

# Safer Injection Facilities (SIFs) for Injection Drug Users (IDUs) in Canada

## A Review and Call for an Evidence-focused Pilot Trial

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As evidenced through numerous studies in recent years, injection drug use (IDU) is a major public health and order problem in Canada.<sup>1,4</sup> The estimated population of 125,000 injection drug users (IDUs) – approximately one third of whom are living in the three major cities of Toronto, Montreal and Vancouver – is characterized by high levels of drug-related mortality (overdose); prevalence of blood-borne viruses (BBV) and other physical health problems; extensive utilization of health system resources and involvement in crime and public disorder.<sup>3,5-9</sup> Since 1990, overdose mortality rates as well as prevalence and sero-conversion rates of HIV and hepatitis among IDUs have risen in most Canadian cities.<sup>4,10,11</sup>

Injection drug-related problems are particularly severe in Vancouver, where an IDU population of a few thousand injectors is concentrated in the small Downtown Eastside corridor, further described by poverty, and lack of housing and addiction treatment services. These closely networked IDUs typically engage in high-frequency (cocaine and opiate) injection habits involving patterns of high-risk behaviour.<sup>3,6,12</sup> Despite the availability of needle exchange services in Vancouver, needle sharing, needle reuse and injecting in public places are still prevalent among IDUs.<sup>13</sup> These factors have contributed to record high rates of: an annual average of 312 overdose deaths; HIV incidence rates of 13.4 to 18.6 per 100 person-years; and hepatitis C incidence rates of 29.1 per 100 person-years among IDUs over the past five years in Vancouver.<sup>3,12,13</sup>

The dire need for effective responses to this desperate situation related to IDU, mirrored in other Canadian cities, has led a number of health research and policy authorities to call for the establishment of 'Safer Injection Facilities' (SIFs) in Canada.<sup>6,14-16</sup> On the political level, a recent Federal/Provincial/Territorial (F/P/T) report under the auspices of Health Canada recommended the implementation of a SIF pilot trial, establishing a Task Force to examine the feasibility, operational and legal parameters of such facilities.<sup>17</sup> Furthermore, the Federation of Canadian Municipalities endorsed a resolution to establish SIFs on an experimental basis in four to six Canadian cities.<sup>18,19</sup>

SIFs are the creation of a number of European countries – specifically Germany, the Netherlands and Switzerland – which were facing intravenous drug-related public health and order crises similar to those currently experienced in Canada.<sup>4,20-24</sup> The rise of injection drug-related overdose deaths, spread of HIV infection and increasing public pressure to

dissolve 'open drug scenes' (involving both drug use and dealing in public spaces) triggered an overall change in local drug policy practices in these countries. This change included substantive expansion of addiction treatment services and needle exchange programs, as well as adjustments to law enforcement practices.<sup>4,20-24</sup> However, these measures did not prove sufficient to effectively deal with the acute problems of injection drug-related overdose deaths, BBV incidence and public disorder, especially for those IDUs not reached by 'higher threshold' treatments or other interventions. These circumstances led local health service providers in the above countries to establish SIFs as a pragmatic measure to reduce these acute problems by providing protected and clean spaces for IDUs.<sup>20,25</sup>

Generally, all SIFs operate under the umbrella of three major objectives: a) to reduce acute mortality and morbidity risks among IDUs, b) to bring IDUs in contact with social, health and treatment services, and c) to reduce public order problems (drug use in public, discarded needles) related to IDU.<sup>15,25,26</sup> Currently, there are approximately 40-45 SIFs in existence in Germany, the Netherlands and Switzerland, with plans for similar facilities in Austria and Spain. Furthermore, an 18-month scientific SIF pilot trial was started in Sydney, Australia, in July 2001.<sup>15,25,26</sup> On the basis of a recent decision by the New South Wales government, this SIF trial will be extended for a further 12 months following the conclusion of the current study.<sup>27</sup>

Despite local differences between facilities, the majority of SIFs operate on the basis of similar operational practices and rules. They are usually run by social or health workers (nurses) who provide clean injection equipment but no drugs or injection aid; access is limited to local or registered users; restrictions are placed on duration and frequency of use; and drug sharing and violence on-site are prohibited.<sup>25</sup> Existing SIFs have also seen operational challenges recently, with an increase in the proportion of cocaine users in Europe, and opiate injectors switching to inhalable modes of drug use.<sup>28,29</sup> While problems have occurred because of the parallel existence of opiate and cocaine use in SIFs due to the different service needs and behavioural characteristics of these two drug cul-

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tures, a select number of European SIFs will tolerate or provide separate spaces for both cocaine injection and opiate injection or smoking.<sup>28,29</sup> SIFs were initially established in potential conflict with existing narcotics control laws, but recent adjustments to these laws or legal regulations have provided permissive legal frameworks for safer injection facilities.<sup>15,23</sup>

Although SIFs have been in existence in Europe for quite some time, and are considered “successful” interventions,<sup>30</sup> very little systematic research exists documenting how well SIFs meet their objectives, especially in comparison to (or in the absence of) other interventions.<sup>15,25,26</sup> The bulk of the research data that exist is anecdotal or observational in nature, providing a crude empirical picture. The Australian pilot study will offer more systematic data from its process, impact and economic evaluation components in 2003 (albeit with limited control); in the meantime, only progress evaluation data exist.<sup>31</sup>

So what do we know at this point about the success of SIFs? In terms of their effects on client and public health, no fatal overdose incidents have been reported from any existing SIF. While overdose incidents in SIFs do occur, their proportion of overall injection episodes is reported as being comparably low (approximately 1 in 500 to 600 in Europe; but 1 in 129 in Australia); these overdose incidences are predominantly handled on-site, and lower the need for hospital admission substantially when compared to street overdoses.<sup>25,32,33</sup> Some facilities indicate a stabilization or improvement of general or drug-related health among SIF clients.<sup>33,34</sup> Data from SIFs suggest intravenous drug-using behaviour changes include lowered infectious disease risks (decreased needle sharing, increased condom use) as well as “greater awareness and practice of hygienic consumption, less stressful consumption ... [and] being more in control of drug use”;<sup>26</sup> however, there is no evidence of actual reductions in BBV incidence among SIF users. While all European jurisdictions featuring SIFs have experienced reductions in the major IDU-related harm indicators targeted by these facilities in the past decade, it is impossible with the existing data to determine the specific role of SIFs in these effects. This is the case because numerous key factors of overall drug policy

and service profiles have changed in these system settings.<sup>4,26</sup>

All SIF facilities seem to be well utilized with up to 200 visits a day.<sup>25,26</sup> At the Australian site, the majority of visits are by irregular users (< twice per month) and health services or treatment referrals are provided to a minority of users.<sup>31</sup> While SIFs appear to be successful in attracting high-risk IDUs, surveys suggest that large proportions of IDU populations do not use SIFs, and that numerous factors (specifically: opening hours, wait time, distance, drug injection only) can explain the limited reach effects.<sup>23,32,35</sup> Most SIFs appear to be well integrated and accepted into their local (mostly residential or small business) environments, and most cities with SIFs have observed reductions in public order problems related to drug use or dealing in public.<sup>20,27,32,33</sup> However, other reports suggest that a ‘honey pot’ effect exists, increasing the presence and visibility of drug dealing and other public disorder events in the vicinity of the facilities.<sup>34,36</sup>

In sum, on the basis of experience with and data from SIFs from abroad, it appears that these facilities have the potential of reducing the individual and public health and disorder burden related to injection drug use. As such, they may be of considerable value to Canadian cities like Vancouver, Montreal, Toronto and Ottawa, where these problems remain excessive and ineffectively addressed, and should be explored on a pilot basis as recommended.<sup>25,26,33</sup> However, proponents of such potential SIF pilot facilities have yet to provide details on how to manage the likely demand from large, local IDU populations undertaking thousands of injection episodes each day, and how to accommodate the predominant patterns of poly-drug use that characterize Canadian injection drug use scenes.<sup>7,11,14</sup>

Furthermore, we are urging that any SIF trial in Canada should be subject to a systematic evaluation consisting of process, impact and economic components, providing a rigorous and detailed empirical account of the operations, costs and benefits of these facilities in the specific Canadian setting as the basis for long-term policy decisions.<sup>37</sup> Specifically, we are emphasizing the need for a properly controlled evaluation, which will potentially demonstrate a clear causal link between

observed potential harm, risk or behaviour changes among SIF users to the SIF intervention. This seems particularly relevant in light of the data from Europe and Australia, suggesting that many SIF users attend these facilities irregularly.<sup>31,32</sup> As such, it will be rather difficult to separate the impact of SIF use from the impact of other interventions or factors on these IDUs.

With the above consideration in mind, SIFs could become a valuable and instructive example of an evidence-based public health intervention in Canada.

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