TORONTO CRACK USERS PERSPECTIVES:

Inside, Outside, Upside Down

Safer Crack Use Coalition

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1.0 BACKGROUND

1.1 SAFER CRACK USE COALITION & STUDY GENESIS

In 2000, the Safer Crack Use Coalition (SCUC) was created. Its mandate: *to advocate for the needs of marginalized crack users and to try to address some of those needs*. In 2002, SCUC received a grant from the Wellesley Foundation to explore the health and social issues of marginalized crack users in the City of Toronto. The intent of the study was to enable SCUC to better understand the breadth and extent of crack users needs. More specifically, the research aimed at exploring the experiences of homeless drug users, why they smoke/inject crack, and the health and social impact of their use. This report summarizes the findings from that 2002/03 study.

1.2 CRACK

1.2.1 What Is Cocaine & Crack?

Crack, a more potent form of cocaine, is an immensely popular substance that is one of the most powerful stimulant drugs. A google-search elicits eight pages of street names for crack. Crack is the street name for a crystallized form of cocaine. Crack is made by 'cooking' or processing powder cocaine with water, heat, and sodium bicarbonate (baking soda) or ammonia, which produces solid, whitish small lumps or 'rocks', thus producing a free base form of cocaine that can be smoked. In other words, crack is a form of cocaine that comes in a rock crystal form that can be heated and its vapors smoked. While this process produces the best quality crack it is not typical of crack that is available on the street. Crack bought on the street usually has an extremely small amount of cocaine and is mixed with a myriad of other of other toxic substances. The term "crack" refers to the crackling sound that is heard when it is heated.

1.2.2 What Does Crack Do?

Cocaine/crack is a strong central nervous system stimulant that interferes with the re-absorption process of dopamine, which is a chemical messenger associated with pleasure and movement. Normally, dopamine is released in the brain by a neuron into the synapse, where it can bind with dopamine receptors on other neurons. Dopamine is usually recycled back into the transmitting neuron by a specialized protein called the "dopamine transporter". However, when cocaine is present, it connects to the dopamine transporter and stops or interferes with the normal recycling process of dopamine by blocking its removal. This blockage results in a buildup of dopamine which results in the production of cocaine's pleasurable, euphoric effects. The faster the absorption of crack (e.g. smoking, injection) the more intense the high but also the shorter the duration of the high. As use continues, a higher tolerance often develops. In order for the brain to register and obtain the same effects, higher, more frequent dosages are needed.

1.2.3 How Is Crack Used?

The main routes in using crack are intravenous and inhalation. In other words: "injecting" or "smoking" (which includes freebase and crack cocaine). "Injecting" releases the drug directly into the bloodstream, and heightens the intensity of its effects. "Smoking" involves the inhalation of

cocaine vapor or smoke into the lungs, where absorption into the bloodstream is as rapid as by injection. Some users combine cocaine powder or crack with heroin in a "speedball."

1.2.4 What Is Its Prevalence?

For over a decade it has been the most commonly used illicit drug among Toronto's homeless and street-involved people (City of Toronto, 2005a, 2005b (Toronto); Research Group on Drug Use (RGDU), 2004). That said, crack is not just a drug for the marginalized population, it is a drug that is widely used by individuals from varying social and economic backgrounds and is found in both rural and urban settings. Recent studies of homeless and street-involved youth (Goodman, 2004) and adults in Toronto (Vance, Philipa & German, 2002) found a combination of crack, alcohol and cannabis their preferred drugs of choice. Both studies found at least two-thirds of participants used all three substances. The combination of alcohol and crack compounds the danger of both, as the mix produces cocaethylene, which potentially increases risk of death

In Toronto, it is estimated that 1% to 2% of the population use cocaine (Toronto, 2005a; RGDU, 2004). More specifically, it is estimated that there are approximately 30,000 people in Toronto who are injection drug users. Of these, 70% have reported using cocaine, particularly crack. With respect to street youth, a recent study of 76 homeless youth found 60% use crack (Goodman, 2004). Whether users smoke or inject crack cocaine, and especially for those living in poverty, crack use results in serious health and social problems.

1.2.5 What Are Its Health and Social Consequences?

There are many health and social issues that have been associated with the use of crack. The high increased risk of spread of infections, HEP C (33%) and HIV/AIDS (6%), an increased risk of chronic lung infections (23%), and a heightened number of mental health issues (41%) are a few that have been researched in this study. Other adverse outcomes linked or associated with crack use include, but are not limited to malnutrition, overdose, compulsive use, dependence, and an increased risk for cardiac problems (City of Toronto, 2005a; RGDU, 2004).

1.3 STUDY RATIONALE

Few studies have solely looked at crack users as topic experts and focused on just their views of the drug's impact on them. Given the broad range of effects due to crack use, it is imperative to better understand the health and social impact of the drug from the users' perspective. This study is unprecedented, groundbreaking and adds to the extant literature by providing crack users' perspectives and addressing methodological concerns (e.g. adequate sample size). It is hoped the study findings will better inform service providers, policy makers and researchers about crack users' experiences and their health and social needs so that best, most effective practices and policies are in place.

2.0 METHODOLOGY

2.1 RESEARCH MATERIALS, PILOT GROUP & AGENCY SITES

The SCUC research team was responsible for the design, development and implementation of this multi-method study. They produced both the survey (appendix A) and the focus group discussion guide (appendix B) that was used by all participating agencies. Both the survey and focus group questions were first pilot tested to ensure that they were clear and relevant. Crack smokers then gave feedback to the facilitators. In this way the study was community based in its design and implementation.

The study goal was to explore the health and social issues of marginalized crack users in Toronto. The key research questions were: *What are the experiences of homeless crack users? Why do they smoke/inject crack? What are the health consequences and social impacts of their use?*

A multi-method design was used which included a survey and focus group discussions. Data were collected between October 2002 and June 2003. Participants for the study were recruited by SCUC members working at local agencies throughout the Greater Toronto Area (GTA). Study agencies were:

- 519 Church Street Community Centre MealTrans Program
- Lawrence Heights Community Health Centre
- Parkdale Community Health Centre
- Queen West Community Health Centre
- South Riverdale Community Health Centre
- Street Health (pilot group was conducted here as well as a study focus group)
- Warden Woods Community Centre
- Weston-King Neighbourhood Centre
- Youthlink InnerCity.

2.2 SAMPLE SELECTION

To be eligible to participate in the study, participants had to be current crack users. SCUC members approached potential participants, provided information about the study goals and requirements of participation and invited those eligible to participate.

Across all participating community agencies, 108 current crack users were recruited for the study: A total of fifty-three women (49%), forty-seven men (44%) and eight transgendered adults (7%) participated in the focus groups and survey. The focus group discussions were conducted at each

of the agencies. Participants were compensated $20 for their time, and provided with public transit tickets and refreshments.

2.3 STUDY DESIGN

A mixed-method design, using a convenience sample was employed. Participants first completed a questionnaire, which provided quantitative data, and then participated in a focus group which yielded qualitative data.

At the start of each of the 17 focus groups, study respondents were first asked to complete a short questionnaire. The questions were designed to collect demographic data such as gender, age and ethno-racial background. As well, the survey captured information about current and past drug use, health status (e.g., acute, chronic and infectious diseases and conditions), drug and other health-related risks, housing status, history of incarceration, health and social service usage, and socio-demographics. Additionally, participants were asked to identify service-related barriers, health and social issues. Data from the questionnaire were entered into SPSS 11.5 for analyses. Statistical significance is set at $p < .05$.

Like the survey segment, focus group participation was voluntary. In the focus group discussions participants were asked about their reasons for crack use, any health and social concerns they experienced due to crack use, availability of social supports, service utilization and recommendations for prevention of health and social problems.

A common focus group guide was used to focus each of the discussions. Each discussion group was co-moderated by a SCUC member and an agency worker familiar with the community members. Focus groups at each agency were divided by gender. As noted above, 17 focus groups were completed. Eleven were Toronto-based and six were conducted outside the downtown core. Each discussion group had an average of six participants and lasted between one to two hours.

2.4 DATA ANALYSIS

One recorder was hired to attend all 17 focus groups to ensure consistency across different groups and locations. During each discussion group, she took detailed notes of all discussion groups. The notes were transcribed into a word processing package and compiled into a common dataset. Answers to each of the questions were collated across groups.

Analysis of the qualitative focus group data were conducted by members of the Research Team. Recurring themes in each topic area were identified and categorized by at least 2 researchers separately and then results were compared. This was a measure used to ensure that personal bias was minimized in the interpretation of the data. A summary of the findings point to five major themes that are discussed in section 4.3.

The quantitative survey data were inputted and then descriptive and bivariate statistical analyses were completed with the guidance and assistance of Carol Strike at the Centre for Addiction and Mental Health.

3.0 RESULTS: SURVEY

3.1 DEMOGRAPHIC DATA

3.1.1 Gender

The gender breakdown in Table 1 shows the gender balance of study respondents. In this sample, there were slightly more female crack users (49%) than males (44%), with self-identified transgendered crack users constituting less than ten percent of the sample (7%). Of interest, the dominant gender of street youth are males, where the common ratio is 70:30 males to females (Goodman, 2004). While gender distribution is relatively even with sample participants in the age brackets 16 to 25 and 26-35, women crack users out number men two to one for 36-45 year olds and men out number women two to one in the 46-55 age category. Why this is the case is not readily evident by this data.

Table 1: gender	**N**	***%***
Male	47	*44%*
Female	53	*49%*
Transgendered	8	*7%*
All	**108**	***100%***

3.1.2. Age Group

Table 2 shows the breakdown by "age group" for the overall sample and by gender. Statistical significance on age by gender was not found when "age group" mean was examined, although on average, these males are older (mean 3.89) than the female crack users (mean 3.66), who tend to be older than the transgendered adults in the sample (3.25). Collapsing the age groups into three age brackets (under 25, 26-45, and over 46) and not including the transgendered group due to small numbers, finds no differences between male and female for the *"under 25 age bracket".* The next age group, *"26-45 age bracket"* finds variation; three-quarters (76%) of all the female crack users fall within the ages of 26 to 45, with over half (57%) of all the females being between 36 to 45 years of age. Whereas, just a little more than half (53%) the male crack users are between 26-45. Finally, the *"over 46 age bracket"* finds differences with only one-in-ten (11%) of the females being over 46 versus over one-quarter of all male crack users (28%) being over 46 years of age.

Table 2: age group	**all**		**gender/sexual description**						**All**
	#	%	male		female		transgendered		**age bracket breakdown**
Under 16	0	*0%*	0	*0%*	0	*0%*	0	*0%*	15%
16-25	16	*15%*	7	*15%*	7	*13%*	2	*25%*	
26-35	22	*20%*	8	*17%*	10	*19%*	4	*50%*	64%
36-45	48	*44%*	17	*36%*	30	*57%*	1	*12.5%*	
46-55	19	*18%*	13	*28%*	6	*11%*	0	*0%*	21%

56 +	3	*3%*	2	*4%*	0	*0%*	1	*12.5%*	
All	**108**	***100%***	**47**	***100%***	**53**	***100%***	**8**	***100%***	**100%**

3.1.3. Ethno-Racial

Respondents were asked about their ethno-racial background. See Table 3. What is most striking about the data: the over-representation of Aboriginal/Native adults and the greater ethno-racial diversity amongst male and transgendered crack users compared to female users. This same ethno-racial finding occurred in the study that examined 103 Toronto street youth, ages 16 to 25 (Goodman, 2004).

Table 3: ethno-racial background	**all**		**gender/sexual description**					
	#	%	male		female		transgendered	
Aboriginal	19	*18%*	11	*24%*	7	*13%*	1	*12.5%*
White	54	*50%*	19	*41%*	32	*61%*	3	*37.5%*
Middle Eastern	1	*1%*	1	*2%*	0	*0%*	0	*0%*
African	4	*4%*	3	*6%*	0	*0%*	1	*12.5%*
Caribbean/WI	6	*5%*	2	*4%*	3	*6%*	1	*12.5%*
Latin, C/S America	1	*1%*	1	*2%*	0	*0%*	0	*0%*
Mixed Heritage	10	*9%*	3	*6%*	5	*9%*	2	*25%*
Other	13	*12%*	7	*15%*	6	*11%*	0	*0%*
All	**108**	***100%***	**47**	***100%***	**53**	***100%***	**8**	***100%***

3.2 HOUSING

3.2.1 Homeless Status

Respondents were asked if they were homeless any time within the last year. Overall, 78 (72%) said "yes" and 29 (27%) said "no", with one with missing data. However, when the results are rank ordered, from the group most at risk of homeless to at least risk, the data suggest male crack users experience homelessness at a rate much higher than females and transgendered people.

	Experienced Homelessness	*Did Not Experienced Homelessness*	*Total*
➢ Males	87% (n= 41)	13% (n= 6)	N= 47
➢ Females	64% (n= 34)	36% (n= 19)	N=53
➢ Transgendered	37% (n= 3)	43% (n= 4)	N=7

When the data are examined just by *"age category 16 to 45",* the analysis again found the males to be at significant risk of homelessness.

	Experienced Homelessness	
➢ Males	97%	31 out of 32 men

- Females 57% 27 out of 47 women
- Transgendered 29% 2 out of 7 transgendered

3.2.2 *Housing Types*

The 108 crack users were surveyed about the different types of housing/shelter they used in the last twelve months. See Table 4. Again, gender analysis finds some interesting differences.

- The 108 respondents selected 182 housing types, indicating many employ more than one type. What was not asked and is not known is the frequency of use – in other words, the number of times they used a shelter or how many types (e.g. an apartment, used a squat, was in prison and in hospital)
- As a group, the transgendered crack users had the fewest number of moves per person and appear to secure the most stable and preferred housing type: independent housing (67%) versus women's use at (34%) or men's use at (14%)
- The most employed housing type for both male and female respondents was prison, with 60% of the 47 males and 49% of the 53 females indicating they had been in prison in the previous year
- T-test analysis of the differences between males (n=47) and females (n=53) for each housing type (transgendered sample was too small for analysis) finds only two were at a level of significance: *living in an apartment/house* (p =. 048) where women were more likely than men to use it and *squat living* (p = .007) with the reverse – men were more likely than women to use a squat

Table 4: housing types	**all – "yes used this type…"**		**gender/sexual description**		
	# N=108	*"yes" %*	male n=47	female n=53	transgendered n=8
Independent Housing					
apartment /house	36	*33%*	10	21	5
boarding/room house	11	*10%*	2	8	1
hotel room	1	*1%*	0	1	0
group home	0	*0%*	0	0	0
% use by gender	*48*	*% use*	*14%*	*34%*	*67%*
Supportive Housing					
hostel / shelter	18	*17%*	11	6	1
out-of-cold program	14	*13%*	8	6	0
transition house	1	*1%*	1	0	0
with friends/family	19	*18%*	6	12	1
% use by gender	*52*	*% use*	*31%*	*27%*	*22%*
Homeless					
Squat	6	*6%*	6	0	0
street	18	*17%*	10	8	0
% use by gender	*24*	*% use*	*19%*	*9%*	*0%*
Other					
Hospital	3	*3%*	2	1	0
Prison	55	*51%*	28	26	1
% use by gender	*58*	*% use*	*36%*	*30%*	*11%*
Total %			***100%***	***100%***	***100%***
Total Types Selected	***182***		***84***	***89***	***9***

MOVE RATIO #selected / # adults	**1.68**	**1.79**	**1.68**	**1.12**

3.3 INCOME SOURCES

Survey participants were asked to indicate their sources of income. See Table 5.

Table 5: Income	**all**		**gender/sexual description**					
	# "yes"	% *"yes"*	male		female		transgendered	
			n	Male % use	n	Female % use	n	Trans % use
Social assistance	50	*47%*	19	*40%*	28	*54%*	3	*43%*
ODSP	28	*26%*	8	*17%*	16	*31%*	4	*57%*
Family	10	*9%*	3	*6%*	7	*13%*	0	*0%*
Friends	14	*13%*	9	*19%*	5	*10%*	0	*0%*
Paid work – legal	11	*10%*	6	*13%*	4	*7%*	1	*14%*
Paid work – under table	19	*18%*	11	*23%*	6	*11%*	2	*28%*
Panhandling	24	*23%*	14	*30%*	10	*19%*	0	*0%*
Sex trade	15	*14%*	1	*2%*	11	*21%*	3	*43%*
Drug dealing	23	*22%*	10	*21%*	13	*25%*	0	*0%*
Other	16	*15%*	12	*25%*	4	*8%*	0	*0%*

"Other" sources of income noted by females were: babysitting and sex trade work. For the males, "other" included – hustling, scavenger, squeegee work and illegal activities like stealing.

Table 7 shows that there is different reliance by gender on different types of income. The "TOP 5" sources of income by gender:

	Males	**Females**	**Transgendered**
1st	social assistance (40%)	social assistance (54%)	ODSP (57%)
2nd	panhandling (30%)	ODSP (31%)	social assistance (43%)
3rd	other (25%)	drug dealing (25%)	sex trade (43%)
4th	paid work under table (23%)	sex trade (21%)	paid work under table (28%)
5th	drug dealing (22%)	panhandling (19%)	paid work –legal (14%)

3.4 HEALTH ISSUES

3.4.1 Prevalence

91 of the 108 survey respondents provided information about their health issues. See Table 6. Areas asked about were:

HIV/AIDS	Tuberculosis	Lung Infections
HEP C	Mental Health	Foot Problems
HEP B	Diabetes	Poor Diet/Malnutrition
HEP - other	STI	

T-test analysis by gender (male vs. female) and by age groups did not find any statistical differences except for one area: foot problems with 16 to 25 year olds reporting more foot problems (mean 0.58) than the 36 to 45 year olds (mean 0.19) and this was at a statistically significant level (p = .007). Of note, although women crack users more frequently reported mental health issues (mean = .48) compared to males (mean = .30) it was not at a statistically significant level (p = .111). Again, analysis of transgendered was excluded due to the small sample size.

Table 6: health issues	**all**		
	"yes"	"no"	*% "yes"*
HIV diagnosis	5	86	*6%*
HEP C	30	61	*33%*
HEP B	4	87	*4%*
HEP – other	1	90	*1%*
Tuberculosis	4	87	*4%*
Mental Health Issues	37	54	*41%*
Diabetes	5	86	*5%*
Sexually Transmitted Infections	9	82	*10%*
Chronic Lung Infections	21	70	*23%*
Foot Problems	26	65	*29%*
Poor Diet/Malnutrition	22	69	*24%*

The "Top Five" health issues as reported by the crack users are:

1.	Mental Health Issues	41%
2.	HEP C	33%
3.	Foot Problems	29%
4.	Poor Diet/Malnutrition	24%
5.	Chronic Lung Infections	23%

3.4.2 Heath Care Service Use

All 108 respondents provided data on their use of health care services in the past year. They were asked to provide examples of their health concerns. One-in-six identified health issues that ranged from minor maladies (e.g. had crabs once, enemic) to moderate conditions (e.g. asthma, arthritis, hypoglycemia) to major health issues (e.g. artificial arteries, gangrine of the foot, cancer). See Table 7. Analysis did not find health use differences by gender but some were found by age group.

Table 7: health service use	**all**		
	"yes"	"no"	*% "yes"*
Visited doctor/nurse in last year	102	6	*94%*
Used community health center	59	48	*55%*
Visited nursing clinics	4	103	*4%*
Used health bus	34	73	*32%*
Visited doctor/nurse at drop-in	28	79	*26%*
Used family doctor	41	66	*38%*
Used walk-in clinic	29	78	*27%*
Used methadone clinic	18	89	*17%*
Used hospital	44	63	*41%*
Visited dentist	19	88	*18%*
Used drug treatment program	14	93	*13%*
Used detox	18	89	*17%*

By comparing the following age groups to each other, significant differences ($p<.05$) and *approaching significance* levels *($p <.08$)* are noted. See next page:

16 to 25 26 to 35 36 to 45 46 to 55

Overall, almost all (102) of the 108 crack users stated they had seen a doctor or nurse in the past year. Of those who said they had not, it was those in the 16-25 age bracket who were most likely not to have seen a health professional (3 out of 16 of the 16-25 said no (19%) vs. 2 out of 22 of those aged 26-35 said no (9%) vs. 1 out of 48 of the 36-48 (2%). Half to two-thirds of all crack users, regardless of age, rely on community health centers.

The younger aged crack users (16-25) appear to rely more heavily on immediate response health services such as nurse clinics, walk-in clinics or drop-in clinics. This is compared to nearly two-thirds (63%) of the older crack users (46-55) saw a family doctor , whereas with the other age brackets, a third or less used a family doctor. While a third of all the crack users indicated the use of the "health bus", nearly three-quarters of those (70%) were crack users between 36 to 55, in other words older crack users. Detox was predominantly used by the 16-25 (27%) and 36-45 (21%) age groups.

Hospital use was nearly equally distributed across all age brackets. Of interest, for each age bracket except those 35-46, where only 10% accessed a methadone clinic, all other age bracket use of methadone clinics ranged from 20% to 25%. Less than one-in four saw a dentist.

Age Group	p	Health Use	Interpretation
16-25 (mean .13) vs. 26-35 (mean .00)	*p=.082*	*nursing clinic*	*16-25 higher use of nursing clinics*
16-25 (mean .27) vs. 26-35 (mean .05)	p=.055	detox	16-25 higher use of detox
16-25 (mean .81) vs. 36-45 (mean .98)	p=.017	visit doctor	36-45 almost all saw doctor/nurse
16-25 (mean .60) vs. 36-45 (mean .19)	p=.002	drop-in clinic	16-25 higher use of drop-in clinic
16-25 (mean .81) vs. 46-55 (mean 1.00)	p=.050	visit doctor	46-55 all saw doctor/nurse
16-25 (mean .60) vs. 46-55 (mean .11)	p=.001	drop-in clinc	16-25 higher use of drop-in clinic
16-25 (mean .27) vs. 46-55 (mean .63)	p=.035	family doctor	46-55 higher use of family doctor
16-25 (mean .40) vs. 46-55 (mean .11)	p=.046	walk-in clinic	16-25 higher use of walk-in clinic
26-35 (mean .27) vs. 36-45 (mean .10)	*p=.074*	*methadone*	*26-35 higher use of methadone clinic*
26-35 (mean .05) vs. 36-45 (mean .21)	*p=.084*	*detox*	*36-45 higher use of detox*
26-35 (mean .36) vs. 46-55 (mean .11)	p=.057	drop-in clinic	26-35 higher use of drop-in clinic
26-35 (mean .27) vs. 46-55 (mean .63)	p=.021	family doctor	46-55 higher use of family doctor
36-45 (mean .35) vs. 46-55 (mean .63)	p=.039	family doctor	46-55 higher use of family doctor

3.5 SOCIAL ISSUES

The literature has found that substance users, especially those who are street-involved, are adversely effected by social or systemic factors, such as poverty and homelessness (Toronto, 2005a). The 108 survey respondents were asked nine questions related to their perception of whether they were impacted by specific social issues. For six of the nine items, two-thirds or more answered "yes" indicating the profound level of adversity on daily life. See Table 8.

Table 8: social issues	**all**		
	"yes"	"no"	*% "yes"*
Poverty	81	27	*75%*
Homelessness	92	16	*85%*
Police harassment	72	36	*67%*
Discrimination	54	54	*50%*
Poor health	73	35	*68%*
Violence	69	39	*64%*
Sexual assault	48	60	*44%*
Isolation	60	48	*56%*
Addiction	87	21	*81%*

T-test analysis of gender differences found statistical significance between male and females with one item: sexual assault (p = .000) where female crack users indicate it happens to them at a rate significantly higher (mean =.58) than males (mean = .19).

Analysis by age bracket found a consistent linear relationship and a level of significance ($p<.05$) for each of the following items: *police harassment, discrimination and sexual assault.* In short, the younger the age bracket, the higher their response that they experienced it. For example, those 16-25 indicated they experienced police harassment at a higher rate (mean = .88) than those 26-35 (mean = .73), yet those 26-35 stated they experienced police harassment at a higher level than crack users aged 36-45 (mean = .67).

	MEAN		
	Police harassment	**Discrimination**	**Sexual assault**
Age 16-25	.88	.88	.69
Age 26-35	.73	.59	.50
Age 36-45	.67	.46	.48
Age 46-55	.42	.21	.11

3.6 USE OF SERVICES

104 survey respondents answered the queries about the services they used within the last 30 days prior to completing the questionnaire. Given the combination of poverty and homelessness couple with the chronicity of drug use, it is not surprising that the most utilized services: drop-in centers (63%), needle-exchanges (54%), and a food banks (52%). Previous analysis found 35 respondents indicated they had HIV (n=5) or HEP C (n=30), and coupled with this data, only 6 of the 9 who visited a specific HEP C or HIV/AIDS program, actually had HEP C or HIV/AIDS. The same issue is found with mental health, where over 40% indicate mental health issues but only 10% used such a service in the last month. Underutilization of programs specific to an issue (e.g. mental health) may be due to further stigmatization concerns. Gender analysis found males tended to use drop-in center ($p= .021$) and employment centers ($p=.010$) more than females and women used drug treatment programs ($p = .028$) more than the men crack users. See Table 9.

Table 9: service use: last 30 days	**all**		
	"yes"	"no"	*% "yes"*
Needle exchange	56	48	*54%*
Outreach program	39	65	*37%*
Drop-in center	66	38	*63%*
Food bank	54	50	*52%*
Counselling/support group	25	79	*24%*
HCV / HIV/AIDS program	9	95	*9%*
Employment center	14	90	*14%*
Ethno-cultural center	1	103	*1%*
Mental health agency	10	94	*10%*
Community agency	18	86	*17%*
Drug treatment program	26	78	*25%*

3.7 DRUG USE

3.7.1 Drug(s) of Choice

Analysis of the gender responses (male and female) to drug /substance use in the 30 days preceding the survey found statistical significance with just one area: alcohol use, where males indicated they used it a higher rate (87% use) than the female (72% use) crack users (p =.058).

Response to what drugs survey participants use are noted in Table 10. It is not surprising to find a broad range of legal and illicit drugs are used. However, of the "Top 4" drug preferences for the 108 crack users, three (alcohol, cannabis and tranquilizers) are relatively "mainstream". When people mix crack and alcohol they create a new compound called coacaethylene, which intensifies crack's euphoric effects, while possibly increasing the risk of sudden death.

	% USE			
	Overall N=108	**Male n=47**	**Female n=53**	**Transgendered n=8**
1st Smoke Crack	89%	87%	96%	50%
2nd Alcohol	77%	87%	72%	50%
3rd Cannabis	62%	70%	57%	50%
4th Tranquilizers	43%	34%	51%	37%

Table 10: drug use: last 30 days	**all**		
	"yes"	"no"	*% "yes"*
Alcohol	83	25	*77%*
Non-beverage alcohol	10	98	*9%*
Crack - smoked	96	12	*89%*
Crack - injected	28	80	*26%*
Cocaine - powdered	34	74	*32%*
Heroin	13	95	*12%*
Opiates - other	40	68	*37%*
Methadone - treatment	17	91	*16%*
Methadone – street	8	100	*7%*
Solvents	2	105	*2%*
Ritalin	6	102	*6%*
Speed	5	103	*5%*
Ecstasy	12	96	*11%*
Cannabis	67	41	*62%*
Tranquilizers	46	62	*43%*
Amphetamines	7	101	*7%*
Hypnotics	5	103	*5%*

3.7.2 Crack Use Methods

When asked how often they used crack in the last 30 days, 88% of the 106 who reported frequency, said they did crack at least once a week; nearly four out of ten did it every a day or more than once a day. Gender differences were not found.

- 38% indicated either every day
- 16% said every other day
- 24% said once or twice a week
- 12% reported once or twice a month
- 10% less than once a month

Respondents were asked directly about the methods they used for crack. See Table 11. Gender differences were not found. Differences ($p<.05$) between age brackets were found with one item: *injected drugs*. Those in the 16-25 year old age bracket consistently noted they injected drugs with greater frequency (mean = .69) than the other three age brackets: 26-35 (mean = .29; p = .014), 36-45 (mean = .26; p = .002) and 46-55 (mean = .39; p = .086 approaching significance)

Table 11 crack methods	**all**		
	"yes"	"no"	*% "yes"*
Used a crack pipe	71	34	*68%*
Lent a crack pipe	49	57	*46%*
Injected drugs	37	68	*35%*
Used injection equipment	14	91	*13%*
Lent or used a needle	4	101	*4%*

3.8 BARRIERS

The study respondents were asked about the barriers they experienced in obtaining health care, social services and access to services. Their responses reflect the hurdles, challenges and frustrations at the personal as well as social level.

Participants' comments noted that they could not afford needed medicine, or they had been refused service by a family doctor, or they could not obtain transportation to get to an appointment on time, or that they experienced discrimination and racism. See Table 12.

Table 12: barriers	all		
	"yes"	"no"	*% "yes"*
Don't have health card	37	52	*42%*
Don't know the nearest clinic	1	88	*1%*
Don't have transportation	31	58	*35%*
Can't afford it	20	69	*23%*
Bad experience in past	23	66	*26%*
Don't trust medical people	16	73	*18%*
Racism	6	82	*7%*
Homophobia/heterosexism	5	84	*6%*
Discrimination – drug use	35	54	*39%*
Discrimination – poverty	24	65	*27%*
Discrimination – disability	6	83	*7%*
Discrimination – gender	6	83	*7%*
Discrimination – sex trade	10	79	*11%*
No time	8	81	*9%*

When compared to males, the transgendered adults and female crack users both appear similar by reporting high response rates for discrimination due to *sex trade activities.* The transgendered respondents also reported significant levels of discrimination due to homophobia / heterosexism and gender bias compared to minimal reporting by men and women crack users on the same barriers.

Respondents reported the following, as the "Top 5" barriers, in rank order from most to least. Please note, not all barriers are experienced equally by males, females and transgendered.

	% EXPERIENCED BY GENDER		
	Male n=37	**Female n=45**	**Transgendered n=7**
No health card (42%)	51%	33%	43%
Discrimination due to drug use (39%)	40%	40%	29%
No transportation (35%)	38%	36%	14%
Discrimination due to poverty (27%)	24%	29%	28%
Bad experience in the past (26%)	16%	27%	71%

4.0 RESULTS: FOCUS GROUPS

4.1 OVERVIEW

Upon completion of the survey, respondents were asked to participate in a focus group.
A common discussion guide was used to ensure all groups were asked the same questions. Key areas and questions included:

AREA	QUESTIONS
➢ *Crack Use*	Why do people use crack? What are some of the attitudes people have about crack users/use?
➢ *Health Issues*	What are some of the health issues? Which health problems are most common? How does crack contribute to these health issues? What ways, if any, do you think these problems could be prevented? Crack users report trouble getting health care when needed - why? How does health care need to change to better serve crack users?
➢ *Social Issues*	What are some of the other issues faced by crack users? What is the impact of these issues on health & well-being of crack smokers? What are some of the things that would make it better?
➢ *Support*	What/who are some of the supports that could be useful to crack smokers? Do you think crack smokers get these kind of supports? If not, which ones are commonly lacking? Why?
➢ *Services*	A harm reduction approach is what most agencies use to provide service to crack users – do you think harm reduction is an appropriate strategy for providing service to crack users? How could harm reduction services be improved?

Findings from the focus group data are presented in two ways:

- Summary of the responses to the question areas
- Selected study themes

4.2 SUMMARY OF RESPONSES TO STUDY QUESTIONS

4.2.1 Crack Use - Why do people use crack?

As a *coping mechanism*

Crack provides immediate relief from physical and mental pain, loneliness, isolation, boredom, numerous health and social issues, including depression, loss of family, Hepatitis C infection, low self-worth, a history of violence and incarceration as well as the pain associated with being homeless. Many people simply responded to the question: "to escape".

"It's a way to run and hide"

"It's an escape, even if it only last momentarily. It's an escape from depression, isolation. It's better than anti-depressants"

"I just want all the pain to go away; reality comes flooding back - you want to go and do it again."

"It becomes a habit, it's a cycle. You smoke crack so that you can make money [numb yourself to do sex work or commit crime], so that you can smoke crack"

It is addictive, available and cheap

Participants describe the powerful psychological addiction of crack Many respondents noted that they started using crack as a replacement drug or as a way to cope with withdrawal symptoms associated with heroin or alcohol. As noted previously, crack provides quick relief from many kinds of pain, including withdrawal symptoms.

"Once you start, you can't stop"

"You have to, it's a compulsion"

"Crack is easier to get than weed. A lot of people wanted weed and couldn't get it, so they bought crack."

4.2.2 Crack Use - What are some of the attitudes people have about crack users/use?

Worthless

Participants were quick to respond with many negative words: *diseased, scum, garbage, thief, filth, liar, violent, dirt.* A large number of people simply said, "worthless". There were also specific derogatory terms such as, "crack-head" and "crack-ho", a term often mentioned by the women.

"People think you are dirt"

"They harass you, just because of who you are and because of what we do"

"Crack users are the bottom of the barrel, socially"

"There's a stigma about crack-heads"

"If you are female, they think you are a crack–whore"

"They think you're easy and that you'll do anything for a toke or money"

4.2.3 Crack Use - How do these attitudes affect you?

Heightened Isolation

The majority of participants reported that the unrelentless, adverse, negative attitudes of the general public resulted in further isolation or led to a cycle of use where real/perceived negative attitudes from family, friends and service providers led to depression and more use. Many find themselves in a vicious cycle of drug use, shame and isolation.

"You feel like an alien"

"It makes you feel shitty. You get high to get over it…"

"I keep my use secret".

"It makes you angrier at society and then you don't want to be a part of it"

"People hesitate to get proper equipment, because they are afraid of the attitudes they might come across."

4.2.4 Health Issues – What are they?

Acute & Chronic Physical & Mental Health Problems

Almost every participant in the study reported health issues related to crack smoking. Sexually transmitted infections (STI's), HIV/AIDS and HEP C, were the highest reported concerns. Interestingly, the second highest reported concern was increased vulnerability precipitated by crack use. This concern included neglect of daily living needs, poor hygiene, and a lowered immune system. Other health problems cited were: sores and burns on lips, dental health, foot problems, malnutrition, weight loss, lung infections, and exhaustion.

Participants also voiced their concern about mental health issues and spoke of paranoia, depression, mood swings, and anxiety. Many disclosed deep feelings of self-loathing and poor self-esteem that led, in some cases, to suicidal ideation.

The causes of poor physical and mental health were described by participants in two ways

1. As an effect of the drug itself
   - *Participants recognized that crack use impacted their physical and mental health causing problems such as respiratory distress, teeth grinding, paranoia, depression and overdose.*

2. As an effect caused by their environment.
   - *Respondents were also aware that their environment played a significant a role in their illnesses related to poverty, homelessness, malnutrition, stress and a lack of quality control over their drugs*

"People wear themselves down. They have no strength to eat, and their system runs down."

"Sexually transmitted infections—crack takes away your inhibitions, makes us more vulnerable to STDs. Guys never want to use a condom."

"Malnutrition is a drug issue. Once you've had that first toke, you don't care about food."

4.2.5 *Health Issues* - How to prevent them?

In terms of preventing these health issues, participants' responses fell in to three broad categories:

- *Personal drug use*
  Participants knew abstaining or decreasing their drug use would lessen their health problems. They identified harm reduction strategies they can use: prioritizing responsibilities (e.g. rent, food, work and health), planning ahead, not sharing equipment, avoiding areas of high drug use and remembering to sleep, eat and drink

- *Policy changes*
  Respondents suggested that drug law reform and welfare reform would better their health – such as a safe place to go, improved housing equals improved health, and having FBA and ODSP forward money directly to the landlord, so rent is automatically paid

- *Services/resources*
  Recommendations included increased access to health services, especially mobile services, one-stop service, increased access to support and counseling, and increased access to nutrition

4.2.6 *Health Issues* – What are the barriers?

Focus group participants identified two key barriers: *discrimination* and *inaccessible services.* Secondary barriers included *attitudes of health care professionals* and *inequitable access to medical services.* Participants reported that they had been denied service or made to wait specifically because they were drug users, services were often inconvenient, there was a lack of confidentiality, demands for unavailable ID, and an overall lack of knowledge by health care professionals about drug use issues. Respondents noted that service design and delivery created barriers for drug users. For example, one participant stated that the requirements of their health provider were too complicated for them to follow. Lack of awareness by the crack users of the services available is another issue. Many stated their fear of being judged by the health system, of being "found out" as a user, often stopped them from accessing medical services until in dire need. Participants spoke of the need for more health services and a greater choice in services (e.g. more treatment, crisis workers, aboriginal services, mental health workers, drop-ins, harm reduction services, affordable housing, free dental work, and counselling) with harm reduction services better integrated with other health and social services and harm reduction workers committed to working with users. Finally, improved services while in jail/prison was noted.

"Doctors & nurses don't properly identify the issues, they just write everything off as associated with drug use."

"There's this "brought it on ourselves" idea in society that you only give compassion to people who didn't bring their problems on themselves."

"They should just give people help when they get there; they should look at you as a person & care about <u>you</u>."

"I want doctors to not treat all of your health problems as though they are all crack-related, just because you do crack."

4.2.7 Social Issues – What are they?

Focus group responses identified *police harassment* (67%) and *violence* (64%) as their major social issues. Additionally, every focus group mentioned poverty, homelessness and discrimination as social issues that crack users face.

"If they [police] know you, even if you're not doing anything, they jack you up anyway"

"They [police] think you're thieves, just cuz you panhandle"

"In rehab there's limited space, but those stipulations don't exist in a jail cell. They'll pack you in there with three or four other people."

"There should be a place to recognize people who have been killed by violence involving crack use."

4.2.8 Support and Services

A summary of their above comments for improved support and services:

- Eliminate discrimination (individual, professional [e.g. health, police] and societal)
- Ensure access to equitable services
- Have knowledgeable health & service providers committed to working with drug users
- Reduce violence and risk of violence
- Increase crack specific harm reduction services i.e. safer crack kits

4.3. SELECTED STUDY THEMES

The focus group responses were analyzed for themes across the question areas. The following five themes emerged as elevated in importance for the crack users.

- Homelessness Hurts
- Start Crack for Coping – End Up Not Coping
- Personal/ Social /Structural Discrimination
- Decline in Health
- Harm Reduction Works

4.3.1 Homelessness Hurts

Homelessness is a major theme for the crack users, regardless of gender or age. Both the quantitative survey data and the focus group data identify the high incidence of homelessness (85%) for the crack users and the reality that it is always on their minds. Related to homelessness is poverty (75%) and lack of finances. Their comments are telling of the plight of individuals who are dependant on crack.

Women's Focus groups

" People are homeless, and they need a place to smoke, like washrooms. They don't have homes to go to".
" Housing. The system should find housing for everyone. All your money goes to rent and you can't eat"
"Homelessness…"
"I've got a room but I am still struggling – I'm out scoring more than just crack. I have to do it for food, smokes and other stuff"
"$520 isn't enough for a decent room in a decent area."

Men's Focus groups.

" Homelessness. Housing issues".
"Homelessness."
"Poverty ".
"Homelessness. You get thrown out you, lose your house".
"It's never enough – the more you get – the more money you want."

Transgendered Focus groups

"Homelessness".
"There's discrimination at CAMH- their programs need to include Homeless People and crack users"
"Homelessness- people living on the street have nothing else to do…"

4.3.2 Start Crack for Coping – End Up Not Coping

Responses suggest that crack often acts as a coping or escape mechanism from troubles, worries and problems. Crack allows the user a needed escape, albeit temporarily. But the crack use heightens, magnifies and adds to the original issues. The aftereffects of crack use make the option of escape again from the problems that much more appealing.

Women's Focus groups

I use crack…

"To escape reality." **"Escape ".** **"It enhances sexual cravings".**
"It's a good buzz a quick high" **"It gets rid of loneliness".** **"It reduces inhibitions"**
"To take (away) pain". **"It's like heaven"**

What happens when the rush is over?

"Coming down sucks".
"It's hard to stop"
"The mental issue is number –you've got so many downfalls –you know it's wrong, but you do it anyway".
"The mental issue is number one; when you're coming down, you get depressed, when you get depressed, you get suicidal".

Men's Focus groups

I use crack…

"To get away from reality". **"15-20 seconds of sheer euphoria"** **"It's a way to run and hide ".**

What happens when the rush is over?

"Paranoia. Some people get it when they do a blast. Crack encourages it".
"As a mental or chemical adversary. It's like a chess match. Personally, it's a way of keeping myself from digging too deep a hole and crawling in it. It challenges my intellect.
"It's a dangerous addiction".

4.3.3 Personal / Social / Structural Discrimination

Crack users experience profound systemic, structural, and personal discrimination, every day.

Women's Focus groups

"People think you are dirt".
"If you're a female they think you're a crack whore".
"They think you're not worth anything"
"You're labeled a crack head."
"Scum-of-the-earth"
"At my family doctor's I am out of there in 30 seconds; they tell you to come back in a week; they don't take you seriously".
"People think that crack users are illiterate and don't have knowledge about anything".
"We are judged - that's the number one problem".

Men's Focus groups

"You're a crack head you're a thief".
"Crack makes liars out men and whore out of women".
"It's like you got an infectious disease".
"They don't like crack users. They put them down, they think you're lower than they are".
"Discrimination - they know you do crack, they have your record; they'll let you die ' cause you're a crack user".
"Health care professionals - think you don't care about yourself, so they don't bother helping you; they think you're dumb.
"They should just give people help when they get there. They should look at you as a person, care about you. No matter what you chose to do in your life, there's always someone who looks at you like you're crazy".

Transgendered Focus groups

"They think you're a prostitute, a crack whore, but there are CEOs of companies who do it."
"You're dirty. They think you're a lower class of a human being".
"They'll anything for the next hit just like"
"Health care people should be more accepting".
"When you need to reach out for help, if you think they're judging you you'll never go back".
"There's discrimination at CAMH – their programs need to include homeless people and crack users".

4.3.4 Decline in Health

The great equalizer with crack use is the toll it takes on one's entire health: physically, mentally, emotionally, behaviourally and cognitively. Users' comments underlie the many serious health issues they experience due to crack use. Further analysis of the focus group data found women and the transgendered more apt to disclose that they did not practice safe sex when smoking crack. On the other hand, review of the men's data find they never mention that safe sex matters. The women's comments suggest they are expected to give sex when smoking crack with their boyfriend or dealer, and sex is considered a form of payment for the drug. Sexual assault and drug use are primarily a concern noted in the women's groups.

Women's Focus groups
"Malnutrition, weight loss".
"People forget to wash because they are smoking crack".
"Lung problems –problems breathing"
"Things are transmitted because people share pipes, needles and stuff".
"People don't use condoms when they are on crack"
"Cookie feet"

Men's Focus groups
"My feet go to pieces, they ring like a bell. Sore feet, smelly feet".
"STDs –I assume so, although I've had no sex drive since I've started mixing".
"HIV and Hepatitis C".

Trangendered Focus groups
"Unsafe sex "
"Sharing pipes /needles"
"Cold sores"
"HIV"

4.3.5 Harm Reduction Works

Comments from the crack users: they perceive a harm reduction approach to be the preferred intervention method for them and street-involved people. They emphasize that services need to be 24/7 and that counsellors need to be empathic to drug users. Also, an increase in the different harm reduction tools available needs to be addressed and incorporated so all crack users have the same access to sterile and new crack smoking supplies.

Women's Focus groups
"[Harm reduction assumes] when they want to stop the are referred to the appropriate person"
"[With harm reduction] the attitude is that we're here to support you while you're using, and then, when you're ready to stop, we'll support you there, too".
"It [harm reduction] is certainly appropriate. Since the province adopted it, things have improved a lot".

Men's Focus groups
"It [harm reduction] helps me quit".
"{Harm reduction] = there are better crack kits".
"It [harm reduction] is realistic and it's not abstinence–based"
"Because ex-drug or even current drug users are employed by them [harm reduction agencies] - they know what you are going through"

Trangendered Focus groups
"Yes – it [harm reduction] works to hand out kits. It stops people from getting HIV".

5.0 CONCLUSIONS/RECOMMENDATIONS

The undertaking of this project and the vast data that has been generated is only a step in the right direction in order to better understand and address the difficulties faced by crack users. This research is only the beginning but with the lack of research, attention and focus on crack users and their plight, further work needs to continue. Listed below are the key themes, which emerged from this study of the users' perspectives on the impact and effects of crack use and recommendations for better serving their health and social needs.

- The need for all service areas (e.g. health, counselling, police, social services) to work collaboratively to diminish structural barriers, decrease personal discrimination and reduce systemic bias for crack users. Increased training for all staff to understand what crack is, the effects of crack, and sensitivity training to the needs of crack users.

- The need to see substance use as a health and social issue and not a criminal issue.

- The need to improve the health services offered to crack users. This need is especially crucial in addressing the barriers to accessing health care (i.e. having no identification) and the lack of respect that happens in the health care field when one is identified as a crack user and homeless.

- The need to address mental health issues without further stigmatizing and labeling the individual according to their crack use.

- The need to advance and infuse harm reduction methods into best practices. A large-scale collaboration between the municipal, provincial and federal levels of government regarding the distribution of safer crack use kits.

- The need to create a safe inhalation room where crack users will not be persecuted for using drugs and can address their health and social needs in a safe and non-judgmental environment.

- The need to create harm reduction strategies and equal access to these services within the prison system.

- The need to increase outreach and counselling services to positively impact and create a connection to services otherwise inaccessible for many users.

- The need to advance knowledge and research that is specific to crack users (e.g. etiology, gender and age effects, social and health consequences, and evidence-based practice).

- The need to address the lack of housing and affordable housing. Which coupled with poverty and the lack of support through income-support systems (OW, ODSP) only increases one's displaced social location.

- The need to advocate for crack users and to increase their knowledge of crack and their role as a collective in order to network and create a users union among other crack users.

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APPENDIX A

Questionnaire

Please fill out the following questions as best as you can. All your answers will be kept confidential and your identity will remain anonymous.

1. What age are you (please √ mark one box)?

☐ Under age 16
☐ 16 - 25
☐ 26 - 35
☐ 36 - 45
☐ 46 - 55
☐ 56 and over

2. What gender are you (please √ mark one box)?

☐ Female
☐ Male
☐ Transgender/sexual

3. What best describes your ethnoracial background (please √ mark one box)?

☐ East Asian
☐ Aboriginal
☐ White
☐ South Asian
☐ Middle Eastern
☐ African
☐ Caribbean/West Indies
☐ Latin, Central and South American

☐ Other origins _____

☐ Mixed origins _____

4. Have you been homeless in the last year (please √ mark one box)?

☐ Yes
☐ No

5. Have you been in jail/prison in the last year (please √ mark one box)?

☐ Yes
☐ No

6. Where do you currently live (please √ mark as many boxes as needed)?

☐ (a) Apartment or house that you rent or own
☐ (b) Boarding/rooming house
☐ (c) Hostel/shelter
☐ (d) Out of the Cold program
☐ (e) Hotel room
☐ (f) Squat
☐ (g) Street
☐ (h) Transition house
☐ (i) Hospital
☐ (j) Staying with friends or family
☐ (k) Group home
☐ (l) Other _____

7. Have you been diagnosed with any of the following health issues or conditions (please √ mark as many boxes as needed)?

☐ (a) HIV/AIDS
☐ (b) Hepatitis C
☐ (c) Hepatitis B
☐ (d) Hepatitis - type not known
☐ (e) TB
☐ (f) Mental health problems (i.e. depression, anxiety, schizophrenia, etc.)
☐ (g) Diabetes
☐ (h) Sexually transmitted infections (i.e. Herpes, Warts, Syphilis, Chlamydia, Gonorrhea, etc.)
☐ (i) Chronic lung infections (i.e. bronchitis, pneumonia, etc.)
☐ (j) Foot problems
☐ (k) Poor diet or malnutrition
☐ (l) Other _____

8. In the last year, have you seen a doctor or nurse (please √ mark one box)?

☐ Yes
☐ No

9. In the last year, what health care services have you used (please √ mark as many boxes as needed)?

☐ (a) Community health centre
☐ (b) Nursing clinics
☐ (c) Health bus
☐ (d) Nurse or Doctor at a drop-in centre or shelter
☐ (e) Family doctor
☐ (f) Walk-in clinic
☐ (g) Methadone clinic
☐ (h) Hospital

☐ (i) Dentist
☐ (j) Drug treatment program
☐ (k) Detox
☐ (l) Other _____

10. What barriers, if any, do you have to get health care (please √ mark as many boxes as needed)?

☐ (a) I don't have a health card
☐ (b) I don't know the nearest clinic
☐ (c) Don't have transportation to get there
☐ (d) Can't afford it
☐ (e) Bad experience in the past
☐ (f) Don't trust medical people
☐ (g) Racism
☐ (h) Homophobia/heterosexism
☐ (i) Discrimination due to drug use
☐ (j) Discrimination due to poverty issues
☐ (k) Discrimination due to disability
☐ (l) Discrimination due to gender
☐ (m) Discrimination due to being involved in the sex trade
☐ (n) No time
☐ (o) Other _____

11. In the last 30 days did you visit any of the following services (please √ mark as many boxes as needed)?

☐ (a) Needle exchange and/or harm reduction program (i.e. to get needles, crack kits, info, support, etc.)
☐ (b) Outreach program
☐ (c) Drop-in centre
☐ (d) Food bank
☐ (e) Counselling/support group
☐ (f) Hepatitis C or HIV/AIDS program
☐ (g) Employment centre
☐ (h) Ethno-cultural centre
☐ (i) Mental health organization
☐ (j) Community organization
☐ (k) Drug treatment program (methadone, detox, etc.)
☐ (l) Other _____

12. What do you consider to be your greatest support (the person, place or things that help you cope with life)?

Please Describe _____

_____

13. What are some of the social issues faced by crack users (please √ mark as many boxes as needed)?

☐ (a) Poverty
☐ (b) Homelessness
☐ (c) Police harassment
☐ (d) Discrimination
☐ (e) Poor health
☐ (f) Violence
☐ (g) Sexual assault
☐ (h) Isolation
☐ (i) Addiction
☐ (j) Other _____

14. In the last 30 days, which of these drugs did you use (please √ mark as many boxes as needed)?

☐ (a) Alcohol
☐ (b) Non-beverage alcohol (i.e. Listerine, rubbing alcohol, rice wine, etc.)
☐ (c) Smoked crack
☐ (d) Injected crack
☐ (e) Powdered-cocaine
☐ (f) Heroin
☐ (g) Other opiates (Dilaudid, Demerol, Talwin, T=3/4s, Morphine, Percadan, etc.)
☐ (h) Methadone (from treatment)
☐ (i) Methadone (from street)
☐ (j) Solvents (airplane glue, nail polish remover, etc.)
☐ (k) Ritalin
☐ (l) Speed
☐ (m) Ecstasy/MDMA, or Special K
☐ (n) Marijuana (pot) and/or hash
☐ (o) Tranquillizers (i.e. Valium, Librium, Ativan, Halcion, etc.)
☐ (p) Amphetamines (i.e. Benzadrine, Dexedrine, Preludin, etc.)
☐ (q) Hypnotics (i.e. Seconal, Nembutal, Barbituates, etc.)
☐ (r) Other _____

15. In the last 30 days, How often did you use crack (please √ mark one box)?

☐ Twice or more every day
☐ Once every day
☐ Every other day
☐ Once or twice a week
☐ Once or twice a month
☐ Other _____

16. How do you normally pay for your crack (i.e. bartering, sex for drugs, illegal activities, panhandling, sex trade, paychecks, welfare, etc.)?

Please Describe _____

17. What is your main source of income (please √ mark as many boxes as needed)?

☐ Social assistance/welfare
☐ ODSP (disability benefits)
☐ Family/partner
☐ Friends
☐ Paid work (legal)
☐ Paid work (under the table)
☐ Panhandling
☐ Sex trade work
☐ Drug dealing
☐ Other illegal activity
☐ Other _____

18. During the last 30 days, have you used a crack pipe that someone else used before you (please √ mark one box)?

☐ Yes
☐ No

19. During the last 30 days, have you given, lent, rented or sold a pipe that you had used to someone else (please √ mark one box)?

☐ Yes
☐ No

20. During the last 30 days, have you injected drugs (please √ mark one box)?

☐ Yes
☐ No

21. During the last 30 days, have you used injection equipment (i.e. needles, water, filter, spoon, etc.) that someone used before you (please √ mark one box)?

☐ Yes
☐ No

22. During the last 30 days, have you given, lent, rented or sold a needle that you had used to someone else (please √ mark one box)?

☐ Yes
☐ No

APPENDIX B

Discussion Guide for Focus Groups

Crack Use

1. In your opinion, why do people use crack?

   (prompt: What are the 'pro's and con's of using crack?)

2. What are some of the attitudes people have about crack users and crack use?

   How do these attitudes affect users?)

Health Issues

1. What are some of the health issues that affect crack users? Which health problems are most common?

   (Hep C, HIV, lung problems, mental health problems?)

2. How does crack use contribute to these health issues?

3. What ways, if any, do you think these problems could be prevented?

4. Crack users sometimes have reported that they sometimes have trouble getting health care when they need it. Why do you think this happens?

5. Brainstorm session (write on flipchart): How does the health care need to change in order to better serve crack users?

   (prompt: what type of service – clinic, emerg, drop-in; hours of operation?; location?; services offered- alternative, nursing care etc, type of staff, attitudes of staff, training for staff?)

Social Issues

1. We have talked about health issues. What are some of the other issues faced by crack users?

2. What is the impact of these issues on the health and well-being of crack smokers?

3. Brainstorm session (write on flipchart): Given the list of issues amongst crack smokers; What are some things that would make it better?

Support

1) Everybody needs support. This could be a friend who listens, some good advice from a family member or worker and practical supports like financial help. What are some of the supports - places, people or services that could be useful to crack smokers?

2) Do you think most crack smokers get these kinds of support? If not, which ones are commonly lacking? Why?

Services

1) Many agencies that provide services to crack smokers use a harm reduction approach. Harm reduction is: a non-judgmental approach to drug use that focuses on reducing the harms associated with drug use without requiring abstinence. Some examples of harm reduction programs include:

    - Needle exchanges and safer crack kit distribution projects
    - Counseling and education on safer drug use practices including Hep C and HIV prevention
    - Methadone clinics
    - (Advocating for policy and legislative changes, re decriminalizing marijuana)

2) Do you think harm reduction is an appropriate approach strategy for providing services to crack users?

3) How could harm reduction services be improved?

Closing

Anything we have missed? Anything people would like to add?