment after the pharmacies close. In some locations, outreach workers also hand them out, even though it's not their primary role. They undertake this task to help clients out and to tell them where to obtain equipment.

Evaluations revealed an increase in the number of safe injection kits distributed since the program's implementation in 1993. The pharmacies are the most frequently visited sites. It appears that consumers are younger and the number of women who inject is increasing.

The implementation of the NESSIA program did encounter some obstacles. Emergency nurses and decision makers lacked understanding of the program's objectives. The costs were high and funding was insufficient. Access to Aboriginal communities in the region was also a challenge. To address these obstacles, more information about the program was disseminated and site visits were conducted. NESSIA also circulated an injection equipment distribution policy, offered training on the harm reduction approach, and obtained financial support at the regional level.

After fourteen years of operation, NESSIA still encounters difficulties, such as resistance from new emergency room personnel to handing out the number of kits people request, lack of sufficient funding, drug use on distribution sites, and used-needle littering.

In 2007, NESSIA decided to update the distribution policy and resume site visits. They obtained financial support from the Health and Social Services Agency and requested an increase in budget at the provincial level. They also did an outreach worker intervention to address drug use by clients at the hospital access site.

As for the needs of Aboriginal people, NESSIA is raising awareness with band councils and the communities about the importance of acting on the issue of injection drug use. Access to injection equipment has been made possible through the reserves' health centres at Pikogan and Kitcisakik. In another locality, there is informal access through the nurse. As mentioned before, the approach must respect the pace of the community. Raising awareness has been slow and it is taking some time to build relationships of trust.

Additional challenges remain. Within health and social services, information, vaccination, testing, and support for people who use injection drugs must be increased. Proper disposal and recovery of used equipment needs to be improved. Plus, it is a continuous challenge to encourage people who inject drugs to use new injection material. NESSIA is also looking into strategies to prevent people from starting to inject. The living conditions of youth also need to be improved.

# Programme Travail de rue (Street Work Program)

The Programme Travail de rue (Street Work Program) was one of the first programs of its kind to be established in the Abitibi-Témiscamingue region of Québec. It was seen as a crucial measure for working with people who use injection drugs. The program has now been operating for fourteen years, with recurrent funding.

There are nine outreach workers in the Abitibi-Témiscamingue region, funded annually by the Health and Social Services Agency at a cost of \$400,000, including some funding for coordination. The recurrent funding has brought stability for the outreach workers and the program. Unfortunately, no outreach van serves the region, due to its vastness, nor are crack use kits being distributed there.

NESSIA conducted a study of outreach work with the Université du Québec en Abitibi-Témiscamingue and the public health unit, and developed a training manual for outreach workers. This will serve as a manual for all new workers and will also assist members of the boards of directors of outreach organizations.

The outreach program encountered some challenges when they received complaints from the youth protection services, the police, and other groups that did not understand this work. They had to raise awareness about the harm reduction approach. They scheduled meetings with municipally elected officials to help them understand. Significant ongoing efforts ensure awareness is maintained within the community. The programs are constantly challenged, but at least they don't have to worry about funding.

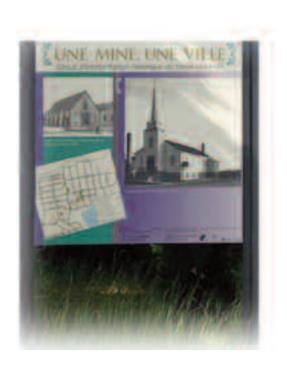
# The Prevention Project

The Prevention Project is targeted to people who use injection drugs. It is housed at an organization called Pikatemps in Val-d'Or. They offer a training program on harm reduction, a Peer Helpers Program with Arrimage Jeunesse in Rouyn, and a project in prisons at the Amos Detention Centre.

Pikatemps does street outreach and also visits strip bars and related establishments four or five times a year. Danielle Gélinas, Coordinating Nurse at the HIV/AIDS Regional Clinic describes the need for the service:

"Pauline Clermont is a visionary. Pikatemps was established for a very specific reason. A pharmacist contacted her to inform her that they were handing out so many needles and that something had to be done. She was the only pharmacist who was handing them out. The others refused. Now all pharmacies in Val-d'Or are handing them out, but there was still a major public health problem with regard to Hep C and HIV, so Pikatemps was created to do street outreach."

Once all of these three programs were established, it was quickly recognized that even more services were required, so they created nursing positions in all six cities. Then, they realized that people in the region living with HIV/AIDS had to travel to Montréal to obtain care, so they decided to establish a specialized clinic. See below.



# ABITIBI-TÉMISCAMINGUE HIV/AIDS REGIONAL CLINIC – AN AWARD-WINNING MULTIDISCIPLINARY APPROACH

#### **Awards**

Danielle Gélinas, Coordinating Nurse of the Abitibi-Témiscamingue HIV/AIDS Regional Clinic, was presented the Jill Sullivan Award for Excellence in Clinical Practice by the Canadian Association of Nurses in AIDS Care in 2007 for her exceptional contribution to the development of nursing care in AIDS.

The Clinical Innovation Award from the Québec Order of Nurses was awarded to:

- Danielle Gélinas, Suzanne Fiset and Pauline Clermont in 2006 for the Clinic project and its multidisciplinary approach. It is the only clinic of this model in a remote region in Québec.
- Pauline Clermont, Suzanne Boucher-Veilleux and Isabelle Cornet in 2007 for the Pikatemps Program, which offers prevention services, support and testing for STIs and blood-borne diseases.

#### Mission

The Abitibi-Témiscamingue HIV/AIDS Regional Clinic is the only integrated care clinic specializing in HIV/AIDS in a remote region in Québec. One advantage of a one-stop shop for care is that it is easier to retain people and ensure continuity of care.

The clinic was set up in Rouyn, since it is the central hub of the region, with most surrounding towns about one or one and a half hours away.

The Clinic's mission is to coordinate and ensure the delivery of high quality health care services by applying up-to-date, leading-edge knowledge in HIV/AIDS care and services, and to support other health care providers across the region.

The HIV/AIDS Regional Clinic consists of a regional team of health professionals which responds to the needs of the local community. The team includes a nurse, a pharmacist, a nutritionist, a social worker and a physician specializing in HIV/AIDS. The social worker on the interdisciplinary team helps with food needs, refers people to various social services and also helps them with social and financial assistance. Staff also pay house calls to new patients in order to assess how they are living and what their needs are. The clinic would like to add an occupational therapist to the team to address related client needs.

The clinic has two main mandates: continuity of care for people living with HIV/AIDS and peer training regarding HIV/AIDS for social workers, nutritionists, pharmacists and nurses. Staff sit on various roundtables, including one on gay and lesbian issues and one on substance use, and work with the Québec strategy on HIV/AIDS.

# Harm Reduction Approach

While the focus of the clinic is on the delivery of care to people living with HIV/AIDS, the clinic does embrace a harm reduction approach. The entire multidisciplinary team received training in harm reduction from the Health and Social Services Agency, as well as a session called "Get Fixed" by Darlène Palmer of Montréal's CACTUS. Every year, the team gets a day of training on harm reduction. They also work very closely with Pikatemps and hand out some injection equipment at the clinic.

#### **Services**

For people living with HIV/AIDS, the clinic offers: health assessments; follow-up on laboratory results; joint follow-up with the attending physician; continuity of care and vaccination; nutritional assessment and follow-up; psychological assessment, support and referral to appropriate resources; pharmacological assessment and follow-up (side effects, dosing schedule, etc.); information; and documentation.

The clinic also welcomes people who are co-infected with HIV and hepatitis C. Hepatitis C is an important health issue in Québec, and Danielle Gélinas believes it is essential for people who are going through treatment for hepatitis C to have the support of a multidisciplinary team. She would like to see clinics devoted to hepatitis C in the future, given the increasing number of cases.

The multidisciplinary team at the HIV/AIDS Regional Clinic is an excellent resource for all health professionals in the region. They provide: training and teaching; mentoring and placement opportunities; joint follow-up with attending physician; genotype interpretation for HIV resistance to medication; and links with the HIV/AIDS Research, Teaching and Care Hospital Unit of the University of Montréal Hospital.

The clinic refers people to the Centre des R.O.S.É.S., a local AIDS service organization, although the Centre prefers that people come to them on their own. Plus, they offer various activities and services for people living with HIV/AIDS: "meet and greet" coffee; movies; workshops; financial aid to help with travel fees and medication costs that are not covered; and vitamin supplements and Ensure. They also offer support and run a help line and a drop-in.

# Profile of People Living with HIV/AIDS in the Region

There are about 35 to 40 people who have files at the clinic. They see the attending HIV specialist at the clinic and they may also have their own family doctor who is involved in their treatment. The physicians work together to ensure a joint follow-up.

Many people living with HIV/AIDS in Rouyn-Noranda have lived in bigger urban centres and have come back to the region to be with family. There is a significant







need for housing people who return to the region. They are often older, sicker and homeless. They use shelters, and the clinic staff may have to intervene and assist them to get into shelters, given discrimination and misunderstanding related to HIV/AIDS.

"Even in 2007, to have cancer is socially accepted, but not to have HIV... I am convinced that if we continue to speak openly about it, we will succeed in overcoming some harriers"

Danielle Gélinas,
 Coordinating Nurse,
 HIV/AIDS Regional Clinic

### To Be Discrete in a Small Town

A small town presents particular challenges with regard to privacy and confidentiality. For example, people assume that everyone Danielle talks to is living with HIV. As the coordinating nurse, she is often asked to synchronize appointments in order to avoid people from the same town seeing each other in the waiting room. This is challenging to accommodate, as the physician comes to the clinic from Montreal only a few days per month.

# Fear, Ignorance and Stigma

Danielle Gélinas, the clinic's coordinating nurse, and Kathleen Sullivan, the clinic's social worker, are still surprised at how many health professionals have never been exposed to a person living with HIV, or even a gay man. In the community, they encounter a lot of stigma associated with HIV.

The multidisciplinary team will continue to raise awareness in the community and work on discrimination issues. There are challenges in getting into some places to do the training. They find they have better success by calling the training "information sessions", rather than "training sessions". They also find they have to be creative to find ways and venues to speak about HIV/AIDS. The annual AIDS Awareness Week is an ideal opportunity. There is a thirst for information and, once you get people in a room, they are interested in learning and talking about it.

CONTACT

Abitibi-Témiscamingue HIV/AIDS Regional Clinic

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# ARRIMAGE JEUNESSE - YOUTH OUTREACH IN A SMALL TOWN

#### Mission

Arrimage Jeunesse provides outreach services in Rouyn-Noranda, as well as support, referrals and accompaniment. It was founded in 1996 as a result of the involvement and support of 19 organizations and the municipalities of Rouyn-Noranda.

Arrimage Jeunesse is a not-for-profit community organization dedicated to improving the living conditions of youth in the Rouyn-Noranda region. The outreach workers employ a harm reduction approach, which aims at the overall reduction of negative consequences of risky behaviours for youth and society.

Technically, the outreach workers cater only to people aged 12 to 30, but they will serve people of any age. Their goal is to prevent, reduce and, if possible, eliminate the negative effects of risky behaviours on the physical and mental health of youth, and to promote the adoption of healthy practices. Outreach workers also help youth develop autonomy and the ability to adapt to their social environment.

As part of the Programme Travail de rue (Street Work Program), outreach workers visit places where youth live and hang out, in order to be known as an available resource. They ensure follow-up and support for youth who wish it, provide information and materials for the prevention of sexually transmitted infections and blood-borne diseases and observe social phenomena among youth, which they communicate to concerned stakeholders, for the purpose of improving services.





# Services

## **USEFUL RESOURCES**

- Centre des R.O.S.É.S de l'Abitibi-Témiscamingue
   A regional resource centre on HIV/AIDS; tel: 819.762.8403; email: centre-r.o.s.e.s@ cablevision.qc.ca
- Info Sidaction an information publication on HIV/AIDS published by the Centre des R.O.S.É.S. de l'Abitibi-Témiscamingue (see above)

The services of Arrimage Jeunesse include: listening and support; referrals and accompaniment; distribution of prevention material, such as information pamphlets, condoms and safe injection kits; support for youth in the completion of projects; emergency food service; mediation and defence of youth interests; information, listening and support for parents; conferences; and facilitation of information and awareness workshops.

Arrimage Jeunesse has been in its current location for a year. It is a convenient, central, storefront location that is inviting for people who need the services. Their hours vary, with each worker serving 35 hours a week. Only the nurses, who come in two hours a week and hold hepatitis A and B vaccination clinics, and the food service are on fixed schedules.

Staff refer people to the Centre des R.O.S.É.S for HIV/AIDS related issues and services, and to the Centre Écho Jeunesse, which assists youth in finding employment. They also send youth to the Youth Clinic.

# Being an Outreach Worker in a Small Town

Ugo Lavigne, Outreach Worker, explained that outreach workers in small towns and remote areas often experience isolation. They don't always know who to talk to for service information and support, since the programs in large urban centres are not always applicable to their local situation. Fortunately, good collaboration between organizations and workers in Rouyn helps.

CONTACT INFORMATION

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# 6. OTTAWA, ONTARIO

# OASIS - A MULTIDISCIPLINARY APPROACH TO OUTREACH AND DROP-IN SERVICES

Oasis is a program of the Sandy Hill Community Health Centre. It opened in 1996, as a result of community pressure on funders to address gaps in services. Its mandate is to provide services to street-involved people who have or are at risk of HIV and hepatitis C. Oasis' legal responsibility is to the Sandy Hill Board. Fifty plus one percent of the seats on the Oasis Advisory Committee are held by people who use the services.

#### **Services**

Oasis services include: a drop-in with snacks, showers, laundry, a computer, clothing, food vouchers and bus tickets; a physician, nurse practitioners, a dietician and complimentary therapies; counsellors and a practical assistant worker; a life skills and an addictions worker; outreach services both by car and on foot; peer projects; a women's clinic; needle exchange, condoms, safer crack use kits; a dietician; arts and crafts; and cooking.

Oasis' one-stop-shop, multidisciplinary team approach was an innovative concept at the time of its launch. Its interdisciplinary model of practice, service delivery and integrated harm reduction approach has since attracted international attention. They were the first off-site needle exchange in Ottawa, partnering with Ottawa Public Health. The health care workers, who offer harm reduction-based primary care on site, are very empathetic and work very effectively with their multiply-challenged clients. Students can do placements within the organization when they are training to be community nurses, social workers, medical residents, interns, or paramedics.

Oasis holds a weekly Men's Harm Reduction Support Group, an annual Street Angels Memorial, and since 2001, has been supporting "Choices and Voices", Ottawa's first peer-driven harm reduction newsletter.







Oasis staff offer presentations on harm reduction, health promotion and non-violent crisis intervention. They are also research partners in a Best Practice Study on HIV/AIDS in community health.

Oasis serves about 600 medical clients and 1,100 drop-in clients: 95% are past or current substance users; 50% are diagnosed with a mental health condition; about 21% are living with HIV; and 42% are living with hepatitis C. The program has received federal funding from the homelessness funded programs.

As Ryta Peschka, Community Outreach Worker and Community Educator on Harm Reduction, explains:

"When we did open our doors... even though that was over ten years ago, I can't stress how radical the particular program was. It was very exciting times because we were sort of able to run with the ball... When we first started as well, there were not many other agencies that had the concept and the service of outreach... As people started to change and the climate of the community started to change with more infections and more addicts coming out of the woodwork, we really had to try and be one step ahead of everybody to see if we could help fulfill the needs that they had. And some we did, and sometimes we stumbled and fell."

## **Client-Based Guidelines for Behaviour**

Another innovative part of the Oasis program was that the guidelines for conduct in the drop-in were based on mutual respect and overall behaviour and focussed on the safety of both clients and staff. It was the people who use the services who determined what behaviour was deemed acceptable, and what behaviour could lead to their being barred from the premises. Conflict resolution is based on non-violent crisis intervention and a barring process. The clients are empowered by having an official complaint process through which they can place a grievance.

If clients are barred, they may return. Ryta Peschka describes the process:

"We have a re-entry process as well, so if people have been asked to leave and they want to come back, with the support of community members or outreach workers, they do come back and go through that process, so that they are able to recognize what some of the inappropriate behaviours were that put them at risk of being denied a particular type of service in the first place...They get to bring their support person, if they want, and I would be perhaps working with them to help them problem solve around the incident and go through it and give them the support, if they needed, to come in to meet with the physician and the nurse... So, it's not like a three strikes you're out."

### Oasis' Outreach Program

In 1996, Oasis started their outreach by delivering condoms to escort services. They partnered with Ottawa Public Health to provide health information and hepatitis B shots to exotic dancers in the Ottawa area. In 1998, they created the first support group for sex workers.

Subsequently, they developed partnerships with community agencies such as Amethyst Women's Addiction Centre, Bruce House, and Sobriety House. They introduced Peer Projects and life skills programming, and they provide awareness education on HIV/AIDS, addictions and harm reduction within the larger Ottawa community. They also provide mentorship for their clients and advocate for consumer representation on committees and advisory boards.

Oasis has a regional mandate, so it does provide some support for clients in Kingston, Brockville, Carleton Place and the area east of Ottawa.



Oasis is presently working with women using illegal drugs, who are pregnant and who have children under the age of six, to address their substance use treatment needs. In partnership with the Champlain District Health Council, the Children's Aid Society and a women's treatment facility, they have developed family and youth programs and parent resource centres. For example, Oasis facilitates a parenting group for children with Attention Deficit Disorder and Attention Deficit and Hyperactivity Disorder (ADD/ADHD).

Oasis has been sitting on the Champlain District Advisory Committee for the Early Childhood Development and Women with Addictions Project since 2001. The project, funded by the Ministry of Health and Long Term Care, works with allies in the addictions, early years and child welfare sectors, with the aim of improving treatment services for women with addictions who may be pregnant or have children under the age of six. One of the Committee's goals was to develop training modules to help identify early addictions, and to introduce and implement risk reduction strategies. The training was offered to frontline workers and agencies that provide services to women, including Children's Aid Society, Addiction and Mental Health Services, Ontario Works, Ontario Disability Support Program, and social services.

Ryta Peschka helped develop and implement the harm reduction component in the training modules for the Early Childhood Development educational manual. As one of its community facilitators, she went to Brockville, Cornwall and Kingston to provide training, advocate for clients, and support high-risk parents in making the changes necessary to increase the chances of their keeping their children. When children are apprehended, her role is one of intensified support as women grieve and experience the trauma of separation, the increased risks of relapse, and the need for advocacy on legal rights and visitation.



"We had a lot of great, innovative programs. Funding got cut, and in that sense the... users of the services were kind of let down. So it's almost like an elastic band, in the sense that we would be able to pull them in, and when the money was gone, they would be gone, and we'd have to start looking for them again."

— Ryta Peschka, Community Outreach Worker and Community Educator on Harm Reduction, Oasis



## **Challenges for Oasis**

One of the challenges Oasis, and many other organizations, face is the fluctuations and insecurities of project funding, both for the organization and for the community. Fluctuations in funding result in fluctuations in services, and instability for the people who use the services.

Oasis was recently forced to relocate, when the building they were in was sold and the new owners did not renew their lease. They have integrated into the Sandy Hill Community Health Centre. Though they were not located in the same neighbourhood, they do share a similar clientele. According to Wendy Hyndman, an outreach worker at Sandy Hill, "The Oasis move will be for the better. Better location. More people hang out closer to here ... More harder-to-serve clients. Their clients will have access to more services."

The move has had its ups and downs. The new space Oasis occupies is much smaller. They are on a different floor from the rest of Sandy Hill Community Health Centre, and do not have much contact with each other, which has advantages and disadvantages. And, although many clients have followed Oasis to seek services at their new Sandy Hill location, some did not. The move has, however, brought some new clients, and Oasis is very busy.

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#### OTTAWA PUBLIC HEALTH'S SAFER CRACK USE INITIATIVE

## Background

The City of Ottawa Public Health reports that research suggests people who smoke crack cocaine are at increased risk of HIV, hepatitis C infection, and other sexually transmitted infections, such as syphilis and herpes. <sup>19</sup> The pipes used for smoking crack, which are often improvised out of metal, glass, or plastic, can cause burns, blisters and cuts on users' lips and inside their mouths. Given that crack pipes are frequently shared, people who smoke crack cocaine and have oral sores may be exposed to the potentially infectious blood left on the pipe by other smokers. <sup>20</sup> Some studies have also found that people who smoke crack cocaine are at increased risk of HIV through unprotected receptive oral sex. <sup>21, 22, 23, 24</sup>

The City of Ottawa is in the midst of a public health crisis concerning HIV and Hepatitis C infection among people who inject drugs. There are between 3,000 and 5,000 people who inject drugs in Ottawa. It is estimated that 70% of the people in Ottawa who inject drugs also smoke crack. The HIV prevalence rate among this group is at 21%, which is the highest in the province of Ontario and the second highest in Canada. It is three times greater than Toronto's rate and four times greater than the rate in the rest of Ontario. Hepatitis C is estimated to be 10 to 15 times more transmissible than HIV and is significantly more prevalent among people who inject drugs in Ottawa. The prevalence is estimated to be at 76%, higher than either Montréal's (70%) or Toronto's (54%). Significantly more people who smoke crack reported being infected with Hepatitis C (45%) compared to non-crack smokers (14%). Disease prevention efforts among this population are much needed.

<sup>&</sup>lt;sup>19</sup> Wong J, Cheung Y, Wilson W & Methven T. A Review of the Literature Concerning the Risk of Transmission of HIV/hepatitis/TB among Crack Users in Toronto. Toronto: Unpublished report.

<sup>&</sup>lt;sup>20</sup> Porter J & Bonilla L. Crack users' cracked lips: An additional HIV risk factor. Am J Public Health 1993; 83: 1490.

<sup>&</sup>lt;sup>21</sup> Faruque S, Edlin BR, McCoy CB, Word CO, Larsen SA, Schmid DS, von Bargen JC, Serrano Y. Crack cocaine smoking and oral sores in three inner-city neighbourhoods. *J Acquired Immune Defic Syndromes* 1996; 13: 87-92.

<sup>&</sup>lt;sup>22</sup> Jones DL, Irwin KL, Inciardi J, Bowser B, Schilling R, Word C, Evans P, Faruque S, McCoy HV & Edlin BR. The high-risk sexual practices of crack-smoking sex workers recruited from the streets of three American cities. The Multicenter Crack Cocaine and HIV Infection Study Team. Sex Transm Dis 1998; 25: 187-93.

<sup>&</sup>lt;sup>23</sup> Wallace J I, Weiner A, Steinberg A & Hoffman B. (1996) Fellatio is a significant risk behaviour for acquiring AIDS among New York City streetwalking prostitutes. *11th International Conference on AIDS* 1996, Vancouver (Abstract no. PoC 4196).

<sup>&</sup>lt;sup>24</sup> Wallace JI, Porter J, Weiner A & Steinberg A. Oral sex, crack smoking, and HIV infection among female sex workers who do not inject drugs. *Am J Public Health* 1997; 87: 470.

## History of the Safer Crack Use Initiative in Ottawa

In Ottawa, a needle exchange program started in 1991, and started very small. In 1992, 10% of people who injected drugs had HIV, an important issue from a public health perspective, since the spread can escalate rapidly, and get out of control, when the prevalence reaches 9% or higher. This is even more of an issue for hepatitis C, with rates typically much higher than those for HIV in people who inject drugs.

Ottawa is a very political and conservative city. The needle exchange program was not well received and has faced opposition throughout its existence. There has been much lobbying to City Council, many complaints to the Health Department, and numerous articles written in the newspapers against needle exchange in the city. As a result, the program had implemented repressive policies which were maintained for many years. They included one-for-one exchange of new needles for used ones and penalties for not returning needles to the exchanges. At the time of implementation, however, the program had very good support from the Chief of Police.

In 1997, the Ontario Ministry of Health and Long Term Care made needle exchange programs mandatory health programs for communities' health units. In 1999, Ottawa City Council approved the needle exchange program, despite remaining under fire from the community.

In 2000, City Council ordered a complete review of the program, which led to an action plan with recommendations approved by City Council. One recommendation was to establish a balanced advisory committee. In October 2002, therefore, Paul Lavigne was hired to organize the committee.

The advisory committee consisted of a University of Ottawa researcher, one member of a community agency, active and former users of the needle exchange program, representatives from community residents associations, ex-officio public health staff and Ottawa Police Services staff.

One of its first tasks was to look at the supplies that were being distributed through the needle exchange program. The need for crack pipes was identified on Paul Lavigne's first shift on the outreach van. One woman was angry because she felt that public health was doing nothing for her as a crack smoker. She was as much at risk as everybody else, yet it seemed that Public Health did not care about her needs. "She showed me her lips that had burns and cuts, and she told me the story that she had to go to the hospital to have burnt bits of Brillo<sup>25</sup> removed from her throat," stated Lavigne. He recommended to the committee that they also examine the provision of safer inhalation equipment.

<sup>&</sup>lt;sup>25</sup> Note that Brillo (steel wool) or something similar to it is used as a base to hold the crack as it is being heated in pipes; it can be inhaled and lodge in the user's throat.

The Advisory Committee reviewed all the products that were given out in the needle exchanges and made the recommendation to provide the full range of safer injection equipment. Ottawa Public Health was the first health unit in Ontario to do this. Their guiding principle was that if a product proved to prevent transmission of a disease, whether HIV, hepatitis C or other blood-borne pathogens, they needed to provide it to the people. It is the ethical thing to do.

Providing injecting equipment was not a problem because it was provincially mandated. The discussion around inhalation equipment, however, was more politically sensitive. Nevertheless, the Committee pushed it through, which meant that the Medical Officer of Health needed to make the decision, because he was ultimately responsible for it. The Public Health staff met with him and he was very supportive.

In October 2004, the Medical Officer of Health presented a proposal regarding the distribution of safer crack use supplies to City Council. Implementing the proposal required less than \$10,000. It was presented to the Council for their information only, since the Medical Officer of Health did not require permission from City Council to start the program. The program generated media frenzy. However, opposition from the general population was limited, as people were more concerned about discarded needles than they were about crack pipes. At that point, the Chief of Police came out publicly and said he understood why the Medical Officer of Health would make such a decision in the spirit of disease prevention.

The Public Health staff got the go-ahead to plan the program by March 2005. They trained all the partner agencies, developed best practice guidelines, put the kits together and prepared the educational material. They were set for an April 1, 2005 launch and sent a memo to the Chief of Police at the beginning of March to inform him. To their surprise, the Chief called a press conference on March 31st, after drug busts of neighbourhood crack houses. While he invited the Medical Officer of Health to attend, he seized the opportunity to tell the media that he was against the program.

The Medical Officer of Health was very surprised. Nonetheless, the program was launched the next day under a lot of tension and media scrutiny. People were scared to come in to the needle exchange. The staff was nervous and some were refusing to give out the equipment because the Chief had threatened to lay criminal charges for distributing crack equipment. Regardless, the program operated successfully for several years.

## Safer Crack Use Initiative - Program Design and Policies

The Safer Crack Use Initiative provides kits with materials for safer crack use, including glass stems, latex mouthpieces, brass screens, chopsticks, lip balm, condoms and lubricant; educational material on safer crack use, disease prevention, proper disposal of glass stems and access to safe disposal containers; information

#### **USEFUL RESOURCES**

- City of Ottawa's
   Public Health website:
   http://www.ottawa.ca/
   residents/health/index
   en.html
- Safer Crack Use Initiative Evaluation Report available at http://www.medecine. uottawa.ca/epid/eng/ hiv\_itrack.html
- Leonard L. DeRubeis E. Pelude L, Medd E, Birkett N, Seto J. "I inject less as I have easier access to pipes": Injecting, and sharing of cracksmoking materials, decline as safer cracksmoking resources are distributed. International Journal of Drug Policy, In press. Available at http://www.canadian harmreduction.com/read more/Crack\_Ottowa\_ Leonard.pdf

about testing for HIV, HCV and sexually transmitted infections; information on hepatitis A and B and influenza immunization; guidelines for basic medical care, such as first aid and wound care; and referral sources for counselling, addiction treatment and health and social services.

The Ottawa Public Health policies regarding the Safer Crack Use Initiative state that the distribution of safer crack use supplies is restricted to people 18 years or older. This policy was developed in consultation with the Ottawa Police Service. Clients can request a maximum of 20-five glass stems per visit for personal use. In practice, most clients ask for one to ten stems per visit. Harm reduction products, including glass stems provided by Site, have no City of Ottawa identification.

There was a 140% increase in the number of service encounters during the first month of the initiative. A significant increase in the number of first-time users was also observed. For 2005, the program recorded an increase of more than 100% in the total number of service encounters. Each client encounter with public health staff presented an opportunity for education, prevention, care, support, access to health care services and referrals to other social service agencies, including drug treatment services.

#### **Evaluation of the Safer Crack Use Initiative**

An evaluation of the safer crack use initiative was completed by 2006.<sup>26</sup> It provided the following key findings:

- Uptake by users was immediate, high and sustained 94% at the one year post-implementation evaluation point;
- Reduced sharing of crack pipes, from 37% to 13% of users who share every time;
- Decreased injection drug use 40% had reduced drug-injecting behaviour and 18% had stopped injecting;
- 77% of people who smoke crack reported using in a public place at least once in the 12 month post-implementation of the initiative;
- 25% of people who smoke crack reported that police officers had confiscated their new and unused glass stems;
- Marginal decline in the proportion of participants reporting the presence of oral sores;
- 46% of people who smoke crack declined to collect the rubber mouthpieces, stating they preferred alternate materials.

<sup>&</sup>lt;sup>26</sup> Leonard LE et al. *Harm reduction success as needle exchange program distributes safer crack smoking resources.*16th International AIDS Conference, Toronto, abstract THLB0104, 2006.

- Approximately 84% of users utilize brass screens given by program. The remaining tend to use Brillo pads.
- The majority of users reported disposing of glass stems in the garbage. Stems are rarely returned to The Site office, but may be discarded through the black box program.

#### **Current Situation in Ottawa**

Although the Safer Crack Use Initiative operated for a few years without incident, the new mayor, elected in November 2006, made a promise in his election campaign to shut it down, along with the needle exchange program.

In the summer of 2007, the mayor led the City Council in a vote of 15 to seven to cancel the safe inhalation program, despite excellent evidence favouring the program and the medical officer of health's support for it.

As a result of the mayor's political interference, relations between the police service and public health have broken down and staff morale has been undermined. However, those who lost the most are the people who smoke crack and who need the service.

Local organizations have found some funds to keep the program operating, and organizations and individuals from across the country have sent letters to the mayor expressing their concerns and outrage about the cancellation of the program. Recently, the AIDS Bureau of the Ontario Ministry of Health and Long-Term Care funded the safer crack use kit program through the Somerset West Community Health Centre.

This controversy has created some good opportunities for dialogue. Residents got involved in the debate and became informed and educated. People came forward and talked about harm reduction and drug use in their communities, and the city is now developing a drug strategy.

As well, Ottawa also has a new Chief of Police, who says he is supportive of needle exchange and harm reduction and wants to be educated on the evidence related to inhalation equipment.

Furthermore, outreach workers and agencies from neighbouring Gatineau, in Québec contacted the City of Ottawa's Public Health staff to work with them in developing their own safer crack use initiative. They are now distributing the safer crack use kits, despite Ottawa City Council's decision to cancel the program.



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#### METHADONE CASE MANAGERS IN ONTARIO

In May 2007, a new position of methadone case manager was funded by the Ministry of Health and Long-Term Care for each health district in Ontario. The goal of implementing a case management model is to help clients remain in treatment.

Methadone Maintenance Treatment (MMT) is an outpatient program. It is client-directed to a degree, with some clients setting their own goals. The role of the case manager is to work on their goals with them, at the client's pace.

The main activities and caseloads of the methadone case managers vary greatly. Currently in Ottawa, the case manager's caseload consists of about 18 clients, with tasks including: advocacy and mediation between client and community services; accompaniment to appointments; assisting in housing search; goal setting, emotional support and motivating the clients, and providing methadone- and treatment-related information.

The methadone services coordination varies across Ontario, and in some cases, the methadone case manager is not affiliated with a specific methadone clinic. This has some advantages, in that an unaffiliated case manager may be freer to advocate and mediate in the best interest of the clients and refer them to resources that best meet their needs, rather than those of their MMT program. For example, if someone has to pay for their methadone, the case manager can help them locate a place that has the best prices.

In Ottawa, the methadone case manager works for an outpatient treatment agency for Addictions and Problem Gambling Services Ottawa, at the Sandy Hill Community Health Centre.



"Another thing that I put a lot of effort in is that [for] everyone [who] comes in, if they come and see me in my office, ... is actually get a coffee on a saucer with a spoon and little creamers, and they think it's quite funny to see me come out with my little tea service, and I do that for a very specific reason...it's one of the things to try really hard to de-stigmatize the fact that they're getting methadone... So I put a lot of effort into that to make it so that it's normal, that it's good, that kind of service."

The frontline staff and health care providers appreciate the advocacy and mediation aspect of the case manager's work, as well as being able to contact difficult-to-reach clients through the case manager.

The methadone case manager also acts as a liaison between the client and the physician. As clients spend only about ten minutes at a time with their physician, there may be things that they did not get a chance to discuss. The case manager can address some of these issues.

## **Challenges**

MMT still faces many challenges. More physicians are needed who will prescribe methadone. Stigma and unfounded myths still surround methadone and methadone use. Despite guidelines, recently revised by the Methadone Maintenance Treatment Practices Task Force, practices vary and are inconsistent across methadone providers. And they are sometimes arbitrary. For example, if a methadone physician decides to kick someone off the program because of drug use or a momentary lapse, there is no recourse for the client. Some physicians will limit the methadone dose arbitrarily and refuse to give someone more, or less, than a set amount. Clients who change physicians may find their carries privileges revoked. Some physicians will not listen to clients' requests to taper them off methadone, or to change their dose levels. As well, a number of people have criticized the private, group-practice model of MMT which has become widespread across Ontario, as more interested in profit than good care. Further, good practice guidelines recommend that group and/or individual counselling be available as part of MMT, to address personal and mental health issues which occur concurrently with most addictions, and this is rarely the case.

#### **Successes**

There are some successes to be celebrated. The fact that the need for case management and accompaniment for people receiving methadone treatment has been recognized and acted upon by the Ministry of Health and Long-Term Care is a positive outcome. Ottawa's emergency funds for clients are also very useful. Moreover, the methadone case manager has improved collaborative relationships with the methadone providers and ensured the flexibility and customized pace of

the program works well for the clients. The fact that the Ottawa case manager can hold funds for clients, serving as a kind of safe-deposit bank, has the added benefit of allowing some clients to control their substance use as well.

## Political Climate Regarding Methadone in Ontario

According to Dr. George Kolbe, Medical Director of Ottawa's clinic, the Ontario Addictions Treatment Centre, methadone treatment is in a lot of turmoil across the province of Ontario at the moment, making physicians feel threatened. Ontario set up a provincial Methadone Maintenance Treatment Practices Task Force after some controversies arose regarding methadone maintenance treatment in Ontario, especially in the group practice clinics, including the death of an Ottawa man from an overdose of methadone. There were also issues regarding inconsistencies in practice, the costs of methadone and billing practices. The Task Force released a report with recommendations (see Useful Resources below). Dr. Kolbe feels that there were politics involved in developing the recommendations and that many physicians feel anxious because they are spread thin and feel obligated to the people they are treating.

## More education for medical community and the public

There continues to be barriers to health care, detox and problematic substance use treatment for people on MMT. Some abstinence-based treatment programs refuse to allow people to participate if they are on methadone. Other programs will insist on drastically reduced (and not necessarily therapeutically appropriate) daily doses of methadone in order for people to get into treatment, causing great discomfort and withdrawal.

Dr. Kolbe would like to see better information made available to the medical community and the public, and to see improvement in the treatment people on methadone receive from health professionals, which deters them from seeking medical care when they need it.

"We have our patients end up in emergency for whatever reason. They are treated as a drug addict, which they hate, and so they feel discriminated against. So even if they have a serious non-drug-related issue, they just refuse to go... or they go and I phone the emergency physician and say this patient wants to be checked in for 24 hours... A typical case... a patient told me that it felt like their methadone was too strong. We checked the labels to make sure everything was correctly labelled. The methadone is sent to our clinic via a pharmacy. And I sent him home, and he phoned again within the hour and said he was feeling a little drowsy. So I said, 'OK, you are going straight to emergency.' I phoned the physician, I explained to him that methadone is long-lasting and we have to assume that this

"For example, the three of us who work in this clinic, we commute a long distance, we have a family practice [elsewhere], we are thinly stretched. If my income drops from methadone. I am going to have to review this. But we feel pretty obligated to be here. We have lots of patients who come from living on the streets to living in their own apartments, married, with children, working to become more productive members of society, and if the program disappeared, they would end up back on the street."

Dr. George Kolbe,
 Medical, Ontario Addictions
 Treatment Centre (Ottawa)

patient has overdosed. It certainly looks like it. He was sent out in an hour and was treated quite badly and that's a common scenario, unfortunately."

The faculties of medicine in our universities provide very little training (if any) about illegal drugs, let alone about methadone maintenance as part of their core curricula. Few physicians graduate with a solid concept about the issues surrounding drug use. MMT itself remains stigmatized, and not enough physicians want to provide it. Methadone physicians are overwhelmed and cannot accommodate the number of people seeking treatment.

Methadone Maintenance Treatment was introduced almost 50 years ago. It is still under-resourced, misunderstood and rife with stigma and myth. Case managers are a help, but the necessary improvements in the delivery of this vital treatment service cannot be left entirely in their hands.

#### **USEFUL RESOURCES**

- Report of the Methadone Maintenance Treatment Practices Task Force, March 2007. Available at: http://www.health.gov. on.ca/english/public/ pub/ministry\_reports/ methadone\_taskforce/ methadone\_taskforce.pdf
- Methadone Maintenance
   Treatment Clients
   Handbook, revised (2008):
   Available at the Centre
   for Addiction and
   Mental Health at
   http://www.camh.net/
   Care\_Treatment/
   Resources\_clients\_
   families\_friends/
   Methadone\_Maintenance
   \_Treatment/mmt\_
   client\_hndbk.pdf



# 7. QUÉBEC, QUÉBEC

#### POINT DE REPÈRES - COMMUNITY-BASED NEEDLE DISTRIBUTION AND MORE

### **Award**

Mario Gagnon, Executive Director at Point de repères, won the 2008 Kaiser Foundation's National Award for Excellence in Reducing the Harm Associated with Addiction and Substance Abuse for his work in community programming.

#### **Mission**

Point de repères is an organization for people who inject drugs. Its mission is to provide health promotion, disease prevention, and health care delivery with regard to blood-borne and sexually transmitted infections and substance use.









#### **Services**

Point de repères provides: needle and injection equipment distribution and recovery; condom distribution; outreach on the street, in shooting areas, in people's homes, and in prisons; a drop-in area; HIV and hepatitis C testing and prevention; vaccinations for hepatitis A and B; education about safe injection; wound care; overdose prevention; support for people living with hepatitis C; accompaniment for people living with hepatitis C to access treatment; counselling services; and advocacy. They do not distribute safer crack use kits. There are five types of services: nursing care; outreach; on-site harm reduction services; research; and student placements. Yearly, Point de repères serves about 3,000 people who inject drugs. They hold an annual memorial service on December 1, World AIDS Day, for the clients and other marginalized people who have died over the years.

## **Funding**

Point de repères is funded mainly by the provincial government, with some funding from the federal government. The funding they receive is primarily for their needle exchange program. They have 17 staff, six of whom are permanent employees. The rest of the funding comes from projects of six months to a year in duration. They currently have two three-year projects on the go. Funding does not always reflect their need, however. For example, treatment for hepatitis C lasts one year, but the programs are funded for six months. They also had to start refusing projects that do not come with adequate funding, since this created expectations and then let people down.

## Approach

Their approach in service delivery rests on harm reduction. They recognize that certain behaviours are a fact, and not necessarily a problem to be resolved. With this in mind, they attempt, through realistic and pragmatic objectives based on a holistic view of the individual, to reduce the negative consequences which may be associated with drug use and sexual behaviour.

# **Philosophical Principles**

Point de repères provides a welcoming, respectful environment, and without judgement. Staff develop significant relationships with the people who use their services, based on trust, in order to encourage the adoption and/or maintenance of safe and responsible behaviours regarding both sexual activity and drug use. They consider people who use their services to be individuals wholly capable of taking charge of their own development and of acting in their community in a responsible manner.

Point de repères refers people to services they do not provide and acts as a bridge between their clients' living environment and social and community services. To ensure that services are continuous and complementary, Point de repères has developed collaborations with community, private and governmental organizations.

Point de repères does not post its code of conduct in its lobby or reception area. They find that too institutional and prefer, rather, to act it out. They do, however, post the Charter of Rights and Freedoms and the Charter on quality of life in their drop-in area.

"For the moment, I am very well served here at Point de repères.
When I needed help, they never closed the door in my face."

- focus group

## **Relationship with Surrounding Community**

Point de repères is located in a poor neighbourhood that is currently undergoing gentrification. It rents space in the basement of a church, the only place they could find that was willing to rent to them. The surrounding community has mixed reactions to their presence. Some fear them, some do not want them around, and some think they are doing good work. Most of the reactions they get are negative, not so much because of their work, but because people do not want them in their backyard.

Point de repères is under lots of pressure from local businesses who do not want their clientele hanging out in front of their shops. The people who use their services have been experiencing lots of police repression, and they are being pushed further and further away, making it a challenge for them to get the services they need and for Point de repères to reach them.

Many community-based organizations are being pressed to provide services outside the scope of their mandates or expertise. For example, they may have to deal with people in withdrawal, or experiencing medical issues like heroin or cocaine overdoses, wounds, abscesses, phlebitis, "cotton fever", etc. Their clients do not have access to medical services, and the community agencies have had to find their own ways to handle this. Point de repères has a nurse on-site who can attend to some of the health care needs of the clients. They also have a physician who comes in one afternoon a week to provide HIV and hepatitis C follow up and abscess treatment.

A network of community partners, public health and police services has been set up to address some of the issues faced by people who inject drugs and to hand out equipment and do some education. There is a learning curve to surmount, as some of these organizations do not understand harm reduction principles.

Point de repères is also working on a project to increase compassion toward people who inject drugs. It includes training and testimonies for police, residents, local merchants and community organizations. However, they find they are not really

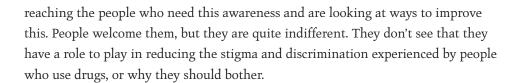
"What I love about Point de repères is that we are not judged. We are always truly welcomed with good spirits. And if we get there and we are not in a good mood, it cheers us up. They are not afraid to give, you know, when we ask for more so that we don't run out... It is possible to get a sufficient quantity so as not to run out. I appreciate that a lot because I am not always able to get there."

- focus group

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"The street guides are a wonderful thing because we reach a clientele that does not always come to Point de repères."

- focus group



#### **Practice Guidelines**

Point de repères is collaborating with researchers from Université Laval, and devised some practice guidelines for non-medical staff working with people who inject drugs, one on cocaine and opiate overdoses, one on skin infections, and one on fever and hyperthermia. These provide guidance on how to identify causes of illness or infection and how to manage these situations to prevent complications. They have also developed tools on wound care and on how to identify other infections, which they distributed to other organizations for their use. They have been so popular that Point de repères has received some funding to get them translated, so they can reach a broader audience. See 'Useful Resources' for more information.

#### "Street Guides"

Point de repères, in collaboration with Université Laval's Faculty of Nursing, trains people who use their services to become guides de rues or "street guides". The street guides can be people who inject drugs, sex workers or drug dealers, and they are trained to provide education to people who use injection drugs. The training is done every two weeks for a period of one year and addresses sexually transmitted infections, first aid, cardio-pulmonary resuscitation (CPR), wound care, how to manage abscesses, phlebitis and cotton fever, assistance relationships and legal issues. Through the street guides, Point de repères has been able to broaden the scope of their service provision and make contact with a hard-to-reach clientele. The street guides developed little booklets with referral and other useful information for their use when they do outreach, often in collaboration with the staff and researchers. The project has reduced the distance between street-involved people, researchers and staff.

### PRIMARY CARE SERVICES

Point de repères also offers primary care on-site. One of the important services they provide is hepatitis C and HIV follow-up care. According to Isabelle Têtu, the on-site nurse, it is a myth that people who use drugs are non-compliant with their treatment for HIV or hepatitis C. With education which develops their awareness, people will understand why compliance is important for their health and continue their treatment.



"As a nurse, I do follow-up for hepatitis C treatment and I have some people who inject cocaine every week, and they are able to comply with their treatment. They adhere to the treatment and they come to their appointments. When they don't come, they call me. It's like anyone else who does not use drugs. It's all, I think, in the developed trust and therapeutic relationship with that person... our strength is in welcoming these people and in the development of a relationship. We tell ourselves that if we have a good relationship, we will be able to work with that person and to bring them to where they want to go."

Isabelle also points out that although talking about HIV and hepatitis C prevention is good and important, this is often not the main concern of street-involved people. There are many other priorities that come first, such as food and housing, for example. And to be able to act on HIV and hepatitis C, we may first have to act on addressing the determinants of health.

#### Research

Point de repères has changed their vision regarding research, as Mario Gagnon, Executive Director, explains:

"Researchers would come, do their study, leave and there would be no follow-up. Now we are more selective about which research we take part in and choose studies that will meet our needs and the needs of our clientele and that will give something concrete at the end, not just to publish scientific articles or to put a gold or bronze plaque on a researcher's wall."

It does serve the organization well to have support from university researchers. It provides them with scientific evidence to support their proposals and services. Point de repères staff have also been trained to do research, which has helped them to better understand the health needs of the people they serve. They also have greater access to scientific literature, which has increased their awareness of problems related to drug use in other areas of Canada, enabling them to predict what may come their way in the future.

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#### **USEFUL RESOURCES**

### AVAILABLE FROM POINT DE REPÈRES

- Guide de rue: the "Street Guide": a pocket-size booklet with practical information about safe injecting, how to avoid complications and what to do if they occur
- Guide « Ressources »: a pocket-size booklet of available health and social services
- Practice Guide 1: Acute Complications of the Skin and Soft Tissue Associated with Drug Injection Among People who Inject Drugs: Know Them, Recognize Them, Manage Them.
- Le Petit Guide
   "Le transposon":
   a practical pocket-size
   booklet that summarizes
   the Practice Guide 1,
   for use on the street
- Practice Guide 2: Cocaine and Opiate Overdoses: Know Them, Recognize Them, Manage Them
- Practice Guide 3:
   Fever and Hyperthermia
   in People who Use
   Injection Drugs

# PROJET INTERVENTION PROSTITUTION QUÉBEC – OUTREACH AND AWARENESS IN THE COMMUNITY

#### Mission

The Projet Intervention Prostitution Québec (Prostitution Intervention Project of Québec (PIPQ) has existed since 1984. It is an organization that helps sex workers, as well as their families. Its mission is to reach people who are involved in prostitution, directly or indirectly; to develop alternatives to prostitution; to inform and raise awareness about the issues and consequences of prostitution; and to provide support for outreach workers who work with this population.

#### **Services**

PIPQ accomplishes its mission by raising the awareness of youth about the causes and consequences of sex work, and through a drop-in program for, and supportive outreach to, people working in the sex trade. PIPQ involves sex workers in all aspects of the organization.

#### **Prevention in Schools**

When PIPQ was established, prevention services in schools were at the heart of their mission and were part of the objectives they sought to meet. After a youth prostitution ring was uncovered in Québec, PIPQ managed to get into high schools to do prevention work, through the help of the youth protection services. The workshops were developed with many partners, including institutional networks, social services, the educational system and the community. The workshops last one and a half hours and are delivered by a PIPQ team. They focus especially on the recruitment of young girls into prostitution by street gangs. PIPQ has created a cartoon that illustrates this, which is used in the workshops. PIPQ also trains other community organizations which are part of the prevention network on how to intervene with the sex worker population.



## **Drop-In Space**

PIPQ has a drop-in which is open during the day and two evenings a week. Here, people can come for coffee and to chat. They can also shower; get hygiene kits, injection equipment and safer sex supplies; have something to eat; get some clothing; see the nurse; or meet with the social worker, who specializes in substance use, and comes in once a week. Local hotels donate soaps and shampoo. Moisson Québec (Québec Harvest) donates some food, and PIPQ purchases food to supplement this. They host dinners and a weekly collective kitchen. They also organize activities around photography, films, and the arts in general. Job postings are displayed on a bulletin board, and internet, phone, and fax services are available.

PIPQ obtains their injecting equipment from Point de repères. Eventually, they would like to hand out safer crack use kits, which are currently needed. They have a self-serve for condom and lubricant distribution and sell sponges for the women for \$1.50.

The on-site nurse provides vaccines, testing and basic nursing care. Plus, they have a small pharmacy of first aid supplies.

PIPQ also offers emergency food services and sometimes gives the women some change to do laundry at a laundromat.

PIPQ volunteers, usually women who are no longer involved in the sex trade, help out.

PIPQ has moved often, following the sex work as strolls re-locate to other neighbourhoods around the city. They would like to own their building, since this would provide some stability; however, it would also prevent them from moving around easily to follow the clientele.

## Outreach and the Cat Woman Project

The Cat Woman Project has existed for about five or six years. Cat Women are female outreach workers who go to agencies, massage parlours, strip bars, and homes of working women. They raise awareness, do some prevention work, distribute safer sex supplies, and organize vaccination and testing clinics. Funding for this initiative is recurrent, as it has proven its value. Cat Woman projects also exist in Sherbrooke and other places.

Other outreach workers offer support by providing accompaniment to appointments with the Youth Protection Department, lawyers, etc., and by making referrals to other services. They use the information guides for outreach workers developed by Point de repères as guidelines to do their work.

PIPQ would like to collaborate with other sex worker organizations, such as Stella in Montréal, given that women travel frequently between the two cities. They would also like to network with similar organizations in Canada.









## Relationship with Surrounding Community

PIPQ has a good relationship with the neighbourhood it is located in. The neighbourhood is poor, and their clientele does not really stand out. There is no sign to identify PIPQ, which makes it discrete.

The police drive by a lot. They know the organization exists. They often look for women, but they leave the organization alone, for the most part. If they are searching for a specific woman, they will usually get her before she enters PIPQ. They do not do this often. As Julie Lederman, a worker at PIPQ, explains, "If we get involved, we just make sure that the woman is treated properly, that her rights are respected. Police are not welcome inside the organization."

## Low Threshold Accessibility Project

Services for street-involved people are offered in several places, but they are not necessarily accessible to sex workers. There are many criteria that prevent people from using some services. Certain organization insist clients be sober, in the process of reintegration, or of a certain age. For that reason, organizations such as PIPQ and Point de repères, that serve people who use drugs, got together and are developing a low threshold service.

The Low Threshold Accessibility Project works to facilitate access to health care and services to people who use drugs; improve access to testing, vaccination, treatment and follow up; provide psychological support, especially during hepatitis C treatment, for example; do health promotion for people who use drugs; encourage maintenance and rebuilding of social networks by limiting exclusivity and offering user support groups; do advocacy for people who use drugs; and organize social activities.

Low threshold means that people are welcome even if they are high, although drug use is not tolerated on site. It also means that they do not have to provide proof of residence to obtain food boxes.

The low threshold room at PIPQ is the nurse's station. The nurse provides basic services outside the system. There is no need to show a health insurance card. Anonymity is ensured, except for testing for reportable diseases. The nurse's room is also used as a chill-out room, as it has a bed.

The organizations involved in the Low Threshold Accessibility Project dream of a safe injection site, a mobile unit to access the hard-to-reach populations, expanded distribution of injection supplies and the recovery of used equipment.

PIPQ facilitates training and raising awareness in organizations that offer services to people who use drugs or are working in the sex trade, as lack of knowledge feeds fear and prejudice. They also offer workshops on healthy sexuality.

They are developing evaluation tools and want to produce status reports. They are also currently in the process of establishing collaborations with institutions, to develop an ethics review committee.

## **Obstacles for PIPQ**

An obstacle PIPQ faces is the lack of information or the misinformation that organizations have about sex workers. As outreach worker Patricia Caron explains, "People don't know how to act with sex workers. And yet, a human being is a human being. We do not need to put a label on someone to know how to act." PIPQ works hard on education and awareness.

Lack of funding, and more specifically lack of recurring funding, is a challenge because it causes high staff turnover. People don't like the uncertainty and want job security. This is particularly true at the end of a project, when it is not certain if funding will be renewed. This also affects the trust of people on the street, who require stable services and staff contacts.

PIPQ could also use more staff to be able to offer longer hours of services.

## **Success of PIPQ**

Many founding members of PIPQ took part in establishing outreach services in Québec City, as well as the Association des travailleurs et travailleuses de rue du Québec (ATTRueQ – Québec's Outreach Workers' Association). They also participated in the development of a code of ethics for sex workers.

PIPQ reports that they have been successful in raising the awareness of staff in other organizations. They can see that agency staff are opening up more and more to sex workers, are starting to get to know their sex-worker clientele and are moving beyond the labels.

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# 8. HALIFAX, NOVA SCOTIA

# MAINLINE NEEDLE EXCHANGE – A COMMUNITY-BASED NEEDLE DISTRIBUTION SERVICE

## History

Mainline Needle Exchange began in May 1992, with a storefront location on Agricola Street. It is a health promotion project dedicated to supporting current and former drug users through harm reduction.



#### **Services**

In the beginning, Mainline provided needle exchange services from a fixed site in downtown Halifax. It expanded to provide provincial mobile outreach to rural areas throughout Nova Scotia in 1994. The central mobile outreach in Halifax Regional Municipality travels to various locations for clients to access services.

The Mainline fixed site operates six days a week and offers needle exchange, safer crack use kits, condoms, cookers, filters, vitamin C, and sterile water. Two nights a week, when funding permits, they offer bag lunches, which consist of a sandwich, fruit and a beverage. Their services also include counselling and court and peer support. They refer people to and advocate for drug treatment, beds in shelters and support from social service agencies. They participate in research, provide education in the community and work to empower their clients.

Staff at Mainline have real life experience. As a result, the services are very user-directed. They build trusting relationships with youth and people who use drugs, and strong partnerships with other programs and services. They have an open door policy with staff available to assist anyone in need.

## **Challenges**

Disposal of used injection equipment has been a challenge. Staff sometimes receive phone calls from landlords, neighbours or police to come and clean up when used injection equipment is found. To address this issue, Mainline has arranged for sharps containers in all the shelters. Drug use is not allowed on site, but staff know people will use, so they have safe disposal containers available. Some of the people who use their services assist with this effort and take sharps containers to their home for everyone to use. Mainline has also paid people to do community sweeps.

#### **Successes**

Mainline has managed to overcome some community resistance by working on the community's perception and awareness of drug use on an ongoing basis. They have not experienced any legal, justice or government opposition to the services they offer.

Though Mainline Needle Exchange still has limited resources and financial limitations, they have improved their financial situation by building strong partnerships with other organizations.

Mainline now provides full-time outreach. The provincial outreach covers a lot of territory. There are other needle exchange programs on Cape Breton Island (Sharp Advice), and in Amherst (a Mainline Satellite). As Donnie Bennett from Mainline explains:

"[Outreach] has proven to be a real asset in providing services. We didn't realize how many people were not coming to the services. It's been a real success. There are still some communities that are not being served. We are hoping to make some inroads in the future."

Mainline started handing out safer crack use kits about two years ago. About one year into the program, the politicians, police officers and the Chief of Police complained that they were "funding crack addicts". Luckily, one strong supporter from the Department of Health came out in support of the program as a viable harm reduction option. Mainline didn't have any trouble getting the kits together, but they did have trouble getting funding for the program. For a while, they could only give out the safer crack use kits twice a week, but they are now back to handing them out every day, thanks to an increase in provincial funding in 2006-07.

Mainline is proud that in 1992, a methadone program was launched with one employee on methadone. Two other employees on methadone joined Mainline within two years. Staff dedication to a community-based methadone program remained strong, and in 1994, Mainline joined a committee to advocate for a community-based methadone program. In 2001, this dream became a reality with the creation of the Direction 180 Methadone Clinic.

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# DIRECTION 180 – A COMMUNITY-BASED LOW THRESHOLD METHADONE MAINTENANCE PROGRAM

## History

The Direction 180 Low Threshold Methadone Maintenance Program came to be after a ten-year period of work with Mainline Needle Exchange. At the time, a committee was formed to advocate for a community-based methadone program. Mainline sat on the committee, as did the Medical Officer of Health, public health representatives, and staff of the Department of Health.



The provincial Addiction Prevention Treatment Services Program had strict criteria for their methadone maintenance program, and many people were not meeting them. It was abstinence-based, and it still continues to operate this way. If a person is late for an appointment, uses coarse language, or tests positive for any substance, they are penalized, and after five strikes, they are thrown out of the program. A program that would take people's realities into consideration was needed, and it was needed in the community where people who use drugs were accessing the services.

In 2001, Direction 180 opened as a pilot project for 30 people. It received funding from the Supporting Community Partners Initiative (known as SCPI, or "Skippy" Funding), after the Director of Mainline, Diane Bailey, along with the Nova Scotia Advisory Commission on AIDS, framed the program proposal as a homelessness initiative.

"Unlike Skippy Peanut Butter, the funding did not spread very far, as at the end of the two years, we were facing closure, due to lack of sustainable funding," says Cindy MacIsaac, Executive Director of Direction 180. "Fortunately, people involved in the early development of the program had the foresight to develop a process evaluation for the program's first year to confirm that the program was doing what we set out to do and meeting the need of opiate dependent individuals. A funding application was submitted and accepted by the Public Health Agency of Canada, AIDS Community Action Program (ACAP), which revealed the program's success in meeting its goals and objectives. With operational funding to treat 30 individuals, the program was treating over 60 within the first three months, with a waiting list for admission."

With ACAP's funding support in the second year, Direction 180 was able to build on the previous evaluation with an increased focus on short-term outcomes over a two-year period, employing a determinants of health framework. The findings demonstrated the program's effectiveness in providing clients with services and supports that produced improved health and functioning, increased stability, and increased access to primary healthcare and other ancillary support services. Additionally, funding support was received by the Public Health Agency of Canada's Programs Unit, HIV/AIDS Policy, Coordination and Programs Division, to develop a literature review and a document demonstrating Direction 180 as a model of Best Practice in Methadone Maintenance Treatment, entitled "Meeting a Need and Moving Forward".

These documents, coupled with individual champions within the Nova Scotia Department of Health and other federal and provincial supporters, led to the province's emergency response to provide funding for a one-year transitional period. The funding relief was accompanied with a direct command from the Capital District Health Authority that, during the transitional year, Direction 180 would be forced to amalgamate with and be governed by the provincial Addiction Prevention Treatment Services (APTS). It was an unstable year for program, clients and staff, because of a philosophical conflict between APTS' conservative approach and Direction 180's low-threshold, community-based model of MMT. Despite the potential loss of the program, clients, staff, board and community members offered support and assistance in contingency planning. They continued in the abyss of the unknown for three years as changes in personnel at the Capital District Health Authority bought them time.

Simultaneously, the Nova Scotia Department of Health set up a collaborative working group to guide the development of service standards for the prevention of the transmission of blood-borne pathogens (BBP's), including BBP standards for needle exchange services, counselling, testing and referral, health education and social marketing, and Methadone Maintenance Treatment. This working process echoed the need for Direction 180's services and provided them with the measuring tools which enabled them to secure additional operational funding in 2005 and, more importantly, a blessing to maintain their autonomy.

Without the threat of loss of autonomy or closure, the staff agreed that it was time to move forward in strategic planning. They identified what they wanted to do, instead of just responding to the overwhelming demand of their client needs. Due to the wide range of health and social issues their clients faced, they needed to streamline their service as much as possible, without having a negative impact on their clients. The caseload for the program is 150 individuals: of these, 75 visit the clinic daily for methadone, and many have concurrent mental health issues, continue to use drugs, have hepatitis C (60%) and/or HIV (18%), are directly street-involved and have multiple physical health needs.





The clinic is a program of the Mic Mac Native Friendship Centre, which makes it unique. The Friendship Centre was the only organization that would take them at the time they initiated the pilot project. Now that the core funding has been increased, other organizations have expressed an interest in administering the program.

After 17 projects to enhance and expand services and respond to the needs of the population, the program has grown and evolved into what it is today. Still, Direction 180 is aware of individuals in the provincial government who would like to change the program and its position in the community. They have compiled a lot of information that demonstrates the need to stay in the community and continue doing what they are doing. In terms of harm reduction, it is the only program of this kind in Atlantic Canada.

**Primary Care and Other Services** 

There was a concern that people were not being treated for hepatitis C if they were on methadone, much less if they were using drugs. The program's physician, Dr. John Fraser, took the initiative to participate in a fellowship with the Liver Clinic at the Queen Elizabeth II Health Sciences Centre to improve access to treatment for clients accessing services at Direction 180. The services now include collaborative rounds and education and support for individuals in all stages of Hepatitis C. A similar collaboration with the Infectious Disease Clinic has increased the program's capacity in the daily dispensing of HIV medications and support for clients. The program's primary health care program is beyond capacity, since individuals present with myriad physical and mental health issues. Wound care is a regular function, along with crisis support and counselling.

The program staff has strong links with the Department of Community Services. Some of the referrals and supports requested include: transportation; special dietary needs; telephones; and high fibre diets to combat the side effects of constipation related to methadone treatment. Trustee and housing supports and links to private and government landlords have helped individuals gain stability.

Direction 180 had to be creative because of their limited resources. They collaborate with the Infectious Disease and Liver Clinics, IWK Grace Maternity Hospital, Pain Clinic and others, as needed. It was important to bring these services together since people who use drugs are often misunderstood and judged in tertiary health care settings, which creates huge barriers. Individuals with chronic pain are often perceived as drug seekers. Expectant mothers are disdained and Children's Aid Services gets involved. People need support to walk through these fears in order to make the best choices for their health and well-being, and the services themselves must be educated about their barriers and how to lower them.

"I've put stuff in place, I know how to change my life around, so I'm on methadone. I quit work because that's where my number one addiction came from was in my workforce and I couldn't go back down there, because I knew if I went down to that dock. I'd be back into it again. I quit my work. Now I've got my counts back up so I'm back to school now... So I am putting stuff in order."

- focus aroup

In addition to methadone, the clinic dispenses psychiatric medications and insulin every day. They offer vaccinations, peer support and counselling and have hired a social worker. Clients of the clinic are assigned a case manager. The collaboration with the IWK Grace Maternity Hospital fills the gaps for opiate-dependent women from rural communities who have appointments with specialists in Halifax, as Direction 180 provides them with methadone and support during their stay in the city.

Direction 180 has a very good relationship with the pharmacy just across the street. The pharmacists prepare the methadone for them and deliver it to them daily. When Direction 180 was facing the potential loss of their funding, the pharmacist even offered to find a way to house the program. The pharmacist also sits on Direction 180's board of directors. For other medications, people often don't have coverage, so Direction 180 works with the pharmacy until they can obtain coverage. Either Direction 180 or the pharmacy will cover the costs until people are stable enough and get their identification.

The people at Direction 180 work as a multidisciplinary team, which was the model established to provide primary health care. Upon onset into treatment, about 90% of people do not have primary health care providers, unless through physicians who were noted for prescribing. Now, most of the people who use the clinic have family physicians and/or their needs are being met at the clinic.

Direction 180 works with Correctional Services of Canada to provide a seamless transition for individuals on MMT upon discharge. With the demand far greater than their resources permit, there have been challenges with this service. In order for an offender to receive methadone in prison, they must have confirmation that they will be accepted by a methadone provider upon their release.

## **Challenges for Direction 180**

The neighbourhood where Direction 180 is situated has been undergoing gentrification, as Cindy MacIsaac explains:

"When we opened, ...you could get your income supports cheque and visit your parole officer on the corner across the street. The needle exchange is around the corner and hot meals less than a block away. Direction 180 sits amidst these services including a variety of shelters and half-way houses in the community. These services are all essential to this community's long term members, however, with the influx of condos and property enhancements, business and residents want us to disappear and they wonder why we didn't consult with them first before we opened our doors."

Direction 180 appreciates the fact that its location is close to other services its clients use, but would like to have a space where people could access their services more discretely. There is a high volume of traffic on their street and as people wait for their doors to open in the morning or afternoon, they are on display.

#### **Successes of Direction 180**

Direction 180 started off in a tiny room and gradually expanded one room at a time. They recently moved into a much larger space. They are now spread over three floors.

The success of the program is largely attributed to the quality of staff and the non-punitive, low threshold approach. They consider the mere fact they are open as a success. They are also seeing people who have a successful sustained response to hepatitis C treatment, and people living with HIV/AIDS who once had zero CD4 counts come back to health.

"We've got people since day one that will use drugs 'til the day they die and they don't want to stop, so by keeping them engaged in the process, we're keeping them alive," states Cindy MacIsaac.

CONTACT NFORMATION Cindy MacIsaac Executive Director

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#### PHOENIX YOUTH CENTRE - A SHELTER FOR YOUTH

## **History**

The Phoenix Youth Programs offer a variety of services: a drop-in centre, supportive housing and emergency youth centres, such as the Phoenix Youth Centre.

The drop-in centre sees about 40 to 50 youth a day. They can do laundry, get some food, meet with social workers and case managers, and have a shower. The program also has a parent support worker and a nurse in the afternoon. Drop-in hours are Monday to Friday, from 9:45am to 5pm.

The Phoenix Youth Centre is a shelter that houses 20 youth from the age of 16 to 25: 15 males and five females. Each person gets their own room, and they can stay for up to eight weeks, with the option to extend, if needed.

In the communal eating area, breakfast is put out in the morning, and lunch and dinner are served. The centre's frontline workers and volunteers assist in meal preparation, and the residents also chip in.

The centre has a nurse who provides health services from a harm reduction, social work and youth care perspective.

Patti Melanson has used her position as a nurse to weave harm reduction throughout Phoenix Youth Programs. For example youth can come back to the shelter under the influence and just go to their rooms, so that their behaviour does not get them into trouble. They have sharps containers in selected locations, and residents can turn their rigs in when they come in, and get them back when they leave.

"And I think that... health care professionals don't recognize the privilege and power that they bring to situations. And so they often ... cause more harm... through just judging and being disrespectful and making sighs or asking questions that I wouldn't get asked if I walked in, like feeling some entitlement around delving into someone's history. I try to take the position of doing no more harm, so really inviting someone to be with me where they are and to offer a health service that's really reflective of what it is that they need."

 Patti Melanson, Nurse with Phoenix Youth Programs





"I think that youth sometimes are around people that break them or people that want to fix them, and there's nobody that's just able to be with them where they are."

Patti Melanson,
 nurse at Phoenix Youth Centre

The shelter requires youth to leave at 9:30 am. Most end up hanging out on the street and have nothing to do. However, the shelter is now beginning to provide some day programming. Patti works with the Special Initiative Program that has initiated a running program and has managed to induce some Nova Scotia physicians to provide sneakers. They have also done kayaking programs, and they have held prenatal programs and sex and chocolate chats, where participants talk about sexual health over fresh fruit and chocolate fondue. Patti has also looked into the food being served to the residents and has been helping staff make healthier choices. All of these efforts are about reducing harm and creating healthy people and healthy networks.

In terms of health services, Patti offers prenatal care, pap tests, and STI checks. She also provides plenty of mental health care, with the support of a psychiatrist who works out of the North End Community Health Center on a fee-for-service basis. Phoenix sees a lot of youth with schizophrenia and psychosis, depression, anxiety and post-traumatic stress disorder. It is a significant challenge for mental health and addictions people to come together to provide care for these youth, who are often homeless or insecurely housed, street-involved, marginalized and using drugs. One positive side of working with youth is that they may not yet be entrenched in their drug use and may be open to alternatives.

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"I don't know for others, I just know that it's hard. To maintain, being on a crutch and people might tell them methadone being a crutch, but I mean, sometimes it's better than injecting myself and it's better than having my body behind the fucking pole or behind the garbage can dead."

- focus group



# 9. ST. JOHN'S, NEWFOUNDLAND

# TOMMY SEXTON CENTRE – INTEGRATED HIV/AIDS SERVICES AND EMERGENCY SHELTER

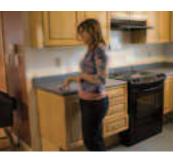
## History

The Tommy Sexton Centre is a project of the AIDS Committee of Newfoundland and Labrador (ACNL), a provincial organization committed to preventing the spread of HIV and supporting people living with HIV/AIDS. ACNL services include: advocacy; HIV and hepatitis C education; the provision of male and female condoms; needle exchange; a health clinic; a health fund for people living with HIV/AIDS; student and work placements; treatment information; a toll-free provincial phone line; volunteer training; short-term shelter services; transitional housing for people living with HIV/AIDS, and a resource library.









Tommy Sexton was a comedian and entertainer who gained renown as a member of the comedy troupe CODCO. He was from St. John's and died of AIDS-related problems in 1993. His family has been really active in Newfoundland in terms of prevention, education and support related to HIV/AIDS. They played a big role in the creation of the Tommy Sexton Centre.

The Tommy Sexton Centre was just an idea in December 2003. By June 2004, however, the ACNL had submitted the first draft of a proposal to make it a reality. They received funding to build the Centre from the National Homeless Initiative and the Newfoundland and Labrador Housing Corporation, and in August 2006, they moved in. It all happened very fast.

The Centre held its official opening in September 2006. Its hours of operation are 8:30am to 4:30pm, Monday through Friday. The short-term shelter is open 24 hours a day, seven days a week. It provides on-going assessment, planning, implementation and evaluation of service plans; hands-on support and active listening; life skills teaching; links to services and resources; and advocacy. It also has a common drop-in area with a computer.

The Centre is located in the quiet neighbourhood of Pleasantville. This location was determined in part by the fact that the government gave them the land. It is bit of a distance from downtown St. John's, where ACNL was previously situated; however, it is adjacent to two main bus routes. This suburban neighbourhood is an ideal setting for the apartments for people living with HIV/AIDS and the shelter, but is quite far from the downtown drug scene. To counter this problem, the Centre provides bus passes for residents of the transitional housing program.

The entire building is wheelchair accessible. People in wheelchairs can easily access all counters, stoves and sinks, as well as all light switches and electrical outlets.

#### **Services**

#### SHORT-TERM SHELTER

The Tommy Sexton Centre houses a short-term four-bed emergency shelter where people can stay for up to three weeks. With the support of the Centre's staff, most of the shelter residents eventually find some kind of permanent housing.

The shelter accepts men and women between the ages of 16 and 65 who are in need of emergency housing. It is not just for people living with HIV/AIDS, although they are given priority. Each resident has a private room.

The shelter's three-week residency limit is actually a guideline: some people don't need to stay that long, and some may need to stay longer. In terms of demographics, residents reflect St. John's vulnerable populations, including people at risk, people

who use drugs, people with mental health issues, young people, people from the sex trade, and women escaping from abusive relationships.

Initially, staff at the Centre wondered if the wide age range and having both male and female residents, as well as people from a broad variety of backgrounds, would be troublesome, but this has not been the case. They have also noticed that they get a lot of young people who couldn't keep beds in shelters in St John's. They seem to do well here, due perhaps to the fact that they are away from their peer group and from downtown, where they are exposed to more opportunities for getting into trouble.

The shelter is staffed 24 hours a day. It has four full-time staff persons and some part-time staff. They sometimes get students in to help out.

The shelter has guidelines regarding behaviour and responsibilities that residents must follow, and residents are assigned daily chores. They can also attend information sessions on various topics such as HIV/AIDS, addictions, harm reduction, skills for living on their own in the community, personal hygiene, and cooking.

Unlike in most other shelters, the residents do not have to leave in the morning. They can stay for the day and hang out, or do their chores, but they are encouraged to go out, be active and get some fresh air.

The shelter has a laundry room, and each resident is responsible for doing their own laundry. There is a resident lounge area where they can socialize, play games, and read books. They also have their own BBQ.

The shelter is separate from the apartments in the transitional housing section of the building.

#### Transitional Housing for People Living with HIV/AIDS

The transitional housing section of the Centre provides secure and affordable housing for people living with HIV/AIDS. It has six apartments: four one-bedroom apartments and two two-bedroom apartments. It is the only housing facility of this kind in Canada that offers two-bedroom apartments, as Michelle Boutcher, Executive Director of the Tommy Sexton Centre, explains:

"We had private development teams who gave us advice in terms of designing the building, [including] several [people living with HIV/AIDS] and one thing that came out clearly for people [was that] they have partners and children and home care workers, and a bachelor apartment is not big enough. So two of the apartments have two bedrooms and one of them is completely accessible, with a wheelin shower and everything."

The housing is transitional and residents work with staff to determine the length of their stay and to develop community reintegration plans.

#### **USEFUL RESOURCES**

- DVD Tommy Sexton Centre
- Reaching Injection
   Drugs Users Project:
   Needs Assessment of
   Injection Drug Users in
   St. John's the report
   of is available at
   www.acnl.net

Rent is set according to the affordable housing guidelines. The rent for the one-bedroom apartments is \$470/month, heat, lighting and cable included. There is a waiting list to get an apartment; however, since some of the residents are there for a short term, there is some movement. Each apartment has a private external entrance and an internal entrance from a common hallway. Three apartments are completely furnished, and all tenants share a laundry room. Pets are permitted. Since this is not an assisted living residence, residents are free to come and go as they please.

#### **Harm Reduction Measures**

The Centre has a needle exchange on site, as well as an outreach van. The van operates in partnership with Street Reach, mainly in the downtown area, given that the fixed site is too far from the action for people to walk.

The Centre does not allow the use of illicit drugs on site. Although residents are encouraged to be discrete and to go off-site to use, they are not refused entry into the Centre when they are intoxicated. The staff will keep an eye on them to make sure they are not sick or overdosing.

Shelter residents who need new needles can get them 24 hours a day from shelter staff. Staff will not interfere with residents' drug use and will work with them to help them stay safe. If a resident wishes, staff will help develop plans and set goals to address drug use. The discrete use of cannabis for medical purposes is allowed on site.

Sharps containers for the shelter are kept in the office and residents are encouraged to use them to dispose of their needles. As staff are supportive about harm reduction measures, residents seem to be more open with them about their drug use. They know they will not lose their bed for it, as Richard Baker, Housing Coordinator, explains:

"We seem to be getting more and more people who inject drugs and... wanting harm reduction because a lot of the other shelters are not able to handle that and support the residents as much when it comes to the harm reduction model. We are fine with it. As you can see, we have our needles, everything is laid out... We just want to make sure that they are safe and that they are doing it safely."

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## SAFE WORKS ACCESS PROGRAM – COMMUNITY-BASED NEEDLE DISTRIBUTION

#### History

During the late 1980s, at the request of people who injected drugs, an informal needle exchange program operated out of the AIDS Committee of Newfoundland and Labrador (then called the Newfoundland AIDS Committee), thanks to the Executive Director and dedicated staff.

Until the late 1990s, the treatment of people with problematic substance use was punitive and abstinence-based. Around the year 2000, an OxyContin crisis hit the city of St. John's. Tracy Butler, Program Manager, Mental Health and Addictions Program, Eastern Health recalls:

"All of a sudden, it seemed like everyone was using "Oxys"... We were not prepared and it seemed like it became a problem overnight, and people were coming in looking for help for OxyContin addiction and we didn't know what we were up against."

It also became clear that youth were bypassing less risky drug use routes and going right to the needle. Previously, this had been unheard of in Newfoundland and Labrador. Addiction Services were not prepared to deal with the scope and magnitude of these situations. The media picked up on the OxyContin abuse, and there was a major public outcry. Sadly, over a four-year span, there were eight oxy-related overdose deaths, and people were calling on the government to do something.

In 2003, the government struck an OxyContin Task Force, which released an interim report in January 2004. As a result of its recommendations, funding was allocated for harm reduction measures, and a Methadone Advisory Committee was set up. Out of the recommendations from the report came the province's first opioid treatment service offering methadone maintenance, which is currently operational.

As well, in 2005, the provincial government formalized needle exchange programs and the Department of Health provided funds to the AIDS Committee of Newfoundland and Labrador to implement a needle exchange program and undertake an assessment of the needs of people who use injection drugs. The Safe Works Access Program, or SWAP, became a program of the AIDS Committee of Newfoundland and Labrador. They received funding for salary for one staff person and for supplies and were housed, rent-free, in the ACNL building. Then, in September 2006, because it is a program of ACNL, SWAP moved into the Tommy Sexton Centre when it opened.









#### **Services**

SWAP offers needle and injection equipment distribution, peer education regarding safer drug use and safer sex, and peer support, through a fixed site, a mobile van and satellite needle exchanges.

People come to SWAP's fixed site through the front door of the Centre and go directly to the SWAP office. There is no counter or physical barrier. They simply get the supplies they need from the worker and head out, or they can sit in the office and have a chat. They can dispose of their used equipment here too.

SWAP is not currently distributing safer crack use kits, but they recently received some sample kits from another organization. They are looking into setting up a safer crack use program, as soon as they are able. They do, however, give out piercing kits.

SWAP's main partners include the Community Youth Network/Street Reach, Choices for Youth, Youth and Family Services, the Canadian Red Cross, Pretrial Services, the Naomi Centre (a young women's shelter), and the ACNL.

Traffic at SWAP is light, due to its out-of-the-way location. However, SWAP volunteers do outreach runs in an unmarked minivan on Tuesdays and Thursdays, in conjunction with Street Reach (see p. 177).

Street Reach is a street outreach program that operates on Tuesday and Thursday evenings in the downtown area of the city. The Red Cross emergency response vehicle (ERV) parks downtown and is the base for outreach, along with two two-person foot patrols. The ERV has a side window that people can come to. In observance of Red Cross policy, Street Reach does not hand out injection equipment from the ERV, but they call the SWAP van, which then comes to meet the individual seeking service.

SWAP offers harm reduction education throughout the community, as well as materials and training for other organizations interested in providing needle distribution. The Naomi Centre, the Tommy Sexton Centre's Shelter, Choices for Youth and the Street Reach office are involved in needle distribution so far.

#### Challenges

SWAP has one employee. Operating with only one position would be problematic, since the outreach van policies and good common sense dictate that, for safety reasons, there must to be two people present in the general area where services are delivered. At the fixed site this is not problematic, due to the proximity to the reception desk of the Centre. At present the lack of sufficient staff is addressed through the use of a peer volunteer (when available), a student on placement with SWAP or another staff person from ACNL participating with SWAP staff on outreach in the van.

There have been challenges finding items necessary for safer injecting, such as ascorbic acid, sterile water ampoules and other equipment. SWAP continues to try to purchase supplies from Eastern Health, but that is a painstakingly slow process. Thus far, two and a half years into operations, approval for purchase of sharps containers has been the only one received.

It has also been a challenge to gain the trust of people who use drugs, given that the program is so new and remote. Staff anticipates that it is simply a matter of time before they build the rapport and reputation necessary to be accepted by those who most need their services. Once the rapport is established, they will work at developing a secondary distribution network.

St. John's small-town mentality is also an issue: everybody knows everybody else's business. This translates into a lack of privacy. The fear of being recognized when attempting to access addiction counseling services, methadone programs, detoxes or needle exchanges deters some people from seeking help, at least initially. Moreover, many methadone clients fear being seen when visiting the needle exchange since they are cautioned to maintain total abstinence.

Long waiting lists to see specialists are an unfortunate reality. Quick accessibility is especially important for people who are using drugs because it requires a great deal of courage and effort for them to commit to seek health care. If services aren't immediately available, they could change their mind, resulting in a lost opportunity.

#### Research

ACNL received funding from Health Canada (now the Public Health Agency of Canada) in 2004 for a study to examine the needs of people in St. John's who inject drugs. This needs assessment explored the extent and type of drugs they use, determined the services they most needed, and identified the barriers they experienced to health, health services, and harm reduction information.

Recommendations from the needs assessment included:

- That a province-wide needs assessment be conducted;
- That undergraduate and graduate students in medicine, nursing, social work and pharmacy receive proper education regarding the issues that people who inject drugs face;
- That programs and services be developed, delivered and evaluated to better meet the needs of a diverse community of drug use;
- That research be conducted to assess province-wide perceptions of risk-taking behaviour and harm reduction strategies that will provide evidence for governmental policies and community-based intervention and services for people who inject drugs;

- That community forums be held to increase awareness of harm reduction approaches to substance use and injection drug use;
- That the Safe Works Access Program be expanded to include a mobile unit and another fixed site;
- That needle exchange programs be located in neighbourhood pharmacies, doctors' offices, family practice clinics, and hospital emergency departments;
- That student placements be arranged to address the long-term need for knowledgeable and skilled health professionals in substance use and harm reduction and to encourage the transfer of skills from hospital-based to communitybased care;
- That the Regional Health Authorities incorporate the range of health needs
  when planning, developing, revising and evaluating programs and services for
  people who inject drugs through their Addiction Services programs;
- That the Provincial Department of Health and Community Services establish an Inter-Agency Committee with multi-stakeholder representation to establish formal links to share information and to support the development of responsive services for people who inject drugs;
- That the Department of Justice develop and implement a methadone maintenance program for persons in correctional facilities in St. John's; and
- That the Recovery Centre consider ways to integrate harm reduction and health promotion strategies into the delivery of the planned medical detoxification services.

ACNL has received funding from the province of Newfoundland and Labrador to expand the needs assessment to rural Newfoundland, as Phase 2 of the Reaching Injection Drug Users Project. Both reports are available on the ACNL website at www.acnl.net.

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#### STREET REACH - STREET OUTREACH FOR YOUTH

Street Reach operates as part of the Community Youth Network. It provides disconnected youth with information, resources and support, food, and referrals to appropriate services. It acts as a link between street youth and community agencies, and documents needs and gaps in services observed through their outreach.

#### **Services**

Through outreach twice each week, Street Reach provides contact cards, information and referrals, snacks and hot chocolate, condoms, and basic care kits. Its partners include Choices for Youth, Youth and Family Services, Eastern Health, the Canadian Red Cross, Pre-Trial Services, the Naomi Centre, and the AIDS Committee of Newfoundland and Labrador. Its funding comes from Eastern Health. Street Reach's home base offers all of these services, as well as needle distribution.

Tuesday and Thursday evenings, four outreach workers walk the streets of downtown St. John's in pairs, with backpacks, handing out contact cards for referrals, hot drinks, granola bars and emergency clothing. In the summer months, they do their best to offer outreach during the daytime as well, once a week, usually on Wednesday afternoons. The hours vary according to the season.

Volunteer outreach workers can drop by the Street Reach office during the day for anything they may need. They may also bring youth into the office for particular referrals or support, or private, confidential conversations.

Street Reach currently has 35 volunteers. Some have been with them since they started outreach in March 2005. Volunteers are required to have experience working with young people. Volunteer meetings, held every six weeks, provide an opportunity to discuss what is happening on the front line, what they are seeing, and concerns that have arisen. It's also a great mechanism to support the outreach workers.

Street Reach sees between 10 and 30 people on a given day. Kerri Mahoney, Street Reach Coordinator, explains,

"Some of them will be regulars we'll be seeing just about every time we are out, and then sometimes we will meet people who we have never seen before and we try to make a good connection with them. The number of clients will go up a little bit during the summer months. There is a population of backpackers that are hitch-hiking across the country. We see them more in the summer months."

"For some of the young people we talk to, they are not aware of what is available. We make a lot of connections, we try to make sure that we are aware of changes within the community, if there are new shelters that open up or whatever services we need. A lot of it is that they are not aware that there are people there who will support them or even how to go about it. They get really frustrated. They want it now. We struggle a little bit. [...] If they are not immediately supported, then they shut themselves off."

Kerri Mahoney,
 Street Reach Coordinator





Street Reach keeps a database of statistics on all the contacts they make. They record first name, age, items distributed, their assessment of the youth's issues, and the referrals they make. For males, food shortage and homelessness are top issues; for females, sex work is one of the higher ones. There are male sex workers, but they are not very visible. Females tend to approach the outreach workers for condoms more frequently than the males.

#### Challenges

While Street Reach recognizes the importance of harm reduction measures, such as needle exchange, they are not able to hand out injection equipment as part of their outreach. They do however, partner with the local needle exchange service (SWAP – see page 173) which operates by van during Street Reach hours and is available for referrals. The Canadian Red Cross, their outreach partner, makes their emergency response vehicle available to Street Reach as an outreach van. However, the Red Cross policies do not allow needles in the vehicle. The driver of the vehicle has to be a Red Cross volunteer and Street Reach volunteers ride along in the van.

The van and driver must also respond to any emergency to which they are called. In such a situation, outreach efforts are temporarily suspended.

Another challenge is not always being able to meet the needs of the people they serve.

#### Relationship with the Community

Street Reach has a good relationship with the police and cooperates with them in missing persons cases. As Kerri Mahoney explains, "We do an information session with all the officers, so that they are aware of our services. It was important that we make sure that they knew exactly what we are there for."

There is a pressing need for nurses and physicians to work with Street Reach's clients, but none are available. There is a nurse at the Youth Services site, but she does not work during Street Reach hours. Outreach workers can refer people there so they can seek shelter from the cold, eat a little, and shower, but that's all. The ACNL used to have a street nurse who worked during Street Reach hours, but they no longer do. The city is working on a primary care centre, which may improve the situation.

#### **Efforts Related to Sex Work**

Sex workers work mainly in the downtown area. Although Street Reach serves only the downtown core, they are involved in the Coalition Against Sexual Exploitation of Youth (CASEY) Group, which is a coalition looking at issues related to sexual exploitation and youth. The CASEY Group has representatives from about 15 community organizations. Projects are still in the planning stage. They focus on educating youth on how to stay safe. For example, they are developing tip sheets with safety and safer sex tips.

#### **Successes**

It took some time for Street Reach workers to get to know the youth, and for the youth to trust them. Now the youth welcome and appreciate the help they receive, knowing they will be supported by the workers and treated non-judgmentally. Word about the services is spreading through their channels as well.

"For a while there, even initially when we were out, we had a lot of young people that would come up and they were not ready to come and talk to us. It's been fantastic, the supportive networks, like having Tree [an ACNL staff member] out on the van with the needles. If we get a call that someone needs needles picked up, then we can contact Tree and she goes and picks them up. Even just being here, people within the neighbourhood are starting to know that we've got clean needles, so that's been great," reports Kerri from Street Reach.

Pairing volunteers for outreach shifts enables seasoned volunteers to introduce new volunteers to the youth. This helps build both relationships and continuity of service.

Volunteers come from a variety of agencies, and they are able to bring back to their respective organizations the insight and experience they gain from their Street Reach experiences. Street Reach has also fostered many new connections with staff from different agencies, and it has also provided volunteers with an increased understanding of the local scene.

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#### **OTHER ORGANIZATIONS CONSULTED**

## THUNDER BAY'S SUPERIOR POINTS — COMMUNITY-BASED NEEDLE DISTRIBUTION

#### **Description**

Superior Points is an outreach-based program with three staff specializing in different areas of practice: the program manager oversees medical and problematic substance use issues; a senior outreach worker addresses homelessness and poverty issues; and an outreach worker, works on women and youth issues. They have several fixed sites and a number of sites that provide supplies and training, which do not advertise.

They deliver harm reduction services not only to direct consumers, but to the entire community, through their clean-ups and community informational and educational forums. They are also active in promoting the de-stigmatization of people who use drugs. Every city department has benefited from the drug user harm reduction and needle awareness training and assistance. Now, schools will also benefit from a training module on substance use and informed decision-making that Superior Points has developed for students from junior kindergarten to grade 12.

Superior Points program has the responsibility of covering the geographic area of the District of Thunder Bay. With a land area is 103,706 km, it takes them approximately seven hours to drive to their furthest voluntary site.

#### Relationship with the Community

Feedback from the general public and service providers has been very positive. They even have a waiting list of schools that have requested presentations and training for educational days. The largest concern they hear about is the lack of resources for harm reduction development and education.

#### **Challenges**

Superior Points indicates that the community has been resistant to recognize issues related to drug use. In response, they have used media and other venues to educate and provide the community with effective, non-threatening messages about the local realities. They developed a community-based advisory committee early on, which included opponents to the program. This helped to solidify and legitimize

"I am proud of the program here in Thunder Bay. We do more with less, and do it well. We have an amazing network of providers, as well as formal, and even better informal contacts. As a general rule, the community expresses its gratitude."

Don Young,Program Manager,Superior Points

their efforts. The community advisory group was made up of police from all three jurisdictions, health providers, AIDS service organizations, public health, and people who use or have used the services.

They also gained acceptance by doing what needed to be done, speaking out fearlessly, refusing to hide in shame, demanding that their voice be acknowledged, and advocating for greater understanding about drug use and an end to the shaming of drug users. As a result of their efforts, they have never had to respond to negative press coverage.

Don Young, Program Manager at Superior Points, acknowledges that they were met with resistance in the high-risk community:

"It took a significant amount of time for people who use drugs to trust us. The total and complete hero or champion was our very first client, Debbie. She fought for over five years to develop and keep needle exchange and harm reduction at the forefront with the initial agencies involved. Her passion and the time she took after we, the staff, were hired, to educate us and to spend the time and energy to introduce us to people was invaluable. Debbie and her spirit are the guiding principles of our program."

One of the largest hurdles they face is the slow pace of bureaucracy in responding to the ever-changing strategies needed in harm reduction work.

Funding is also an ongoing challenge, since it is usually unsustained and channelled to projects. To address this, Superior Points now carefully evaluates timelines and the effects of the loss, or cessation, of the programming on the consumers. They have reached a decision internally not to apply for funding that is short-term or non-sustainable.

#### **Lessons Learned**

If they had to do things differently, they would have fought harder to have a stronger voice on the advisory board. They also would not have sought time-limited project funding that has had an adverse impact on the people they work for. They would have tried to offer more comprehensive services under one roof.

#### **Successes**

Their outreach-driven client services meet clients where they are at. The Program development was and is driven by the people who use the services. Feedback and evaluation is sometimes very difficult, but the evaluations returned from presentations and workshops have been overwhelmingly supportive. The street-involved drug use survey they conducted last year showed glaring gaps in harm reduction services for youth.

#### **USEFUL RESOURCES**

- Ontario Needle
   Exchange Programs:
   Best Practice
   Recommendations:
   available at
   http://www.ohrdp.ca/
- Street-Involved Youth
   Drug Use Questionnaire
   — available at
   http://www.tbdhu.com/
   Resources/Reports/R2C/
   StreetInvolvedYouth.htm
- Video: The Sleeping
  Giant: A Day in the Life
  of a Needle Exchange
  Program available
  from Superior Points –
  won award from
  Ontario HIV Trials
  Network and the
  Ontario Needle
  Exchange Network

The leaders in the harm reduction movement are people who were at first consumers. These are their programs. "They are the heroes by teaching and sharing with us, and allowing us to journey with them in their daily lives, also by allowing us to see the joy, the happiness, the despair, and the pain as they see it and live it," adds Don Young.

The heroes are the people who knew that anything was possible and believed in the philosophy of harm reduction. They are the ones who pushed the envelope and challenged the status quo, calling to attention the human side of drug use. The most important thing we can learn from them is that looking at anyone can be like looking in a mirror: though the glass may be shattered, we can still see our own image in the fragments.

Superior Points also organizes a biannual infectious disease and harm reduction road show. For the program, they assemble 10-12 people who travel throughout Northwestern Ontario and talk with approximately 2,500 students from very small communities, on reserve and off reserve, with no hindrance of jurisdictional issues.

CONTACT INFORMATION

Superior Points Harm Reduction Program

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Tel: 807.624.2005

Website: http://www.tbdhu.com/ID/NeedleExchange/

Arrimage Jeunesse – Youth Outreach in a Small ouyn-Noranda, as well as support, referrals and accompaniment. It was founded in 1996 as a result of the involvement and support of 19 organizations and the municipalities ge unit traveling throughout the West Kootenay/Boundary region, which

has more than 16 communities over an area of 25,000 sq. km and a population of about 50,000.

ANKORS provides support to three volunteer satellite needle exchange fixed sites and has partnered with Mental Health & Addictions Outreach, which provides Nx Care Packages. The packages consist of 10 syringes, 10 sterile water ampoules, alcohol swabs, cotton filters, condoms, lube, a health services contact information sheet and a harm reduction brochure. The kits supplement the existing needle exchange service.

The program provides harm reduction services to people who may be at risk of or affected by HIV, hepatitis, and other harms associated with the use of drugs. The ANKORS harm reduction and outreach program provides direct services to an average of 120 clients per quarter, at a provision rate of approximately 115,040 needles and a 95% return rate of 109,374. The program helps to bridge the gap between people who use drugs and health service providers and to increase the ability of people who are at risk to access harm reduction services in the more isolated rural areas.

#### Challenges

Access barriers to harm reduction services include finding the people who live in isolated areas and who may be at risk, building trust among this marginalized community, as well as the time it takes to accomplish this, and people's reluctance to come out until they feel safe. In the smaller rural areas, stigma tends to be more deeply entrenched than in core communities, making people fearful.

Adequate health services are not always available in rural communities. People may have to travel hundreds of kilometers to access drug treatment programs and methadone maintenance treatment, specialists. Many people even have difficulty reaching their own general practitioners, if they have one.

Homelessness is an evolving issue in areas such as Nelson, Castlegar, Trail and Grand Forks. People tend to couch surf, stay at places known as crack or drug houses, sleep behind businesses, under bridges, and in tent cities, which are raided

Homelessness is an evolving issue in areas such as Nelson, Castlegar, Trail and Grand Forks. People tend to couch surf, stay at places known as crack or drug houses, sleep behind businesses, under bridges, and in tent cities, which are raided and taken apart on a regular basis. Homelessness is putting people under extreme duress and forces them into vulnerable situations. In effect, it increases the spread of HIV, hepatitis, overdose and other harms associated with the use of drugs. Although there is homeless support in some communities, it is insufficient. Alex Sherstobitoff of ANKORS' Harm Reduction and Outreach, comments on efforts to better serve the community:

"Prior to the inception of the ANKORS Needle Exchange, we met with, and continue to meet with, key health service providers and other stakeholders. The stakeholders are people who live with HIV/AIDS, people who are current and former drug users, Public Health, West Kootenay & Boundary Addiction Services, Nelson Community Services, local pharmacies and the police. We all recognize a need for a needle exchange service, identify issues and gaps in services and decide how we can work together to provide better services in our communities."

#### Successes

ANKORS strives to partner and collaborate with consumers, community, regional, provincial, national and international agencies, organizations and health service providers within their funding capacity to help stem the spread of HIV/AIDS, hepatitis, overdose and other harms associated with the use of drugs.

ANKORS supports and helped to initiate Rural Empowered Drug Users (REDUN), a network of people who use or have used drugs. The group meets twice monthly, and though it has no funding, it is eager to be heard and to help make positive change in the community. Their mission is to help create an environment that supports dignity, health, human rights and respect for current and former drug users, as well the community at large.

#### **Lessons Learned**

"If I had to do it over again I would begin by focusing at an earlier stage more on helping to organize networks of people who use drugs," states Alex Sherstobitoff, of ANKORS' Harm Reduction & Outreach. "People are still being infected with bloodborne pathogens and dying of disease and overdose at unacceptable rates. There is much work to be done and therefore it is difficult to be content at this point."

# CONTACT

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## CONCLUSIONS, RECOMMENDATIONS, CHALLENGES AND LESSONS LEARNED

## CONCLUSIONS AND RECOMMENDATIONS FROM THE FOCUS GROUP

#### TREATMENT AND COUNSELLING

Focus group participants want treatment for problematic substance use.

- The number of treatment and detox programs must be increased.
- Programs must be more accessible and available when requested.
- Treatment must be varied, flexible and tailored to participants' needs, goals and culture.
- Treatment programs must be available for people no matter what drug(s) they are using.
- Long-term counselling and support must be available and continue for as long as needed, to address the issues underlying problematic substance use.
- Treatment services must be delivered from a harm reduction perspective, meeting people where they are at.
- Service providers must treat people with dignity and respect and be nonjudgmental.

#### METHADONE MAINTENANCE PROGRAMS

Focus group participants state that methadone maintenance programs help some of them to stay off drugs and get their lives in order.

- Access to low-threshold methadone dispensing and to "carries" that can be taken
  home are crucial components of a successful methadone treatment program and
  must be more available.
- Treatment to address the use of non-opiate drugs must also be available to people on methadone.
- Long waiting lists for admission into programs represent a barrier which needs to be addressed.
- The significant increase in the number of people on methadone and of methadone overdose deaths, and concern over perceived misuses of methadone (e.g., prescribing methadone for cocaine use) and dosing inconsistencies have raised questions about the operation of programs and the training of physicians. These concerns must be addressed.

- Additional physicians must be trained to prescribe methadone.
- Better access to methadone in prisons is needed.
- There was general consensus and concern that methadone is difficult to wean off
  of, and that it is seen by some as a "medical handcuff". Alternatives to methadone
  must be made available.
- Cannabis should be available as a drug substitute, instead of methadone, to those
  who wish to try it.

#### **DRUG SUBSTITUTION**

Focus group participants want to see additional treatment options for people who use cocaine, especially some type of drug substitution.

#### PEER INVOLVEMENT

Focus group participants are keen to be involved in all aspects of programming, from design to evaluation.

- It is essential that people who use drugs be included in program development, implementation, delivery and evaluation ("Nothing about us without us"). Many, compelled by a sense of altruism, have long been involved in providing outreach on their own, showing initiative and good leadership skills in filling in service gaps.
   User involvement improves programs' credibility, products and output; gives users a sense of empowerment, belonging and purpose; and builds their self- esteem and self-confidence. Involvement can also enhance the users' life skills and employability.
- People who use drugs recognize the importance of educating others, especially
  youth, on the realities of drug use and want to be a part of this. Their expertise
  and commitment should be utilized.
- People who use or have used drugs should be offered training and mentoring for specific tasks, such as public speaking and writing proposals for funding, and provided with support at the same level as other staff.
- Barriers to involvement and participation exist, such as systemic barriers within organizations (e.g., policies) and exclusion (e.g., not being allowed to make presentations at schools), and must be addressed.
- For some, getting involved in service provision can be a trigger for relapse.
   Supervision and support are essential.

#### NEEDLE AND INJECTION EQUIPMENT DISTRIBUTION

Focus group participants report that needle distribution works best in a community-based, non-judgmental environment.

- Peer involvement is a necessary component of needle distribution programs. Peer
  outreach enables programs to provide supplies and services to people who do not
  access needle distribution services. Peer or secondary distribution should also be
  supported, as picking up needles for and distributing them to their peers is both
  a common and effective practice.
- There must be no limitation on the number of needles which can be obtained in a given contact, since needle distribution services are not always available or close by.
- Needle distribution must include distribution of all equipment required for injection.
- Outreach services must be equipped to disseminate information about resources, such as drop-ins, shelters, and other relevant services.
- Longer hours of operation are required to make needle distribution services available when people need them.
- Additional outreach vans are needed to provide more frequent service at locations where it is needed.
- Home delivery of injecting supplies is an essential component of service that should be provided.
- The attitudes of the healthcare professionals are often a barrier to obtaining injection equipment from pharmacies and hospitals and must be addressed.
- To eradicate existing stigma and discrimination toward people who use drugs, AIDS service organizations, shelters and drop-in centres must employ a harm reduction approach to service delivery.
- Needle distribution must be put in place for people in rural and remote areas.
- Safer crack use kits must be universally available.
- Needle distribution must take place in prisons.

#### SAFE INJECTION SITES

Focus group participants say that safe drug consumption sites are a necessity.

#### DROP-IN CENTRES & SHELTERS

Focus group participants report that drop-in centres and shelters are most effective when they have friendly, caring staff and provide a welcoming and non-judgmental space for people who use drugs.

- Drop-in and shelter staff are often seen as surrogate family, which should be a consideration for staffing.
- Drop-in centres and shelters must welcome people who use drugs.
- Drop-in centres and shelters should ensure that health professionals are available
  on site to work with the clientele. This provides both on-the-spot service and the
  opportunity for the health care workers to gain insight into the realities that
  people who use drugs face and live with.
- The practice of closing shelters first thing in the morning and of barring people
  who use drugs and those who have pets from shelters and drop-in centres must be
  eased, since they pose significant barriers.
- Food services, such as meals or emergency food boxes, must be provided in both shelters and drop-in centres.
- Additional drop-in centres and shelters, plus sufficient staff to run them, are required.
- The use of legal "squats" should be explored as alternative housing.

#### EDUCATION, AWARENESS AND INFORMATION DISSEMINATION

Focus group participants express interest in public speaking to raise awareness and educate people about the realities of substance use.

- Prevention efforts targeted at youth are essential and need to be done from a harm reduction approach.
- People with drug-use experience should participate in the education of youth in schools.
- The dissemination of information about harm reduction, HIV, hepatitis C and other consequences of substance use must be increased.
- Police need to be educated about harm reduction and the realities of people who
  use street drugs' lives.
- Referrals are an effective means of disseminating information about services.
   Others must be developed and utilized.

#### HEALTH PROFESSIONALS AND SERVICE PROVIDERS

Focus group participants appreciate health professionals and service providers who are caring, interested, non-judgmental and cheerful, and who provide services unconditionally.

- Health professionals and service providers need to be educated regarding harm reduction.
- Program administrators should take into consideration that people who have had personal experience with substance use or have been immersed in an environment frequented by people who use drugs are often the most helpful and effective service providers.
- Opportunities for clientele to make direct contact with health professionals who
  might otherwise be inaccessible to them (i.e. nurses, doctors, social workers,
  mental health specialists, etc.) will break down barriers to appropriate care and
  can enhance external referrals.
- Opportunities for health professionals, social workers and others to be exposed
  to the clientele and services help break down resistance of professionals to serve
  a marginalized clientele:
  - Various programs host nursing and social work practicum students, work terms, training sessions, ride-alongs, etc.
  - Having a variety of services in the same building can enhance mutual understanding and effective collaborations for the best interests of their common clients (e.g., Children and Family Services in same building as a drop-in service).
- Most healthcare professionals are reluctant to provide pain medication to people who
  use drugs. They experience pain and deserve treatment. Healthcare professionals
  must be better trained to manage their pain respectfully and effectively.
- Physicians and other health professionals must develop expertise in caring for people who use drugs, so that care will be consistent from one healthcare professional to the next.
- Health professionals must ensure that they speak in a language understandable to their patients/clients and check to see that they are indeed being understood.
- Health professionals and service providers should work from a harm reduction perspective, providing clients with options regarding their substance use, and celebrating their successes instead of punishing them for their failures.
- Harm reduction messages are rendered more effective through frequent restatement. With repetition over time they are more likely to sink in. This approach saves lives.

#### **OUTREACH**

Focus group participants express great appreciation for outreach services. Outreach delivers materials, information and services to them and reaches people who do not access agencies.

- Agencies must recognize and unconditionally support outreach workers for their
  unique role as the sole service providers of many people who use street drugs, as
  surrogate family, and as trustworthy partners who are able to develop relationships
  with a highly cautious client group. They are called upon to be everywhere to
  provide services, which is a significant challenge.
- Outreach teams must provide a broader range of information about available services.
- Additional outreach workers and vans and longer hours of operation are needed.
- Outreach must take place where people use.
- Peer outreach is especially effective and desirable.
- Outreach to people in prisons and hospitals is essential, since people are particularly lonely and isolated in these situations.

#### HARM REDUCTION AND DRUG POLICY

Focus group participants expressed frustration at the government's elimination of harm reduction from the National Anti-Drug Strategy. They call on the government to view substance use as a health and social issue rather than a criminal one.

- Harm reduction works. It meets people where they are at, without judging them or their use of drugs, and focuses on their health and safety and that of the community.
- Harm reduction helps people to connect with services, including treatment.
- Research on the effectiveness of harm reduction measures has been conducted and published internationally. There is sufficient evidence to support them.
- An alternative to current drug policy, such as the regulation and taxation of drugs should be considered. Suggested models of drug regulation and control have been developed and published.
- An end to prohibition would have a positive impact on the lives of people who use drugs as well as to society in general. They reported that they would not need to support their habit by illegal means. There would be less forfeiting of children to children's aid. They would not need to run underground safe houses. Their personal safety would be enhanced.

## CHALLENGES AND LESSONS LEARNED FROM THE SITE VISITS

Learning from other cities' experiences in the development and implementation of programs can be very beneficial to avoiding the same challenges and reinventing the wheel. Challenges and lessons learned have been compiled based on the interviews conducted during the site visits for this project.

#### CHALLENGES FOR HARM REDUCTION PROGRAMS AND PRACTICES

- Some policies are an infringement of human rights, drive clients underground and out of reach, and are antithetical to harm reduction.
- User groups and organizations experience challenges to organizing, obtaining funding and finding spaces to meet.
- It is often difficult to find people willing to go public about their drug use and be spokespeople, due to stigma and the illegality of drugs.
- Privacy and confidentiality are hard to maintain, especially in rural or remote areas.
- Services are called on to cover vast territories, which is often beyond their capabilities.
- Programs should not discriminate based on age. That said, providing service to minors is considered controversial, even though they may legitimately require it.
- With the widening divide between the rich and poor, increasing gentrification, further marginalization of already marginalized populations and growing rates of homelessness, it is difficult to find workable solutions without government support and good funding.
- Racism exists and is inadequately addressed.
- In an environment with no sustained funding for particular initiatives and a tendency towards project-based funding that ends with no assurance of continuity, services fluctuate and experience high staff turnover, often leaving clients without the services they have come to rely on.
- Proper disposal and recovery of used injection equipment remains a challenge in some communities. This is a legitimate concern, but it is sometimes used as a "red herring" to de-legitimize harm reduction programming.

- Harm reduction messages have to be constantly repeated, in order to get through to those opposing them.
- Sometimes programs and services have difficulty finding a space to rent due to the nature of their services.
- Community-based models of methadone maintenance treatment constantly feel under threat that they will be forced into the (provincial) medical model.
- The dispensing costs for methadone and sometimes for carries militate against access to treatment for the poorest people.
- Community-based hepatitis C treatment for people who use drugs is taking place in some areas, but is not universally available, despite its effectiveness.
- Pain management treatment for people who use drugs is not available in a manner that is effective and respectful of their situation.
- Continuity of care and services for people who are in and out of prison ranges from non-existent to highly variable.
- Police opposition to programs, which sometimes borders on political repression, is not being addressed by people with authority.
- There are long waiting lists for treatment, and to see specialists.
- Policy conflicts among collaborating agencies can limit service. (e.g., Red Cross
  will not allow needles to be distributed from their van, which is used in a
  collaborative outreach program).
- Bureaucracy may "move", but its pace is intractably slow.

## LESSONS LEARNED – SUGGESTIONS FOR WHAT WORKS WELL TO ADDRESS CHALLENGES AND NEEDS

#### Community buy-in strategies

- Establish a coalition of community members, service organisations and potential partner organisations. Be creative in reaching out.
- Ensure that program logistics, including the procuring of sufficient supplies, are
  worked out before launching a harm reduction program. In all areas, consider the
  law of unintended consequences.
- Develop contacts in the media and educate them about what you are doing and why, before a program is launched.
  - Develop a proactive media strategy. Provide media kits/ information prior to program launch, so that messaging about the program is consistent.

- Try to establish a good working relationship with local police services. A "bubble zone" or a hassle-free space around the service delivery areas can be negotiated.
- Court politicians; get them on board.
- Anticipate community/neighbourhood concerns and be prepared to address them.
- Hold community consultations prior to moving into a location or neighbourhood. Identify champions from the community, set up a process where community concerns can be heard and respected, and develop strategies for how best to address these concerns.
- Perform periodical community clean-ups (e.g., picking up needles) and information forums as a public service.
- Identify and support agency and community champions.
- Celebrations and ceremonies, including memorials, are valuable for community building and healing.
- When involved in awareness raising endeavours, remember that though it is
  easiest to preach to the converted, this is not usually what you need to do.
  Identify and "preach to" those in the mushy middle, who are more likely to
  change than are those on either end of the spectrum.
- Develop and advocate for policies appropriate to your community's needs (e.g., needle distribution in pharmacies).

#### Coalitions of organizations and people from the community

#### ADVANTAGES OF COMMUNITY COALITIONS

- They bring agencies, business, service organizations, residents and community members together to discuss problems and solutions.
- They provide a platform where members share experiences and perceptions and learn from one another.
- The "brainstorming" of ideas and strategies from differing perspectives is inherent in them and provides a broader range of solutions to choose from.
- They can encourage community buy-in and ownership of programs.
- They can broaden the scope of financial and human resources, since expertise, support, work, in-kind assistance and financial help are shared among coalition members.
- The shared ownership of programs ensures continuity of services. When funding in some organizations fluctuates, others can compensate.

- They encourage information dissemination about programs, and about harm reduction, across a diverse sample of the community, which helps generate support.
- They can be run by their own board (with terms of reference) and remain distinct from any of the partnering agencies, thus taking the "heat" off a particular agency.
- Through collaborations and partnering they can demonstrate community buy-in, which can help with obtaining funding.
- They can establish special committees to address specific community issues, which may result in the development of new programs.
- They can catalyze the establishment of larger networks to address issues that exist in multiple cities (e.g., provincial networks or coalitions).

#### CHALLENGES OF COMMUNITY COALITIONS

- Funders may be confused as to where to direct funds. However, funds can be filtered through one organization on behalf of the coalition.
- Developing policies and procedures that incorporate those of all the member organizations may not be possible. This can be addressed through caveats that allow certain policies and procedures of specific organizations to supersede those of the coalition.
- There may be confusion as to who runs a specific program; however, a
  coordinator can be hired, and job description and reporting criteria developed.
- Finding common ground and a common language may be difficult and timeconsuming. Making fiscal arguments instead of moral judgements sometimes helps.

#### Involvement of community members with drug use experience

- They have a right to be involved in decisions that affect their lives; you have an
  obligation to ensure that this takes place.
- They have unique expertise and experiences to share. Recognise their expertise: they know how it is.
- Many want to share their experience and expertise. This is invaluable.
- Include them in program planning, delivery and evaluation to capitalize on their experiential understanding and street smarts.
- When allowed to participate fully, they have a sense of ownership and commitment to the program.
- They will help you to tap into existing resources and reach people who would otherwise not be accessible to you.

- They can gain the trust of their peers more easily than you can.
- They are credible and thus have the potential to help their peers stabilize and improve their quality of life, health and well-being.
- They can do advocacy work and be a voice within their community and to the general public.
- User groups or organizations are great advocates and provide valuable assistance, so encourage and support their development.
- Using peers as spokespersons can help counter the flagrant lack of information and the misinformation about people who use drugs, street involved people and sex workers.

#### Adopting a harm reduction approach

- Treat everyone as equals, in a person-centred, respectful and non-judgmental manner.
- Outreach to distribute harm reduction equipment, condoms and information is
  as much a means of relationship-building and getting people connected with
  programs and services as it is to assist them in taking better care of themselves,
  discovering new options and opportunities, and making positive changes to
  improve their quality of life and well-being.
- Dignity and respect are basic needs, along with food, shelter and the other social determinants of health.
- Harm reduction can be justified as a public health or health promotion priority, which may work to face down opposition.
- Harm reduction information sessions (don't refer to them as training!) must be repeated often, to contend with staff turnover.
- Provide speakers for schools and in-services.

#### Fostering patience and perseverance

- Patience and perseverance are usually required when developing and implementing harm reduction programs and practices. Don't give up!
- It takes a long time to influence social thinking. Don't give up!
- Often a community's fears are worse than reality and, after services have been open for a while, the fears may subside. Don't give up!
- Don't take no for an answer. Where there's a will, there's a way. Don't give up!
- There may be other ways to attain your goal. Don't give up!

- Be creative. Think outside the box. Don't give up!
- Find your allies and support them. Don't give up!
- Celebrate successes, especially small ones.
- DON'T GIVE UP!

#### **Enhancing Human Resources**

- The use of volunteers can enhance the scope of specific programs and develops a cadre of supporters and spokespeople.
- Celebrate and support dedicated staff and volunteers.
- Provide practice guidelines and support for outreach workers.
- Seek out and hire staff with experiential knowledge.
- Pair seasoned outreach workers/volunteers with new ones, to ensure support, continuity and appropriate work performance.
- Employ a multidisciplinary approach and ensure that all collaborating "disciplines" buy in to harm reduction.
- Hold monthly information and support meetings for outreach workers.

#### **Enhancing Harm Reduction Programs and Services**

- Provide a welcoming, non-judgmental space and staff. They are essential for success.
- Provide services/items other than those directly associated with drug use, such
  as food, clothing, medical care, personal support, social support, activities and
  referrals, to enhance the use, credibility and effectiveness of programs.
- Deliver services close to where prospective clients are, for ease of accessibility.
- The collaborative provision of services by several agencies will ensure continuity under all conditions.
- Services should be as comprehensive as possible and should include food, supplies, information, support, outreach and referral.
- Look for innovative approaches to cost recovery (e.g., renting space).
- Work to ensure that policies at shelters accommodate active drug users (e.g, provide them with injection equipment and training and store equipment for them, which they can access upon request).
- Employ mobile outreach vans and secondary distribution of harm reduction equipment to reach rural and remote areas.

#### **Funding tips**

- The scrupulous collection of data on the use of services and on the clientele will
  prove invaluable when applying for funding, evaluating programs, and adapting
  to changing trends.
- Conduct process evaluation to help in applications for funding.

#### Involvement in research

- Involvement in community-based research can contribute to the body of
  evidence on the efficacy of harm reduction programs and practices and help
  ensure that the research is applied.
- Be selective in the research you get involved in and ensure that it will be used to benefit the clients and program.

#### Be an advocate

- Advocate for the adoption of client-centred methadone maintenance treatment
  in your province. Consider Ontario's methadone case management approach as a
  model. It is set up to work with the client and ensure that she/he cannot fail the
  program. It also provides advocacy, mediation, support, and flexibility.
- Advocate for low-threshold methadone programs and buprenorphine.
- Support hepatitis C treatment for active injection drug users.
- Advocate for low-threshold medical care.
- Advocate for freer access to harm reduction equipment, including sharps containers, in shelters and other sites. Destignatize harm reduction!
- Advocate for provincial and federal funding to support harm reduction efforts as part of public health strategy and to ensure stability.
- Address the political climate and ideological opposition by calling on the Charter
  of Rights and Freedoms, or other international human rights treaties, to force
  implementation of harm reduction programs.
- Participate on community advisory committees/boards to get your message out.

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