



**What Women and Men Who Smoke
Crack Have to Say about
HIV and Hepatitis C Prevention:
*Implications for Policy and Program
Development***

FINAL STUDY REPORT

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The views expressed herein do not necessarily represent the views of OHTN.

Executive Summary

Purpose

This project, *What Men and Women who Smoke Crack Have to Say about HIV Prevention: Implications for Policy and Practice*, represents a starting point from which to consolidate knowledge about a largely ignored segment of people living at risk of HIV/AIDS and Hepatitis C (HCV) in Ontario. Despite an increasing prevalence of crack smoking, the experiences of people who smoke crack and their understanding of and access to harm reduction services for the prevention of HIV and HCV are not well understood. Harm reduction programs and services tend to be designed primarily for people who inject drugs. Resources for people who smoke crack are sometimes added to existing services but may fail to adequately consider and respond to the social and environmental contexts in which people smoke crack. This project was designed to explore the social and contextual conditions that surround people's use of crack, including access to and use of harm reduction services.

Methods

As a preliminary exploratory component of a multi-phase, multi-year study, this report presents findings from focus groups and in-depth interviews that were intended to explore underlying social and environmental factors that impact people's use of crack, people's drug smoking practices and access to safer crack use supplies for the prevention of HIV and HCV.

Findings from the focus groups and interviews have been used in the design of a structured quantitative questionnaire examining the contextual factors that impact people's use of crack, drug using practices and safer use of crack. The questionnaire has been pilot-tested with people in Ottawa who smoke crack. Results from the pilot study are being incorporated into the questionnaire for its use in a province-wide study of the HIV- and HCV-related prevention needs of women and men in Ontario who smoke crack.

Knowledge Transfer

This project incorporated a knowledge transfer (KT) plan that ensured the continued alignment of research objectives with the needs and priorities of a range of stakeholders in order to enhance uptake of knowledge to improved policies and programs for people in Ottawa who smoke crack. In addition to engaging a diverse research team, the KT plan involved a three-part workshop series hosted at the beginning, middle and conclusion of the project, to which a broad spectrum of partners from across the country were invited to participate and contribute to the design, analysis and interpretation of findings.

Findings

There is a complexity of contextual factors that influence: whether crack is smoked versus injected; where (at what location) crack is smoked; what materials (glass stems versus other devices as well as additional protective equipment such as mouth pieces) are used to smoke crack; and whether materials (glass stems or other devices) are shared among users while smoking crack. Through this research project, it became clear that there are a number of personal and environmental factors that appear to contribute to Ottawa men and women's use of crack and to their use of safer smoking practices. For instance:

- The availability and affordability of crack in Ottawa appeared to positively impact the prevalence of crack use and the frequency of instances in which crack was opted for over other injection drugs. It was suggested that the availability of crack might be contributing to a reduction in the frequency of drug injection;
- Factors that determined whether a dual user (person who smokes crack and injects drugs) would inject or smoke crack included: the availability and source of crack or other injection drugs; a preference for either smoking or injecting; and availability of safer injecting versus safer smoking equipment. It was suggested that the provision of sterile stems might be a contributing factor to a reduction in the frequency of drug injection;
- The lack of safe spaces to smoke (indoor and outdoor) left people with little option but to smoke crack outdoors. Smoking outdoors often posed additional risks to users (unsafe environments) and to the community (public crack smoking and unsafe discard of used crack smoking devices);
- Age was identified as a distinct factor for greater risk-taking when smoking crack on account of the fact that some Ottawa agencies are required to impose restrictions on the distribution of safer crack smoking supplies to people aged 18 and over. This had the potential to affect younger users' propensity to use someone else's stem or to use another less safe device such as a pop can or medicinal inhaler to smoke crack;
- Younger people who smoke crack reported being taken advantage of by older users or drug dealers. This introduced additional HIV- and HCV-related risk behaviours, particularly in situations where crack and sex were being negotiated and exchanged;
- Power dynamics in relationships between men and women were articulated. These power dynamics often involved coercion and violence and introduced additional HIV and HCV risk, particularly during sexual encounters;
- Risk of exposure to HIV and HCV appears to have been heightened in situations where crack was exchanged for sex. Gender and power dynamics that accompanied male-female or male-male transactions coupled with the power of drug addiction often involved the negotiation of sexual acts that carried higher risk (e.g. sex without a condom);

- Negative encounters with law enforcement and reports of safer drug using equipment being taken or confiscated were frequent. Such negative encounters with law enforcement produced fear of police that resulted in a reluctance to collect or carry safer smoking equipment;
- Sharing of devices used to smoke crack occurred as a result of not having access to one's own or a clean unused stem at the time when it was needed. This was due to factors including accessibility/availability of safer smoking resources (agency location, hours of operation or age restriction policies) or choosing not to carry one's own stem for fear of being caught by police;
- In general, whenever possible, glass stems were used to smoke crack. However, mouthpieces were rarely used and brillo was often used in place of the brass screens that are included in safer inhalation kits;
- There was a lack of awareness of the importance of safer disposal of devices used to smoke crack. Smoking supplies were often disposed of hastily for fear of being caught by the police, particularly among those who faced release conditions that prohibit them from carrying drug-using equipment;
- There was a general sense of awareness of risk for disease acquisition and transmission (HIV and HCV) associated with the sharing of smoking devices, as well as other health risks related to smoking crack. However, risk of transmitting/contracting HIV or HCV was perceived as remote. As well, participants in this study were knowledgeable about where to access safer smoking resources¹; and
- While there was a level of comfort expressed with accessing health services and disclosing drug use to agencies that offer harm reduction services, there were numerous accounts of stigma and discrimination encountered when accessing mainstream health services, from stigmatizing language to perceived differential treatment based on a person's drug use.

Discussion and Recommendations

Findings from this study and confirmed through discussions with project partners during the knowledge translation workshops point to the urgent need for programs and services to address the lived experiences of people who smoke crack. That is, programs and services must consider the personal and environmental contexts that are contributing to people's risk of exposure to HIV and HCV.

Recommendations are presented within five broad categories. First, individuals must possess accurate knowledge of the HIV and HCV risks associated with sharing devices used to smoke crack. Second, harm reduction resources for people who smoke crack

¹ Participants were recruited through community agencies that provide harm reduction resources and services, therefore the knowledge expressed by these users may not be representative of the general population of people in Ottawa who smoke crack, particularly those who were not accessing community harm reduction resources.

must be provided within a continuum of services that are responsive to users' immediate needs, including the provision of safer smoking resources in the most readily accessible fashion for all people regardless of age, as well as access to safer smoking facilities and broader treatment options. Third, there is a need for expanded knowledge of drug use and addiction among health service providers in order to reduce stigma and discrimination and improve access to health and medical services for people who smoke crack. Fourth, the structural barriers that law enforcement objectives and practices create in terms of negatively impacting access to safer inhalation calls for immediate enhanced cooperation and alignment of objectives among law enforcement bodies, harm reduction programs, and communities of people who use drugs. Finally, while this research has begun to explore contextual factors that impact access to safer inhalation, there is a need for further investigation to expand our understanding of these complexities. Each of these areas is further detailed below.

Enhanced Education and Access to Information

- Improved information outlining HIV- and HCV-related risks involved in sharing devices used to smoke crack and connection with sexual risks.
- Enhanced drug safety education in schools with possible involvement of drug users in awareness-raising and educational initiatives.

Broader Access to Safer Inhalation Resources

- Removal of age restrictions (18 and over) for the distribution and collection of safer smoking supplies through agencies that offer harm reduction services.
- Expansion of existing harm reduction services through extended hours (24 hours) as well as broadened access to support and outreach services.
- Examination and development of safer smoking best practices including the design of improved safer smoking devices and materials.
- Increased attention to best practices for safer disposal of used smoking supplies.

Expanded Drug Treatment Options

- Adoption of a more holistic continuum model of service delivery for people who smoke crack in order to enhance responsiveness to users' immediate needs.
- Creation of safer drug use facilities and safe spaces to be high for people who smoke crack.
- Greater access to detox and treatment options and increased availability of post-discharge support and transitional housing.

Improved Access to Health and Medical Services

- Development and incorporation of drug use and addiction education and sensitivity training for medical and health staff in order to reduce stigma and discrimination of people who use drugs.

Enhanced Cooperation with Law Enforcement

- Work towards alignment of safer inhalation program objectives with policing and law enforcement objectives and practices. Contradictory policies and efforts create structural barriers that ultimately lead to a fear of collecting and carry safer inhalation equipment among those who smoke crack.

Continued Investigation and Research

- Further exploration is needed to examine contextual factors, including determinants of health such as housing and gender that impact people's smoking practices and affect access to safer inhalation resources and their connection with sexual risk.
- Further investigation exploring the connection between safer inhalation knowledge, internalization of knowledge and enactment of knowledge – i.e. knowledge of the HIV- and HCV-risks, internalization of this knowledge, and enacting this knowledge through safer smoking and safer sex practices.

1.0 Introduction

1.1 What is Crack?

Crack is the street name for a crystallized form of cocaine made into small lumps or rocks that can be smoked. Crack is a powerful central nervous system stimulant; the high from smoking crack and inhaling the vapor lasts between five and ten minutes. Psychological dependence develops as the pleasurable feeling caused by the drug is craved and the crash following the diminished effects of the drug needs to be avoided. As tolerance to the drug develops, there is an intense need to smoke to recapture the intense high. A single-use rock of crack can be obtained in Ottawa for less than CA\$10.00.

1.2 How is Crack Smoked?

Ontario guidelines for safer crack smoking recommend that crack is smoked using a clean, single-use glass tube (stem) with a rubber or latex mouthpiece to prevent burns to the mouth and lips. The rock of crack is placed on a “screen” securely wedged into the end of the tube, heated and the vapors are inhaled. The screen should comprise several layers of small gauge brass mesh ⁽¹⁾. In the absence of access to the resources described above, “pipes” to smoke crack are often made from a number of readily available materials. Aluminum pop cans are frequently used; the rock of crack is placed on a screen over a hole made in the body of the dented can and the vapors from the heated crack are inhaled through the opening in the top of the can. There are also reports from Brazil that yoghurt pots may be used in the same way ⁽²⁾. Metal piping is used alone or often as the stem of a pipe, the bowl of which is a pill bottle; the rock of crack is placed on a screen on the top of the bottle and the vapors inhaled through the metal stem. Medicinal inhalers are also commonly used, as is steel wool for the screen.

1.3 What Physical Harms are Associated with Smoking Crack?

Chronic cuts, burns, blisters and open sores inside the mouth and on the lips and gums are a frequent consequence of using these makeshift pipes through sustained contact with hot smoke and hot metal ⁽³⁻⁶⁾. These injuries to the oral cavity, as well as cuts and burns to the hands, also arise when smoking with a glass stem, splintered and broken through multiple use ⁽⁶⁾. There is increasing epidemiologic evidence that suggests that these injuries promote the parenteral transmission of the hepatitis C virus (HCV) and human immunodeficiency virus (HIV) through blood-to-blood contact when smoking devices are shared among users; the risk of transmission of HCV and HIV is possible due to the combination of infected biological fluids and mucosal membrane trauma. Specifically, crack users with oral sores may be exposed to the potentially infectious blood left on the pipe by other smokers with mouth injuries ⁽⁶⁻⁸⁾. This epidemiologic evidence has recently been substantiated by virologic evidence documenting the presence of HCV on a glass stem used to smoke crack by an HCV-antibody positive user ⁽⁹⁾. There is also strong evidence that crack and crystal meth smokers increasingly

engage in risky sexual behaviour such as multiple unprotected sexual encounters, anonymous sex and trading of unprotected oral sex for money or drugs (4, 10-12).

1.4 A Growing Concern

Over the past decade, the non-injection use of crack cocaine has risen dramatically in many Canadian cities (13-17). For example, a pan-Canadian surveillance study documented that almost two thirds (63%) of 3,031 active injection drug users (IDUs) recruited between 2003 and 2005 reported smoking crack, with over three-quarters smoking with previously-used equipment (16). Among 1,622 active IDUs recruited from 26 Ontario cities participating in a recently conducted evaluation of Ontario's Harm Reduction Distribution Program (OHRDP), prevalence of smoking crack was 67%. Frequency of engagement was high; close to two-thirds (64%) reported smoking crack on a regular basis (at least once a week) and 26% were frequent smokers (on a daily basis) (18). Among stimulant users, smoking crack is becoming the preferred method of drug administration over snorting and injecting due to its low cost, ease of ingestion and efficiency (16).

Crack smoking is emerging as a serious public health challenge because of the harm it poses to users and to the wider community. Negative impacts for the community are the result of much of this drug use happening in public; its impact felt by entire communities, creating a serious problem for public order (17, 19-21). A recent Ottawa study among women and men who smoke crack found that 39% of participants reported that their most common place to smoke crack was in public, with 59-69% disposing of their equipment loose in the garbage (22). It has been observed that current enforcement tactics to increase public order and decrease drug use, such as increased reliance on incarceration, supply reduction and displacing addicts, have not worked to curb public consumption of drugs and that different approaches which include the perspectives of users are needed (22).

Despite the widespread prevalence of smoking crack with its associated HIV and HCV risks, the HCV- and HIV-related prevention needs of crack smokers are poorly understood and thus have largely been ignored in the development and implementation of harm reduction programs. While harm reduction programs tailored to the needs of people who inject drugs, such as methadone maintenance and needle exchange programs, have been developed in most Canadian jurisdictions, there have been few harm reduction interventions to support people whose route of drug administration is smoking. Many researchers and front-line workers are now advocating for existing harm reduction programs to include programs specifically designed for people who smoke stimulants and opioids rather than, or in addition to, injecting drugs (15, 23-24).

Smoking crack is an increasingly complex problem facing communities in Ontario and other regions across Canada. As the popularity of smoking crack continues to grow, it carries specific public health risks as well as concerns for the broader community. Despite efforts to provide harm reduction services for people who smoke crack, little is currently known about this population to drive policy and programming practices.

2.0 Objectives

Funding for this project was received from the Ontario HIV Treatment Network (OHTN) through their Strategic Applied Research and Training (START) program. This funding allowed for the completion of two important phases of a multi-year study designed to enhance understanding of the distinct HIV- and HCV-related prevention needs of people who smoke crack.

The objectives of the multi-year program of research are to:

- Identify and characterise the HIV- and HCV-related risks experienced by women and men who smoke crack;
- Identify and characterise the HIV- and HCV-related prevention needs of women and men who smoke crack;
- Collaborate with policy makers and program managers to inform the development of culturally-sensitive, gender-appropriate HIV- and HCV-related prevention interventions for women and men who smoke crack; and,
- Collaborate with policy makers and program managers in the implementation and evaluation of prevention programming for women and men who smoke crack.

Prior to implementation of the multi-year study, preliminary work needed to be undertaken to inform the research themes and questions to be addressed. **The START project reflects the initial phases of this program of research investigating and responding to the HIV and HCV prevention needs of women and men who smoke crack.** Our program of research is comprised of four distinct phases, each with its own objectives and activities, and each building on and integrating the objectives and findings of previous phases. Highlights of each phase are described below.

PHASE ONE

The need for this program of research emerged through our work evaluating Ottawa Public Health's *Safer Crack Use Initiative*. Through this process, we became acutely aware of this emerging group of drug users and their complex HIV- and HCV-related challenges. During analysis of the evaluation data we also became aware of the limited literature relating to this population. We applied for and received competitive funding through CIHR's Knowledge Translation Strategy to complete the first phase of our research program - a review of literature titled *Effectiveness of Harm Reduction Programs to Prevent HIV and HCV Transmission among People who Smoke Drug: A Systematic Review*.

PHASES TWO and THREE

The START project comprised the second and third phases of our research program – a developmental study using an iterative mixed methods study design. Data collection methods included focus groups and in-depth interviews to establish a broad understanding of the parameters around engagement in risk and prevention behaviour and practices. Themes from the focus groups and interviews were used to design a

quantitative questionnaire that was pilot-tested with people in Ottawa who smoke crack. Completion of these essential tasks through the auspices of the START grant have ensured the development of a culturally-competent pilot-tested survey instrument on which to base our application for funding to undertake Phase 4 of our program of research.

PHASE FOUR

Building on our team's work during the previous phases of research, using qualitative findings from the focus groups and in-depth interviews and results from the pilot structured interviews, we have developed and submitted a large multi-site proposal to examine the needs of people who use crack in the regions across Ontario. The unique and timely information that will be gained from this extensive program of research will provide a better understanding of the social, cultural and economic realities that affect people who smoke crack and their HIV- and HCV-related prevention needs. The evidence generated, including levels of HIV and HCV prevalence, will drive policy and program development to provide tailored HIV and HCV prevention services to a level at least comparable to that provided for women and men who inject drugs.

We have included below a summarized schema of our Safer Inhalation Program of Research characterising and responding to the HIV- and HCV-related prevention needs of women and men who smoke crack (refer to Figure 1).

Figure 1: Safer Inhalation Program of Research Schema

*** Note: Activities undertaken through resources of the START grant appear in bold typeface.**

PHASE	OBJECTIVES	METHODS
<p>ONE</p> <p>Knowledge Investigation/ Knowledge Transfer</p>	<p>To examine the research and grey literature on the effectiveness of harm reduction interventions to reduce the harms associated with smoking crack, other stimulants and opioids, including but not limited to, safer crack-smoking distribution programs and safer drug consumption rooms.</p> <p>To provide fora for discussion of findings with a wide range of key policy makers, legal experts, frontline workers and users themselves to craft the most efficient knowledge transfer strategies tailored to each group with the ultimate goal of reducing the harm associated with smoking crack through policy and program re-formulation and development.</p>	<p>Systematic Review</p> <p>Interactive workshops to design knowledge transfer strategies.</p>
<p>TWO</p> <p>Knowledge Creation: Qualitative Component/ Knowledge Transfer</p>	<p>From the perspectives of crack smokers themselves, to gain a specific and enhanced understanding of the impact of individual risk behaviours and personal and structural risk conditions which are contributing to the high levels of HIV and HCV infection among people who smoke crack.</p> <p>From the perspectives of crack smokers themselves, to gain a specific and enhanced understanding of their needs for HIV- and HCV-related interventions.</p> <p>To provide fora for discussion of findings with a wide range of key policy makers, legal experts, frontline workers and users themselves to craft knowledge transfer strategies with the ultimate goal of reducing the harm associated with smoking crack through policy and program re-formulation and development.</p>	<p>Focus Groups</p> <p>In-depth personal interviews</p> <p>Interactive workshops to design knowledge transfer strategies.</p>
<p>THREE</p> <p>Knowledge Creation: Quantitative Component</p>	<p>To receive feedback from a small subset of participants as to the acceptability of the quantitative survey instrument to be administered in Phase Four to include comprehension and inclusivity of questions, structure of the instrument and interview length.</p>	<p>Pilot structured survey</p>
<p>FOUR</p> <p>Knowledge Creation: Quantitative Component/ Knowledge Transfer</p>	<p>Identify and characterise the HIV- and HCV-related risks experienced by women and men who smoke crack.</p> <p>Identify and characterise the HIV- and HCV-related prevention needs of women and men who smoke crack.</p> <p>Collaborate with policy makers and program managers to inform the development of culturally-sensitive, gender-appropriate HIV- and HCV-related prevention interventions for women and men who smoke crack.</p> <p>Collaborate with policy makers and program managers in the implementation and evaluation of prevention programming for women and men who smoke crack.</p>	<p>Province-wide structured survey</p> <p>Interactive workshops to design knowledge transfer strategies.</p>

3.0 Methods

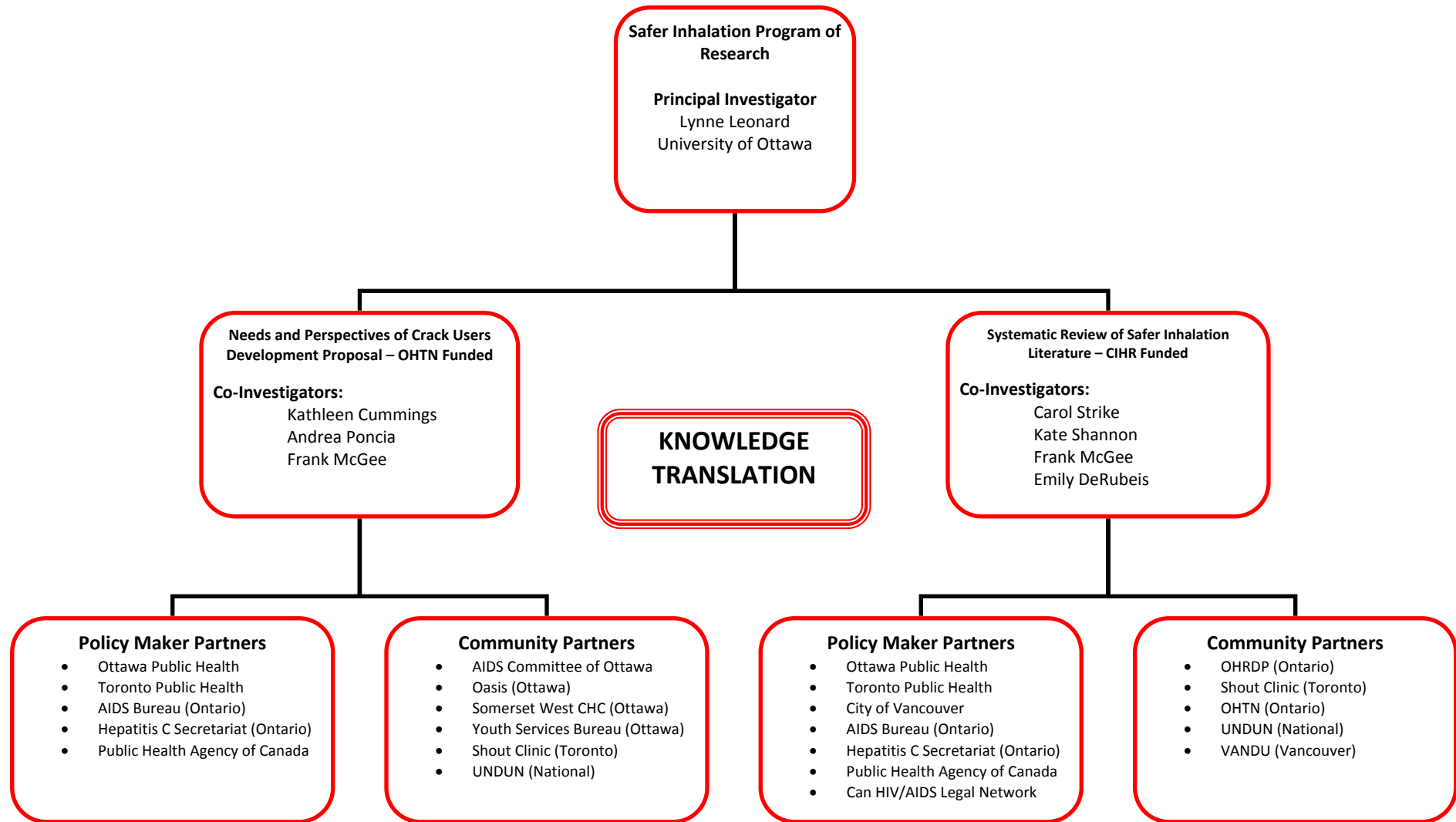
3.1 Knowledge Transfer

As part of a broader program of research, knowledge transfer has been an integral part of the study design, operationalised throughout the three phases of the project in order to ensure upfront engagement of end-users of the data and thus to promote and encourage the translation of the knowledge into policies and programs. To facilitate the transfer of the knowledge to be generated, the project engaged a team of investigators and research partners that was comprised of representatives from community, academia, and those in decision making roles – refer to Figure 2 *Safer Inhalation Program of Research Partners*. To further broaden community engagement, a three-part workshop series was hosted with stakeholders from across the country in order to draw from a range of expertise to ensure that project goals and outcomes remained aligned with the needs and mandates of policy makers and service providers more broadly.

Specifically, a preliminary workshop was hosted at the outset of the project in May 2008 to discuss the overall purpose, goals and objectives and to ensure alignment of project goals with the needs and priorities of stakeholder groups. Such discussion allowed for fine-tuning of questions to be addressed during the focus groups. A second workshop in November 2008 provided an opportunity to discuss preliminary findings from the focus groups and seek input to the in-depth interviews and development of a quantitative questionnaire. A third and final workshop was convened in October 2010 with project stakeholders to have a more in-depth discussion about the research findings and to determine key programming, research and policy recommendations for specific audiences.

In general, there was consensus that the majority of key findings from this research project (results from focus groups and in-depth interviews with people who smoke crack) are common to the realities of people who smoke crack in other regions across the country. While some challenges have been or are being addressed in other regions, many of the issues identified through this research project remain major concerns in need of attention across the country. Refer to Appendix - *Research to Policy and Practice: Safer Inhalation Knowledge Translation Workshop Series Report* for a full account of workshop proceedings.

Figure 2: Safer Inhalation Program of Research Partners



3.2 Data Collection

As an exploratory study, a sequential mixed methods design was adopted comprising: an initial series of focus groups among diverse groups of crack smokers; in-depth personal interviews to further explore themes raised in the focus groups; and structured pilot interviews using a questionnaire developed out of the themes raised in the two qualitative components.

To be eligible to participate in each phase, participants were required to:

- be capable of informed consent;
 - have smoked crack within the month prior to interview AND not to have injected drugs in the six months prior to interview (Crack Only);
- OR**
- have smoked crack within the month prior to interview and to have also injected drugs in the six months prior to interview (Dual User)

The complete START proposal including all data collection instruments were reviewed and received approval from the Ottawa Hospital Research Ethics Board.

Focus Groups

Focus group discussions are a type of interview designed for the purpose of gathering data about a specific topic from a group of individuals. Using purposive sampling guided by predetermined selection criteria, recruitment into the focus groups was assisted by our community and peer partners. In an effort to achieve representation of diverse experiences, participants were assigned to focus groups according to their age, gender and drug use (crack smoker only vs. crack and IDU dual user). We also conducted two focus groups with Aboriginal men and women. A total of ten focus groups were conducted between August and September 2008 comprising between three and twelve participants in each group (refer to Table 1).

There were originally five focus groups planned, however in order to achieve representation of all demographic groups, it was necessary to hold 10 focus groups. The groups were co-facilitated by a member of the HIV and Hepatitis C Prevention Research Team and a peer member of the drug-using community. The sessions were audio-recorded and participants were compensated \$50 for their time spent away from other tasks and the costs of traveling to the interview location. Drinks and snacks were also available for focus group participants.

The focus group sessions were transcribed verbatim with the exception of removal of all identifying information including names of people, places, and community agencies. Transcriptions were verified comparing the audiotape to the text and independent analysis was conducted by the Principal Investigator and Research Coordinator. Using a modified "open coding approach", the next phase of team analysis was line by line analysis to identify and categorise similarities, contrasts and potential connections among key words, phrases and concepts within and among each of the focus groups.

The emergent main themes and subcategories of themes were summarised with the addition of phrases or quotes that most accurately represent the identified themes (45).

Table 1 – Focus Groups

Focus Group	Population	Number of Participants
FG1	Female – Dual User ²	4
FG2	Female – Crack Only	6
FG3	Male – Dual User	12
FG4	Male – Crack Only	10
FG5	Young Female – Dual User	9
FG6	Young Female – Crack Only	3
FG7	Young Male – Dual User	3
FG8	Young Male – Crack Only	3
FG9	Aboriginal Male – Crack Only	8
FG10	Aboriginal Female – Crack Only	9
TOTAL		N = 67

Personal In-Depth Interviews

Analysis of the focus groups revealed gaps in information about particular sub-groups of people who smoke crack. The individual interviews were used to further explore the experiences of these specific groups of people who smoke crack including, trans-populations, men who have sex with men, and people (men and women) involved in sex work. Recruitment of participants for the in-depth personal interviews was assisted by our community and peer partners. Between May and June 2009, 10 individual in-depth interviews were conducted (refer to Table 2).

With the participant’s consent, the interview was audio-recorded and participants were compensated \$50 for their time spent away from their other tasks and the costs of traveling to the interview location.

Analysis of the transcribed interviews was inductive and took place throughout the data collection period, thereby informing the focus and direction of subsequent interviews as well as the need for further purposive recruitment to further validate emerging themes.

² “Dual user” refers to a person who had smoked crack within the month prior to interview and also injected drugs in the six months prior to interview.

Table 2 – In-Depth Interviews

Population	Number of Participants
Female - Sex Worker	4
Male - Sex Worker	2
Male – MSM (Men who have Sex with Men)	3
Transgender Female	1
TOTAL	N = 10

Structured Interviews – Pilot Test

Findings from the qualitative portion of the study were used to develop a quantitative structured questionnaire that was pilot-tested with 10 people in Ottawa who smoke crack. The questionnaire was tested for clarity and flow. Participants were asked to provide feedback on individual questions as well as to the overall flow of the questionnaire. Participants were compensated \$50 for their time spent away from their other tasks and the costs of traveling to the interview location.

4.0 Findings

The discussions during focus groups and in-depth interviews centred around the following thematic areas: context of drug use and smoking patterns; knowledge of harms associated with smoking crack; experience with stigma and discrimination (health services and law enforcement); knowledge and use of health services; and suggestions for crack user-tailored programs.

Table 3 – Focus Group Participant Demographics

Sample size	N=67 (46% Female, 54% Male)
Age (years)	Average female: 32, Average male: 36
	33% under age 25, 13% over age 50
Ethnicity	55% Caucasian, 39% Aboriginal, 6% Other
First Language	55% English, 19% Aboriginal Languages, 15% French, 11% Other
Unstably Housed	75% (71% of female participants, 92% of male participants)
Annual Income	57% made less than \$10,000 (65% of female participants, 50% of male participants)
	33% made between \$11,000 - \$30,000 (26% of female participants, 39% of male participants)
Source of Income	51% welfare (39% of female participants, 61% of male participants)
	36% dealing/drug runs (35% of female participants, 36% of male participants)
	34% panhandling (35% of female participants, 33% of male participants)

Table 4 – In-Depth Interview Participant Demographics

Sample size	N=10 (4 Female, 1 Trans-Female, 5 Male)
Age (years)	Average female: 32, Average male: 46
	3/10 under age 25, 4/10 over age 50
Ethnicity	8 Caucasian, 1 Aboriginal, 1 Black
First Language	7 English, 3 French
Unstably Housed	6/10 (4/5 of female participants, 2/5 of male participants)
Annual Income	6/10 made less than \$10,000 (2/5 of female participants, 4/5 of male participants)
	3/10 made between \$11,000 - \$30,000 (2/5 of female participants, 1/5 of male participants)
Sources of Income	7/10 welfare (4/5 of female participants, 3/5 of male participants)
	7/10 sex work (5/5 of female participants, 2/5 male participants)

4.1 Smoking Practices and Contextual Factors

The context in which crack smoking occurs may be impacted by and may have implications for whether people are practicing safer smoking techniques. A number of contextual factors were explored in this study. Included amongst these factors were: the availability of crack; where people use crack (inside or outside); with whom people use crack (alone or with others); and, how people use crack - whether it is injected or smoked, what factors determine whether it is injected or smoked, and when smoking, what materials are used to smoke crack. As well, this study explored the factors that impact (facilitate or contravene) the collection and use of smoking resources as well as the safer disposal of used smoking materials. The following sections provide a summary of themes that emerged through analysis of the focus groups and in-depth interviews.

4.1.1 Availability and Quality of Crack

According to participants in this study, crack was readily available and affordable in Ottawa. In fact, it was suggested that crack was more accessible than marijuana. In terms of drug quality, participants reported to have been sold substances such as soap or wax in place of crack, and there was discussion about the physical and psychological effects of chemical additives such as crystal meth and formaldehyde in the crack available in Ottawa. Among the physical and psychological effects mentioned were hair loss, itchy skin, excessive drug jonesing or “fiend-like” behaviour, and stealing. Participants suggested that in addition to the provision of safer smoking supplies, there is a need for increased attention to “what’s being put in the crack pipe”, in other words, the quality of crack and its effect on people. However participants in this study claimed that knowledge of poor crack quality was unlikely to reduce people’s use of crack.

“It’s more easy getting crack at 4 o’clock in the morning than you can get a beer on a Sunday morning in Ottawa. So, uh, it’s really easy.” (Female in-depth interview participant - sex trade worker)

“...There’s not one place in Ottawa. I know Ottawa from East, West, North, South, there’s not one place that in no more than five minutes I can get what I want.” (Male interview participant - MSM)

“Just that it seems to be getting scary, what they’re putting in the drugs lately. Like they’re mixing in the crystal meth and all that...It seems to be getting worse and worse. There’s so much crap that they’re mixing, in you’re not even smoking crack anymore. You don’t know what you’re smoking...” (Male in-depth interview participant - sex trade worker)

“...We didn’t have this problem with the quality like 5, 10 years ago. I don’t think anyhow. It wasn’t here...this is something that’s been recently really bad – there’s been shit in the crack, right? Like how are we going to address this?” (Male in-depth interview participant - sex trade worker)

“...The price hasn’t gone down or hasn’t gone up, but the quality and quantity has lowered dramatically, dramatically...” (Female in-depth interview participant - sex trade worker)

“... It’s the substance, the added substances in order to make it look bigger and make it look larger, whatever they are adding to it. They are cutting down the actual cocaine in it and it is having side effects and that’s why people are lying, cheating, stealing, robbing.” (Female in-depth interview participant - sex trade worker)

“...But there is somebody that’s mixing this shit, and it’s killing us off. I mean I had somebody turn around and rip me off and give me wax. At least wax ain’t gonna kill me, its just gonna dissolve right in the pipe. But in the other thing, I don’t understand it. That’s dangerous.” (Female in-depth interview participant - sex trade worker)

“I lost half of my hair. That’s from that shit. And me being sick with the HIV and the Hep C, its not good. It’s like...I’m celebrating my body. And another thing too, when you’re doing the smoke, your body goes itchy. Your body shouldn’t fuckin’ go itchy from smoking crack.” (Female in-depth interview participant - sex trade worker)

“...With the crack right now, I’m completely lost on this. I’m 40 years old. 20 years ago, they never had none of this shit like this. I mean it’s getting worse. And what the hell are they putting in it? They say oh cause of crystal meth, they’re doing this. But I mean, I think a lot of it that everybody is putting different levels, but they need to do more focusing on that crack pipe. And what’s being put in the crack pipe.”(Female in-depth interview participant - sex trade worker)

“...You learn, you see it in the face of the dealer. You can see it in the face of the dealer if their coke’s good...You never know the quality of the coke before you buy it. You never know. So I cannot tell you the quality of coke is pretty good and I don’t think that any of us that use...for me it’s in the past for the last few months that I don’t use. But there’s not one user who’s going to tell you, ‘this guy’s got good coke, this guy no’. Everybody is going to tell you it’s shit, we know we’re buying shit, but we need that fucking shit.” (Male in-depth interview participant - MSM)

4.1.2 Smoking Locations

When asked about their preference for smoking crack indoors or outdoors, a preference for smoking indoors was often related to one or more of the following factors: a user's wish to keep their drug use private; a preference for smoking alone and/or not wishing to share drugs; a user's tendency to experience paranoia or to engage in socially unacceptable behaviour when high on crack; and, the fear of being caught smoking crack by police. According to study participants, despite a preference for smoking crack indoors, the availability of a home (one's own or another person's) or other safe indoor place to use impacted their ability to smoke crack inside.

Lack of availability of a home or safe indoor space forced many people to smoke crack outside, which contributes to additional risks to the user (less safe physical locations, uncontrolled social environments or risk of being caught by the police) and risks to the community (public crack smoking and unsafe discard of used crack smoking devices). Further, among those who did have a home, there was a fear of smoking crack at home related to the tendency for one's home to quickly be labeled a "crack house", even in the absence of crack dealing. Many participants suggested the need for a safe place to smoke – a designated outdoor location (park) or an indoor safer smoking facility.

"Yeah, I smoke outside more because we don't have an apartment any more. We live in a shelter now... Right now we're smoking on the street." (Female dual user focus group participant)

"I like using outside in parks and stuff but it makes me so much more sketchy. I just like really like the feeling of being outside and being alone and like this field or in the woods or somewhere, like I really like that. But it's hard to find a place that's not like, 'Oh that's city.' Or that's safe or something." (Younger female dual user focus group participant)

"You don't want to do it in public, you don't want to do it in the general population because of the fact that there's lots of people who don't do it and you don't want to do it around children." (Male crack only focus group participant)

"I used to smoke out in the park a lot. I always smoke along the street, behind an ally, behind a building, behind a parked car, in the park." (Female in-depth interview participant - sex trade worker)

"Like [name of location], I think every city should have an area like that, that they can go, especially Ottawa because...everything is right down where all the homeless people are and they're complaining. They should make a little area, you know, give them a park cause that's all they want is to sit in the park and do a blast, they're gonna have it anyway so you know, so they don't have to sneak behind this building and sneak behind that..." (Female dual user focus group participant)

"They make it pretty hard in general, there's no place to use unless you got your own place and you usually got 3 tokes and 100 people there and then they call it a crack house. And people are polite and there's no ignorance going on and there's respect for everybody in that room, they still want to call it a crack house, but it's not, it's just

somebody's apartment where everybody's using..." (Male crack only focus group participant)

"But, that's what, like the parks, stuff like that, you know. I think areas like that are just, you know, make a little area. Okay, well you know, maybe it's not gonna be a pretty sight all the time but you know like, wouldn't the government rather have, like you know, one area than having it all spread around?.. like with the tourists and all." (Female dual user focus group participant)

4.1.3 Age and Crack Smoking

Throughout the focus groups and interviews, age emerged as a distinct factor in crack smoking practices and consequently in vulnerability to risk for HIV and HCV. Chief amongst participants' concerns was the age limit (age 18 and over) placed on agency distribution and therefore, on the collection of safer inhalation equipment in Ottawa.

Younger participants referred to crack smoking in the context of the public school system, suggesting inappropriate and insufficient education for youth. Younger users also referred to being taken advantage of by older users, particularly in transactions that involved sex and crack. Some experienced users reported a reduction in their crack use to the point where it is a more manageable habit. It was further suggested that experienced crack users may be a valuable resource to provide advice and mentorship to younger peers who smoke crack and many indicated an interest in helping younger users.

"...When I was 17, I went to the [name of agency] and they wouldn't [give me safer inhalation resources]. I gave them a fake birthday and everything but nope. 'No, sorry, you can't'. OK so I'm 16 and I want to smoke crack, but because I'm 16 and not 18, they're going to put me at risk, so whatever." (Younger female dual user focus group participant)

"You think they'd try to protect the young, you know...Like, they ask if you're young and then they fucking... 'No, you can wait until you're older because you're not allowed to use our services when you're young and actually are at risk'..." (Younger female dual user focus group participant)

"I got denied here at [name of agency] because I wasn't old enough ...I made a big fuss about it. I'm like, 'OK, fine, then I'm going to go use someone else's crack pipe. Like how are you going to deny me a freaking crack pipe?'... I ended up finding some means of getting high that night, but I was just really shocked that I couldn't get a crack [pipe], like I asked for it...Whether or not you give someone a crack pipe, you're not going to stop them from smoking crack. They're going to find another way. They'll go pick a freaking can out of the garbage if it takes that you know." (Female in-depth interview participant - sex trade worker)

"We asked for a stem. They said, 'No' because we were too young. So then we went to [name of agency] and we got one. So stuff like that. Even if you're thirteen, you should be able to come in here [name of agency] and get a stem. Even if you're ten. I know it

sounds fucked up, but you should be able to...Because you need to be safe about it right. If you're starting when you're 13, you could be fucked up by the time you're 15. You can have something serious, you know what I mean? With needles and shit? I just think it's really, really important...If I wasn't as planned out as I was, I'm pretty sure that I'd have something. If I wasn't crazy about health stuff, I'm pretty sure I'd have it. But I think it should be offered to anybody. Any age, it doesn't matter.” (Female in-depth interview participant - sex trade worker)

“Well, they use me for sex. So they, like, they use me to do runs, drug runs, or to go and do certain things. Like, I'm always the go-to guy... I'm kind of used to it now because I know that's just kind of just how society works. The young one is the person to be treated that way. Doesn't mean I like it, but it just means that I'm used to it at this point. I don't really...it doesn't faze me anymore. I know that eventually I'm going to get older, and its going to not be me then. Just have come to some sort of a realization.” (Male in-depth interview participant - sex trade worker)

Many participants articulated the potential of experienced older users to contribute to educating and mentoring younger peers who smoke crack.

“We're slowing down so much now. We're kind of becoming weekend smokers, more or less, rather than daily users like we used to be.” (Male in-depth interview participant - sex trade worker)

“I would like to see old users [in peer roles] because old user[s] have a lot of power over young user[s]. You don't know how much power they have. They are so powerful that if you had an old user that talks to a young user, the young user will listen right away. There's a connection, there's a bond in between. So the first time that person comes to get the tool, he meets the guy. The next time he comes, he does more than meet the guy, he sits down and he says, 'You don't know what happened to me. I got fucked..dah, dah, dah, dah...' And the talking begins and the cure for him to stop using begins [at] that point, at that level. But we don't have that in [name of city] yet... We have some and those we have, some of them I've met, think too much of themselves today. They don't remind, they don't remember being there. I think, and that is what makes a good worker: remembering where you come from.” (Male in-depth interview participant - MSM)

“Yeah, I have a lot of friends that are older users... when I'm using I feel a lot more comfortable when they're around. If something goes wrong or if I start freaking out, I just kind of feel like they know what to do like because they've been using for so long right?” (Female in-depth interview participant - sex trade worker)

“Well just overall, I mean, you don't want to see, you know, people die...You don't want to see people get sick, you know that the younger new users, they're gonna keep using, their gonna keep, so you want them to be safe and all...I look at the younger people and I think 'God, if someone would have'. You know, like me, when I see young people using or whatever, I try to say like 'Man, quit now. I've lost everything in my life so many times.’

You know, like, so I do kind of do to the young people what I wish someone would have done for me, you know what I'm saying?" (Female dual user focus group participant)

4.1.4 Gender and Crack Smoking

The social relationships between women and men that are connected with crack use may impact risk-taking in terms of exposure to HIV and HCV. Power dynamics between men and women and particularly male dominance, were articulated by participants in this study. These power dynamics, often involving coercion and violence, are heightened during sexual encounters or in situations where crack is being exchanged for sex. This will be discussed in greater detail in the following *Crack and Sex Work* section.

"But I find, especially when crack's concerned, you know the whole - 'I gotta pimp you out, you're my bitch'. Like, a lot of women, especially when they're doing the drug, they don't get a lot of help in that area" (Male crack only focus group participant)

"...I've noticed a lot to do with working girls that they seem to get on this merry-go-round...I think that maybe it's their emotions or an emotional thing that they...There's a lot of girls out there that are, most of them are damaged, really damaged by the work you know. Maybe the work is too heavy on their heads. And so they get into this vicious circle where they need to get high to, to get away, over their emotional pain and they're running to make more money and then they're running, you know, to get, and it's just, it's a big merry-go-round and it's just sad. It's a sad thing". (Female in-depth interview participant - sex trade worker)

"And there's one other guy, and he likes to slap you in the face before he has sex with you. Or he wants you to bend down, and he wants you to take a toke off a pipe and then he wants to hit you. It's like he wants you to be a slave, or whatever. (Female in-depth interview participant - sex trade worker)

4.1.5 Crack and Sex Work

The in-depth interviews allowed for exploration of the impact of crack use on risk-taking during sexual encounters. The findings represent experiences from in-depth interviews with people involved in sex work - men and women; men who have sex with men; and trans-populations.

Crack may be exchanged for sex. In these situations, an individual's need or urgency for the drug may be used by the drug holder to negotiate sexual acts (e.g., sex without a condom), many of which are associated with higher risk for potential exposure to HIV and HCV. This negotiation often occurs within a power dynamic that is characterized by violence and where the drug holder (and purchaser of sexual acts) is in control.

According to several interview participants, crack is a stimulant that enhances sexual feelings and sensations of arousal among men. Further, being high on crack reduces an individual's inhibitions which may lead to greater risk-taking during sexual encounters and that may contribute to greater exposure to HIV and/or HCV.

Finally, on account of stigma and shame associated with sex work, people can get into a vicious circle where they smoke to escape lived experiences or to forget about their sex

work – the means to support their drug habit. This is often the case for women and may also be the experience of male sex workers or men who have sex with men. These men often experience internalised homophobia in addition to facing the stigma and homophobia of their sexual partners.

“I rarely ever pay for drugs...Yeah, I have a few friends if you will, like sugar daddies and they give me money or whatever I want basically.” (Female in-depth interview participant – sex trade worker)

“...Because if you say [use a condom], you get a broken nose. You get a broken jaw and they have fun, after the first one they give you, they have fun. You have to prevent the first one. Because if you don’t prevent the first punch, the rest is, you’re gonna get.” (Male in-depth interview participant – MSM)

“With a straight man, you cannot bring up the subject of condom too much. You cannot bring the subject of HIV...Because you are overwhelmed by his presence, by his power and by the coke he is providing. Cocaine is everything. Sucking your dick is nothing. Cocaine is everything. So he’s overpowering. He’s overpowering you already, so one puff, ‘I’ll give you a good one.’ He gives her a good one and after that, he gives a small one and after that he’s... I’ve seen it happen. Ok, he takes control of the other one. Completely, in any way and in every way. The other for uh, ‘Do the dog. Ruff, ruff, ruff’. ‘Alright, bark like a dog on the floor.’ The guy will go on the floor and he’ll bark like a dog. ‘Lick my foot, lick my finger, suck my big toe’. “ (Male in-depth interview participant – MSM)

“And that’s where the girls are, and that’s where I think all the trouble is that the girls are getting themselves into, not using that condom just so they can get something to smoke. Or the man has some stuff and ‘here I’ll give you another piece if you let me have sex without a condom’. And that’s where the high risk is.” (Female in-depth interview participant – sex trade worker)

“Yeah, [sex] just feels better...just better, more intense... I don’t know how to describe it any better than that, just more intense.” (Male in-depth interview participant – sex trade worker)

“.. Ok, when I do puff, I think that someone’s playing with my dick and my dick becomes hard like that and I don’t see nobody around me and I have the feeling of somebody’s playing with my dick, but there’s nobody. So certainly, sometimes when your dick is like that and you see another dick like that, what do you do? ...You take the other one and the other one takes yours and it goes on and on and on and on. Cocaine brings that to me. I am not the type of person that will do that...would do sex with men normally. I did that only on the influence of cocaine...[Before] I use with syringe or puff, I go in my apartment and I lock the door because I could be too much of a problem to society. They would have locked me up. They would have locked me up. You’re sitting on a corner jacking off when you see people. Like, you can’t do that in [name of area]...”

The police will [catch] you and bring you to the hospital and you will stay there for a couple of months. So my use of cocaine brought that to me.” (Male in-depth interview participant – MSM)

“It’s just, OK, when you smoke, you want to come. You want to get an orgasm. But the thing is, you cannot get an orgasm. That’s why people smoke and they keep smoking. Its like the supreme, the highest orgasm you can get when you smoke crack. But the thing is, you don’t get the orgasm. The only way you can get an orgasm is when you’re straight...” (Male in-depth interview participant – MSM)

“Well it’s unhealthy. It makes you really sketchy. It makes you paranoid. Unprotected, unsafe. Just, inhibitions are gone. I was with someone who I got HIV through using meth and being unprotected myself. So just the idea of someone who’s not doing meth or crack, it’s the same thing. You lose your inhibitions. You have sex, and you keep going, keep going, keep going. And clearly, after awhile you just...you’re going to have a few issues. I can see someone getting HIV or something very easily from that type of practice.” (Male in-depth interview participant – sex trade worker)

“Well, I’ll tell you what. When a man smoke crack with another man, there’s no protection. Forget about it. Free for all. Free for all. You go to some bath and sauna in [name of location], you can smoke there, never seen people with condom there. Well some of them [do use condoms] but they’re not on crack”. (Male in-depth interview participant – MSM)

“There’s a lot of girls out there that are, most of them are damaged, really damaged by the work you know. Maybe the work is too heavy on their heads. And so they get into this vicious circle where they need to get high to, to get away, over their emotional pain and they’re running to make more money and then they’re running, you know, to get, and it’s just...It’s a big merry-go-round and it’s just sad. It’s a sad thing.” (Female in-depth interview participant – sex trade worker)

“Like when I was doing the whole sex trade thing, I’d smoke before I did it and then I’d smoke after I did it. So I’d forget right. Because really I’m not there because my brain’s not actually thinking. I’m just doing. It’s almost like if I give myself tasks to do when I’m high, I know those four tasks are there so when those tasks are done, then I’d smoke and it goes away, but the next day it’s still there. But it’s not as permanent or is like as fresh as it should be. You know what I mean?” (Female in-depth interview participant – sex trade worker)

4.1.6 Smoking versus Injecting

Participants included people who only smoke crack (crack only) as well as people who smoke crack and inject drugs (dual users). As the risks associated with injecting drugs are different from those associated with smoking crack, there was an effort made to gather information about what leads dual users to either inject or to smoke.

Among dual user participants, frequent transitioning between injecting drugs and smoking crack was reported. Many of these participants indicated a preference for

injecting drugs other than crack, making crack a last resort drug. While some did prefer to smoke crack, there were others who viewed injection as the best mode of administration for crack. This preference was due to a “better high” from injecting versus smoking and also related to not wanting to have the push (resin in the stem) – they preferred the finality that comes with injection – once the drug has been injected, it is gone.

When asked about the factors that influence whether a person will smoke or inject crack, a number of considerations were presented. For people who prefer injection drugs other than crack, the availability and source of other drugs was a primary factor in determining whether the person would use crack or inject other drugs. For people who indicated a preference for injecting crack over smoking crack, the availability of equipment (injecting equipment versus smoking equipment); time and effort involved in preparing to inject versus to smoke; and the availability of a safe place to inject were among considerations that people take into account when deciding whether to smoke or inject. Finally, it was suggested that the provision of stems for smoking crack may contribute to overall reduction in the frequency of drug injection.

“If there’s no downs around, you’ll pick up anything. Smoke crack until you find something. You need something man, you know...” (Younger male dual user focus group participant)

“Also, what would make you choose to do it is who you’re getting it from. For me, to buy powder on the street... If I knew the person, I would trust it, if I didn’t know the person, if I did anything, I would take the rock.” (Female dual user focus group participant)

“In any situation, I’d rather inject something than smoke it. When you smoke it, there’s always the god damn push in your pipe and you can sit there and do it for hours and hours and hours and people buy your push off you. If you rig a crack rock and shoot it, then there’s nothing left. Nothing left, it’s gone.” (Younger female dual user focus group participant)

“I think there are environmental factors at play if you want to inject. I mean, if you’re on the street, like you don’t really want to shoot up anywhere so you might keep smoking. Whereas, you might get caught if you’re sitting there preparing it for a few minutes to inject it.” (Younger female dual user focus group participant)

“If I scored a piece, it would, you know, be easier and more work than go and get the drug, break it down and inject it as opposed to, if I didn’t have a good pipe, finding a can, like you know what I mean, or finding something to smoke it on where I would waste it so having the pipes is stopping a lot of people from injecting, you know.” (Female dual user focus group participant)

4.1.7 Materials Used to Smoke Crack

When investigating the HIV and HCV prevention needs of people who smoke crack, it is important to consider people’s experience with and use of safer smoking resources provided through community agencies and mobile services in Ottawa. In particular,

participants were asked about their use of glass stems compared with their use of other devices (e.g. pop cans, medicinal inhalers), as well as their use of mouthpieces and brass screens that are provided as part of the safer inhalation kits.

Most participants indicated that they use glass stems whenever possible, however, most indicated use of other devices (pop cans, medicinal inhalers, etc.) as well. According to participants in this research, mouthpieces were rarely used. Reasons for not using mouthpieces included not liking the mouthpieces, finding them difficult to put on and remove from the stem, and interfering with 'doing the push'. While many participants use the brass screens provided, some voiced preference for using brillo. In terms of reaction to resources provided, some participants suggested offering longer mouthpieces as well as stainless steel screens as opposed to brass. In addition, there were comments about the strength of the glass stems and perhaps the need for a stronger material.

"I rarely see a pipe with a mouthpiece on it. Rarely. Like sometimes, I'll borrow one and they'll take the mouthpiece off, let me use it, and then put it back on themselves. But I rarely borrow a stem with a mouthpiece on it." (Male dual user focus group participant)

"Yeah, but that's absolutely, I think, that's a big thing, getting them on. Nobody...you know, I need to use your stem, I don't have enough time to friggin' put that thing on, you know. But if it was something, yeah, that could just clip on quick, like that, yeah..." (Female dual user focus group participant)

"Those things [mouthpieces] are so hard to get on and off. I don't want to be fumbling with this for 20 minutes." (Aboriginal female crack only focus group participant)

"I honestly rarely see any mouthpieces. And like, the most common ones I see are the hoses [longer mouthpieces]." (Young male dual user focus group participant)

"No, it [the brass screen] clogs too much." (Male crack only focus group participant)

"...Ha, I only use the mouthpieces when I was using a metal pipe and I didn't have a real pipe because I was in the south so there was no where to get pipes there." (Younger female dual user focus group participant)

"Oh ya, you can get the stainless steel screens, they're better than the brass – they last longer." (Aboriginal male crack only focus group participant)

"They gotta figure out a way to... I find some of them [stems] are really flimsy. We've picked them up here at [name of agency] and we didn't even do a half a [toke] in it yet and when you went to go push, it friggin, it just split and cut his hand. Some of them are really...they gotta fix that." (Female dual user focus group participant)

4.1.8 Disposal of Used Crack Smoking Supplies

When asked about disposal of their used crack smoking supplies, participants indicated that they do not dispose of their supplies, rather, they used their stems until they broke, got lost, or were stolen. Responses from participants in this study suggested a lack of awareness of the need for safe disposal of used crack smoking supplies. In cases when

participants did dispose of their used smoking materials, most indicated that they put the materials in the garbage. When asked if they ever used the bio-hazard black box disposals, many indicated that these boxes are intended for used injection equipment not smoking equipment and thus they hadn't thought of disposing of used stems in that way. Finally, it was found that smoking materials are often discarded in a hurry for fear of being caught with used smoking equipment by police. This hurried disposal contributes to an increase in used smoking equipment being discarded in the community.

“You know what’s funny? I never thought of that (putting used pipes in the drop boxes) I was supposed to? With those pipes? I don’t know... I just throw them in the garbage.”
(Male in-depth interview participant - MSM)

“I have (seen people throwing them out in the community), when cops are around, in the parks people don’t want to pocket them.” (Aboriginal Male crack only focus group participant)

4.1.9 Sharing Behaviours

Whether a person shares (lends or borrows) their smoking devices directly affects their potential exposure to blood-borne infections. This is particularly concerning when one considers the reported non-use of mouthpieces among participants in this study.

With the exception of a few participants who insisted that they never share, participants generally indicated that they have shared (lent or borrowed) pipes with others. One of the main factors related to sharing is the lack of availability of one's own or a new stem at a time when it is needed. This may be due to a user being too far from their own stem or inaccessibility (location or hours of operation) of an agency that distributes stems. In addition, on account of distribution restrictions, youth who are under age 18 may be unable to access stems. According to participants in this study, sharing of stems may be related to the convenience of using someone else's stem rather than going to get one's own or to collect a new unused one. It was also suggested that the propensity to share a stem is often directly related to an individual's urgency for the drug.

Another reason that leads to sharing lies in the fact that some people choose not to carry their own stems. People may choose not to carry stems for personal reasons. For instance, some participants in this study indicated that carrying stems is a “trigger” – that it leads to crack use or is a constant undesirable reminder of their drug use. However, more often, participants suggested that the choice to not carry one's own stem is related to fear of being caught by police. For some, it is simply the fear of being caught and charged with possession of a used crack stem, while others have parole conditions that forbid them from carrying any “drug using paraphernalia”.

A final reason for sharing that was noted among participants in this study was related to the sole purpose of collecting other people's resin – “for the push”. There are crack users who habitually lend or provide the use of their stem to others in exchange for the crack resin that collects in the stem during the process of smoking. This crack resin in the stem may be smoked at a later time. The existence of users who have this specific

objective to collect other people's resin contributes directly to the availability of used stems for use by people described above who for one reason or other do not have access to a clean stem at a time when they need one.

(What do you do if it is after hours?) "You take a can, that's at that point, you take a plastic bottle, you take a ventilator thing or you share a pipe, or you share pipes." (Male in-depth interview participant – MSM)

"I think what it is like, you can't wait to get that first toke, that morning wake up. You know where your own pipe is, it's just too far to reach. His is closer." (Male crack only focus group participant)

"If the need (for crack) is too high in you, yeah, you will accept anything to smoke." (Male in-depth interview participant – MSM)

"When I was 17, I went to the [name of agency] and they wouldn't [give me a new pipe]. I gave them a fake birthday and everything but, 'Nope. No, sorry you can't.' OK so I'm 16 and I want to smoke crack, but because I'm 16 and not 18, they're going to put me at risk, so whatever." (Younger female dual user focus group participant)

"If they're used, you're fucked cause it's used material so...If I got arrested with a dirty pipe or a dirty needle, I'd get arrested right away." (Male dual user focus group participant)

"I was always getting caught, so I leave it [pipe] at home." (Aboriginal female crack only focus group participant)

"While I was smoking it, a cop came up to me and then I tried to hide my other 10-piece but he noticed it, so he was trying to fight my hand to take the 10-piece so he did and he charged me with it. So now I'm on condition not to have any paraphernalia or any drugs." (Female dual user focus group participant)

"You know what? A lot of people have conditions and they're not allowed to carry their paraphernalia and that's not fucking right. I think that should change. Whether you're an addict or not, cause there's a lot us being an addict. And a lot of people have conditions and they can't carry pipes and I don't think that's good because they're stuck using somebody else's." (Male crack only focus group participant)

"Someone will just come out and say 'Do you have a pipe? Can I use your pipe?' And, you know, say I don't have any money at the time, and I wanna do a toke, somebody says, 'Hey, can I use your stem?'. You know, there are certain rules to using other people's stem - how many times...it has nothing to do with disease, that's not ever in the rules. It's to do with the drugs, you know. 'Sure, I have no money, I want to do a toke, you need to do a toke, here use my stem.' So, they don't get to light it twice, they only get to light it once and they can't push the stem cause when you light the crack, the resin drips down the stem, so when you're lending your stem, when you're burning it once, I'm getting all your resin from your crack, you know what I mean? So that's how people are... 'Sure, here use my stem...Oh you wanna use it too, here use it'. So I got the resin from all your tokes..." (Female dual user focus group participant)

“I honestly hate having a stem on me cause it is really craving...So I’ll be walking and I’m mostly an opiate user and like...I just had a crack pipe on me, you know...And then someone came up to me and like ‘Hey, do you got a pipe? I’ll give you a toke for it.’ And I started noticing, every time I had a crack pipe on me, I was using crack a lot more. It’s like you’re taking free dope.” (Younger male dual user focus group participant)

“Cause then it [having pipes on me] gives me more of a chance to do it...The less I can have, the better...I know, it’s a catch 22.” (Female in-depth interview participant – sex trade worker)

“Me myself, if I don’t have any crack, I look for people around or I hang around people that are buying and give them my pipe so I can get the resin so I can get high.” (Younger male crack only focus group participant)

“... And there’s one girl that comes around, and she’s the one, she says, ‘Here, you can use mine.’ And that’s where it’s being shared by probably ten or twenty girls.” (Female in-depth interview participant – sex trade worker)

4.2 Knowledge of Harm and Risk for HIV and HCV

In general, participants indicated knowledge of the harms associated with crack use, both in terms of risk for diseases (HIV and HCV) as well as other health risks involved in crack smoking. In terms of other health risks, participants mentioned weight loss; loss of appetite; skin problems; lung infections; psychological problems; and social isolation. It was also noted that such health issues have become worse with the declining quality of available crack, as discussed in the section titled *Availability and Quality of Crack*.

In terms of risk for disease transmission, participants were able to articulate the risk of transmission through open cuts or sores on the lips or in the mouths of two users who are sharing a device to smoke crack. There was a sense that risk for HCV was greater than for HIV and that risk for either disease was greater for people sharing injecting equipment than for people sharing crack smoking devices. Many participants indicated that there were some people with whom they would not share a stem. Reasons for not sharing were largely based on knowledge of a person being infected with HIV or HCV, presence of sores or cuts on the person’s mouth, or perceived general cleanliness of the other person.

While participants indicated knowledge of the risks, they felt that the risk for disease transmission was remote. That is, the chance of two people having open sores at the same time while sharing a stem seemed to be unlikely. When asked whether the risk of sharing a stem was similar to that involved in sharing a cigarette, most participants agreed that it was similar. Moreover, participants’ comments suggest that the urgency of smoking crack and the power of addiction tends to take precedence over users’ knowledge of harm and taking precaution to reduce potential harm associated with sharing crack smoking devices.

Younger participants commented on the need for improved drug education in the school system. Current drug education is ineffective in terms of discouraging drug use and is absent in terms of empowering students with knowledge of safer drug using

practices. It was suggested that involvement of drug users in education programs, speaking about their personal experiences with drug use, might have more impact in preventing drug use and enhancing safer drug practices among youth.

“Shouldn’t be sharing. Especially with us, people with HIV and Hep C. Should not be sharing the pipes because what happens is that person gets it from us, from the saliva in our mouth. Its like me right now, I have a cold sore. Now I could open up to an infection and give it to someone, this might turn into herpes.” (Female in-depth interview participant – sex trade worker)

“It [sharing smoking devices] doesn’t really bother me. In my mind I can’t see. I can’t see how you’d really catch a disease from it.” (Male in-depth interview participant – MSM)

“A lot of people just don’t care. Like I have Hep C. And you know, I got it years and years ago when I first started using and I knew, like I was sharing with this guy, I mean this is back when I was 21 years old. I knew he had Hep C, I didn’t care. I just did it anyway. I know a lot of people who have contracted HIV through just not giving a shit, not caring, you know, thinking, ‘Well, I’m gonna die anyways.’ ” (Female dual user focus group participant)

“You have the illusion that you’re not vulnerable to diseases. Most people think like, ‘OK, I’m smoking, you can’t catch anything’. But injecting, I mean people realise like you get shit that way, with the blood. But with smoking, most people think it’s a safe alternative to injecting, you know. So it’s, they don’t think they’ll catch anything...” (Younger male dual user focus group participant)

“What I don’t like is like, how when you’re sitting in school, they’re just like, ‘Don’t do it, just don’t do it, don’t even think of it’, you know. Doesn’t that make you curious? Why is it so bad, you know. I want to try it. It’s like curiosity, you know. That’s why I smoked weed, you know like, when I first started smoking crack, anything, anything, you know. Why is it so bad? I want to find out.” (Younger male dual user focus group participant)

“Yeah, ex-addicts, and like tell em, you know, ‘Guys, you’re gonna get fucked out of your head, you’re gonna get messed up and you’re gonna, it’s gonna change the way you think.’ And yeah, definitely get ex-addicts in there and like scare the shit out of kids. If I was old like, you know, ‘You guys that do opiates, this is the way you’re gonna end up.’ Or, ‘You’re gonna do crack smoking, this is how you’re gonna end up.’ ” (Younger male dual user focus group participant)

4.3 Experiences of Stigma and Discrimination

4.3.1 Health Services

Personal experiences of stigma and discrimination toward people who smoke crack became apparent in two major domains – when participants were accessing health or medical services and during interactions with law enforcement.

Participants indicated that their own health tended not to be a priority. When asked whether they disclose their crack use to service providers, most participants indicated

that it depends on the situation. Most claimed to be comfortable disclosing their drug use to people in agencies with harm reduction mandates and services. However, in mainstream health or other services, they tended to disclose their drug use on a 'need to know basis'. This is largely due to the stigma that is associated with being a "crack user".

Participants shared several personal accounts during which they felt stigmatized. The stigma was experienced in a variety of forms, for example: through negative commentary; a lack of language sensitivity among health and medical personnel; and many felt that the medical services that they received were different, and in some cases, poorer than those that might be received by a non-drug user. There were cases, for example, where medical conditions had not been taken seriously and could have had dire outcomes. Moreover, pain management was cited as an issue because medical professionals hesitate to prescribe larger doses of stronger medications to people who use recreational drugs. There was a suggested need for education of medical staff about drug use and addiction.

"I think accessing services as a drug user...we tend to not even access the services, just a lot out of the stigma, and a lot out of just [being] too busy using and stuff. But um, yeah, and if there are services like, say I had a choice of two services right, I could deal with the one here at [name of agency] where there's you know, people that understand or there's, you know, services up the road, like normal, you know, I would choose the centre that had, you know what I mean? Had the needle exchange in it, or had the...I would feel more at ease than a regular, you know?" (Female dual user focus group participant)

"It's hard to find a doctor. When you're smoking crack, your health is not exactly on the top of the list, right? I've been really badly sick, like puking blood and stuff and I don't really care, you know. I just want to get my fix, you know. It's pretty bad. And then eventually, the staff or something, like, 'Okay, we're giving you bus tickets or we're calling you an ambulance and you're going to the hospital'. I know someone who's a crack user and he just recently broke his foot and he's walking around all day and like, he got it two days ago and he doesn't even care. And you're like, we tell him to get off it, stop walking so much, rest it or something." (Younger male dual user focus group participant)

"Discrimination and stuff. You walk into any clinic and like he [fellow focus group participant] said, if you're a junkie or a crack head, they won't help you cause you're homeless and a junkie or you're a crack head. That's why I think you should have like special clinic especially for [people who use drugs]." (Male dual user focus group participant)

"I went to the hospital. This was a few years back and I had been getting really really bad pains in my stomach and...I guess I had track marks. Like, I didn't tell her that I use and she noticed my track marks and I'm in the hallway and you know, she's near me or whatever, and one of the doctors goes by and I don't know who it was but somebody went by and said 'Who's the doctor on call?' and she says 'Oh, it's [name of doctor] from

Infectious Disease' and looks at me and says, 'That's who you should be seeing, eh?'"
(Female dual user focus group participant)

"Sometimes I [disclose my drug use to my doctor] but I wouldn't [disclose] otherwise. Cause then they don't help you, they're like 'What the hell do you care about your health?'" (Younger female dual user focus group participant)

"It's like they treat you differently. Like as a person, they're rude. But they also treat you differently medically too" (Younger female dual user focus group participant)

"I had flesh eating disease and by the time I got to hospital, I was hours away from losing my arm and more than like an hour or two and I was supposed to be dead...The doctor said I was okay...As soon as he saw my tracks, he didn't talk to me like I was a normal person and he just changed everything he was saying. Like all he had to do was treat me like a regular person and I wouldn't have almost died. Like, how easy is it to say, 'This is dangerous, go to the hospital.'" (Younger female dual user focus group participant)

About whether they would disclose crack use "...depends. They'll only give you Tylenol, they won't give you anything stronger." (Aboriginal Male crack only focus group participant)

"I have nothing to hide. Because they're not supposed to be there to judge you right? So that's what I have in the back of my brain. But I remember like, when I'd go get stitches. They're like, 'What are you on?' I'm like, 'Well, I drank a 40 and I smoked a lot of crack.'... I find they treat me differently, less respectful." (Female in-depth interview participant – sex trade worker)

"I mean, even as far as my doctor [name], he's an addiction specialist and he's not even like, you know. I've come back positive for coke and I've said, 'What? You can't, oh my god, I can't believe that!' You know. And he says, 'Well, drug abuse, smoking – do you roll, do you smoke weed?' I say 'Yes.' 'Do you roll your own joints?' 'Sometimes I smoke with other people.' 'Well, they must have put crack in it...we've been hearing that there's marijuana laced with crack going around.' . You know, how would that make any sense, like, it just makes no sense, you know. Yeah, I'll buy \$10 gram of friggin' pot laced with \$20 worth of crack. Doesn't make sense, you know...And, I mean he's an addiction specialist. So, regular doctors, no not at all...they have no idea." (Female dual user focus group participant)

"I think absolutely that there's a need to educate doctors and stuff. There's been conventions and stuff where they, with health professionals and Canadian Mental Health and like, from all over the country and they invited a few users and stuff to speak and he [my husband] spoke at the thing. And he's [my husband] done a radio interview about it. So yeah, they need to be educated about it, that we're just you know, like there's such a stigma attached to it, you know." (Female dual user focus group participant)

4.3.2 Law Enforcement

Experience with police directly impacted participants' comfort with collecting and carrying safer smoking devices. Negative interaction with law enforcement where police had taken or confiscated new or used stems seemed to translate into a fear of police and being caught with drug using equipment. This fear directly impacted whether a person felt safe carrying their own stems (new or used) for smoking crack. This fear was heightened among individuals who have parole conditions that prohibit the carrying of drugs or drug using equipment. For many individuals, fear may ultimately result in sharing of devices used to smoke drugs.

Participants in this study felt stigmatised by police. A drug-related first encounter with police, even in the absence of an actual arrest, tended to lead to further encounters. Such encounters were characterised by a power dynamic in which members of law enforcement exhibited the right to approach, search and use both verbal and physical abuse on a person of whom they have suspicions about drug use. Moreover, police were said to use their power to interrogate users, particularly younger women, about their source for drugs. Such interrogation was seen as potentially endangering to users' safety. Drug users (particularly younger female users) felt targeted and preyed upon, as they were regularly subject to verbal and physical abuse by police.

Finally, participants discussed the presence of law enforcement outside and/or near agencies that distribute harm reduction resources. This police presence further contributed to fear of being caught which contributed to reducing people's comfort with accessing harm reduction materials and enhancing people's propensity to share crack smoking devices.

"You may be just walking down the street and you actually didn't do anything and you don't have anything on you, but they turn around and because you're in that area and you look like you're a street runner, they'll come. Like I've had them come up to me, take my bag, throw it on the ground and slam my head off their car and I didn't do a damn thing..." (Male dual user focus group participant)

"Yeah, like they treat you like a piece of shit you know...I've had the odd cop that's actually really nice but overall, they see us as the lowest of the low where we all have to be criminals, we all have to be you know, breakin' into your house or robbin' the stores or, you know, we're not all like that." (Female dual user focus group participant)

"If they arrest you once, they think you're using outside anyway even if you're not, so really there's no getting away from it. Like, all you have to do is get arrested once, and not even arrested, like a ticket or handcuffed, and for some reason they have a photographic memory and they just remember you and they, like you meet them once and every time you walk by, they're like, 'Empty your bag.' And you're like, 'But I'm just going to work.' And you're like half an hour late for work because the cops had to run your name and enter your bag cause you were walking down the street. So like every time they see you, that happens. So it doesn't even matter if you're using outside or not cause like you're going to have to deal with that..." (Younger female dual user focus group participant)

“Police is an aggravation for users, a very big aggravation, because it seems they shit on always the small guy. They should leave the small guy alone. They should get the dealers. The guy who smokes the little puff in the building there, he’s not dangerous. He’s not dangerous. The only thing he’s going to do, he’s going to dig into the soil, he’s going to be freaky like that, but that’s it. It’s not him that I’d like to catch. It’s the guy who provides the crack for him in order for him to be as a rat, you know, as not human. It’s the dealer.” (Male in-depth interview participant – MSM)

“So you walk around the corner and you’re pulled over right there. So nobody wants to take a chance at getting busted with their dope. I won’t walk into these places to grab, to pick up my gear, okay?” (Male dual user focus group participant)

“I’ll be in a car or on a bus and a cruiser will drive by and my heart will stop and I’ll freak out. Like all they have to do is pick you up and beat the shit out of you and leave you in the middle of the road. You’re a street kid. No one’s going to know where you are and no one’s going to try...And you know that they know they can get away with anything and that’s what scares me the most about them...” (Younger female dual user focus group participant)

“...They don’t even care if you’re a girl and you’re tiny...They’re like ‘Ah, I can over power them easier.’ ” (Younger female dual user focus group participant)

“They try to take advantage of the users though, because like, a lot of girls will get pulled over and they’ll have a piece and they say, ‘Tell me where you got this piece and we’ll let you go’. And the girls, you can’t blame them, because they don’t want to go to jail but, I don’t know, but it’s not right for them to rat though either. But it’s either tell them where you got the piece so, you say, the biggest line is ‘The black guy on the corner’...I tell you, that black guy is getting in a lot of shit.” (Female dual user focus group participant)

“I think cops are used to it. Like usually, if they find a crack pipe on you, they throw you down, they smack you.” (Younger male dual user focus group participant)

“I have, sometimes I got beatings, extreme beatings, for you know, something that I didn’t think was, you know. Sometimes they’re just angry and they do hurt you.” (Aboriginal male crack only focus group participant)

“[When police take away your stem], you gotta wait to get it from somebody else. That’s where the sharin’ pipes are coming in.” (Female in-depth interview participant – sex trade worker)

4.4 Enhanced Services for People who Smoke Crack

Among participants in this study, there seemed to be a general awareness of harm reduction services that are currently available to people in Ottawa who smoke crack. It is necessary to keep in mind however, that participants for this study were recruited through harm reduction agencies. This group of users may therefore possess greater awareness of harm reduction resources compared to the general population of people in Ottawa who smoke crack.

The participants indicated awareness of how and where to access harm reduction resources as well as knowledge of the specific safer smoking materials that are available for collection. Despite knowledge of harm reduction services, there were some participants who refused to go to agencies to collect harm reduction resources. This was largely due to fear of police as previously discussed. These participants relied on other people (a partner or friend) to provide them with safer smoking materials, used other people's stems, or used other less safe objects such as a pop can or inhaler to smoke crack.

Participants were asked to comment on harm reduction services that are currently offered. As well, they were asked to reflect on and describe ideal services designed for people who smoke crack. There were a number of suggestions made regarding how services might be expanded or tailored to better address the needs of people who use crack as well as ideas for new services. The suggestions fall within a continuum of services that span from the expansion of current harm reduction services and resources to enhancement of support for people emerging from drug treatment programs or being discharged from jail. Recommendations under each heading within the continuum have been summarised in the chart below (Figure 3: *Continuum of Services for Women and Men in Ottawa who Smoke Crack*) and are further discussed in the paragraphs that follow.

4.4.1 Continuum of Services Model

Figure 3: Continuum of Services for Women and Men in Ottawa who Smoke Crack

Harm Reduction Services	Safer Drug Using Spaces	Safe Spaces to Come Down	Detox Programs	Treatment Programs	Post-Treatment Follow Up & Support
<ul style="list-style-type: none"> - 24-hour service access - Peer workers - Counseling/ Support - Nutrition - Access to other life programs – goal setting/ planning 	<ul style="list-style-type: none"> - Designated park or other outside location - Safer Drug Using Facility open 24 hours to serve people who smoke crack as well as those who inject drugs - Involvement of peer workers 	<ul style="list-style-type: none"> - Place to come down off high or "chill out" - Beds available for people to sleep 	<ul style="list-style-type: none"> - Revise admittance requirements (e.g. admittance of people on methadone) - More accessible detox options, (e.g. programs for couples, programs for women only) 	<ul style="list-style-type: none"> - More accessible treatment options - Shortened wait lists for admission - Adjust admittance requirements (e.g. admittance of people on methadone) - More holistic – goal setting/ career programs 	<ul style="list-style-type: none"> - Follow-up support post discharge from treatment - Follow up support post release from jail - Transitional housing options located away from drug-using community - "Life-long treatment" - Safe houses

4.4.2 Harm Reduction

The need for 24 hour access to harm reduction resources and services was noted as the most important recommendation by participants in this study. Recognising that a significant portion of drug using activity happens in the early hours of the morning, there is a need for harm reduction resources to be available through the night. In addition, it was suggested that having someone to call for help 24 hours a day would enhance the feeling of safety among people who use crack in Ottawa.

Some participants suggested that rather than spending additional effort on making adjustments and improvements to safer smoking materials that are provided, additional resources might be better spent on enhancing outreach and support services. In addition, there was a suggestion for the provision of holistic harm reduction and support services tailored to people who smoke crack, but not focused solely on safer drug use. Such programs would include addressing other facets of people's lives such as mental health, goal setting and life planning.

Overall, participants agreed with the involvement of drug-using peers in the provision of harm reduction services and support. Several indicated that they felt more comfortable disclosing aspects of their drug use and their personal lives to people who have had experience with drug use. However, it was also felt that on account of the specific characteristics of crack addiction, that people who are current users of crack would not make suitable peer workers. It was suggested that previous users of crack or people who use opiates may be more appropriate.

"...And I also find another way would be to extend the hours, you know, because they stop running at a certain time and then that's when, you know, and if the purpose of the programs are to stop spreading disease and stuff like that then they need to constantly be available or you know, come 11 o'clock when the van's off and the pipe's broken, they're gonna buy one from Joe Blow or they're gonna use Joe Blow's, or they're gonna, you know..." (Female dual user focus group participant)

"It's like the dealers, you know, they sell till like 12, one o'clock, well after 12, one o'clock, that's you know, 3, 4, 5 in the morning, that's the peak hours, that's rush hour, you know." (Female dual user focus group participant)

"Yeah, yeah. And more extended hours. You know, cause there are so many people who aren't getting reached because they're up all night, they sleep all day, and by the time they wake up, most of the, they're out, they're gone, you know..." (Female dual user focus group participant)

I know there's a gay man's clinic, but...I'd rather go to like a....what is that? [Name of agency]! You know... they have a male trans on Mondays and stuff like that... go there and meet with the girls...(Transgendered female in-depth interview participant – sex trade worker)

“Just knowing that it’s there. Knowing that there is someone to call in case there is accidents.” (Female in-depth interview participant – sex trade worker)

“I think it’d be good to have, I don’t know, not glorified crack pipes and needle exchange, but...more resources where it’s like [more outreach workers for example], you know what I mean?” (Younger male dual user focus group participant)

“I think that uh, a little more advertising that the services are here. Like a lot of people, they’re just not aware of it.” (Female in-depth interview participant – sex trade worker)

“I think also a service like, some sort of like, picturing [name of agency] as a building specifically for crack users right? So, like I said, there would be areas you could deal with your mental health, or areas you could deal with your physical health, there’s areas that you could deal with treatment then there could be areas for um, just overall helping people like, goal planning, goal setting, you know, how to reach your goals, um and to, like, something to sort of encourage and teach users that there’s more out there, you know what I mean?” (Female dual user focus group participant)

“I think that there should be someone to speak to in terms of medical, you know, things like that. That should be available. As well as psychological, you know, mental health. Also, I mean all these things put together into one. And accessing treatment, they should make that much easier, you know. It’s so difficult to you know, that’s what I think would be the best and a place that hands them [pipes] out and...” (Female dual user focus group participant)

“...Peers would be excellent. Yeah, peers would be...and then there wouldn’t be such a stigma connected to it you know. Counselors are authoritative and peers would be easier to associate with.” (Female in-depth interview participant – sex trade worker)

“The feelings are genuine – they know what it does to you emotionally, physically, mentally and even spiritually – they [past or current users] just know because they’ve been there.” (Aboriginal Male crack only focus group participant)

“So as far as crack users, I don’t think...they could be like, you know, in a, like in a peer-support-peer. But they couldn’t be using while they were doing that. Like, you know, I couldn’t go speak to you and me to talk to you and tell you my problems after you just did a puff, you’re not gonna give a shit about my problem, what I’m talking to you about. But absolutely to be a part of it, but not using while they’re a part of that, you know. It’s just impossible, you wouldn’t be able to do it...” (Female dual user focus group participant)

4.4.3 Safer Using Spaces

Participants indicated an interest in safer places to smoke crack, particularly for those without a home. As mentioned in the *Smoking Practices* section, the idea of having a dedicated outdoor crack smoking location was suggested. This was offered as a suggestion to reduce some of the harm-enhancing situations and behaviours (e.g., sharing stems, rushed drug use, discard of stems, using in less safe locations) that result from fear of being caught by police while smoking crack outside.

Participants also commented on the idea of a safer smoking facility. There was a general sense that the facility should cater to the needs of both people who smoke crack as well as those who inject drugs. Again, it was suggested that the facility operate 24 hours per day. While participants generally indicated a willingness to use such a facility if one were to exist, they cautioned about a potential overwhelming effect on the facility on account of the sheer volume of crack smoking clients, many of whom will want to use repeatedly.

“Cause I don’t think... I would think it would have to be a place combine. It’s not just crack. Like, it would have to be combined cause I don’t know, most people, any, really anybody that uses just crack, you know, so it would have to be a combined thing...”

(Female dual user focus group participant)

“Yeah, I think you’d have lineups coming up the ying yang, just up the stairs and around the corner, everybody waiting for their toke and then once they do their toke, ‘Oh, I want to do my push.’ So they go to the end of the line. I don’t think that would work exactly...”

(Younger male dual user focus group participant)

“Well, they have to make it safe for the public. They have to make it safe for the people...Like, they have mats on the floors, everybody has a mat. Whatever mat. Maybe you have to stay there for two hours, three hours ‘cause you’re so high that you can’t leave. At least you’re safe around people. You’re around people to take care of us. Maybe the nurse might want to check your pulse. Maybe...” (Female in-depth interview participant – sex trade worker)

4.4.4 Safe Spaces to Come Down, Detox and Treatment Programs

A significant portion of the discussion about tailored services for people who smoke crack revolved around the provision of holistic services that support people where they are in their drug use and addiction, and take into account the context of people’s personal lives and the community in which they live. This was articulated most clearly when discussing availability of and access to: safer spaces to be high and to come down from being high; detox programs; treatment programs; and support following discharge from a drug treatment program or jail.

Participants suggested that currently available detox and treatment programs do not meet the needs of people who smoke crack. First, often users simply need a place to ‘chill out’, be high, or come down from being high. There is currently no such option for people who smoke crack. This can be particularly difficult for people without a home when all they need is sleep. For those interested in accessing detox or treatment programs, both programs have admittance conditions, such as abstinence requirements and refusal of people who are on methadone, that make the programs less accessible to users. Also, particularly for treatment programs in Ottawa, it can take up to six months before a person gets admitted. Participants reminded us that if a person who uses drugs feels that they would like to stop, often this is a moment that needs to be seized, for as time passes, the chance that the user will continue using and forget about their desire to stop using increases. Additionally, there were complexities related to people with

children and access to treatment programs. Finally, there was a suggested need for detox and treatment programs that will admit couples as well as women-only programs.

“For me to get in, like I say, I went to [name of agency], and I’m telling you it took me five to six months and I called every week. Like, I was, cause CAS had just taken my kids and stuff so I, you know, I wanted to get in there. So, it took me six months to get into.” (Female dual user focus group participant)

“And the point is, we do need better treatment facilities. We do need a better detox where they’re able to take methadone patients and detox you from other drugs. We do need after care following up if there is not an immediate bed in treatment from detox, somewhere safe to go until you go to treatment. After treatment, you need aftercare. We need some sort of community where all of us who are struggling coming out of jail and coming out of these treatment facilities can go and meet and talk and lend support to each other because there is no more support. Everybody’s so distrusting of one another, there’s no more support.” (Male dual user focus group participant)

“There have been a few times when I’ve said, ‘I’m done. I wanna quit’. But there is no where to go, you know what I mean?...Yeah, sure...there’s...but I think there should be more people that have been there, done that, you know like workers and stuff that have been clean for like 15-20 years. They have more resources...You should be able to go somewhere and like calm down, get a bed somewhere, and like, get a bite if you haven’t eaten in a few days, you know and like, come down you know? You gotta come down, you know? Not just to get off it but just to like come down...” (Younger male dual user focus group participant)

“...With welfare, it’s always a concern that you’re going to get cut off or forced to go to some program that you can’t handle.” (Male in-depth interview participant – sex trade worker)

“It’s like, you have to catch me at the right time, when I actually want the help. Like, I could want to get off drugs right now, right this second, but there’s no services available to help me do that. Eventually, I will do that. And there you go, another eight months gone.” (Younger male dual user focus group participant)

“I think you guys need a place, like, ‘I want to quit. I want to come down.’ Where do I go? I can’t go some where, be like, finally in my head, I want to quit, there’s nowhere I can go, just like detox.” (Younger male dual user focus group participant)

“I mean, your personality can change radically. If you want to quit today and there’s a program in three weeks. What are you going to do in that time? You’re going to be using – I’m not going to say that I won’t. I know I will. And I know in my heart that something has to change you know. That’s why I mentioned the groups – like self esteem and management...” (Aboriginal Male crack only focus group participant)

“Yeah, especially if I want to quit. I could come to this place and like, ‘Okay guys, I want to quit. What does it take if I want to quit today?’...It takes me six months to get into treatment, six months to get into a treatment centre. I have a whole six months before I

can go into treatment. Six months of this hell and then I can get better, you know?" (Younger male dual user focus group participant)

"I still use. But at the same time, I know I had enough and I want to stop, but I still use. But I'm trying to do something for myself – programs and treatment and you know. But meanwhile, I am in the community and the community is pretty um, it's wild" (Aboriginal male crack only focus group participant)

"[Name of agency] – and that was a place where they would take you even though – they had like an emergency room and it would detox you, right. Like, you can be high or drunk or whatever and they would help you. That was great. But unfortunately it shut down – from lack of funding. They had a place where you could reside, you know you could stay there, you could take it for six months. I stayed there a year. I liked the program so much I stayed another six months..." (Aboriginal male crack only focus group participant)

"It's like treatment, treatment centres. I think it's ridiculous that, he ended up running away from drug court cause we couldn't find a treatment centre for couples. They wanted to put him over here and they want to put me, you know." (Female dual user focus group participant)

4.4.5 Post-Treatment / Post-Discharge Support

The importance of environment came up repeatedly as a major hurdle for people who are trying to detox from drug use - for those who are attempting to stop smoking either temporarily or permanently, and for those wishing to remain drug-free after discharge from drug treatment or discharge from prison. Often, people do not have a home to return to, and if they do, the home may be physically located within the drug using community and culture. Being physically located and/or feelings of connection or belonging with that community were cited as factors that draw people back into using drugs.

Among ideas that were presented as ways to address the impact of environment on people being discharged from treatment or released from prison, were enhanced follow-up support and counseling, including peer support programs, and expanded residential options such as safe houses or transitional housing located away from the drug-using community.

"It's not just the treatment centres. What it is is follow-up. And we've been crying for that for years – second and third stage housing. Because it's like jail, once you go to jail, we're all coming out clean but we need somewhere to go from there right away. For me, personally, when I come out of jail, the first place I go is right down town cause that's where I'm accepted. I believe I belong to that community. But if I had an alternative, if I had somewhere else to go...I'll put it to you this way, everybody here knows me and none of them have seen me in the last couple of weeks cause I got a place out of the core of the city." (Male dual user focus group participant)

“When you come out of detox, as soon as you come out, you’re right back on the streets. And you have no house or room to go to. You clean up for a month in detox, and then, you’re just right back on the streets downtown. Like, there’s no transitional housing in Ottawa. There’s nothing. There’s drop in centres but that’s where all the dealers are at so you can’t even go to a drop in centre and have a coffee without having 10 people trying to sell you crack. What are you supposed to do?” (Male dual user focus group participant)

“That would be excellent – help you to get out and look for work and meet people who can help you” (Aboriginal male crack only focus group participant)

“When I wanted to get clean, safe houses were really good because you can go to it and nobody around the house is using” (Aboriginal male crack only focus group participant)

“Life long treatment – that’s what we need more – life long treatment...” (Aboriginal male crack only focus group participant)

“Another thing. Let’s say you want to quit. I mean, what are you going to do after you quit? I mean, are you going to keep running around the streets here or would you rather go out and work? Like I mentioned before about ambition, if you want to go back and work and leave this alone. Because this is a completely different society – this is a crack society.” (Aboriginal male crack only focus group participant)

“My suggestion would be that in these safe houses there would be micro management courses, self esteem, anger management. You know, things that will help you not fall back into the old ways or patterns. I mean, it’s not hard to be walking down the street and get this euphoric high because you’re walking down the same street where you used. You know, I mean, I know it takes a little while and you have to develop a new way of life.” (Aboriginal male crack only focus group participant)

5.0 Discussion and Recommendations

Findings from this study, confirmed by discussions with project partners across the country during the knowledge translation workshops, point to the urgent need for programs and services to address the lived experiences of people who smoke crack. That is, programs and services must consider the personal and environmental contexts that are contributing to people’s risk of exposure to HIV and HCV.

Recommendations are presented within six broad categories. First, individuals must possess accurate knowledge of the HIV and HCV risks associated with sharing devices used to smoke crack, must have awareness of harm reducing drug using practices and disposal techniques. Second, harm reduction resources for people who smoke crack must be provided within a continuum of services that are responsive to users’ immediate needs and include the provision of safer smoking resources in the most readily accessible fashion for all people regardless of age, as well as access to safer smoking facilities and broader drug treatment options. Third, there is a need for expanded knowledge of drug use and addiction among health service providers in order to reduce stigma and discrimination and improve access to health and medical services

for people who smoke crack. Fourth, the structural barriers that law enforcement objectives and practices create in terms of negatively impacting access to safer inhalation call for immediate enhanced cooperation and alignment of objectives among law enforcement bodies, harm reduction, and communities of people who use drugs. Finally, while this research has begun to explore some of the contextual factors that impact access to safer inhalation, there is a need for further investigation to expand our understanding of these complexities. These six recommendation categories are described in greater detail below.

5.1 Enhanced Education and Access to Information

Despite awareness of the risks involved in sharing devices used to smoke crack in terms of potential exposure to or transmission of HIV and/or HCV, people continue to share smoking devices. There is a lack of internalization of this knowledge where HIV and HCV are not perceived to be a real threat, are highly unlikely, or are considered “low risk” when sharing smoking devices compared to sharing injecting equipment. In addition, one’s urgency for the drug appears to override concern about HIV or HCV risk. Our research suggests that this may be particularly the case during sexual encounters where power dynamics, urgency for crack, and effects of crack use itself further impact a user’s ability to exert control and take precautions to practice safer sex and safer drug use. More effort needs to be paid to ensuring that people who use crack are made aware of and internalise knowledge of the risk of sharing devices used to smoke crack. As well, additional research is needed to explore contextual factors that impact the relationship between the knowledge of risk, internalization of knowledge and risk-taking behaviours. Research results therefore suggest the need for:

- **Improved information outlining HIV- and HCV-related risks involved in sharing devices used to smoke crack and connection with sexual risks.**
- **Enhanced drug safety education in schools with possible involvement of drug users in awareness-raising and educational initiatives.**

5.2 Broader Access to Safer Inhalation

There is a need to examine existing harm reduction programs that are currently available to people who smoke crack in order to ensure maximal accessibility. Hours of operation must be extended to meet ‘around the clock’ need for services in addition to enhanced resources for outreach and support. Age restrictions on the distribution of materials need to be lifted in order to ensure that all users have access to safer smoking resources for the prevention of transmission of HIV and HCV.

Reported non-use of mouthpieces and brass screens suggests that currently provided safer smoking materials may not adequately address the needs of users. This calls for further investigation into the design of more appropriate safer smoking materials including confirmation of actual risk-reduction potential of safer smoking devices. Finally, the possibility of safer smoking locations, including designated outdoor spaces as well as indoor safer smoking facilities with peer workers, need further feasibility assessment and exploration. Research results therefore suggest the need for:

- **Removal of age restrictions (18 and over) for the distribution and collection of safer smoking supplies through agencies that offer harm reduction services.**
- **Expansion of existing harm reduction services through extended hours (24 hours) and enhanced support and outreach services.**
- **Examination and development of safer smoking best practices including the design of improved safer smoking materials.**
- **Increased attention to best practices for safer disposal of used smoking supplies.**

5.3 Expanded Drug Treatment Options – detox, treatment, recovery

There is a call for expansion of existing services as well as exploration of additional service options along the harm reduction – treatment/support continuum in order to meet users where they are in their drug use and addiction. Findings from this study tell us that currently offered programs and services are not meeting the needs of users. For example, the absence of safer spaces to be high and/or to come down from being high, and current conditions for admittance into detox and treatment programs do not suit many people who smoke crack. As well, current waiting lists for treatment make these programs inaccessible. There is urgency for the provision of enhanced post-treatment or post-discharge (from jail) support services. Such support includes residential options such as safe houses and transitional housing located away from the drug using community as well as the provision of follow up counseling and peer support programs. Overall, harm reduction programming for women and men who smoke crack needs to be further studied and evaluated to determine promising practices.

The complexity of individual users' lives and interplay between individual experience, situational context and environment necessitates HIV and HCV prevention information, resources, and services to be offered within a continuum that allows for responsiveness to an individual's holistic needs and to where they are in their addiction and their current drug using practices. Research results therefore suggest the need for:

- **Adoption of a more holistic continuum model of service delivery for people who smoke crack in order to enhance responsiveness to users' immediate needs.**
- **Creation of safer drug use facilities and safe spaces to be high for people who smoke crack.**
- **Greater access to detox and treatment options and increased availability of post-discharge support and transitional housing.**

5.4 Improved Access to Health and Medical Services

Testimonies of negative encounters with health services and perceived differential treatment on account of being a drug user suggests the need for education for health service professionals and staff in order to expand knowledge and understanding of people who use drugs, to enhance sensitivity toward this population, and to improve

health services and thus health outcomes for people who use drugs. Research results therefore suggest the need for:

- **Development and incorporation of drug use and addiction education and sensitivity training for medical and health staff.**

5.5 Enhanced Cooperation with Law Enforcement

Harm reduction services appear to be working at cross purposes with law enforcement. Contradictory policies and efforts create structural barriers that ultimately lead to a fear of collecting and carrying safer inhalation equipment among those who smoke crack. Negative interactions with police, police presence near harm reduction agencies, and/or parole conditions that make people afraid to carry their own new or used smoking devices often leave people with no option other than to share devices used to smoke crack. There is a need for enhanced coordination between the objectives of law enforcement and harm reduction efforts. Research results therefore suggest the need for:

- **Establishment of alignment of safer inhalation program objectives with policing and law enforcement objectives and practices.**

5.6 Continued Investigation and Research

Through this research we have uncovered some of the contextual factors that appear to impact people's drug using practices and risk of exposure to HIV and HCV. That is, the personal, social, and environmental factors that impact the availability of, and access to safer crack using practices. As the context is a complexity of interrelated factors, further research is required to better understand these relationships and their impact on risk associated with smoking crack. This includes enhanced understanding of power and gender dynamics that characterize sexual encounters and further complicate risk of exposure to HIV and HCV among people who smoke crack.

The dissonance between reported awareness of HIV and HCV risks and risk-taking behaviours (e.g., sharing smoking devices) suggests the need for exploration of the information being provided. In addition, further study is required to investigate the relationship between knowledge acquisition, knowledge internalization and enactment of knowledge related to HIV and HCV risk among this population. This will require investigation of the contextual factors that impact (enhance or hinder) each of these knowledge-to-action processes. Research results therefore suggest the need for:

- **Further research to examine contextual factors, including determinants of health such as *housing* and *gender* that impact people's smoking practices and affect access to safer inhalation resources and the connection with sexual risks.**
- **Further investigation exploring the connection between safer inhalation knowledge, internalization of knowledge and enactment of knowledge – i.e. knowledge of the HIV- and HCV-risks, internalization of this knowledge, and enacting this knowledge through safer smoking and safer sex practices.**

6.0 Conclusion

This study was designed to enhance our understanding of the HIV and HCV risks as well as the HIV and HCV prevention needs of people who smoke crack. Through focus groups and in-depth interviews with people who smoke crack we explored the contextual factors that surround drug using practices – factors that may affect people’s access to HIV and HCV prevention as well as factors that affect an individual’s propensity to share crack smoking devices and thus increase risk for contracting or transmitting HIV and/or HCV. A number of recommendations have been outlined for improved policies and programming to address the needs of people who smoke crack. As well, areas requiring future study have been identified.

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8.0 Appendix

Research to Policy and Practice: Safer Inhalation Knowledge Translation

Workshop Series Report

WORKSHOPS:

May 5, 2008 - Toronto

May 6, 2008 - Ottawa

Nov 7, 2008 - Ottawa

Oct 25, 2010 - Ottawa

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Workshop Participants - Knowledge Translation Partners

INTRODUCTION

A research project titled: *What Men and Women who Smoke Crack Have to Say about HIV Prevention: Implications for Policy and Program Development* was funded under Ontario HIV Treatment Network's Strategic Applied Research and Training (START) program. The project represented a starting point from which to consolidate knowledge about a largely ignored segment of the population of people living at risk of HIV and Hepatitis C in Ontario. Despite an increasing prevalence of crack smoking, the experiences of people who smoke crack and their understanding of and access to harm reduction services for prevention of HIV and HCV are not well understood. Harm reduction programs and services tend to be designed primarily for people who inject drugs. Resources for people who smoke crack are sometimes added but may fail to adequately consider and respond to the social and environmental contexts in which people smoke crack.

Through focus groups and in-depth interviews conducted in August and September, 2008 and May and June, 2009, respectively, this project was designed to explore the social and contextual conditions which surround people's use of crack, including access to and use of harm reduction services. As part of a multi-phased study, results from the focus groups and interviews informed the development of a survey instrument that will be used for a provincial study examining the HIV and HCV prevention needs of people in Ontario who smoke crack. It is hoped that findings from this study will ultimately be incorporated into program design and delivery in order to enhance responsiveness to the HIV- and HCV-related prevention needs among people who smoke crack.

KNOWLEDGE TRANSFER WORKSHOPS

Engagement of a diverse research team and involvement of collaborating partners from across sectors (academia, community, programming and services, and policy) throughout all phases of this project has ensured relevance of the research questions and enhanced potential for the research findings to improve policy and programs for the prevention of HIV and HCV among people who smoke crack. In particular, a series of three knowledge transfer workshops were hosted, to which experts and key stakeholders from across Canada were invited to discuss the relevance of the research project and its findings to policy and programming priorities. This report represents the culmination of discussions and recommendations from all three workshops.

The first workshop was held in two parts – with partners in Toronto on May 5th, 2008 and with partners in Ottawa on May 6th, 2008. Hosting the meeting in two parts facilitated broader participation of a variety of key stakeholders. These workshops provided an opportunity for the research team to gather input from collaborating partners to two research projects: a systematic review of safer

1st Workshop

To solicit input from partners to research questions

inhalation literature³, funded by the Canadian Institutes for Health Research, and this START project, an exploratory study of the HIV and HCV prevention needs of people who smoke crack, funded by OHTN. Input from collaborating partners at these initial meetings ensured the alignment of research questions with the needs of people who use drugs and with identified the priorities of decision-making and program delivery partners.

The second workshop, hosted in Ottawa on November 7, 2008 provided an opportunity for the research team to share preliminary results from the systematic review as well as emerging results from ten focus groups that had been conducted with men and women in Ottawa who smoke crack. Workshop participants offered reactions to preliminary findings and provided guidance and suggestions regarding subsequent phases of the research process. In addition, during this workshop, a forum was created for collaborating partners to share information about crack-specific research and programming happening in their regions.

The purpose of the third workshop titled *Safer Inhalation: Research to Policy and Practice* was to continue our dialogue with collaborating partners and key stakeholders in order to share concluding findings from the study including results from a series of ten in-depth interviews with people in Ottawa who smoke crack. This workshop was largely dedicated to discussion of the relevance of key findings to what is happening in other regions across Canada and to explore existing and/or potential solutions to the issues identified. The group worked as a collective to identify specific recommendations from the research findings.

2nd Workshop

To share preliminary results from the Systematic Review and Focus Groups

3rd Workshop

To discuss policy implications of final study results

SUMMARY OF ISSUES AND SOLUTIONS

According to workshop participants, the majority of key findings from this research project – results from focus groups and in-depth interviews with people who smoke crack (shown in **bold font** in the sections below) are common to those encountered in other regions across the country. While a few of the issues have been or are being addressed in other regions, many of them remain major concerns in need of attention. This section provides an overview of the discussions related to each of the key themes as identified through the research project. Each section includes a summary of the key finding, a review of related issues and suggested solutions or strategies that were proposed to address the identified issues as discussed during the knowledge transfer workshops.

³ *The Effectiveness of Harm Reduction Programs to Prevent HIV and HCV Transmission Among People who Smoke Drugs: A Systematic Review*

1. Law Enforcement and Policing

The Issues:

The role of the criminal justice system and police in the lives of people who use drugs came up repeatedly as a barrier to safer drug use and service access. Participants in the focus groups and in-depth interviews spoke of how **negative encounters with law enforcement (including violence), as well as police presence outside harm reduction agencies, issuing of red zones or release conditions, and reports of safer drug using equipment being taken or confiscated, were frequent. Such negative encounters with law enforcement produced fear of police that resulted in a reluctance to collect or carry safer smoking equipment.**

Workshop participants from British Columbia (BC) reported an increase in the use of city bylaws in order to prevent people from carrying drug paraphernalia. In Kelowna for example, people are fined \$100 for having unused paraphernalia on them. This not only contributes to increased financial risk for people who use drugs, but such policies have the effect of dissuading people to collect or carry safer smoking supplies which has the potential to contribute to increased prevalence of sharing crack-smoking equipment and to unsafe disposal of smoking equipment (anecdotal evidence - no research currently exists documenting this effect). [<http://vhrrcs.wordpress.com/2010/11/10/fha-urged-to-push-needle-exchanges-into-hostile-cities/> – article discussing bylaws imposed in Lower Mainland cities banning drug paraphernalia]

The use of city bylaws that prohibit people from carrying drug using equipment

Participants noted a strategy being used in Victoria that involved the creation of a “no-service zone” in the high tourist area within the downtown core where harm reduction services are forbidden to operate. This creates barriers to safer drug use by hindering access to services for those living or staying in the region or by forcing people who use drugs to travel or move to a “service zone” in a region outside the downtown core. [<http://www.harmreductionvictoria.ca/?q=node/81> – article outlining the service access gaps resulting from the creation of the “no-service zone” in Victoria]

Similarly, the use of “red zones” and release conditions that prevent people from carrying safer drug using equipment appears to be increasing in Ottawa and in other regions across the country results in restrictions in the movement of people who use drugs and provides police with cause for additional searches and/or arrests. In particular, it was explained that “red zones” and paraphernalia restrictions influence recidivism and set people up to fail by imposing unrealistic conditions that people will be forced to breach. For example, a participant from Vancouver relayed a story of a friend who had had 55 court appearances after being caught with one \$5.00 rock of crack. The initial arrest led to this individual being red zoned from the downtown core where all of their social contacts and support services were located. While awaiting their court appearance, the person was caught in the red zone, which resulted in another court date being

Increasing use of “red zones” and “release conditions”

scheduled for their breach of conditions. According to front-line workers, in addition to negatively affecting their access to safer drug use equipment and support services, this cycle can lead to “a life in jail - in 3 month bits”.

Another issue that emerged through the research findings and was verified among workshop participants is with respect to police confiscation and/or destruction of both used and unused glass stems. Legally, police do not have the right to take or destroy a person’s property except by due process of law, which means that any property seized by police is to be retained until a court makes an order for its disposal. The majority of focus group and in-depth interview participants reported having had their glass stems taken by police and often reported that they were crushed on the ground in front of them. This is clearly an issue, as the confiscation of unused pipes is in direct conflict with disease prevention and health promotion objectives of safer crack use programs. Finally, in addition to setting a poor example among people who use drugs, such unsafe disposal of smoking devices including police crushing stems on the ground, serves to increase health and safety risks to the community. [<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1390> - a discussion of the legal issues related to distribution and possession of safer crack use kits]

Police confiscation and/or destruction of peoples’ used and unused glass stems

Although some workshop participants reported having had some success working with the law enforcement system, many of these successes are being reversed by the election or appointment of more conservative officials to senior levels of government and to police forces. Despite this, participants in all three workshops expressed the urgent need to enhance collaborative relationships with police and the judiciary on various issues, and to strategize around how to better support people who use drugs to protect themselves against police harassment and violence.

It was felt that working with and educating the judiciary would be particularly important with respect to the imposition of **red zones** and/or **conditional release terms**. These conditions are intended by law to be both “effective” and “reasonable”. There is a call for research to demonstrate how these measures contribute to enhanced risk and set people who use drugs up to fail. Specifically, such terms often restrict a person’s access to health and support services (including harm reduction services), interfere with the ability to use public transport and/or limit ability to do their jobs (for peer harm reduction workers, for example). There is a need to engage clients who are subject to these conditions in order to demonstrate how and why the imposition of red zones (or other conditions such as “no service zones”) are neither effective nor reasonable. Although this was accomplished in one case in B.C. (*R v. Reid*), there have been no precedents set by higher courts with respect to this issue. It was suggested that conducting community-based research on the impacts of red zones on the lives and risk behaviours of people who use drugs would be a valuable and timely contribution to this effort.

Need for research on the impacts of “red zones” and “release conditions” on lives and risk behaviours of people who use drugs

The establishment of an organization that assists marginalized people with legal matters could be very beneficial in advocating for the legal rights of people who use drugs as well as assisting them in protecting themselves against police harassment and violence. Pivot Legal Society is an example of such an organization operating in Vancouver (www.pivotlegal.org).

There is a need to bridge the gap between harm reduction/health promotion efforts and law enforcement – to arrive at common set of goals and objectives and a shared understanding of addiction as a health issue. In addition to improved relationships with front-line police officers, participants noted the need for a cultural shift that will require engagement at a higher level involving community groups, Medical Officers of Health, and Chiefs of Police. Such improved relationships will require the identification of a middle ground. Community agencies will need to consider the police mandate to apprehend people who are using illegal drugs and similarly, law enforcement officials will need to consider the health promotion objectives of harm reduction programs.

The contradictions inherent in the complex relationship among people who use drugs, harm reduction providers and front-line police officers exist due to the criminalisation of drugs and drug use. As such, it is essential that we work toward enhanced cooperation with police in order to advance their understanding of the issues and to reduce stigma and abuse of people who use drugs. However, to address these issues in a sustainable way, there is also the need for higher level debates concerning Canadian drug policy and the decriminalization of drug users.

Need enhanced collaboration with law enforcement including education for judiciary about impacts of “red zones” and release conditions
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Suggested Solutions:

- Collect affidavits from people who use drugs who have experienced police violence and/or harassment including the confiscation of glass stems;
- Provide greater opportunity for front-line police officers to learn about the lived experiences of people who use drugs in order to advance their understanding of addictions as a health issue;
- Provide more opportunity for police at all levels to learn more about the health risks of drug use and the role of harm reduction services in reducing those risks until such time as people are ready to cease their drug use;
- Learn from regions where there is greater collaboration and cooperation with police in order to initiate dialogue around issues such as the need for more greater access to drug treatment and overdose prevention;
- Conduct community-based research on the impacts of red zones and/or release conditions on the lives and risk behaviours of people who use drugs;

- Engage Medical Officers of Health to collaborate with Police Chiefs and other law enforcement and judiciary officials in order to strengthen the understanding of drug use and harm reduction as a health issue; and,
- Collaborate with groups across the country through such initiatives as the Canadian Drug Policy Consortium to build support for changes to Canadian drug laws and the de-criminalization of drug users.

2. Sharing Practices

The Issues:

There was general awareness among research participants of the risk for diseases, particularly HIV and HCV that are associated with the sharing of smoking devices, as well as other health risks involved in smoking crack. However, the risk of transmitting and contracting HIV or HCV was perceived as remote and regarded as similar to that of sharing a cigarette. As well, participants were knowledgeable about where to access safer smoking resources.⁴

Sharing of devices used to smoke crack occurred as a result of not having access to one’s own clean unused stem at the time when it was needed. This was due to such factors as accessibility/availability of safer smoking resources (agency location, hours of operation or age restriction policies) or choosing not to carry one’s own stem for fear of being caught by police. Finally, some reported that they offer their stem to others for “the push” - to collect crack resin that may be smoked later.

It was reported in the research findings and verified by workshop participants that almost everyone who smokes crack will share a smoking device with others at some point. It was expressed that sharing is part of the culture of drug use and that it is a way of showing friendship or intimacy among people who smoke crack. Based on this, on account of potentially alienating people who smoke crack, it was felt that caution should be exercised when messaging around sharing of smoking devices. In particular, messages designed to dissuade sharing ought to be broadened to include the prevention of conditions that increase risk when sharing – for example, education about injuries to the lips, hands and oral cavity – and risk reduction strategies when oral sores are present, including the use of one’s own mouthpiece when sharing smoking devices and the use of a barrier while participating in oral sex. Further, it was suggested that the benefits of sharing be recognized. Such benefits may include enhanced social connection; access to shelter; and access to drugs. Messages that focus on ‘safer sharing’ might be better received by clients than those designed to dissuade sharing.

The possible role of “a culture of sharing” among people who smoke crack

Caution about overemphasis on preventing sharing rather than on “safer sharing strategies” to reduce the risk of disease transmission

⁴ Participants for this study were recruited through community agencies therefore the knowledge expressed by these users may not be representative of the general population of people who smoke crack in Ottawa, particularly those who are not accessing community harm reduction resources.

There is a need for research to explore the sharing culture among people who smoke crack; the benefits that people experience through sharing drugs and devices used to smoke crack; and ways that people may protect their health while continuing to share smoking devices. Such information may result in messages that are more reflective of the experience and reality of people who smoke crack.

Need for research on the role of sharing to identify determinants of sharing and “safer sharing” strategies

Despite a general awareness of the risks associated with sharing and knowledge of where to collect safer smoking supplies, research participants reported high rates of sharing devices while smoking crack. In addition to the possible sharing culture as described above, what leads to sharing is not having access to their own or a clean stem at a time when they have needed it. This may be due to structural barriers such as harm reduction agency location, hours of operation, or abstinence policies of shelters. However, it is also often linked to a fear of being caught by the police, particularly for those facing red zones or release conditions that prevent them from accessing or carrying safer drug use equipment.

Need for research examining the structural and social barriers to safer drug use

There were discussions of additional power imbalances that exist within drug using communities and how they have the potential to influence individuals’ ability to avoid sharing smoking devices. For example, some people (usually women and/or young people) have little control over their drug use, that is, they rely on others for their drugs and for drug using equipment. There is a need for research examining the determinants of sharing crack smoking devices, including the structural and social factors that act as barriers to safer drug use.

The impact of power dynamics on sharing behaviours and safer drug use practices

Alcohol and Risk

Alcohol use was raised as a factor with respect to crack use initiation and sexual and drug use risk taking and that this relationship must be considered in any prevention program. Many people try crack for the first time after they have been drinking alcohol, making them less likely to ask questions about the drugs or to consider the risks and take precautionary measures to protect themselves. In many regions, crack is readily available and relatively cheap compared to other drugs. Crack is known for its potential to provide people who have been drinking with renewed energy to continue partying, known as “sucking on the whistle”.

People who smoke crack recreationally (when they are drinking) or first time users may be less likely to take precautions or have their own drug using equipment on them as they often haven’t planned to smoke crack. It was expressed that this can be a particular problem for young men who have sex with men as crack has the effect of enhancing both energy and sex drive and it may be easily purchased after hours. The importance of looking at the context in which people initiate crack use was stressed by workshop participants.

Contexts of first time crack use and the role of alcohol among recreational users of crack

Suggested Solutions:

- Incorporate more prevention messages that are aimed at reducing particular risk factors, such as oral sores;
- Research the determinants of drug sharing, including the benefits of sharing drugs and drug using equipment, as well as the social and structural barriers to safer drug use;
- Engage peer workers, secondary exchanges, and ‘dial a dope dealer’ (dealers who don’t use drug themselves) to help develop and relay prevention messages;
- Improve safer smoking materials to better reflect crack using experience and drug using cultures;
- Make prevention information and harm reduction materials available after hours at bars and clubs; and
- Work with police and child protection workers to improve their understanding of the health risks associated with using non-recommended materials and sharing crack smoking equipment with the aim of helping them to understand their role in promoting health among people who smoke drugs.

3. Age

The Issues:

Age and gender were identified as distinct factors resulting in greater risk-taking when smoking crack. In particular, age restrictions on the distribution of safer crack smoking supplies in Ottawa (18 years and over) have the potential to affect younger users’ propensity to use someone else’s stem or to use another less safe device such as a pop can or medicinal inhaler to smoke crack. In addition, power imbalances in male-female and male-male relationships contribute to risk-taking.

The age restriction policy for accessing safer inhalation supplies in Ottawa (18 years and over to access stems) was initially put in place by Ottawa Public Health (OPH) as a required concession made by the Medical Officer of Health in negotiations with the Board of health in order to allow the program to go ahead (an additional concession was the imposition of a 5 stem limit per visit). The age restriction was kept in place by Somerset West Community Health Centre when they took over the distribution of safer inhalation resources because it was believed that the program would eventually be transferred back to OPH and that keeping existing policies in place would facilitate this transition. The shift back to OPH has not happened and, nearly three years later, these policies continue to exist. Workshop participants from Ottawa-based community agencies commented on how this policy is inconsistently applied, due to the reality that it

Age restriction policies (18 and over) for the distribution of safer smoking supplies

is an anonymous service and therefore no identification is required for the collection of safer smoking materials. As such, youth may be able to provide false birth dates in order to access safer smoking supplies in Ottawa. The age restriction for accessing safer injection equipment, on the other hand, is 16. This sends younger users mixed messages regarding risk reduction and choice of drug administration method.

Participants from other jurisdictions do not have imposed age restrictions for the distribution of safer inhalation supplies. It was expressed that these types of policies are discriminatory and dangerous for young people who use drugs – a population that community agencies should be most interested in protecting.

Age restriction policies send a message to youth that they are not able to access the service. As such, many youth may not be aware that they may access the service if they lie about their age. A dynamic is therefore set up through this policy in which youth are told they must lie to workers about their age, which is not a great foundation from which to develop a trusting relationship. These policies may result in youth putting themselves at additional risk, by using other people's smoking devices or by making devices out of various non-recommended materials. In addition, **youth who participated in the focus groups and in-depth interviews reported being taken advantage of by older users or drug dealers. Not being able to access their own supplies in addition to power dynamics between older and younger users introduced additional HIV- and HCV-related risk behaviours, particularly in situations where crack and sex were being negotiated and exchanged.**

Power dynamics particularly for youth being taken advantage of by younger users

Suggested Solutions:

- Eliminate age restriction policies for the distribution of harm reduction supplies;
- Conduct research for the design of services with specifically targeted information and resources for youth who smoke crack; and
- Provide drug education at an earlier age in schools, as there are areas where drugs are more affordable and easier to access than cigarettes.

4. Gender and Sex

The Issues:

Experiences of power dynamics in sexual relationships between men and women and between men and men were articulated by participants in both the focus groups and in-depth interviews. These power dynamics often involved coercion and violence and introduced additional HIV and HCV risk, particularly during sexual encounters. In addition, the risk of exposure to HIV and HCV appears to be heightened in situations where crack is exchanged for sex. Gender and power dynamics that accompanied male-female or male-male transactions coupled with the power of drug addiction often involved the negotiation of sexual acts that carried higher risk (e.g., sex without a condom).

Workshop participants expressed a particular concern with respect to power dynamics within drug using communities and the coercion and violence experienced particularly by women and compounded for youth, transgendered people, and those who are Aboriginal. Men who smoke crack experience enhanced sexual arousal, which puts women in a position where they can trade sex for crack, and are often encouraged to do so. It was noted that many of the issues that come up for young women also exist for young men who have sex with men.

Gendered power dynamics contribute to increased risk of exposure to HIV and HCV, particularly among women and men who have sex with men

Workshop participants, particularly those from Vancouver, described how some men, often dealers, will try and get women addicted to crack and/or heroin in order to establish a debtor relationship so that they can exert power and control over them. This power may be used to force the woman into the sex trade or it may be used to encourage women to sell or carry drugs in order to shift the risk of police arrest from the dealer onto the woman.

Drug-based power and control of women

Women who are mothers and use crack face additional threats of arrest or child apprehension which compound feelings of powerlessness and inability to get out of violent or oppressive relationships and/or to seek support or treatment for their addictions or other health concerns. For women with children, the fear of child apprehension can have a significant impact on their willingness to access harm reduction services or drug treatment, making them more vulnerable to risk taking. It was noted that in some regions ALL women on methadone maintenance therapy have their children taken away from them. Further, the majority of women's shelters for victims of abuse are abstinence-based. Therefore, being caught with safer drug using equipment may result in being thrown out, forcing women back into abusive relationships and/or back to increased risks involved in street life.

The impact of women-specific issues such as fear of child-apprehension on their drug using practices, as well as their access to safer crack smoking and treatment services

In addition, research has shown that mothers who are charged with dealing drugs get longer sentences than fathers charged with the same crime (reference: Susan Boyd – *Mother's and Illicit Drugs: Transcending the Myths*) and that women have a much harder time than men in drug courts due to restrictive policies and impositions of red zones which set them up to fail. For women (and men) who smoke crack and are involved in the sex trade, existing laws governing this work (solicitation, communicating and bawdy house laws) make them even more vulnerable to arrest or child apprehension. Workshop participants spoke of how police will arrest women and pressure them to 'rat out' their boyfriends or dealers.

Women face tougher drug-related sentences and more restrictive drug court policies than men

Suggested Solutions:

- Expand programs and services for men who are abusive to women in order to address the core reasons that they treat women in this way;
- Provide gender-specific harm reduction services including women peer support workers for women who use drugs, and young peer support workers to support young MSM, especially those involved in the sex trade. For these vulnerable groups, it is important to respond to their

immediate needs (food, shelter, drugs and paying off dealers) before they will be able to consider getting treatment for their drug use; and

- Create and nurture support networks for marginalized women. Several examples of existing groups were noted including:
 - Vancouver Coastal Health Authority offers harm reduction van services for people who use drugs as well as one specifically for transgendered people;
 - SWAV – Sex Workers Against Violence (BC) – delivered by and for women;
 - POWER – Ottawa sex workers group; and,
 - STORM van - sex worker outreach for Aboriginal people in Ottawa – just received training to distribute harm reduction materials, including stems. This service will run through the night to eight in the morning.

5. Stigma and Health Services

The Issues:

Among study participants, there was a level of comfort expressed in accessing health services and disclosing drug use to agencies that offer harm reduction services. However, there were numerous accounts of stigma and discrimination encountered when accessing mainstream health services, from stigmatizing language to perceived differential treatment based on a person’s drug use.

Vancouver Area Network of Drug Users’ women’s group recently completed a research study entitled [“*Me, I’m Living it: The Primary Health Care Experiences of Women who use Drugs in Vancouver’s Downtown Eastside*”] in Vancouver’s Downtown East Side on the experiences of women who use drugs in accessing health care services. The research has found that many women who use drugs reported being told by health providers that all the health issues they have are a result of their drug use and, as such, are often treated without consideration of all facts.

Suggested Solutions:

- Educate health and social service professionals on addiction and drug use in order to reduce stigma and improve access to health services for people who use drugs.
- Extend the provision of harm reduction services and supplies to general health care agencies in an effort to normalize and reduce stigma involved in accessing these services and to provide enhanced access to other health support services for people who use drugs.

Drug users’ experience of stigma and discrimination from health care providers suggests the need for enhanced drug use and addiction education for health professionals

6. Treatment

The Issues:

Participants in the focus groups and in-depth interviews spoke of difficulties encountered in accessing treatment when they needed/wanted it and how treatment options and policies, such as abstinence requirements, tend to set people up to fail. Some examples of problematic policies included the fact that facilities are designed for people who are single, there are no options for couples who want to go through treatment together, and the majority of programs are abstinence-based, meaning that people get kicked out for using any drugs (including marijuana which has been known to help some people deal with withdrawal symptoms from heavier drugs).

These sentiments were confirmed by workshop participants who indicated that the best time to reach someone to enter treatment is when they are coming down. Treatment should be available on-demand for those who want it. In addition, treatment needs to be culturally appropriate and offered within a holistic continuum of services and care that considers the whole person, including their individual experiences and needs and where they are in their addiction.

Suggested Solutions:

- Ensure that treatment is available when people are ready (on demand);
- Remove limits on the number of times someone may access drug treatment – it may take several attempts before someone is able to stop using drugs;
- Make treatment options for couples available as well as culturally appropriate services and programs, particularly for women;
- Provide a continuum of harm reduction, detoxification and treatment services. For example, a European model was described as the ideal – where the 1st floor includes a safer consumption facility, the 2nd floor a sobering centre, the 3rd floor a detoxification centre, and the 4th floor has a treatment facility; and
- Design treatment programs to include life planning and career training opportunities to people as a means of filling the void that is left when their drug use stops.

Limited treatment options for people who smoke crack

Need for a holistic continuum of harm reducing and drug treatment options for people who smoke crack

7. Public Drug Use and Housing

The Issues:

Many focus group and interview participants indicated that housing instability or homelessness left them with little choice but to smoke outdoors in public spaces, often further compromising their personal safety. Fear of being caught by police forces people to use in dark, isolated corners, which contributes to additional environmental (physical or social) risk. Among those who had housing, a fear of using at home was expressed on account of the risk of having their home labelled by police and others as a “crack house” and experiencing the consequences of this.

Workshop participants confirmed that housing must be central to discussions about public drug use. There is a need to consider the role of housing in people’s safety and access to safer drug using practices. Housing instability and the safety issues related to public drug use emphasizes the need for safer smoking spaces (both indoor and outdoor).

Despite the importance of housing, workshop participants reminded the group that there is no ‘typical drug user’. Rather, there are stereotypes that exist as a result of seeing people who use drugs who are also homeless. It was suggested that the stereotype would change if we were able to access and include stably housed people who use drugs as participants in our research. People who use drugs and who are stably housed tend to get overlooked in drug use research, policy and programming. However, these groups may be among the most at risk on account of isolation and a lack of connection with support services.

Suggested Solutions:

- Expand current research on drug use and the determinants of health, with a particular focus on access to affordable and/or supported housing;
- Advocate for increased access to supported and affordable housing for people who use drugs;
- Explore options and feasibility of safer drug using spaces; and
- Expand understanding of the needs and experiences among people who use drugs and who are stably housed

8. Safer Crack Use Materials

The Issues:

According to study participants, whenever possible, glass stems were used to smoke crack however, mouthpieces were rarely used and Brillo was often used in place of the brass screens that are provided as part of distributed safer inhalation kits.

The role of housing on public drug use and access to safer drug using practices

A tendency to stereotype drug users as “homeless” suggests the need to broaden our research to include the unique experiences and needs of people who smoke crack and are stably housed

Mouthpieces

It was felt that the rubber mouth pieces that are distributed by the Ottawa-based safer inhalation program are good because they are flexible (even in cold weather), although they are more difficult to put on and can have a rubbery taste. A workshop participant from Ottawa presented a new mouthpiece (made of clear plastic tubing) that had been pilot-tested with people in Ottawa who smoke crack. However, these new mouthpieces may not be acceptable to users because although they are easier to put on, they are difficult to remove and there is risk of breaking the stem in the process, with broken glass increasing the risk of injury and blood transfer. Mouthpieces must be easy to put on and take off, otherwise they interfere with people's ability to do the 'push' (to smoke the crack resin that collects in the stem) which involves turning the stem around and smoking from the opposite end.

Need for research to assess and improve currently available/recommended safer crack smoking materials, particularly mouthpieces and brass screens

The length of mouthpieces provided was also deemed important due to different length preferences. Longer mouthpieces are preferred by some for the ability to hide the stem/mouthpiece in their sleeve, while others' preference for longer mouthpieces lies in their ability to watch the smoke move through the tube on its way toward their mouth. On the other hand, participants from Toronto expressed a preference for shorter mouth pieces – approximately 1/3 of an inch long. The consensus was that mouthpieces should be cut according to individual preference. Participants from BC indicated that they offer a variety of gages and lengths.

There was also discussion about the use of electrical tape around pipes in lieu of mouthpieces. Some agencies in Toronto continue to offer tape despite the fact that tape has a tendency to leave a sticky residue around the end of the pipe making it difficult to turn the pipe around when a person wishes to do the 'push'. Many agencies in Toronto continue to provide electrical tape based on the fact that some users prefer it over mouthpieces.

Screens

Workshop participants from BC distribute stems that are pre-packed with screens. The workers do not have funding for this safer inhalation distribution program so they have to receive a \$2 donation for each one that is distributed. However, the cost of the stems does not seem to be a deterrent - people do come in and buy them, some people collecting 20 at a time.

Potential risks involved in pre-packing the stems with screens were discussed. For example, a pre-packed/assembled pipe is more like paraphernalia than an unpacked stem, therefore enhancing risk of being arrested or charged. In addition, there are potential HIV and/or HCV risks associated with pre-packing the screens due to small puncture wounds to fingers that may leave traces of blood on the stem during the assembly process.

It was suggested that the lack of awareness of how to properly pack a stem with a screen is what leads many people to use non-recommended materials such as

Brillo. A peer worker from an Ottawa-based agency distributes instructions on proper stem assembly, including screen packing.

Brillo has been deemed a dangerous alternative to brass screens because it breaks down when heated which results in people inhaling or swallowing pieces of hot metal, causing oral and lung damage. Research carried out in 2006/08 in Ontario showed a lot of Brillo being used among people who smoke crack. A program manager from Ottawa commented that they rarely give out stems without screens now. The impression therefore is that the message regarding the risks of using Brillo may be catching on and Brillo use may be decreasing. However, participants from a Vancouver-based agency noted that in Vancouver they are continually being asked for Brillo.

Suggested Solutions:

- Allow people to pack their pipes while they are in the harm reduction agency. This will provide the opportunity for support and education related to stem assembly and will help to avoid possible police harassment and weather conditions that can make assembly challenging;
- Offer a variety of safe products in order to meet personal preference so that uptake may be optimized;
- Work toward the development of a universal kit for crack and crystal meth smoking (Toronto-specific suggestion);
- Offer direct one-on-one prevention and risk reduction support to individuals during exchange encounters with people who use drugs;
- Explore and compare currently distributed harm reduction materials with those being distributed in other parts of the world. Perhaps there is a need to hire someone to develop a pipe specifically for smoking crack (or other drugs) rather than trying to put one together from existing materials – there was a suggestion to run a contest; and
- Expand prevention messages regarding transmission of blood-borne pathogens (such as HIV and HCV) to include other health risks, such as damage to the mouth and lungs, as these risks may be more real and more immediate than the more remote risk of HIV and HCV transmission and infection among people who smoke crack.

9. Safer Disposal of Used Smoking Materials

The Issues:

Among study participants, there was a lack of awareness of the importance of safer disposal of devices used to smoke crack. Smoking supplies were often disposed of hastily for fear of being caught by the police, particularly among those who face parole conditions that prohibit the carrying of drug-using equipment.

There are currently no guidelines for the safer disposal of used crack smoking equipment although existing research would suggest that they should be disposed of in the same way as used needles – in a biohazard container. There was discussion about the importance of safer disposal among workshop participants, most of whom remained unclear as to whether or not unsafe disposal of used crack pipes is in fact a safety issue and therefore whether it should be considered a programming priority. Although research has demonstrated the presence of the Hepatitis C virus on used stems (*Hepatitis C virus transmission among oral crack users: viral detection on crack paraphernalia* Fischer et al., 2008), there is a need for additional research to determine whether there is a risk of transmission. It was suggested that there may be too much riding on this one exploratory study and that other research is needed to ascertain (a) whether there is enough of the virus on the stem to facilitate transmission, (b) whether the virus is alive, and (c) whether it could make it into a receiving host system.

While safer disposal may be important in order to avoid the risk of viral transmission and risk of harm to others when handling used equipment, safer disposal is definitely important with respect to public relations. It was agreed that following precautionary principles and in the interest of public/community relations, people who smoke crack should be encouraged to return their used crack smoking materials to needle exchange programs or deposit them in biohazard containers.

Many agencies are now providing personal sized biohazard boxes. They are not currently part of the Safe Inhalation Program in Ottawa but people seem to prefer them. However, according to workshop participants, one problem with these boxes is that people break out the insert that separates clean from dirty equipment so that they have space for all of their pipes (the dirty side fills up too quickly). As such, users risk getting clean and used stems mixed up, which is of particular concern if they are carrying pipes that have been used by other people.

As described in the ‘Law Enforcement and Policing’ section, policing and threat of arrest also contribute to unsafe disposal of pipes. In particular, the fear of being caught by police while carrying used equipment results in people feeling that they have to dispose of their used equipment quickly (get rid of the evidence) before they have a chance to do so more safely. Further, police confiscation and crushing of stems on the street perpetuates the belief that there is no risk to others and sets a poor example for people who use drugs.

Suggested Solutions:

- Initiate discussions with people who smoke crack regarding the importance of safer disposal and develop acceptable guidelines for safer disposal techniques;
- Reframe messages related to safer disposal to reflect healthy communities rather than individual responsibility;

Lack of awareness among people who use drugs and harm reduction agencies of the importance of safer disposal of used smoking materials

Existing evidence of risk may contribute to reducing emphasis on safer disposal as a programming priority however disposal remains important for public/community relations

Need for research examining the benefits of safer disposal for the development of best practice guidelines for the disposal of used crack smoking materials

Law enforcement contributes to unsafe disposal of used crack smoking materials

- Address issues surrounding fear of being caught with equipment by police as this is a major contributor to unsafe disposal;
- Increase accessibility of biohazard containers and black boxes, particularly in areas with high rates of discarded used supplies;
- Increase the role of mobile services and other fixed site agency partners in the collection of used equipment; and
- Engage agencies, frontline workers and people who smoke drugs in creating an environment that encourages, supports and values safer disposal of used crack smoking equipment.

CONCLUSION AND NEXT STEPS

The primary purpose of the early knowledge translation workshops was to ensure that the research objectives aligned with the needs and priorities of partners and stakeholder groups including community members, researchers, decision-makers and those involved in service delivery for people who smoke crack. Alignment of priorities at this initial stage and continued engagement through participation in subsequent knowledge translation workshops throughout the research process was designed to enhance the potential for research findings to result in improved policy and programming to address the HIV and HCV prevention needs of men and women who smoke crack.

The meetings presented an opportunity for cross-regional sharing of the collated data about a group of people whose particular health needs are not well understood. Findings from this research project provided a starting point from which to dialogue about a number of important and challenging issues. The workshops were designed to allow time for in-depth discussion and brainstorming solutions to address crucial issues that are common to most if not all regions across the province and country.

Workshop participants highlighted the importance of opportunities for further transfer of knowledge from this research project and others through subsequent partner meetings. As well, it was suggested that recommendation fact sheets (written in accessible language and made available in different languages, particularly French) that summarize the various issues and solutions as identified during the workshops be prepared to target specific programming, policy and research audiences.

Solutions to the issues discussed are complex and involve a variety of actors at all levels of government and civil society. We encourage our partners and collaborators to consider what role they are able to play in advancing some of these issues as individuals, as organizations, or through the formation of collective movements.

University of Ottawa's HIV and HCV Prevention Research Team is committed to ensuring a continuing life from this project. First, we intend to continue our research exploring the needs of people who smoke crack and documenting issues surrounding access to safer smoking practices for specific population groups. As well, we will ensure that findings from this project reach the hands of appropriate actors – community members, policy makers and programmers – in order that findings may lead to improved policy, programs and service delivery for people who smoke crack.

In particular, the HIV and HCV Prevention Research Team will:

- Consider advice presented by our colleagues to broaden the disease model approach traditionally taken in our research with men and women who use drugs, and consider ways in which other factors, such as the determinants of health, may be explored more thoroughly.
- Arrange a meeting with the Ottawa Police Force to discuss research findings related to enforcement issues and red zoning practices.
- Apply for funding to carry out a province-wide survey of men and women who smoke crack in order to gather evidence in support of safe inhalation programming in order to reduce HIV and HCV risk behaviours. (Proposal submitted to the Canadian Institutes for Health Research (CIHR), 2011)
- Apply for funding to conduct research exploring the harm reduction and HIV and HCV prevention needs of youth in Ottawa who smoke crack. (Proposal submitted to CIHR 2011 and approved for funding)
- Apply for funding to carry out additional age-based analyses of existing Ottawa-based SurVIDU (I-Track) data in order to gain a better understanding of age-related differences in drug use, service access and risk factors. (Proposal submitted to CIHR 2010)
- Apply for funding to carry out a community-based research project exploring the impacts of the use of red zones and other conditional releases on the lives and HIV and HCV risk behaviours of men and women who smoke crack.
- Apply for funding to conduct additional analyses of existing data as well as new data regarding the factors and particular environments which influence whether or not a person shares their crack pipe – to explore the determinants of sharing crack smoking devices.
- Apply for funding to explore the context in which people initiate crack use and how the context of this initiation (e.g. social situation, devices used, and physical environment) may be linked to their current drug using practices.
- Apply for funding to research the advantages of safer disposal practices for the purpose of developing best practice guidelines for safer disposal of used crack smoking materials.

APPENDIX

Workshop Participants - Knowledge Translation Partners

Organization	Region	Individual(s)
AIDS Bureau, Ministry of Health and Long Term Care	Ontario	Frank McGee
AIDS Committee of Ottawa (ACO)	Ottawa	Kathleen Cummings
BC Centre of Excellence on HIV/AIDS	British Columbia	Kate Shannon
BC Ministry of Healthy Living and Sport	British Columbia	Ciro Panessa
Canadian AIDS Society (CAS)	National	Lynne Belle-Isle, Brittany Graham
Canadian AIDS Treatment Information Exchange (CATIE)	National	Jeff Reinhart, Laurel Challembe
Canadian Centre for International Health	National	Alison Marshall
Canadian Harm Reduction Network	National	Walter Cavalieri
Canadian HIV/AIDS Legal Network	National	Richard Pearshouse, Alison Symington
Canadian Students for Sensible Drug Policy (CSSDP)	National	Tara Lyons, Caleb Chepesiuk
Centre for Addiction and Mental Health (CAMH)	Toronto	Carol Strike
Dalhousie University	Halifax	Joanne Parker
Drug Users Advocacy League (DUAL)	Ottawa	Sean LeBlanc
First Nations Inuit Health Branch (FNIHB)	National	Emily DeRubeis
Hepatitis C Secretariat - Ministry of Health and Long Term Care	Ontario	Janis Tripp
Mobile Outreach Street Health Services (MOSH)	Halifax	Patti Melanson
Oasis and Sandy Hill Community Health Centre	Ottawa	Rob Boyd
Ontario Aboriginal HIV/AIDS Strategy (OAS)	Ontario	Tania Dopler
Ontario Harm Reduction Distribution Program (OHRDP)	Ontario	Cathy Cleary, Nadia Zurba
Ontario HIV Treatment Network (OHTN)	Ontario	Melissa Dickie, Jessica Harris, Glenn Betteridge, Jason Globerman
Oscapella and Associates	Ottawa	Eugene Oscapella
Ottawa Public Health – City of Ottawa	Ottawa	Pam Oickle, Rick Diaz, Orhan Hassan, Paul Lavigne
Public Health Agency of Canada (PHAC) – Hepatitis C Prevention, Support and Research Program	National	Katherine Dinner
Public Health Agency of Canada (PHAC) – HIV/AIDS Policy, Coordination and Programs Division	National	Kevin Muise, Jocelyn Guay
Public Health Agency of Canada (PHAC) – Canadian Nosocomial Infection Surveillance Program (CNISP)	National	Linda Pelude
Shout Clinic Community Health Centre	Toronto	Lorraine Barnaby
Simon Fraser University	Vancouver	Benedikt Fischer
Somerset West Community Health Centre	Ottawa	Jennifer Simpson
The City of Vancouver	Vancouver	Don MacPherson
Toronto Drug Strategy Secretariat – City of Toronto	Toronto	Susan Shepherd
Toronto Safer Crack Use Coalition (SCUC)	Toronto	Barb Panter
Unified Networkers of Drug Users Nationally (UNDUN)	National	Debs Breau, Brent Taylor
University of Ottawa	Ottawa	Lynne Leonard, Aideen Reynolds, Charles Furlotte, Kate Smith, Sue McWilliam, Andree Germain, Emily Medd
University of Toronto	Toronto	Peggy Millson, Carol Strike
Vancouver Area Network of Drug Users (VANDU)	Vancouver	Ann Livingston, Richard Utendale, Dean Wilson, Robb Chauhan, Tracey Reynolds, Laura Shaver
Youth Harm Reduction Advisory Committee – YSB	Ottawa	Krista Driscoll, Max Rowsell, Kaylin McGregor-Nolan, Peter Gindl
Youth Services Bureau YSB	Ottawa	Andrea Poncia