INJECTION DRUG USE AND THE EPIDEMIC OF HIV IN THE LOWER MAINLAND

Final Report

Sun - Tues

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A NOTE OF THANKS

Many people assisted us in the preparation of this report. In addition to the key informants noted in Appendix A, we would particularly like to thank:

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EXECUTIVE SUMMARY

This report was commissioned by the Medical Health Officers of the four Lower Mainland health regions (North Shore, Simon Fraser, South Fraser and Vancouver/Richmond) in response to the epidemic of HIV and other communicable diseases in injection drug users in the area. In recognition of the intensive efforts which have been applied to documenting the issues in Vancouver's Downtown Eastside (DTES), this report purposefully focuses on the remaining areas of the Lower Mainland.

The most reliable estimates available (from the VIDUS study) indicate the prevalence of HIV infection among injection drug users at approximately 28%, with annual incidence now at approximately 4%. There are an estimated 11 700 regular injection drug users in the Lower Mainland, and within this group there are concurrent epidemics of Hepatitis C and HIV. Injection drug use now represents about half of the new HIV infections recorded, and 80% of newly-identified Hepatitis C cases.

Historically, the focus of injection drug use problems has been concentrated in Vancouver's Downtown Eastside. Our research has shown what injection drug users already knew — "There is a Downtown Eastside in every community. You may not see it, but it's there" — areas of easy access to drugs, coupled with poverty, violence and social dysfunction.

Women, youth, aboriginal persons and those with concurrent mental disorders have been consistently identified as populations of concern associated with injection drug users at risk of HIV. Our research supports this finding, and points to a host of difficulties in addressing the needs of these groups within the Lower Mainland.

Addiction treatment programs designed specifically to meet the special high risk needs of women, youth, aboriginal, mentally ill and homeless injection drug users tend to be clustered in Downtown Vancouver, and are insufficient to meet the needs of other Lower Mainland health regions. Youth at risk and youth who use injection drugs are of particular concern. The average age of individuals newly diagnosed with HIV is now just 23 years of age, and there are over 300 homeless street youth in Vancouver alone. Yet there are only 11 youth detox beds in the Lower Mainland, most addiction treatment services for youth are concentrated in downtown Vancouver, and many have waits ranging from weeks to months to gain access to service.

The findings of this study point to one irrevocable conclusion: there can be no progress made against the epidemic of HIV and communicable diseases in injection drug users until the underlying epidemic of addictions and injection drug use are addressed. This

implies an effective addiction treatment system, and adequate harm reduction measures to reduce the risk to IDUs for whom abstinence is not immediately attainable. To this end, we add our voices to the many others who have called for a reorganization of addictions treatment services in the Lower Mainland, and an infusion of resources to allow the system to respond to the need.

There are a multitude of compelling arguments which lead to the inevitable conclusion that the investment must be made now to halt and to prevent the destruction caused by injection drug use. It is impossible to ignore the well-documented evidence that the root causes of addiction are the same as the root causes of crime, and include poverty, abuse and neglect, family dysfunction, inadequate education and employment. Millar (1998) observed that we are currently spending more than four times as much on attempting to enforce laws related to addictive and illicit drugs ($80 million) as we spend on treatment (less than $20 million). Dollars spent on treatment would be an investment in future reductions in costs related to law enforcement and health care.

The epidemic of deadly communicable diseases among injection drug users compels health authorities to take a leadership role in managing the care of this disease, in establishing effective prevention programs, and in advancing the understanding of addictions as a health condition, rather than as moral weakness or deviant behaviour.

An inter-regional, inter-sectoral approach to addressing the joint epidemics is required. The four regional health boards, in partnership with government, community and professional bodies should assume leadership in assuring that the appropriate policy, service and support structures are in place to address the epidemic of HIV and other communicable diseases in injection drug users in the Lower Mainland, and the underlying epidemics of poverty, despair and hopelessness which are the root of addictive behaviour.

ORGANIZATIONAL RECOMMENDATIONS

Organizational Recommendation 1: An Inter-regional, Inter-sectoral Task Group
The four Lower Mainland Health Regions should advocate for the establishment of an inter-regional, inter-sectoral task group whose task it would be to develop integrated and coordinated strategies for the prevention and treatment of drug addiction across the Lower Mainland.

Organizational Recommendation 2: Inter-Regional Coordinator
The four Lower Mainland Health Regions should support the creation of a permanent

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senior public health position as an Inter-Regional Coordinator to monitor the extent of problems related to injection drug use and communicable diseases, and to support the development and implementation of the health components of inter-regional strategies.

Organizational Recommendation 2.1: Epidemiological Surveillance
Adequate epidemiological surveillance techniques to support the inter-regional task group need to be undertaken using a standardized methodology in each of the four regions.

Organizational Recommendation 2.2: Agreed Outcomes
The four Lower Mainland Health Regions need to reach consensus on *outcomes* to be achieved through an inter-regional strategy.

Organizational Recommendation 2.3: Standards, Protocol and Evaluation
The four Lower Mainland Health Regions need to support:

- standards of service access, comprehensiveness and integration of services,
- protocols for service coordination, and
- standards for the evaluation of effectiveness of programs.

Organizational Recommendation 2.4: Funding Strategy
The four Lower Mainland Health Regions need a funding strategy to support a comprehensive, flexible approach to meeting the overall and targetted needs of those with drug (and alcohol) addictions.

Organizational Recommendation 3: Alcohol and Drug Treatment Model
The four Lower Mainland Health Regions should advocate for an inter-regional alcohol and drug treatment model which incorporates local control and accountability.

Organizational Recommendation 4: Staff Development
Each health region (or the regions collectively) should sponsor a series of workshops on harm reduction approaches for front-line workers in services for those with addictions.

Organizational Recommendation 5: The Role of Injection Drug Users
Health Regions should foster the development of mutual support networks for injection drug users in each region, and health regions should include injection drug users wherever possible in planning activities for new services.

Organizational Recommendation 6: Methadone Maintenance
Administration of methadone maintenance programs should be placed within an integrated model of health and addictions care.

Organizational Recommendation 7: Public Education
Public education should be undertaken to assist with the reconceptualization of addiction as a health issue, and of harm reduction as a sensible public health approach.

SERVICE RECOMMENDATIONS

These "Service Recommendations are based on key issues which emerged during the development of this report. The inter-regional committee resulting from the implementation of the Organizational Recommendations should consider the following recommendations.

Service Recommendation 1: Needle Exchange
Health Regions should work with community partners to ensure that there are multiple sources of needle exchange services in each region, with access available 24 hours a day, 7 days a week.

Service Recommendation 2: Mobile Outreach Health Service
Health Regions should study the feasibility of increasing mobile health services, which would include, but not be limited to:

- needle exchange
- harm reduction strategies (e.g., information about safe shooting techniques, safe sex information, availability of condoms and bleach, basic health information)
- linkages to primary health care, and to alcohol and drug addiction treatment
- outreach, and
- ongoing needs assessment.

Service Recommendation 3: Transitional Housing
Health Regions should work to ensure that adequate supportive transitional housing is available for people who are attempting to overcome their addictions.

Service Recommendation 4: Detox
The Health Regions need to ensure that there is a substantial increase in detox services.

Service Recommendation 5: Expanded Treatment Services
Expanded detox capacity must be linked to an expanded treatment system within an integrated coordinated system of care.

Service Recommendation 6: Integrated Service Agencies
Where appropriate, Health Regions should work to ensure the development of at least one integrated service agency for injection drug users in that region.

Service Recommendation 7: Methadone Maintenance
The Lower Mainland Health Regions should take steps to ensure that comprehensive methadone treatment, including counselling, be readily available without charge.

Service Recommendation 8: HIV Treatment for Injection Drug Users
The Health Regions and inter-regional coordinating committee should enter into dialogue with the BC Centre for Excellence to coordinate expansion of HIV treatment to injection drug users as their addictions stabilize with addiction treatment.

Service Recommendation 9: Improved Training and Safety for Hospital Staff Treating Injection Drug Users
The Health Regions and inter-regional coordinating committee should strike a committee to examine and address training and safety needs for hospital staff in each of the four health regions.

INTRODUCTION

This report was commissioned by the Lower Mainland Communicable Diseases Working Group (LMCDWG), representing the North Shore, Simon Fraser, South Fraser and Vancouver/Richmond Health Regions. The study was launched in response to the epidemic of HIV and other communicable diseases among injection drug users (IDUs). The purpose of the study was to assess the extent and distribution of the outbreak, the contributing factors and the needs, gaps and overlaps in service available to IDUs outside Vancouver's Downtown Eastside. This work is meant to contribute to the development of an inter-regional action plan to address the epidemic of HIV and communicable diseases in injection drug users. The LMCDWG, which included five Medical Health Officers from the regions, acted in an advisory capacity to this study, which was conducted between May and August 1998.

BACKGROUND TO THIS STUDY

The context of the epidemics of injection drug use and the associated epidemics of communicable diseases and premature death in the Lower Mainland has been well documented in a number of recent reports (British Columbia, Office of the Chief Coroner, 1994; Whynot, 1996; Health Officers Council of British Columbia, 1998; Millar, 1998). Both the Ministry of Health and the Ministry for Children and Families have acknowledged the need to address the health, addictions and social needs of injection drug users, establishing specific goals for these areas (Ministry of Health, 1997; Ministry for Children and Families, 1997).

Previous reports provide an important backdrop to understanding the needs of people living with addictions, as well as a context for many of the recommendations in this report. There are compelling humanitarian and economic arguments for society to address the needs of people with addictions. While it is beyond the scope of this report to re-examine all these issues in depth, there is a striking unanimity of opinion regarding the actions necessary to prevent addiction and injection drug use. Authors of previous reports argue the need for expanded resources to address the immediate needs of those living with injection drug use, and its many associated health and social disabilities.

INFORMATION GATHERING METHODS

Information for this report was gathered in four ways:

- A review of relevant policy and research literature. (See "References", at the end of this document).
- A series of key informant interviews, attendance at various public and professional meetings, and informal discussions with a range of people knowledgeable about the field. (See Appendix A for a list of key informants and contacts.)
- Focus groups with injection drug users and methadone clients.
- A service inventory. (Details about methodology and findings of the service inventory are presented beginning on page 18. See Appendix B for the service inventory questionnaire. Various summaries of information obtained from the service inventory are presented, Appendices C through G).

Within the scope and time-frame of the present study, it was not possible to conduct an extensive review of the academic literature on the topics of HIV and injection drug use, although many key sources were consulted. Similarly, it was not possible to contact everyone who was identified as knowledgeable about this complex topic.

THREE CONCURRENT EPIDEMICS

The Lower Mainland of British Columbia is plagued by three inter-related and concurrent epidemics: HIV, hepatitis C and injection drug use. There has been a collective false impression that these problems exist only in Vancouver's Downtown Eastside, but in fact these problems know no geographic boundaries. Recent data from the BC Centre for Disease Control (BCCDC) indicate that in the fourth quarter of 1997, newly diagnosed HIV infections outside Vancouver exceeded those in Vancouver for the first time (STD/AIDS Control, BC Centre for Disease Control Society, unpublished tables, November 1997). This is reflected in the experience of injection drug users, who have told us that "there is a Downtown Eastside in every community — you may not see it, but it's there": areas of easy access to drugs, combined with poverty, violence and social dysfunction. Public health offices are beginning to see this reality reflected in their HIV incidence statistics.

There is a downtown eastside in every community — you may not see it, but it's there.
(Injection drug user)

Heroin destroys friendships to the point where no one cares.
(Injection drug user)

There exists a substantial body of evidence which leads to the conclusion that substance abuse disorders are a health condition, involving physiological changes to the body and brain. As Millar points out:

> Addiction is neither a lifestyle choice or a moral lapse...it is a disease of the brain, with measurable and demonstrable changes in brain physiology, chemistry and performance. These changes can be reversed with appropriate treatment, which is usually a mix of drug therapy, psychological counselling and social support... (1998, p.3).

People don't understand. They think quitting heroin is like stopping smoking.
(Injection drug user)

The *epidemic of HIV* in the Lower Mainland is extremely serious, even by world standards. Vancouver has the highest prevalence of HIV

infection among IDUs in Canada. The best data currently available — from the Vancouver Injection Drug Use Study (VIDUS)[1] — suggest that at least 28% of active injection users in the Lower Mainland have already contracted HIV. Current incidence (that is, the number of new cases) among VIDUS participants is about 4% per year. Nationally, one-third of all *new* HIV infections in 1997 were among injection drug users (Health Canada, 1998).

People that OD down there [in the DTES], people just step right over them as if they weren't there.
(Injection drug user)

In the City of Vancouver report to CCENDU (1998), it is reported that:

> The 1996 CCENDU report noted the devastating effects of the epidemic spread of HIV and hepatitis C documented in the Vancouver Injection Drug Use Study... Through 1996 and 1997, VIDUS provided data analyses confirming a significant HIV outbreak among users, with incidences as high as 18% per year over a six month period... Incidence has predictably declined to about 4% per year, with **an overall HIV prevalence in injection drug users of about 30%.**

The *epidemic of hepatitis C* is also extremely serious. Hepatitis C is caused by a virus which is transmitted primarily by blood-to-blood contact , although sexual transmission is also possible. Hepatitis C has a very long latency period in most of those infected, although in a some cases, the disease progresses quickly. Alcohol consumption, which is significant in injection drug users, can accelerate progression of the disease. About 90% of IDUs enrolled in VIDUS have already contracted Hepatitis C.

Everybody talks about drugs. If only we could really talk about them, together.
(Pubic Health Office, Switzerland)

The *epidemic of injection drug use* is also alarming. In 1993, there were over 350 deaths in British Columbia due to illicit drugs, and **illicit drugs are the leading cause of death in adults age 30-49** (Millar, 1998). The extent of the problem led to a report by

[1] Bognar, Legare and Ross (1998)

the Chief Coroner (British Columbia, Office of the Chief Coroner, 1994, the "Cain Report"). Cain recently commented on his disappointment that the majority of recommendations made in that report had not yet been implemented (Globe and Mail, July 20, 1998). It appears very likely that mortality associated with use of illicit drugs will exceed numbers for 1996 and 1997 (City of Vancouver Report to CCENDU, 1998).

The most reliable figures concerning the extent of injection drug use are those recently reported by Health Canada in its "capture-recapture" study[2] (Consortium to Characterize Injection Drug Users in Canada, 1998), which estimates that **there are approximately 11 700 injection drug users in the Lower Mainland**. Other estimates range as high as 15 000. Half of these people reside in the Downtown Eastside (DTES) — a difficult burden for that neighbourhood, to be sure — while **half live elsewhere in the Lower Mainland**. All Lower Mainland health regions need to develop a coordinated strategy to deal with this problem.

It's too easy to get trapped downtown, and it's too hard to get out. I don't like going there.
(Injection drug user from South Fraser Region)

Data concerning place of residence within Lower Mainland Health Regions have been obtained from the 807 clients most recently interviewed for VIDUS. These data are presented in Table 1. It must be stressed that these data do *not* accurately portray the extent of injection drug use outside DTES, but rather, are a minimal estimate of it. Participants volunteer to enrol in the study, which has its offices in DTES, limiting accessibility for other IDUs.

Hospital discharge data, as well, lead to the conclusion that there are substantial numbers of illicit drug users outside Vancouver. Substance abuse issues were identified in 4.7% of total discharges for residents of Vancouver, but 6.8% of non-residents. In both cases, about half of the substance abuse

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Table 1: VIDUS Participants:
Place of Residence (by Health Region)

	Number	Percent
Vancouver/Richmond		
DTES	448	59
DTS	43	6
Grandview	42	6
Mount Pleasant	12	2
Fraser	10	1
Richmond	8	1
Vancouver Other	25	3
Subtotal	*588*	*78*
Simon Fraser		
New Westminster	40	5
Burnaby	25	3
Maple Ridge/Pitt Meadows	24	3
Coquitlam/Port Coquitlam/Port Moody	10	1
Subtotal	*99*	*13*
South Fraser		
Surrey	55	7
White Rock	3	<1
Langley	2	<1
Delta	11	1
Subtotal	*71*	*8*
North Shore		
North Vancouver	5	<1
Subtotal	*5*	*<1*
TOTAL	**753**	**100**

Notes to Table 1: These are unpublished data based on 807 participants most recently included in VIDUS follow-ups. Forty participants residing primarily elsewhere in BC, other parts of Canada, or the US, have been excluded from this analysis. Similarly 14 participants from neighbouring health regions have been excluded. Difference in Total from 100% is due to rounding.

DTES = Downtown Eastside, and includes Chinatown, Gastown and Strathcona; defined by Great Northern Way (south), the waterfront (north), Clark Drive (east) and Cambie Street (west).

DTS = Downtown South, and includes Yaletown and the West End; defined by Cambie Street (east), Denman Street (west), the waterfront (north), Pacific Boulevard (south).

Grandview = Grandview/Woodland; defined by Clark Drive (west), Nanaimo Street (east), waterfront (north), and Broadway (south).

Mount Pleasant is defined by Great Northern Way (north), 18th Avenue (south), Cambie Street (west) and Clark Drive (east).

Fraser includes Riley Park and Kensington-Cedar Cottage; defined by 18th Avenue (north), 41st Avenue (south), Cambie Street (west) and Nanaimo (east).

diagnoses were alcohol related, and 42% were related to the use of illicit drugs (City of Vancouver Report to CCENDU, 1998).

While the majority of *known* injection drug users are in Vancouver, there are visible "clusters" of drug-related activity in Simon Fraser and South Fraser regions, particularly along the Kingsway corridor in Burnaby and along the Skytrain route in New Westminster and Surrey. Data in Tables C2 (persons newly testing positive for HIV with risk category IDU), C4 (reported cases of hepatitis C), and C5 (deaths due to illicit drugs) all suggest that the number of injection drug users is similar in Simon Fraser and South Fraser regions. Less is known about the situation in North Vancouver, West Vancouver and Richmond.

None of these numbers provide very accurate estimates of the extent of the three concurrent epidemics. They are the best currently-available epidemiological data, but more exact estimates are impossible, for a variety of reasons. People who inject drugs may be unwilling to admit to this fact for fear of legal, personal or social consequences. People who are tested for HIV may wish to seek anonymity, and may be tested outside their own communities. Test results from the provincial laboratory are grouped by the region where the testing was undertaken. **Laboratory indicators of prevalence include only those people who come forward for testing, and reflect only the location where they were tested, not their place of residence.**

However, **all available statistics tend to underestimate the extent of each of the three epidemics**. The statistics certainly *underestimate* the extent of the problems, and probably the most significant underestimates are those for communities

outside DTES.

In addition, estimates generally become less accurate as real numbers decrease. Too many other factors --- the availability of health services, or housing, or transportation — may all have a significant impact on these estimates. Therefore, referring back to Table 1, it would not be justifiable on the basis of the present data to conclude, for example, that there are more active users in New Westminster than there are in Maple Ridge/Pitt Meadows. Our knowledge of where injection drug users reside is confounded by the fact that they can only be "counted" where they access services.

These facts need to be considered when using available statistics to develop an inter-regional plan within the Lower Mainland. They present only minimal estimates of the magnitude of the problem. The cumulative evidence does indicate, however, that **the problem is pervasive across the Lower Mainland**.

You'll find as much dope in Langley as anywhere along the Skytrain. (Injection drug user)

Potential costs to the health care system for those IDUs currently infected in the Lower Mainland will "cost thousands of people their lives and is going to cost the taxpayers of British Columbia about a billion dollars" (O'Shaughnessy, 1998 in press).

WHO ARE INJECTION DRUG USERS IN THE LOWER MAINLAND?

A majority of injection drug users we contacted spoke of painful experiences within dysfunctional families and other "support" networks, and as victims of physical, sexual and/or emotional abuse. At least initially, drugs (and alcohol) were a way of dealing with this pain.

Through the VIDUS study, insights are being gained into some of the characteristics of HIV-positive injection drug users in the Lower Mainland Approximately 25% of VIDUS participants are aboriginal people, and an increasing proportion are women and youth. Those who have contracted HIV are more likely to have low education, unstable housing, to have experienced sexual abuse, to inject cocaine, and be involved in the sex trade (Strathdee et al., 1996).

I'm an addict because I can't handle feelings. (Injection drug user)

Research indicates that most social problems, including those resulting from addictive behaviour, stem from the same root causes: child poverty, inadequate living conditions, inconsistent and uncaring parenting, childhood traumas such as physical and sexual abuse, family breakdown, racism and other forms of discrimination, difficulties in school, delinquent friends/peer pressures, and living in situations where there is alcohol, drug and other kinds of substance abuse. Regional strategies can be maximized if directed toward preventing the root causes and building a healthy safe community for our children and youth.

There are particular problems for youth, women, aboriginal persons, and those with mental health disorders which make it difficult for them to access treatment and to reach recovery. These four overlapping populations have special issues associated with injection drug use, and have repeatedly been identified as populations meriting special attention (see, for example, Health Canada, 1997).

Youth

Since the beginning of the epidemic of HIV, the mean age at infection has dropped from mid-30s to its current level of about 23 years of age (Health Canada, 1997).

I started taking drugs when I was 12 because I thought it would be fun. It was for a while. Now I do stick-ups to support my habit. It's stopped being fun. (Injection drug user)

Early experimentation is a problem. It is our understanding that of the 10% of injection drug users who become chemically addicted, those who have experimented with **injection drug use before they are 18 are at highest risk** (Robert Barraclough, personal communication). Fully 50% of the VIDUS participants, for example, had first 'fixed' by the time they were 18, and three-quarters by age 25.

I used to work on an NA crisis line. You'd get so many women calling, trying to come off — clean six hours or twelve hours and trying to get help. You'd talk to them for a couple of hours, but then they'd go back out and use because there's nothing there to help them.
(Injection drug user)

"Street kids" and school drop-outs are obviously high-risk groups. There are repeated reports of high school students, and even children as young as 12 or 13, seriously addicted to drugs and alcohol. This is often mixed with a history of abuse, neglect and sexual exploitation. Once a young person breaks his or her connection with the school system, their social situation often deteriorates rapidly (Vancouver School Board, 1997). Such young people can easily fall into street and/or gang involvement, prostitution and the drug trade, and are at risk of becoming a casualty of the HIV epidemic. Homelessness of children under age 17 is increasing. It is estimated that there are at least 300 homeless "street kids" in Vancouver alone (McCreary Centre, 1994).

While most students do not abuse drugs, risky behaviour (including substance use and unsafe sex) is already present in students in Grades 7 through 9 and increases proportionately in Grades 10 to 12. Risky behaviour is usually accompanied by telltale signs, such as skipping school, receiving poor grades, or fighting. At the extreme, some four per cent of the high school population report binge drinking and cocaine use (McCreary Centre, 1993, 1994).

Those who have already dropped out and hit the streets are more likely than their classmates to be from socially disadvantaged families, to have been abused, to be less successful in school, and to report

attempting suicide. Street youth are more likely to be sexually active, to have become so at a younger age, and to take more risks associated with sexually transmitted diseases and pregnancy. There is a much higher prevalence of alcohol, smoking, marijuana and cocaine use among street youth (McCreary Centre, 1993, 1994).

About 40% of the estimated over 300 street youth in Vancouver come from the Lower Mainland (McCreary Centre, 1994). High risk youth tend to congregate in neighbourhoods that injection drug users tell us are "gateways" to the DTES. Every community has a neighbourhood where young (apparently aimless) young people "hang out". Risk-taking behaviours threaten the health and future of socially disenfranchised youth, yet *are* largely preventable with adequate, effective services. The primary targets for intervention at this stage are young people who have dropped out of school (or are in danger of doing so), and young adults who have difficulties finding or keeping employment.

Women

About one-third of the known injection drug users in the Lower Mainland are women (VIDUS, unpublished data, 1998). Similarly, DEYAS reports that one-third of the clients of its needle exchange program are women.

Women have special issues associated with the risks inherent in injection drug use. The nature of the power balance within relationships for disadvantaged women poses a host of additional risk factors: women are generally "second on the needle", and thus risk contamination from previous users. Sexual exploitation leads to loss of control over sexuality, and the ability to practice safe sex, which puts women at risk of both contracting and spreading diseases, including STDs, HIV and hepatitis.

I went to the methadone clinic for an intake interview. The guy sat there with a form and just motored through the questions. After a while I realized he was just writing down N/A to everything. He wasn't listening to a word I was saying. Five minutes later, he packs up, says "you're done, go get your drugs". I felt like I wasn't even there.
(Methadone patient)

While all women face potential barriers due to inappropriate models of treatment and care, those with children face additional barriers to treatment. IDUs (and some agency personnel) agree that the co-location of addiction services with Ministry for Children and Families has increased the perceived risk of seeking treatment among women with children. For many women, this means that they will go without treatment, or will attempt to detox and treat themselves out of the eye of authorities. This may actually put their children at greater risk.

I wanted to get clean and was trying to get into detox. I called twice a day for days. They kept telling me there was a six month wait. I got tired of it and went back to using. Three days later, guess who calls. By then I was right back to using, right back to what I had wanted to leave.
(Injection drug user)

Aboriginal People

About 25% of users enrolled in the VIDUS study are members of the First Nations or métis. Vancouver is home to the largest Canadian urban aboriginal population, and young people and families come from over 300 diverse aboriginal communities. Affordable housing and employment are difficult to realize, poverty is a reality for many, and substance abuse contributes to family disruption.

As many as 50% of Vancouver's aboriginal youth drop out of school during their Grade 12 year. Aboriginal people account for approximately 40% of HIV cases in IDUs in the Lower Mainland.

The methadone clinic charges me $65 a month. It comes right out of my welfare cheque. All they care about is the $65.
(Methadone patient)

An understanding of the prevention and harm reduction strategies for HIV and addictions, and the treatment and recovery programs that would best serve the aboriginal community, should include the needs of urban residents, those living on Lower Mainland reserves, those moving between the two and those wishing to return home for palliative care. Movement on and off reserves, along with poor connections with health services, can result in undetected spreading of epidemics of communicable diseases. The continuum of services will need to span the urban/reserve links. In key informant interviews, it became apparent that there is not a

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strong interface between health regions and on-reserve populations.

Individuals with Mental Health Problems

People with mental health problems are particularly vulnerable to injection drug use, and are not well served by mainstream programs. IDUs recognize that this is one subset of their population which requires specialized outreach and support services. 24% of VIDUS participants report that they have, at some time, been "diagnosed with a mental disorder". This is considered to be an under-estimate of the prevalence of mental disorders among injection drug users, since many have not been formally diagnosed. In the VIDUS study, 31% of injection drug users who become HIV+ have some psychiatric diagnosis (unpublished data, 1998).

In treatment they told me I was so messed up I'd never get clean. What kind of treatment is that?
(Injection drug user)

Prison Populations

Many people are incarcerated, federally and provincially, for drug-related crimes, or for crimes which are not recorded as drug-related, but which are motivated in one way or another by drug usage, for example, break-and-enter.

It doesn't matter what you do to try and change — people still look at you like you're nothing, and you feel what's the use, why am I trying to change?
(Injection drug user)

There are a number of provincial correctional institutions in the four Lower Mainland Health Regions, notably in Simon Fraser Region. However, all Health Regions must be concerned about prison populations. While provincial prisons have taken a harm reduction approach with respect to the provision of bleach and condoms, needle exchange is not available in provincial facilities. HIV testing is voluntary. Unofficial estimates of HIV prevalence in provincial correctional institutions reflect the current rate in Lower Mainland IDUs in general, that is, approximately 28%.

...when you ain't got a rig, and you're junk sick, and you meet someone who does — I'm gonna use it to get the drugs into me — I'm sick. I gotta score so I don't feel sick.
(Injection drug user)

The most important consideration in conceptualizing

the impact of HIV in provincial correctional facilities is that there are only 2500 beds, while there are 27 000 admissions each year. The average stay in provincial institutions (including remand while awaiting trial, and sentence) is less than 34 days. A very large number of people are moving in and out of correctional facilities each year.

I've been HIV-positive for two years and you don't see anybody offering me treatment.
(Injection drug user)

LEARNINGS FROM LOWER MAINLAND INJECTION DRUG USERS AND KEY INFORMANTS

Through focus groups with active injection drug users and methadone clients, and key informant interviews with experts and individuals working with IDUs, we have identified a number of compelling needs which must be addressed if there is any hope of halting the epidemic of communicable diseases.

1. *Issues Related to Existing Addiction Treatment Services*

Key informant interviews verified the perception of IDUs that the existing alcohol and drug treatment system is struggling to provide a service where demand far exceeds supply. As researchers, we found the system difficult to understand, penetrate and navigate. Portions of the system (for example, services for IDUs with mental illness) were almost invisible. Injection drug users spoke of multiple "moments of readiness" to end their addiction, and of staggering barriers to gaining assistance. These include:

Difficulties in Accessing Addictions Treatment Services

Many IDUs find it necessary to navigate their own entry into drug treatment. Lack of available detox

service is a major barrier to entering treatment. We have many reports from IDUs that they have not been able to access services on request, and entry into detox appears to require multiple attempts — particularly by telephone. For IDUs without ready access to a telephone or with unstable lifestyles (the majority of homeless, heavy and long-term users), entry to detox is most often accomplished through a series of telephone calls from phone booths, using panhandled quarters, looking for an opening at one of the Lower Mainland detox centres. Indeed, many potential clients were able to recite the telephone numbers from memory. With these barriers to access, many IDUs wait months to access detox.

The alcohol and drug treatment system is fragmented, with inadequate capacity and significant barriers to entry. These include waiting lists and service gaps which require clients to return to their home (or the street) for days or weeks until a space opens for treatment or recovery.

Methadone maintenance programs are largely funded through client user fees, paid for by clients on social assistance benefits. In Surrey, for example, patients are required to pay $440 per month for a residential program. Clinics dispensing methadone charge a minimum $65 per month. While general practitioners do not charge patients directly for methadone maintenance, patients do not have direct access to counselling services through private practitioners, and many IDUs do not have adequate access to physicians in private practice. For those struggling on fixed incomes, these costs associated with methadone maintenance constitute a significant barrier to entry and to retention in the program.

Clients must travel to access treatment, counselling and support services. However, there are minimal (if any) subsidies for transportation. This too must be financed from a fixed income. Travel subsidies for

Doctors don't understand about addictions. They think we do this to ourselves, on purpose, think we choose to spend our lives like this — addicted and on the street, having no home and no family and no future.
(Injection drug user)

Once they find out you're usin', it's a whole new ball game — out the f--'n door right now!
(Injection drug user)

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medical appointments, which would normally be available to people with other disabilities are not available to IDUs.

28 days of treatment doesn't work for me. I've got 20 years as a junkie to overcome.
(Injection drug user)

Models of Care and Treatment Are Not Relevant to Many IDUs

There many different theories on drug addiction and its treatment. However only a small range of treatment models is available to Lower Mainland IDUs. One of our key informants provided a historical overview of addictions services in British Columbia. Initially, addictions programs were responsive to the prevalent problem at the time: alcoholism among men. Services developed in response were primarily abstinence-based. With the rise of feminist perspectives in the 1970s and 1980s, more holistic treatments oriented towards women were developed. More recently, a number of innovative programs for young people have been developed. Our key informant suggested that now it is time for treatment models to reflect injection drug use, a problem that has grown exponentially in the Lower Mainland in the 1990s.

Much of the treatment available in the Lower Mainland is based on an abstinence model, and many programs follow a 12-step approach to recovery. Many injection drug users find these models alienating and non-supportive, and are unable to reach or maintain recovery within them. We spoke with numerous IDUs who had been in and out of detox scores of times, who had endured treatment models which reinforced perceptions of self-negativity and failure while preventing them from addressing their core addiction issues. Despite these barriers, many wanted to end their addiction so strongly that they kept returning for treatment. There is a need for addiction treatment models tailored specifically to the needs of injection drug users.

2. *Inadequate Availability of Needle Exchange*

The Vancouver/Richmond Health Region has formally endorsed harm reduction approaches, and needle exchange is now being offered at a variety of clinical sites and health units.

DEYAS has vans with routes in Vancouver's West End and DTES, and distributed about 2.5 million needles in 1997 (City of Vancouver Report to CCENDU, 1998). The provincial street nurse program is the second largest exchanger, at about 430 000 needles. These programs collect more syringes than they distribute, for an average return rate of 101%.

However, outside Vancouver, the situation is much more difficult (and therefore much more dangerous) for injection drug users. In New Westminster, needle exchange services are generally available only during the public health unit's normal operating hours. In Surrey, South Fraser Community Services operates a needle exchange until 6:00 pm six days a week, and until 8:00 pm one day per week. Finding a clean needle outside these hours therefore requires that IDUs must travel to the DTES.

We were unable to identify any needle exchange on the North Shore or in Richmond.

There are few local pharmacies which will sell syringes to addicts, and most will not recycle or exchange used syringes.

3. *Lack of Appropriate Health Services Outside of Vancouver and the DTES*

IDUs believe that many physicians, hospital and health care staff do not have adequate training in recognizing and treating addictions and their

complications.

We heard many reports of refusal of service or maltreatment from physicians and hospital emergency staff in all regions. There were few places IDUs felt they could go for health care and be treated with respect. St. Paul's Hospital was a noted exception.

IDUs perceived that they were unable to access treatment for their HIV until they had successfully conquered their addictions. A number of individuals reported that they had been refused HIV treatment on these grounds. We calculate that less than 5% of known HIV-positive IDUs in the Lower Mainland are participating in the Drug Treatment Program at the Centre for Excellence.[3]

Further, it is clear that many IDUs neither have nor seek out linkages to the primary health care system, thus increasing the risks for morbidity, mortality and the spread of communicable diseases in this group.

4. Concerns Regarding Standards of Care

Supportive recovery homes and methadone clinics were repeatedly identified as areas of concern. IDUs reported that many — not all, but many — of these programs appeared more concerned with income than with care, and we heard a number of very disturbing allegations of inappropriate treatment, profiteering and excessive control.

5. A Need for Stability and Long Term Support as IDUs Attempt to Rebuild Lives

Recovering addicts require long-term support to overcome poor self image, inadequate life skills, a lack of education and job experience or skills, and poverty.

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An alarming proportion of injection drug users grew up in dysfunctional family and social networks, and are victims of physical, sexual and emotional abuse. In this context, drug use is a coping mechanism, and a symptom of a deeper disease. Drug withdrawal must be accompanied by alternate means of support for these individuals to successfully rebuild their lives in the face of extra challenges that injection drug users face in addressing the root causes of their addictions.

THE INVENTORY OF SERVICES FOR INJECTION DRUG USERS IN THE LOWER MAINLAND

An inventory of services relevant to injection drug users in the Lower Mainland was constructed through a combination of methods, including:

- a survey of agencies known or believed to be offering such services
- focus groups with injection drug users and methadone clients
- site visits to a number of service provider agencies, and
- key informant interviews.

Survey Method

The survey questionnaire was designed by the consultants, with input from the health officers and some service providing agencies. (See Appendix B for the questionnaire.) Medical health officers representing each region assembled a list of appropriate agencies within their region, and assumed responsibility for distributing the survey. During the week of June 23, 1998 the survey was faxed to approximately 170 agencies in the Lower Mainland, under the signature of the appropriate health officer. (See Appendix D for a list of participating agencies). Agencies were asked to fax responses to the consultants by July 10.

During the week of July 13, health region staff began follow-up with agencies that had not responded to the survey, based on an updated list provided by the consultants. Some regions re-issued the questionnaire and covering memo; others issued an urgent request for reply. Some regions supplemented this with additional telephone calls to contact persons within the agencies. A technical difficulty in the Vancouver region

resulted in some agencies not receiving page 2 of the questionnaire, which captured data on services offered. Vancouver Health Region staff conducted a separate follow-up for these agencies, but some confusion was generated among agencies, with some agencies still not returning page 2 and others returning only page 2. The consultants conducted an independent follow-up with agencies where these problems persisted after Vancouver's second contact with them. In addition, the consultants provided follow-up to a number of key agencies that had yet to respond, and to agencies that had responded where information needed clarification or was missing. The survey was closed on August 10, 1998.

The survey response rate ranged from 73% in Vancouver to 50% in Simon Fraser, with an overall response rate of 59%. In Simon Fraser and Vancouver health regions, the agencies that responded were more likely to be those providing services to IDUs, while on the North Shore and in Richmond, substantially fewer of the agencies that responded offered appropriate services.

Given the difficulties inherent in conducting a survey of this type over the summer months, the consultants also undertook site visits to a number of key service provider agencies in Vancouver, Simon Fraser and South Fraser regions. In addition, we added questions to our key informant interviews in all regions to attempt to identify major services that were not captured by the survey response.

Notes on the Survey of Agencies

In some regions, there was considerable difficulty identifying and/or locating appropriate agencies and service locations. Regionalization and restructuring of services, still in the implementation stages for both Ministry of Health and the Ministry for Children and Families, contributed to the difficulty. It also became apparent that in some areas there was minimal connection between the health region and identifiable populations at risk (particularly aboriginal peoples), or lack of familiarity with agencies serving injection drug users.

We were surprised at the frequency with which agencies that had been expected to provide relevant services did not see themselves as doing so: this included mental health centres, hospitals, women's centres, youth agencies, and some offices of the Ministry for Children and Families. The difficulty in identifying agencies offering services provided a startling education in the difficulties people with addictions might encounter when attempting to navigate "the system". We concluded that many parts of the drug and alcohol treatment system are virtually invisible to clients, and place the onus on clients to navigate their own system of care.

Table 2: Numbers of Agencies Surveyed and Identifying as Service Providers for IDUs

	Agencies Surveyed	Agencies Responding	Agencies Offering Services to IDUs	Agencies Not Offering Services
North Shore	11	6	2	4
Simon Fraser	10	5	5	0
South Fraser	67	34	16	18
Vancouver	63	46	35	11
Richmond	13	8	2	6
Total	164	99	60	39

Findings Regarding Access to Services and Waiting Lists

Injection drug users describe many "moments of readiness", when they are ready to confront their addiction and are in need for alcohol and drug treatment services. One potential barrier to service is the need to wait until services are available, rather than "service on demand". We attempted to capture information on waiting times for service through two questions on the service inventory questionnaire: "Are there waiting lists to access services delivered by your agency?", and if so, "What is the average wait time to enter each program?".

We found that there was not good quality information on waiting times, and that the information that does exist can be misleading, for a number of reasons.

- *Many Agencies do not Keep Waiting Lists*

  A number of key services, including detox and some alcohol and drug services, do not keep a formal waiting list, and do not have data which capture the unmet demand for their service. In this circumstance, a lack of reported wait to enter services does not necessarily imply that service is readily available, but rather that data are not available since no list is maintained.

- *No Comprehensive System to Track Clients*

  The fragmented nature of service delivery makes it extremely difficult to track individual clients as they move from service to service. Anecdotal information and key informant information strongly suggest that many clients encounter a break in

service when moving through detox, into treatment and recovery, and that waiting periods between services were frequent.

For services where waiting lists are kept, the number of individuals on the list cannot be interpreted as the number of clients seeking treatment. Clients may be on multiple waiting lists for the same service, while others may have chosen not to join the queue. Clients waiting for service may be passed over because they are not available by telephone when a service opening arises, or may be seen almost immediately if they arrive "at the right place at the right time" or are able to arrange admission through a physician, hospital or emergency room.

- *Unstable Lifestyle May Lead to Longer Waiting Times for IDUs*

  Through conversations with key informants and injection drug users, we came to understand that the lifestyle instability which accompanies heavy injection drug use — including homelessness, disturbances in mentation from heavy use of drugs, and the criminal activity necessitated by the constant search for drugs and the $200+ per day required to purchase them — make it very unlikely that traditional methods of accessing treatment are effective for this group of clients. Many have no phone and no fixed address, so it becomes very difficult to contact them to inform them of treatment openings. Treatment on demand and outreach services linked to treatment are required.

- *Inconsistent Information from Clients and Agencies*

  At the time of this survey, Maple Cottage reported a one to two day wait for adult admission. At the same time, injection drug users in both South and Simon Fraser region consistently reported that they were informed that the wait was approximately six months for admission to heroin detox, and "good luck" if cocaine detoxification was required. In Vancouver, MCF Youth Services reported no wait for detox service, yet community and MCF informants suggested that Vancouver's youth detox services had turned away between 300 - 1000 calls for service in June as there were no vacancies. (There are eleven youth detox beds in the Lower Mainland. Maple Cottage has three, Downtown Eastside Youth Activities Society (DEYAS) has five, and Youth Services has three.)

The lack of consistent methods of measuring client demand, coupled with the special access needs of injection drug users make it difficult to assess the true magnitude of waiting periods as a barrier to service. While waiting lists may not be an accurate measure of demand for services, the data do support the widely held impression that alcohol and drug services are not readily available, and that treatment on demand for

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alcohol and drug addictions is not available.

A Note on Methadone Therapy

Information on the availability of methadone treatment is difficult to obtain in the Lower Mainland. We have identified three ways in which Lower Mainland IDUs can access methadone: a comprehensive methadone treatment centre in Surrey, through publicly and privately financed clinics in most regions, and through family doctors registered with the College of Physicians and Surgeons of British Columbia (CPS). Methadone clinics were not well captured by this survey. Table 3 presents the number of physicians authorized to prescribe methadone in each region, based on information from the BC College of Physicians and Surgeons. Table 4 presents the number of pharmacies and an estimated number of patients receiving methadone for each region, based on information from the BC College of Pharmacists.

Methadone patients who do not receive their drug directly from a clinic can have a prescription filled at some pharmacies. However, there are strong disincentives to a pharmacy serving more than 30 publicly funded clients at any given time, and pharmacies are not required to dispense methadone. These factors combined make it difficult to locate methadone treatment, and can make it difficult for clients to secure a supply of the drug.

Table 3: Number of Physicians Authorized to Prescribe Methadone (by Health Region)

North Shore	12
Simon Fraser	30
South Fraser	29
Vancouver/Richmond	142
Total	213

There are not any generally accepted benchmarks for determining required capacity for methadone treatment. New York City has approximately one methadone treatment opportunity for every five heroin users, although some of these programs have vacancies, due to attitudinal and cost barriers (Sam Friedman, personal communication). A "rule of thumb" that has been applied over the years is that roughly 20% of opiate addicts are in methadone treatment (if such treatment is available locally) (Ron Jackson, personal communication). It is important to note that both estimates are based on the American system of health care, where basic health care

Table 4: Number of Pharmacies Dispensing Methadone and Number of Patients Receiving Methadone (by Health Region)

	Pharmacies Dispensing Methadone	Patients Receiving Methadone
North Shore		
North Vancouver	3	60
West Vancouver	0	0
Subtotal, North Shore	*3*	*60*
Simon Fraser		
Burnaby	5	100
New Westminster	3	160
Maple Ridge	2	40
Pitt Meadows	1	10
Port Coquitlam/Coquitlam/Port Moody	8	120
Subtotal, Simon Fraser	*19*	*430*
South Fraser		
Delta	3	20
Langley	2	20
Surrey	13	550
White Rock	0	0
Subtotal, South Fraser	*18*	*590*
Vancouver/Richmond		
Richmond	1	40
Vancouver Downtown and West End	4	40
Vancouver Main Street and East	18	900
Vancouver West of Main Street	6	250
Subtotal, Vancouver/Richmond	*29*	*1 230*
TOTAL	**69**	**2 310**

Note: All figures are as of August 1998. Numbers of patients receiving methadone are estimated by the College of Pharmacists of BC.

funding and the range of social supports available are different than in Canada, and the applicability of these figures to British Columbia may be limited. Nevertheless, these are the best available estimates. Using this model, it can be estimated that there

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should be methadone maintenance available for 2340 of the estimated 11 700 IDUs in Vancouver. This is very close to the actual numbers observed in Table 4. Further, about half of the 2310 methadone clients in the Lower Mainland are in Vancouver, and half outside, as would be expected.

Key Findings from the Service Inventory

The variety of strategies employed in compiling the service inventory allowed us to understand the nature of the services offered and was particularly useful in understanding the barriers to access which exist for all alcohol and drug clients, but injection drug users in particular. In addition, the strategies highlighted the magnitude of the information gap created by a non-functioning alcohol and drug information system, and the fragmentation of care that exists. Not only was it virtually impossible to accurately estimate the number of clients served by the alcohol and drug system, there was no mechanism beyond the educated guess to gauge the unmet demand or the capacity of the system. Specific findings from the service inventory are presented in Appendices E, F and G.

The key findings are:

1) Alcohol and Drug services in the Lower Mainland are provided by a wide variety of different agencies in a manner that creates a fragmented rather than coordinated response to addictions. The current services are overburdened and unable to effectively respond to the epidemic of HIV in injection drug users.

2) Agencies receive funding from multiple sources, making system accountability difficult, and gathering data about system capacity extremely difficult. There is the potential for missing and/or double-counting services and clients.

3) While there are addiction services in all regions, programs designed specifically to meet the special high risk needs of women, youth, aboriginal, mentally ill and homeless injection drug users tend to be clustered in downtown Vancouver, and are insufficient to meet the needs of other Lower Mainland health regions.

Identified Needs and Service Capacity by Health Region

All health regions show visible signs of injection drug use, ranging from requests for needle exchange from addicts to needles littering public spaces, to the more obvious street activity which characterizes sections of Vancouver, South and Simon Fraser regions. However, with the notable exception of the DTES, there is very poor data

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regarding the number of injection drug users living in each health region, and very little epidemiological data that is useful for planning health services. In attempting to estimate the magnitude of service increase that would be required, we drew upon the population prevalence information developed through the Health Canada's "capture-recapture" study, and applied this to the population of each health region. Where available, we also include anecdotal and other information we have gathered which may suggest the presence of active injection drug use in each region.

There is general consensus that half of the 11 700 injection drug users estimated by the Health Canada study (Consortium to Characterize Injection Drug Users in Canada, 1998) to be in the Lower Mainland reside within Vancouver, while the remaining 50% (5 850) are spread among the health regions. Based on population figures for Vancouver and the surrounding municipalities, this amounts to a prevalence of 0.70% within Vancouver, and 0.41% in the surrounding health regions. This assumption does not account for differences in population demographics (for example, more children outside of Vancouver, more youth in Vancouver), or socioeconomic differences (for example, New Westminster vs. West Vancouver), and thus the figures should be viewed as a general guide rather than a precise estimate.

We have not included needs specific to HIV treatment in this discussion. As noted earlier in this document, less than 5% of infected injection drug users are currently being treated for HIV disease through the HIV/AIDS Treatment Program at the BC Centre for Excellence. The prime barrier appears to be their unstable lifestyle, which makes them unsuitable candidates for the demanding and expensive prescription drug regimens currently used to halt the disease. This is reinforced by justifiable fears that inadequate adherence to treatment regimens will result in the emergence of treatment-resistant strains of HIV. While other models of care may be more appropriate to this population, the reality is that the most promising treatments cannot be provided until addiction needs are stabilized. Therefore, we have concentrated on services to treat addictions and to prevent the spread of HIV and other communicable diseases, to allow for the earliest opportunity for HIV treatment by stabilizing the lives of people with addictions.

Needs and Service Capacity in North Shore Health Region

Based on population, we estimate that there are 730 injection drug users residing in the North Shore Health Region. In 1996, the coroner reported eleven deaths from illicit drugs in this health region. Recently, there have been repeated reports of used needles littering schoolyards and public spaces. This suggests that there is an existing problem with injection drug use, but that more information is needed to assess the extent of the problem. Street-level surveillance through outreach workers and mobile

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health units are one way of achieving this.

We were able to identify only two agencies providing addiction treatment services on the North Shore, and these are primarily oriented toward alcohol addiction. A six-week waiting period was reported for one-to-one addiction counselling, while there is no reported wait for home detox. We were unable to identify services specifically targetted to IDUs with concurrent mental illness, or to aboriginal people, despite the existence of First Nations reserves within the region. We were unable to identify any needle exchange services on the North Shore. In August of 1998, about 60 patients received methadone from pharmacies in the North Shore Health region, and there were 12 physicians authorized to prescribe methadone.

Needs and Service Capacity in Simon Fraser Health Region

Based on the population of the region, and the capture-recapture estimates of the prevalence of injection drug use, it can be estimated that there are 2000 injection drug users in Simon Fraser Health Region. It has been estimated that there are approximately 500 - 1000 injection drug users in the Kingsway strip of Burnaby alone, and there are also known problems in the Edmonds and Metrotown areas (personal communication, John Contarines). The Columbia Street area of New Westminster has a large visible population of street-involved IDUs, although the numbers fluctuate due to police actions aimed at controlling the visible signs of drug use in urban areas. These actions, including "round ups" and area-specific enforcement of bylaws, result in a highly mobile population along public transportation, particularly the Skytrain. Injection drug users and health officials also report pockets of injection drug use in Maple Ridge.

There is a range of alcohol and drug programs in Simon Fraser region, including Maple Cottage, which operates adult and youth residential detox services for South, Simon and Upper Fraser Valley regions (22 adult beds and three youth beds). There is one day treatment program specially designed for women, one youth residential treatment program, and services of unknown capacity to treat dually diagnosed individuals. Reported waiting times for access to treatment averaged one to two months for alcohol and drug outpatient services, and approximately one month for residential treatment. Average wait times of one to two days were reported for Maple Cottage detox services. Recovery homes responding to the survey reported average waiting times of zero to six weeks.

At present, there are two needle exchange services in Simon Fraser Health Region. The New Westminster Health Department offers a daytime needle exchange service, while the AIDS Prevention Street Nurse Program is running a trial program through a

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mobile van in Burnaby and New Westminster on Wednesday and Friday nights between 8 pm and midnight. The van offers outreach services as well as needle exchange, condoms, STD and HIV referrals and follow-up, and first aid. There are pharmacies in Simon Fraser region that will sell needles to injection drug users. In August of 1998, an estimated 430 patients received methadone from pharmacies in the Simon Fraser Health Region, and there were 30 physicians in the region authorized to prescribe the drug.

Needs and Service Capacity in South Fraser Health Region

Based on the population of the region, and the capture-recapture estimates of the prevalence of injection drug use, it can be estimated that there are 2300 injection drug users in South Fraser Health Region. There are visible pockets of drug use in various areas of the region, but Whalley is considered the "hot spot".

After Vancouver, South Fraser region had the highest number of known agencies providing services to injection drug users. This may be due, in part, to the fact that South Fraser Region has a highly effective "Community Action Group" which meets regularly and is comprised of various agencies offering services relevant to IDUs. Together, the seventeen agencies responding to the survey offer a range of alcohol and drug treatment services to adults, except residential detox, which is operated through Maple Cottage in neighbouring Simon Fraser Region. Average waiting times for access to service were reported as zero to three weeks for assessment, one to three months for group counselling, and three to four months for individual counselling. We were unable to identify any youth treatment programs in South Fraser. South Fraser Health Region has 50% of the provincial total of recovery houses (personal communication, Dr. Anna McGuire), but this is felt to be more influenced by municipal zoning regulations than service planning. No waiting times were reported for recovery homes.

South Fraser Community Health Services offers the only needle exchange service in South Fraser Health Region (from 1 to 6 pm daily, with extended hours to 8 pm on Wednesdays). In addition to needle exchange, the agency provides access to medical and nursing care, showers, nutrition, recreation areas and many other supportive activities within an integrated service centre. There are pharmacies where IDUs may purchase needles. In August of 1998, about 590 patients received methadone from pharmacies in the South Fraser Health Region, and there were 29 physicians in the region authorized to prescribe methadone.

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Needs and Service Capacity in Vancouver

Based on the population of the region, and the capture-recapture estimates of the prevalence of injection drug use, it can be estimated that are an estimated 5800 injection drug users living in Vancouver. The DTES has the most visible problem, but there are numerous other areas with acknowledged pockets of injection drug use, including South Granville mall (particularly for street youth), Grandview/Woodlands, Mount Pleasant and Strathcona. Vancouver is unofficially known as the "injection drug capital of Canada", and has perhaps been more studied for this reason than any other Canadian city.

Agencies in Vancouver reported the broadest range and highest number of services for injection drug users of all the health regions. Vancouver has a range of alcohol and drug services for adults, as well as residential and day treatment for both women and youth. There are a number of specialty programs for homeless and street-involved and street-entrenched youth, and a broad range of support services for all injection drug users. The only services reporting waiting periods to access service were individual counselling (a one month wait) and women's residential treatment (one to three weeks). However, the impression received from key informants and agency personnel was of a seriously overburdened system. We have no reliable information on waiting times for adult detox services in Vancouver.

Vancouver has the widest range of specialty services for youth, including non-residential detox, day treatment programs, programs for street youth, and youth-specific recovery homes. Reported waiting times for youth services range from no waits for MCF sponsored services to one week for DEYAS Youth Detox, eight weeks for the WATARI Street Youth Detox program, and six to eight months for Peak House adolescent residential treatment. Vancouver was the only health region where we were able to identify alcohol and drug services specifically for aboriginal people, both an adult and a youth program.

Vancouver also houses a number of support centres, including those specifically for women and youth, where injection drug users can obtain relief from the elements, some nutrition, attend to hygiene needs and connect with support services.

Needle exchange in Vancouver is provided through a number of agencies, including DEYAS (24-hour mobile van service as well as a fixed site exchange), the AIDS Prevention Street Nurse Program (mobile outreach van five days per week and "on foot" six days per week, with day to late evening hours), and five health unit offices (daytime hours). There are also needle exchange services available at the Dr. Peter Centre and the Portland Hotel. There are many pharmacies in Vancouver, particularly

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downtown, where injection drug users can purchase needles. In August of 1998, an estimated 1190 patients received methadone from pharmacies in Vancouver, and there were 142 physicians in Vancouver/Richmond who authorized to prescribe methadone. (A breakdown for Vancouver alone is not available).

Needs and Service Capacity in Richmond

We estimate that Richmond has a population of about 650 injection drug users. There is very little anecdotal or other data against which to balance this estimate. One community pharmacist estimates that there are at least 30 methadone clients in Richmond, and the health unit has recently received a number of requests for needle exchange from injection drug users. As is the case with the North Shore, more community-level information is required to assess the extent of the problem. Again, street-level surveillance through outreach workers and mobile health units are a practical way of achieving this.

Alcohol and drug treatment services in Richmond are offered through the Richmond Alcohol and Drug Action Team (RADAT) in partnership with some community agencies. Services are largely oriented toward alcohol addictions, and include non-residential detox services for adults, as well as alcohol and drug screening and counselling. RADAT reports a three to four week wait for assessment, and a seven to ten day wait for orientation to their regular program. With the exception of counselling addictions treatment and recovery support do not appear to be available in Richmond. There is no official needle exchange program in Richmond, although needles may be obtained from one health unit office if pre-arranged. We are not aware of any pharmacies in Richmond which will sell needles to injection drug users.

THE COSTS OF TREATING (OR IGNORING) THESE EPIDEMICS

Addictions and injection drug use pose enormous health, social and financial burdens for the individuals affected directly, for communities and for taxpayers. This fact is made more poignant by the realization that most of these costs are avoidable. Millar (1998) estimates that in 1997, almost $100 million of direct government spending in British Columbia was a result of illicit drug use. Direct health care costs for treatment of addictions and HIV accounted for more than $17 million. This figure is a low estimate, in that it does not include costs for health care diagnostic services and preventive programs, or the costs of treating Hepatitis B and C. Additionally, many of the health costs related to illicit drug use are hidden, as much use goes undetected or unreported.

Of the $100 million British Columbia spent in dealing with illicit drug use in 1997,

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almost $80 million went to law enforcement costs related to illicit drug use, more than four times that spent on treating addictions and related health complications. In addition to direct costs to government, communities bear a significant portion of the cost of addictions, through property crime and criminal activity required to support a drug habit — estimated by users as approximately $40-$80 per day for heroin and $150 to more than $1000 per day for cocaine.

Social assistance, unemployment benefits and other social assistance costs related to untreated addictive behaviour could be as high as $67 million per year in BC alone.

The arguments to act now to halt the epidemics of HIV and injection drug use are compelling. From a humanitarian perspective, IDUs are suffering from a health condition, and are entitled to and in need of health services to help them overcome their addictions and the resulting complications. The community must be protected from the spread of communicable diseases associated with injection drug use. And significant investments must be made to prevent youth from risky behaviours that lead to addiction and/or the spread of communicable diseases.

Regardless of the rationale, there is a strong urgency to act now. The longer the wait for action, the larger the toll, be it human misery and death, deterioration of neighbourhoods, waste of avoidable tax dollar expenditure, or the further deterioration of a society which does not care. To paraphrase John Millar - pay now, or pay (more) later.

THE NEED FOR A MODEL FOR ADDRESSING INJECTION DRUG USE

The findings of this study point to one irrevocable conclusion: **there can be no progress made against the epidemic of HIV and other communicable diseases in injection drug users unless and until the underlying epidemic of addictions and injection drug use are addressed**. This is consistent with reports from other studies and forums: The City of Vancouver Report to CCENDU (1998), for example, notes that

> The consensus among these bodies, and their reports, is that injection drug use is now such a problem that comprehensive and innovative action has become a necessity. All reports note the inadequacy of the treatment system in British Columbia.

Given the weight of expert opinion and the findings of this study, we are recommending restructuring of addiction treatment services in the Lower Mainland toward

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implementation of a comprehensive service model that aligns regional strategies and enables coordination and sharing of information, services, research and evaluation. It is essential that new services be developed to manage these epidemics. To be most cost-effective they must be planned to meet the concurrent needs of independent regions and the whole of the Lower Mainland. A common vision and service model, and an appropriate structure for planning and implementing inter-regional strategies are required.

Comprehensive service models have recently been re-articulated for regional Alcohol and Drug Addiction Services. The City of Vancouver and the Vancouver/Regional Health Board have outlined service models and principles specific to the issues of the epidemics of HIV and injection drug use. These provide ready opportunities to move quickly to agreement about a common inter-regional vision and comprehensive service model.

It is not our aim to reiterate service models and service principles that have already been presented well by experts in the field. The following considerations should be made in the design and implementation of services and systems:

- Services should be *client-centred,* continually informed by clients' needs and responsive to them. Clients have strengths to offer with respect to our understanding of the problem.

  The participation of IDUs in the design and delivery of programs for support, treatment and recovery should be fostered. As the potential consumers of any program, IDUs should be consulted about program design. Friedman (1998) stated that although "action plan documents and minutes make it clear that "consumer voice" is seen as a useful, perhaps necessary, part of HIV prevention and care...it is clear that there has been little strategic thought or effort into making [consumer] voices real" (p. 2). Vancouver Area Drug Users' Network (VANDU) is the exception to this generalization. Friedman notes that "it may be one of the strongest users' groups in the world".

- Communication, education and training is required to ensure the principles and philosophy of service are consistently demonstrated throughout the system. For a system to change, those working within the system must understand and be advocates of the change. There is not yet a common understanding of addictions as a health problem, or the importance of harm reduction, for example.

- Services need to be *comprehensive and seamless.* A range of services should be available at each location. Every effort must be made to engage injection drug

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Bognar, Legare and Ross (1998)

users in these services and to maintain their participation in addiction treatment. In order for these efforts to succeed, every effort must be made to support IDUs in establishing a stable environment and assist them in planning a future.

- The service system should emphasize the necessity of *timely access to services,* to take advantage of "moments of readiness". The opportunities to engage clients in treatment are time and situation limited. For those who have the desire to end their addiction, treatment must be available, and available on demand.

- Strategic initiatives for the Lower Mainland should recognize the importance of *determinants of health* in the prevention and treatment of addictions, and should respond to drug addiction issues as *health issues.*

Addressing the Toughest Issues

There is a general consensus that there can be only negligible long-term impact of treatment services in the absence of dealing with the issues of abject poverty, despair, homelessness, and the lack of a stable environment facing the most at-risk injection drug users.

Portland (Oregon) has developed a service response to the 'homeless' that appears to achieve longer term success in dealing with addictions and its attendant problems. The Portland model was investigated as part of a recent report by the City of Vancouver (Vancouver, 1998), and we have used the model to provide benchmarks for developing desirable levels of targeted drug treatment services.

Table 5 presents estimations of service needs in the Lower Mainland based on the Portland Model. We used the Portland Oregon model as a benchmark for service need by population and extrapolated this to the populations of the health regions. We then compared these estimates to what we know of existing services, to suggest a service gap and the volume of resources that would be required to close the gap.

We emphasize the Portland Model is not a population health model and there are serious limits to extending these estimates for the overall population of injection drug users. Service needs estimated in this way include detox beds, transitional supportive housing, and counselling/acupuncture. All estimates in Table 5 are based on the relative populations of Portland and Greater Vancouver, and using the capture-recapture estimate of 11 700 IDUs in the Lower Mainland. We have broken down estimated requirements by Health Region, but stress that these *intra*-regional requirements will be affected by population characteristics such as poverty levels. Intra-regional requirements will need to be determined more accurately before

implementation, and will be affected by decisions about inter-regional cooperation in service enhancements.

Based on the calculations described above, it can be estimated that the Lower Mainland requires 200 detox beds to provide an adequate level of service for the current population of injection drug users. There are approximately 70 detox beds at present (48 in Vancouver and 22 in Simon Fraser and South Fraser Regions). Therefore, an additional 130 detox beds could be required in the Lower Mainland.

The Portland model includes 90 days of transitional, supportive housing (as distinct from recovery housing). Supportive housing has been shown to be an important gateway to treatment and overcoming addiction, and stable housing should be considered a necessary prerequisite for the success of other subsequent treatment options. Portland provides 1.58 transitional supportive housing units for each detox bed unit. It is not known what quantity of transitional supportive housing is provided in the Lower Mainland.

Evaluation of outcomes of the Portland model have shown that provision of counselling and acupuncture increase the completion of detox programs from 25% to 75%. Based on Portland's capacity for visits per day, it can be estimated that the Lower Mainland requires the capacity for 1538 counselling/acupuncture visits per day. If 50% of IDUs seek some form of treatment, this would translate into approximately 5 visits per month.

Table 5 presents an interpretation of these levels of treatment and support for health region, based on the earlier assumptions about prevalence of injection drug use in each region.

Table 5: Projected Treatment and Support Requirements by Health Region

	Detox (Beds)	Transitional Housing (Beds)	Counselling/ Acupuncture (Visits per day)
North Shore	13	21	99
Simon Fraser	36	57	275
South Fraser	40	63	305
Vancouver	100	158	769
Richmond	11	17	85
Total	200	316	1 538

Bognar, Legare and Ross (1998)

ORGANIZATIONAL RECOMMENDATIONS

To successfully deal with the complexity of issues related to the epidemics of injection drug use and communicable diseases that face decision-makers and service providers in each of the regions of the Lower Mainland, it is essential to provide a mechanism to coordinate inter-regional and multi-sectoral action. The first recommendation addresses this need in its broadest context. All other recommendations identify joint actions for consideration by the Health Boards in each of the regions.

Organizational Recommendation 1: An Inter-regional, Inter-sectoral Task Group
The four Lower Mainland Health Regions should advocate for the establishment of an inter-regional, inter-sectoral task group whose task it would be to develop integrated and coordinated strategies for the prevention and treatment of drug addiction across the Lower Mainland.

The mandate of the task group should include, but not be limited to, strategies for:

- addiction prevention
- community safety and crime prevention
- target group needs, such as prisoners, youth, women, Aboriginal people, the homeless
- health care and addiction service systems
- education, information and communication
- research and evaluation needs
- funding and accountability.

Organizational Recommendation 2: Inter-Regional Coordinator
The four Lower Mainland Health Regions should support the creation of a permanent senior public health position as an Inter-Regional Coordinator to monitor the extent of problems related to injection drug use and communicable diseases, and to support the development and implementation of the health components of inter-regional strategies.

Projected Cost: $150 000
Start Date: January 1, 1999

Organizational Recommendation 2.1: Epidemiological Surveillance
Adequate epidemiological surveillance techniques to support the inter-regional task group need to be undertaken using a standardized methodology in each of the four

regions.

These surveillance techniques should be designed to:

- identify drug abuse patterns and the impact of drug abuse in defined geographic areas,
- identify changes in drug abuse patterns over defined time periods in order to establish trends and determine response to actions taken,
- detect emerging substances of abuse, and
- communicate and disseminate the information to appropriate community agencies and organizations so it can be used in developing policies, practices, prevention strategies, and research studies.

Similar work has been undertaken in Vancouver by the Canadian Community Epidemiology Network on Drug Use (CCENDU).

Start Date: January 1, 1999

Organizational Recommendation 2.2: Agreed Outcomes
The four Lower Mainland Health Regions need to reach consensus on outcomes to be achieved through an inter-regional strategy.

Responsibility: Inter-regional Coordinator
Report: March 31, 1999

Organizational Recommendation 2.3: Standards, Protocol and Evaluation
The four Lower Mainland Health Regions need to support:

- *standards of service access, comprehensiveness and integration of services,*
- *protocols for service coordination, and*
- *standards for the evaluation of effectiveness of programs.*

Appropriate standards of care must be in place for all addiction treatment services. All new services should enhance the continuum of care model, and improve both regional and inter-regional outcomes. Methadone maintenance and recovery homes are in particular need of standards, review with respect to those standards, and evaluations of effectiveness.

Bognar, Legare and Ross (1998)

Responsibility: Inter-regional Coordinator
Report: June 30, 1999

Organizational Recommendation 2.4: Funding Strategy
The four Lower Mainland Health Regions need a funding strategy to support a comprehensive, flexible approach to meeting the overall and targetted needs of those with drug (and alcohol) addictions.

There needs to be public accountability at the regional level.

Organizational Recommendation 3: Alcohol and Drug Treatment Model
The four Lower Mainland Health Regions should advocate for an inter-regional alcohol and drug treatment model which incorporates local control and accountability.

Since IDUs are mobile within the Lower Mainland, any attempt by any region to address the problems inherent in injection drug use will attract populations seeking treatment and support, disproportionately increasing their costs. This is clearly a disincentive for public support for the development of services in any region. Regions which do not address the problems will inevitably create added burdens for the surrounding regions.

Local control and accountability are necessary to effect appropriate change.

Organizational Recommendation 4: Staff Development
Each health region (or the regions collectively) should sponsor a series of workshops on harm reduction approaches for front-line workers in services for those with addictions.

In addition, Health Regions should take appropriate steps to ensure that personnel in programs funded by the health regions receive appropriate training to recognize and treat addictions and communicable diseases in addicted individuals.

Organizational Recommendation 5: The Role of Injection Drug Users
Health Regions should foster the development of mutual support networks for injection drug users in each region, and health regions should include injection drug users wherever possible in planning activities for new services.

Friedman (1998) notes that users' groups can help resolve issues related to HIV and injection drug use in the following ways:

- IDUs can provide advice on interventions, including methadone and other drug treatment, needle exchange, social services, and medical care. This input can be used to enhance the effectiveness of existing programs.
- Users' groups can encourage risk reduction among other IDUs, and disseminate information about the availability of medical and other services.
- IDUs can provide information about developments in drug use that may be useful for the prevention of epidemics.

Organizational Recommendation 6: Methadone Maintenance
Administration of methadone maintenance programs should be placed within an integrated model of health and addictions care.

Methadone maintenance should be integrated within an alcohol and drug treatment model. Methadone maintenance alone is not enough to overcome addiction, and methadone maintenance should be accompanied by counselling and other ancillary addiction treatment services.

Organizational Recommendation 7: Public Education
Public education should be undertaken to assist with the reconceptualization of addiction as a health issue, and of harm reduction as a sensible public health approach.

Initial messages for a public education campaign should include:

- Addiction is a health issue.
- Drug abuse exists in all communities.
- Drug abuse affects the health and safety of the entire community.
- There is a need for public dialogue about drug abuse, and about finding appropriate and effective solutions to the problems.
- Harm reduction is already part of many successful drug treatment programs, and harm reduction approaches that provide links to treatment need to be expanded.

SERVICE RECOMMENDATIONS

These "Service Recommendations" are based on key issues which emerged during the development of this report. The inter-regional committee resulting from implementation of the Organizational Recommendations should consider the following recommendations.

Principles of harm reduction underpin all Service Recommendations.

Service Recommendation 1: Needle Exchange
Health Regions should work with community partners to ensure that there are multiple sources of needle exchange services in each region, with access available 24 hours a day, 7 days a week.

Because HIV is spread among IDUs through used syringes, significantly enhanced needle exchange is critical to stemming the epidemic of HIV and other blood-borne diseases. This recommendation must be given the highest priority.

Options for enhancing needle exchange should be explored. Needle exchange should be increased through a combination of mobile and fixed sites, such as health offices, clinics and pharmacies.

Service Recommendation 2: Mobile Outreach Health Service
Health Regions should study the feasibility of increasing mobile health services, which would include, but not be limited to:

- ***needle exchange***
- ***harm reduction strategies (e.g., information about safe shooting techniques, safe sex information, availability of condoms and bleach, basic health information)***
- ***linkages to primary health care, and to alcohol and drug addiction treatment***
- ***outreach, and***
- ***ongoing needs assessment.***

Personnel in mobile vans have the potential to assess the extent of the injection drug problem in various communities and to respond to the shifting geographic nature of drug use. Information gathered by mobile van personnel should be used as part of the surveillance information noted in Organizational Recommendation 1.2, as well as

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Bognar, Legare and Ross (1998)

providing needle exchange. An estimated budget for a mobile outreach health service is presented in Appendix H.

Service Recommendation 3: Transitional Housing
Health Regions should work to ensure that adequate supportive transitional housing is available for people who are attempting to overcome their addictions.

The importance of stable housing for injection drug users cannot be overstated. It is the foundation on which successful treatment rests. It is estimated that a total of 316 supportive transitional housing units are required to bring the Lower Mainland to Portland standards. It is not known how many such units currently exist.

Service Recommendation 4: Detox
The Health Regions need to ensure that there is a substantial increase in detox services.

Since detox is a common "gateway" for those seeking assistance with their addictions, its importance in stemming epidemics of communicable diseases cannot be overstated. In light of the findings of this report, Millar's recommendation (1998) of a 50% increase in detox services for the province to be extremely conservative. We recommend that an additional 130 detox beds be developed for the Lower Mainland alone — an increase from the existing 70 beds to 200.

Services should be developed with special attention to the needs of youth, women (especially pregnant women and those with children), aboriginal people, and people with mental health problems. New models of detox may be required and should be investigated, for example, physician-assisted home detox.

Service Recommendation 5: Expanded Treatment Services
Expanded detox capacity must be linked to an expanded treatment system within an integrated coordinated system of care.

Previous reports have provided expert opinions regarding the magnitude of expansion necessary. Millar (1988) recommends a 50% across the board increase in treatment, and the addition of 1000 methadone treatment spots in Vancouver and 500 in the rest of the province. The City of Vancouver (1998) benchmarking exercise recommends a 130% increase in residential support and recovery beds (to a total of 175), and a 100% increase in counselling services for Vancouver (a total of 50 alcohol and drug

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Bognar, Legare and Ross (1998)

counsellors). Assuming that the combined service needs of the other health regions are similar to Vancouver, the total figure may be doubled to arrive at an estimate of the needs of the Lower Mainland. This may in fact be an underestimate of the needs outside of Vancouver, as it appears that there are more pre-existing services in Vancouver than in the other health regions. Services should be specifically targetted to areas outside of Vancouver, particularly South and Simon Fraser health regions.

As with detox, treatment services should be developed with special attention to the needs of youth, women (especially pregnant women and those with children), aboriginal people and people with mental health problems. Additional models of treatment, including acupuncture services may be required and should be investigated.

Service Recommendation 6: Integrated Service Agencies

Where appropriate, Health Regions should work to ensure the development of at least one integrated service agency for injection drug users in that region.
The number of such service agencies will vary from region to region.

South Fraser Community Services operates an integrated service centre. Programs at this agency should be reviewed for comprehensiveness, and augmented if necessary. A needs assessment should be undertaken to determine whether a second integrated centre is required in South Fraser Health Region.

Simon Fraser Health Region requires an integrated service centre. Existing services in Vancouver should be amalgamated to develop an integrated service centre.

Each integrated agency should include, as a minimum:

- a "safe environment" for users to get off the streets
- educational resources for harm reduction, including information about safer sex and safe injecting techniques
- peer and professional counselling
- information about social other services, especially financial assistance and housing
- medical diagnosis and treatment, and
- needle exchange and condom availability.

Start-up costs for an integrated service centre are roughly estimated at $250,000, plus $725,000 per year for operation. This would include a fixed-site needle exchange program 24 hours per day, fixed-site health service, drop-in centre, and counselling. Additional budget details are presented in Appendix I. If mobile needle exchange is

operating in the area, it may not be necessary to operate the fixed site 24 hours per day, possibly resulting in cost savings.

Service Recommendation 7: Methadone Maintenance

The Lower Mainland Health Regions should take steps to ensure that comprehensive methadone treatment, including counselling, be readily available without charge.

We note that Millar (1998) made a similar recommendation. An integrated approach to health and addictions care, along with case management, is expected to demonstrate better results than the combined results of services provided independently.

Service Recommendation 8: HIV Treatment for Injection Drug Users

The Health Regions and inter-regional coordinating committee should enter into dialogue with the BC Centre for Excellence to coordinate expansion of HIV treatment to injection drug users as their addictions stabilize with addiction treatment.

Service Recommendation 9: Improved Training and Safety for Hospital Staff Treating Injection Drug Users

The Health Regions and inter-regional coordinating committee should strike a committee to examine and address training and safety needs for hospital staff in each of the four health regions.

Injection drug users are frequent clients of Lower Mainland hospital emergency departments. Staff in these facilities require adequate training to recognize and treat the complications of addictions. In addition, it is necessary that their safety not be compromised by the behavioural difficulties that often accompany acute drug use.

Bognar, Legare and Ross (1998)

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ENDNOTES

1. VIDUS is a longitudinal study of a cohort of approximately 1200 injection drug users in the Lower Mainland. Given that participants volunteer for the study, and its fixed location in DTES, participants are not representative of IDUs in the Lower Mainland. Some VIDUS participants were recruited at New Westminster Health Department and at the Surrey Clinic. Enrolment in VIDUS is currently limited to specific subgroups not adequately represented in the existing cohort.

2. For a discussion of capture-recapture methodology, see Nanan and White, 1997.

3. If there are 11 700 injection drug users in Greater Vancouver (as estimated by Health Canada's capture-recapture study), and 28% of these IDUs have already contracted HIV, then it can be estimated that there are approximately 3 275 HIV-positive injection drug users in the Lower Mainland. This estimate appears to be reasonable in light of other evidence. However, in December 1997 there were only 141 people who self-identified as injection drug users participating in the HIV/AIDS Treatment program operated by the Centre for Excellence (see Table C3, in Appendix C.)

APPENDIX A:
Key Informant Interviews/Contacts

John F. Anderson
Medical Consultant
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BC Ministry of Health and Ministry Responsible for Seniors
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Robert Barraclough
Project Manager
Alcohol and Drug Services
Vancouver Regional Operating Agency
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Cheryl Bell-Gadsby
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Social Services and Community Safety Division
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New Westminster

Jim Bennett
Executive Director
South Fraser Community Services
Surrey

Chris Buchner
Agency Coordinator
Youth Community Outreach AIDS Society (YouthCO)
Vancouver

Michael M. Burgess
Chair in Biomedical Ethics
Centre for Applied Ethics
University of British Columbia
Vancouver

Paula Carr
Executive Director, Community Development
Collingwood Neighbourhood House
Vancouver

John Contarines
Senior Supervisor
Burnaby Alcohol and Drug Services
Ministry for Children and Families
Burnaby

Sue Currie
Research Manager
Vancouver Injection Drug Use Study (VIDUS)
Vancouver

Sergeant C.D. (Chuck) Doucette
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Drug Awareness Unit
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Andrew Johnson
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Instructor, Emergency Nurse Specialty Program
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Mitzi Jones
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Squamish Nation
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Henry Koo
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Ann Livingston
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Janet Madsen
Communications Coordinator
Positive Women's Network
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Michael V. O'Shaughnessy
Director
BC Centre for Excellence in HIV/AIDS
Vancouver

Brenda Osmond
College of Pharmacists of British Columbia
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Patti Pike
Needle Exchange Worker
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Dianne Rothon
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Sylvie C. Tourigny
Senior Postdoctoral Research Fellow
National Development and Research Institutes, *and*
Medical and Health Research Association
New York City

Diane Wenham
Adult Services Manager
Simon Fraser Region
Ministry for Children and Families
Coquitlam

Ian V. Woodcock
Consultant
"HIV/AIDS Outreach at the Richmond Hospital"
Burnaby

Meetings Attended

- Collingwood Neighbourhood House, Commmunity Issues Panels (June 8, 9)
- Collingwood Neighbourhood House, Action Planning Meeting (June 23)
- Health Canada, Population Health Workshop (May 4)
- Richmond Needle Exchange Program Advisory Group (June 4)
- Simon Fraser Community Forums, Maple Ridge (May 20); New Westminster (May 29)
- Simon Fraser Health Region, Community Forum Planning meeting (May 5)
- South Fraser Community Action Group (May 5, June 2, July 7)
- University British Columbia, Department of Health Care and Epidemiology Rounds (Nancy Meagher: "Mathematical modelling of AIDS prevention: Towards a new evaluation framework" (May 15)
- VANDU Public Meeting: "Alternatives to Current Drug Strategies" (July 14)

APPENDIX B:
Service Inventory Questionnaire

HIV/Injection Drug Users:
Inventory of Community Services

Your responses to this questionnaire should be faxed to Bognar and Associates (the consulting group undertaking this contract) at 331 1224 or 738 6901, by ***July 10th****.*

Please tell us about your agency.

Name of agency: _____

Street address: _____

City or Municipality: _____ Postal Code: _____

Health Region: _____

Contact person for
further information: _____

Telephone: _____

Does your agency offer programs which have been specifically designed for, or are relevant to people who are injection drug users?

❑ Yes, programs specifically designed for people who inject drugs.
❑ Yes, programs that may be relevant to people who inject drugs.
❑ No.

Does your agency offer programs which have been specifically designed for, or are relevant to people who are HIV positive or who have AIDS?

❑ Yes, programs specifically designed for people who are HIV+ or have AIDS.
❑ Yes, programs that may be relevant to people who are HIV+ or have AIDS.
❑ No.

If you have answered "no" to BOTH of these questions, you do not need to complete the rest of this questionnaire. Please fax ***this page only*** *to Bognar and Associates at 331 1224 or 738 6901.*

Otherwise, please continue.

What services does your agency provide?
Please check all services delivered by your agency.

Services Related to Alcohol and Drug Use

- ❑ assessment/screening/referral
- ❑ day treatment
- ❑ detoxification centre
- ❑ home detox
- ❑ methadone
- ❑ needle exchange
- ❑ outpatient counselling
- ❑ recovery home
- ❑ residential treatment
- ❑ sobering centre
- ❑ other treatment options ➜ Please specify: _____
- ❑ other ➜ Please specify: _____

Health Services

- ❑ contraception/prenatal services
- ❑ counselling about sexuality
- ❑ dental
- ❑ HIV testing
- ❑ public health services
- ❑ medical clinic with physician(s)
- ❑ medical clinic without physician
- ❑ specific mental health services
- ❑ STD testing/treatment
- ❑ other ➜ Please specify: _____

Support Services

- ❑ advocacy for individuals
- ❑ advocacy for groups
- ❑ community support services
- ❑ financial aid
- ❑ food bank/meal provision
- ❑ homemaking services
- ❑ housing/hospices
- ❑ HIV / AIDS education
- ❑ legal aid
- ❑ life skills/job skills
- ❑ medical equipment
- ❑ peer counselling/peer support
- ❑ professional counselling
- ❑ transportation
- ❑ other ➜ Please specify: _____

Do you operate from...

❑ fixed site(s)➜ On page 8, please provide the program name and address for each site your agency operates.

❑ mobile unit(s) ➜ For each mobile unit, please indicate...

the geographic area served	and how often the area is served.
_____	_____
_____	_____
_____	_____

If you have more than three mobile units, please make a list on a separate page, and fax it with this questionnaire.

When do your programs operate? *Please check all that apply.*

❑ day
❑ extended day (approximately 8 am -6 pm)
❑ evening (approximately 4 pm -10 pm)
❑ night (approximately 10 pm-8 am)
❑ weekends
❑ holidays

In total, how many hours per week are programs available through your agency? _____ hours

How do clients access your service?

❑ self-referral (telephone/walk-in)
❑ through contact with outreach worker
❑ professional referral (MD, health nurse, etc)
❑ agency referral
❑ other ➜ Please specify: _____

Is there a charge to clients who access your services?

- ❑ no charge to clients
- ❑ flat fee for service
- ❑ pre-approval by insurance or other second party payer
- ❑ means tested
- ❑ subsidies available

Do you provide services in languages other than English?

- ❑ No
- ❑ Yes → What language(s)?
  - ❑ Cantonese
  - ❑ Farsi
  - ❑ French
  - ❑ Mandarin
  - ❑ other → Please specify: _____
  - ❑ Punjabi
  - ❑ Spanish
  - ❑ Serbo-Croatian
  - ❑ Vietnamese

Are there waiting lists to access services delivered by your agency?

- ❑ No
- ❑ Yes → For which program(s)? What is the average wait time to enter each program?

Program	Average Wait Time
_____	_____
_____	_____
_____	_____

How are potential clients triaged, that is, how does your agency decide which clients to serve first?

- ❑ no triage system
- ❑ by urgency of need
- ❑ first come, first served
- ❑ referral to other agency if waiting list

Are there eligibility criteria for your services based on the following factors?
Please check all that apply.

- ❑ active injection use
- ❑ age
- ❑ alcohol and drug free
- ❑ gender
- ❑ geographical location
- ❑ income
- ❑ must be HIV+
- ❑ ethnocultural background
- ❑ restrictions on frequency or duration of service
- ❑ sober/detoxed
- ❑ specific conditions (e.g., pregnant)

❑ other ➜ Please specify: _____

Who are your clients?

Their age?

children (pre-adolescents)	____ %
young teens (12 - 16 years)	____ %
older teens/young adults (16 -24 years)	____ %
adults (25 - 50)	____ %
older adults (over 50)	____ %

Their gender?

male	____ %
female	____ %
transgendered	____ %

Their income?

< $20,000	____ %
$20,000 - 60,000	____ %
over $60,000	____ %
not known	____ %

Do you provide *direct ("one-on-one" or small group)* service to clients?

❑ no

❑ yes ➜ Approximately how many clients do you work with or see each day (or in each 24-hour period)?

_____ clients per day/24 hours

Approximately how many *individual* clients *per year* does your agency serve?

_____clients per year

Is your interaction with each client primarily...

❑ episodic: one-time only

❑ on-going ➜ What is the average length of time a client is in your program(s)?

_____ weeks

Where do your clients live? *Please check all that apply.*

❑ Burnaby
❑ Delta
❑ Langley
❑ New Westminster
❑ Maple Ridge/Pitt Meadows
❑ North Shore
❑ Richmond
❑ Surrey North
❑ Surrey South and White Rock
❑ Tri-Cities (Coquitlam, Port Coquitlam, Port Moody)
❑ Vancouver Downtown Eastside
❑ Vancouver West End
❑ Vancouver East Side
❑ Vancouver West Side
❑ elsewhere in British Columbia
❑ outside BC

Do you have plans to change your service over the next year (for example, to add more staff, to provide more outreach, to move to another location)?

❑ No

❑ Yes ➜ Please explain. _____

_____

Do you offer programs ***specifically designed*** for any of the following special populations? *Please check as many as apply.*

- ❑ aboriginal persons
- ❑ people with mental health problems
- ❑ people with disabilities
- ❑ dual diagnosis clients (mental health and addiction)
- ❑ lesbian, gay, bisexual and/or transgendered persons
- ❑ homeless persons
- ❑ immigrants/multicultural communities
- ❑ sex trade workers
- ❑ survivors of sexual abuse
- ❑ women
- ❑ women with children
- ❑ women who are pregnant
- ❑ youth

❑ other ➜ Please specify: _____

Who are your staff and volunteers?

How many full-time equivalents (FTEs) on your staff provide services to injection drug users and/or people who are HIV+? _____ FTEs

In your agency, how many people who work with injection drug users or people who are HIV+ are...

professional counsellors/workers? . . . . . _____
peer counsellors/peer support workers? . . . . . _____
volunteers? . . . . . _____
other? ➜ Please specify_____ . . . . . _____
other ? ➜ Please specify_____ . . . . . _____
other? ➜ Please specify_____ . . . . . _____

Please write a description of your service.

_____

_____

_____

_____

_____

From your perspective, what does your community most need to prevent the spread of HIV and other communicable diseases among people who inject drugs?

_____

_____

_____

Fixed Sites

*If you indicated on page 3 that you operate more than one fixed site, please complete the following information for each site. You do **not** need to list the site you provided information about on page 1.*

Program/Site Name _____

Street address _____

Municipality _____ Postal Code _____

Telephone _____ Facsimile _____

Program/Site Name _____

Street address _____

Municipality _____ Postal Code _____

Telephone _____ Facsimile _____

Program/Site Name _____

Street address _____

Municipality _____ Postal Code _____

Telephone _____ Facsimile _____

If necessary, please attach an additional sheet listing this information for additional program sites.

*Thank you very much for taking the time to complete this questionnaire. Please return it -- **by July 10th** — by fax to Bognar and Associates at 331 1224 or 738 6901.*

APPENDIX C:
Various Indicators of the Epidemic By Health Region

Table C1: Persons Testing Newly Positive for HIV by Health Board, 1996

	Number	Percent
Vancouver/Richmond		
Vancouver	469	
Richmond	8	
Subtotal	*477*	*80*
Simon Fraser		
Simon Fraser (former region)	40	
Burnaby (former region)	19	
Subtotal	*59*	*10*
South Fraser	41	
Subtotal	*41*	*7*
North Shore	13	
Subtotal	*13*	2
TOTAL	**590**	**100**

Notes to Table C1: Number of newly positive HIV cases (persons who tested HIV positive for the first time) in 1996. Difference in Total from 100% is due to rounding. Source: STD/AIDS Control, BC Centre for Disease Control Society.

Table C2: Persons Testing Newly Positive for HIV with Risk Category IDU by Health Board 1996:

	Number	Percent
Vancouver/Richmond		
Vancouver	258	
Richmond	3	
Subtotal	*261*	*80*
Simon Fraser		
Simon Fraser (former region)	24	
Burnaby (former region)	8	
Subtotal	*32*	*10*
South Fraser	31	
Subtotal	*31*	*9*
North Shore	3	
Subtotal	*3*	*1*
TOTAL	**327**	**100**

Notes to Table C2: Number of newly positive HIV cases (persons who tested HIV positive for the first time) in 1996 with risk category injection drug use (IDU, men who have sex with men/IDU, and sex trade worker/IDU). Source: STD/AIDS Control, BC Centre for Disease Control Society.

Table C3: HIV/AIDS Drug Treatment Program Participants who are Active Injection Drug Users (by Self-Report) by Health Board 1997:

	Number	Percent
Vancouver/Richmond		
Vancouver	79	
Richmond	<5	
Subtotal	*<84*	*60*
Simon Fraser		
Simon Fraser (former region)	26	
Burnaby (former region)	13	
Subtotal	*29*	*21*
South Fraser	23	
Subtotal	*23*	*16*
North Shore	<5	
Subtotal	*<5*	*3*
TOTAL	**141**	**100**

Notes to Table C3: Source: HIV/AIDS Drug Treatment Program, BC Centre for Excellence in HIV/AIDS.

Table C4: Reported Cases of Hepatitis C by Health Board 1997

	Number	Percent
Vancouver/Richmond		
Vancouver	1 997	
Richmond	140	
Subtotal	*2 137*	*50*
Simon Fraser		
Simon Fraser (former region)	600	
Burnaby (former region)	408	
Subtotal	*1 008*	*23*
South Fraser	921	
Subtotal	*921*	*22*
North Shore	225	
Subtotal	*225*	*5*
TOTAL	**4 291**	**100**

Notes to Table C4: Source: Epidemiology Services, BC Centre for Disease Control Society.

Table C5: Deaths Due to Illicit Drugs by Health Board 1996

	Number	Percent
Vancouver/Richmond		
Vancouver	135	
Richmond	4	
Subtotal	*139*	*66*
Simon Fraser		
Simon Fraser (former region)	17	
Burnaby (former region)	14	
Subtotal	*31*	*15*
South Fraser	29	
Subtotal	*29*	*14*
North Shore	11	
Subtotal	*11*	*5*
TOTAL	**210**	**100**

Notes to Table C5: Source: BC Coroner's Service, Vancouver.

Table C6: Intake of New Clients at AIDS Vancouver by Health Board

	Number	Percent
Vancouver/Richmond		
West End	73	
Downtown South	18	
Downtown Eastside	120	
Vancouver East	72	
Other Vancouver	16	
Subtotal, Vancouver	*299*	
Richmond	6	
Subtotal, Vancouver/Richmond	*305*	*71*
Simon Fraser		
Burnaby/New Westminster only	28	
Subtotal	*28*	*7*
South Fraser		
Surrey only	41	
Subtotal	*41*	*10*
North Shore	*6*	*1*
Other GVRD	*17*	*4*
No Fixed Address	*24*	*6*
TOTAL	**421**	**100**

Notes to Table C6: Difference from 100% is due to rounding. Includes new intakes for AIDS Vancouver fiscal year ending March 31 1998. Excludes 9 cases from elsewhere in British Columbia and 14 cases where address is not known. Other municipalities in Simon Fraser and South Fraser Health Regions are included as "Other GVRD". Source: Graham, O'Briain and van Steenes (1998).

APPENDIX D:
Service Inventory Respondents (by Health Region)

		Responded	Services for... IDUS	HIV/AIDS
North Shore Health Region				
1	Burrard Band Drug and Alcohol Program	No		
2	Capilano Community Services Youth Outreach	Yes	No	No
3	Family Services North Shore	Yes	No	No
4	North Shore Neighbourhood House	Yes	No	No
5	Queen Mary Community Services	Yes	No	No
6	Seaview	Yes	Yes	Yes
7	Seycove Community Programs	No		
8	Seymour Area Youth Services	No		
9	Squamish Nation Community services	No		
10	West Coast Alternatives Society	Yes	Yes	Yes
11	West Van Youth Outreach	No		
Simon Fraser Health Region				
1	Inner Visions Recovery Society	Yes	Yes	Yes
2	Last Door Recovery Centre	Yes	Yes	Yes
3	Lower Mainland Purpose Society	No		
4	MCF Regional Office - Burnaby	No		
5	MCF Regional Office - Coquitlam	Yes	Yes	Yes
6	Self Addiction Management	Yes	Yes	Yes
7	Simon Fraser Health Region Mental Health Services	No		
8	Simon Fraser Health Region Preventative Services -Coquitlam	No		
9	Simon Fraser Public Health Maple Ridge	Yes	Yes	Yes
10	Simon Fraser Public Health New Westminster	No		
South Fraser Health Region				
1	Alcohol and Drug Education Program and Treatment (ADEPT)	Yes	Yes	No
2	Altered Attitudes Recovery	Yes	No	No
3	Astra Substance Abuse Program	No		
4	Breakaway House	No		
5	CHR Rwanda Society	No		
6	Community Action on Substance Abuse Society	No		
7	Cornerstone Counselling	No		
8	Cornerstone Manor	Yes	Yes	Yes
9	Courage to Change Recovery	No		
10	Cwenengitel Aboriginal Support Centre	No		

		Responded	Services for... IDUS	HIV/AIDS
11	Delta Community Living Society	Yes	No	No
12	Delta Family Services	No		
13	Delta Youth Services	Yes	No	No
14	Exodus Substance Abuse Program	No		
15	Family and Youth Services Society	Yes	No	No
16	Hope-in-Vision Alcohol and Drug Treatment	Yes	Yes	Yes
17	Integrity Healing Clinic Society	No		
18	Kinsmen Place Lodge	Yes	No	No
19	Ladner/Tsawwassen Food Bank	No		
20	Langley District Help Network/Food Bank	Yes	Yes	Yes
21	Langley Family Services Alcohol and Drug Program	Yes	Yes	Yes
22	MCF Alcohol and Drug Services South Delta Clinic	No		
23	MCF Alcohol and Drug Services North Delta Clinic	No		
24	MCF Alcohol and Drug Services Surrey Clinic	Yes	Yes	Yes
25	MCF Alcohol and Drug Services Youth and Child Services	No		
26	Meals on Wheels	No		
27	New Step Society	Yes	Yes	Yes
28	Newton Advocacy Group Society	Yes	No	No
29	Newton Youth Centre	No		
30	Nisha Family & Children's Services	Yes	Yes	Yes
31	OPTIONS	Yes	No	No
32	Peace Arch Community Services	No		
33	Phase 1 Recovery Home Society	No		
34	Phoenix Drug and Alcohol Centre	No		
35	Quality Recovery House	No		
36	Quality Recovery Society	No		
37	Rainbow Community Health Co-op	Yes	No	No
38	Renaissance Society	No		
39	Salvation Army Langley Community Youth and Resource Centre	Yes	Yes	No
40	South Fraser Community Services	No		
41	South Fraser Health Region Boundary Health Unit	Yes	Yes	Yes
42	South Fraser Health Region Continuing Care Delta	Yes	No	Yes
43	South Fraser Health Region Continuing Care Langley	Yes	No	No
44	South Fraser Health Region Continuing Care Newton	No		

		Responded	Services for... IDUS	HIV/AIDS
45	South Fraser Health Region Continuing Care Whalley	No		
46	South Fraser Health Region Continuing Care White Rock	Yes	No	No
47	South Fraser Health Region Mental Health Services Delta	No		
48	South Fraser Health Region Mental Health Services Langley	Yes	No	No
49	South Fraser Health Region Mental Health South Delta/Tsawwassen	Yes	No	No
50	South Fraser Health Region Mental Health Services Surrey Central	No		
51	South Fraser Health Region Mental Health Services Surrey North	No		
52	South Fraser Health Region Mental Health White Rock/South Surrey	Yes	Yes	Yes
53	Step by Step Recovery	No		
54	Surrey Community Services Society	Yes	No	No
55	Surrey Delta Immigrant Services Society	Yes	Yes	No
56	Surrey Food Bank	Yes	No	No
57	Surrey Memorial Hospital Adolescent Day Treatment Program Crisis Response Program	Yes	No	No
58	Surrey Memorial Hospital Youth Clinic	Yes	No	Yes
59	Surrey Methadone Treatment Centre	Yes	Yes	Yes
60	Surrey Street Youth Services	No		
61	Surrey Women's Centre Society	Yes	No	No
62	The Warehouse Drop-in Centre	Yes	Yes	Yes
63	Unity Holistic Recovery Society	No		
64	Visions Integration House	No		
65	Wagner Hills Farm Society	Yes	Yes	Yes
66	White Rock/South Surrey AIDS Project	Yes	Yes	Yes
67	White Rock/South Surrey Food Bank	No		
Vancouver				
1	Aboriginal Friendship Centre	No		
2	ACES	No		
3	AIDS Prevention Street Nurse Program	Yes	Yes	Yes
4	AIDS Vancouver	Yes	Yes	Yes
5	ASIA	Yes	No	No
6	Association First Nations Women	No		
7	BC Coalition of People with Disabilities	Yes	No	No
8	BCPWA	Yes	Yes	Yes
9	Bridge Clinic	Yes	No	Yes
10	Britannia Community Services Centre	No		

		Responded	Services for... IDUS	HIV/AIDS
11	Carnegie Community Centre	Yes	Yes	Yes
12	Centre for Lesbian, Gay, Bisexual and Transgendered People	No		
13	Children's Advocate	No		
14	Covenant House	Yes	Yes	Yes
15	Crabtree Corner	Yes	No	No
16	DEYAS	Yes	Yes	Yes
17	Dr. Peter Centre	Yes	Yes	Yes
18	Drug and Alcohol Meeting Support for Women (DAMS)	Yes	Yes	Yes
19	DTES Women's Centre	Yes	Yes	Yes
20	East Vancouver Youth Initiative	Yes	No	No
21	Family Services of Greater Vancouver Women's DEW program	Yes	Yes	Yes
22	Food for Thought HIV and AIDS Support Society	Yes	Yes	Yes
23	Gathering Place	Yes	Yes	Yes
24	Gordon Neighbourhood House	Yes	Yes	No
25	GVMHS Dual Diagnosis Program	Yes	Yes	Yes
26	Healing Our Spirit	No		
27	High Risk Project Society	Yes	Yes	Yes
28	Immigrant Services Society	Yes	No	Yes
29	Indian Homemakers	Yes	Yes	Yes
30	Kiwassa Neighbourhood House	Yes	Yes	Yes
31	Lookout Emergency Aid Society	Yes	Yes	Yes
32	Loving Spoonful	Yes	Yes	Yes
33	MCF - Youth Services	Yes	Yes	Yes
34	MCF Addiction Services Midtown/South Vancouver	Yes	Yes	Yes
35	MCF Addiction Services West Side Team	Yes	Yes	Yes
36	McLaren Housing	Yes	No	Yes
37	Mental Patients Association	Yes	Yes	Yes
38	Mid-Main Community Health Centre	Yes	No	No
39	National Congress of Black Women	No		
40	Native Courtworkers	No		
41	New Dawn/New Day	Yes	Yes	Yes
42	Nexus Substance Abuse Outreach Program	Yes	Yes	Yes
43	Peak House	Yes	Yes	Yes
44	Portland Hotel	Yes	Yes	Yes
45	Positive Women's Network	Yes	Yes	Yes
46	Ray-Cam	No		
47	Reach Community Health Clinic	Yes	No	No
48	Safe House	No		

		Responded	Services for... IDUS	HIV/AIDS
49	Sheway	No		
50	Storefront Orientation Services	Yes	Yes	Yes
51	Strathcona Mental Health	Yes	Yes	Yes
52	Street Youth	No		
53	SUCCESS	Yes	Yes	No
54	Urban Native Youth	No		
55	Vancouver Aboriginal Child and Family Services	Yes	No	No
56	Vancouver Native Health	No		
57	Vancouver Richmond Health Board -North Health Unit	Yes	Yes	Yes
58	Vancouver Youth Voices	No		
59	WATARI Research Association	Yes	Yes	Yes
60	WISH	No		
61	Youth Action Centre Drop-in	Yes	Yes	Yes
62	YouthCo	Yes	Yes	Yes
63	YWCA Focus	Yes	No	No
Richmond				
1	Chimo Crisis Services	Yes	No	No
2	City of Richmond	No		
3	Heart of Richmond	No		
4	Kinsmen Home Support	Yes	No	Yes
5	MCF Cedarbridge	Yes	No	No
6	MCF Youth Services - Minoru	Yes	No	No
7	Richmond Alcohol and Drug Action Team (RADAT)	Yes	Yes	Yes
8	Richmond Health Department Home Care	No		
9	Richmond Hospice Association	No		
10	Richmond Hospital Emergency	No		
11	Richmond Mental Health Team	Yes	No	No
12	Richmond Youth Services	Yes	No	No
13	Touchstone Family Association	Yes	Yes	Yes

APPENDIX E:
Services Known to be Offered (by Health Region)

	North Shore	Simon Fraser	South Fraser	Vancouver	Richmond
Harm Reduction Services					
Needle Exchange	No	Yes	Yes	Yes	No
Methadone	No	Yes	Yes	Yes	Yes
Alcohol and Drug Treatment Services					
Assessment and Referral	Yes	Yes	Yes	Yes	Yes
Detox:					
Residential adult	No	22 beds	No	48 beds	No
Non-residential adult	Yes	Yes	Yes	Yes	Yes
Residential youth	No	3 beds	No	8 beds	No
Non-residential youth	No	No	No	Yes	No
Day Treatment:					
Adults	No	Yes	Yes	Yes	No
Youth	No	No	No	Yes	No
Women	No	Yes	No	Yes	No
Residential Treatment:					
Adults	No	Yes	Yes	Yes	No
Youth	No	Yes	No	Yes	No
Women	No	No	No	Yes	No
Recovery Homes:					
Adults	No	Yes[1]	Yes[1]	Yes	No
Youth	No	No	No	No	No
Women	No	No	No	Yes	No
Counselling	Yes	Yes	Yes	Yes	Yes
Services Targetted to Special Populations					
Women	Yes	Yes	Yes	Yes	Yes
Youth	Yes	Yes	Yes	Yes	Yes
Aboriginal Adults	No	No	Yes	Yes	Yes
Aboriginal Youth	No	No	No	Yes	No
Dual Diagnosis or Mentally Ill					
Adults	No	Yes	Yes	Yes	Yes
Youth	No	Yes	No	Yes	No

[1]Program will also accommodate male youth.

Note: This appendix includes services known to be offered, by region, based on responses to the service inventory questionnaire.

APPENDIX F:
Agencies Self-Identifying as Offering Programs Specifically Designed for Special Populations (by Health Region)

Specific Services for Persons with Mental Illness or Dual Diagnosis

North Shore	(none)
Simon Fraser	MCF Regional Office Alcohol and Drug Services
South Fraser	ADEPT Langley Family Services Alcohol and Drug Program MCF Alcohol and Drug Services, Surrey Clinic White Rock/South Surrey Mental Health Centre
Vancouver	Covenant House GVMHS Dual Diagnosis Program Lookout Emergency Aid Society New Dawn/New Day Portland Hotel WATARI Research Association Youth Action Centre Drop-In
Richmond	Touchstone Family Association

Specific Services for Aboriginal People

North Shore	(none)
Simon Fraser	(none)
South Fraser	Hope-in-Vision Alcohol and Drug Treatment Salvation Army Langley Community Youth and Resource Centre
Vancouver	Covenant House Kiwassa Neighbourhood House MCF — Youth Services New Dawn/New Day Youth Action Centre Drop-In
Richmond	Touchstone Family Association

Specific Services for Women

North Shore	West Coast Alternatives Society

Simon Fraser	MCF Alcohol and Drug Services
South Fraser	MCF Alcohol and Drug Services — Surrey Clinic Hope-in-Vision Alcohol and Drug Treatment
Vancouver	Covenant House Drug and Alcohol Meeting Support for Women (DAMS) Family Services of Greater Vancouver, Women's DEW Program Kiwassa Neighbourhood House New Dawn/New Day Positive Women's Network WATARI Research Association Youth Action Centre Drop-In
Richmond	Touchstone Family Association

Specific Services for Youth

North Shore	West Coast Alternatives Society Seaview
Simon Fraser	MCF Alcohol and Drug Services
South Fraser	ADEPT Nisha Family and Children's Services Hope-in-Vision Alcohol and Drug Treatment Salvation Army Langley Community Youth and Resource Centre
Vancouver	Covenant House DEYAS Kiwassa Neighbourhood House MCF — Youth Services New Dawn/New Day Nexus Substance Abuse Outreach Program Peak House WATARI Research Association Youth Action Centre Drop-In YouthCo
Richmond	Touchstone Family Association

Note: This appendix includes services known to be offered, by region, based on responses to the service inventory questionnaire.

APPENDIX G:
Agencies Self-Identifying as Offering Specific Services (by Health Region)

Assessment, Screening and Referral to Alcohol and Drug Services

North Shore	West Coast Alternatives Society Seaview
Simon Fraser	Inner Visions Recovery Society Last Door Recovery Centre MCF Alcohol and Drug Services Self Addiction Management
South Fraser	ADEPT Langley Family Services Alcohol and Drug Program MCF Alcohol and Drug Services — Surrey Clinic New Step Society Nisha Family and Children's Services Salvation Army Langley Community Youth and Resource Centre South Fraser Health Region, Boundary Health Unit Surrey Delta Immigrant Services Society Wagner Hills Farm Society
Vancouver	Covenant House DEYAS Drug and Alcohol Meeting Support for Women (DAMS) GVMHS Dual Diagnosis Program High Risk Project Society Indian Homemakers Kiwassa Neighbourhood House Lookout Emergency Aid Society MCF Youth Services MCF Addiction Services, West Side Team New Dawn/New Day Nexus Substance Abuse Outreach Program Positive Women's Network Storefront Orientation Services WATARI Research Association YouthCo
Richmond	Richmond Alcohol and Drug Action Team (RADAT)

Day Treatment

North Shore	(none)
Simon Fraser	Last Door Recovery Centre MCF Alcohol and Drug Services

South Fraser	Cornerstone Manor New Step Society Nisha Family and Children's Services Salvation Army Langley Community Youth and Resource Centre Wagner Hills Farm Society
Vancouver	Family Services of Greater Vancouver, Women's DEW program GVMHS Dual Diagnosis Program MCF Youth Services WATARI Research Association
Richmond	(none)

Residential Detox for Adults

North Shore	(none)
Simon Fraser	MCF Alcohol and Drug Services (Maple Cottage)
Vancouver	Vancouver Detox
Richmond	(none)

Residential Detox for Youth

North Shore	(none)
Simon Fraser	MCF Alcohol and Drug Services (Maple Cottage)
South Fraser	(none)
Vancouver	DEYAS MCF Youth Services WATARI Research Association

Home Detox

North Shore	Seaview
Simon Fraser	Self Addiction Management
South Fraser	New Step Society
Vancouver	New Dawn/New Day
Richmond	Richmond Alcohol and Drug Action Team (RADAT)

Methadone

North Shore	(none)
Simon Fraser	Self Addiction Management
South Fraser	Surrey Methadone Treatment Centre
Vancouver	Portland Hotel Vancouver/Richmond Health Region, Downtown Clinic
Richmond	Richmond Alcohol and Drug Action Team (RADAT)

Needle Exchange

North Shore	(none)
Simon Fraser	Simon Fraser Public Health, New Westminster
South Fraser	South Fraser Community Services
Vancouver	DEYAS Dr. Peter Centre High Risk Project Society Portland Hotel Street Nurse Program Vancouver/Richmond Health Region, North Health Unit Vancouver/Richmond Health Region, Downtown South Clinic Vancouver/Richmond Health Region, Pine Clinic Vancouver/Richmond Health Region, Downtown Clinic
Richmond	(none)

Outpatient Alcohol and Drug Counselling

North Shore	Seaview West Coast Alternatives Society
Simon Fraser	Inner Visions Recovery Society MCF Alcohol and Drug Services Self Addiction Management
South Fraser	ADEPT Cornerstone Manor Langley Family Services, Alcohol and Drug Program MCF Alcohol and Drug Services, Surrey Clinic

	New Step Society Nisha Family and Children's Services Salvation Army Langley Community Youth and Resource Centre Surrey Delta Immigrant Services Society Surrey Methadone Treatment Centre White Rock/South Surrey Mental Health Centre
Vancouver	Covenant House DEYAS Dr. Peter Centre Drug and Alcohol Meeting Support for Women (DAMS) GVMHS Dual Diagnosis Program MCF - Youth Services MCF Addiction Services- West Side Team New Dawn/New Day Nexus Substance Abuse Outreach Program Positive Women's Network WATARI Research Association YouthCo
Richmond	Richmond Alcohol and Drug Action Team (RADAT)

Recovery Homes

North Shore	(none)
Simon Fraser	Inner Visions Recovery Society MCF Alcohol and Drug Services (funds)
South Fraser	Wagner Hills Farm Society Cornerstone Manor New Step Society Surrey Methadone Treatment Centre Nisha Family and Children's Services
Vancouver	New Dawn/New Day
Richmond	(none)

Residential Alcohol and Drug Treatment

North Shore	(none)
Simon Fraser	Inner Visions Recovery Society Last Door Recovery Centre MCF Alcohol and Drug Services (funds)
South Fraser	Wagner Hills Farm Society

	New Step Society
	Hope-in-Vision Alcohol and Drug Treatment
Vancouver	MCF - Youth Services
	Peak House (Youth)
	WATARI Research Association (Youth)
Richmond	(none)

Note: This appendix includes services known to be offered, by region, based on responses to the service inventory questionnaire.

APPENDIX H:
Approximate Budget for Mobile Health Outreach Service

This budget does not include cost of supplies.

MOBILE UNIT COSTS	
Van	30,000
Modifications for mobile health unit	30,000
Insurance and Maintenance	15,000
Fuel	15,000
STAFF COSTS	
Driver/outreach worker[1]	39,200
Health Nurse[2]	62,400
TOTAL	$ 191,600

[1]Salary 35,000 plus 12% benefits (DEYAS rates)

[2]Salary 52,000 plus 20% benefits

APPENDIX I:
Approximate Budget for Integrated Service Centre

This budget includes a needle exchange, health service, counselling, and drop-in.

	Year One	Year Two
Start-up costs[3]	250,000	0
Operating costs[4]	400,000	400,000
Non-physician medical costs, including 8 hour needle exchange	200,000	200,000
Additional 16 hour needle exchange, staffing	116,480	116,480
Physician time[5]	76,700	0[6]
Total	1,043,180	716,480

[3]Includes renovations necessary for provision of medical services, needle exchange, showers, furniture and equipment.

[4]Includes rent, heat, hydro, supplies, salaries.

[5]Sessional physician services, one half day five days per week.

[6]Second year budget assumes MSP will cover sessional relief.