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

A number of research and evaluation studies – albeit most, aside from the Vancouver and Sydney evaluation studies, in the form of reports rather than peer-reviewed literature – have provided insight on utilization dynamics, outcomes and impacts of SCS programs. For example, a variety of important factors influencing drug users' utilization of SCS facilities have been identified, including distance required to travel to use the facility, types of services offered, perce -0.0 -1.2162aveanilS22008 a6Bf16 Td [(dpf16 TdcTw T*

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

3. Component 2: Stakeholder Survey

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

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

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

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

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

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

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

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

RECOMMENDATIONS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. **That** the role of the police in maintaining accessibility to an SCS, as well as the order and safety in and around an SCS for both users, staff and the community is recognized as crucial. Specifically, the police should be included in the development of SCS options from early planning stages onward, commit to

B. BACKGROUND

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

1. Key Characteristics of Drug Use in Victoria

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

of IDUs (27.2%) living outside of Victoria in the six months before recruitment across all seven sites (average

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

2. Mortality- and Morbidity-related Harms and Risks

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

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

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

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

3. Drug-related Crime Indicators

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

4. Other Preliminary SCS Feasibility Data

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

5. Political Context for SCS Options in Victoria

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

April 2004. Victoria's harm reduction strategy emphasizes the areas of treatment, prevention, housing and enforcement, and aims to reduce public drug and alcohol p

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

1. Introduction

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

2. History and Present Landscape

The idea and practice of SCS first appeared in Western Europe in the late 1980s, in the context of local drug policy measures and interventions gradually shifting away from abstinence and enforcement towards acceptance- or health-oriented initiatives, in the midst of intensifying drug-related public health and order crises described primarily by the rise of overdose deaths, the spread of HIV, and the existence of large open drug scenes, which existing measures were unable to effectively curtail (Fischer et al., 2002). In essence, SCS aim to fill a service gap between enforcement, treatment and targeted interventions like needle exchange programs by providing safe, protected and clean environments in which drug users consume their pre-obtained illicit street drugs in the presence of professional staff, thereby reducing various harms associated with street drug

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

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

4. Legal Context

The implementation of SCS has been contentious not only for ideological reasons, but also with regard to legal issues – specifically the legality of SCS, as well as potential liability implications given that drug possession remains illegal, and that staff could potentially incur criminal or civil liability in the event of injury or death of a client. The Internat -0ir.0.002-5(menr(tgrralia, ics in)-oly)-4(f)- Bo del(tg5(men in)-Bext)]T(el(tg5(s7f)-2)6(ev)-

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

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

5. Design, Operations and Services

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

A review of documents describing SCS suggests that most facilities provide the following core services: a drug consumption space (injection and/or inhalation); washroom; café or common room (typically offering beverages and light snacks); drug use, health and treatment information; overdose management; provision of sterile drug use equipment and/or needle exchange; counselling and basic medical care (Broadhead et al., 2002; Poschadel et al., 2002; Anoro et al., 2003; Spreyermann & Willen, 2003; Hedrich, 2004; Independent Working Group, 2006; Skretting, 2006). Facilities that are limited to these services are known as 'pure' or specialized facilities (e.g., Sydney, Australia), in contrast to 'comprehensive' or integrated models that are more common throughout Europe, which in addition to the aforementioned services, typically provide a range of social or health serv

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

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

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

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

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

2003). In Victoria, willingness among IDUs to use SCS increased with frequency of injection (VIHA, 2006). In Montreal, younger IDUs who inject predominantly in public and older IDUs who inject predominantly in private reported a greater willingness to use SCS

7. Service Uptake

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

While the gender and ethnic composition of the clientele varies according to location, SCS cater in large part to older (e.g., 30 years +) users, having initiated injection drug use before age 20 and with a history of drug use of at least 10 years. Furthermore, clients of SCS are disproportionately described by characteristics of: public injection; intensive drug use; low education; unstable housing and income (many reporting crime and/or social assistance as main source of income); and a history of injection-related health problems, non-fatal overdose or previous incarceration (Wood et al., 2006d; MSIC Evaluation Committee, 2003; Hedrich, 2004). In the European SCS surveyed, between 15 and 50% of clients have never been in treatment, and it is

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

Decentralized facilities – as they are sometimes installed for political acceptability (e.g., Hamburg) – may be located away from open drug scenes or drug markets, and can consequently be underused. In fact, a couple of underutilized SCS in Europe have been moved or closed. Conversely, centralized SCS generally operate at capacity, and often cannot keep up with the demand (Hedrich, 2004). Weekly

8. Impacts and Effects

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

ii) Health and Risk Behaviours

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

iii) Public Order

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

iv) Service Referrals

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

v) Cost-effectiveness

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

Specifically drawing on the Sydney example, the set-up costs of the facility were $1,334,041 and the operating costs for the first year were $1,995,784. In the initial year of operation, the cost was $63.01 per client visit and assuming increased uptake and

the opening of the facility) and 2002 (17 months after the opening of the facility), the attitudes of representative samples of local residents (n=515/540) and business owners (n=209/207) towards the facility became significantly more positive, although these benefits can only be demonstrated in the short-term. The proportion of residents who agreed with the establishment of the injection site (68% in 2000 vs. 78% in 2002), agreed that the facility reduced the risk of HIV/HCV transmission (87% vs. 92%), and reduced discarded needles (80% vs. 82%) increased, while the proportion of residents who agreed that the facility attracted drug users to the area (65% vs. 55%) decreased. Increasingly, residents disagreed that the site encouraged injection drug use (62% vs. 73%), made law enforcement difficult (55% vs. 63%) or encouraged people to think that it is legal to inject heroin (44% vs. 52%). The proportion of businesses who agreed that the facility reduced public injection increased (67% vs. 72%). In general, businesses and residents wanted the facility to be located in socially suitable areas, namely, away from children, young people and residential areas and located in areas of high drug use (Thein et al., 2005). In 2002, one in three businesses and half of the residents in Kings Cross were not aware of the facility's location, implying that the facility had little or no impact on this population. Furthermore, one in four businesses and one in three residents found no disadvantages with having a medically supervised injection centre (MSIC Evaluation Committee, 2003). However, the community believed that drop-in and ancillary services would attract IDUs from elsewhere in greater number than would health services and therefore, the provision of such services was limited in order to increase acceptability among the community (van Beek, 2003). In Vancouver, close to 50% of 117 surveyed local business people were in favor of the facility, with businesses further away and with higher traffic levels showing less support (BC Centre for Excellence in HIV/AIDS, 2004). A representative general population survey in Ontario asked respondents about their attitudes towards SCS in 2004. A little more than half of (the 16srv)(e)1(areas a2 inif)-4(a)or ofn

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

10. Conclusions

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

In terms of impacts with regard to the objectives of SCS, it is probably aptly summarized that "the evidence on the effectiveness of [SCS] as a means of reducing a range of drug-related harms is promising, but it is less conclusive than supporters of [SCS] might have wished" (Roberts et al., 2004, p.5) (see also Fischer et al., 2002; Hall & Kimber, 2005; Kimber et al., 2005; Independent Working Group, 2006). To date, what appears empirically known from the limited quality evaluation data available is that SCS: reach their target groups and attract street drug users – particularly users who are highly marginalized and characterized by high-risk behaviors – to utilize their services; relocate many injection and non-injection drug use episodes from public spaces into SCS; successfully deal with overdose episodes occurring within the facilities which otherwise would have taken place in less safe environments, and likely reduce overdose fatalities in public spaces; reduce health risk behaviors, including H[t.437ing H[tl5street 13(gimhi1k4(y1t)4[(riv<002

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

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

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

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

1. Introduction and Methods

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

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

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

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

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

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

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

2. Attitudes Towards Drug Use in the Victoria Context

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

i) Nature of the Drug Problem

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

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

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

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

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

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

iv) Locations of Drug Use

In discussing where drug use activity takes place in Victoria, there was widespread agreement among stakeholders that there is not one concentrated area, but rather that there are pockets of drug use dispersed throughout the city. As a political representative noted, "*one reason people may come here from Vancouver is because they find it unsafe there, they're scared because of the concentration [in Vancouver], but in Victoria, we're all over the place*" (SCS13). When asked to identify specific locations where drug-related activities take place, stakeholders most commonly mentioned areas where services for drug users are located, especially near the following organizations: AIDS Vancouver Island (Blanshard St. & Cormorant St.), Streetlink (Swift St. & Store St.), Mustard Seed (Government St. & Queens Ave.), St. John the Divine (Quadra St. & Mason St.), and Sandy Merriman (Quadra St. & Burdett Ave.). As a drug user informant noted, "*downtown, people inject in the underground [parkades], outside of Streetlink, outside the door here [AVI], they go up to the church to [St. John the Divine]*

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

Most stakeholders agreed that the drug problem is widespread and that it is not limited to downtown Victoria. As a social service provider noted, "*the drug scene is often what people see in the downtown core but it's so much more than that… it's not just the small percentage of people who are seen daily on the street, it's a much larger issue*" (SCS01). Some stakeholders explained that as residents and businesses complain about the visibility of drug use downtown, drug users are displaced to areas just outside the downtown core: "*cops get on the bandwagon and it gets pushed out to North Park and Fernwood*" (SCS21). Similarly, a social service provider thought that some drug users are "

Many stakeholders also expr

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

vi) Landscape of Existing Services

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

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

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

vii) Gaps in Existing Services

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

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

Many stakeholders agreed that there are significant gaps in services, especially for those who are marginalized by their drug use and for those who are the most vulnerable. As a social service provider noted, "*there is virtually no help at all for people who are addicted in this region*" (SCS03). A strong majority of stakeholders agreed that a full continuum of services from health care to housing is needed in order to improve service provision for drug users in Victoria and that different points of entry into the system are needed, along with appropriate screening and referral mechanisms to properly assess clients' needs and subsequently refer them to the most appropriate programs. In

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thought that drug education is needed to inform drug users about what drugs they are taking, and that additional equipment such as sharps containers and needle drop boxes are needed in various locations throughout the city. Some stakeholders thought there should be longer opening hours at the needle exchange program and that more fixed sites for needle exchange services are needed. Other stakeholders stressed the need for additional street nurse outreach, especially after the needle exchange program closes and one social service provider said that a drop-in centre that is open at night is needed: "*when I'm in Rock Bay at night, people come up to the car looking for rigs [needles], pipes and condoms, there are no services there at night and this is when most of the activity takes place…a drop-in centre at night is needed*" (SCS31). Overall, stakeholders felt that addictions and mental health issues should not be treated in isolatoul 6,(isovostak)24t of the

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

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

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

ii) Benefits of Possible SCS Options

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

informant said that "*it's a good idea, it'll be a place to get [needles], people use dirty water, so it would be cleaner and people wo*

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

iii) Risks or Challenges of Possible SCS Options

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

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

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

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

i) SCS Delivery Model Options

When stakeholders were asked which delivery model they preferred for possible SCS options in Victoria, an overwhelming majority supported a *decentralized* (e.g., two or

ii) Possible SCS Locations

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

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

iii) Preferred SCS Design Options

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

small and because the belief was that drug users might not otherwise attempt to access, or might not know about available services. If they were first-time clients, they would go to a private room, as part of the waiting area, to register and be assessed by a staff member to find out which services would best meet their needs. After clients made use of the consumption facilities, they would then move to a chill-out room where snacks and coffee would be provided and, once again, have the opportunity to consult with staff before leaving. A few people mentioned that it would be good to have separate rooms for clients who needed to be secluded or who wanted to be alone either for their drug-use episodes or afterwards. As a drug user informant said, “

the immediacy of access: "*the window of opportunity is very small…if someone wants to get clean, the service needs to be [available] immediate[ly]*" (SCS36). Others believed that having day beds (sometimes referred to as "daytox") would be a good resource for dealing with highly intoxicated clients who presented themselves at the facility. Rather than turning the client away or allowing the client to consume drugs – two responses that

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

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

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

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

5. Attitudes Towards Rules and Requirements of Possible SCS Options

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

i) Behavioural Rules

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

ii) Potential Barriers to Access

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

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

iii) Assisted Injection

Stakeholders were quite divided on the specific issue of whether assisted injection should be allowed at an SCS facility. Many stakeholders said that it was really difficult to know what to do, and some stakeholders expressed mixed feelings. Of the people who said assisted injection should be permitted, some thought that only staff should be allowed to provide assistance while others believed that drug users known to each other should be able to assist each other. However, the majority of people thought that qualified staff should be the ones to provide the assistance. As a social service provider said, "*assistance should be given on a case-by-case basis with staff assessing whether more harm would result if the client self-injected*" (SCS07). Others mentioned that it should be part of service delivery given that many potential SCS users have physical disabilities, such as paralysis, amputated limbs or blindness. Another social service provider stressed that "*it should be part of the nurse's duty of care…assistance should be provided only if people have legitimate limitations, not simply because they are too high*

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

Stakeholders were asked their opinion about whether pregnant women who use drugs s

risky for a non-user to be around all the drug use because it could be a trigger [to initiate drug use] or they might get curious, but at the same time, everyone should have the right to come in the door and get help…maybe they just want information or counselling"

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

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

7. Indicators of Success and Failure of Possible SCS Options

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

service provider hoped “*people would be healthier from their veins to their brains*”

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

E. APPENDICES

1. Recommendations

RECOMMENDATIONS:

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

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

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

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

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

6. **That** an SCS initiative in Victoria ideally be implemented in a decentralized fashion, e.g., featuring, at minimum, one facility in the downtown core, as well as one or two additional facilities in other locales in need (e.g., other areas of Victoria or adjacent municipalities). If, for financial reasons, only one fixed SCS facility was possible, this program should be located in downtownpc rangdjacTJ EMaci

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

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

2. Stakeholder Survey Participants' List

Business, Tourism and Community Representatives

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

Consultants

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

Drug User Informants (anonymous)

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

Health Care and Social Service Providers

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

Law Enforcement Representatives

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

Political Representatives

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

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

3. Acknowledgements

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