

Safer injecting facilities in Vancouver: considering issues beyond potential use

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In this issue (page 759), Thomas Kerr and colleagues¹ report on a cross-sectional study of the attitudes of Vancouver injection drug users (IDUs) toward rules for safer injecting facilities proposed by Health Canada.² They examine the impact of selected rules (specifically, prohibition of on-site drug sharing, prohibition of assisted injection and mandatory client registration) and of police presence on rates of potential use of such facilities by IDUs. The study is clearly significant for the Canadian context. Vancouver's first legal trial of a safer injecting facility will commence in September 2003 after a protracted debate. The study adds to what is still a small body of published research on the feasibility of these facilities and their acceptance by IDUs, despite more than a decade of experience in Switzerland, Germany and the Netherlands (and, more recently, Australia and Spain).^{3,4} Given the large number of participants in the Vancouver study¹ (more than 450) and their demographic and drug-use characteristics (Kerr and colleagues state that the study sample was representative of the target population for the new facility), the results represent valuable baseline data for the coming trial, particularly if formative process evaluation methods, in which ongoing consultation with service users about service operations is a key feature, are to be employed.

From a public health viewpoint, the main findings of interest are the high levels of reported willingness by IDUs (particularly public injectors) to use a safer injecting facility, and the extent to which this endorsement dropped (particularly among women) in the face of prohibition of drug-sharing, prohibition of assisted injection, mandatory client registration and proximal policing. The study replicates findings from similar research that my colleagues and I have conducted in Melbourne, Australia; in those studies, although most IDUs supported the establishment of safer injecting facilities, their reported willingness to use such services varied according to the restrictions in effect.^{5,6}

Two major weaknesses in the current study deserve comment. First, the authors do not discuss why the Health Canada rules they targeted are important for the health and safety of clients of safer injecting facilities. In this context, rules related to drug-sharing, assisted injecting and client registration, as well as those related to handwashing and infection control, violence, on-site dealing and loitering, have

relevance beyond the state's concerns about civil and criminal liability. Hygienic injecting practices are necessary because of the theoretical risks of transmission of bloodborne viruses and bacterial infections. In particular, hepatitis C virus can be efficiently transmitted by injecting practices that cause blood to be spread on hands, fingers and various injection items.^{7,8} The prohibition of on-site drug-sharing is important in preventing disputes between clients, and client registration is crucial for purposes of evaluating the facility. Kerr and colleagues¹ rightly conclude that the design of a safer injecting facility should seek to balance regulatory requirements with accessibility for high-risk groups. However, strict service protocols will be necessary for the Vancouver facility, given that it will be operating in the context of a scientific research trial, where, for better or worse, the main goal will be to deliver a reliable and valid evaluation of outcomes.

A second, related weakness (acknowledged by the authors) is that the researchers considered the possible impact of only 3 Health Canada rules (and 1 environmental factor, proximal law enforcement) on potential use of the safer injecting facility. Furthermore, they do not tell us what strategies Vancouver IDUs might employ either on site or off site to adapt to the rules they disagree with, or indeed *why* they disagree with the rules that are being imposed. These are critical issues if the goal of the research is to inform the development of operations protocols for future facilities. The impact of such guidelines on the extent of use of the facility and on behaviour on site will of course become clearer when the Vancouver trial commences. In this regard, it will be important to monitor the attitudes and behaviours related to safer injecting facilities of both attendee and nonattendee cohorts of Vancouver IDUs. However, it appears that an important opportunity may have been missed to gather a comprehensive set of baseline data on IDU attitudes toward other key components of the Health Canada protocol and possible adaptive responses before implementation.

Beyond the matter of potential use of the facility, the Vancouver study¹ raises an important, broader set of issues that have to date received less attention, given the focus on outcomes in recent international trials of safer injecting facilities.⁴ One such issue is the role of IDU opinions and ex-

expertise in the development of protocols for these facilities. A compelling case can be made for consulting closely with the intended target group — street-based IDUs — about the suitability of recommended models and operational protocols. In the recent literature on health program evaluation, the value of purposive consumer consultation for service design, evaluation quality and community acceptance has been rated highly.^{9,10} I join Kerr and colleagues¹ in expressing the hope that their latest findings will have some impact on the Health Canada guidelines.

A related issue is the ethics of trials of such facilities. Macro ethics issues have emerged in the public debate in Vancouver, where questions of the moral status and implications of safer injecting facility trials and the drug policy of which they are a component have figured prominently.^{11,12} In the study by Kerr and colleagues,¹ micro ethics issues such as privacy and confidentiality were clearly salient for the IDU sample: the greatest decline in willingness to use a safer injecting facility occurred in the face of client registration and proximal policing. Other significant micro ethics issues that should be considered in the design of any safer injecting facility trial include: differences in the requirements of facilities functioning as research projects from those of facilities operating as treatment sites; decisions about resource allocation; distributive justice and questions about community representation and consultation (e.g., Are the benefits and costs of trials of these facilities shared fairly among different IDU groups?); informed consent in the case of intoxicated clients; and voluntary consent in the context of dependent relationships (e.g., with staff of the facility) or inducements for research participation (e.g., payment, treatment). Although the protocols for safer injecting facility trials normally require approval from institutional research ethics committees, neither the prominent ethical dilemmas that arise nor the ensuing committee deliberations are typically published. We have a responsibility to do more than consign these difficult ethical questions to the veiled processes of ethics committee review. The continuing debate about safer injecting facilities will benefit from further explication of these important issues. Researchers, the Vancouver safer injecting facility trial team, the community, research ethics committees, the media and government all have important roles to play here.

The Canadian experience with safer injecting facility trials will be of substantial interest to international audiences and of value for those jurisdictions where similar trials have been proposed. The parties involved in implementing and evaluating this first Vancouver trial (and perhaps others that follow) have an exciting opportunity to collect and contribute high-quality data to the growing international evidence base on the processes and outcomes associated with safer injecting facilities. In doing so, they might also tackle some of the broader issues that are important to these trials.

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