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SAFE INJECTION ROOMS FOR INTRAVENOUS DRUG USERS IN THE DOWNTOWN EASTSIDE: An Investigation and Policy Framework for Decision-Makers

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Vancouver's Downtown Eastside (DTES) has a long history of poverty, marginalization, social dislocation and crime. Serious health and social problems associated with injection drug use have led to a variety of responses from community leaders, residents, business owners, law enforcement agents, health and social workers and politicians. Two general categories of response have been the use reduction approach and the harm reduction approach. The former stresses the need for rehabilitation and detoxification of drug users, while the latter advocates a comprehensive approach that attempts to reduce social and health problems associated with drug use. One component of harm reduction is the establishment of Safe Injection Rooms (SIRs). Safe Injection Rooms are facilities where users can inject drugs in a sterile, safe facility. Specifics of SIR management and components vary between cities and countries.

This report represents a policy analysis on the possible establishment and maintenance of SIRs on Vancouver's Downtown Eastside. Various groups, or stakeholders, were contacted to determine the community's concerns and objectives about SIRs. The fundamental objectives were: (1) enhancing the social environment of the area; (2) maximizing the health of the community; (3) maximising the safety of the community; (4) ensuring the economic viability of the area; and (5) minimizing costs to the public. Based on these community objectives, five alternatives to establishing SIRs were created. They fall within two broad categories: 'establish SIRs' and 'do not establish SIRs.' The former category includes three different models that would be implemented within a broader framework of harm reduction. These were: the User-Based Model, the Health/Medicalized Model, and the Community-Driven Model. The two options for addressing the concerns through means other than establishing SIRs were the Enforcement Model, and the Harm Reduction without SIRs Model.

A matrix was created to evaluate the degrees to which alternatives satisfy the objectives. Based on this analysis, the Community-Driven Model for SIR establishment appears to be the most attractive alternative. A discussion is given on how this and the other alternatives could be implemented. Before the Community-Driven Model can be implemented, significant discussion between all of the stakeholders must occur in order to refine the model and tailor it to the specific needs and resources of the community.

1. INTRODUCTION

Vancouver's Downtown Eastside (DTES) has a long history of poverty, marginalization, social dislocation and crime. A reputation for drug use has drawn a disproportionate number of drug users and dealers to the neighbourhood. In Vancouver, problems associated with injection drug use, such as high mortality, morbidity and economic decline, are highly concentrated in the area surrounding the intersection of Main Street and Hastings Street. A variety of responses to address the issue of drug abuse in the DTES are being investigated.

Within this context, the question of whether to establish Safe Injection Rooms (SIRs) arises. This study addresses the issue of SIRs in the DTES through a framework based on the elicitation of stakeholder values, and the subsequent development of policy alternatives. With this approach, the study aims to contribute to the debate on harm reduction by incorporating fundamental stakeholder objectives into the formulation of clear and realistic opportunities for action.

1.1 History of the DTES in the Context of SIRs

There are an estimated 1500 intravenous drug users with HIV in the Downtown Eastside. In 1998, drug use resulted in 375 overdose deaths (Mulgrew, 1999). In total, emergency services responded to 2048 overdose calls in 1998 (Smith, 1999). Public residents, merchants and police worry about the multiple impacts associated with public injection which include improper discarding of used needles, loss of business, poor public perception of the area and lower property values. Despite these difficulties, many people find a caring community where visitors feel safe, if not entirely comfortable, on the streets, (City of Vancouver, 1998).

In 1958, the removal of the street car terminus changed the previously bustling community – large businesses left and were replaced by low-income residents. Street prostitution became visible in the 1970s, and many mentally ill people, released from institutions because of budget cuts, moved into the neighbourhood (A Brief History). Eight thousand liquor licences served 16,000 people. Heroin, at that time considered the most addictive drug available, was also present (Sergeant Frail, interview 1999).

In the late 1980s "the existing drug situation worsened when the drug of choice went from injection-based heroin to cocaine, which is cheaper, makes people more hyperactive and is more addictive," (A Brief History). Cocaine can be used up to 20 times a day so crime rates increased because of the need to finance the addiction (Mulgrew, 1998). The number of discarded needles also increased.

In 1992, the demise of Woodward's and the subsequent flight of many businesses led to the further concentration of marginalized people in the area as well as services to cater to them. Many of the

remaining residents and businesses are unhappy with the situation. Some interest groups support gentrification of the area, which is heavily opposed by DTES social-action groups.

From November 1995 to October 1996, the province inadvertently funded an unofficial SIR that had started as a drop-in centre to help addicts rehabilitate themselves. A group of users called the Innovative Empowerment Society indirectly received funding from the Vancouver Foundation and the Central City Mission Foundation to start up the centre, called the Back Alley. Shortly after opening it became an SIR. Users were paid a small honorarium to work there and were trained in First Aid and CPR. The site offered a 1:1 needle exchange program. Dealers were not allowed in the centre and workers were not allowed to buy drugs when they were working a shift. Users decided on the rules and the consequences for people who broke them (Thia, VANDU, interview 1999). Police were aware of its presence and for a time referred addicts to it, but the centre had some problems and funding was cancelled. The Back Alley closed. According to Judy McGuire at DEYAS, the negative perception of the Back Alley among community members has contributed to their opposition against the establishment of any further SIRs.

The City of Vancouver put out a report on the DTES in July 1998. That report favours harm reduction and says that accepting non-abstinence is compatible with the "eventual goal of abstention." The report does not mention SIRs either positively or negatively (City of Vancouver, 1998). It instead concentrates on ensuring housing supply, revitalizing the area and providing services for treating addicts (Mulgrew, 1998).

In July 1998, the Vancouver/Richmond Health Board commissioned a new report on "how to reduce the incidence of drug overdoses in the Downtown Eastside," (McMartin and Bains, 1998). The report committee, which had members from various backgrounds, including current and former users, recommended the establishment of four deluxe safe-injection sites. The report was leaked and so does not represent the Health Board's official position.

Response to the report from other groups came quickly and was predominently negative, at least in the newspapers. The police, Mayor Phillip Owen, Dr. Stan de Vlaming (head of addiction medicine at St. Paul's Hospital), Ujjal Dosanjh (then Attorney-General), DEYAS, and some addicts all spoke up against the idea (Drug Havens, 1998; de Vlaming, 1998; Steffenhagen, 1999). Those in favour stressed that a controlled environment would prevent overdose deaths and that it would reduce the HIV epidemic.

The idea of safe-injection sites was shelved after the reactions from the community. In the last month, however, the idea has resurfaced with the November release of a report from Health Canada. Included in the 66 recommendations are the following:

- "decriminalize possession of small amounts of illegal drugs, including heroin;
- medically-supervised injection rooms for addicts;

- heroin prescriptions for addicts, as part of their treatment" (Canadian Drug Laws, 1999).

It remains to be seen whether the recommendations will be implemented and what effect of the report will have on the problems in the Downtown Eastside.

1.2 Harm Reduction

Crime, health problems and safety concerns associated with drug use has had a number of policy responses. Considering the overwhelmingly deleterious implications for users and for the general public, governments, citizens, and private organizations clearly have a responsibility to address the issue of widespread drug use. Less clear than this responsibility, however, is the question of what the best overall strategy is. Answers to this question range from avoidance to intensive intervention, and reflect sometimes conflicting values. For example, a fundamental distinction can be drawn between policies that aim to eliminate drug use by enforcing laws and prosecuting drug crimes, and those that adopt measures to reduce the harms associated with addiction. The former can be characterized as use reduction strategies, while the latter are known as harm reduction. Whereas use reduction is a more traditional and perhaps intuitive response, proponents of harm reduction suggest that such efforts are fundamentally misguided and essentially futile; they argue for an ostensibly more pragmatic approach.

While the United States has remained committed to eradicating drug use, Australia and many countries in Europe have been accepting and developing harm reduction strategies for well over a decade. Canada finds itself somewhere between these two poles, but as the 'drug problem' grows more apparent policy makers are trying to find a clear basis for policy development. This report addresses the possibility of pursuing a harm reduction strategy to combat the negative social, economic and health effects of intravenous (IV) drug use on the DTES. Specifically, it focuses on the role of safe injection rooms as a component of this strategy. By first outlining the more general philosophy of harm reduction, a framework for the remainder of the report is established.

For the purpose of definition, the following quotation is instructive:

> [The concept of harm reduction] holds that drug policies need to focus on reducing crime, whether engendered by drugs or by the prohibition of drugs. And it holds that disease and death can be diminished even among people who can't, or won't, stop taking drugs (Edelmann in Buckley et. al., 1996, p. 39).

This passage highlights three key components of drug related harm - crime, disease, and death. It makes the clear argument that all three can best be mitigated by acting on the assumption that drug use is not likely to be eradicated in the manner suggested by use reduction approaches. In fact, Edelmann (in Buckley et. al., 1996, p. 38) argues that "drugs are here to stay. The time has come to abandon the concept of a drug-free society. We need to focus on learning to live with drugs in such a way that they do the least possible harm." Thus, the philosophical basis of harm reduction is that drug use is a fact of life

in modern society and that any response to its negative impacts must accept this fact and proceed to address the associated human suffering.

Harm reduction initiatives include needle exchanges, health care extension, support networks, and safe injection rooms. Many proponents of harm reduction in North America point to examples of European cities where harm reduction policies have been successful in achieving goals of reduced crime, mortality, and morbidity among populations of drug users. In all cases, the focus is on establishing a coordinated network of *support* for drug users, rather that attempting strict enforcement of anti-drug legislation and the associated incarceration of offenders.

Harm reduction is also attracting proponents in Australia. A recent report suggesting harm reduction was generated through a formal government initiative, rather than a private interest group or research organization, which highlights the legitimacy of harm reduction as a policy concern. Though cognizant of vocal opposition to harm reduction and SIRs and possible shortcomings of this purportedly pragmatic approach, this report examines its potential for addressing stakeholder objectives in the context of Vancouver's DTES.

1.3 Safe-Injection Rooms

Safe Injection Rooms (SIRs) currently operate in Germany (Frankfurt, Hamburg, Hanover, Bonn, Bremen), Switzerland (Basel, Bern, Zurich), the Netherlands (Rotterdam, Arnhem, Maastricht, Venlo, Apeldoorn) and one will be opening next year in Sydney, Australia.

1.3.1 What conditions led countries to consider Safe Injection Rooms?

In Switzerland, public drug consumption in downtown areas increased dramatically during the late 1980s and early 1990s. Frankfurt faced a similar problem in the inner city during the 1970s and 1980s. Thousands of people came from surrounding areas to buy and use drugs. In Frankfurt, as in Switzerland, efforts to disperse the drug scene through enforcement achieved limited, temporary success (MacPherson, 1999, p. 9).

In both countries, there was widespread concern about the public nuisance of public drug use and concern about the health of users. Statistics confirmed these health concerns, showing rising levels of transmission of blood borne diseases like HIV, Hepatitis B and C, and an increase in overdose deaths (MacPherson, 1999, p. 9). Users did not have easy access to treatment. In Switzerland, services were only reaching about twenty percent of the active drug users. Inaccessibility to harm reduction and treatment services, and observations of the marginalization of IV drug users, contributed to the decision to establish SIRs. In Switzerland, police favoured harm reduction programs because they would enable police to spend resources on other public safety issues. In Australia, concern about the corruption of police working in the drug trade also led to the consideration of SIRs.

1.3.2 How do different countries operate Safe Injection Rooms?

In Switzerland and Germany, many SIRs are operated by non-governmental organizations and non-profit societies. In Switzerland, they are funded by the Department of Welfare. Recently, the Swiss have developed a prescription heroin program for serious drug users. In Frankfurt, the Drug Policy Coordinator, together with agencies from various levels of government, works to develop a coordinated response to the drug problem. This response included the establishment of five safe injection rooms between 1994 and 1996, after a bill providing a legal framework for the establishment of safe injection rooms was passed in the legislature in 1994 (MacPherson, 1999, p. 10).

In Australia, three SIR models are being considered. The first is to build a new facility managed by the New South Wales Health Department, or contracted out to a non-governmental organization. They are also considering incorporating SIRs into existing health or drug treatment service. The last option consists of licensing and regulating an existing commercial enterprise.

1.3.3 What do they look like and how are they run?

Most SIRs have medically trained staff and social workers who advise users, talk to them about their situation, and provide assistance in the event of an overdose. The staff do not administer injections to the user. The SIR usually accommodates up to twelve people at a few stainless steel tables where the equipment is provided. The equipment usually includes sterilized needles, syringes, candles, water, spoons, cotton pads, Band-Aids and garbage bins. The users are allowed between twenty and sixty minutes to inject and clean up after themselves.

Many SIRs are part of centres that provide many other services to drug users, including counselling, food and drink, laundry, medical and methadone clinics, work training programs and opportunities for clients to be employed or to volunteer. Although staff discourage loitering outside centres, space is provided within the centre for users before and after injecting. Some facilities offer longer term care for users. In Frankfurt, the Eastside facility provides shelter for six to twelve months as well as emergency overnight shelter for up to four weeks. SIRs are usually located near public transportation and in areas previously known as a public injecting sites. Some provide free service. Hours of operation vary, but most try to minimize their impact on the community. Most have tried to include the stakeholders, businesses and residents of the area, in the process of establishing and maintaining the SIRs.

SIRs usually have rules to determine who can use the facility and who cannot. Users must be a minimum of sixteen years old in Switzerland and eighteen in Australia to use SIRs. In general, users must have a previous history of injecting drugs, be a resident of the city in which they are using the SIR, and be registered to use the SIR. Drug dealing is not permitted in the SIRs or in the centres (MacPherson, 1999, p. 14).

1.3.4 What have been the results of SIRs?

SIRs in Germany, Switzerland and the Netherlands have been found to alleviate health problems associated with IV drug use and to decrease the public nuisance resulting from public drug use. Safer injection practices in SIRs have improved the health of users, measured by fewer overdoses, less vein damage and a reduced incidence of blood borne disease transmission. Public nuisance and public drug use has decreased since the establishment of SIRs. In Arnhem, public drug use has declined, and in Swiss cities, fewer needles have been found on the streets. Drug related criminal activity has decreased. More users have been accessing treatment as a result of visiting SIRs. People who go to SIRs are found to take fewer risks with their health. Safe Injection Rooms have been found to reach the population of drug users who are hardest to reach. In Rotterdam, close to fifty percent of the people who go to SIRs are immigrants and forty percent are homeless. In Switzerland, the Netherlands, and Germany they found that most of the people frequenting the SIR were above the average age of drug users. In these SIRs, benefits have been found to outweigh the costs, but not as substantially as other programs like needle exchange and methadone clinics.

2. METHODOLOGY

2.1 Methodology

To address the question of a best policy for the possible establishment and maintenance of SIRs in the DTES, a methodology based on stakeholder objectives was adopted. This approach, based on Ralph Keeney's *Value Focused Thinking* (1992), uses the values of interested parties as a foundation for developing and choosing among a set of policy alternatives. The process is comprised of seven key steps, which allow for a flexible and iterative process, rather than suggesting a rigid analytical framework.

2.1.1 Identify the Problem

Before any kind of methodology can be developed, a clear understanding of the policy problem or decision context must be reached. This point is especially relevant to a methodology based on stakeholder values, because a clearly identified problem provides common ground for discussion with a range of individuals and groups.

2.1.2 Establish the Research Question

Any policy problem necessarily involves multiple levels of interaction between the researcher(s) and the research context. In the case of SIRs these levels, varying from broad social goals to individual needs, suggested various questions of importance to decision-makers. To guide inquiry, a research question was developed to address just one level of interaction while remaining cognizant of the relevance of other levels. A question hierarchy illustrates this point (see Figure 1).

2.1.3 Identify Stakeholders

Having developed a clear and succinct research question, the next step was to identify a variety of individuals or groups who have a stake in the outcome of a decision pertaining to SIR models. Possible stakeholders were identified through suggestions from people knowledgeable about the area and through group brainstorming. Preliminary research was conducted to fill in remaining gaps and to ensure that the range of stakeholders chosen was as inclusive as possible.

2.1.4 Elicit Stakeholder Objectives

Having compiled a list of stakeholders, a list of questions (see Appendix B) was developed to structure interviews and gather objectives. Throughout the interviews, conducted by telephone or in person, stakeholders were asked to identify what values and objectives were important to them or to their organization when considering the possible implementation and maintenance of SIRs. These are separated into fundamental and means objectives, which are shown in Table 1. For a complete list of stakeholder objectives see Appendix C.

2.1.5 Develop Measurement Criteria

After a set of alternatives was designed, the objectives of stakeholders were once again invoked to develop criteria for evaluating the alternatives. These criteria, presented in Table 2, provide an objective reference point for assessment and comparison of the alternatives in terms of their ability to respond to important values.

2.1.6 Create Alternatives

After conducting a number of interviews with a variety of stakeholders, it became clear that while some groups supported SIRs and had clear ideas about how they might be implemented, others were more inclined to suggest other strategies for tackling the problems associated with injection drug use. Within these broad categories of supporting or not supporting SIRs, stakeholder objectives suggested a number of alternatives (see Tables 3 and 4).

2.1.7 Evaluate Alternatives

The next step is the evaluation of the alternative in light of the fundamental objectives which had been identified earlier. The use of a matrix enables a clear comparison to be made, as can be seen in Table 5.

2.1.8 Identify Trade-offs and Implementation Issues

After the impacts of the alternatives have been described in the matrix, key trade-offs are identified and elaborated. Factors influencing policy implementation are also considered.

2.1.9 Re-evaluate Alternatives

Given additional time, the alternatives would be presented to stakeholders for evaluation, clarification and refinement. Stakeholder responses would indicate the strengths and weaknesses of the different options, and suggest possible improvements.

2.2 Limits of the Methodology

Although the chosen methodology has many strengths, which justify its application in the current research context, a few weaknesses are evident and should be considered when examining the results, as follows.

2.2.1 Time Constraints

Time constraints prevented necessary iteration. Alternatives were developed based on initial interviews. It was not possible to present stakeholders with these alternatives and refine them further in light of responses. Given more time, it would also be useful to have a group meeting with the multiple stakeholders to discuss objectives and alternatives.

2.2.2 Structural Limitations

The structure of the process can, by focusing on stakeholder objectives, mask anecdotal data and limit the incorporation of unstructured but qualitatively rich material.

2.2.3 Limited Experience with the Issue

The researchers had limited knowledge of and experience in the Downtown Eastside. As outsiders, their ability to identify all important stakeholders and elicit honest, candid and open responses was constrained.

2.2.4 Possible Bias of Informant Group

It is unclear whether the chosen informants were representative of larger fundamental values, or whether their personal biases on a sensitive issue guided responses.

2.2.5 Research Question

The specific research question was developed before interviewing stakeholders. There is thus a risk that the question might not be wholly relevant to the key objectives of research participants. In terms of the need for participatory research design, a methodological shortcoming is evident.

3. The Research Question

3.1 The Problem

Having defined the specific problem to be addressed through the policy analysis, it is necessary to take a broader view of the context within which this problem is embedded. Any response to the issue of drug use in a particular inner-city neighbourhood is linked to more general societal goals with wider implications and larger geographic boundaries. Although such issues cannot be resolved with discrete and realizable policies, they must inform any decision.

Just as certain questions are too broad for realistic policy analysis, others are unnecessarily narrow. They tend to take many uncertainties for granted and are thus unsatisfactory as a basis for further study if larger issues have not yet been clarified. The hierarchy presented below illustrates the range of questions relevant to the context of problems associated with IV drug use in the DTES.

3.2 Hierarchy of Questions

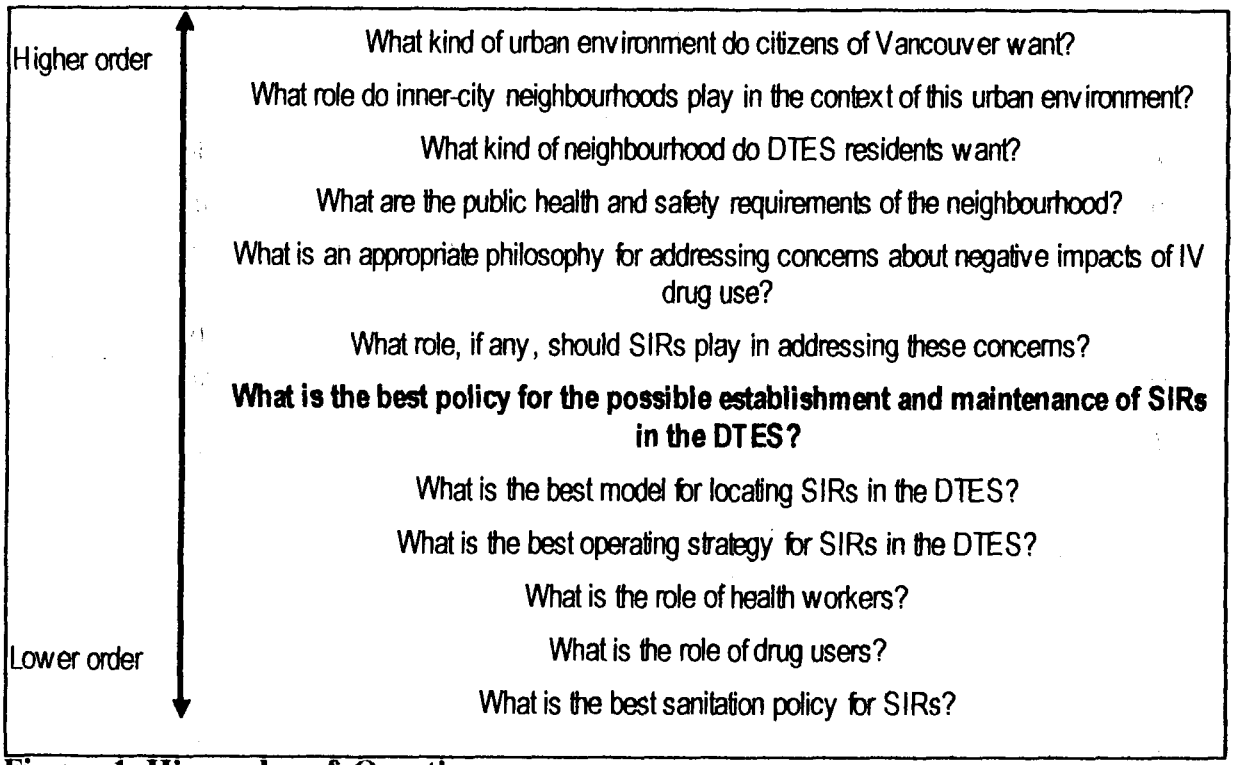

Figure 1 Hierarchy of Questions

The selection of the question highlighted above acknowledges that SIRs may not be a realistic alternative for some stakeholders. Those who would advocate SIRs are encouraged to suggest specific strategies for how they might be designed to best address stakeholder objectives. Thus, the present inquiry is situated between the range of general and specific issues outlined above.

4. STAKEHOLDERS

The following is a brief summary of the concerns and histories of the stakeholders with whom we spoke. It is the intention of this synopsis to inform the reader about what influences inform our stakeholders. These include tendencies inherent in the individual's position and personal experience and history.

Mr. Lee is the spokesperson for the **Chinatown Merchants Association**. He is primarily concerned with the perception of the area as a dangerous place, which ultimately discourages business. However, his compassion for users and others who live in the area is strong. He considers these people to be his "brothers and sisters". He mentioned a fellow who was a long time resident of the area and also a drug user. He recently died and Mr. Lee attended the funeral. While discussing the funeral an interesting insight was revealed. This individual was Mr. Lee's "adversary" but still his "brother". Mr. Lee approaches the problem with a realistic understanding of economics as well as a healthy dose of compassion.

The **Consumer Board of the Downtown Eastside HIV/IDU Action Plan** is mandated by the Vancouver/Richmond Health Board to implement the National Action Plan on persons living with AIDS. The intravenous drug user community is the Board's focus in providing support and assistance to those in need. The Consumer Board advocates the establishment of Safe Injection Rooms across the region as part of a larger harm reduction strategy. It believes the SIRs should be community-driven, with a broad range of medical and social services on site.

The **Downtown Eastside Residents Association (DERA)** is an community-based organization that battles homelessness and poverty, advocates decent and affordable housing, fair wages, increased employment opportunities, livable incomes, community and recreation facilities, park space, safety, security and community based planning. DERA would like to see the problem of IV drug use medicalized and an approach to IV drug use that focuses on what they consider to be the root of the problem, poverty.

Downtown Eastside Youth Activities Society (DEYAS) was created to deliver primary outreach services to the street-involved people of the DTES. The agency's priority is youth, but it also runs a number of Health Outreach Programs for adults. Services encompass a range of interventions, including crisis management, advocacy, service referrals, counselling and risk-reduction initiatives. DEYAS would like to see SIRs as part of a holistic harm reduction strategy. Its priority is to rehabilitate users and promote housing and life skills development with a range of decentralized community-driven services to improve the lives and health of the DTES community.

The **Native Health Centre** is a community health centre that provides medical help to anyone who seeks it. They feel that a continuum of services is needed to help IV drug users to improve their health

and rehabilitate themselves. If SIRs were to be implemented, they would need to be accompanied by access to a range of short term and long term services.

Sergeant Frail has been a **police officer** for many years. He has seen the drug problem on the DTES escalate recently. He is closely involved in a number of projects being undertaken to improve livability in the region. These endeavours include stopping the distribution of rice wine, working towards implementing a Carrall Street Corridor, closing hotels that do not offer sanitary accommodation and working to create a period of peace and calm on the street between the hours of 3 a.m. and 5 a.m. He considers the current problem of IV drug use to be an extension of problems with the welfare system, health care and societal attitudes. His primary goal is to create a livable DTES community for everyone.

Wayne Nelson of the **Strathcona Association of Merchants Society** approached the issue primarily with concern for his business. He is strongly opposed to drug use and does not want it to effect his livelihood; He would like to see the area 'cleaned up' in order to attract more customers.

Gillian Maxwell of the **Strathcona Residents' Association** clarified that she did not speak on behalf of the organization but expressed just one view from within it. Gillian's primary concern is the safety and health of users as well as the well being of her community.

Strathcona School is an elementary school located within the neighbourhood of Strathcona on the DTES. The school principal is concerned about the health and safety of their school children. They are also concerned about concentrating services for drug users in their neighbourhood because it is contributing to a "ghettoization" of the neighbourhood.

Thia and Brian of the **Vancouver Area Network of Drug Users (VANDU)** were strongly in favour of SIRs within the larger context of harm reduction, provided that they offered certain services, for example, a nurse on site. They made economic and health related arguments in favour on the issue. Thia and Brian also emphasized the importance of users having control over how such services would be offered as well as having some control and focus in their own lives. They expressed concern for the lack of dignity and privacy that users are afforded in the present system.

Although we did not have the opportunity to speak with the **Vancouver-Richmond Health Board**, from their reports it is possible to deduce that they are concerned about the health of the community of users and non users on the DTES.

5. FUNDAMENTAL AND MEANS OBJECTIVES

In talking to the stakeholders about the strategic objective, "What is the best policy for the possible establishment and maintenance of SIRs on the DTES?" we identified a number of general fundamental objectives that represent the basic values of the stakeholders. Fundamental objectives address the question, "What matters most?" In this context, they are:

1) Enhance the positive social environment of the Downtown Eastside community

2) Maximize health of users and non-users

3) Maximize safety

4) Maximize economic viability

5) Minimize costs to public

Fundamental objectives were then broken down into more specific means objectives which contribute to the realization of fundamental objectives. These are presented in the table on the next page.

Table 1 Fundamental and Means Objectives

Fundamental Objectives	Means Objectives
Enhance the positive social environment of the Downtown Eastside (DTES) community • for users • for residents • for school children • for business workers and owners	• improve housing conditions for users and non-users on the DTES • minimize the social costs of crime • maximize the services within the community • minimize stigma associated with drug users by educating society
Maximize health of users and non users • mental health • physical health	• maximize user dignity • maximize the feeling of community among users • maximize the education (medical and life skills) of users • minimize the exposure to blood borne viral diseases, e.g. HIV, Hepatitis C & B • maximize access to health care • maximize cleanliness of facilities
Maximize safety • to users • to business owners and workers • to health care workers • residents • school children • police	• minimize activities associated with IV drug use, e.g. property crimes, assault, prostitution, drug dealing • maximize cleanliness of streets • increase police presence • minimize opportunity for police harassment • minimize public disputes related to IV drug use • decrease vulnerability associated with unsafe lifestyles • increase perception of safety • maximize education about safety
Maximize economic viability • for business owners-in Strathcona, Chinatown, Gastown • for residents	• maximize property values • maximize number of customers • increase the aesthetics of the business environment • decrease the visibility of activities associated with IV drug use • maintain financial security of residents and business owners
Minimize costs to public • medical costs • policing costs • justice system costs • education costs	• maximize the efficiency of allocation of resources and expenditures • maximize integration of users into society

6. PERFORMANCE MEASURES

The following table provides performance measures that give a method for evaluating policy outcomes in terms of stakeholder objectives.

Table 2 Fundamental Objectives and Performance Measures

Fundamental Objectives	Performance Measures
Enhance the positive social environment of the Downtown Eastside (DTES) community • for users • for residents • for school children • for business workers and owners?	• survey perceptions of environment • compare population demographics • chart business migration • change in clinical depression rates
Maximize health of users and non users • mental health • physical health	• number of psychological health workers required • reduced rates of disease, overdose fatalities, users, numbers of needles on streets • increased rates of rehabilitation and people receiving treatment • decrease rates of worker compensation claims
Maximize safety • to users • to business owners and workers • to health care workers • residents • school children • police	• decrease in altercations with police and social service workers • survey perception of safety of streets • decrease in crime rates
Maximize economic viability • for business owners-in Strathcona, Chinatown, Gastown • for residents	• monitor change in number of customers • change in property values • change in business earnings • change in number of business establishments
Minimize costs to public • medical costs • legal, judicial, penal, policing costs • education costs	• change in cost of facility, number of staff • change in the number of fines and incarcerations processed • change in expenditures on ambulances • change in residential occupancy rates • change in number of calls to police and emergency services • reallocation of resources

7. ALTERNATIVES

After talking to stakeholders and structuring their concerns into fundamental objectives, a few alternatives were developed to address the strategic objective of "What is the best policy for the possible establishment and maintenance of SIRs in the DTES?" These alternatives fall within two broad categories: establish SIRs; and do not establish SIRs. They include:

Establish SIRs:

1) The User-Based Model

2) The Health/Medicalized Model

3) The Community-Driven Model

Do not establish SIRs:

4) The Enforcement Model

5) The Harm Reduction Without SIRs Model

As SIRs alone do not address all of our stakeholders' objectives and concerns about IV drug use on the DTES, the 'Establish SIR' models would all fall within a larger context of harm reduction. (Please see Section 1.2 for a discussion on harm reduction). When creating the alternatives, it was determined through interviews and experiences in other countries that every 'Establish SIR' model should incorporate a few basic elements. Common to the three alternatives would be a decentralization of the sites throughout the Lower Mainland; the provision of a range of medical services; the availability of counselling and life-skills development; the need for strong regulations and registration components; and the provision of secure accessibility. Though each of these elements should be present, the alternatives may vary in the degree to which they are incorporated. The alternatives also differ in their management structures, their primary funding mechanisms, and their control. The specific components of each "Establish SIR" model are presented below, in Table 4.

In identifying the alternatives, it was evident that certain objectives may not be addressed by the 'Establish SIRs' option. Analysis of stakeholders' concerns revealed two other alternatives: the Enforcement Model, and the Harm Reduction Without SIRs Model. Some stakeholders saw the need for a more efficient allocation of public resources than establishing SIRs, whether through improved law enforcement, or targeted funds to other harm reduction activities such as education, job training, or rehabilitation. The specifics of these models are discussed in Table 3, below.

It should be mentioned that all of the stakeholders identified the need to address larger, structural problems when attempting to deal with the issues of IV/Drug Use on the DTES. Nearly everyone interviewed saw the need to improve the provision of affordable and safe housing, reform the welfare system, and address the root causes of poverty and abuse. As these issues fall outside the range of the policy question, we have not included them as specific components of the alternatives. However, their significance should not be discounted.

Table 3 Alternatives Without SIRs

Attributes	Enforcement	Harm Reduction Without SIRs
enforcement	• police presence: number, visibility, authority • detoxification as an alternative to jail	• decriminalize • reformed jurisprudence
treatment	• mandatory counselling • education for preventing use • availability of treatment increased • post-treatment care	• provision of detoxification program on request • methadone more available • needs-based counselling • comprehensive approach, e.g. life skills, job training, employment creation
rehabilitation	• mandatory • more widespread • alternative rehab programs available (i.e. less reliance on 12-step programs)	• encouraged and available • no wait list • long term • alternative rehab programs available (i.e. less reliance on 12-step programs)
control	• model designed and administered by penal and judicial system	• model designed and administered by social services and medical system

Table 4 Alternatives with SIRs

Attributes	User-Based	Medicalized/Health	Community-Driven
age[1]	• options available for young users	• no one under 19	• no one under 19
education & social services	• provided	• emphasized	• mandatory
community outreach	• concern incorporated	• incorporated into existing programs	• SIR involved in community outreach
fees	• none	• none	• nominal
time in facility[2]	• flexible	• restricted, e.g. 20-60 minutes	• restricted, e.g. 20-60 minutes
on-site staff	• trained users and medical staff	• existing medical staff - nurses and on-call doctor	• combination trained users, medical staff and social workers
amenities (examples?)	• social and safety	• focus on hygiene	•
type of substance	• IV only	• Heroin only	• Heroin only
hours	• 24	• within existing clinic hours	• based on local needs
location/number	• high-use areas, numerous facilities	• within existing facilities	• limited number with mobile option[3]
source of substance	• user brings	• controlled and provided	• user brings

[1] The issue of a minimum age requirement presents some difficulties. Those opposed to SIRs argue that if a young person is not allowed into an SIR but instead directed into a treatment program, the same tactic should be taken with older users. We resolve the issue by relying on research that led us to conclude that younger users generally respond better to treatment than older users or those who have used for a longer duration.

[2] Drug potency and content is often unknown. To inject safely a user needs time to inject partially, then after learning the potency, inject further as necessary. Monitoring after injection also helps to prevent deaths from overdoses, especially when mixtures of drugs are used.

[3] Mobile option refers to a large van or RV which would function as a travelling SIR. This would work as a deconcentrating factor.

8. Objectives by Alternatives Matrix

Objectives by alternatives matrices provide a useful method for presenting policy analysis by compactly summarizing the information and communicating the impacts. Objectives by alternatives matrices do not dictate a best alternative. To find a best alternative, prioritization of objectives is necessary.

In this matrix each cell represents how each alternative meets each of the fundamental objectives as laid out in Section 5. This is measured using a qualitative ranking scale with three gradations: Low, Medium and High. These rankings are based on our interpretations of a number of factors, the most salient of which are given below. Those with a plus (+) symbol represent a positive force for meeting the objective and those with a minus (-) are seen to act against meeting the objective.

Table 5 Objectives by Alternatives Matrix

Alternatives	**No SIRs**		**SIRs**		
Objectives	**Enforcement**	**Harm Reduction without SIRs**	**User-Based**	**Medicalized/ Health**	**Community-Driven**
Enhance the positive social environment of the Downtown Eastside (DTES) community	**LOW** - increase police presence - fear of authority - stigmatization/ marginalization of users - users likely to return to street soon - long term problems not addressed	**MEDIUM** + compassion for users - drug use still visible + sense of long term commitment	**MEDIUM** + community education may bridge the user-resident gap - lack of authority - little accountability - non-users left out - questionable stability - perception of irresponsibility	**MEDIUM** + legitimacy of response + users off street - low empowerment of non-professionals - limited facilities - not welcoming/ accessible to some users	**HIGH** + local people involved and empowered + sensitive to local conditions/context + users off street + potential for education and outreach + shared sense of responsibility by all

Alternatives	No SIRs		SIRs		
Objectives	**Enforcement**	**Harm Reduction without SIRs**	**User-Based**	**Medicalized/ Health**	**Community-Driven**
Maximize health of users and non users	**LOW** - users remain afraid of arrest and continue to inject quickly in hiding - fast injection increases risk of disease, overdose & needle sharing	**MEDIUM** + more services are available to users - users are still injecting in public places and discarded needles will remain widespread	**MEDIUM** + users can inject slowly and avoid problems associated with fast injection - all staff are not medically trained professionals	**HIGH** + medically trained professional staff	**HIGH** + some medically trained professionals on staff
Maximize safety	**MEDIUM** + increased police presence decreases activities associated with IV drug use on the street and results in increased safety for non users - user safety decreases as they may engage in higher risk activities to avoid arrest	**MEDIUM** + harm reduction programs increase skills of users and safety to users. - programs may draw more activities associated with IV drug use to the area	**MEDIUM** + safety increases due to more control over IV drug use - may draw activities associated with IV drug use to the area	**MEDIUM** + safety increases due to more control over IV drug use - due to there being office hours, use on the street may increase after hours	**HIGH** + safety increases due to more control over IV drug use + ensures access to service 24 hours, increasing safety to users and non users + education increases safety + comprehensiveness of service increases safety
Maximize economic viability	**HIGH** + less drug users impacting on business + immediate, clear and definitive approach + acceptability of business community	**MEDIUM** + may improve business in long term - still users on the street in short term	**LOW** - higher visibility of users - attract users to area	**HIGH** + low visibility + institutionalized and sanitized	**HIGH** + buy-in from business community + addresses problem

Alternatives	No SIRs		SIRs		
Objectives	Enforcement	Harm Reduction without SIRs	User-Based	Medicalized/ Health	Community-Driven
Minimize costs to public	LOW + decreased costs of property crime - costs of increased number of officers - judicial system costs - costs of treatment	LOW + decreases costs of providing emergency services - the variety of programs increases costs	MEDIUM + user model has fewest facilities + decreases costs of providing emergency services for users - cost of harm reduction measures	LOW + decreases costs of providing emergency services for users - high cost of providing heroin to users - increased costs to medical insurance system - cost of harm reduction measures	MEDIUM + decreases costs of providing emergency services for users - cost of harm reduction measures

9. TRADE-OFFS

When choosing between alternatives, it is important to keep in mind that there will be trade-offs. In this policy analysis, no alternative met stakeholder objectives completely and thus no perfect policy exists.

A careful consideration of the kinds of trade-offs implicit in any alternative will lead to a better informed policy decision. Cost is always a factor when comparing alternatives, but the cheapest alternative is not always the best.

9.1 Health of users vs. economic viability of business

While models that incorporate harm reduction measures (methadone programs, SIRs, and needle exchanges) will increase user health, they will also draw more users to the area resulting in fewer non-user customers frequenting the businesses.

9.2 Effective education vs. impinging on user freedom

Harm reduction programs that incorporate health and safety education increase the health and safety of the user but impinge on the user's freedom to use the service without unsolicited advice.

9.3 Provision of some services vs. the provision of other services

Assuming that groups are limited by budget constraints, providing certain services within one alternative or between alternatives may mean trading off the provision of another type of service. For example, offering extensive counselling services may mean foregoing other amenities such as laundry facilities or community outreach.

9.4 Long term goals vs. short term goals

Certain alternatives may address immediate short term needs of the community, but may have a limited potential to achieve strategic long term goals. For example, increasing law enforcement may address some of the concerns of the business community in the short term without adequately handling issues that will take longer to control, such as addiction and homelessness.

9.5 Long term costs vs. short term costs

Some models may incur large initial investments of time and financial resources. For instance, a new facility may need to be built, medical personnel hired, or staff trained. Alternatives with minimal short term costs, such as those using existing medical facilities, may be more expensive to run in the long term.

9.6 Comprehensive assistance to a few vs. limited assistance to many

Use reduction approaches such as detoxification and subsequent rehabilitation require significant investment for each individual treated and may not reach a broad population. Harm reduction can offer basic assistance to many users (e.g. clean needles) but may not succeed in offering a comprehensive approach for each individual.

9.7 Accessibility vs. safety of service

Depending on who controls a particular service, and how it is operated, users will feel generally welcome. An environment that is more accessible and conducive to user's comfort, might not be as safe as a stricter, medically supervised model.

9.8 Costs to public vs. comprehensiveness of response

A variety of short and long term solutions to problems associated with IV drug use are available. Funding constraints and public willingness to support such solutions will limit the ability of policy makers to adopt the most comprehensive combination of available strategies.

9.9 Progressive image for businesses vs. economic viability

Businesses may be interested in participating in harm reduction programs and SIRs to increase their credibility and involvement in the community. The mandate might conflict with short term needs to "clean up the streets" and decrease the local population of drug users.

9.10 User acceptability vs. public acceptability

Models attempting to cater to users' needs through involving them in design, implementation and maintenance are unlikely to gain acceptance in light of public fears about the problems of drug use in the community.

10. IMPLEMENTATION

Prior to implementing any model, a few aspects that affect all alternatives need attention. First, in order to be successful, proposed models require public support since buy-in from the public is a necessary component. Unfortunately, there is no best method of obtaining this crucial support. In addition to public support, political acceptance by all levels of government is mandatory. Obviously, effective public relations work is a key component in laying the foundation upon which to build a successful model.

A realistic analysis of the feasibility of implementing any of the suggested models needs to be undertaken. Budget limitations will be a primary consideration in every circumstance. The implementing agency will need to be creative and resourceful. Funding from government sources will likely be required. Another issue that needs to be kept in mind are the legal implications associated with a specific course of action. If an illegal activity is being condoned implicitly, serious consideration and an understanding of possible repercussions is critical. Changes to Canadian law may also be required before implementing options that include medicalization or legalization. Before selecting an option, the practicality of pursuing the option must be contemplated.

Finally, the implementing agency must grapple with the difficult question of whether certain drugs are better suited to SIR models than others. In the DTES, this question has prompted debate surrounding the differences between heroin and cocaine and how these differences would be addressed by an SIR. Some stakeholders specified their tolerance for heroin but prejudice against cocaine use. This discrepancy exists because the effects of cocaine are more immediate and ephemeral when compared to those of heroin. Moreover, cocaine is currently more prevalent than heroin in the DTES. Availability of drugs at the street level fluctuates; for some stakeholders this variable complicates the issue of establishing a best policy for SIRs. This distinction is problematic in practice, as drugs are often impure and users do not always know what substance they are injecting. Whether to make a distinction between heroin and other drugs is a decision that will have a major impact on the number of people the SIR influences and its acceptability to various stakeholders.

Table 6 Suggested Implementation Measures

Model	Suggested Implementation Measures
Use Reduction	• Assign more police officers to the neighbourhood • Establish a detoxification centre outside the penal system • Link police actions and counselling services through the establishment of well-funded counselling centres operated by trained staff • Integrate drug education into school curricula (involvement of police officers, counsellors and users) • Fund research into alternatives to existing 12-step rehabilitation programs • Long term monitoring of former users by counsellors &/or parole officers
Harm Reduction	• Inquiry into decriminalization of illicit substances • Use courts to address only significant drug infractions (i.e. dealing vs. possession) • Well funded counselling centres operated by trained staff • Implement a 'no-waitlist' list policy for individuals requesting assistance • Make methadone available: dispensation at convenient locations & implement a 'no-waitlist' policy for those interested in receiving methadone treatment
User Model	• Solicit user opinions and involvement in determining location and structure of the governing body as well as formulation of program goals • Facilitate contact between the medical community, users, public educators and staff • Provide training for users who can then become valuable resources in daily administration of the establishment • Identify viable funding sources. Consider involving a public relations expert. Involve former and current users in outreach • Establish connections with business suppliers who may be willing to donate necessities such as coffee, tea, laundry detergent, etc.

Model	Suggested Implementation Measures
Community Model	• Provide training for users who can then become valuable resources in daily administration of the establishment • Staff should include on-call doctors, nurses, professional counsellors and administrative staff. Recruit volunteer staff from the community • Use of the centre by the larger community. It can be used to bring together merchants, residents and community members • Funding from government, community, local merchants, donations, etc.
Medical Model	• Decriminalize medical provision of heroin • Require all clients to produce proof of age. Enforce age restriction • Provide in-house education materials for all users, including videos, books, staff consultants/advisers • Clinic operated by nurses and doctors • Provision of sinks, showers and clean equipment • Allocate space for SIRs within existing hospitals and clinics • Impose time limits (usually 20-60 minutes) • Funding obtained from the provincial government health care budget

11. RECOMMENDATIONS AND AREAS FOR FURTHER STUDY

Based on analysis of the Objectives by Alternatives Matrix (see page 23) the 'Community-Based' model of SIR establishment appears to address the greatest number of stakeholder concerns.

However, before recommending a policy, these alternatives should be discussed with the stakeholders for an iterative process of reflection and refinement to ensure that the best policy option is chosen. Time constraints impeded our ability to distribute a draft version of this report to solicit feedback and suggestions. Feedback would allow us to define the chosen option more clearly and take into account stakeholder objectives that may become clear in reaction to this report.

Implementing any of the alternatives outlined in this report will require input from the larger community. Due to the nature and extent of the social and health problems in the DTES, all stakeholder groups need to come together to create a viable, sustainable, long term solution.

We hope that the information presented in this report will prove helpful; however, we realize that there is room for further study in this area.

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APPENDIX A - FACT SHEET GIVEN TO INTERVIEWEES

Information Sheet

A number of cities in Europe and more recently some cities in Australia are actively promoting harm reduction strategies. These policies respond to the social, economic, and health and safety concerns associated with intravenous drug use.

During the past decade, harm reduction has come to include the provision of safe injection rooms, or SIRs. SIRs are places where IV drug users can inject drugs in a controlled environment with medical supervision, sterile injection equipment, and possibly access to treatment programs or facilities.

The following table presents some of the more commonly cited arguments for and against SIRs.*

	Arguments For SIRs	Arguments Against SIRs
Social	Reduce public nuisance Reduce opportunities for police corruption Reduce certain criminal activities Reintegration of users into society Contact with most marginalized users	Assumption that drug use condoned Congregation of IV drug users Labelling of areas as drug centres Feeling of social experimentation Increase dealing/opportunistic crime
Economic	Reduce treatment costs to community Reduce costs of IV use Less time/costs of community clean-up More law enforcement not cost effective	Drug users don't warrant expenditure Negative impact on local businesses Decrease property values Money better spent on alternative treatment, rehabilitation, enforcement
Health	Reduce fatal overdoses Reduce transmission of infections Access to primary medical care Access to drug treatment programs Improve health workers safety	Increase in drug use Increase in number of users Delay attempts to seek rehab Adverse health/safety impacts for workers and users

Problems associated with IV drug use in Vancouver's Downtown Eastside cannot be ignored and SIRs are one possible initiative. Before assuming their suitability as the best possible alternative, however, the objectives of interested stakeholders must be identified. Bearing in mind the possible advantages or disadvantages of establishing SIRs as part of a broader harm reduction strategy, we hope to discover the objectives of a number of stakeholders, and to develop a range of alternative that address these concerns.

If you could take the time to think about what matters to you, or to the people you work with, we would greatly appreciate the opportunity to listen to your concerns and to understand what objectives you consider important. Through this process, we hope to address the following question:

What would be the best policy regarding the possible establishment and maintenance of SIRs in the Downtown Eastside?

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* Joint Select Committee into Safe Injection Rooms (1998) "Report on the Establishment or Trial of Safe Injection Rooms," Sydney: Parliament of New South Wales, Australia.

APPENDIX B - INTERVIEW QUESTIONS

Safe Injection Rooms for Vancouver's Downtown Eastside?

Interview Guidelines

Here is a series of questions that should help to structure our interviews. Each question is meant to prompt further discussion where necessary. It is up to us, as interviewers, to focus on key points that might reasonably be elaborated to arrive at fundamental objectives. Then we need to find out how SIRs might relate to these objectives, promoting or preventing their realization. So use your imagination and discretion when referring to the following preliminary questions:

1. Can you tell us a little bit about what your organization/association does?
   -elaborate on any goals/objectives

2. Do you perceive drug use to be a problem in the DTES?
   2. b. If yes, how does this problem affect your organization/members/constituents?

3. What do you think are some possible responses to the problem?

4. Do you think that SIRs might be a part of this response?

5. What are some problems/disadvantages associated with SIRs

6. Why might they be a good option? What are some advantages?

APPENDIX C - OBJECTIVES

Chinatown Merchants Association

- strong unified voice for Chinatown merchants and residents. Not marginalized
- business prosperity
- safe neighbourhood
- remove stigma from the neighbourhood
- compassion for those in need (users)
- promotion of Chinese culture
- consistency between observance and enforcement of legal and law system

Consumer Board of the Downtown Eastside HIV/IDU Action Plan

- advocate SIRs within broader harm reduction strategy
- reduce incidence of HIV
- provide for all users
- provide education and counselling

Downtown Eastside Residents' Association (DERA)

- need to address poverty
- provide treatment as a medical problem

Downtown Eastside Youth Activities Services (DEYAS)

- provide other harm reduction measures; SIRs are not a priority
- provide life-skills and life-counselling
- effectively administer SIRs
- reduce harm for all groups - harm reduction means the entire community
- get increased, continuous funding

Native Health Centre

- to meet the health needs of everyone that seeks help, except if under influence of drugs
- maximize the health of users and community
- reduce incidence of blood borne diseases-AIDS, Hepatitis B, Hepatitis C
- maximize ability for users to improve their lives
- to provide a continuum of services for drug users- from harm reduction, detoxification, provide long term health care and help
- teach life skills
- make drug rehabilitation services accessible
- to take advantage of time when person wants to get clean, minimize waiting time
- reach as many people as who need it
    - provide service as frequently as needed (now if go once, wait for 30 days)
- maximize services available to users
    - detoxification
    - services to help people out of the predicament of their lives on the DTES

Police

- good conditions in the community (livability and economic viability)
- law abiding citizenry
- promotion of economic viability of the area
- provision of proper medical care for users and mentally ill
- reduction in small crimes
- better use of police services
- provision of safe housing

Strathcona Association of Merchants Society

- to get users and sex trade workers (STWs) off streets
- to keep businesses afloat
- de-centralize services to users, eg. according to police statistics quoted by Nelson, 80-85% of STWs don't live in the area, there should be a proper expansion of services throughout city not just in DTES
- don't let any more services into the DTES
- STWs should have to work in their own neighbourhood
- discourage johns form coming into area
- rehabilitate addicts and educate against drug use

Strathcona Residents' Association

- improve safety for people using–would lead to fewer health problems
- improve safety for the neighbourhood residents by decreasing their chances of encountering user paraphernalia
- decrease the visibility of users in the neighbourhood for those who find it distasteful, objectionable
- increase the vibrancy of the community (through aesthetics and improving morale)
- improve community businesses—increase diversity
- maintain home owners financial security (help home owners maintain property value)
- support users, give them the feeling that society is not ostracizing them and acknowledges their needs (indirect support)
- give the users privacy and hopefully self-respect, help maintain their dignity

Strathcona School

- increase the safety of school children
- reduce IV drug use and activities associated with drug use on or near school grounds
- reduce number of users found in school building
- maximize the health of school children
    - reduce number of needles, condoms found on school grounds
    - reduce encounters with needles and blood of users in school building
- reduce exposure of school children to serious problems
- reduce the vulnerability of children turning to prostitution and drug dealing
- maximize the livability of the neighbourhood, minimize the ghettoization
- minimize the vulnerability of new immigrants and other residents of the neighbourhood
- increase education about drug use-to populace as a whole and school children

- minimize costs incurred by the school associated with IV drug use
    - reduce need to pick up syringes before school starts and patrol grounds

Vancouver Area Network of Drug Users

- decriminalization
- educate against negative stereotypes about users
- educate parents, they need to understand and deal with and be protected from child's behaviour
- need to give addicts a focus eg. watering gardens, anything to help them focus
- reduce damage and chance of disease
- save many lives by preventing death from ODs
- decrease the spread of AIDS, Hep C, Hep A, TB, Pneumonia, bacterial infections, abscesses, eudociditis (dirt in blood) through provisions of clean rigs, water, materials and access to water
- gives users opportunity to socialize with one another, often their only access to info is through the grapevine
- eliminate incentive for unsafe use eg. if SIR exists, users don't have to pay $10 guest fee to go shoot in someone's room
- prevent expensive health care bills

Vancouver Richmond Health Board [hypothetical]

- improve the health of the community on the Downtown Eastside (DTES)
    - reduce the incidence of drug overdoses
    - minimize health risks to community at large(e.g. needles in the parks) due to IV drug use on the DTES
- address the health concerns of all groups, particularly marginalized ones, such as minority groups and women and children
    - minimize health risks to emergency workers
    - minimize health risks to Safe Injection Room workers
- improve users ability to access help
    - identify users
    - minimize drug use and the number of drug users
- improve safety of community in regards to activities associated with IV drug use (e.g. drug dealing, crime and prostitution)
- improve safety of users in regards to activities associated with IV drug use
- reduce costs to society of activities related to IV drug use
    - reduce medical costs