Second National Workshop on HIV, Alcohol, and Other Drug Use

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February 6 – 9, 1994

Co-hosted by:
Health Canada, the Canadian Centre on Substance Abuse, the Alberta Alcohol and Drug Abuse Commission and the Alberta Health AIDS Program

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Foreword

The First National Workshop on HIV and Injection Drug Use, funded by Health Canada in collaboration with the Canadian Public Health Association, was held in Montreal in March of 1990. This allowed more than 120 participants from a wide range of disciplines and affiliations to exchange information and experiences gathered in their communities across the country.

Between 1990 and 1993 the nature of the HIV epidemic as well as the strategies being used to deal with its spread, changed. It was agreed by the partners involved that another national workshop on HIV and drug use was needed to provide an update and to fill gaps. As a result, a planning committee was formed to coordinate a second workshop — one that would address not only injection drug use but also other forms of drug use.

The Second National Workshop on HIV, Alcohol and Other Drug Use was held in Edmonton, Alberta in February of 1994. The workshop brought together more than 130 participants from all areas of Canada. The workshop was co-hosted by Health Canada, the Canadian Centre on Substance Abuse, the Alberta Alcohol and Drug Abuse Commission and the Alberta Health AIDS Program. It was funded by Health Canada through the AIDS Education and Prevention Unit, under the National AIDS Strategy and the Alcohol and Other Drug Unit, under Canada's Drug Strategy.

As a result of discussions with people across Canada, members of the Organizing Committee specified the goal of the workshop as follows: to contribute to the prevention of HIV infection and its consequences by highlighting new information and strategies to reduce HIV transmission associated with the use of alcohol and other drugs (licit and illicit). The workshop provided a means whereby people working in the area of HIV, alcohol and other drug use could exchange information and skills and work towards the development of a comprehensive strategy for dealing with these issues in Canada.

Participants were invited from all parts of Canada and from a broad range of sectors and disciplines including public health, addiction treatment, community-based service agencies, the research community, all levels of government and nongovernmental organizations.

The workshop served to reinforce a theme that is recurrent in this area: in order to bring about true harm reduction, the sharing of skills and information must continue so that appropriate, multifaceted programs that are sensitive to the needs of Canada's diverse communities can be developed. The workshop also reinforced another theme, one that we tend to forget when facing the grim situation with respect to AIDS and drug use: although working alone we may feel overwhelmed by the enormity of the problem before us, working together we can prevent the spread of HIV.

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Introduction

Drug use and drug injecting can result in a number of problems for the individual, the community and society as a whole. HIV has greatly increased the direct harms associated with drug injecting in particular and the indirect harms associated with drug use in general. HIV and other infections can be transmitted when used needles, syringes and other paraphernalia are shared and they thereby pose a direct risk to injection drug users. In addition, use of alcohol and other drugs may pose an indirect threat in that drug use in general may be associated with the practice of risky behaviours including unsafe sex and unsafe injecting.

The implications of HIV transmission among drug users are profound. In Canada as in many other countries, the heterosexual transmission of HIV is in part fed by the epidemic among injection drug users. The gravity of the situation is made more apparent by consideration of the fact that the majority of injection drug users have non-injecting sexual partners. In addition, women with HIV infection due to drug use or sexual activity with an injection drug user are at risk of bearing HIV infected children.

Experience in a number of countries has shown that, in the absence of preventive measures, the number of people infected with HIV can increase very rapidly once the virus has spread among drug users. Experts around the world agree that intensive efforts to keep infection rates among injection drug users below 10 percent are necessary. If infection levels go beyond this, the epidemic can become explosive in nature as has been seen in several cities around the world. In Edinburgh, Scotland, seroprevalence in injection drug users increased from 5 in 1983 to 57 percent in 1985 (Robertson et al., 1986). In Bangkok, Thailand, rates rose from 1 per cent in 1987 to 43 per cent in 1988 (Berkelman et al., 1989). In both of these cities, the primary reason for the rapid rise in levels of infection was the lack of availability of clean injection equipment.

In Canada, proportions of injection drug users with HIV infection vary from 5-6 per cent in Vancouver to 6-8 per cent in Toronto and 10-20 per cent in Montreal.

Among inmates of correctional institutions, rates of HIV infection appear to reflect the level of infection among injection drug users in the general community. in a study of provincial jails in BC, 2.1 per cent of inmates with a history of injection drug use were found to be HIV positive (Rothon, 1993). In an Ontario study of the provincial system, this rate was 3.8 per cent (Calzavara, 1993). In Quebec, the rates among male and female provincial prison inmates who had injected drugs were found to be 8 per cent and 13 per cent respectively (Hankins et al., 1991, 1994).

There is an urgent need to prevent the increase of HIV infection rates among drug users, their sexual partners and unborn children. Preventive measures aimed at these groups should be a priority in all areas of the country. Implementation of prevention programs with injection drug users is, however, extremely difficult. Marginalized by the laws and attitudes of our society, injection drug users are often hard to reach both literally and figuratively. Many tend to distrust services because of a history of unpleasant experiences with authority. Many rank prevention of AIDS a low priority in their day to day struggle to find food, drugs, shelter and escape from abuse. In order to reach these individuals, programs must be sensitive, non-judgmental, multifaceted, and innovative in nature. Data from Canada and a number of other countries show that drug users can and do try to protect themselves and others from HIV infection. Studies of cities with syringe exchanges and other harm reduction programs show that the spread of HIV among injection drug users can be slowed and even halted.

In many cases, however, our current preventive measures are inadequate for the purposes of significantly reducing the spread of HIV among drug users on a long term basis. It is important to mobilize drug users, their partners and those who work with them to encourage them to adopt harm reduction practices such as the use of clean needles and

[1] For a definition of "harm reduction" and other terms, see the following *Definitions* section

condoms. People practice risky behaviours for complex reasons related to attitudes, pressures and barriers. It is only through training, research and cooperation that we will be able to deal adequately and humanely with this complex and compelling problem.

In 1988, the World Health Organization designated drug users as a target group for measures to be adopted to prevent the spread of AIDS. In the same year, the National Advisory Council on AIDS (NAC-AIDS) established a Working Group on HIV Infection and Injection Drug Use with members appointed from the field of drug treatment, epidemiology, and public health. The mandate of the group was to assess the level of HIV infection among Canadian injection drug users, to identify issues, and to make recommendations about the development of national strategies to reduce the transmission of HIV associated with injection drug use in Canada.

Because of the concern regarding the spread of HIV in Canada, the NAC-AIDS Working Group recommended, in early 1989, that a national workshop be held on this topic. Sponsored jointly by the Federal Centre for AIDS, Health and Welfare Canada, NAC-AIDS and the Canadian Public Health Association AIDS Education and Awareness Program, this workshop provided the first opportunity in Canada for those working in the AIDS and injection drug use fields to exchange information and experiences from various, communities across the country. More than 120 participants from many disciplines and affiliations and many areas of Canada attended this meeting. A report on the proceedings of the first workshop is available from the National AIDS Clearinghouse at the Canadian Public Health Association, Ottawa.

One of the outcomes of the NAC-AIDS Working Group on HIV Infection and Injection Drug Use was a document entitled *Principles and Recommendations on HIV Infection and Injection Drug Use*, which was released as a discussion paper for use at this workshop. The purpose of the Principles and Recommendations document was "to stimulate discussion, to challenge our perceptions, and to motivate all of us to examine policies and practices in agencies, departments, municipalities, hospitals, correctional services, and educational systems which may be contributing to the spread of HIV infection, affecting the quality of care, or which may be discriminatory" (1993, page 3). This document, included in these proceedings, served as background material for the Second National Workshop, and was the foundation on which workshop discussions and recommendations were based. Participants were encouraged to read the document in preparation for the meeting and to consider ways in which strategies and programs could build upon its recommendations. Participants were also asked to consider additions and/or modifications to the *Principles and Recommendations* document in light of their own experiences and recent trends. The recommendations that came out of this process are included in the current proceedings.

In the years that followed the first workshop the nature of the HIV epidemic in drug users changed in nature as did our understanding of it. On the one hand it became clear that, while harm reduction efforts were working, more intensive, multifaceted approaches to the problem were needed. On the other hand, it also became apparent that the focus of the epidemic was no longer injection drug users alone. Other drug users, including users of alcohol, were clearly at risk because of the association between drug use and the practice of risky sexual and drug injection practices. Because of the need to both update and broaden prevention efforts in Canada, it was decided in 1993 that another national workshop was called for.

The Second National Workshop on HIV, Alcohol and Other Drug Use took place in Edmonton, Alberta in February of 1994. The workshop was co-hosted by Health Canada, the Canadian Centre on Substance Abuse, the Alberta Alcohol and Drug Abuse Commission and the Alberta Health AIDS Program. The overall goal of the workshop was to contribute to the prevention of HIV infection and its consequences by highlighting new information and strategies to reduce HIV transmission associated with the use of alcohol and other drugs (both licit and illicit). Session themes included effective prevention strategies and suggested new models and partnerships for outreach, care and intervention.

The specific objectives of the workshop were:

1. To review relevant research, policy and program developments.

2. To raise the profile of selected issues through special sessions on, for example, risk environments and target populations.

3. To work towards agreement on effective strategies, and promote partnerships for action on harm reduction objectives.

As was the case with the first meeting, participants of the workshop represented a number of disciplines and affiliations including community groups, public health agencies, treatment centres, governments, clinics, and other nongovernmental organizations in the health field. The population of a province/territory was also a criterion for determining the number of persons representing that area. Every effort was made to ensure representation from smaller and remote communities so that information was shared as widely as possible around Canada.

Speakers at the workshop were from a wide variety of disciplines, services and community groups. They included street workers, counselors, administrators, police officers, lawyers, policy analysts and public health professionals. Their expertise provided participants with valuable information and strategies for reaching drug users and helping individuals, families and communities to prevent the spread of HIV.

The Second National Workshop on HIV Infection, Alcohol and Other Drug Use, like the first, provided an opportunity for individuals working in the area to share their experiences with colleagues from across Canada. The workshop provided a vital step towards improved prevention methods by facilitating the exchange of information and skills regarding the reduction of drug-related harm in Canada. It was apparent to all in attendance that the ongoing threat of HIV leaves no room for complacency. An increased and sustained emphasis on preventive interventions which focus on reducing the harms associated with drug use is essential if we are to contain the spread of HIV.

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Definitions

AIDS *(Acquired Immunodeficiency Syndrome)*
A syndrome resulting from a virus that attacks the body's immune system, causing it to malfunction, thereby leaving the person vulnerable to infections and cancers. AIDS is the most advanced stage of the disorder associated with the Human Immunodeficiency Virus (HIV).

Decriminalization
A system in which drug trafficking and possession are forbidden by law but in which simple possession (and sometimes cultivation for personal use) is not associated with criminal penalties.

Harm Reduction
A social policy which focuses on the reduction of the negative consequences of drugs and drug use rather than on the elimination of drugs and drug use. Also called harm minimization, risk reduction and risk minimization.

HIV *(Human Immunodeficiency Virus)*
The virus associated with AIDS found primarily in the blood, semen or vaginal fluid of an infected person.

Injection Drug Use *(IDU)*
Any drug use involving injection of drugs into the vein, muscle or other parts of the body through the use of a syringe or similar device.

Legalization
A system in which the manufacture, possession and distribution of drugs is legal. This can take many forms, ranging from medicalization (see below) to regulation and taxation models, similar to alcohol regulation.

Medicalization
A system in which drugs are legally distributed to dependent users by physicians; also known as Prescribing Programs.

Methadone
Methadone is a synthetic alkaloid which is chemically similar to morphine. The effects of methadone are similar to those of the other opiates, the main differences being that some of the effects of methadone last longer than those of morphine or heroin. Under current Canadian law, methadone can be legally prescribed to people dependent on opiates but heroin and morphine can not.

Methadone Maintenance
A program in which drug users are provided with methadone from a clinic or a general practitioner for as long as is considered necessary for the well-being of the user.

Needle Exchange
See Syringe Exchange.

Prescribing Programs
A form of harm reduction program, in which dependent users are prescribed their drugs legally by physicians.

Prohibition
A system which makes the manufacture, sale and, in some cases, possession of certain substances forbidden by law.

Seroconversion
The fact that a person's blood serum shifts from being negative to being positive for a particular pathogen, in this case HIV.

Seroincidence
The rate at which new cases of HIV seropositivity occur in a population.

Seropositivity
The fact that a person's blood serum is positive for a pathogen, in this context HIV.

Seroprevalence
The level of seropositivity in a population.

Syringe Exchange
A place, either stationary or mobile, where clean needles/syringes are distributed in exchange for used ones. These sites often provide condoms and educational materials as well as access to workers who will give counselling and refer users to other services, including treatment.

Zero Tolerance
A policy which does not permit any use whatsoever of a particular substance.

Papers Submitted by Plenary Speakers and Panel Members

Papers submitted by plenary speakers and panel members appear in the following pages. Ms. Carolyn Nutter, Alberta Alcohol and Drug Abuse Commission (now with the Ontario Addiction Research Foundation), skilfully chaired all of these sessions. Plenary presentations covered a great deal of ground and were often provocative.

What is Known

HIV Infection and Drug Use in Canada

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Introduction

This overview of HIV infection and drug use in Canada will highlight the significant attempts that are being made in Canada to quantify the problem of HIV infection related to injection drug use. After examining data derived from the surveillance of AIDS cases, the geographical, temporal, and contextual variations in seroprevalence among injection drug users will be reviewed. Next, the gold standard for evaluating the impact of prevention programs, seroincidence, will be discussed as well as risk behaviours for seroconversion. Finally, attenders and non-attenders of needle exchange in one city win be compared in order to provoke some thought about potential answers to the question "Who are we reaching through needle exchange programs?". The overview will conclude with some future directions for ethnographic and qualitative research that may help fill some of the gaps in our knowledge.

AIDS Case Surveillance

The proportion of injection drug users among adult AIDS cases varies worldwide from a high of 66% in Spain and 37% in Europe as a whole to 23% in the United States and 2.5% in Canada.

Although overall the cumulative proportion of injection drug users among adult AIDS cases in Canada is 2.5%, the following table shows that this proportion has been increasing steadily since the beginning of the HIV epidemic, from less than 1% before 1987 to 4.3% from January 1992 on. A similar increase is not evident in the category of men who have had sex with other men and who have also injected drugs. In combining both categories to create a category of injection drug user regardless of sexual orientation, one sees that the proportion has doubled from 4% before 1987 to 8.1% after January of 1992. Because the epidemic among injection drug users in Canada is in its early stages, we can expect the proportion of injection drug user cases among all AIDS cases in Canada to increase over the coming years.

GEOGRAPHICAL VARIATIONS
Proportion of Injection Drug Use Among Adult AIDS Cases

	No. of adult AIDS cases	% IDU only	% IDU + homo/bisexual	% total IDU
Europe[1]	93,700	36.8	1.7	38.5
United Kingdom[1]	7,583	4.9	1.7	6.6
France[1]	25,008	23.0	1.6	24.6
Spain[1]	19,270	66.0	2.3	68.3
United States[2]	249,199	22.9	6.4	29.3
Canada[3]	8,553	2.5	3.6	6.1

[1]Data as of June 30,1993 [2]Data as of July 1, 1993 [3]Data as of October 25, 1993

TEMPORAL VARIATIONS Proportion of Injection Drug Use Among Adult AIDS in Canada				
	No. of adult AIDS cases	**% IDU only**	**IDU + homo/bisexual**	**% total IDU**
before 1987	1197	< 1	3.6	4.0
1987-1991	3553	2.3	4.3	6.7
1992 Oct. 1993	2912	4.3	3.7	8.1

Source: Proceedings of the 2nd Annual HIV / AIDS Epidemicilogic Research and Surveillance Meeting, 1993.

HIV Seroprevalence: Geographical Variations

In the same manner that marked variations are seen worldwide in the proportion of adult AIDS cases who are injection drug users, the prevalence of HIV among injection drug users also varies dramatically. As the following table shows, HIV infection levels as low as 2 to 4% in Glasgow contrast with those as high as 50% in Edinburgh and 69% in Milan. On the North American continent, where most cities have documented prevalence proportions below 5%, in both New York and Puerto Rico levels above 50% have been documented.

Geographical variations in the prevalence of HIV among injection drug users in Canada may reflect differential timing of introduction of the human immunodeficiency virus into injection drug using populations in various cities. The most recently presented in the following table, with the proviso that those wishing to cite these data should address themselves directly to the author indicated on the right of the table to confirm these preliminary figures. Rates as low as 1.8% in Calgary and 2.3% in Winnipeg have been documented on the Prairies and contrast quite markedly with those found in Toronto (5.7%), Ottawa (8.4%), and Montreal (14.9-17.4%). The 95% confidence intervals presented next to each rate provide the range within which the true prevalence result has a chance 19 times out of 20 of being found. The greater the sample size tested, the smaller is the confidence interval and the more accurate is the rate estimate indicated to the left of the confidence interval.

GEOGRAPHICAL VARIATIONS Prevalence of HIV among Injection Drug Users	
UNITED STATES	
New York	35 - 65%
Puerto Rico	45 - 59%
South-East	7 - 29%
Detroit	7 - 13%
San Francisco	7 - 13%
elsewhere	<5%
EUROPE	
London	5 - 13%
Glasgow	2 - 4%
Edinburgh	50%
Amsterdam	28 - 34%
Rome	35%
Milan	69%

GEOGRAPHICAL VARIATIONS Prevalence of HIV among Injection Drug Users in Canada				
	Year	**Rate %**	**95% C.I.**	**Source**
Montreal	1993	17.4*	12.3 - 24.0	Lamothe
	1993	14.9	10.6 - 20.3	Hankins
Ottawa	1993	8.4	6.3 - 11.0	Baskerville
Toronto	1992	5.7*	3.0 - 10.0	Millson
Winnipeg	1986-90	2.3	0.5 - 6.5	Hammond
Calgary	1991-93	1.8	0.6 - 4.0	Abernathy
Vancouver	1992	4.2	2.3 - 7.5	Rekart

* Injection drug users not in treatment

Source: Proceedings of the 2nd Annual HIV / AIDS Epidermiologic Research and Surveillance Meeting, 1993.

In both Montreal and Toronto, higher rates were found among injection drug users not in treatment, these rates being asterisked with a star.

HIV Seroprevalence: Contextual Variations

Seroprevalence among injection drug users may also vary according to context. Information is now available from three prison studies in Canada which reveal HIV seroprevalence rates which reflect those found among injection drug users in the surrounding communities outside of prison.

A study conducted in British Columbia involved all inmates admitted to a provincial correctional institution between October 1st and December 31st 1992. The methodology used was voluntary and anonymous, with a systematic approach being made to each new inmate to solicit participation. Overall, 31.4% (854 of 2719) inmates had previously used injection drugs. Injection drug users were significantly more likely to refuse participation than non-injection drug users (12.9% versus 6.8%). In total, saliva samples were available for 2482 individuals. The HIV infection rate was calculated including those who refused with resultant rates, which potentially are underestimates, of 0.5% for non-injection drug users and 2.1% (95% CI=1.3-3.3) for injection drug users (Rothon, 1993).

An Ontario study also focused on newly admitted inmates. All inmates admitted to 42 provincial correctional institutions between February and May of 1993 for men's institutions and February and August of 1993 for women's institutions were included in the study. The methodology used was anonymous unlinked with leftover routine urine specimens taken at admission unlinked from personal identifiers before testing for HIV. Overall, 12% did not take part in the study: for 9.5%, there was no sample, for 1.2% there was a documented refusal, and for 1.4% no reason was noted. Urine samples were available for 12,421 individuals of whom 1446 were injection drug users. Among 262 women injection drug users, the infection rate was 4.2% (95% CI=1.8-6.6). Among 1184 male injection drug users, the rate was 3.6% (95% CI=2.6-4.7) (Calzavara, 1993).

In a Quebec study conducted from January 1990 to January 1992, inmates from three institutions accommodating 32.7% of men and 83.5% of women incarcerated in the province were approached for participation. The methodology used was voluntary, non-nominal, and inmate-initiated.

As can be seen from the following table, striking differences were found between male and female injection drug users with women injection drug users more than twice as likely to have HIV antibodies as men injection drug users.

	WOMAN		MEN	
	IDU	**Non-IDU**	**IDU**	**Non-IDU**
N	249	223	444	527
Rate %	16.5	2.3	7.7	0.2

Source: Hankins, 1994, unpublished.

Seroprevalence: Temporal Variations

Needle exchange evaluation programs can provide useful information concerning prevalence, incidence, and behaviour changes in the population of active injection drug users. At CACTUS-Montreal, Montreal's major needle exchange, seroprevalence rates in the first three years of operation increased significantly from 11.1% to 16.7% and than appeared to plateau in 1993.

CONTEXTUAL VARIATIONS: NEEDLE EXCHANGE
Prevalence Among Injection Drug Users Attending CACTUS-Montreal

	HIV+	N	Seroprevalence	95% C.I.
1990	49	442	11.1%	8.4 - 14.4%
1991	51	345	14.8%	11.3 - 19.0%
1992	45	270	16.7%	12.4 - 21.7%
1993	34	227	14.9%	10.6 - 20.3%

N.B. Significant increase in seroprevalence from 1990 to 1992, p = 0.003 chi square for trend

Source: Hankins and Gendron, 1994.

Of potentially greater usefulness in determining the dynamics of the HIV epidemic among injection drug users in Canada is seroincidence. As can be seen from the following table, cumulative incidence may appear similar in cohorts and therefore, the best measure of incidence is incidence density, meaning the rate per 100 person/years.

SEROINCIDENCE AMONG INJECTION DRUG USERS IN MONTREAL

	Period	Cumulative incidence		Incidence per 100p-y*
STUDY		*N*	*%*	
St. Luc Hospital[1]	1988-1991	653	8.8	6.7
CACTUS[2]	1990-1993	185	8.1	11.2

* person-years
1 Source: Lamothe and Bruneau, 1993.
2 Source: Hankins and Gendron, 1994.

From 1988 to 1991 in the St-Luc Hospital cohort, which includes individuals in and out of treatment, the incidence rate was 6.7 per 100 person/years (Lamothe, Bruneau, et al., 1994) whereas from 1990 to 1993, a rate of 11.2 per 100 person/years was documented among active injection drug users at the CACTUS-Montreal needle exchange (Hankins, Gendron, et al., 1994). However, as we will see later in this paper, it is difficult to extrapolate from information obtained from needle exchange attenders to the population of injection drug users at large in a city.

Risk Behaviours for Seroconversion

The principal risk factors for HIV infection among injection drug users include needle borrowing and lending, attendance at shooting galleries, the frequency of injections, presence of an abscess at the injection site, and sexual risk factors such as prostitution (mainly male), number of sexual partners, previous history of sexually transmitted disease, and lack of condom use.

Among the observations that have been made concerning the epidemiology of HIV among injection drug users around the world, is that in all settings there is a potential for an explosive epidemic following the introduction of HIV into an injection drug use community. Classical examples include Edinburgh, Scotland where seroprevalence rose from 5% to 57% in a period of 24 months (Robertson, et al., 1986), and Bangkok, Thailand where it rose from 1% to 43% during a period of 24 months (Berkelman, et al., 1989).

In many industrialized countries during the 1980s, a rapid increase in prevalence was observed followed by a stabilization of prevalence. Incidence appears to have peaked at somewhat greater than 10 per 100 person/years in the mid 1980s to be followed by a progressive decline stabilizing at about 4 to 5 per 100 person/years. In general, success has been documented for interventions aimed at altering needle exchange practices but, in general, failure has been observed for interventions aimed at modifying sexual risk factors among injection drug users.

As a member of a team evaluating CACTUS Montreal's needle exchange, I have been asked many times whether the seroprevalence and seroincidence figures for CACTUS indicate a failure of the intervention. As a result, I have been very interested in attempting to better profile the population that we are reaching at CACTUS-Montreal. We have asked incarcerated injection drug users who have attended and who have not attended CACTUS to provide us with information concerning their risky and protective behaviours. Julie Bruneau and Francois Lamothe have also asked individuals in their cohort whether they have attended a needle exchange. The following tables provide some information from both of these studies demonstrating differences between needle exchange attenders and non-attenders. As can be seen from the table below, St.Luc cohort needle exchange attenders were more likely to be older, to have less social support, and to know someone who is living with HIV. No differences were found for history of incarceration, attempted suicide, or having shared needles.

Principal Differences Between Attenders and Non-Attenders of Needle Exchange Programs			
	Attenders; (n=457)	**Non-Attenders (n=393)**	**P Value**
Age	31.7 (s.d. 7.5)	30.8 (s.d. 2.9)	0.008
Incarceration	70%	69%	0.9
Attempted suicide	42%	49%	0.06
Social Support	69%	77%	0.02
Knows HIV+	50%	33%	< 0.001
Shared	90%	88%	0.42

Source: Bruneau, 1994, unpublished.

Other differences found between attenders and non-attenders, participating in the St-Luc cohort were the findings that attenders were more likely to have visited shooting galleries, to have shared needles with someone who had HIV infection, to have been a man who had had sex with another man, to have engaged in prostitution ever in their lifetime, and to be currently active in prostitution as a man. No differences were found in the percent of attenders and non-attenders who were engaged in female prostitution.

Principal Differences Between Attenders and Non-Attenders of Needle Exchange Programs			
	Attenders (n=457)	**Non-Attenders (n=393)**	**P Value**
Shooting galleries	24%	13%	< 0.001
Shared with HIV+	12%	5%	< 0.001
Homo/bisexuals	12%	7%	0.05
Prostitution ever	28%	19%	0.004
Prostitution men	22%	11%	< 0.001
Prostitution women	52%	47%	0.85

Source: Bruneau,1994, unpublished

In our study conducted in three correctional institutions, in which we asked incarcerated injection drug users whether they had attended CACTUS or not, attenders were 7.6 times more likely to have had income from prostitution or exotic dancing in the previous 12 months, were 7.4 times more likely to have had at least one client per month, were 3.4 times more likely to be women, were twice as likely to have had an STD, and were twice as likely to have shot up with a used needle that they had borrowed from an HIV positive person. This latter rate was almost double among attenders in the prison setting compared with attenders in the previously cited street-based and treatment-based study. Thus, needle exchange attenders who are interviewed in prison tend to have had a higher rate of exposure to people living with HIV infection.

Principal Differences Between Attenders and Non-Attenders of CACTUS Exchange			
	Attenders (n=252)	**Non-Attenders (n=293)**	**Odds ratio**
Income from prostitution or dancing	39.8%	8.0%*	7.6
Had at least 1 client per month	52.1%	12.8%*	7.4
Women	56.9%	27.7%	3.4
Has had an STD	19.0%	10.7%**	2.0
Shot up with used needle from HIV+ person	23.7%	12.6%**	2.1

* P Value < 0.001 ** P Value < 0.005

Source: Hankins, Gendron, et al., 1994, unpublished.

On the other hand, attenders in our study had also made significant changes in their own behaviours. A total of 60.3% had used condoms to prevent STD, making them 6.2 times more likely to have done so than non-attenders. Needles came from a safe source in the last months of shooting up before incarceration for 94.3% of attenders, making them 5.9 times more likely to have had new equipment than non-attenders. Attenders were twice as likely as non-attenders to have had at least one half of their friends who had changed sexual practices and were also twice as likely to have had an HIV antibody test in the past. Since this study was conducted on individuals who did not know their current HIV status at the time of the interview, it is clear that the adoption of protective behaviours. happened too late

for many attenders. A total of 19.6% of attenders had HIV antibodies compared to 7.9% of non-attenders in the prison study.

Principal Differences Between Attenders and Non-Attenders of CACTUS Exchange

	Attenders (n=252)	Non-Attenders (n=293)	Odds ratio
Uses condoms to prevent STD	60.3%	19.8%*	6.2
Needles come from safe source	94.3%	73.5%*	5.9
At least half of friends changed sexual practices	31.2%	17.1%	2.2
Had an anti-HIV test	66.9%	49.1%	2.1
HIV+	19.6%	7.9%	2.9

* P Value < 0.001

Source: Hankins, Gendron, et al., 1994, unpublished.

Thought-provoking Data

Some thought provoking data concerning prisons and injection drug users have been provided by several studies in Canada. In a study by Noël and Gagnon of 230 drug users in Quebec of whom 139 were injection drug users, a total of 82% had previously been arrested and 75 had been incarcerated. In a study by Millson, et al. in Toronto, 81% of the injection drug users attending the needle exchange called The Works had previously been incarcerated. In our Montreal study, 81% of male inmates and 21% of female inmates had used drugs in prison of whom 10% had injected. Overall, 6% of the 693 incarcerated injection drug users in our study had injected while in prison (Hankins, Gendron, et al., 1994). And finally, keeping in mind the multiple diagnoses that injection drug users may have, a study by Lauzon, et al. found that 46% of the first 41 women admitted to a methadone program in Montreal had attempted suicide at least once.

Future Directions For Research

As we have seen, quantitative information can provide us with important parameters to monitor the HIV epidemic in Canada among injection drug users. However, gaps in our knowledge remain that cannot be addressed by quantitative methodologies. Qualitative approaches, in particular ethnographic approaches, would help us to better understand current needle and syringe use behaviour. In particular, we need to know about the meaning of certain needle behaviours to injectors. This includes the meaning of purchasing, storing, and discarding practices; injecting practices; reuse, sequential use, and sharing practices; and cleaning practices. The ways in which these practices may change depending on the drugs that are injected and depending on any accompanying non-injection drugs needs further study.

Furthermore, there are micro-contextual features that have to be better understood such as ethnicity, gender, site and scene of injecting, and the personal network of injectors. Macro-environmental factors include the availability of shooting galleries, of needles and syringes, the local law enforcement environment, and the cultural, social, and economic features of each injection drug use community.

The HIV epidemic among injection drug users is in its early dynamic phases in Canada. A combination of quantitative and qualitative methodologies are needed to follow this epidemic and to help inform and plan for future interventions. Although there are many fine prevention efforts underway as we will see in this conference, our guard cannot be dropped at this point in time.

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HIV, Sexual Behaviour and Substance Use Research: Contextual and Community Considerations

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Introduction

Frequently in anecdotal accounts it is claimed that substance use contributes to unsafe sexual practices. HIV / AIDS educators struggle to know how best to address the issue of substance use and its relationship to safer sex, and how to raise issues concerning this association in a community which values the socializing and the effects provided by the use of alcohol and drugs.

For centuries, society has faced a dilemma when dealing with social problems associated closely with behaviours that are highly valued, such as substance use and sexual behaviour. This paper reflects briefly upon how such problems have been dealt with in the past, and presents highlights from studies conducted by the author that show the importance of examining this relationship from a number of perspectives, including one that reflects the community environment.

Societal Responses and Problem Definitions

Until the appearance of AIDS, sexuality and substance use research for the most part were regarded separately (Schuster, 1988). Yet, there is much in common in these two areas: 1) societal responses to sexuality and substance use have been similar, 2) problems associated with each may be contextually defined, and 3) actions in response to issues in the two fields may require a multi-level focus.

While alcohol and other recreational substances have been around for some time, Room (1991) points out that society's responses to substance abuse and other social problems has changed over time. Involvement at a 'community' level has been prominent in defining the problems. For example, to control the Gin Epidemic of the 1700s, power and control over emerging problems was given to local magistrates. In the 1830s, a different level of community action appeared with the rise of the temperance movement. With prohibition, senior governments assumed control. Then, evolving out of a confusion of economic and social policies, a stronger preventive focus arose with a greater reliance on information developed from experimentation and research.

Responses to sexual behaviour and sexuality have followed a similar pattern. Attempts to control non-normative sexual behaviour have led to forms of isolation, discrimination and punishment, perpetuated both by legislation and community action.

Community-Based Research Focus

A number of arguments may be made for the need for community-based and action-oriented research in the substance abuse area. Similar arguments could be made in the area of sexuality and sexual behaviour. Hyndman and Giesbrecht (1993) have noted that community-based health promotion research is important for a number of reasons. First, problematical social/health behaviours, evidenced in a community, may have a number of common risk factors. Second, problems at the individual level may also be seen at a "community" level. Third, social behaviour is regulated by community conditions, norms and support systems.

In the AIDS field the importance of community-based research has been recognized:

> *Much of the best behavioral and statistical research on AIDS has occurred through collaborations among scientists from universities, the staffs of government agencies (at all levels), and the organizations rooted in the communities that have borne the brunt of the AIDS epidemic.*
>
> *Collaborations of this kind are seldom without conflict; differences of social origin, ethnicity, economic status, or sexual orientation may sometimes lead to misunderstandings.*
>
> (National Research Council, 1989)

The importance of community-based research is increasing because of a changing society and changing definitions of community. In most western, "developed" societies community can no longer be simply defined as a specific group of people living within a geographical area who share a common culture. In modem society individuals maintain membership in a range of communities based on geography, occupation, social contacts or leisure interests (Nutbeam, 1986). Understanding how substance use, sexuality and sexual behaviour relate to community membership is an important area for study.

Research Highlights

To date, research on the associations between substance use and sexual risk-taking is not extensive. This may reflect the complexity and difficulty in conducting research in this area. Most of the studies conducted to date focus on *global associations* between measures of overall substance use (e.g., quantity or frequency of use) and measures of risky sexual behaviour (e.g., frequency of engaging in unprotected intercourse) (Leigh and Stall, 1993). Leigh and Stall point out that more relevant research will require the examination of frequency of use of alcohol and drugs in conjunction with sexual activity (*situational association studies*) and *event analysis*, focusing on discrete sexual events. I would argue that these are very important, and also that it is important to examine and understand the community environment within which substance use and sexual behaviour occur.

Substance Use and Risk Behaviour

In the "Talking Sex Project" cohort no association was found between the use/non-use of alcohol and sexual risk behaviour for HIV infection (see Table 1). While there was a significant association with marijuana/hashish, poppers and cocaine use and penetrative sex, there was no significant difference in the reported rate of substance use between those who reported protected and unprotected anal sex (Myers, et al., 1992).

TABLE 1
Prevalence of Substance Use in Past Month Relative to Level of Sexual Risk in Past 3 Months

	none/ limited	no anal	anal protected	anal unprotected
Alcohol (past week)	68.9%	75.4%	76.8%	81.3%
Marijuana	13.1%	29.4%	41.0%	41.5%
"Poppers"	3.3%	10.6%	25.0%	26.3%
Cocaine	3.3%	2.9%	6.5%	7.9%

Source: Talking Sex Project (Myers, et al., 1992)

Community, Socializing and Risk Behaviour

Table 2 compares the proportion of gay men in the "Talking Sex Project" cohort who consumed alcohol in the past week with the proportion in a community sample of single men of unknown sexual identity. This might lead one to believe that gay men have high levels of substance use, and in turn, may lead one to suspect that substance use is a factor in risky sexual behaviour. We do not have dear evidence of such a relationship in this population, and must be cautious in interpreting these data, in particular as the sampling of gay men was conducted through bars, where it is logical to expect that the proportion

of substance users would be greater than in a general community sample.

TABLE 2 **Ratio of Substance Users in the Talking Sex Cohort (Gay Men) to Substance Users in a Community Sample of Single Men**	
Alcohol	1.3:1
Marijuana/Hashish	3.6:1
Tranquilizers	4.0:1
Cocaine	2.3:1

The National Men's Survey (Myers, Godin, et al., 1993) (Table 3) shows that there is considerable variation in the percent of men in different communities across the country who report substance use on at least one occasion prior to having sex. Again, patterns of socializing in different communities may account for this variation and the variation in safer sex across the country While little has been written about socializing patterns and safer sex per se a fairly large body of literature has been written on the somewhat related topic of HIV related risk-behaviour and the influence of peer and social norms (Becker and Joseph, 1988). These would seem to be stronger influences dim the use of substances.

TABLE 3 **Reported Use of Substances on at Least One Occasion Prior to Having Sex (Past 3 Months)**		
Substance	**% use**	**Variation in % Across Strata**
Alcohol	74.9	70.5 - 83.0
Marijuana/Hashish	31.4	24.0 - 38.3
Tranquilizers	28.5	18.4 - 39.8
Cocaine	11.9	7.0 - 18.4

There are similar regional variations in the use of substances reported in the Ontario First Nations AIDS and Healthy Lifestyle Survey (Myers, Calzavara, et al., 1993). These differences most probably reflect differences in availability of substances, community attitudes and policies. Alcohol use was reported by 30.5% of the study population living in the North compared to 45.1% in the South. The use of drugs was reported by 30.1% in the North compared to 14.4% in the South. Access to knowledge about AIDS also differed. There were lower levels of knowledge about AIDS in the North than in the South. While lifetime sexual experiences and reported sexual activities differed between the regions, there was little evidence that level of sexual risk reported by the participants differed geographically, despite the variation reported in substance use.

Substance Use and Risk in Specific Situations

Data for the Ontario First Nations AIDS and Healthy Lifestyle Survey examined sexual behaviours reported by the participants when 'sober' and while 'drunk or high'. Overall, 27.5% of the respondents reported change in their behaviour between these two states. The greatest change (42.7%) was neutral, with no change in level of risk for HIV transmission, and almost equal proportions changed toward safer (32.5%) as toward more unsafe behaviours (31.6%) (Myers, et al., 1994).

Research into the relationship between the substance use, sexuality and sexual risk taking will require a comprehensive understanding of the individual behaviour in specific contexts and sexual events. For planning educational programs it is important to understand these relationships as well as to understand a community's cultural, physical, spiritual and social environment.

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Risk Taking Contexts Among Addicts

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Introduction

This paper is concerned with risk taking behaviour among addicts. Some of them are homosexual, some are heterosexual; some practice prostitution to earn a living and support their habit; others have a life structured by trafficking; still others have a seemingly normal life. However, all share a model of pathological consumption of psychoactive substances, of exhibiting numerous social and personal problems related to their consumption and of having developed a physical dependency for the products they consume.

For the purposes of this paper, we shall consider primarily data from in the Montreal area because they are numerous and because they allow us to show the importance of risk behaviour among addicts, injection drug users and non-injection drug users, multi-drug users or alcoholics.

The data of the St. Luc Hospital team (Lamothe and Bruneau, 1993) show that the rate of seroprevalence has increased among injection drug users in our city: in 1988-89 it was 5.8%; in 1989-90, 9.4%; in 1990-91, 17.4%; in 1991-92, 11.1%; in 1992-93, 13.7%. These rates are among the highest for large Canadian cities. For injection drug users, the two contamination vectors are (1) sharing needles and (2) unprotected sex. In addition, the Lamothe and Bruneau team data indicate that sharing needles is the factor which causes the greatest proportion of contamination.

Focus Groups with Intervenors

My colleague, Jocelyne Migner (1994) conducted "focus groups" with intervenors who work with addicts to identify the conditions that lead these clinical populations to take risks. We wanted to know what circumstances had a direct influence on the kind of behaviour that can lead to potential HIV contamination. Consequently, these are second hand data; but we are dealing with people who have a long experience with these addicted clients. Our participants identified four conditions likely to increase risk taking.

1. Intoxication and the Lack of Drugs
The first condition which promotes risk taking is intoxication and a lack of drugs. Subjects who are under the influence of products are less conscious of danger. There is also a component of negligence which goes with intoxication. If he[1] is an injection drug user, he does not take the time to clean his syringe; if he is a drug abuser or an alcoholic, injection drug user or non-injection drug user, he does not take the time to put on a condom. The danger is perceived differently and the need for protection does not seem as important. Moreover, there is a desire to follow the pack and the peer pressure factor seems more significant in subjects who suffer from dependency.

2. The Effects of Cocaine
The effects of cocaine, which is widely used in Montreal, are particularly troublesome. This product results in a feeling of invincibility in addition to heightened sexual pleasure. Users are not always ready to make concessions about pleasure by using a condom. On the other hand, when consumption becomes chronic, sexual dysfunctions increase (meaning erection and erection maintenance problems) and using a condom becomes unlikely because of the desensitization it creates as well as

[1] The masculine gender, when used in this text, refers to both women and men.

because of erection problems. In general, pleasure is paramount for drug users and anything that hampers this pleasure is avoided. Moreover, these subjects frequently go to shooting galleries because the half-life of cocaine is very short.

3. The Special Risks of Homosexual Men
These meetings with intervenors highlighted the special risks of homosexual men: they attend gay bars to excess and have numerous casual partners. But, as indicated by the clinical practitioner participating in the focus groups, those who have difficulty assuming their homosexuality tend to consume more drugs and this results in an increased likelihood of risk taking.

The Fear of Loosing Attachment Among Women

Among women it seems that the greatest vulnerability is being "in love": female addicts are scared of losing their man, find it difficult to negotiate his demand for unprotected sex and consider that true love consists in the gift of self. They have unprotected sex with their boyfriend. This concept of the gift of self does not seem as prevalent among men who, on the contrary, are attracted by risk taking.

Study of a Clinical Sample

Solange Keighan (Keighan and Nadeau, 1994) examined the risk behaviour of a small sample of men being treated for drug abuse: 20 injection drug users and 20 non-injection drug users. The results confirm those of other studies in Montreal with larger samples: 95% use syringes and very few clean them; 75% of injection drug users and 45% of non-injection drug users never use a condom with a casual partner.

This study consisted in checking whether these subjects engaged in other risk activities. The findings were that subjects:

1. engaged in illegal activities and stated that they do this for money but also for the pleasure of risk taking;
2. indulged in dangerous and drunken driving of their car. If, when taking such risks at the wheel they don't get arrested, they conclude that they are omnipotent and believe themselves stronger than the police;
3. liked games of chance (three of them reported having played Russian roulette during the last year); and
4. repeatedly attempted suicide and stated that they liked playing with death.

Thus, risk taking is not limited to drugs or unprotected sex but occurs in several areas of the lives of these people. It is a kind of gestalt where sharing needles and unprotected sex are but one of several types of risk taking.

Among male injection drug users and non-injection drug users, intoxication increases risk taking. However, data confirm that injection drug users take more risks than non-injection drug users. It is noteworthy that 57% of all subjects like taking risks for the fun of it and in search of strong stimuli: 82.5% of subjects are not afraid of death while intoxicated. One detects ambiguity about death, which is always present in their conversation, consisting of the desire to die and the fear of dying. It is probably this ambivalence, which we find hard to understand, which leads to some of the failures of prevention programs.

Conclusions

Our results confirm the clinical observations made in France (Valleur, 1988; GRECO, 1994) and those made in our work at the Correctional Service of Canada with addicted inmates. There are four conclusions to be drawn from this work:

1. Risk taking is increased by intoxication and this is particularly true of cocaine.
2. For many drug users, needle sharing and unprotected sex are two risk behaviours that fit into a large scheme of such risk taking actions. We must continue to target transmission vector behaviours in our interventions but the intervenors should understand the risk taking process as it manifests itself in each addicted patient.

3. A certain proportion of addicted patients are in a chronic state of depression so that, for them, drug abuse is a form of self medication. In addition, many exhibit serious emotional deprivation and a good portion of them have had a childhood marked by adversity. Their lives do not make much sense and risk taking is part of these desperate attitudes. In terms of psychiatric nosology, to drug abuse are added depression and anxiety problems on Axis I and antisocial, borderline and narcissistic personality disorders on Axis II.

   The suicidal behaviour often occupies an important place in their lives: the subjects claim they are conscious of the risk of death but still continue their various dangerous behaviours. Even if they in fact are scared of dying, this fear is not enough to change their behaviour, and this is the paradox of all addictions. It may be as a result of this ambivalence to death and risk taking that this group differs from the gay community.

4. In our AIDS prevention programs with addicts, we should integrate this dimension of the love of risk and of the pleasure of defying death. It seems necessary to work on risk taking as such as well a on the target behaviours which are HIV transmission vectors. Indeed, addicts indicate that they love taking risks and this love of risk seems paramount for many of them. It may not be only because of negligence but also because they deriv pleasure from defying death that these subjects indulge in risk taking.

When the AIDS epidemic started spreading to addicts, we noted that our prevention programs had less impact on them than on the gay community. Some clinicians, particularly the French, have maintained that it is not only intoxication that leads to risk taking but also the pleasure of risk as such. Our data have confirmed these clinical observations to the effect that addicts test themselves to demonstrate that they are "stronger" than the authorities and that "they cannot be had" to quote one of our clients. Some keep testing their invincibility. Conversations with drug users we have met point to a search for the giddiness associated with risks whether in the commission of crimes, of games of chance, of needle sharing or an intoxication with an uncertain outcome. Their relationship with death is complex: it is a flirt made up of a desire to win and a desire to die.

Until recently, there was a relative consensus in the scientific community to the effect that addiction could be interpreted as a slow and gradual form of suicide. Clinicians and researchers looked upon alcohol and other drug abuse as essentially self-destructive forms of behaviour caused by a depression prior to this pathological consumption. To this traditional concept should be added a proactive dimension: addiction likely includes a dynamic dimension, an active pole (as opposed to the passivity of dependency). Perhaps we should look upon addicts as warriors for whom risk is the challenge. Sharing needles and not wearing condoms become ways of testing one’s own powers, to check one’s own control over one’s life. For scientists, this behaviour seems irrational but clinical data lead us to think that we should introduce a bit of irrationality into our prevention programs.

For my part, I am always astonished to see how quickly the uneducated men that are addicted inmates can grasp the rather complex notion of risk taking: they understand it because this conceptual statement only puts into words what they have intimately experienced. And they then tell us of the "thrill" of challenging fate. While this cognitive universe is not part of the usual public health frame of reference, perhaps we should begin to listen to the remarks of our clients.

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Interventions

HIV Infection Prevention Measures for Drug Users

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Introduction

HIV infection preventive measures for drug users have increased substantially over the last few years. Practically non-existent prior to 1988, programs are now found in all large Canadian centres and in a large number of smaller municipalities.

The first Canadian pilot projects were launched starting in 1988 in response to the rapid progression of the infection among drug users in many large European and American cities. Nine projects were funded for a two year period. These projects were to offer multi-faceted programming including such things as information on the reduction of risks, counselling, distribution of kits (condoms and bleach) and referral to other services such as detoxification and treatment. Seven locations out of nine included a syringe exchange service.

I will give you a brief overview of the results of the various pilot locations and will attempt to highlight some of the main issues raised by these programs.

Program Implementation

If program relevance is determined by the degree of penetration in a community, pilot projects have amply shown their usefulness. The number of visits and contacts is progressing constantly or remains steady in spite of new services being opened.

For instance, the number of contacts per quarter doubled between 1992 and 1993 in Vancouver going from 15,000 to more than 30,000. During the first two years of operation, an average total of 933 contacts per month were recorded in Winnipeg. In Montreal, the program CACTUS received 311 visits during the first week of intervention in 1989. This number increased to more than 1,000 per week in the tenth month. More than 221,746 visits were recorded between 1989 and 1992.

In addition to the number of visits, the number of syringes handed out is also counted. Here again, the numbers are impressive. For our reference period (1989 and 1992) distribution in large centres has gone from 150,000 syringes to more than one million. The Vancouver program distributed more than 600,000 syringes in 1992 and now exceeds one million a year.

The Clientele

The clientele of the various locations is no different from the clientele of treatment centres. More than half have already received treatment for their dependency They are between 13 and 72 years old and average close to thirty. Women tend to be younger than men. These people are frequently marginalized. About 10% of them have no fixed address and in spite of the fact that most indicate that they have been living in the same city for more than one year, they seem to be relatively mobile. Thus, 45% of the Winnipeg clientele had injected drugs in another city during the previous six months. In Ottawa, 41% had used a service in another city.

Schooling and employment are also indicators of social integration. Our clientele goes from one extreme to the other. While the majority does not have a high school diploma and many have hardly gone further than grade school, there are still 15% who have received post-secondary education. On the other hand, they are more affected by economic

conditions. Nearly half live from welfare and only 10% state that they have a job. Finally, most of these people have had dealings with the justice system. In Toronto, 81% of clients had been jailed at least once.

Substances Used

The substances of choice for all of the clientele are cocaine and heroin. In spite of the fact that proportions vary from one centre to the next, cocaine is the dominant drug and is used by about 80% of clients while heroin is used by about 15%.

Winnipeg	
53%	cocaine (half inject)
31%	talwin and ritalin (44% injection drug users)
9%	solvents
4%	heroin

Toronto	
70%	cocaine
15%	heroin

Ottawa	
79%	cocaine
26%	crack
15%	heroin

Montreal: CACTUS	
75%	cocaine
10%	heroin
8%	both

Montreal: Pic-Atout	
80%	had injected cocaine during the last 7 days
35%	heroin

There is a difference between men and women in the choice of drug.

Toronto	
68%	of women select heroin
29%	of men select heroin

Montreal	
15%	of the women at CACTUS say they use only heroin versus
8%	of the men

Risk Behaviour

Needle sharing is common practice for about 50% of clients. Several clients state that they clean the equipment but often inadequately. The rate of utilization of bleach was 17% at Pic-Atout, 34% in Winnipeg and 41% in Ottawa. Differences between project participants and non-participants were minimal. On the other hand, there are some encouraging signs. The proportion of people who have stopped sharing has increased in most projects. This same trend can be seen in the proportion of people who use bleach to clean their syringes. It seems that information is getting into the different settings and that some users are changing their behaviour.

Reasons for Sharing

Most locations report that the age of the first injection is about 20 years old. The main reason given for sharing needles is the lack of access (82% in Toronto). Few clients indicated that they like to share (5% in Calgary, 7% in Ottawa).

This difficulty of access to equipment is particularly great in prisons. In Toronto, 25% had injected while in jail and 62% of them had shared the equipment. The same proportion was seen in Ottawa (19% injecting and 61% sharing).

Sexual Behaviour and the Use of Condoms

Several projects reach people involved in prostitution. The percentages are particularly high among women, as shown in the following table.

	Women	Men
Edmonton	57%	7%
Winnipeg	86%	25%
Pic-Atout	40%	2%

Since some clients have multiple sexual partners of the same sex or of the opposite sex, it is important to assess the percentage utilization of condoms. This rate varies enormously from one project to the next. Among women who practice prostitution, 86% say they always use condoms in Montreal (CACTUS) and 68% in Toronto.

Men who have sexual relations with same sex clients report a lower rate of condom use (61% in Toronto and 49% in Montreal [CACTUS]).

The use of condoms with casual partners is much lower. For instance, 15% of women and 25% of men in Winnipeg never use condoms with casual partners of the opposite sex.

On the other hand, a positive trend has been noted. Regular program clients report a more frequent use of condoms than irregular clients. This same trend has been observed between program clients and non-participants.

Testing and the HIV Infection Rate

Most injection drug users have already had HIV tests (approximately 60%) and a higher rate of infection has been found among participants than among nonparticipants. Programs seem to reach a clientele at higher risk or at risk for a longer period.

It has been noted that the level of knowledge of clients concerning prevention and transmission is generally high. However, the perception of personal risk is low. Only a small percentage of clients feel that they are at higher risk than other drug users. The health condition of these persons is rather low. A multitude of problems have been reported from abscesses to hepatitis, STDs and mental health disorders.

Satisfaction Ratings

The level of user satisfaction with programs is clearly high. It remains above 90% in all respects except for hours of business and exchange policies.

The level of satisfaction with the programs also seems high in the community. Locations are often consulted because of their expertise and they are involved in various forums. Several projects indicate that the involvement of the police is crucial for the success of the program.

Present and Future Trends

In view of this positive evaluation of pilot projects and of the increasingly large place occupied by these programs in our communities, I would like to deal with some factors that are complementary to this kind of intervention. I refer to outreach, to the use of the existing health and social services network and to access to rehabilitation services.

1. Outreach (Street Work)
Most of the intervention programs have a street work component. Interventions in arcades, bars or shooting galleries are the logical extension of actions taken in fixed locations. On the other hand, this kind of work requires special qualifications and cannot be launched quickly. The role of street workers goes way beyond referrals to syringe exchange locations. These people are the real front line with a clientele that does not trust official organizations and has a marginal lifestyle.

Because of the areas they work in, the behaviours they observe and their undefined professional status, street workers are constantly on a tightrope. During a recent meeting held in Montreal, street workers expressed a lot more concern with the ethics of this practice than with the work itself. Thus, the next challenge of street workers will be to establish criteria and standards for this kind of practice while preserving the flexibility and creativity required to work in a constantly changing environment.

2. Use of the Existing Network
The creation of specialized locations in large centres met, at the time, a definite need of town centres. Since then, we have been trying to extend this network and reach injection drug users in all milieus. From a central core, the outreach needle exchange locations and the outreach programs are extending towards peripheral neighbourhoods. The aim is also to provide smaller centres and less populated regions with syringe exchange services.

In Quebec, the existing network of hospitals, CLSCs, drugstores and private clinics is called upon to contribute to syringe exchange. This approach provides a large number of locations without necessarily adding significant financial resources. There are currently 146 exchange locations in Quebec. Should we promote two exchange networks: specialized locations in town centres. where the clientele is more marginalized and locations integrated into other facilities in outlying neighbourhoods where the needs of the area are already being met? It will be important to evaluate these new services to find out whether the locations limit themselves to equipment distribution or the intervention tends to become more personalized. We know that pilot projects are often a benchmark for clients, can we recreate this climate in public centres?

3. Access to services
The main objective of setting up pilot projects is undeniably the prevention of HIV infection. However, prevention efforts can also promote a demand for help and referral to drug addiction centres. We must therefore ensure that the linkage between street interventions and access to treatment is as fast as possible. Most drug addiction treatment centres operate on two basic principles: client motivation and the objective of abstinence. This structure meets the needs of a large number of addicts and our centres are unable to meet demand. However, if the mission of centres is to meet all of the demands for services by drug addicts, it will be necessary to provide methods to meet the specific needs of injection drug users. To this end, we must plan programs to receive people for whom abstinence is not a realistic objective. Rather, the aim must be to improve quality of life and reduce harm. We must accept that this clientele can only complete part of the rehabilitation program and that this does not mean failure. We must therefore define success in relation to social adaptation and not only in relation to consumption. This social adaptation must include variables such as the acquisition of social skills and access to work and housing.

Conclusion

Pilot projects for drug users carried out in large Canadian cities have shown their usefulness and relevance for HIV prevention. Data confirm the need for this kind of service. These locations continue to grow and provide more and more services. The HIV infection prevention objective among injection drug users has promoted the emergence of a network of services for this often neglected clientele. We are now in a period of consolidation of these frontline services as well as of greater integration of these with the traditional health and social services network.

The Example of *Needleworks*

Hope Hunter
Boyle Street Co-op
Edmonton

I will discuss our experience in Edmonton as I gleaned from *Needleworks*, an AIDS prevention program targeted at injection drug users. *Needleworks* is one of the Federal Demonstration projects and has now been operating for the past 3 1/2 years. My comments serve to reinforce many points already made at this workshop.

First, allow me to provide some socio-cultural context so you can make the transition from Montreal to Edmonton and realize that there is more to Edmonton than malls and pedways.

Needleworks operates in a western prairie inner city. Our inner city is a lot like a small town — it is remarkably conservative; discussions about sex, which some have referred to as "talking dirty" are taboo; and people know each other and each other's business and interpersonal relationships. There is a very large and diverse aboriginal community that has a high profile not only in the core, but throughout the northeast part of the city. It is again conservative and is composed of extensive social networks. The population is quite mobile. There is a lot of movement between the city and smaller communities throughout northern Alberta, Saskatchewan, the Yukon and the Territories. Particularly for those involved in the sex and drug trades, there is a lot of travel between Edmonton, Calgary and Vancouver.

Needless to say, poverty and racism are endemic. The community has high unemployment, low education levels and extensive criminal justice involvement and compromised health status. The correlation of these factors with risk have been highlighted in previous presentations as have the barriers this reality poses for people attempting behaviour changes. Most significantly however, Edmonton's inner city is a community and as such has many strengths on which to build. Social networks provide opportunities for support, caring and change. There is a strong culture that values survival, family (particularly children), humour, flexibility, a commitment to doing what works and a belief that things happen when they are supposed to. As well, there is an infrastructure of community resources that work together to ensure access to relevant help when its needed.

Needleworks exists thanks to the determination of nine organizations to stem the transmission of HIV amongst needle users and sex trade workers. These organizations form the project coordinating committee and were instrumental in building the support and the political will necessary to establish Needleworks. I'd like to name the organizations because they brought not only commitment and expertise but legitimacy to the effort.

As a member of the committee, the Alberta Alcohol and Drug Abuse Commission allayed concerns that an exchange would increase drug abuse and advocated a position that gave primacy to preventing AIDS. The Capital Health Authority; Public Health Services clearly positioned the program as a public health concern requiring public financial support. The involvement of AIDS Network Edmonton signalled recognition by mainstream AIDS groups of injection drug users and sex trade workers as people requiring targeted prevention efforts. STD Services and Catholic Social Services Safehouse brought expertise and critical links with both the population and needed support services. The Boyle McCauley Health Centre, a community health centre, and the Boyle St. Co-op, an inner city community centre, both provided street-front links to the population. During the second year of operation, the Canadian Native Friendship Centre joined the program allowing for expansion through the addition of a van. Edmonton Police Services, a supporting partner to the program, has helped us

manage the often conflicting agendas of crime prevention and AIDS prevention. Overall, the experience is evidence of the efficacy of strategic collaboration.

The length of time it took to secure funding for *Needleworks* worried the organizers. The fear was that HIV may have taken hold in the community and we might have missed the opportunity to prevent its spread. On the positive side, the time did ensure we could plan and replan — and replan the program.

The effectiveness of this program is well documented in the evaluation released in 1992 and our ongoing statistical reports. I will highlight a few numbers:

- over the first 2 years seroprevalence remained low — less than 1%;
- a large number of people have been reached — 4,014 individuals as of Dec 31/94. This translates to between 1500 and 2600 contacts per month;
- all most as many needles have been brought in (1,273,792) as are going out (1,291,650);
- users of the program report increased safe injection and safer sex practices;
- the program is reaching people considered hard to reach. Just under half the program users are women and 50% are aboriginal people;
- community norms are slowly shifting and there is more openness and recognition of HIV as a health issue; and
- as experienced elsewhere, people are using the exchange as a route to other help including drug treatment.

Why are we effective? As I mentioned, we had lots of time to engage in sound analysis and good planning. Our analysis was rooted in our collective experience and so we planned based on the following principles;

- involve the consumer in planning and design what they want;
- learn from the experiences of others;
- reach people in their own environment;
- provide relevant opportunities;
- ensure accessibility;
- give people concrete resources;
- provide appropriate support; and
- manage the opposition and build support amongst friends and foes.

As a result, we have a multi-faceted program integrated into the operation of 3 community based agencies and complemented by a mobile van and outreach. We offer information, health counselling, referral and support, and needle exchange. The program operates within a core set of values, but presents differently in each site thus providing options to the user. The practise framework encourages an holistic approach. Ongoing evaluation and monitoring combined with a "do what works" attitude ensures continuing adaptation of the program to maintain it's relevance. We have learned a lot about what works and also what else we need to do. We face a number of challenges which I'm sure are shared by many of us in the room. Let me give you some examples:

1. We've done a pretty good job getting people to use only clean needles and to use condoms in the sex trade. However, people's private sex lives remain a bastion of condomless sex. How often have we heard: "I know he or she is safe — we've been together three months!"; or, "If I use a condom he will think I'm cheating on him." Ms. Nadeau's presentation provided further insight to this behaviour pattern.

2. There are people who do not use the needle exchange. Various reasons are cited including fear of police harassment, the wrong time, place or day, concern about drug use being exposed and a belief that there will be a lecture.

3. The drug and sex trades are ever changing. Police crackdowns disperse populations and new players in the trade change the dynamic. Increased usage of guns, selling of loaded syringes in drug houses and "mattress girls" pose new challenges for prevention outreach.

4. Changes in social supports particularly welfare cutbacks and fees for addictions treatment — are

generating new barriers for people attempting to make changes and move away from the streets.

5. Co-ordinating with other systems including housing, justice, mental health and addictions treatment to ensure ongoing relevant education, support and appropriate care continues to require considerable time, particularly when working with people who have a dual diagnosis or are frequently incarcerated.

So where are we headed? It is to be hoped that we are on a steady path with a few side trips. Here are some of the things we are doing:

1. We are exploring avenues for increasing the availability of clean needles and condoms. A pilot with five drug stores offering a commercial exchange is in the planning.

2. We continue to draw on the community to further develop the program through peer education and supporting a wider spectrum of businesses and community organizations to actively promote prevention practices and influence community norms.

3. We are looking for ways to more effectively reach women, teenagers and Asian members of inner city communities. In particular, we are working with a view to increase their capacity to control events in their lives including the impact of alcohol and drug use.

4. We are working to build a network of inner city people infected and affected by HIV who want to take action to improve both prevention and care activities in our community.

Our biggest challenge is money: *Needleworks* annual budget is $375,000. Compared to the care costs for a person living with HIV, this seems an effective investment in the health of our city as well as the many communities our program users visit. However, securing adequate ongoing funding for our core program continues to be an illusive goal. Program efficacy continues to be challenged and methods questioned. Interest in broadbrush public campaigns erodes support for specifically targeted initiatives. The insatiable thirst by funders for new and innovative approaches force us to abandon techniques that work. And everyone seems to be looking for someone else to foot the bill. Perhaps during the next three days we can find the solution to the problem we all share — supporting what works.

Issues

Issues and Concerns When Addressing HIV / AIDS and Substance Abuse

John Turvey
Downtown Eastside Youth Activities Services
Vancouver

The following points issues and concerns must be Taken into consideration when assessing the prevention of HIV among substance users:

- acknowledge and address discrimination by substance abuse services;
- Mobilize traditional substance abuse services to embrace harm reduction models, as opposed to promoting abstinence;
- assess the merits and practicalities of decriminalization;
- examine the discrimination experienced by subgroups within the community (e.g., Aboriginal youth, transgender, ethnic groups, dual diagnosed people);
- because care is designed for compliant groups, HIV infected injection drug users are discriminated against when attempting to access this care; flexibility in programming must be considered;
- hospitals must learn how to be more effective (e.g., pain management and addiction management): doctors need training in differentiating between what is physical pain and what is pain related to addiction; at present, addicts are not getting services they need;
- different ways of dispensing methadone should be considered; it must be more inclusive, readily accessible; control over such programs should be at the provincial rather than federal level;
- service/access to substance abuse programs is unsatisfactory;
- detoxification programs must to be evaluated and assessed; de-institutionalized models have a high level of recidivism and therefore present a lack of continued care; it must be accepted that relapse is part of the recovery process, however, some factors that contribute to relapse (such as lack of job readiness, homeless, poor health) should be dealt with; make sure planning steps address factors which contribute to addiction relapse;
- don't penalize women (50% of users are women) for accessing treatment (most must give up their kids when they are in treatment) strategize to build day care into treatment programs, otherwise women will remain in the closet;
- youth must be targeted with freestanding treatment centres; need to take an holistic model which includes skills in job readiness, unresolved trauma, homelessness, and health;
- the issues specific to prisons must be addressed and challenged;
- Aboriginal peoples must be empowered to become involved in injection drug user programs;
- needle exchanges in the community should be supported;
- start training and utilizing ex-addicted people as resources and for their expertise (also include current users);
- highlight the role of advocacy in needle exchanges;

- we should understand that many substance users will continue using, therefore we need to consider addiction management — starting with imparting responsibility when using and in returning needles for exchange;

- we should be looking at forming groups of users so that they can develop programs or at least have input into current/future programs;

- we have to be willing to evaluate and understand that there will be some failure because we are dealing with the most marginalized populations in the community;

- we have to ensure addicted people with HIV will pass on the virus (due to denial or taking more risks to purchase drugs) are treated as individuals; we need non-judgemental services (they do not currently exist); most existent programs are controlled by AIDS service organizations (which sometimes raises issues of homophobia among users), rather we need to focus on accessing services (because groups could inadvertently discourage access); and

- we have groups who have difficulty accessing services controlled by traditional AIDS service organizations and the medical community, therefore we need to become enlightened concerning our own attitudes and as well as the attitudes of users.

Current Issues and Challenges in the Management of HIV Prevention

Brian Kearns
Alberta Alcohol and Drug Abuse Commission

Introduction

Collaboration is never without conflict and always fraught with challenge. AIDS provides the biggest challenge to change the way health and addictions professionals provide service. But progress in changing the way we deliver services will be hampered unless we learn the lessons of public health:

1. Do What Is Practical.

2. Focus On The Larger Public Interest.

It is on these two lessons that I wish to reflect.

1. Do What is Practical

a. Harm Reduction
Harm reduction, if anything, is practical. It is focussed on reducing the negative consequences of drug use, in contrast to reducing its prevalence. Its focus, therefore, is on immediate and realistic goals of risk free use. However, we are having a hard time both understanding and selling this concept to the public. It is often considered less than ideal.

Welcome to the real world! Some kids will drink at graduations whether they are under age or not. Some people party and still want to drive. Injection drug users will inject and people will continue to have sex. And that may be the problem — because harm reduction often introduces us to the seamier parts of life, which may confront traditional values and offend public sensitivities. As a result, selling the idea of harm reduction is politically difficult, since the majority (taxpayers) seem to sense that they are paying for the "sins" of a minority.

Harm reduction, therefore, has to be sold on the basis of pragmatics, not on the basis of its concepts or theories. The public has real vulnerability to harm via the sex trade industry and there is a great deal at stake for the public taxpayers with regard to the cost of health care. Clearly, an ounce of prevention is worth a pound of cure. Prevention in this context has to be seen as making healthy choices the easier choice. This involves issues of convenience, and requires community, police and other professional support.

b. Addictions Treatment
Addictions treatment agencies are often accused of irrelevance when it comes to injection drug users and the prevention of HIV. This is frequently introduced as an attack on the traditional commitment of addictions treatment agencies to a goal of abstinence. However, treatment is designed primarily to address drug dependence (i.e., to interrupt the dependency cycle).

Based on our experience, abstinence is the only reasonable goal for addicted injection drug users wanting to escape drug addiction. Anything less, as with tobacco and other addictive substances, is counterproductive and may be setting up addicts for further failure. When it comes to tobacco, I don't think anybody would seriously suggest that smoking filtered cigarettes is any real answer. It may be more healthy, but it is hardly smoking cessation. But this debate distracts from the facts:

1. The majority of injection drug users are casual users. Clearly, if they are unwilling to cease this casual use, they should at least learn how to protect themselves.

2. Relapse rates with addictions are very high, from one third to two thirds of the population having some experience with relapse. This is true with or

without abstinence as a goal. The experience of relapse would be just as high for behavioural modalities with moderate users as it is with abstinence modalities for those who are chronically dependent. Successful treatment, therefore, is not the only way (albeit, the most desirable) to provide for HIV prevention. In other words, AIDS prevention is not dependent on abstinence as a goal, even if successful addictions treatment is. Therefore, we should clearly separate in our minds the goals for treatment and HIV prevention and not simply use one to distract from the purpose of the other.

The real question is "What can addictions treatment professionals do to assist with HIV prevention?" Clearly, we can provide support and care without imposing treatment goals, as in detoxification. At the very least, we can anticipate relapse and inform and educate clients during treatment regarding their health risk behaviours. We can also support and participate in public health initiatives aimed at harm reduction. On a more immediate and practical level, addictions professionals can commit themselves to new procedures for continuous admission so that those at risk can have easier access to treatment. In the current economic climate, I do not think we can necessarily design new programs for this specific purpose, but we can certainly make programs both culturally and gender specific to make them more attractive to specific target groups.

I challenge other helping agencies and professionals to relinquish their traditional view that treatment is a site — usually a residential treatment program of 4 to 6 weeks or longer. If that remains the expectation for treatment, admission will always be limited to beds and it will restrict response to the most costly and least flexible modality. While some will need residential treatment, many can be assisted very capably with intensive day treatment and outpatient modalities.

c. Methadone Maintenance

Methadone maintenance has clearly demonstrated itself to be an effective management tool for narcotic addicts. It is not only good HIV prevention, but assists these clients in becoming more amenable to further treatment interventions and to their retention in treatment. It is our experience that methadone treatment lends itself to multi-modal delivery involving addictions agencies, pharmacies and primary care physicians. It is harm reduction at its best, with a powerful capacity to normalize people's lives and to minimize their risks. Clearly, we should continue to explore multi-modal delivery of methadone maintenance as both cost efficient and effective in meeting the needs of narcotic addicts for HIV prevention and treatment retention.

2. Focus on the Larger Public Interest

a. Drug Legalization

Again, this issue is often introduced with little definition of terms and to great emotional response. Let's not add to the cost and consequences of legalized alcohol, tobacco and other addictive substances. Easier access to drugs will only add to an overall rise in their consumption and consequence. But, this does not mean we should oppose measures to decriminalize for simple possession of these drugs, precisely to avoid creating greater harm or consequence than the drug possession itself. No doubt the public policy debate on these issues will continue for decades with no predictable outcome. However, it is highly unlikely that we will ever achieve drug legalization in Canada without similar accords across North America, unless we were to accept that Canada or parts of Canada would become a drug haven. This would make for very poor social policy and it is also unlikely that the whole of North America is ready to entertain this option. In the meantime, we have a major job to do in terms of preventing HIV and assisting injection drug users in protecting themselves and seeking treatment.

b. Public Awareness

It is clear that a large portion of the population discounts the threat of AIDS. In their minds, it is still identified with certain groups and not with the risk behaviours that are attendant with unprotected sex or needle injection. People simply don't recognize their own vulnerability. This is true of the injection drug user who still feels that it won't happen to them, as it is for the whole population who may be more vulnerable to the problem than they realize. We

have a big job to do in getting people to understand their own vulnerability and the need for harm reduction in order to protect public health. just as individuals do not assess their own vulnerability, neither does the public. Perhaps the focus should move off individual risk behaviours to the routes of transmission to the whole population, via the sex trade industry. The focus here would be on the female partners of injection drug users, bisexual males and the sex trade population, both male and female. I can hear the cries of discrimination and this is not my intention! However, people will not adopt safe sex and injection drug using practises unless they can identify their own vulnerability with regard to the routes of transmission and the bridge to the whole population.

Conclusion

It's time to stop getting emotionally distracted by arguments that will not end, and will not add an awful lot of light to the situation. What we need is to gain agreement on what we can accomplish together. This requires an evolution of thinking. As little as five years ago, it seemed like a big step to get one site of consolidated service to reach injection drug users with needle exchange. Now we recognize that needle exchange is just one piece in the whole spectrum of service. What we need is a range of cohesive, sustained and coordinated efforts across a broad group of sectors, including local pharmacies, police, health agencies and addictions agencies. This is needed to meet a spectrum of needs for clients of different risk and gender. No single player has all the resources to combat AIDS. This requires that agencies get together and agree on a strategy as in the Edmonton pilot project [*Needleworks*, see presentation by Hope Hunter]. This is much more than a call for voluntary coordination, pooling of resources, or inter-agency committees. What is required is that we come together to form partnerships for a strategy that no one alone can accomplish. If we can successfully negotiate our roles in support of an agreed strategy, the result will be value added services, with an independent power and capacity to move to the intended purpose.

In other words, there will be no real action unless it is together and we are not together without an agreed strategy. It is not simply a common cause or a mutual interest or mandate. We are called around a strategy with a power to act that is beyond any one of our single mandates. No one has a monopoly on care and AIDS will not be dealt with effectively until we deal with it together. We have the skills — it's a new attitude and new partnership that is needed.

Drug Policy, Criminal Justice and Law Enforcement

Criminal Law and Drugs

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Founding Member, Canadian Foundation for Drug Policy

In this paper, I will deal with the criminal law and drugs. This inevitably brings into play a discussion of the role of the police in enforcing the criminal law. I want to make it quite clear that I am not targeting the police for criticism. They enforce the sometimes unworkable laws that we through our elected officials impose on them.

But I am encouraging the police to become part of the solution by speaking about the reality of the inability of law enforcement — no matter how well intentioned — to solve drug problems that the criminal law simply cannot solve, and that the criminal law has actively made worse.

The simple thesis of my presentation is that our drug laws — the laws prohibiting the possession, sale and distribution of certain psychoactive substances — are the greatest shame of 20th century criminal justice. They represent an utterly inappropriate application of the criminal law. They cause far more harm than they prevent. They are witch hunts; they are chemical McCarthyism. The criminal law of the future will be ill-served by the continued presence of criminal prohibitions like those we now have.

Drug prohibition started formally in Canada with Mackenzie King's 1908 *Opium Act*. The decades that followed have seen a pattern of increasingly repressive and irrational measures that have done little to stop the use of the targeted drugs. What they have done is to further the profitability and violence associated with the drug trade and the misunderstanding about the effects of drug consumption.

These same measures have also forced those unfortunate enough to have chosen the "wrong" drug — marijuana, heroin or cocaine, instead of alcohol, nicotine or prescription drugs — to be stigmatized, alienated, vilified, and prosecuted. They have curtailed civil liberties, not just of drug users, but of all Canadians.[1]

Instead of showing the tolerance of which democratic societies boast, Canada has through its drug laws turned hundreds of thousands of otherwise law abiding citizens into criminals and thrown many of them into prison for their involvement with drugs. In 1989/90 alone, 3,137 people were sentenced to incarceration in Ontario institutions for drug offenses. In the three years leading up to 1990, the percentage of incarcerations accounted for by drug crimes in Ontario rose from four to seven percent. Federally, the proportion of inmates admitted under the *Narcotic Control Act* grew from nine to 14 percent between 1986 and 1990.[2] Among the many other flaws of prohibition, throwing people into prisons represents an economic folly that a besieged Canadian economy cannot afford.[3]

Prohibition has encouraged marketers to sell and users to use more potent forms of drugs or more dangerous methods of ingestion. Users have no guarantee of quality. As a result, some — especially the young and inexperienced — will die and others will be maimed. The story of U.S. alcohol prohibition in the 1920's (and similar attempts to limit vodka availability in the Soviet Union in the mid-1980s) is being repeated, only this time with adulterated drugs or drugs of unknown potency.[4]

Instead of looking for policies that might minimize the harm flowing from the use of all psychoactive substances, Canada has arbitrarily created a black

market for some. In so doing, it has poured billions of dollars into the hands of those willing to milk the prohibition cow and to use violence to do so. And Canada's active support for prohibition is destabilizing both developing countries and the fragile states emerging from the former Soviet Union and Eastern Bloc.

Current drug laws and criminal justice policies, no matter how well-intentioned, may greatly increase the likelihood that drug users will become infected with the HIV and that they in turn will place others in the community at risk.

Current drug laws and policies may increase the risk of HIV infection in several ways:

1. Our laws prohibiting certain drugs — heroin and cocaine, for example — have encouraged people who use drugs to ingest them in more efficient ways, often by injecting.

   This happens for several reasons: First, the high price of illegal drugs means that users cannot afford to waste the drug. Therefore they inject, rather than taking the drug through some less efficient means, such as orally. Second, because the drugs are illegal, users will attempt to keep as little of the drug with them as possible, to avoid detection or to attract lesser punishment if they are caught. The need to keep smaller quantities of drugs means that users will compensate by using more efficient means of taking the drugs — often injection. Third, drug laws often outlaw substitutes that could be taken orally.

   As a result, users will often inject certain drugs, with the risk of HIV infection if needles are shared.

2. Our laws prohibiting certain drugs have created a culture of marginalized people by making them into criminals for using drugs and, in some cases, by driving people away from their traditional support networks. In some cases, users may share needles out of a sense of solidarity. And because of their marginalization and distrust of authority, it is difficult to reach these people with educational messages about safe injection practices or drug treatment.

3. Our laws prohibiting certain drugs have fostered a reluctance to educate drug users and non-users about safe injection practices, for fear of encouraging illicit drug use. Ill-informed drug users may continue to share needles and risk HIV infection.

4. Our laws prohibiting certain drugs have been the foundation for the strong opposition in some communities to syringe exchange programs, which some see as condoning drug use. In some cities, syringe shortages have in the past been caused by reluctance of some pharmacies to sell needles to drug users. As well, some people operating needle exchange programs are concerned that they may be charged with possession of drugs (the drug residue contained in the barrel of the syringe that is being exchanged).

5. The high price of illegal drugs has forced some drug users — women, men and adolescents — into prostitution to pay for their habits; if drug users then engage in unprotected sex (simply because it pays better and may allow them to buy drugs at the inflated black market price) this increases the risk of spreading HIV infection both to the drug user from an infected client, and to the client and the "general" community through an infected drug user.

6. Drug users who fear being arrested for possession of drugs (and who also fear having their needles used as evidence against them) may forego using their own drugs and needles. Instead, they may attend "shooting galleries", where they will be supplied with drugs and needles, and can therefore avoid being caught with either by the police. However, the galleries may supply needles contaminated with the HIV.

7. In prisons, the increased risk of HIV infection brought about by laws prohibiting certain drugs arises in several ways:

   - drug laws result in drug users being placed in high risk prison environments, where they will continue to want to use drugs, but will have little if any means to protect themselves from HIV infection.

   - condoms have not been available until recently, and are still not available in all Canadian

institutions. This, in part, is because condoms could be used to hide illegal drugs. Hence, high risk intercourse occurs with no protection available.

- bleach kits are frequently not available to clean syringes as this might be seen as condoning an illegal activity.

- there is no legitimate source of access to clean syringes in prisons, in part because this might be seen as condoning an illegal activity.

- attempts to educate prisoners about safe drug use have been restricted for fear of being seen as condoning an illegal activity.

- drug testing programs instituted in Canadian prisons may persuade prisoners to switch from drugs that can be detected long after use (like marijuana) to drugs that can be detected only up to a few days after use (like heroin and cocaine). This likely means that drug users will shift from smoking to injecting. With no access to clean needles, this greatly increases the risk of HIV infection.

It is strongly arguable that prison drug testing programs are an offshoot of the mentality brought about by criminalizing certain drugs and that, had these drugs not been outlawed, drug testing might never have been implemented.

8. Our laws have encouraged a "conventional wisdom" that is vehemently anti-drug and anti-drug user: "If they want to use drugs, let them die". In this climate, it is difficult to persuade people to care about what happens to people who use these drugs. This conventional wisdom is driven, not by our inner senses, but by the simple existence of a law saying that some activities are bad.

    - our drug laws have fostered a largely false belief among some people that drug users don’t care about their own lives. "If drug users don’t care about their lives, why should the public bother trying to stop the spread of HIV infection among those who inject?"

Alternatives

Many people have argued that changing the laws prohibiting certain drugs would greatly reduce the risk of HIV infection.

They argue that, by treating injection drug use as a health problem, not a criminal justice problem:

1. We would stop using the law to drive drug users to the margins of society, where they are difficult to reach, suspicious of authority, and difficult to help. In short, drug users would be treated as human beings who have may have problems with substance use, but who have a right to humane treatment.

2. We would educate people honestly and openly about the possible harms of injecting drugs.

3. We would spend money trying to help those who want to stop using drugs, rather than spending money on throwing them into highrisk prison environments.

4. We would accept that some people will inject drugs and try to find ways to prevent them from harming themselves, through syringe exchanges, the supply of bleach kits, and honest education about safe injection practices. This would include prisoners.

5. We would look for ways to ensure that people who are dependent on drugs can get them at a reasonable price, not the grossly inflated black market price caused by the criminal law prohibiting the drugs. This would prevent many users from turning to prostitution to support their habits, and would therefore decrease the risk of HIV transmission to others.

6. We would rethink the whole notion of drug testing, particularly in prisons, where its use may increase the risk of HIV infection.

Conclusion

Our drug laws may not have been responsible for the start of the HIV epidemic among injection drug users, but they appear to be responsible to a significant degree for its growth.

We can no longer afford the luxury of this futile, destructive approach to drug use. Above all, we can no longer tolerate the inhumanity of wasting the lives of Canadians through our current drug policies and laws. That means we must find ways to prevent HIV transmission among drug users — even if we must use what are perceived as radical means to do so. That means we must move away from treating drugs as a law enforcement issue and towards treating them as a health and social issue. The criminal law approach has not worked, it is not working, it will not work. No matter how we dress it up, the criminal law kills people — people who are human beings, people who are Canadians, people who are someone's child, perhaps someone's spouse, perhaps someone's parent.

How much longer can we as a supposedly democratic society allow ourselves to perpetuate this inhumanity on our own citizens? Is what we are doing now the mark of a democracy or is it the mark of an authoritarian state? Is that the mark of a country that otherwise commands respect in the international community? Is that what we, as caring, thinking people, want to allow our country to do to its very own people?

In light of the increased risk of HIV infection brought about by current federal laws outlawing certain drugs, and the policies that accompany those laws, the federal government should reconsider these laws to prevent unnecessary risks of HIV infection among drug users, their non-using contacts and their offspring.

Endnotes

1. One need only think of Canada's history of powers of search and seizure, the use of entrapment, informers, reverse onus provisions, mandatory minimum penalties, rectal searches, choke-holds, reporting requirements for large cash transactions and drug testing to see where some of those liberties have been cast aside in the name of battling drugs.

2. Erickson, P. (Summer, 1992). Recent trends in canadian drug policy: The decline and resurgence of prohibitionism. Journal of the American Academy of Arts and Sciences, 121(3), 239-267.

3. And the folly does not end with the cost of imprisonment (about $50,000 per year per person in a federal institution) and the loss of those imprisoned from the work force and their families. Take, for example, a drug bust reported in the Ottawa Citizen, November 28, 1992. Twenty-one alleged drug dealers and users were charged in a raid involving nearly 20 officers. The average value of the drugs (mostly hashish and marijuana, LSD) seized was $50. Add to that the cost of prosecuting (court administrative costs, and the value of the time spent by the policy, prosecutors, social workers and judges, plus the possible cost of legal aid for the accused. Most of these offenders, of course, would not go to prison.

4. Recent overdose deaths in Vancouver (109 in 1992) from high-grade heroin point to the same conclusion — that prohibition increases the risk to drug users by encouraging the distribution of substances of unknown potency.

Drug Policy, Criminal Justice and Law Enforcement

John Lindsay
Edmonton Police Service

As a police officer who is also a community stake-holder I value this opportunity to consider and review one of the important social issues of our day. Although my remarks will focus on drug enforcement strategies, let me open by acknowledging that this subject is very much a health issue, a political issue, a legal issue. As you have already heard, Mr. Oscapella has drawn those threads together in a way which challenges our normal understanding of drug enforcement. But the positive implementation of an aggressive drug strategy is equally a policing concern and priority. Let me explain why by giving you some understanding of the Edmonton experience and approach.

Historically police officers have been discouraged from becoming too involved with the public. Police chiefs relied on a reactive policing model that, year by year, was promoted by technological advances in transportation and communications. With cars, mobile radios, telephones, and then computers, it was assumed that the police should respond quickly enough to catch most criminals. It made sense. But time has shown this theory to be wrong. Police agencies became more and more detached from the people they served. Police facilities became centralized, and officers working mostly out of cars only had contact with people when there was something wrong. The structure and culture of policing needed to be redefined.

For the Edmonton Police Service (EPS), things were no different. Edmonton is a culturally diverse city of 625,000 people. One hundred years old in 1992, the city is the capital of Alberta. The E.P.S. also readied its centenary in 1992 and currently employs 300 civilians and more than 1,100 sworn officers. But like so many other urban centres, in the 1980's we saw our service delivery systems breaking down. Why?

Along with the rest of conventional North American policing, Edmonton had a system of police response that primarily dealt only with the incident, not the problem, and also exclusively with the application of laws and the criminal justice system. I would characterize that blind faith on the effectiveness of law as a solution to be the furthest and last acceptance by the police of the limits of law enforcement. So, what did we do about that? In June of 1990 the Edmonton Police Service decided to change the way we did things. We embarked upon a "cultural transplant" in order to restructure ourselves around the strategy of community based policing.

The conventional model of policing emphasized specialization and centralization. Research and experience demonstrated that this approach fosters allegiance to the function of the unit at the expense of the cause of the organization. Specialization champions efficiency over effectiveness we needed to turn that process around. To do so, we needed a new culture. To achieve that, we agreed upon "a process for change" that contains four main components:

1. decentralization;
2. de-specialization;
3. ownership; and
4. new form of service delivery.

Our goal was to make the generalist police officer the "impact player" in our system. Our motto was "de-specialize and decentralize where possible. Specialize and centralize where necessary". But first, we needed a core value.

A core value must serve as the supreme target for the entire Service. It must be universal in application, simply understood, and attainable for every unit and person. The core value of the Edmonton Police Service is "committed to community needs".

So, in 1994 the drug strategies of the Edmonton Police Service are shaped by a leadership that expects every drug detective:

- to be a police officer first, not just a "narc";
- to reflect the core value of the organization - committed to community needs - in his work; and
- to integrate the ethic of problem solving into his work at the expense of mere law enforcement.

These three exceptions are also shaped by the strategic goal of the Edmonton Police Service to make Edmonton "Canada's safest city". While you may think that this is just so much rhetoric, and that not much has really changed, I'm going to disagree! These are the expectations that can prompt meaningful reform in redefining the work of detectives and drug investigators. Although I will shortly give you some examples of how that new approach has become manifest in 1992 and '93 and '94, I should also tell you about the assumptions which direct my own work as the Officer in Charge of the Criminal Investigation Division. In respect of drug strategies there are three:

1. immediacy;
2. prohibition; and
3. containment

Let me explain.

1. Immediacy

The first is immediacy. By this I mean that my day-to-day police concerns are more immediate than reforming the laws of Canada.

As you must know there were recently many tragic deaths in Vancouver because of the use by addicts of 80-90% pure heroin — easily many times the normal concentration. That same type of heroin has also now appeared in Edmonton, where at least some of it has thankfully been seized by the police. I don't want to speculate on what might have happened if we had not enforced the law in this case. But it is in cases like this that I must give prospective users my promise to protect their lives with the authority that I am given. Is a lesser response sufficient? I think not.

Like any other major urban centre Edmonton has its share of drug problems. Drug trafficking, like any business, depends on supply and demand. And large centres, because of their higher populations, have a greater and more concentrated demand for contraband drugs. It is also fair to say that a significant percentage of the crimes and social problems which occur here are in some way drug related: people still want to buy drugs, people sell drugs to support their own addictions, and people sell drugs to meet the never ending demand of others. The families, friends, employers, and communities in which these people live are all in some way adversely affected by drug use and drug trafficking.

Two examples of problems which have created situations of immediate risk for this community are organized drug trafficking and fortified drug houses. With respect to organized drug trafficking we have in the past two years made separate cocaine seizures of one kilogram or greater from Canadian, Greek, Iranian, Vietnamese, and Chilean criminals. These huge quantities of cocaine represent a large potential health and safety risk to this community. In 1993 the Edmonton Police Service seized more than 16 kilograms of cocaine from the streets of Edmonton with a street value of nearly 1.7 million dollars. Yet, this represented only a little more than one-third of the 4.2 million dollars of illegal narcotics seized here. Of particular concern to me is that in 1993 there was a relative increase in the seizures of truly dangerous drugs — cocaine, LSD and heroin and a decrease in the softer drugs — marijuana, hashish, hash oil, and so forth: clearly the immediate risks are getting higher for us all.

Fortified and semi-fortified drug houses have also proliferated here in the last two years. Most are individually run with little similarities except for their method of operation. But investigation has shown them to be highly organized and primarily operated by oriental groups. These drug houses and shooting galleries make vast profits, and because of this violence has also flourished with daily robberies, stabbings, and shootings directly linked to these types of buildings.

I can't afford to experiment with social action in these situations. But I will concede that the immediacy of these emergency situations for the community and the police is an example (as is suggested by Mr. Oscapella) of where law reform could start. But, I will not go so far as to suggest that law reform should embrace a decriminalization of drug abuse and drug trafficking. This leads me to consider the second of the assumptions which prompt my work. This first was immediacy, the second is prohibition.

2. Prohibition

Many commentators on drug policy point to the Netherlands as an example of a jurisdiction which has integrated a progressive, liberal, and more honest approach to its national drug strategy. The de-emphasis on law enforcement in that strategy is striking when compared to North America. Naturally, the police have a real responsibility to study this different approach ... and we tried to do just that about 16 months ago when the Edmonton Police Service sent my predecessor in C.I.D., Al Buerger, to Amsterdam for one month as part of an exchange program.

I'm going to borrow heavily from Al Buerger's observations and thoughts — and from his conclusions which I share. You see, Amsterdam is a very interesting comparison to Edmonton because it is an urban centre which is almost exactly our own size. Although there is a different system of criminal justice, and a different policing structure, the Amsterdam Municipal Police number 3800 — three times the size of this city. Yet, in 1991, Amsterdam reported approximately 115,000 total crimes in comparison to 117,000 in Edmonton. At the risk of being overly simplistic I believe that most of the extra police which Amsterdam must employ, when compared to Edmonton, are because of the Dutch policies concerning drugs and prostitution.

The National Drug Policy in the Netherlands rejects law enforcement as a drug abuse strategy, except in regard to higher levels of trafficking in hard drugs. it accepts as inevitable the existence of deviant drug use in a modem society. It believes that aggressive attempts to eliminate drug use will likely cause social damage rather than preventing or curing the problem. It is based on the principle that supply reduction programs will breed a violent underground illicit drug market and increase the number of minor users and traffickers.

The Dutch have stuck with a drug policy that was widely pursued by many European countries in the 1960's, but has now been abandoned — that the criminalization of drugs does little to control drug use, and associating drugs and crime creates more problems than it solves. In the Netherlands, although it is legally a crime to own or traffic in cannabis products, or to use or possess hard drugs, the authorities do not prosecute abusers found in possession of drugs. Consequently the sale and use of cannabis products is allowed to go on openly and undisturbed.

The Dutch say this policy has stabilized the use of drugs in the Netherlands. Stabilized is a word you hear a lot in the Netherlands depending who you talk to, or what study you read. But most agree that — the heroin addiction problem is increasing dramatically with about 7,000 to 10,000 addicts in Amsterdam alone. The Amsterdam needle exchange program distributes 350,000 needles monthly. One thing you can say with certainty is that this policy has seen Holland and Amsterdam become a haven for drug addicts — and perhaps by some process which is not a coincidence — a growth centre for the spread of HIV.

The Dutch policy certainly raises strong passions within Europe. The laxness of drug enforcement in Amsterdam has drawn organized crime there in droves making Amsterdam the major drug distribution centre for much of Europe. In Amsterdam's defense, their police do take the distribution of hard drugs very seriously and do mount a major effort against it. Unfortunately the scope of organized crime and the extent of drug distribution within and from Amsterdam make this a very difficult task. As a matter of priorities their entire enforcement effort is directed toward the distribution of heroin, cocaine and other "hard" drugs. This policy causes foreign countries a great deal of frustration as they see hundreds of tons of

cannabis products passing through Amsterdam and entering their countries virtually unchecked.

People in the Netherlands grow up in a society where the sale and use of cannabis products is normal. They are generally proud of their policy and believe it is the right one to have. They genuinely believe they are right and the rest of the world is wrong. In any event the reality is this — faced with a choice between a pound of heroin and a shipload of hashish they will take the heroin every time. It is this attitude that has an impact on foreign countries and causes frustration with other police agencies worldwide.

But the acceptance of drug use is still a community issue and from a local Edmonton perspective this reality cannot be ignored. I know that Al Buerger was shocked by the overwhelming presence of the drug culture in downtown Amsterdam when he first arrived there. The smell of cannabis is everywhere. Young adults from all over the world flood the area and the open sale and use of cannabis is widespread. There are in excess of 150 coffee shops where hashish and marijuana are sold and used. Beggars, pick pockets, and panhandlers abound. Heroin cooking and fixing is a common sight. But most Amsterdamers turn a blind eye to what is going on — they rarely go downtown and indeed have abandoned downtown to the tourists and foreigners. Most Canadians and Edmontonians are not yet ready to make that sacrifice.

Just for a moment though let us look at one drug — heroin. The Dutch policy regarding addicts is to register them and provide them heroin substitutes by way of prescription. This policy attempts to ensure that addicts remain a medical rather than a criminal problem. It appears to work comparatively well, but there are serious drawbacks. Addicts often sell their prescribed drugs, spreading the habit. It also does not lead to addicts leading a more stable life. Many still experiment with heroin as well as with the prescribed substitute.

It is recognized in Holland that there is little point in filling the prisons with those who are themselves victims of drug abuse and addiction while the real — criminals the dealers and profiteers — go free. The obvious fault with this policy is that it confirms the addict to a life of addiction by prescribing maintenance doses only. Surely, is it not better to attempt to cure them through abstinence programs? Al Buerger tells me this idea is completely rejected b the police officers in Amsterdam. They maintain there is no cure for heroin addiction and it is better to maintain the habit by creating the least possible harm to society. This is, in fact, the official Dutch policy. It’s as if a whole segment of their society has been written off as helpless and they therefore contribute to this hopelessness with their maintenance program offering no other real alternative. I consider this to be extremely sad.

As a postscript on this issue, in September 1992 the Rotterdam Police forwarded a proposal to city administrators calling for the distribution of heroin — not heroin substitutes — to addicts in another effort to cut down on drug related crime. A police spokesman there said that the police had reached the limit of their capacity to deal with the collateral crime problems caused by addicts and abusers. The Rotterdam police conceded that if they raised the police presence in affected areas to get tougher on the "junkies", the problem would just be shifted elsewhere. And, as the distribution of methadone doesn’t seem to help, the last solution is simply to give the addicts heroin.

To me, the Amsterdam problems and Rotterdam solution illustrate the Dutch dilemma caused by the policy that drug abuse and prostitution are just social phenomenons, not crimes. With police population ratios three times larger than our own, who don’t spend any time arresting drug users and rarely dealers, they continue to allocate more and more resources to halting the crime that surrounds the growing drug and sex industries.

Drug addiction is such a complex problem, and the trade in drugs so difficult to prevent, that it must be tackled simultaneously at every level. This includes production, trafficking, using, and dealing by enforcement, prevention, education, treatment and rehabilitation. You cannot reject some of these strategies, as the Dutch have done, and expect success. Similarly, the strong Canadian and North American emphasis on enforcement is also a

fragmented approach. And while no fragmented approach can provide a complete solution, enforcement in conjunction with prevention, education, treatment and rehabilitation surely has the best prospects for making a positive difference. I, for one, won't trade Canada for Holland.

Now, let me return to the problem of drugs in Edmonton. The last of the three assumptions which drive my work in this field is containment.

3. Containment

Every police officer will probably agree that law enforcement in isolation rarely, if ever, provides a long term solution to anything. In a community based policing environment which values results more than ever before, this lack of a problem solving capability within the enforcement methodology is a serious drawback. For this reason I view enforcement as a means to an end — it is to contain the problem while a long term solution is identified, applied, and achieved. Let me explain this with examples.

1. Fortified Drug Houses

There has been quite extensive national attention given to the spread of crack houses in Edmonton — actually fortified and semi-fortified drug houses and shooting galleries, as crack is not currently an Edmonton problem. The best known of these fortified drug houses was a set of buildings in the inner city known as "the Fortress". The Fortress may be the most fortified criminal building in all o Canada.

From the bottom of the basement to a height of 10 feet above grade the building is encased in concrete up to 10' thick. Every window, including those on the third floor and the attic, are encased in steel frames secured with 8-10" bolts embedded in either solid concrete or solid wood. The windows themselves are comprised of four alternating layers of ½" lexan — bullet proof glass — and 1" steel strips. The doors are similarly encased in secured steel frames, and are made from multiple layers of solid 1" plywood each screwed into the other with literally hundreds of grabber screws on each plate — to a thickness of between 6 and 10". Even the inner doors are constructed in a similar fashion.

Admission to the Fortress is at the back door, and when admitted the door is remotely closed and locked behind the customer, sealing him/her into the house inside a cubicle which is also secured from the rest of the house. All the customer ever sees is a small metal box into which he places his money, before it disappears into the wall and then returns with his "order". If the customer is well known, he may be admitted into the house to shoot up.

Even using the most advanced and powerful cutting equipment and hydraulic spreaders, it has frequently taken the police 30 minutes or more to gain entrance into the Fortress. This is not a normal building standard. In fact, City Building Inspectors tell us that the concrete fortifications alone would support a 15 storey building.

We must also remember that the Fortress was deliberately situated next door to Edmonton's most disadvantaged community and has preyed for years on the poorest of the poor, hookers, and street people. The operator of the Fortress clearly believed that he could disregard the rest of the community, and all of our legal and social sensibilities by doing just as he wished with total impunity. He sold and promoted serious drug abuse and attracted street prostitutes to work in the vicinity of the Fortress. "Rigs" needles and condoms became common garbage throughout the area. Although there had been previous attempts over the years to enforce the law against the operator and the Fortress, these had generally only had limited success. However, and in response to the growing sense of outrage by other members of the community the Edmonton Police Service undertook an aggressive, persistent, and relentless enforcement campaign against the Fortress in the fall of 1992. Today the operator is in jail and the Fortress is closed. I regard this as a great success, and a great service to this community by the Police.

There are many other fortified and semi-fortified drug houses in Edmonton — but none as well fortified or as well known as the Fortress. For several months a police task force has targeted these types of buildings, identifying, entering, and enforcing the laws of Canada at well over two dozen separate addresses. In the last two months of 1993, 113 persons were arrested in connection with these

investigations and 288 charges were laid. In so doing we have obtained a great deal of valuable information and experience that has given us the opportunity to close many of these drug houses down. There have been, however, two notable successes where long term solutions have been achieved:

1. A drug house was closed after our cooperation with the Board of Health which produced a order condemning the premise as unfit.

2. Another drug house was condemned by the Planning and Building Inspections Branch as a consequence of being unsound.

In both cases we have benefited from the utilization of problem solving skills in conjunction with enforcement. We have learned that we cannot do it alone, and that we — the police — need to involve other stake holders, and political leaders. Alderman Leroy Chanley, who is a former chief of police, has championed a policy and legislative initiative at City Hall which is making it the business of every employee of The City of Edmonton to oppose crime. That too is a citizens right and duty.

2. Beaverhill House Park

Containment through enforcement was also the approach of this Police Service at the downtown Beaverhill House Park for the six year period that has just ended. Beaverhill Park was through all of those years Edmonton's equivalent of a "drive through full service drug outlet". With great frequency the police targeted the profiteers who used that location, but because of the design of the park we could never solve this problem or even displace the drug trafficking. We tried every conceivable idea that had merit — even piping in classic music which we hoped would discourage the dealers who worked the park.

In the end we were able to secure the full cooperation of the City Parks and Recreation Department who spent a considerable sum of money to flatten the park and redesign it to provide sight lines that would inhibit illicit activity. Environmental design, at least in Edmonton, in now a part of the police skill inventory! The point is, though, that all of the problem solving ideas which we tried needed time to work ... and enforcement was the tool to contain the problem in the interim. The eventual solution at Beaverhill required significant time and lobbying to effect. So in a not so small way the inclusive efforts of enforcement and problem solving here virtually eliminated yet another long term problem in Edmonton's downtown core. This is, as I have been told repeatedly by businessmen along Jasper Avenue, a real improvement to the quality of life in this city.

Conclusion

While I have talked about the importance of immediacy, prohibition and containment in the drug enforcement strategy of this Police Service, I have also told you of our commitment to community based policing initiatives and problem solving. When I spoke of the Netherlands I also alluded to the danger of embarking on a course of action which is fragmented, or too heavily weighted towards just enforcement or just decriminalization. Recognizing this, a firm commitment to drug prevention education has been fully incorporated into the daily work of Edmonton's Drug Unit with the training and appointment of a D.A.R.E. — Drug Abuse Resistance Education — Specialist. In 1993 the Drug Unit cleared 451 cases by charge but over 550 D.A.R.E. presentations were delivered in the same period. This is a fundamental and integral part of our drug strategy. It more than deserves to be.

Prevention, Treatment and Care: Issues and Gaps

Prevalence, Incidence and Risk Factors of HIV for Drug Addicts Using Injectable Drugs

Julie Bruneau
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Introduction

The use of drugs by injection is now recognized as Tone of the major means of transmission of HIV. Yet, in Canada and in Quebec, statistics are apparently reassuring in this regard since the number of cases of AIDS linked to the illicit use of drugs remains low in comparison with other countries. This phenomenon can be explained both by the long period of incubation that is characteristic of AIDS and by the belated introduction of HIV among injection drug users of this country. In Canada, since 1985, many studies of prevalence have been carried out among the injection drug users. In Montreal, prevalence varied from 4.8% to nearly 20%, depending on the period and sub-populations studied. In Toronto, prevalence rates of 1.0% and 5.7% have been reported, while in Winnipeg and Vancouver, the rates were respectively 2.3% and 3.0%. These data show that HIV has spread in varying degrees among the various populations of injection drug users in Canada.

Our research team has been interested in this important public health problem since the mid-80s. Here I will give a summary of the results obtained to date; we will discuss public health implications and the development of services, particularly as regards to medical practice.

Population Studied

This project started up in September 1988 and is firmly established in the community. Sources of recruitment are varied: 33% at the Detoxification Unit of the St. Luc Hospital, 6% in treatment centres, 42% by word of mouth and 19% from various sources (mainly, shelters and community agencies). Of the 1167 injection drug users recruited between September 1988 and September 1993,634 (54%) consider themselves in the process of undergoing treatment for their drug addiction at the time of recruitment (TIDUs) compared to 533 (46%) who are not (WIDUs). Since the setting up of exchange programs in Montreal in July 1989, 49% report undergoing treatment for drug addiction at the time of entry; 54% report having participated in a syringe exchange program in the six month period preceding the recruitment and 17% say they neither undergo treatment, nor participate in exchange programs.

Of the 987 injection drug users recruited between September 1988 and February 1993, 775 (78%) are men and 212 (22%) are women. The average age is 31.9 years old (median: 31.6, interval: 16.2 - 62.4). The average number of years of drug injection is 9.2 (median: 7.2, interval: 0.03 47). Sociodemographic data speak for themselves: 88% are unemployed, 46% report a legal revenue of less than $10,000, 45.7% have already attempted suicide and 16.3% of men and 51% of women report having already prostituted themselves. The preferred drug of 69% of the injection drug users is cocaine; 91% have already shared their injection equipment at least once during the six months preceding recruitment; 39% know a person who is HIV positive and 18% have been to a shooting gallery. For 70% of the injection drug users, the reason given for sharing syringes is the absence of clean equipment at the time when they are ready to inject themselves.

In summary, we recruit injection drug users who are mainly cocaine addicts and have long-standing injection habits. Most are not involved in long term change processes (therapies, methadone maintenance). We also recruit injection drug users participating in exchange programs as well as injection drug users who are not involved in any program. These last two groups present a higher seroprevalence and seroincidence.

Method

The participants are met by a research nurse. After having signed a consent agreement and having been informed about the HIV test, the participants reply to a questionnaire lasting 60 minutes and a blood sample is taken for serological analyses. Afterwards, the participants are informed of the risks of HIV transmission. The nurse answers their questions and leaflets are made available to them. The subjects are seen again after three months, then every six months. They receive $10 for each visit.

The serological tests are the following: HIV-1 and HIV-2 antibodies, HTLV-I-II and Hepatitis B and C antibodies.

Prevalence of HIV Among Injection Drug Users and Risk Factors

We were interested in risk factors associated with the transmission of HIV among injection drug users. The descriptive prevalence data are analyzed from a sampling of 987 injection drug users recruited in Montreal from September 1988 to February 1993. We sought to better describe two populations of injection drug users: the TIDUs (who state that they are undergoing treatment at the time of the initial interview), and the WIDUs (not undergoing treatment).

The overall prevalence is 11.4% (CI 95%: 9.6 - 13.6) with 8% among the TIDUs (CI 95%: 6.2 - 10.8) and 16% for the WIDUs (CI 95%: 12.5 - 19.3) ($p<0.001$, Chi-square). The WIDUs, in comparison with the TIDUs, presented the following characteristics: a higher proportion of men, less schooling, low legal revenue, less family support, greater solitude, more unemployment, greater use of cocaine, more sharing of equipment, more acquaintances of FIN infected persons and finally, more stays in prison. By logistic regression, independent factors found for the TIDUs were: prostitution (ORm=3.77, CI 95%: 1.30 - 4.41), previous history of imprisonment (ORm=3.11, CI 95%: 1.40 - 6.93), sharing of syringes with an HIV positive person (ORm=3.23, CI 95%: 1.49 - 7.02), homo/bisexual orientation (ORm=2.70, CI 95%: 1.32 - 5.52), prostitution (ORm=2.39, CI 95%: 1.30 - 4.41) and acquaintance with HIV positive persons (ORm=1.83, CI 95%: 1.00 - 3.35).

We have also carried out a descriptive analysis of prostitute injection drug users. The data enabled us to conclude that men who prostitute themselves form a particular sub-group whose behaviour presents risks of FIN transmission.

Injection Drug Users and Exchange Programs

CACTUS, the first syringe exchange program to open its doors in Montreal, has been in operation since July 1989. Also, the analysis concerns the subjects who became part of the study between September 1989 and February 1993. Of the 850 subjects, 457 (54%) had been part of an exchange program. Exchange program users have a seroprevalence of 18.2%, compared to 5.6% for the non-users ($p<0.001$, Chi-square). Exchange program users are older, have a lower revenue and less social support. They go more often to shooting galleries and are acquainted with more persons who are HIV positive. Moreover, they report greater sharing with such persons. Men who axe exchange program users are more often involved in prostitution. In addition, exchange program users show an HIV prevalence rate of 11.6% (CI 95%: 8.5 - 15.6) compared to 3.5% (CI 95%: 1.9 - 6.1) ($p<0.001$, Log-rank test). In the CACTUS exchange program, a rate of 13% during the 1990 and 15.3% in 1991 was reported among the injection drug users participating in this program.

These data suggest that the use of an exchange program among injection drug users is a tracer, an indicator of persons presenting a combination of factors and behaviour that place them at risk for

contracting HIV. *These figures in no way measure the effectiveness of exchange programs*, but seem to indicate that these programs, implemented relatively late-in the epidemic, get to injection drug users particularly at risk. As a consequence, other populations of injection drug users where HIV is active are not reached by these programs.

Incidence of HIV Among injection Drug Users

Since the beginning of our work, we have strived to create an open and dynamic group adapted to the clientele in order to measure the seroincidence of HIV infection. First, we sought to establish correlations between the rates and the responses to the initial interview questionnaire.

From September 1988 to February 1993, among the 608 HIV-negative participants, we observed 55 conversions. The number of person-years come to 874 for a cumulative effect for 100 person-years of 6.3 (CI 95%: 4.7 - 8.2). The results after 12, 24 and 36 months of follow-up are 7.2%, 11.5% and 19.1%. The rate of seroconversion observed is greater during the first year of the follow-up.

Finally, the results of our work, as well as those obtained by other teams, indicate that, on the whole, HIV moves about actively among the injection drug users in Montreal. Various sub-populations of injection drug users with their own characteristics are now identifiable. The injection drug users recruited directly off the streets are particularly affected. The data are disturbing because the transmission occurs in spite of adequate information about injection drug users and participation in syringe exchange programs.

Implications for Public Health and Medical Practice

From these results, we can improve upon the quantitative data, which are limited and too clearcut, with what we, as clinicians, have learned from the drug users after having worked with them. This exercise leads one to make a number of remarks.

We and the Injection Drug Users

Theoretically, our health system gives free access to health care for all. What about the access for injection drug users?

Injection drug users are more or less welcomed in our health system. Often, they show little docility as patients. Once hospitalized, they frequently leave before receiving medical authorization (refusal of treatment), not without demonstrating aggressive behaviour, having taken drugs and having created dissension within the medical teams. By definition they are involved in illegal activities.

Moreover, injection drug users also foster prejudices toward health services and to doctors. According to injection drug users, we show little understanding of their specific problems. We do not know how to wean an addict off drugs and are hesitant to relieve them of their pain. Injection drug users feel they are treated with disdain and are misunderstood. They are afraid of us because, in our hands, they risk suffering. Doctors and nurses are also seen as allies of the forces of repression. The hospital is perceived as a definitely hostile environment.

In spite of this stereotype, many injections drug users are still socially integrated, work and can still count on a structured family environment.

Let us look at things from another angle. We have the good fortune of being able to offer health services to all those who request it. The research data indicate to us that those who are most difficult and most scared of our services — those who come to see health professionals only when they are in a bad way — are those who have and will have the greatest need for our health care. There are also those who we can not reach until they are sick. Therefore, everything leads us to believe that, as doctors, we have a major role to play in prevention, treatment and assistance for these people. We cannot wait until all drug addicts who participate in exchange programs want to stop taking drugs and actually do so. We can develop strategies by stages, centred on the reduction of ill effects, awareness and eventually rehabilitation.

Yes, but how? Missed meetings, frequent moves, in an intoxicated state during meetings, faithlessness to treatments — particularly among the unweaned — that's what a health professional who treats a drug addict on an ambulatory basis is confronted with.

In the past, interactions between health care workers and injection drug users were relatively limited. As long as they did not want to stop taking drugs, we thought we couldn't offer them much. In fact, even before the HIV epidemic, this ideology was being strongly called into question. The idea of waiting until these persons reached the bottom of the barrel and were ready to try anything to overcome their problem through abstinence, does not always correspond with quality of life and health care objectives. Be that as it may, drug addicts infected by HIV, or by viral hepatitis, or sick for other reasons, are part of the population we must serve and provide treatment for. We have developed a plan for a clinic where drug users do not need an appointment. After one year, this clinic is in the implementation phase and we hope that it will respond to these needs.

Prevention, Treatment and Care: Issues and Gaps

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In this paper, I focus my comments on what I believe needs to be added to the National Action Plan regarding AIDS and drug use.

1. With respect to prevention measures, I propose that we take an integrative approach and add a statement to the National Plan "that to prevent HIV infection amongst men who have sex with men, we need tools which move us in our society from positions of non-acceptance to positions where we accept diversity". One of these tools is Legislation. Provincially and Federally human rights protection needs to prohibit discrimination based on sexual orientation. Same sex partnerships need to be honoured in matrimonial law. Failure to do so fosters persecution, self-hatred and loneliness which can be motivators to continue or exacerbate alcohol/drug usage patterns and facilitate high risk sexual behaviours.

2. We also require leadership which promotes an acceptance of diversity. In Alberta last year, we had a cabinet minister who ordered the Human Rights Commission to stop investigating complaints made on the grounds of sexual orientation.

3. In the current NAC-AIDS document and to a lesser extent at the conference, I detect a strong bias to preventing primary infection. As laudable as this goal is I wish to remind us that it is not necessarily realistic in the sense that many of us here are already dealing with people who are infected and dealing with issues around alcohol and drugs. I would like the document to acknowledge that we are also concerned about preventing secondary infections, that is working with HIV positive people to learn or develop behaviours which will reduce or prevent their infecting others. Perhaps we need to add a section to the National Plan entitled "Preventing Secondary Infections".

4. For those of us who are front-line counsellors and volunteers in HIV care, we need addiction consultancy services. This service will ensure that we have strong links with professionals when we have difficult cases and ensure that we are planning community programming together. To illustrate, often our difficult cases are reluctant to approach the formal institutions designated to treat addictions. Instead they approach front-line workers in community-based HIV care organizations. If these workers are to provide the treatment service, they need access to consultants for support as required. I base this proposal on the model of psychiatric consultancy service I am familiar with where treatment and care is designed to be non-hospital based and community workers are supported by psychiatric services as required.

   This linkage between the frontline HIV care workers and the formal institutions may also be critical intermediate steps for those seeking treatment for addictions. Often I have seen that it has been too big a step to go directly to formal treatment institutions. For us to perform this role adequately, continuing education for front-line HIV care workers by addiction treatment personnel will support us in performing our role more skillfully and facilitate and support the necessary referrals to treatment programs.

   A final advantage of this linkage between frontline workers and formal treatment institutions is that we have insights to enhance the traditional treatment approaches. We can speak to the power of self-care as a critical survival tool and the advances in HIV care, treatment and research.

5. With individuals impaired cognitively due to HIV dementia exacerbated by alcohol/drug use, we need strong, collaborative team work between au the players. Often these infected individuals are

not good candidates for active care psychiatric or addiction treatment facilities and are left to the hospices or pre-hospices to manage. Often these facilities operate with volunteers and a staff with insufficient mental health/addiction experience. Again, a consultancy service and a house call system would greatly enhance the support and treatment of individuals in a cost effective method.

6. With respect to other "Treatment Gaps", I would plead with you that the recommendation for methadone treatment programs be stronger by stating that major urban areas above a certain population ensure that adequate facilities are established at the local level for treatment. To illustrate, Calgary, which serves a population of 1.5 million people, has no facility and we attempt to place people in the outpatient programs in Edmonton. We first need to beg from a social services ministry which is cutting back on transport money, then find a facility which will temporarily house the patient for the work-up week and then reaccommodate the person a few weeks later for the treatment program. The AADAC facility in Edmonton is outpatient and none of their other inpatient programs is willing to facilitate these special housing needs to accommodate treatment. In the case I cite, we ultimately failed and from the point of view of HIV prevention, the person involved is back on the streets of both cities selling sex to unwary patrons.

7. Regarding "Treatment Issues", I would propose that you re-examine your assessment tools and practises. I propose that in your assessment that you add questions around same sex experience and probe sexual orientation history. Researchers like Viviene Cass have written about models and stages of coming out. It is my understanding that some counsellors do not probe for this history. I am recommending this assessment because often there are conflicts around coming out, or a person's sexual orientation is a major source of low self-esteem and loneliness.

I would also encourage you to unleash the insight and power that is already within your organization. Utilize the gay and lesbian counsellors within your organizations for in-services and consultancy All too often now I am told that these voices are silent and frustrated. The dilemma I sometimes find myself in with clients is after having made a referral to a treatment facility, the client returns saying they prefer working with me because I understand what they are talking about. What I understand is the rejection, the loneliness and the struggle to connect socially and relationally. The recently completed "Men's Survey" identifies loneliness as the number one concern of gay men in Canada. What makes the work difficult is that there are many treatment counsellors and only a few front-line HIV workers. Perhaps one way out of this dilemma is to invite counsellors from different minorities to come to these treatment facilities to provide the continuing education.

Targeting Vulnerable Populations

Ethno-Cultural Issues

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Ethno-Racial Issues

The population of Canada is comprised of a wide I variety of cultural and racial groups, speaking different languages, living in a variety of locations, and practising different traditions, customs and lifestyles. Given this existing diversity, views of what is acceptable, in terms of behaviour and in encouraging and reinforcing change, vary within ethno-racial populations. Consequently, the development of a "generic" multicultural approach in education, prevention and treatment on issues such as HIV, alcohol and other drug use, is neither possible nor effective.

All national HIV, alcohol and other drug use initiatives must reflect the ethno-racial character of Canadian society and meet the needs of all Canadians. These initiatives must be conscious of and sensitive to differing views on sexuality, alcohol consumption and drug use, and must support the empowerment of ethno-racial communities and individuals in their efforts to take responsibility.

There are numerous unique socio-political circumstances in the many ethno-racial communities. In Canada, many ethno-racial populations have a long history of being discriminated against, marginalized and socially ostracized by mainstream society. Many members of these groups are over-represented in the ranks of the unemployed, and the medically under serviced. In general terms these groups are in situations of powerlessness in Canadian society. This has led to unique life perspectives that require special attention. Consequently, in addressing HIV, alcohol and other drug use strategies, we must emphasize the development of empowerment skills in education and prevention about health issues.

At the same time the challenge in developing HIV, alcohol and other drug use education, prevention and treatment programs addressed to ethno-racial communities becomes one of recognizing the unique needs and diversity within these populations, as well as determining the most effective ways and means to meet those needs. To simply transfer messages and programs that have been developed for mainstream Canada, with their inherent values and mores, to ethno-racial communities would deny access to vital information. In an effort to overcome barriers to ethno-racial HIV, alcohol and other drug use education and prevention and treatment, the federal, provincial and municipal governments, school boards, unions, health and social agencies and mainstream HIV, alcohol and other drug use organizations must work in equal partnership with the ethno-racial communities.

Based on my experiences, here are some suggestions regarding **ways to eliminate inherent barriers** to ethno-racial HIV, alcohol and other drug use prevention programs:

Political

- we must have political will on the part of various levels of government and their officials to address concerns specific to ethno-racial populations;
- there should be representation of the diversity that exists among ethno-racial communities in current policies and programs;
- there should be equitable representation of members of ethno-racial communities on national advisory committees, working groups, councils, and so forth;

- messages and programs should reflect the unique needs and concerns of members of ethno-racial communities;
- we have to increase accessibility to the medical profession, treatment, and extended health care by members of ethno-racial communities;
- professionals who develop and deliver education programs and policies should have the knowledge about and sensitivity to ethno-racial issues; and
- there needs to be adequate funding for ethno-racial initiatives.

Resources

- Staff representative of the ethno-racial communities should develop and deliver programs and services;
- we should provide cross-cultural and anti-racism training for professional staff working in the area of health;
- we need to increase availability of racially/culturally sensitive and linguistically accessible education materials;
- there is a need to increase access by members of ethno-racial communities to existing health related support systems; and
- there is a need to carry out further research on HIV, alcohol and other drug use among ethno-racial populations in Canada.

There are several issues concerning ethno-racial HIV, alcohol and other drug use which require further investigation:

- isolation and "ghettoization" of many ethno-racial communities;
- mistrust of government and its officials/institutions;
- the belief held by certain members of ethno-racial communities that they lack power to change their political, economic and social circumstances;
- discrimination and racism;
- Cultural factors (i.e., traditional gender roles ("machismo"), etc.);
- the denial of these issues in the ethno-racial communities;
- external and internal stigmatization; and
- the relationship between HIV, alcohol and other drug use is not a priority for most ethno-racial communities — how can it be made so?

Many of the issues which need to be addressed require joint action on the part of players in different jurisdictions and in the private sector. In addition, successful and effective HIV, alcohol and other drug use education and prevention programs require joint action between ethno-racial communities and these institutions.

Women Supporting Women: The Challenge of HIV in Shelters

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The Edmonton Women and AIDS Project was developed to enhance the capacities of shelter staff to support women who are HIV positive or at risk of becoming infected. The project does not address substance abuse specifically, however, the strength of the project lies in certain principles that we believe may be transferred to many agencies or settings where substance abuse is a major focus. These guiding principles and the process we used will be outlined here. Issues related to women, HIV infection and substance abuse will be explored in the working session following this panel discussion.

How many women faced with a man unwilling to wear a condom would just take a deep breath and tell him to go and get one? Who can act on this advice? We have to be realistic: few women set the conditions for sexual activity. A fatal consequence of this reality comes to light with HIV and AIDS statistics.

By and large, the risk of HIV to women and their children is not acknowledged by women or by the health profession. The distinct symptoms of HIV infection for women are often missed. Most people still believe it is exclusively homosexual men and injection drug users who need to worry. This is dearly not so. The rate of HIV infection in women around the globe is climbing at an astounding rate and the primary source of transmission is heterosexual. In 1993, two-thirds of Canadian women who tested HIV positive were infected through heterosexual contact.

HIV / AIDS education campaigns directed towards women too often assume women control safer sex practice. It's presumed that information alone leads to the ability to protect one's health. But if we are to make a difference with women who have little or no power in their relationships, the strategies have to be relevant to their life circumstances. This is the basis of a women and AIDS initiative with staff of battered women's shelters. After meeting with shelter directors and after an analysis of the issues, the project was launched two years ago by the Community Health Promotion and Preventive Services of the Capital Health Authority; Public Health Services. We received partial funding from Alberta Health

With a project facilitator hired for eight months, we had high ambitions! The intent was to create strategies *with* women's shelters so that *they* could become proactive in HIV prevention. Their support for women and children affected by HIV and AIDS would be backed up by a wide variety of practical resources appropriate for the shelter setting. We wanted the shelters in Edmonton to be in a position to sustain HIV education and support beyond the life of the project. A second phase of the project is now near completion in battered women's shelters and their networks in Edmonton and throughout Alberta with funding for one year from Health Canada.

Critical Elements

The project is an exciting one for these reasons:

1. The project deals with the power imbalance found in many relationships, particularly in abusive relationships.

2. Through a genuine partnership, advocates closest to the issue are involved in every stage of development.

3. The project supports community workers to weave HIV prevention into ongoing, day to day advocacy work rather than tacking on HIV as yet another issue needing to be addressed.

All three factors make possible a sustainable approach to women's health within communities.

Women and Power

The primary issue with respect to women's health is power and control. Just eight months ago, this is what was said at the 9th International Conference on AIDS in Berlin: women are still dependent on men to protect their health; and a woman in an abusive relationship may fear instigating violence if she insists her partner use a condom. Lowered self-esteem and limited finances make it hard to challenge or walk away from a potentially harmful situation. AIDS, as a silent, invisible and deadly form of violence, becomes one more factor to weigh when a woman assesses her risks and considers her options.

One point of contact for addressing women's health is shelters. Battered women come into shelters voluntarily At some level, they are considering a change and view shelters as providing nonjudgmental services and support. Within the average stay of three weeks, there is time to build trusting relationships with some staff. People need to feel comfortable to explore personal risks and issues related to HIV. Given the nature of shelter work in areas like physical safety, self-esteem and communication skills, HIV can be woven into their services rather than being a health issue that stands alone. Shelters are also one place where women living with HIV might seek support for themselves and their children.

Involving the Advocates Closest to the Issue

Having identified a population of women and a contact point, we knew that our public health department had limited credibility, experience or ongoing contact with women who access shelters. By necessity, shelter staff, the advocates closest to the issue, have been and are involved in the planning and the implementation of this project.

The project is built on a three-way partnership. The partnership has been highly effective, bringing together a lead women's shelter in Edmonton, a provincial advocacy council for women's shelters and the Capital Health Authority; Public Health Services. We shared a common philosophy about the project and a belief that action could be taken preventively rather than the usual crisis response of shelters. The three sponsor representatives at the table and the project coordinator worked very closely together, respecting each other both personally and professionally.

The shelter sponsors played a principal role in shaping every major planning decision. The Alberta Council of Women's Shelters has a province-wide membership of shelters and operates at the policy level on issues which affect battered women. The Council also has a network in place for collective decision-making and the ability to share resources across the province. Locally, the Edmonton Women's Shelter was seen as a credible leader in direct shelter support to abused women and their children, as well as public education and advocacy. Both the provincial and local shelter organizations were enthusiastic about working with the Community Health Promotion and Preventive Services, whose major thrust is redressing inequities in health, and they welcomed the resources available through a public health department. The Community Health Promotion and Preventive Services's way of working is to shift resources to community partners. These are the players who are in the best position to help socially and economically disadvantaged women protect their health.

Integrating HIV Prevention

The Women and AIDS project initially met with some reluctance from shelter directors and staff. The staff were concerned with adding yet another difficult issue to their workload. HIV was a low priority and seen as the domain of health professionals. From the project's perspective, it was clear and sensible that AIDS would not become the top priority. Rather, the intent was that issues related to HIV testing, education, condom access and support services be included rather than avoided in advocacy work.

The reluctance began to disappear when people were presented with scenarios that could well take place in shelters. For example, a 33 year old woman arrives at a shelter Friday evening with two children, ages four and nine. Once they settle in, the woman informs a staff member that she and the youngest child are HIV positive. She wants to know if the shelter will isolate her child from the other children. Even if we know the most appropriate response to this question, even bigger questions surface: How would we handle this situation and what are the overall implications of HIV for us?

When the symptoms of HIV in women were discussed, it became evident that HIV positive women had quite possibly been in the shelters, unknown to the staff. Together with the powerful statistics on the global increase of HIV infection in women, there was also the bond with shelter work. Staff could see the link between women's ability to protect themselves from HIV infection and their level of power within relationships.

Once staff realized that HIV and AIDS were already part of their immediate world, the option not to deal with the issue had disappeared. Although the project was not completely supported by all staff, key staff members were then pivotal in moving the project forward in each shelter.

The subject of HIV raised many unexpected issues for shelter staff. They identified a strong need to explore sexuality issues on a personal level before attempting to address HIV and AIDS. Workshops were held to help staff examine personal attitudes and values.

Shelter staff were actively involved in reviewing existing HIV / AIDS educational resources for women. Most of the materials were judged inappropriate because they were based on the premise that women would be in control of their sexual practice. This is not the reality of many women's lives education initiatives must convey a message to women to act on whatever power they do have. Innovative resources were needed that would be supportive to women in violent relationships.

A variety of resources were produced with the principle of involving the people closest to the issue. Shelter staff and residents participated from the design stage through to completion of each resource. For example, a cosmetic looking, pocket-size condom case was developed to make it easier for women to access condoms and information about HIV antibody testing. The design and information were endorsed by women in the shelters and pilot tested over a two month period. The revisions incorporated the women's input into the final version.

There is a strong sense of ownership by staff members and the residents for each one of the materials produced. The other resources include a poster, a factsheet for women, a video and a set of stories from women in Alberta living with HIV infection or AIDS. To evaluate our experience, we have documented the project from the perspectives of the sponsors and the shelters. This documentation will be distributed in the form of a strategies guide.

The Women and AIDS project has put shelters in a stronger position to address HIV and AIDS. By improving staff knowledge about HIV, their comfort with the topic and the tools for initiating discussion, shelters are more likely to raise the issue and respond to women on a sensitive, life and death matter.

Creating the link with community agencies is the cornerstone of the Women and AIDS Project. The participatory approach assured that the outcomes and strategies would be meaningful to the shelters. Integrating HIV and AIDS into the work of agencies which have credibility with a particular population is critical for sustaining the project over the long term.

What is happening in your community around women and HIV? Who has credibility with the people with the least control over their health? What are the possibilities for a partnership involving your agency? Is there a step you could take to move this issue forward?

Women's shelters in Edmonton alone reach approximately 6500 women and children annually. Although the full impact of the project cannot be measured, the potential to prevent the spread of HIV infection and enhance women's health is heightened by this kind of initiative.

HIV and AIDS cannot be tackled as issues that belong to the health profession. Health is socially located and sustained. Only by analyzing power and control issues and economic factors can we design relevant strategies which make a difference. Weaving HIV prevention and support into sustainable community work is one way to achieve public health outcomes.

Men Who Have Sex With Men

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Introduction

I am aware of the current projects underway in cities like Toronto, Vancouver, and Calgary addressing men having sex with men. I applaud these activities and know that they are essential; I know that the Calgary project is just beginning 10 years into this epidemic because it took up to now to have the right mix of political support for such activities. I remind myself how things indeed happen one slow step at a time!

My perspective on this issue is not as a worker in direct HIV/ AIDS education-prevention but as a frontline counsellor in one of the five major HIV clinics in Canada. I will present three case studies and some reflections about these in terms of what I think prevention workers and organizations should be doing. Then, I propose we open up the debate to include your experiences and what you would propose as laudatory or worth discussing.

The Spirit of Merseyside

When I read about and reflect on the harm reduction approach taken in Merseyside, England with respect to drugs, what stands out for me is the spirit of acceptance and working with both the client, their partners and families and, the broader community structures. In a word, the approach seems to be one of working outside of the drug enforcement "closet". I wonder if our current efforts with respect to working with men who have sex with men are still not too much in the closet. Instead, we need new initiatives to move this issue out into the broader community.

I must also say that the sex therapist training in me is a little amused that we frame our description of this community as a community who relate to each other only as sexual beings. A more accurate phrase might be men who want to be with men, not just for sex but also for touch, community and relationships. Yet I realize we are trying to describe not only self identified gay men but also men who do not accept other labels.

I would like to propose that a missing piece in this story and a missing piece in our programmatic approach to this issue has recently been identified for us in the Canadian "Men's Survey" but has gone unnoticed or little understood in terms of its consequences for us as educators, counsellors and planners. The number one issue identified by men in the men's survey is loneliness. I suggest that unless we understand and take into account this loneliness in our National Action Plan that we will have missed a central insight in how to prevent further infections among men who have sex with men. I think that there are past, present and future dimensions to the question of loneliness; to be successful in our approaches, we must understand and address these. Let me illustrate these with a few case studies.

Case Study 1: Andy
Andy is the youngest in a family of six. All of his siblings drink heavily. He was raised in a small maritime community and comes from a Roman Catholic background. He was aware from a young age that he preferred spending time with his mom rather than roughing it up with his older brothers. He left home at 18 to come to Alberta and work. He moved in with one of the first men he met in a gay bar and has continual struggles in his relationship with his partner. I first met him after diagnosis two years ago because he was drinking heavily and thought to be suicidal. In probing his past what emerged clearly is the sense of aloneness and separateness from an early age, having no one to talk

to about his attractions towards men and moving away to explore that dimension. With his partner what is clear is that there was little discernment about coupling and weak communication and problem solving skills. After a couple of sessions Andy was hospitalized for a suicide attempt and recently seen in emergency for another suicide attempt. His consulting psychiatrist suggested that, he continue seeing me because he felt really connected to me and I understood what his issues were. Earlier attempts to connect him with an AADAC counsellor around treatment for his addiction failed when he choose to come back to me claiming that I was the one he could talk to, the one who really listened to him. One of the things that helped us connect was my understanding on being alone from an early age, being rejected by classmates and being labelled for years as the fairy / faggot even before knowing what the words meant. I also understand that there are not that many places to meet men who want to connect with other men except in bar's and that setting has serious setbacks because of its emphasis on drinking and being a merchandising market for sex or "fresh meat" as some so charmingly describe it.

Case Study 2: Cory
Cory is a aboriginal man who I usually talk to on the telephone every six months or so after he has been drinking and is thinking of committing suicide. Our conversations are usually around how God will punish him for being gay and that it just isn't right. His two closest friends have recently been killed in a motor vehicle accident. I try to put the Old Testament Levitical codes into context and help him see himself as a person worthy of life and love. What I am up against is his minister who has made him stand up in Church and renounce his evilness to the congregation and publicly ask for forgiveness for being infected. Sometimes when I meet Cory in emergency he tells me that I am the only one he feels comfortable talking too. Usually emergency proposes that the best that they can offer him is to check him out for acute problems and send him home to dry out. I haven't yet been successful in connecting him with an addiction treatment program; he claims that he is terrified of anyone knowing about his HIV status on the reserve. In the past he has been beaten up on the reserve for being gay even though he is 6'3". Its hard to stay in touch with him because he moves between the reserve and the city. I talked to him last week to help him sort out if his last sexual experience was an unsafe one.

Case Study 3: Orest
Orest is a young man from a Roman Catholic fancily of twelve in the Maritimes. During his first years of college he recalls how one night when walking home from class he was pursued by an older man whom he ultimately decided to invite in. This was his first sexual experience. He is now HIV infected. The issues we talk about are his drinking when he gets depressed and his questioning of anyone desiring him as a partner. When he went to an addiction counsellor to explore these issues he decided to return to me because he thought the issues were more about relationships with other men, future possibilities and being HIV infected.

Orest is just one of many of the men who attend our clinic who are in their early twenties and were infected early in the exploration of their sexuality. We have a little coterie from the interior of B.C. and a range of people from all over rural Alberta. The theme for these men is often the same: "we thought that we were the only ones and we didn't know anything about anything. We thought the people that we were with would know what was O.K. and what was not O.K."

Key Points

The key points that I am attempting to illustrate are:

1) Frontline HIV counsellors cannot do all of the work with men who are dealing with addictions and their relations with other men. If the HIV clientele are returning to us because they are not connecting, not being understood, what is happening to other men with similar issues?

2) We need to strengthen and create continuing education courses for addiction counsellors and other professionals like psychiatrists and emergency care workers so that they can connect and work with these types of clients and their issues more effectively. One theme that facilitates this connection in terms. of client history and

current issues is the theme of loneliness. It is the loneliness which is supporting the behaviours of substance abuse: people are numbing this experience. The NAC-AIDS document under discussion here describes the need for counsellors and medical personnel to be more familiar with addiction and HIV transmission. Another plank of this recommendation needs to be training around the cultural experience of minorities like men seeking out other men for relationships and sex; without this cultural understanding, there will be difficulty in establishing a counselling relationship and without that not much success in discussing harm reduction and safer sex.

To this end, our assessment protocols require modification. We need to ask about sexual orientation, we need to ask about sexual activities with others. It is not a violation of privacy — it is an opening up of the story.

When I hear professionals at the hospital that I work at say that they don't have difficulties with people's chosen lifestyles or homosexuality I cringe. It first suggests to me that they don't understand the long felt experience of being different, often conscious from an early age. "Lifestyle choice" I understand as a choice that we make when we are adults; the phrase denies the deeper, earlier formative experience. "Homosexuality" I always hear as a condemnatory term that psychiatry used until the last decade. It brings to mind all of the condemnatory forces in society, namely church and state, used to persecute gay and lesbian people.

3) I know that many agencies across Canada have staff who are gay and lesbian but are neither encouraged or used to help in the understanding of this minority and their psycho-dynamic issues. I also know that staff across Canada have asked their managers to do more in these areas and have been told that it is not a priority or that there is no pay off. Let me share with you the costs of some of our drugs at the end stages of AIDS. We have a group of drugs which are prescribed daily for the balance of a person's life which each cost $600 to $800 per month. Usually this continues for six to twelve months: that's $12,000 for drugs. There may also be four to eight episodes of hospital stays of two to three weeks: that's $60,000 for hospitalization costs.

4) Given the fact that we are just getting sex with men campaigns started and given that this is an era of reduced resources for programming, I would propose that in whatever way we can that our existing treatment agencies support and nurture the offering of workshops on coming out, intimacy with others and being in a couple relationship with someone of the same sex. From an addiction centre's programming perspective I am proposing that these workshops fall within the realm of positive life issues and that if no one else if offering them they should be offered on site. I am proposing that focusing on men having sex with men is to narrow and an insufficient response to the issues and the theme of loneliness.

   Both federal and provincial agencies have won countless awards for targeted youth programming with themes like "make the most of you" and "be proud, be you, it's all you need". For gay and lesbian youths can you imagine how strong is the yearning for this acceptance and affirmation. Yet do these images suggest positive images for young gay and lesbian people?

   If nothing else, making your facilities available for others in the community to conduct the workshops would be a powerful contribution to the work that needs to be done. Lending staff or helping support local communities in the development of these initiatives all would be powerful contributions.

5) I would like to comment about how the current political climate and agenda can either exacerbate loneliness, be disquieting or reaffirm positive messages. To use Alberta as an example, gay and lesbian people lived through a provincial election campaign last June where for a few weeks various shibboleths were hurtled about by a junior cabinet minister likening gay people to criminals. The deputy premier of the province openly mocks same sex relationships and makes it clear if he can help it there will not be Human Rights protection around the issue of sexual orientation. Federally, the debate is just beginning about same sex benefits. The positive side of this is that it is on the

public agenda and being discussed, the negative is the debate can reinforce loneliness if not viewed generously and with some sense of history. The point I am trying to make is that these debates help set the tone and climate for risk reduction activity and often this is not considered in the debating of policy around rights protection and same sex couple issues. I do not think that in Alberta anyone has said to the policy makers that an amendment to Human Rights protection would help ameliorate a climate which will also put people at less risk for HIV infection because of how they feel about themselves. What have your agencies said to government about this issue?

Finally, a word about the future and the impact of loneliness for men who survive and continue in their relationships with men. I wonder about our psychological health when all of us are experiencing unrelenting, multiple losses — I am up to 300. Now, I think I understand war and its impact, the difference is that I don't anticipate having the opportunity to go down to the legion to discuss it! In our consideration of programming I suggest we also strengthen and broaden our sweep so that we extend support to men who may be carrying multiple loss and grief around with them which I suspect also makes them vulnerable to risk behaviour. AADAC has developed grief workshop programming; targeting some of these to HIV survivors and their multiple losses may ameliorate the loss being experienced.

In summary, I have attempted to describe in a small way the lonely experience of the closet with its roots in the past, present and future. What I am asking you to consider is to help open this door. It includes opening up to the cultural story, opening up to caregivers who can teach the story, and opening up your assessments and programming. In doing so we will not only close the gap between us but also air out these tired old closets.

Youth, Alcohol, Drugs and HIV: Targeting Vulnerable Populations

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In Canada, as in other western countries, AIDS is rare among 15 to 19 years old. This can be explained in part by the fact that the evolution of HIV infection into AIDS is relatively long, the delay being a median of approximately 10 years. The majority of those who become infected during adolescence go on to develop AIDS between the ages of 20 - 29. This is what we see in Table 1, which shows that in Canada as of October 1993, a cumulative total of 29 cases of AIDS among 15 to 19 year olds was reported representing less than 1% of the national total among adults; twenty - twenty-nine (20-29) year olds however represent almost one fifth (19%) of the reported adult cases. This situation is mirrored in Europe and in the United States where 15-19 year olds represent less than 1% of cases. However, while 20-29 year olds account for dose to 30% of European cases, they represent only 19% of cases in the United States.

Table 1
AIDS IN CANADA
Total Cases by Age Group and Sex

	males	**females**
< 15 years	46	41
15-19 years	26	3
20-29 years	1483	142
30-39 years	3632	160
40-49 years	2157	806
50+ years	58	84

The number of cases diagnosed within the 20-29 year age group jumped by 18% between the years 1987 and 1991 when it declined to the 1987 level. This decline could be explained by reporting delays. Actually, if we compare the cases reported for adults as a whole (that is over 15 years of age) with that of 20-29 year olds we see that they are similar.

The distribution of AIDS cases according to risk factor for 20-29 year olds (n=1625) is presented in Table 2. Sexual transmission between men is the leading category followed by heterosexual transmission (which includes persons from endemic regions), then by sexual transmission between men and drug injection combined, and finally injection drug use and being a recipient of blood or blood products are of equal risk.

Table 2
AIDS IN CANADA
Risk Factors Among 20-29 Years

Homo/bi	70.7%
Homo/bi/IDU	6.7%
IDU	3.7%
Hetero	10.5%
Blood	3.6%
NIR	4.8%

For groups between 20-45 years of age, the proportion of males increases slightly with age along with the proportion of cases related to sexual relations between males. In other words, among cases of AIDS, we find a slightly larger proportion of women and cases related to heterosexual transmission among the young than in the older groups.

Table 3 presents results of the latest studies concerning HIV-1 prevalence and risk factors among adolescent populations in the United Kingdom, the United States and Canada. Throughout the following

presentation, you will notice a peak in infection rate in relation to the type of population studied. This peak effect clearly identifies youth who are most at risk.

I will begin by presenting results concerning youth in general which I define as having no "a priori" risk characteristics with regard to HIV infection. I will continue with youth recruited in clinics where the rate of HIV infection is presumed to be elevated or chosen on the basis of characteristics related to risk for HIV infection.

Table 3
HIV-1 INFECTION AMONG YOUTH FROM "GENERAL POPULATION"

U.K.	Prenatal care clinic, women only	Source
London	0.11%	Clarke, 1993
Outside London	0.02%	Clarke, 1993

	General care clinic, mostly women/AA/hereto	Source
U.S.A.	0-1.4%	Sweeney, 1993

Canada	Sentinel hospitals	Source
Quebec	0/635	Joly, 1993

Canada	Abortion clinic, mostly women/AA/hetero	Source
Montreal	0/841	Remis, 1993

Results from a 1990-91 study undertaken in England and Wales are included in Table 3. In prenatal clinics in London and outside of London the author found rates of 0.11% and 0.02%, respectively, among the young women who participated in this anonymous, unlinked study for which, of course, information on risk factors was unavailable.

In the U.S. researchers at the Centre for Disease Control and Prevention examined results from anonymous unlinked seroprevalence studies done between 1990 and 1992 among adolescents having attended different types of clinics.[1] Most were African-American girls, and almost all of the youth were heterosexual. Rates vary between 0 and 1.4% depending on the city.

Looking at Canada's data in April of 1993, an anonymous unlinked seroprevalence study underway in a network of target hospitals in the province of Quebec reported no cases of HIV infection among the 635 subjects in the 15 - 19 year age group. In June 1992, another unlinked seroprevalence study underway in a Montreal abortion clinic reported no cases of HIV infection among 841 girls aged 14 to 19 years of age.

From these studies which largely recruited girls, we can establish that the infection rate is still relatively low among girls in the "general population" with the exception of certain areas in the U.S. The different rates between clinics can be largely explained by geographic and ethnic differences, the latter strongly correlated with socioeconomic level, rather than by particular behaviours among the youth sub-population. Considering the difficulty of recruiting boys at those kind of clinics and the absence of risk-factor information, any conclusions we might wish to draw from these studies are limited.

Adolescents in these U.S. studies were recruited at sites where the estimated rate of infection is higher than the general population. The Job Corps program is a federal education initiative recruiting drop-outs and youth from socially disadvantaged environments; youth involved in drug use and youth with health problems are excluded. Conway (1993) reported an overall rate of 0.3% with an increase among young women from 0.21% to 0.42% between 1988 and 1992; conversely, the rate among boys decreased from 0.36% to O.22% over the same time period. Overall the prevalence varied by region with the highest rates occurring among boys in the North East and among girls in the South. African-Americans were the most affected group in both sexes. As this was an anonymous unlinked study, information on risk-factors was unavailable but the authors conclude nonetheless "that HIV

[1] All of the results reported here are preliminary and were presented at the international AIDS conference in Berlin last June. The paper was sent to press and more recent results will therefore be available from the author.

seroprevalence among female students in the Job Corps increased and exceeded that seen among male students during this survey period suggests that heterosexual or drug-related transmission of HIV may be increasing in this population".

Using a chart review, Dillon (1993) found an infection rate of 0.4% among 150,984 adolescents who underwent HIV screening in 1992 in various public services in the U.S. The majority of those infected (63%) were African American, were youth who acquired HIV through heterosexual transmission and 56% were girls. This could be explained in part by the fact that the public services concerned were mostly public STD clinics and family planning and prenatal clinics where the clientele was predominantly heterosexual. At the same time, higher infection rates were found among male adolescent injection drug users who had sexual relations with other males (3.7%), followed by non-injection drug users who had sexual relations with other males (3.1%), injection drug users (0.9%) and those who had heterosexual relations with partners at risk (0.7%).

Looking at Canadian data, a Quebec study conducted with the collaboration of a network of physicians reported 5 positive results in 1991 out of a total of 221 screening tests on young adults (under 20 year olds) who were tested for clinical reasons.

Sweeney found rates of 0% to 3.5% in STD clinics depending on the area of the U.S. concerned, with a median of 0.4% among girls and 0.5% among boys. The majority of patients in these clinics reported being strictly heterosexual in their behaviour which undoubtedly explains the predominance (75%) of heterosexuals among cases of N infection.

In British STD clinics, Clarke found marked differences in infection rates according to sexual orientation. Nonetheless, among cases of heterosexual transmission, infection rates were similar for boys and girls. The marked difference between London and other areas is noteworthy.

Among adolescents held in U.S. detention centres, Sweeney found rates varying from 0% to 6.8% depending on the city. The median rate for girls was 0.3% and 0.2% for the boys.

Sweeney recently informed me that the most recent data show a rate approaching up to 12.1% among young women in New York although one must be cautious when dealing with small numbers.

With respect to Canadian data, the study we are conducting in Montreal within various rehabilitation centres for adolescents revealed 2 cases of HIV infection among 1,904 subjects tested representing 0.11% or 1.05 per 1,000 (CI 95%: 0.0-2.4).

If we review these studies, it appears that among adolescents:

1) cases are more frequent among boys, and homosexual transmission accounts for the majority of cases;

2) among subjects who are strictly heterosexual in their behaviour, infection rates are similar for boys and girls; and

3) injection drug use is also reported as a major factor in the transmission of HIV.

Turning to street youth, one study among street youth in Toronto reported an infection rate of 2.2% among 695 subjects. In the 508 14-20 year olds, the prevalence was 0.8% and in the 21-25 year age group the prevalence was 5.8%. In total, 15 of these youth were infected. All were boys, 13 of whom had had sexual relations with other males in the last 5 years and 8 of whom reported injection drug use.

In the U.S., Sweeney documented an infection rate in street youth varying between 0% and 6.8% depending on the city. Among those tested, only 29% were Caucasian. The median was 3.6% among boys and 0.9% among girls. The infection rate was highest among young males who had sex with other males.

There are very few data available concerning young injection drug users. The Montreal study in rehabilitation centres recruited 108 subjects with a history of injection drug use and found one 18 year old girl with HIV infection. It is difficult to determine the true rate of HIV infection in this group due to the small numbers. However, analyses comparing behaviours between young injection drug users and

non-injection drug users have shown beyond all doubt the high level of risky sexual and drug use behaviour in the injection drug user group which confirms that they constitute a core group for HIV infection.

Finally, a study conducted in Puerto Rico revealed an infection rate of 2.6% among girls (n=77) between 13-18 years of age who had engaged in prostitution during the previous year.

Review and Conclusion

In summary, the statistics on HIV infection suggest that the infection continues to be rare among Canadian adolescents. It appears that the spread of HIV is limited to specific sub-groups of the adolescent population. According to the literature and to available information on risk factors, those youth most vulnerable are boys having homosexual relations, boys and girls in difficulty (socioeconomically disadvantaged and with psychosocial problems), notably street youth, prostitutes and injection drug users. Unprotected sexual relations between males, whether or not involving prostitution, are without doubt a serious risk factor, with estimates for HIV infection among males who have sex with other males in the order of 10% to 25% for Montreal, for example. The situation for girls is not very clear. It could be that the situation for a teenage girl engaged in prostitution is quite different from that of her female adult colleagues. It is possible that she is in a more exploited position with less personal control within sexual encounters than a female adult. In any case, few would argue that adolescent boys and girls who, engage in prostitution often have a variety of personal and social problems rendering them more vulnerable than others with regard to HIV infection.

According to the study of youth in difficulty which we are conducting in Montreal, compared to boys, girls have been more often engaged in sex involving penetration with commercial partners (14.7% vs 3.5%) and are more likely to have been sexually abused (37.2% vs 4.4%). The girls were also at least as likely as boys to have a history of injection drug use. These facts, in addition to the physical vulnerability of young females to sexually transmitted disease, can perhaps explain at least in part, the greater proportion of females among adolescent cases of AIDS than among adult cases and suggests a serious risk of HIV infection among certain female adolescent populations.

In conclusion, the forgoing underlines the growing importance of directing HIV prevention efforts towards certain particularly vulnerable adolescent populations and the necessity to adapt intervention strategies to the needs of these groups. This is what I will talk about in the workshop on Tuesday where I will focus on the association between drugs and risk for HIV infection in the context of planning an HIV prevention program for use among youth with drug and alcohol problems.

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Perspectives

A Canadian Perspective

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I was asked to give my impressions of the meeting and perhaps address some extraneous factors that might influence how we go about trying to control this particular focus of the HIV epidemic; that is, the interplay of substance use and HIV.

Twenty years ago astronauts landed on the moon and since then humankind's vessels have probed the furthest reaches of space. It is, however, ironic that we have the exquisite technology, and yet at this meeting, we discuss the fact that needle exchanges are lacking in prisons because their implementation is too difficult. In reality, we have not convinced the decision makers nor society in general that we must have these needle exchanges. The will of society to introduce these harm reduction initiatives has been lacking.

Approximately 20 years ago, HIV was introduced into North America. HIV may have been infecting humanity for about 100 years, but about 20 years ago it infiltrated North America. Ten years ago, in December of 1983 and May of 1984, Montagnier and Gallo published the first definitive information on HIV. Ten years ago, we knew what the high risk activities were; we knew the modes of transmission and we knew how to prevent infection. This information was available 10 years ago. During this meeting we are discussing measures to prevent HIV transmission, yet little new has been added to our understanding of the transmission modes during the last 10 years. I don't mean to be pessimistic but progress in this area has been very limited; that is, prevention of HIV in specific groups has not met our expectations. The impediments are not based in our lack of understanding, but I believe reside in the lack of political will to address the unpopular issues of HIV in the injection drug use community.

I believe the current HIV epidemic is a dynamic process and thinking of the HIV epidemic as a monolithic occurrence is incorrect. The epidemic we recognize consists of a series of smaller HIV outbreaks each one of which is affecting a particular group. For example, the HIV epidemic in Canada is a composite of smaller outbreaks in injection drug users, young gay men, women, natives, street involved youth, commercial sex workers and so forth.

The National AIDS Strategy, phase 2, provides the framework for the Federal response to the AIDS epidemic. This document provides a blueprint for the expenditure of the monies allocated to the strategy by the Federal Cabinet. If a program activity is not specifically addressed in the National AIDS strategy and public servants or politicians are particularly uncomfortable with a specific initiative, I can conceive of a situation where inaction will be supported by the limitations of the strategy. If an activity is not addressed in the strategy, then not doing it can be defended on strictly technical grounds. I think a prime example of such an approach is the complete lack of needle exchanges in federal prisons.

I do not imagine that any of us in this meeting are unaware that Canada is in the process of a blood inquiry. Some individuals in this room will be involved in the deliberations of the Krever inquiry. This is an inquiry not only into the conduct of the Canadian Red Cross Society but many questions have already been asked about the action taken by the various levels of governments in response to the AIDS/HIV epidemic. I believe there are and will be some tough questions posed. I believe ultimately this is an inquiry about responsibility. Did officials do

everything which could be reasonably expected of them to control the spread of HIV?

No one at this meeting has discussed the impact of the Reform Party on the politics of HIV / AIDS. Much of the western part of Canada is represented by members of this Party. I think its presence in Parliament will have a profound effect on the willingness of federal politicians to embrace new initiatives which could be seen to be controversial or provocative. It may be very difficult for any of us to have innovative and aggressive intervention programs implemented if they are first discussed in Parliament because politicians may not be willing to advocate for interventions which may be radical or too progressive for the voters back in their riding. A prime example of this reluctance will be characterised, I believe, by the debate surrounding the provision of clean needles in prison. The feeling in this room is probably unanimous that prisons are places of high risk behaviour but attempts to have needle exchanges in prisons have been dismissed as being politically unacceptable.

Another fact for all of us to remember is that the HIV epidemic is world-wide in scope with approximately 17 million people presently infected. The North American epidemic is a significant component of the epidemic but the total number of infected people in the remaining part of the world far exceeds the North American number. HIV is exploding in the developing world. It is an infection driven by poverty, marginalization and the lack of a political voice. If we think about the potential epidemic in the Indian subcontinent, Asia or South America we must realize that North America's impact will diminish with the passage of time. Consequently, we must remember that our strategies for interrupting the spread of HIV are our attempts. They may be inappropriate for much of the world or they could actually be counterproductive to the global efforts.

In addition, in Canada the competition for money may influence which initiatives are supported. Presently the available money has remained static but the problems grow. The cohesiveness between the non-government organizations, in my opinion, is very fragile and is in jeopardy of breaking down because of the competition for a limited resource.

There are groups that were originally established by gay men because the epidemic was primarily one in gay men. However, as the epidemic broadens its base — to become established in many different communities — there will be increasingly sharp competition for scarce resources. For example, in British Columbia money for some programs aimed at improving the living conditions of persons with AIDS is in the same envelope as funds for the needle exchanges. Consequently, a debate has ensued over the relative importance of funding either interventions aimed at preventing the spread of HIV or initiatives directed towards supporting individuals already infected. The coalition of community based organisations, may be in jeopardy and it's not that they can't get along, it's just because there is not enough money. We have seen this situation in British Columbia, but must we accept the premise that these two types of interventions need be mutually exclusive? Where should governments be directing their money to? Support or prevention? I think they both have to be funded but governments are likely to suggest that decisions one way or the other will be made. I think that this could be a very divisive issue and again I didn't hear it really discussed at this meeting, but it is certainly going to affect all of us.

Another issue that affects all of the programs across Canada is migration. There are two levels of migration. One is the migration of immigrants into the country. Immigrants enter with their different cultural perspectives and languages and reaching them and getting them to be sensitive to risk reduction — clean needles or safe-sex practices — can very difficult because of our limitations. Some new Canadians originate from areas where perhaps 10% of the population could be infected with HIV, hence, this may be a problem with significant impact.

However, inter-provincial migration also has an effect on the HIV landscape in British Columbia. For instance, a number of us designed a study to document where people who are HIV positive originated. We thought that most were from Vancouver but some would be from Prince Rupert, Prince George, the Okanagan, and so on. To our surprise another principal migration pattern was not from within British Columbia to Vancouver, but was

from Toronto to Vancouver, from,Montreal to Vancouver, from Quebec City to Vancouver. So when a needle exchange program is designed, there may be some difficulty on the implementation side if there is a constant influx of individuals who don't know anything about the services. It only takes one person to be a focus of a cluster outbreak of HIV. For instance, if provinces reduce the welfare roles by establishing very strict criteria, the former clients may migrate into neighbouring provinces.

Another influence on the course of HIV in Canada is the politics surrounding AIDS. hi your pre-conference material you received, there was a copy of a document Catherine Hankins prepared in 1990. This document has been restricted from circulation until several weeks ago in early 1994. The report focuses on Principles and Recommendations regarding HIV infection in injection drug users. It was prepared for the committee that I now chair, the National Advisory Committee on AIDS and was considered to be confidential recommendation to the Minister of Health. As such the report could not be publicly released. Why was that? I do not believe program people would not release the document but I propose it was the political side of government which made the decision. When you read this document I doubt you will find anything very controversial or provocative — but the report remained buried for four years.

I am sure all of us here are familiar with the standard epidemic curves which depict the HIV epidemic as having begun early in the 1980s and having increased to today's present levels. It is easy to misinterpret such curves unless we have a solid understanding of what these curves actually represent. Firstly, these figures represent a compilation of data from several epidemics that are ongoing simultaneously. There have been and continue to be infections in gay men, injection drug users, commercial sex workers, and so forth. Another important consideration is that these figures are derived from historical data in that they are based on the numbers of AIDS cases, but the incubation time from infection to the diagnosis of AIDS often exceeds ten years. Consequently, these are nice historical data, where the epidemic is today can be somewhat inferred from these data, but accurate and timely reading of what is occurring on the streets of Canadian cities cannot be achieved by solely relying on the historical data that AIDS case reporting represents. The AIDS case statistics which we are all so familiar with are the results of events (i.e. infections) that occurred in the 1980s.

Another issue that I believe we all need to reflect on is the multiplier effect of substance use in the spread of HIV. Substance use actually has two functions. One is that the use itself, the process of injecting the drugs, can actually be responsible for the transmission of this — and other — infectious agents. We are all familiar with the risk from dirty or shared needles. Consequently, one important cornerstone strategy is the removal of dirty needles from circulation and this has been done in some localities quite effectively The other side of the equation tells us that substance use may not be the direct cause of HIV transmission but it is a co-factor for transmission. Substance use with its inherent need for money can lead to the adoption of risky activities. The use of a substance may be responsible for a whole second arm of transmission. For instance, an injection drug user may not get infected by injection, but may become infected in the process of earning money to buy the injectable substance. Dr. Stanley Read, a Canadian investigator at Sick Children's Hospital in Toronto has shown that the single, largest risk factor for transmission of HIV to women in the Caribbean, is the use of crack cocaine. This drug is not used in this circumstance as an injectable, but the women sell sex to buy the crack. Hence the use of a drug is a very potent risk for the enhancement of the sexual transmission of this virus. Another factor is alcohol. In the Vancouver Lymphadenopathy Study Dr. Schechter and his colleges report that the men who seroconvert now state that the use of alcohol played a role in the events that led to seroconversion. In this longitudinal study of gay men in Vancouver the individuals who seroconvert — even after being enrolled in the study for 12 years- report that they did not practice sex safe following consumption of too much alcohol. This is another method of substance use facilitating the transmission of HIV. When we speak of risk reduction, we are including not only the clean needles but also the provision of condoms. Risk reduction is a package of activities which include not

only the provision of clean needles, but also a guaranteed supply of condoms, a health sheet with information on the safe injection of drugs, bleach, access to health professionals when requested, and so on. This is the direction that pioneering programs, such as the Downtown Eastside Youth Activities Services needle exchange in Vancouver, have chosen to go and many of our Canadian groups serve as models for the rest of the world.

I think we are watching an epidemic shifting gears. During the next five to ten years we will see the majority of new infections centred largely in youth, with young gay men being at highest risk, and the impact of HIV in the injection drug use community will be apparent. The injection drug use community will be one of the principal foci of this epidemic and the clear transmission from positive injection drug users to their sexual partners will be a significant component of the coming epidemic. This has been a good meeting because the participants' eyes have been set on the horizon here. You have been looking into the near future and you have been discussing the measures required to prevent the unchecked spread of HIV into the injection drug use community and from them to other groups.

In addition we have recognised that the approaching epidemic will continue to affect individuals entering prison and we understand this is a very difficult group to reach because its a group that may be not accessing the traditional community groups which target HIV prevention. The other group at very high risk of HIV transmission is the native community. This is a community among which some of the members have a very high risk and it is imperative that an effective, sustained strategy for the prevention of HIV be developed in the native communities across Canada. These communities must provide the solutions which will work for them and we must be committed to ensure that they have access to the means which will ensure the success of their efforts.

This has been a very good meeting and much positive discussion and planning has arisen from it. However, there are many impediments which influence our efforts. What are the impediments? One such lack that comes to mind is the missing leadership we require. The original needle exchange programs received the financial push start when Minister Beatty, took, I believe, a political risk when he approved a document prepared by Health and Welfare's staff regarding the need to support needle exchanges across Canada. These "bureaucrats" were not obstacles but in fact had the vision to go to the Minister with an innovative strategy. We know that Minister Beatty demonstrated leadership. What has happened since then? In my opinion, nothing. There has been a resounding silence around this issue because it's not a popular one. Normally, a Federal or Provincial Minister will develop a position only after they are presented with evidence which indicates that there is support for a particular initiative. Often these initiatives arise from the community groups and work their way up through the system. The same is true for programs which are initially developed within the public service. An idea is germinated, the program developed and if there is adequate support the concept works up through the system. So the information comes up, and if there is support, an announcement ensues. I think right now, we are not in a position of having strong Federal or Provincial leadership on harm reduction with specific reference to the injection drug use community. I think this situation is the result of the political unpopularity of dealing with HIV in the injection drug use community. I believe you all know of the many difficulties there have been in establishing sustainable support for the gay community organisations. I think it's going to be even tougher to get governments to support some of the things that we have been discussing at this meeting. Can you imagine the response when this group recommends establishing needle exchanges in prisons? The Expert Committee on AIDS in Prison report is about to be released, but I do not think anyone in this room believes the Federal Government will accept the more progressive recommendations in the report. The country needs a senior politician who has come to grips with this issue who will state that our prisons are a place where HIV is being transmitted and here is what must be done to stop this spread. Someone has to take the leadership, but we must recognize that initiatives like the provision of clean needles in prisons may not be readily endorsed back in the home riding. Those of us who can help the

politicians must help them, but even we cannot give them the courage to accept the challenge of doing what is necessary even if the political climate is stormy.

One of the messages which we have heard here at this meeting is that there is a window of opportunity. I believe the window is closing and unless action is taken society will pay the price of inactivity for many years to come.

This has been an informative meeting but much work lies ahead. In these sessions we have reached consensus on many issues but we have spoken to ourselves. We have a responsibility to advocate for the adoption of the positive actions which we feel are critical to controlling the spread of HIV through our communities. We have, in my opinion, completed the easy task, the tough road lies in front of us.

An American Perspective

Stephen Jones
Centers for Disease Control, Atlanta

Canada has provided leadership in North America C in developing HIV prevention programs and harm reduction for drug users. Leadership highlighted by the 1989 HIV prevention initiatives that provided federal, provincial and local support for needle exchange programs in many Canadian cities. North American leadership continues with the just released "Principles and Recommendations on HIV Infection and Injection Drug Use" that is being used at the basis for the recommendations of this workshop. From the perspective of Canada's southern neighbour, the clear assertion of public health priorities in HIV prevention is welcome. Particularly, the first principle in the document that the spread of HIV is a greater danger to individuals and public health than injection drug use itself. This document is an excellent and comprehensive plan that is a solid foundation for national, provincial and local planning of HIV prevention among drug injectors.

In the balance of this talk I will touch briefly on two topics, namely priorities for epidemiologic and evaluation studies and the North American phenomenon of increasing heroin purity. Then I will present arguments for increasing the numbers of sterile syringes in the hands of drug injectors.

One of the strengths of Canadian programs for HIV prevention among drug injectors has been a commitment to evaluation. With respect to further research, several areas seem particularly important, for additional work:

1. Behavioral studies using ethnography and qualitative methods to better understand why the particularly high risk activities of multiperson use of injection equipment and "condom-less" sex occur and how we can help injectors reduce or eliminate these risks.

2. Studies of how drug injectors obtain, use, clean, and discard needles and syringes. These studies would allow us to evaluate how public health interventions such as needle exchange and enhanced sales or distribution from pharmacies affect the use of needles and syringes, particularly multiperson use (sharing) of injection equipment.

3. HIV incidence studies in Montreal that follow drug injectors who are not HIV infected and identify what behaviours are associated with becoming HIV infected.

4. Finally, harm reduction is an important new public health approach. Carefully designed studies are needed that in several years will provide data to demonstrate how effective harm reduction is.

Heroin

In this workshop, reports of overdose deaths from unexpectedly pure heroin have been heard from Vancouver and prisons in Ontario. The U.S. Drug Enforcement Authority (DEA) has made regular retail purchases of heroin on streets of several U.S. cities. Purity has increased seven-fold from less than 5 percent to 35 percent. Price has dropped from $4.00 in 1980 to about $1.50 a milligram in 1992. Snorting higher purity heroin gets people high whereas the low purity levels (5-10 percent) are not effective when snorted. Snorting heroin is now common in cities like New York where purity is higher than the national average—in the 60 percent range. Users snort heroin in part to avoid the HIV risk associated with injection. We don't know all the "market forces" behind this change. If the "market forces" change and heroin purity declines, many of the current heroin snorters will turn to injection of heroin and will need safe injection equipment to avoid becoming HIV infected through shared drug injections.

My major message is: flood the world of drug injectors with sterile needles and syringes, get more

"fits" into the hands of injectors. The availability of sterile, new equipment is key to HIV prevention. The goal should be that every drug injection is done with a sterile needle and syringe. A needle and syringe should be used only once and then properly discarded.

Let's look at the reasons. During every intravenous injection, blood is deliberately pulled into the syringe to verify that the point of the needle is in a vein. As a result, every syringe used for an intravenous injection is contaminated every time it is used. That blood contamination potentially carries HIV and/or hepatitis B or C and/or HTLV I and/or II and a variety of other bloodborne infectious diseases.

Bleach

If the needle and syringe are contaminated to what extent will bleach disinfection make it safe to re-use that syringe? The newly released principles and recommendations in the Centers for Disease Control and Prevention (CDC) document are quite dear on this question (CDC, 1993). Advice on cleaning injecting equipment with bleach should make clear that cleaning cannot offer full protection against infection and that cleaning is no substitute for unused equipment. Cleaning with bleach can, however, help to prevent infection when unused equipment is not available.

Personalizing the choice between a sterile syringe and a bleach-disinfected one makes the choice very clear. If I needed an injection, I would always choose a new, never-used syringe over even the most carefully bleached syringe that had been previously used. However, when unused equipment is not available, bleach disinfection can be life-saving.

To illustrate what can be achieved in increasing syringe availability, I will discuss was has been introduced in Australia, a nation that adopted many harm reduction measures in the 1980s. Methadone maintenance treatment capacity was increased tenfold; a network of syringe exchanges was opened; pharmacists work on a public health approach with unrestricted sale and, in some pharmacies, syringe exchange. A 1990 survey of more than 500 injectors from Sydney illustrated how easy it is to obtain new syringes. The average response was that 93 percent of the time it was easy to obtain new syringes. You should ask the same question of injectors in your city, your province. What would their response be? In the United States, it would be much less than in Sydney in 1990.

General access to new equipment is not sufficient to eliminate use of syringes by more than one injector. Two-thirds of the Sydney injectors injected with used equipment some of the time. On average, about 14 percent of the injections were done with equipment used by others.

What were the reasons the Sydney injectors gave for injecting with used equipment? A little more than half of those who used someone else's syringe did so because they had trouble obtaining a new needle and syringe at the time they were going to inject. The other reasons given suggest that drug effects (including craving, withdrawal symptoms and intoxications overwhelmed reluctance to inject with equipment that had been used by someone else. The very first injection also involved sharing.

The common denominator seems to be that shortage of new equipment results in multiperson use. The multiperson use of injection equipment should be studied until we understand it and can help injectors avoid it. The studies should take the form of formal research and less formal inquiries among the people you serve. My hypothesis is that "flooding the market" with new syringes so that every injector had 10 or 20 unused sets would substantially reduce multiperson use of syringes.

The following steps seem appropriate:

1. Syringe exchanges should increase the number of injectors served and the volume of syringes distributed.

2. Partnerships should be formed and strengthened with pharmacies, health centers, physicians offices, and drug treatment agencies to provide distribution or sale or exchange of syringes and other prevention materials. The active participation of pharmacists will be important in increasing access to new injection equipment.

3. Work with police and other law enforcement agencies on the public health importance of sterile syringes for HIV prevention, so that injectors with substantial numbers of syringes are congratulated rather than hassled.

4. Develop a consensus among the injection drug use clients and partners working to improve access to new syringes that a new syringe for every injection is the appropriate goal.

5. Communicate the goal of a new syringe for every injection to the injectors in the community.

6. Monitor how well you are doing in getting syringes into the hands of drug injectors by all the different approaches.

7. Emphasize safe disposal of used needles and syringes. If we are successful in flooding the market with new syringes the number of used syringes will increase. Some of these will be returned to syringe exchanges. The communities should find ways to make safe disposal easy by placing sharps containers where injectors can easily use them. In Vancouver, Downtown Eastside Youth Activities Services has put sharps containers in court buildings and in police vans. Drug users need to be responsible in how they discard used syringes.

Substantially increasing the supply of syringes should make multiperson use of syringes less and less common. As much as we succeed in decreasing sharing we will decrease HIV transmission.

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A British Perspective

Andrew M. Bennett
Mersey Drug Training and Information Centre

I have been asked today to give my perspective on discussions at this meeting as they relate to the development of a national strategy on AIDS and drug use. What I am going to do is to describe to you the approach taken where I come from in Merseyside, England. This approach involves a comprehensive, multifaceted harm reduction strategy which includes but goes far beyond syringe exchange alone.

Introduction

The Mersey Regional Health Authority (MRHA) area covers the counties of Merseyside and Cheshire. In 1993 Merseyside contained the five District Health Authorities (DHA) of Liverpool, Wirral, South Sefton, Southport and St Helens and Knowsley. Cheshire contained the five DHAs Chester, Warrington, Halton, Crewe and Macclesfield. In 1993 the population of the MRHA was estimated to be 2,412,833.[1]

In 1991 (census data) the average unemployment rate in the MRHA was 12.6%. In Liverpool the rate was 21.6%.

Nature and Extent of Drug Use in the Mersey Region

The Mersey Region has a relatively high prevalence of drug use. Local estimates suggest that there are between 15,000 to 20,000 regular opiate users, of whom at least 50% inject. In 1993, the Mersey Region had the second highest number of notified addicts[2] (3663) and the highest rate of notified addicts per million population (1518) of any Regional Health Authority in the UK (Mersey Regional Health Authority, 1994). The use of amphetamines, ecstasy, cocaine and LSD have increased substantially over the last five years. Undoubtedly a significant part of this increase can be linked to the popular culture that is integrated with house music, clubs and ecstasy. Cannabis remains the most widely used illegal drug. A recent survey in the North West of England showed that 42% of 16 year olds have tried cannabis (Parker and Measham, 1994).

Principles

Since 1986, the Mersey Region has pursued a pragmatic response to drugs and HIV by constructing them as public health problems. This is consistent with the recommendations of the Advisory Council on the Misuse of Drugs (ACMD), 1988 that states:

> "...we have no hesitation in concluding that the spread of HIV is a greater danger to public health than drug misuse. Accordingly, services which aim to minimise HIV risk behaviour by all available means should take precedence in development plans."

Working on this principle, priority has been given to services that aim to reduce the risk of acquiring or transmitting HIV In the Mersey Region and the UK as a whole, risk reduction is seen by many services as a broader concept of reducing drug related health, criminal or social harm (Stimson,1990). The concept of reducing drug related harm can be seen as a hierarchy of goals, for example:

- avoid sharing injection equipment;
- switch from injecting to oral use;
- decrease drug use; and
- become drug free.

[1] From 1 October 1993, some DHAs merged. From 1 April 1994, the MRHA will form part of the North West Regional Health Authority.

[2] All doctors must notify the Home Office of anyone they see who they consider to be using one of 13 opiate drugs or cocaine.

Responding to Drug Related Harm

In 1989, the Mersey Regional Drug Advisory Committee provided guidelines within which all drugs and HIV services can be planned. The imperatives of the strategy are that services should:

- make contact with drug users;
- maintain contact; and
- make changes in behaviour.

The Mersey Regional Strategy utilizes the following services:

Syringe Exchange Schemes
There are 14 syringe exchange schemes in the Mersey Region providing clean injecting equipment and condoms. Many of the schemes have evolved to the extent that they provide a range of other primary health care services to drug injectors and prostitutes including instruction on safer injecting, anonymous HIV testing and the diagnosis and treatment of specific conditions such as abscesses and septicaemia.

During 1993, at least 3000 injection drug users made over 23,0000 visits to the schemes. In the same year, 691,297 syringe barrels were given out and 797,626 were returned (Mersey Regional Health Authority, 1994).

Pharmacies provide an additional source of easily available injecting equipment. For example, in Liverpool 20 pharmacists operate a free exchange.

Outreach Work
In parts of the Region, outreach workers are deployed to make contact with the hidden population of either drug injectors, prostitutes or other people at risk of becoming infected with HIV. For example on the Wirral, six workers and a mobile bus offering a syringe exchange service and basic health care contact drug injectors and prostitutes not currently using services.

Flexible Prescribing Clinics
Each district in the Mersey Region operates a prescribing service from either a Drug Dependency Clinic or Community Drug Team. At present over 3500 individuals are receiving prescriptions. Each service offers various flexible prescribing regimes ranging from short term detoxification to long term maintenance. Oral Methadone mixture is prescribed to the majority of clients (approximately 80%). There is a significant minority that receive injectable methadone (approximately 15%) or injectable heroin (5%).

Maintenance prescribing has traditionally been used to stabilize dependent and chaotic users and reduce their criminal activity, improve their health, promote removal from an illegal drug scene and prevent the escalation of drug use. Since the advent of HIV, it has been recommended as a means of attracting injecting drug users into services (Advisory Council on the Misuse of Drugs, 1988).

In addition, a number of General Practitioners also prescribe opiate substitute drugs, usually methadone mixture, to their clients.

Information

There are two services that provide a regional information and advice service.

1. The Mersey Drug Training and Information Centre (MDTIC) provides information by means of a public library, an advice service, the organization of campaigns and a publications service. The aim of the MDTIC is to produce balanced drug information that is easily available, 'user-friendly' and culturally attuned. Often this is done by utilising the existing culture around specific drugs. Recently innovative campaigns, for example 'Chill Out', have been aimed at recreational users of ecstasy and other drugs associated with house music and dubs (McDermott, et al., 1993). Leaflets have also been produced and widely distributed. Recent examples are leaflets on heroin, cocaine, LSD, cannabis, solvents, hepatitis, HIV, anabolic steroids, methadone and information specific for women.

2. Healthwise is a free telephone helpline for people wanting information about drugs, HIV and other

health issues. The service offers advice, information and referral to appropriate services 12 hours a day, every day of the year.

Counselling and support

Each district within the Mersey Region has at least one general counselling and support service for drug users and parents and friends of drug users. Most of these services offer a drop-in facility, information and advice, one-to-one counselling and referral to other services including generic health, social and caring services, residential rehabilitation centres and family support groups.

Cooperation with the Police

The Merseyside Police have an impressive record for enforcing the law on drug offenses. They arrest and charge the second highest number of drug offenders in England (Home Office, 1990). The Merseyside Police also has a national reputation for developing cooperation with the Health Authority and drug services to improve the response to drug use, particularly as regards the transmission of HIV.The Police are represented on Drug Advisory Committees and provide assistance to drug services by agreeing not to conduct surveillance on them, referring arrested drug offenders to services and publicly supporting syringe exchange schemes and information campaigns. The Head of the Drug Squad has stated:

> "As police officers, part of our oath of office is to protect life, In the drugs field that policy must include saving life as well as enforcing the law. Clearly, we must reach injectors and get them the help they require, but in the meantime we must try and keep them healthy, for we are their police force as well"
>
> (O'Connell, 1990).

Summary

Drug policy in the Mersey Region is pragmatic and concerned with reducing the harmful consequences of drug use. It is not concerned with moral hygiene or pleasure promotion. As John Strang stated, "Both the hedonist and the puritan can apply harm reduction" (1993). Nor is it concerned with promoting legalization or decriminalisation. The suggestion that a public health approach is the 'thin end of the wedge' leading to legalization is on ignorance, sloppy thinking and is potentially dangerous.

In the Mersey Region a flexible, multifaceted approach exists that embraces primary prevention and harm reduction. There are a broad range of services meeting a broad range of needs. There are services appropriate for people who are either drug free, who want to be drug free or who are currently using drugs. It is wrong to assume that the emphasis of services is only on maintaining the drug user on substitute drugs or providing literature that advises on safer ways of drug taking.

Contacts with drug users have steadily increased over the last five years and anecdotal evidence suggests that drug related health problems seen by services and acquisitive crime have reduced. Self-reported injecting equipment sharing has declined indicating positive behavioural change. Finally, the level of HIV infection amongst drug injectors in the Mersey Region is very low by all available indicators. The Region has one of the lowest rates of HIV infection in Europe. By December 1993, only 19 drug injectors had tested positive for HIV (Mersey Regional Health Authority, 1994).

I hope this illustration of how we have been able to reduce drug-related harm in Merseyside is of some use to you as you move toward the development of your National Action Plan. I wish you every success in this endeavour.

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Principles and Recommendations on HIV Infection and Injection Drug Use

Document

The following document was released as a discussion paper for use at the Workshop. It served as background material focused specifically on injection drug use, and was used as the foundation for discussions and recommendations on the broader issues of HIV, alcohol and other drug use. In the only vote that took place during the Workshop itself, participants agreed at the final plenary to adopt and promote the document as the foundation for a comprehensive action plan on HIV, alcohol and other drug use.

The document reflects the views of the authors and not necessarily those of Health Canada.

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INTRODUCTION

The first case of acquired immune deficiency syndrome (AIDS) in an injection drug user in Canada was reported in 1982. As of July 1993, 478 people with AIDS who have injected drugs have been notified to the Laboratory Centre for Disease Control of whom 286 or 60 per cent have died. These cases represent only a small proportion of the total number of injection drug users (IDU) with human immunodeficiency virus (HIV) infection in Canada. Research teams in Montreal, Toronto, and Vancouver are monitoring the situation closely in an attempt to determine actual infection rates and the size of the populations of injection drug users who are at risk. Proportions of injection drug users with HIV infection vary from 3-4 per cent in Vancouver (Rekart 1990, personal communication) to 4-5 per cent in Toronto (Coates 1990, personal communication) and 10-15 per cent in Montreal. Among male and female provincial prison inmates in Quebec who have injected drugs, the rates are 8 per cent and 13 per cent respectively (Hankins et al, 1991; 1994).

Among those who are actively working to prevent HIV transmission among injection drug users at the global level there is a consensus that aggressive efforts to keep overall infection rates below 10 per cent are warranted. Beyond this infection level the epidemic can become explosive, as evidenced by the experience of several large urban centres. In cities such as Edinburgh, Scotland HIV seroprevalence was 5 per cent in 1983 and soared to 57 per cent by 1985 (Robertson et al, 1986). In Bangkok, Thailand serosurveys conducted from 1987 to 1988 among IDU clinic attenders demonstrated rises in prevalence from 1 per cent to 43 per cent (Berkelman et al, 1989), and a study at an outpatient narcotic clinic showed an increase from 16 per cent to 45 per cent between 1987 and 1989 (Vanichseni et al, 1990). For both Edinburgh and Bangkok the major factor accelerating the spread of HIV among injection drug users was the restricted availability of sterile injecting equipment which lead to widespread borrowing and lending of needles and syringes among injection drug users.

C'est en 1982 que le syndrome d'immunodéficience acquise (sida) a été décelé pour la première fois chez un usager de drogues par injection. Depuis juillet 1993, 478 personnes atteintes du sida et qui étaient usagers de drogues par injection ont été signalées au Comité consultatif national sur le sida; parmi celles-ci, 286 (60 %) sont mortes aujourd'hui. Ces cas ne représentent qu'une faible proportion du nombre total d'usagers de drogues par injection (UDI) infectés par le virus de l'immunodéficience humaine (VIH) au Canada. Des équipes scientifiques à Montréal, Toronto et Vancouver suivent la situation de près de manière à évaluer le nombre de cas d'infection réels et l'importance des populations UDI à risque. La proportion d'usagers de drogues par injection infectés par le VIH varie de 3 à 4 % à Vancouver (Rekart 1990, communication personnelle), de 4 à 5 % à Toronto (Coates 1990, communication personnelle) et de 10 à 15 % à Montréal. Parmi les détenus des établissements provinciaux de détention du Québec qui ont consommé des drogues par injection, le taux d'infection est de 8 % chez les hommes et de 13 % chez les femmes (Hankins et al, 1991; 1994).

Ceux et celles qui sont engagés activement dans la lutte mondiale contre la propagation du VIH liée à la consommation de drogues par injection s'accordent sur la nécessité de déployer toutes les énergies afin de maintenir le taux global d'infection en deçà de 10 %, sinon l'épidémie risque d'être fulgurante comme on le constate d'ailleurs dans plusieurs grands centres urbains. À Édimbourg (Écosse), par exemple, la séroprévalence, qui était de 5 % en 1983, a grimpé à 57 % en 1985 (Robertson et al, 1986). Selon des études séroépidémiologiques menées en 1987 et en 1988 à Bangkok (Thaïlande) auprès d'UDI faisant l'objet d'un traitement en clinique, la prévalence est passée de 1 à 43 % (Berkelman et al., 1989), et une autre étude dans une clinique externe de désintoxication rendait compte d'un taux d'accroissement de 16 à 45 % entre 1987 et 1989 (Vanichseni et al., 1990). À Édimbourg comme à Bangkok, c'est l'accessibilité limitée, voire la pénurie de matériel d'injection stérile qui a le plus contribué à la flambée

In 1988, preliminary findings that HIV-1 infection levels were as high as 15 per cent among injection drug users incarcerated in a medium security provincial correctional institution for women in Quebec (Hankins 1988, personal communication; 1989) lead to concern on the part of the National Advisory Committee on AIDS (NAC-AIDS) that a silent epidemic among Canadian injection drug users might well be underway. To facilitate a rethinking in Canada of drug policies in the context of AIDS as well as of HIV infection in the context of injection drug use, NAC-AIDS established a Working Group on HIV Infection and Injection Drug Use with expert members appointed from the fields of drug treatment and rehabilitation, as well as epidemiology and public health. The mandate of the group, which first met in October, 1988, was to assess the magnitude of HIV seroprevalence among Canadian injection drug users, to identify issues, and to make recommendations concerning the development of collaborative national strategies to reduce the transmission of HIV associated with injection drug use in Canada.

Among several outcomes of this Working Group is the document in your hands. The first section to be developed concerned correctional settings, in response to the research evidence that HIV infection was clearly at an unanticipated level in a correctional setting. This section had already been approved by NAC-AIDS and forwarded for ministerial study as the Working Group undertook, in late 1989, the larger task of developing Canadian principles and recommendations to address the HIV / AIDS epidemic among injection drug users. After studying publications from several countries, the committee took its inspiration from a British document published in 1988 entitled: AIDS and Drug Misuse, Report by the Advisory Council on the Misuse of Drugs, Department of Health and Social Security. After intensive scrutiny, serious rethinking, extensive rephrasing, and many hours of discussion over a period of eighteen months, the document entitled Principles and Recommendations Regarding HIV Infection and Injection Drug Use in Canada was completed. Without the motivation and dedication of the Working Group members who committed long hours to the task, this document

épidémique du VIH chez les usagers de drogues par injection, un grand nombre d'entre eux n'ayant d'autre choix que de partager des aiguilles et des seringues déjà utilisées.

En 1988, des résultats préliminaires ont révélé que le taux d'infection par le VIH-1 atteignait 15 % chez les femmes UDI détenues dans un établissement provincial de détention à sécurité intermédiaire au Québec (Hankins 1988, communication personnelle; 1989), ce qui a alerté le Comité consultatif national sur le sida (CCN-SIDA) quant à la possibilité d'une épidémie insidieuse faisant rage chez les usagers de drogues par injection au Canada. Afin de susciter une. nouvelle réflexion sur les politiques en matière de consommation de drogues par injection et sur le problème de la propagation du VIH au Canada, le CCN-SIDA a mis sur pied un groupe de travail sur l'infection au VIH et la consommation de drogues par injection, constitué de spécialistes en toxicomanie (traitement et réadaptation), en épidémiologie et en santé publique. Réuni pour la première fois en octobre 1988, ce groupe avait pour mandat d'évaluer le pourcentage de personnes séropositives chez les UDI au Canada, d'identifier les enjeux et de faire des recommandations sur les stratégies de concertation nationale à adopter afin de freiner la propagation du VIH liée à la consommation de drogues par injection au Canada.

Le présent document compte parmi l'une des nombreuses réalisations du groupe de travail. Une première étape a consisté à faire état de la situation en milieu carcéral après qu'une enquête ait révélé un taux effarant d'infection par le VIH dans un établissement provincial. Ce rapport, approuvé par le CCN-SIDA, avait déjà été transmis aux instances ministérielles pour considération lorsque, vers la fin de 1989, le groupe de travail a entrepris la tâche plus complexe de formuler ce que seraient les principes et les recommandations canadiens pour contrer l'épidémie du sida et la propagation du VIH chez les usagers de drogues par injection. Après avoir pris connaissance d'un certain nombre de publications parues dans divers pays, le groupe a retenu un document publié en 1988 par le ministère britannique de la Santé et de la Sécurité sociale intitulé : «AIDS and Drug Misuse, Report by the Advisory Council on the Misuse of Drugs». Un

would not have seen the light of day. Subsequently, it was forwarded to NAC-AIDS where the continuing process of serious debate and deliberation ended in approval of a lightly modified document by NAC-AIDS in August, 1990. The Minister of Health Canada, the Honourable Mary Collins, provided permission in October 1993 to allow this updated version of the document to be made available.

The purpose of this publication is to stimulate discussion, to challenge our perceptions, and to motivate all of us to examine policies and practices in agencies, departments, municipalities, hospitals, correctional services, and educational systems which may be contributing to the spread of HIV infection, affecting the quality of care, or which may be discriminatory. As we enter 1994, Canada can no longer afford to miss a window of opportunity to provide AIDS prevention knowledge, to create a positive social climate which will foster individual preventive behaviours, and to provide injection drug users with the means to prevent the spread of HIV in our communities and in our prisons. It is timely to rekindle the debate regarding the pervasive role of drugs in our contemporary society and potential solutions to the challenges it presents.

As we are now all too well aware, the heterosexual transmission of HIV infection in Canada is in part fueled by the epidemic among injection drug users, the majority of whom have non-injecting sexual partners. Increasing numbers of children are being born to women in Canada with HIV infection acquired through injection drug use or through sexual activity with an injection drug user.

It is time to set aside our prejudices and to think creatively about this growing problem.

MD, MSc, CCFP, FRCPC
Chair/Présidente,
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examen attentif et une révision globale de la situation, une reformulation exhaustive des textes, et plusieurs heures de discussions échelonnées sur une période de dix-huit mois ont débouché sur le document intitulé : «Principes et recommandations concernant l'infection au VIH et la consommation de drogues par injection au Canada». Sans la motivation et le dévouement des membres du groupe qui ont consacré de longues heures à sa préparation, ce document n'aurait jamais vu le jour. Il a, par la suite, été présenté au CCN-SIDA qui, après discussion et délibération, l'a approuvé en août 1990, avec de légères modifications. La diffusion de la présente version a été autorisée, en octobre 1993, par la Ministre de Santé Canada, l'Honorable Mary Collins.

Ce document a pour but de susciter la discussion, de remettre en question nos perceptions et de nous inciter à réévaluer les politiques et les pratiques des organismes, des ministères, des municipalités, des centres hospitaliers, des services correctionnels et du réseau de l'éducation qui sont susceptibles de contribuer à l'augmentation du risque d'infection par le VIH, ce qui affecte la qualité des soins dispensés, ou encore qui peuvent être discriminatoires. À l'aube de 1994, le Canada n'a d'autre choix que de prendre part au développement de la connaissance des moyens de prévention du sida, de créer un climat social positif susceptible d'amener les gens à adopter un comportement préventif, et de donner aux UDI les moyens d'empêcher que l'infection par le VIH ne se propage ni dans la population en général ni dans nos prisons. Il est grand temps de rouvrir le débat sur la drogue, fléau de la société contemporaine, et de proposer des solutions concrètes.

Il est de notoriété publique que la propagation du VIH par voie hétérosexuelle est en partie causée par l'épidémie chez les usagers de drogues par injection qui, pour la plupart, ont des partenaires sexuels non-consommateurs de drogues. Au Canada, de plus en plus d'enfant naissent de femmes infectées par le VIH suite à la consommation de drogues par injection ou à des relations sexuelles avec un UDI.

Devant la gravité de la situation, le temps est venu de mettre les préjugés de côté et de faire preuve de créativité.

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PRINCIPLES

- The spread of HIV is a greater danger to individual and public health than injection drug use itself. Services and programmes which aim to minimize HIV risk behaviour should receive priority attention.

- In the long run, however, reducing drug use could have a major impact on Canada's ability to contain the spread of HIV.

- Combating the spread of FIN linked to injection drug use is a major public health issue. Responsibility for the development and monitoring of appropriate regional services and programmes should be assigned to a local Medical Officer of Health or his/her equivalent, in collaboration with drug and alcohol treatment services, appropriate health and social services, and community agencies. Adequate resources to mount new programmes where necessary should be channelled through local public health offices.

- Major improvement in professional and public attitudes to injection drug use and injection drug users is necessary since policies and actions which fail to respect the human rights and dignity of injection drug users may promote the hidden use of drugs and impair the effectiveness of measures to combat the spread of HIV.

- Risk reduction among drug users requires a combination of individual effort and environmental support. Access on a non-discriminatory, non-judgemental basis must be provided to services and programmes that and to empower drug users in order to support behavioural change.

PRINCIPES

- Sur le plan individuel comme sur le plan collectif, la propagation du VIH constitue une menace beaucoup plus grande pour la santé que la consommation de drogues par injection comme telle. D'où l'importance de privilégier les services et les programmes visant à réduire l'incidence des comportements à risque.

- A plus long terme, cependant, la diminution de la consommation de drogues pourrait contribuer de façon appréciable à limiter la propagation du VIH au Canada.

- La lutte contre la propagation du VIH liée à la consommation de drogues par injection est capitale en santé publique. Dans cette perspective, la mise sur pied et le contrôle de services et de programmes régionaux devraient être confiés à un médecin de santé publique local ou à une autorité équivalente, en collaboration avec des centres de désintoxication et de réadaptation ainsi que des services de santé, des services sociaux et des organismes communautaires appropriés. L'allocation des ressources nécessaires à l'implantation de nouveaux programmes devrait se faire à partir des départements de santé publique locaux, le cas échéant.

- De profonds changements dans l'attitude du public et des professionnels de la santé à l'égard de la consommation de drogues par injection, voire des usagers de drogues par injection, sont nécessaires car toute politique ou intervention qui ne respecte pas les droits humains et la dignité des toxicomanes peut les inciter à taire leur accoutumance, ce qui ne manquerait pas de nuire à Inefficacité des mesures mises en oeuvre pour contrer la propagation du VIH.

- La diminution du risque d'infection chez les toxicomanes repose tant sur une prise de conscience individuelle que sur l'appui du milieu. Les usagers de drogues par injection doivent pouvoir recourir à des programmes et des services où ils ne seront ni stigmatisés ni

- Programmes for injection drug users should actively involve the people they are designed to serve in order to ensure that services remain relevant.

- All programmes and services which are targetted at reducing the impact of HIV on the injection drug using population should be evaluated.

rejetés, visant à les aider à se prendre en main afin qu'ils modifient leur comportement.

- Pour que les programmes destinés aux usagers de drogues par injection demeurent pertinents, il importe d'y associer pleinement les bénéficiaires.

- Tous les programmes et services nus sur pied afin de réduire les risques d'infection par le VIH chez les usagers de drogues par injection devraient comprendre une évaluation de leur efficacité.

RECOMMENDATIONS

General Information and Education

All Canadians should understand the risks associated with injection drug use and have ready access to accurate and up-to-date information on the prevention of HIV infection.

Action

National, provincial, and local information/ education/awareness campaigns should increase and improve content related to HIV / AIDS and injection drug use.

Preventive Services

All injection drug users should have ready access to sterile injecting equipment and condoms, as well as to forthright and non-judgemental advice on safer sex and safer drug use practices. This will require the development of new, creative, and flexible services in many communities.

Action

- All injection drug users need access to targeted multifaceted prevention programmes aimed at promoting behaviour change and maintenance. These may involve an enhancement of existing services or the development of new, fixed or mobile services. Targeted programmes should establish a variety of approaches to outreach work in collaboration with other health and social services. These approaches can include education, counselling, needle exchange, condom provision, and primary health care.

RECOMMANDATIONS

Information générale et éducation

La population canadienne toute entière devrait prendre conscience des risques associés à la consommation de drogues par injection et être en mesure d'obtenir une information exacte et à jour sur les moyens de prévenir l'infection par le VIH.

Mesures à prendre

Les campagnes nationales, provinciales et locales d'information, d'éducation et de sensibilisation devraient accroître la quantité et améliorer la qualité des renseignements concernant l'infection par le VIH, le sida et la consommation de drogues par injection.

Services de prévention

Les usagers de drogues par injection devraient être en mesure de se procurer facilement du matériel d'injection stérile et des condoms et d'obtenir des conseils objectifs et impartiaux sur les pratiques sexuelles et la consommation de drogues à risque moindre. Pour ce faire, de nombreuses collectivités devront repenser leurs services dans une optique de souplesse et de créativité.

Mesures à prendre

- Tous les usagers de drogues par injection devraient avoir accès à des programmes intégrés de prévention adaptés à leurs besoins et visant à stimuler leur intention de modifier leur comportement de façon durable. Cette mesure sous-tend l'amélioration des services existants ou la création de nouveaux services fixes ou mobiles. En outre, des programmes destinés à des clientèles particulières devraient être mis sur pied en collaboration avec les services de santé et les services sociaux. Diverses approches pourraient être envisagées, dont l'éducation, le counselling, l'échange de

- Information should be posted wherever needles and syringes are provided regarding methods of disposal and the location of local services providing counselling and drug and alcohol treatment.

- Targeted prevention programmes should include active consultation and collaboration with local law enforcement agencies.

- All services in contact with injection drug users should enhance their ability to recognize and relate to these clients, should facilitate access to targeted programmes, and should assist with early intervention.

- Advice on cleaning injecting equipment with bleach should make clear that cleaning cannot offer full protection against infection and that cleaning is no substitute for unused equipment. Cleaning with bleach can, however, help to prevent infection when unused equipment is not available.

- Creative measures should be developed and implemented to ensure that partners and families of injection drug users are reached by education, counselling and support programmes.

- Targeted programmes should ensure that they respond effectively to the specific needs of female injection drug users.

- To ensure that injection drug using parents are not deterred from seeking help, social service departments should not use injection drug use per se as a reason for separating parent and child.

seringues, la distribution de condoms et la fourniture de soins de santé primaires,.

- Dans tous les sites de distribution de seringues, des renseignements devraient être affichés concernant l'élimination des seringues et l'emplacement d'organismes locaux de consultation et de traitement de l'alcoolisme et autres toxicomanies.

- Les programmes de prévention devraient inclure la consultation et la collaboration des forces policières locales.

- Tous les services ayant des contacts avec des usagers de drogues par injection devraient améliorer leurs méthodes afin de mieux cibler cette clientèle et de mieux communiquer avec elle; ces services devraient également lui faciliter l'accès aux programmes qui lui sont destinés et contribuer à une intervention précoce.

- Lorsqu'on donne des conseils aux usagers de drogues par injection, on devrait préciser que le nettoyage des seringues et des aiguilles avec de l'eau de javel ne garantit pas une protection à cent,pour cent contre l'infection et que rien ne remplace le matériel neuf. Faute de mieux, le nettoyage à l'eau de javel peut malgré tout aider à prévenir l'infection.

- Des mesures novatrices devraient être élaborées et mises en oeuvre afin que les programmes d'éducation, de counselling et de soutien puissent également rejoindre les partenaires et les familles des usagers de drogues par injection.

- Les programmes ciblés devraient répondre efficacement aux besoins particuliers des femmes qui consomment des drogues par injection.

- Afin de ne pas décourager les parents usagers de drogues par injection à demander de l'aide, les organismes de services sociaux ne devraient pas considérer la toxicomanie comme motif suffisant. pour leur retirer la garde des enfants.

- In keeping with the position of the Canadian Pharmaceutical Association, pharmacists should be encouraged to sell equipment at reasonable cost to injection drug users, to advise customers about local exchange facilities, to encourage the use of condoms, and to provide information concerning other facilities or programmes of value to injection drug users.

- Pharmacists should be encouraged to accept the return of used injecting equipment.

- All legal and administrative obstacles to obtaining needles and syringes for the purpose of self-administration of drugs should be removed.

Drug and Alcohol Treatment Services

Public health goals are compatible with drug and alcohol treatment services. There should be expansion, greater availability, and greater access to existing drug and alcohol treatment services. In addition, there should be development of new, creative, and flexible services,focused not only on complete readaptation and abstinence, but also on the general care and health of the injection drug using population.

Action

- Injection drug users, including opioiddependent persons should have access to treatment suitable to their needs, regardless of their gender, age, geographic location, disability or ethnicity.

- Motivation for abstinence is not mandatory for efficient intervention. Crisis Intervention Units should be developed to provide general care and accommodation for injection drug users in difficulty. These services should be easily accessible, non-judgemen-

- Conformément à la position adoptée par l'Association pharmaceutique canadienne, les pharmaciens et pharmaciennes devraient être encouragés à vendre le matériel d'injection à des prix abordables, à fournir la liste des sites locaux d'échange d'aiguilles et de seringues, à favoriser l'utilisation du condom et à informer les usagers de drogues par injection des autres services et programmes d'aide qui leur sont offerts.

- On devrait inciter les pharmaciens et pharmaciennes à accepter de reprendre les aiguilles et les seringues qui ont été utilisées.

- Tous les obstacles juridiques et administratifs visant à limiter la distribution de seringues et d'aiguilles devraient être supprimés.

Services de traitement-de l'alcoolisme et autres toxicomanies

Les objectifs en matière de santé publique sont compatibles avec les services existants de traitement de l'alcoolisme et autres toxicomanies. Ces derniers devraient cependant être plus nombreux et plus accessibles. Ils pourraient en outre se doter de services novateurs et souples qui seraient axés non seulement sur la réadaptation et l'abstinence complète mais aussi sur une approche globale à la santé des usagers de drogues par injection.

Mesures à prendre

- Tous les usagers de drogues par injection, y compris les opiomanes, devraient avoir accès à des traitements adaptés à leurs besoins, sans égard au sexe, à l'âge, au lieu de résidence, à l'aptitude ou à l'ethnie.

- La recherche de l'abstinence n'est pas une condition nécessaire à l'efficacité des programmes d'intervention. Des centres d'intervention d'urgence devraient être mis sur pied pour accueillir les usagers de drogues par injection en difficulté et leur

tal, and should not include motivation for abstinence as an exclusion criteria.

- Pharmacological treatment of withdrawal and post-withdrawal syndromes and methadone treatments should be more readily available across the country. Low threshold methadone programmes should be made available for those unwilling to commit themselves to abstinence.

- Treatment personnel should receive support through training and continuing education on the prevention of HIV transmission in the treatment context.

- Confidential HIV antibody testing of individuals should only be undertaken with informed consent following full counselling. The treatment population should have full access to this service. All drug and alcohol treatment facilities should enhance their capability to provide counselling on HIV transmission. Where testing cannot be done on site, there should be a streamlined referral system for testing elsewhere. Consenting to HIV antibody testing should never be a precondition for drug and alcohol treatment or rehabilitation services.

- A national needs assessment study should be conducted to determine the ability of existing drug and alcohol treatment services to contribute to the prevention of HIV infection among injection drug users.

dispenser des services de base. Ces centres devraient être faciles d'accès et non discriminatoires. La recherche de l'abstinence ne devrait pas, non plus, être une condition à la prestation de services.

- Le traitement pharmacologique pendant et après le sevrage et le traitement à la méthadone devraient être plus accessibles partout au Canada. Par ailleurs, des programmes plus souples de traitement à la méthadone devraient être offerts aux toxicomanes qui refusent de s'engager à rompre complètement avec leur habitude.

- Le personnel soignant devrait recevoir une formation et suivre des stages complémentaires sur la prévention de la transmission du VIH en milieu de travail.

- Les tests confidentiels de dépistage anti-VIH ne devraient être administrés qu'avec le consentement éclairé du sujet au terme d'une séance approfondie de counselling. Ces tests devraient être offerts à toutes les personnes en traitement. Les services de traitement de l'alcoolisme et autres toxicomanies devraient augmenter leur capacité de counselling en matière de transmission du VIH. Lorsque le dépistage ne peut être fait sur place, un réseau de référence devrait aiguiller le client vers la ressource appropriée. Le consentement au test de dépistage ne devrait jamais être une condition préalable au traitement ou à la réadaptation des personnes alcooliques ou toxicomanes.

- Une évaluation des besoins devrait être réalisée à l'échelle nationale pour déterminer jusqu'à quel point les services de traitement de l'alcoolisme et autres toxicomanies déjà en place sont en mesure de contribuer à la prévention de la transmission du VIH chez les usagers de drogues par injection.

Role of Physicians

The majority of drug users are in contact with the health care system every year. Physicians should be encouraged to provide care and advice to patients who use injection drugs, and a significant number of physicians should be prepared to treat the dual diagnosis of drug dependence and HIV infection.

Action

- All medical students and residents in primary care should receive training at the undergraduate and graduate level on the prevention, detection and management of drug use, including injection drug use.

- Medical students and staff in hospitals should be specifically trained on attitudes and behaviours, towards HIV-infected or sick injection drug users who are seeking help. Support should be provided to practitioners dealing with this population.

- Continuing education should be provided to established practitioners on a regular basis concerning the prevention, detection, and management of drug use and of injection drug use.

- Clinical attachments by family physicians to local drug and alcohol treatment services should be actively encouraged. Short-term (e.g. 6-12 months) sessional contracts should be available to help establish a pool of family physicians with this experience. Family physicians should be supported by recognized consultants or by colleagues who have developed special expertise in drug dependence problems.

Rôle du médecin

La majorité des usagers de drogues par injection ont au moins un contact avec le système de santé chaque année. Tous les médecins devraient être invités à leur offrir les soins et les' conseils dont ils ont besoin, et un plus grand nombre devrait être prêts à traiter les personnes qui présentent à la fois un problème de toxicomanie et d'infection par le VIH.

Mesures à prendre

- Les étudiants en médecine et les résidents en soins primaires devraient recevoir une formation, dans le cadre de leurs études de premier, deuxième et troisième cycles, sur la prévention, la détection et le traitement des toxicomanies, y compris l'accoutumance aux drogues par injection.

- Les étudiants en médecine et le personnel hospitalier devraient recevoir une formation particulière sur les attitudes et les comportements à adopter à l'égard des usagers de drogues par injection infectés par le VIH ou qui sont malades, et qui demandent de l'aide. Les médecins qui interviennent auprès de cette population devraient recevoir les services de soutien appropriés.

- Des stages de formation continue sur la prévention, la détection et le traitement des toxicomanies devraient être offerts régulièrement aux médecins en exercice.

- Les médecins de famille devraient être invités à s'affilier aux services locaux de traitement de l'alcoolisme et autres toxicomanies. Des contrats à court terme allant de 6 à 12 mois pourraient leur être proposés afin qu'un certain nombre d'entre eux acquiert une expérience dans ce domaine. Ces médecins devraient pouvoir compter su r l'aide de consultants reconnus ou sur l'appui de leurs collègues qui ont une expérience particulière dans le traitement des toxicomanies.

Hospital-Based Services

Both injection drug users and services targeted for them need expanded and enhanced support from general hospital-based services. Hospital-based detoxification centres should not be identified as primary care centres for diseases related to HIV infection among injection drug users.

Action

- Hospital-based services should attempt to maximize contact with injection drug users through better dissemination of information on existing services, more flexible opening hours, and a minimization of waiting times.

- Hospitals should provide primary care, medical emergency and crisis stabilization services to injection drug users while enhancing their capability to provide referral, back-up and liaison with specialized drug and alcohol treatment services and with primary care physicians.

- Psychiatric input relating to the management and treatment of injection drug use is urgently needed. New full-time posts for consultant psychiatrists specializing in drug use are required in all major Canadian cities.

Services hospitaliers

Les usagers de drogues par injection et les services qui leur sont destinés devraient être davantage et mieux assistés par les services hospitaliers en général. Il faudrait éviter que les centres de désintoxication des hôpitaux soient perçus comme étant des centres de soins primaires pour les maladies liées à l'infection par le VIH.

Mesures à prendre

- Les services hospitaliers devraient chercher à maximiser les contacts avec les usagers de drogues par injection en assurant une meilleure diffusion de l'information sur les services existants, en ayant des heures d'ouverture plus flexibles et en réduisant les temps d'attente.

- Les hôpitaux devraient offrir aux usagers de drogues par injection des services de soins primaires, d'urgence et de stabilisation en cas de crise, tout en augmentant leur capacité de référence, de soutien et de liaison tant avec les centres spécialisés de traitement de l'alcoolisme et autres toxicomanies qu'avec les médecins qui offrent des soins primaires.

- Il est urgent d'associer des ressources en psychiatrie à la prise en charge et au traitement des usagers de drogues par injection. Des postes à temps complet de psychiatres spécialisés dans le traitement des toxicomanies doivent donc être créés dans tous les grandes villes du Canada.

Correctional Settings

The National Advisory Committee on AIDS reaffirms its concern regarding the prevention of HIV transmission in correctional institutions. The problem remains that:

- *a large proportion of injection drug users will temporarily spend time in prison and this opportunity for prevention is not being maximized;*
- *some inmates who have been injection drug users before incarceration continue to share drug equipment;*
- *unprotected sexual activity occurs in Canadian prisons on a consensual, quasi-consensual and non-consensual basis.*

Action

- Measures must be taken immediately to improve knowledge levels of inmates and correctional officers about HIV and risk reduction. This should include both orientation sessions for new inmates and officers as well as ongoing programmes.
- Adequate detoxification and maintenance programmes for inmates addicted to drugs should be widely available.
- Medical and psychosocial support services should be freely available to every HIV seropositive inmate. These services need to be in continuity with services on the outside such that follow-up can be facilitated and maintained following release from the correctional setting.
- Isolation of inmates with HIV infection from the rest of the inmate population is not medically warranted.

Établissements de détention

Le Conseil consultatif national sur le sida demeure préoccupé par l'épineuse question de la prévention de l'infection par le VIH dans les établissements de détention. Le problème est le suivant :

- *alors qu'une forte proportion d'usagers de drogues par injection séjourneront un jour ou l'autre en prison, ne serait-ce que pour une courte période, on ne profite pas assez de cette réalité pour faire de la prévention;*
- *certains détenus qui étaient des usagers de drogues par injection avant leur incarcération continuent de partager des seringues et des aiguilles avec les autres détenus;*
- *qu'il y ait consentement exprès ou implicite ou refus de I;un des partenaires, les relations sexuelles non protégées surviennent dans les prisons canadiennes.*

Mesures à prendre

- Des mesures doivent être prises dans les plus brefs délais pour que les détenus et le personnel des établissements de détention soient mieux informés sur le VIH et sur les moyens à prendre pour réduire le risque d'infection. Elles devraient comprendre des séances d'information à l'intention des nouveaux détenus et agents ainsi que des programmes de sensibilisation continue.
- Tous les détenus toxicomanes devraient avoir accès à des programmes de désintoxication et de suivi adaptés à leurs besoins.
- L'accès aux services médicaux et aux services d'aide psychosociale devrait être libre et gratuit pour les détenus séropositifs. On doit assurer la continuité entre les services internes des établissements et ceux offerts à l'extérieur de façon à ce que les détenus concernés puissent être suivis une fois libérés.
- Du point de vue médical, rien ne commande l'isolement des détenus infectés par le VIH du reste de la population carcérale.

- Voluntary, confidential HIV testing and counselling should be freely available to all inmates.

- Inmates should have access to decontamination materials such as bleach to prevent transmission of such infections as Hepatitis B and HIV via tattooing equipment and needles/syringes as well as for use in cleaning up blood spills.

- The feasibility should be explored of a programme to provide inmates with confidential access to clean needles and syringes without punishment for possession.

- The feasibility should be explored of increasing the availability of conjugal visits including those for same sex relationships. In addition, environmental conditions in correctional institutions that are conducive to non-consensual sexual activity should be modified.

- Inmates who do not currently have confidential access to condoms should be provided with such access.

- Des tests de dépistage du VIH et des services de counselling devraient être offerts gratuitement, sur une base volontaire et confidentielle, à tous les détenus.

- Les détenus devraient avoir accès à des produits de décontamination, dont l'eau de javel, afin de prévenir la transmission d'infections telles que l'hépatite B et l'infection au VIH par le biais d'instruments de tatouage, d'aiguilles et de seringues, et de permettre le nettoyage de tout ce qui a pu être en contact avec du sang.

- Il y aurait lieu d'étudier la possibilité d'implanter un programme d'accès aux aiguilles et aux seringues stériles qui garantit la confidentialité sans qu'il y ait sanction pour possession de tels matériels.

- On devrait également envisager la possibilité d'autoriser un plus grand nombre de visites conjugales, sans tenir compte de l'orientation sexuelle. Par ailleurs, tout environnement carcéral susceptible de favoriser des contacts sexuels par la contrainte devrait être modifié.

- Les détenus doivent pouvoir se procurer des condoms en toute confidentialité.

Research and Evaluation

Procedures should be established that would facilitate gathering information on the relationship between HIV and injection drug use.

Action

- The spread of HIV among injection drug users should be monitored through voluntary and/or anonymous, unlinked seroprevalence studies.

- All agencies providing services to injection drug users should keep basic records which enable them to monitor their ability to make con-tact with injection drug users and achieve a reduction in risk behaviour.

- To assess their success in reaching drug users, changing their behaviour, and maintaining these changes, new and existing services should be evaluated. In doing so, it must be noted that for some injection drug users, behaviour change may take several months to occur. Consequently, these schemes should not be judged wholly by short-term results.

- Research is urgently required in order to assess the extent of both HIV infection and behaviours conducive to its spread in correctional settings using unlinked seroprevalence and seroepidemiological methodologies which protect prisoners' rights to confidentiality as research subjects.

Recherche et évaluation

Des procédures devraient être établies afin de faciliter la collecte d'information sur le rapport entre l'infection par le VIH et la consommation de drogues par injection.

Mesures à prendre

- La propagation de l'infection par le VIH chez les usagers de drogues par injection devrait être surveillée par le biais d'études de séroprévalence effectuées auprès de volontaires ou sur une base anonyme, sans identificateurs personnels.

- Tous les organismes qui dispensent des services aux usagers de drogues par injection devraient tenir des registres leur permettant d'évaluer l'efficacité de leurs relations avec leur clientèle et leur capacité de réduire les comportements à risque.

- On devrait procéder à une évaluation des services existants et nouvellement mis sur pied afin de déterminer dans quelle mesure ils rejoignent les consommateurs e drogues et les amènent à modifier leur comportement de façon durable. Ce faisant, il faudrait tenir compte qu'un certain nombre d'usagers de drogues par injection n'arriveront à modifier leur comportement qu'au bout de plusieurs mois. Dès lors, une telle évaluation ne devrait pas se faire uniquement à partir de résultats à court terme.

- Il est urgent d'entreprendre des recherches afin d'évaluer le nombre de cas d'infection par le VIH et d'identifier les comportements à risque dans les établissements de détention par le biais de méthodologies de séroprévalence non appariées ou séroépidémiologiques qui protègent le droit des sujets à la confidentialité des résultats.

Major Workshop Issues & Recommendations Extending Beyond *The Principles and Recommendations* Document

In addition to Workshop plenaries, twenty Working Sessions were held. Each Working Session had a Chair (Appendix B) who worked with participants to record issues, problems, gaps and recommendations using the Principles and Recommendations document that appears in the previous section as a foundation. Participants were also invited to submit material on an individual basis. This process is honoured in the Proceedings by including recommendations submitted by individuals as well as those developed in the formal sessions.

The numerous recommendations developed in Edmonton have been divided into two groups. This section outlines the major issues and recommendations that extend beyond the Principles and Recommendations document. Other recommendations developed in Edmonton are listed in Appendix A.

Beyond voting to adopt the Principles and Recommendations document, it was not possible to quantify the level of consensus for over 100 new recommendations during the final plenary session. The Organizing Committee agreed to compile all new recommendations and mail them to participants for feedback. This was done twice a mailing in March 1994 that invited participants to register their response to all Workshop recommendations in their "raw" verbatim form, and a second mailing in August 1994 that focused on those recommendations extending beyond the Principles and Recommendations document. In both instances, roughly one third of the original audience provided feedback by mail.

Feedback after the Workshop followed patterns similar to those that emerged during the event. In most cases, respondents agreed with recommendations. In a few cases, a recommendation was not supported by respondents. In several cases, respondents found the recommendations confusing and wanted a more detailed explanation. Finally, there were a number of issues that attracted particularly strong debate and polarized responses to the mailouts. Ultimately, the post-conference mailings were therefore of limited use in establishing consensus not only because of the low response rate, but also because of the complexity of the material.

The recommendations in this section and in Appendix A reflect the enormous scope of the issues discussed at the National Workshop. They also reflect the diversity of opinion and experience of the participants. It is important to note the nature of the issues that attracted particularly strong debate around Recommendations 32, 37, 41, 44, 45 and 48. These recommendations focus on the human rights of drug users and/or challenge some aspect of the way in which drug use is addressed through the criminal justice system in Canada. It was very clear at the Workshop that these issues now constitute the leading edge of the public policy debate in this area. On the surface, these issues appeared to be divisive with participants either supporting current drug policies, or viewing them as barriers to HIV prevention. However, common ground usually emerged during in-depth Working Sessions. Repeatedly, harm reduction was cited as the conceptual framework that allowed for exploration of this common ground.

As discussed in the next section, the Organizing Committee is promoting the development of a national action plan on AIDS, alcohol and other drug use. Most of the recommendations developed in Edmonton require extensive explanation and debate, and are offered here as the foundation for the collaborative dialogue and decision-making that are so urgently needed.

INFORMATION GAPS

Issues, problems and gaps:

- misinformation is a constant concern, not just the lack of information
- professional staff in detoxification centres often do not understand the needs of injection drug use clients (most are alcohol-focussed)
- need a sound database for drug use in Canada (quantitative and qualitative), especially for treatment (i.e., what works? what does not work?)
- need risk factor, risk behaviour data
- need data on prevention programs, especially primary prevention programs regarding drug use
- need accurate information regarding legalization and decriminalization of drugs (e.g., what is the impact of either or both?)
- need better data concerning needle sharing behaviour
- need to know more about the link between types of drugs used and sexual behaviour, especially with primary sex partners

Recommendations and responses to them:

1 Develop a complete quantitative and qualitative database on drug use in Canada, including data on risk factors, risk behaviour and program efficacy.

Delegates' Response:
majority expressed support

Individual Comments:
difficult to implement; too broad and grandiose; possibly provincial rather than national; only injection drug users who access services in mainstream would be reflected in database

2 Health Canada ensure the development of a common monitoring system for HIV prevention programs for injection drug users, ensure that programs have essential resources to carry out this monitoring, and coordinate the ongoing evaluation of this information.

Delegates' Response:
majority expressed strong support

Individual Comments:
have it coordinated and implemented by organization in community; more feasible at the provincial level; unclear, vague terms (eg.,"common monitoring")

3 CCSA and Health Canada provide a means for local prevention programs across Canada to communicate and share information on an ongoing basis (e.g., regular access to an electronic bulletin board, or e-mail).

Delegates' Response:
majority expressed support

Individual Comments:
local programs must take initiative

OUTREACH TO INJECTION DRUG USERS

Issues, problems and gaps:

- lack of sensitive addictions treatment for different groups/communities (e.g., street involved youth)
- importance of data in justifying and showing the values of services
- partnerships are important but must be aware that partnerships and the relationships on which they are based change/evolve
- identify representatives from target groups to work with you — their point of view is critical as are their personal linkages
- advantages and disadvantages of registering clients (an advantage: a responsible clientele can be developed via a database system and needle/syringe returns)
- funding is inadequate across Canada
- do not create dynamics that become part of the problem
- the issue, in the largest sense, is still getting people to listen and recognize that there is an issue

- displacement of street people from areas where they live is an issue (urban renewal must be examined)

Recommendations and responses to them:

4 The Federal/Provincial/Territorial Advisory Committee on AIDS address the need for incremental and ongoing annualized operational funding for established and needed injection drug use targeted multi-faceted AIDS prevention and health promotion programs that include needle exchange. Furthermore, that the Committee develop and forward to their respective Ministers of Health via the Conference of Deputy Ministers of Health recommendations that clearly identify such programs as requiring federal/provincial operational funding to ensure national accessibility, program stability and thus efficacy in the fight against HIV transmission.

Delegates' Response:
majority expressed strong support

Individual Comments:
breakdown into several recommendations; high priority; need good strategy; agree with principle, disagree with strategy; subsidies for travel from NWT

5 Hold a fully funded national working session of needle exchange workers and program managers to consolidate experience and further develop collective expertise.

Delegates' Response:
majority expressed support

Individual Comments:
priority should be to give funds to grass-roots groups; suggest regional versus national; consider two sessions, one each for workers and managers

6 Develop a program starter kit to assist with the planning and implementation of new programs.

Delegates' Response:
majority did not support recommendation

Individual Comments:
low priority; only if none already exist; only if none already exist internationally; useful for smaller communities only

7 Set national standards on the availability of needle exchange to address the reality of population mobility.

Delegates' Response:
majority expressed support

Individual Comments:
provincial level better than at national level; include "within and between province and community", recommendation not clear

8 Professional pharmacist associations, public health, addiction service agencies and pharmacist educators ensure that basic continuing education is available to pharmacists on HIV / AIDS prevention, harm reduction and related problem solving.

Delegates' Response:
majority expressed strong support

Individual Comments:
already done in some areas; should target all professionals, not only pharmacists; collaborate with public health and addiction service agencies

EDUCATIONAL STRATEGIES FOR DRUG USERS

Issues, problems and gaps:

- lack of access to education (harm reduction)
- limited types of information (lack of recognition that harm reduction means more than bleach, needles and condoms)

Recommendations and responses to them:

9 Foster close alliance between Departments of Health and Education.

Delegates' Response:
majority expressed strong support

Individual Comments:
difficulties with school boards; add Corrections; already exists

10 Provide federal funding to facilitate the formation of user support groups on a basis defined by users.

Delegates' Response:
mixed support for recommendation

Individual Comments:
do users want this?; generate new funds for this, not to take from existing sources; perhaps as a pilot project; concept needs defining

11 Develop educational materials keeping street values and languages.

Delegates' Response:
majority expressed strong support

Individual Comments:
should be a priority; already exists; have community groups do this with ACAP funding; should be national materials

12 Devolve funding and control/responsibility over activities/products to those in contact with target groups.

Delegates' Response:
mixed support for recommendation

Individual Comments:
agree in principle, disagree in practise; need good evaluation; accountability must be maintained; unclear, vague recommendation

MEN WHO HAVE SEX WITH MEN

Issues, problems and gaps:

- isolation/lack of problem solving skills
- lack of social support
- lack of knowledge concerning safer sex
- addictive behaviours are strengthened by lack of support and isolation
- lack of inclusion in service provision
- homophobia among service providers
- little depth of understanding of the issues among staff, doctors
- profound loneliness must be addressed
- widen the scope of prevention programs, include other issues
- gay-positive workplace policies are needed
- look at gaps in professional training
- lack of access to schools and, therefore, youth

Recommendations and responses to them:

13 Get lesbian/gay content and issues into treatment programs through grass roots action. Train addiction workers in gay/lesbian culture, anti-homophobia/heterosexism.

Delegates' Response:
majority expressed strong support

Individual Comments:
rather train gay/lesbian community on addiction issues; include other culture groups (eg., Native awareness)

14 Establish safe, alcohol-free spaces for men who have sex with men.

Delegates' Response:
mixed support for recommendation

Individual Comments:
allow community to do this; not the proper group to address this; how realistic a recommendation?; not relevant as a recommendation

NATIVE ISSUES

Issues, problems and gaps:

- Natives have been robbed of their beliefs and heritage by European invasion: they are disempowered; they live in poverty; children are sent to schools and cut off from family, culture, love, beliefs
- loss of traditional spirituality (values and beliefs) among Native people
- land and livelihood are taken away, producing troubled, depressed and unhappy people who are

given drugs, and who take drugs and alcohol to cope with pain

- education regarding sexual issues is not reaching the people who need it, it must be presented in a way that is accessible
- while Natives are a huge population at risk, little of the money for HIV / AIDS is targeted for Native programs

Recommendations and responses to them:

15 Allocate a budget of $400,000 to cover the needs of First Nations people under a strategy on HIV / AIDS, alcohol and other drug use (would provide a national computer board, a trainer in each province, culturally specific material, counselling for families, curriculum development, networks).

Delegates' Response:
majority expressed support

Individual Comments:
need more money; rather develop a strategy to address needs; ensure grass roots groups have access;funding is already available

WOMEN, HIV AND DRUG USE

Issues, problems and gaps:

- loneliness of women must be addressed
- Compartmentalization of issues/programs is a problem: need flexibility, idea of "one-stop shopping" for services
- health professionals/physicians lack of recognition of women's risks/symptoms (e.g., problems with testing, acknowledgement of women's issues, rights, symptoms, etc.)
- imbalance of power between men and women (e.g., difficulties in negotiating, violence
- importance of being in a relationship: power of "being loved" and how that influences what people will accept
- self-esteem is key issue
- perception that HIV is still a gay/injection drug use issue, denial of risks to other groups
- difference in how men and women perceive sex (power and intimacy)
- recognition of effects of sexual abuse as a young person
- societal pressure to be in a relationship
- fear among women that they will lose their children should they seek/consider seeking services and problem of ignorance within social and justice systems
- major problem is in the socialization of males and females

Recommendations and responses to them:

16 Provide alternative/flexible addiction treatment services which allow women to keep their children and stay in their communities.

Delegates' Response:
majority expressed support

Individual Comments:
already happening in Halifax, important to have services in the community; link with National Working Group for Women (Canadian AIDS Society)

17 Support existing community-based services to expand their services to address and meet the needs of women and children.

Delegates' Response:
majority expressed support

Individual Comments:
linked with the above recommendation; need to explore additional avenues; better at the provincial level; need good strategy

YOUTH

Issues, problems and gaps:

- no reference made to vulnerable populations in document [Principles and Recommendations document]
- geographical disparities are not acknowledged in document

Recommendations and responses to them:

18 Provincial ministries and youth service organizations offer comprehensive life skills education that includes sexuality, drug use, HIV / AIDS.

Delegates' Response:
majority expressed strong support

Individual Comments:
coordinate with HIV programs; encourage provinces to support existing programs, overlooked and essential target group

BARRIERS TO SERVICES (and ways around these)

Issues, problems and gaps:

- fragmentation and compartmentalization of individual/group/community health as the result of:
  - lack of communication and cooperation between agencies, departments, levels of government (municipal, provincial, federal) and health, social and educational systems
  - single focus orientation of agencies/ organizations (agencies which attend to HIV / AIDS or addictions exclusively; not treating individual as a 'whole person')
- funding inequities (insufficient amounts, inaccessible process — e.g., jurisdictional boundaries/issues that decrease access to funds for Native people)
- inaccessible, inflexible health care systems that fall critically short of meeting individual/group/community needs
- health care professionals who lack knowledge, experiences, sensitivity to issues
- discrimination
- denial
- inadequate, inaccessible programs that do not meet/support needs of "targeted" populations
- lack of/non-existence of culturally-specific/ sensitized services (e.g., Native services)
- limited awareness, sensitivity regarding issues involving HIV and addictions, resulting in promotion of stereotypes and lack of relevant services

Recommendations and responses to them:

19 Provide an accredited course on HIV and addictions.

Delegates' Response:
mixed support for recommendation

Individual Comments:
at what level, which institutions?; all addictions workers already require this training

20 Develop a marketing strategy utilizing the regarding dispelling stereotypes, airing issues, increasing awareness and sensitivity, and promoting services.

Delegates' Response:
majority expressed support

Individual Comments:
why and for whom?; incorporate in overall prevention and education programs, develop national strategy guidelines

STEROIDS

Issues, problems and gaps:

- lack of information on steroid use
- lack of large bore needles in distribution/exchanges programs
- no mention in HIV / AIDS policies
- Canadian Centre for Drug-Free Sports study results:
  - 2.8% high school students use steroids (83,000 students per year)
  - 54% use to enhance performance, 46% to change appearance
  - 30% using needles: half share needles (9,000 sharing needles)
- in sport there is a zero tolerance attitude; must change this attitude to one of harm reduction
- "Safe Flex" Program needed in schools (includes posters, videos, speakers)
- professional sports turns a blind-eye to steroid use because it is results-oriented

Recommendations and responses to them:

21 Develop resources that steroid users can consult for information, follow-up, etc.

Delegates' Response:
majority expressed support

Individual Comments:
have brochures, posters in gyms; low priority; does this not already exist?: see Drug-Free Sport Canada; expand on Kingston AIDS Project program

22 Use fitness gym owners to collaborate with programs as multiplier agents to bring others on board who are less willing to collaborate.

Delegates' Response:
mixed support for recommendation

Individual Comments:
low priority; include all sports; also include physical education teachers, university athletic trainers; unclear, vague recommendation

23 Put needles in the fitness gyms.

Delegates' Response:
majority did not support recommendation

Individual Comments:
alternative: needle exchange program to visit gym, provide education on where to acquire sterile syringes; need not identified; already exists

24 Obtain more information about steroid use, its consequences, and steroid users' use of needle exchange.

Delegates' Response:
majority expressed strong support

Individual Comments:
rather, "fund research about steroid use..."; for whom? from where?

ALCOHOL AND HIV

Issues, problems and gaps:

- should implement prevention efforts that recognize the complexity of the link between alcohol use and sexual risk (pharmacology, psychology, immediate circumstances, etc.)
- must work towards social/cultural change to address the root causes of risk behaviours and use opportunities for immediate reduction of risk-taking (e.g., bar-based initiatives for gay men, targeting female university students)

Recommendations and responses to them:

25 Adopt a two-pronged approach work towards social change to address the root causes and identify and use opportunities for immediate reduction of risk-taking associated with alcohol use.

Delegates' Response:
majority expressed strong support

Individual Comments:
use a multi-disciplinary approach; base on client needs; to whom is this recommendation addressed?

26 More research is needed but not at the expense of immediate prevention efforts.

Delegates' Response:
majority expressed support

Individual Comments:
unclear, vague recommendation

27 Legislate against the sale of novelty condoms in bar washrooms.

Delegates' Response:
mixed support for recommendation

Individual Comments:
rather legislate standards for condoms; why?

28 Lobby against subsidized, low-cost provision of alcohol to groups (e.g., sponsoring residences, ladies' nights).

Delegates' Response:
majority did not support recommendation

Individual Comments:
not a priority; who would lobby?

HARM REDUCTION

Issues, problems and gaps:

- make available information on the nature and practice of harm reduction
- start programs early when problem is small and there is a better chance to gain some control over i
- police do not have "official support" or support o supervisors, chiefs or law makers, and therefore must do harm reduction on the side at some career risk
- political problems greater than knowledge and skill problems with respect to implementing reduction

Recommendations and responses to them:

29 Provide a dear framework for what harm reduction is and is not.

Delegates' Response:
majority expressed strong support

Individual Comments:
promote the principles of harm reduction

30 Promote police involvement in harm reduction strategies-

Delegates' Response:
majority expressed strong support

Individual Comments:
cooperation is imperative; contradictory to their interdictory role

31 Establish a pilot program to assess the effectiveness and feasibility of decriminalization of drug use.

Delegates' Response:
mixed support for recommendation

Individual Comments:
not feasible; first examine experiences from other countries; what drug use?

32 De facto decriminalization of personal possession and use of cannabis, coupled with control of narcocriminality elements.

Delegates' Response:
mixed support for recommendation

Individual Comments:
parameters are not clear

LAW ENFORCEMENT ISSUES

Issues, problems and gaps:

- police need to seize syringes for evidence
- many enforcement personnel view HIV as an occupational hazard (i.e., jabbing themselves with a syringe when searching someone)
- many special liaison officers are needed to build rapport with aboriginal communities
- need to provide relevant education, skills and tools to street police

Recommendations and responses to them:

33 Promote more flexible information exchange between police, addiction agencies and needle exchanges.

Delegates' Response:
majority expressed strong support

Individual Comments:
concerned about confidentiality and responsibility to act on information exchanged

34 More staff for law enforcement.

Delegates' Response:
majority expressed strong lack of support for recommendation

Individual Comments:
rather more staff for frontline prevention programs and better training; contradicts advocacy for prevention, community involvement, decriminalization; how does this contribute to harm reduction?

35 More law enforcement staff for prevention.

Delegates' Response:
mixed support for recommendation

Individual Comments:
depends on attitudes and on training; rather focus on staff's education and training; unclear, vague recommendation

36 Clarification of the application of drug paraphernalia laws.

Delegates' Response:
majority expressed strong support

Individual Comments:
must be flexible in order that "new" paraphernalia can be included

37 Change drug paraphernalia laws so that needles can be sold to shooting galleries.

Delegates' Response:
mixed support for recommendation

Individual Comments:
unnecessary if needle exchange programs exist; make specific to shooting galleries; will not solve the problem

HIV AND DRUG USE IN THE CORRECTIONAL SYSTEM

Issues, problems and gaps:

only recommendations am available

Recommendations and responses to them:

38 Organize a national workshop to deal specifically with issues raised by HIV / AIDS and drug use in prisons.

Delegates' Response:
majority expressed strong support

Individual Comments:
first regional, then national; top priority; too costly, rather incorporate into workshops for needle exchange service providers

39 Community-based agencies provide services in correctional facilities.

Delegates' Response:
majority expressed support

Individual Comments:
already exists in areas; education to come from Corrections through public health and AIDS service organizations

40 Give priority to the needs of young offenders with regard to AIDS education, prevention and support.

Delegates' Response:
majority expressed strong support

Individual Comments:
not at expense of adult programs; not priority group; give priority to needs of anyone practising risk behaviours

41 Alternatives to imprisonment be developed for people involved in drug crimes or drug-related crimes. Drug offenders should be generally referred to community helping and treatment services rather than sending them through the courts.

Delegates' Response:
mixed support for recommendation

Individual Comments:
disagree until decriminalization becomes reality; not feasible; policing and treatment do not mix; include traffickers

42 Address the underlying reasons for the over-representation of aboriginal offenders in provincial and federal institutions.

Delegates' Response:
majority expressed strong support

Individual Comments:
this is already known; difficult to achieve; include "visible minorities"; separate issue, unrelated to our agenda

43 Immediate action be taken to prevent the spread of TB in Canadian prisons.

Delegates' Response:
majority expressed support

Individual Comments:
beyond our scope; should be conducted in concert with HIV; is a public health issue; not just in prisons

PRIVACY AND INFORMATION ISSUES

Issues, problems and gaps:

- need to analyze the impact of drug testing
- efforts to protect privacy must be accompanied by increased efforts to protect people against discrimination
- if HIV status is disclosed, fewer people would test for HIV antibodies
- compulsory testing including testing people accused/convicted of sexual assault is not acceptable on many grounds
- effective education and impact of media on perceptions of drug use is needed

Recommendations and responses to them:

44 Stop drug testing programs in prisons.

Delegates' Response:
mixed support for recommendation

Individual Comments:
testing is not harmful, policies concerning it are harmful; test only if harm reduction strategies are in place; pilot test first to show benefits

DRUG POLICY AND CRIMINAL JUSTICE

Issues, problems and gaps:

- application of the criminal law to drug issues needs to be examined
- issues concerning HIV / AIDS in prisons need to be examined, including confidentiality, privacy, etc.
- potential opportunities for more data gathering, research activities, educational activities in prison and in the judicial system should be explored

Recommendations and responses to them:

45 Governments in Canada acknowledge the multiple harms caused by responding to drug issues through the criminal law, including: increased risk of HIV among injection drug user in general population and in prisons; unwarranted criminalization of drug users; done to the fundamental human rights of all Canadians.

Delegates' Response:
mixed support for recommendation

Individual Comments:
too inclusive; needs rewording ("acknowledge"); unclear, vague recommendation

46 Adopt a thorough-going harm reduction approach to drugs throughout Canada.

Delegates' Response:
majority expressed strong support

Individual Comments:
clarify perspective: harm reduction from view of user or public health official; unclear, vague recommendation

47 Thoroughly review the implications of the new bill coming to Parliament dealing with psychoactive drugs.

Delegates' Response:
majority expressed support

Individual Comments:
link with other disciplines (e.g., law, psychiatry, pharmacies); CCSA and ARF have started this; why? who will do this?

48 Stop current legislative amendments (e.g., Bill C-7) aimed at strengthening and perpetrating the use of the criminal law. Governments instead focus on social policy and health measures to reduce drug related harms at the individual and societal level.

Delegates' Response:
majority expressed support

Individual Comments:
make two recommendations; needs clarification

49 Provide more education to the Courts and judiciary about HIV / AIDS.

Delegates' Response:
majority expressed strong support

Individual Comments:
include "drug use", politicians and government need educating; clarify "more" of what education and to whom by whom

50 Conduct a study to determine the extent of human rights violations towards injection drug users.

Delegates' Response:
mixed support for recommendation

Individual Comments:
why restrict to injection drug users?; rather spend funds on awareness and intervention programs; not a priority; directed at whom?

51 Incorporate respect for individuals and respect for difference into all law, policy and programs relating to HIV / AIDS and substance abuse.

Delegates' Response:
majority expressed support

Individual Comments:
clarity: racial, cultural, attitudes toward injection drug users; can not legislate respect; how is this recommendation possible when drug use is criminalized?

Towards a National Action Plan

The Organizing Committee thanks participants at The Second National Workshop on HIV, Alcohol and Other Drug Use for their hard work, commitment and willingness to share their energy and experience.

Given the scope and complexity of these issues, the Workshop did not result in a finely tuned series of recommendations. What the experience and these, Proceedings do demonstrate is the urgent need for a coordinated national response.

In releasing this document, the Organizing Committee calls on all relevant jurisdictions to collaborate without delay to develop and implement a coherent, comprehensive national action plan on AIDS, alcohol and other drug use that is designed to reduce harm. These Proceedings are offered as the foundation for this process.

Planning and overseeing the Workshop provided the Organizing Committee with, an important perspective on the overall event. Consequently, the Committee considered that it had a responsibility to identify key themes and requirements for a successful outcome. In calling for a national action plan, the Organizing Committee wishes to emphasize the following:

1) The national action plan must consist of a series of specific objectives, commitments and measurable outcomes. The plan must be flexible and have the capacity to respond and effectively to this rapidly evolving aspect of the AIDS epidemic;

2) The national action plan must respond effectively to diversity and special needs. For example, special consideration must be given to the history and circumstances of First Nations people;

3) All aspects of the national action plan must include increased involvement of target populations in decision-making and program delivery;

4) Programs and services relating to HIV transmission associated with alcohol and other drug use must be provided along a continuum, from prevention to support for those already infected; and

5) The national action plan must include the link between alcohol use and the spread of HIV. As demonstrated at the Workshop, this issue has been neglected in the past and must be explored in depth.

A mechanism is needed that will support the collaborative development of a cohesive national action plan on HIV, Alcohol and Other Drug Use. It is recommended that this mechanism be practical, independent, have freedom of speech and action, be able to reach beyond institutional barriers, be dedicated to and funded for the task, be able strategically to address policy and program issues, and collaborate across all relevant jurisdictions and across AIDS and drug programs.

The Organizing Committee challenges the National AIDS Secretariat, Health Canada, to accept responsibility to ensure that such a mechanism is established, in collaboration with Canada's Drug Strategy and provincial and territorial governments.

Appendix A

Other Recommendations

Major Workshop issues and recommendations extending beyond the Principles and Recommendations document are described earlier in the proceedings. Other recommendations developed in Edmonton are listed below under the subject heading and in the form in which they were submitted by individuals or by Working Sessions. Many of these overlap with the *Principles and Recommendations* document and/or the material that appears in the section on major issues and recommendations. They are included here to complete the record of the National Workshop, and as an additional resource for the development of a cohesive national action plan.

INFORMATION GAPS

There must be a commitment to professional training for all caregivers, to ensure they understand the needs of their clients.

OUTREACH TO INJECTION DRUG USERS

That experience to date in the operation of injection drug use targeted multi-faceted AIDS prevention/ health promotion programs be documented to facilitate further development of the field by building on what we know and sharing resources.

A mechanism, process and resources be put in place to facilitate communication between programs to enable pooling of expertise.

Needle exchanges must market themselves — collect and use data to their advantage.

Imperative that needle exchanges share resources and transfer information (e.g., electronic bulletin board).

Needle exchanges must own their own information.

Would like Ministry of justice to return evidence (clean needles).

EDUCATIONAL STRATEGIES

Comprehensive educational strategies for target groups — accessible, self-determined and reflective of diversity of issues.

Peer education models run by and for individuals/target groups in conjunction with community-based organizations.

Rejection of traditional (abstinence) "drug treatment models". Support new approaches (e.g., harm reduction) that are accessible and that reflect the diversity of issues and individuals involved.

MEN WHO HAVE SEX WITH MEN

Assistance to deal with isolation and lack of problem solving skills (e.g., coming-out workshops).

National demonstration project in how to organize programs/strategize with safer sex and health promotion work.

NATIVE ISSUES

Recommend a First Nations component within a national action plan.

Read and use the *Circle of Wellness Report*.

Develop a national policy on the distribution of resources so that allocation of resources goes to community based groups in each region.

First Nations people need to be represented at all levels in the National AIDS Strategy — special consideration should be given to aboriginal PHAs.

Go back to the National Strategy recommendations made in 1990 and revive and honour them regarding native issues.

Make services relevant to the community — listen to the community and do not assume that you know what is needed. Make your programs relevant.

There is not enough funding for Aboriginal groups. It must be targeted to native programs since they are often more than 50% of the affected population.

Make use of services already in the community but challenge them to address the real needs, especially of native peoples - to serve them and use native people to deliver these services.

WOMEN, HIV AND DRUG USE

Re-evaluate and change how males and females are socialized from a very young age.

Set a zero tolerance for violence in all institutions, systems, etc.

Change prevention messages and include three essential components of prevention: information, skills and resources.

Those with the biggest stake in an issue must be the senior partners in planning, developing and implementing any strategy (i.e., women living with HIV).

YOUTH

Provide access to appropriate services for groups at greater risk (e.g., injection drug users, sexual minority youth, Aboriginal youth, alcohol and drug abusers).

Youth must be involved in the planning, delivery and evaluation of all programs.

Future funding for youth initiatives must be based on proven models, and make use of existing services where possible.

BARRIERS TO SERVICES (and ways around these)

Increase coordination and collaboration between governments, agencies, health/social/educational systems and communities — establish formal and informal networks.

Increase coordination and collaboration of services that reflect a holistic approach to independent/group/community health.

Increase role of consumers/community stakeholders through meaningful consultation.

Develop a collaborative funding strategy that includes government and non-government (e.g., corporate) resources.

Develop and implement multi-faceted, deinstitutionalized services that reflect support/care/treatment options to meet individual needs — not a "one size fits all" approach.

Develop accessible, community-based programs that are culturally specific and sensitive, and not determined or policed vis-a-vis jurisdictional boundaries.

Initial and ongoing education of health care providers regarding prevention, detection and management of addictions and HIV.

Begin training in smaller numbers and develop and maintain a network of professional with appropriate knowledge, expertise and experience.

Reduce discrimination by increasing awareness and sensitivity in existing community resources/services on addictions and HIV/addictions.

STEROIDS

Try to involve steroid users in focus groups, materials and project development.

Introduce system to allow athletes using steroids to come forward anonymously to get help without being penalized.

Obtain more information on steroid users' use of needle exchanges.

ALCOHOL

Special consideration must be given to the various dynamics that exist concerning alcohol and risk-taking (e.g., for gay men, for Aboriginals, for women).

HARM REDUCTION

Abstinence must be a part of the continuum and is the preferred end result, recognizing that many may not reach that goal.

LAW ENFORCEMENT ISSUES

Identify the role that police can play.

Public health officials must identify strategic partners who must be on board and accept their role within a harm reduction framework.

HIV AND DRUG USE IN THE CORRECTIONAL SYSTEM

Action is needed now to prevent HIV infection in prisons. Federal and provincial correctional systems should finally implement recommendations on HIV / AIDS and prisons that have been put forward since 1988.

PRIVACY AND INFORMATION ISSUES

Testing for HIV should always be voluntary with informed consent and accompanied by pre-test and post-test counselling.

Anonymous testing should be easily accessible to everyone.

Confidentiality of HIV test results should always be guaranteed.

Compulsory drug testing is opposed, particularly in the workplace, schools, the military, and in institutions.

Objective, balanced educational programming on issues relating to drug policy should be undertaken on all levels of society, including in schools and workplaces, to counter public misconceptions, fears, prejudices regarding drug use and drug users.

DRUG POLICY AND CRIMINAL JUSTICE

There should be provision of more options for repeat offenders including community-based multi-factorial programs (including job training and housing) rather than imprisonment.

In order that levels of drug injection do not continue to increase in the correctional system, there must be recognition of the fact that some modes of drug administration are less harmful than others.

There should be reconsideration of the use of drug testing in prisons (and elsewhere) since it may, in fact, increase drug-related harm by encouraging users to turn to drugs that are not readily detectable through testing.

Ensure that input from diverse areas of expertise are accessed by the courts to assure balance in the decisions of the judges.

Arrange for confidential drug/HIV testing in prisons.

DRUG USER NETWORK

Target education/prevention efforts through front line agencies and staff.

GEOGRAPHICAL ISSUES

Need for better communication between substance abuse/AIDS programs at local level.

Need for process, such as cabinet document, to ensure dedicated national HIV /AIDS program funds for off-reserve aboriginal people, and review of AIDS programs under the National AIDS Strategy (such as ACAP) to fund projects for off-reserve people.

Need for more consistent application of harm reduction perspective nationally.

Need for solid research/information for Atlantic Canada (e.g., Men's Survey).

Need more information on family support.

ETHNOCULTURAL ISSUES

The National AIDS Strategy is adequate with respect to ethnocultural communities but we are still waiting for more concrete results. We must continue to do what is already started but at a more rapid pace.

Need to work more closely with community agencies already working with the target groups so that ownership of response to HIV is harboured.

ROLE OF PHARMACIES

Provincial licensing bodies adopt policies that are most conducive to the provision of injection equipment to drug users to reduce sharing.

Inter-provincial and inter-city programmes be set up to identify pharmacies where sales and exchange of injection equipment are provided.

Public health agencies and pharmacy bodies should work together to ensure that comprehensive, appropriate HIV / AIDS, educational materials be made available through pharmacies. Where possible, this should be done at the national level.

All legal and administrative obstacles to obtaining needles and syringes for self-administration of drugs be removed.

RELATIONSHIP BETWEEN PREVENTION, TREATMENT AND CARE

In using the previous NAC-AIDS document, change "injection drug use" to "alcohol and other drug use".

That a comprehensive care plan be developed to better care for individuals post HIV diagnosis.

MENTAL HEALTH

Include a broad definition of mental health in the overall framework for a national action plan.

Establish demonstration projects concerning comprehensive outreach to HIV, alcohol and drug use clientele.

Models of care to bring services from the community to established systems (e.g., community team going into day psychiatric programs to work with patients and staff).

HUMAN RIGHTS

In addressing HIV / AIDS and substance use, the human rights of affected individuals and communities should be fully addressed and integrated into policies and programs.

Special attention must be focused on meeting the needs of persons affected by multiple layers of disadvantage.

Appendix B

Chairs of Working Sessions

1. *Privacy and Information Issues*
   Bryce Larke

2. *Alcohol and HIV*
   Betsy MacKenzie

3. *Geographical Issues*
   Catherine MacLeod

4. *Outreach to Injection Drug Users*
   Penny Mossman

5. *Harm Reduction*
   Pete Conley

6. *Steroids*
   Rick McHutchion

7. *Information Gaps*
   Ron de Burger

8. *Educational Strategies for Drug Users*
   Cheryl White

9. *Law Enforcement Issues*
   Michel Perron

10. *Native Issues*
    Lou Demerais

11. *Drug Policy and Criminal justice*
    Len Blumenthal

12. *The Relationship Between Prevention, Treatment and Care*
    Robert Allen

13. *Barriers to Services*
    Marianne Kobus-Matthews

14. *Men Who Have Sex With Men*
    Michael Graydon

15. *Mental Health*
    Nena Nera

16. *Women, HIV and Drug Use*
    Janet Victor

17. *Drug User Networks*
    Judy McGuire

18. *HIV and Drug Use in the Correctional System*
    Andréa Riesch Toepell

19. *Ethnocultural Issues*
    Sylvie Gendron

20. *Youth*
    Evelyn Wallace

Appendix C

Delegates List

International

Stephen Jones
Centers for Disease Control
Atlanta, Georgia

Andrew Bennett
Mersey Drug Training and Information Centre
Liverpool, UK

Alberta

Brent Allan
Edmonton, Alberta

Sharon Big Plume
Needle Exchange
Calgary, Alberta

Ken Bird
Feather Of Hope Aboriginal AIDS Prevention Society
Edmonton, Alberta

Len Blumenthal
Alberta Alcohol and Drug Abuse Commission
Edmonton, Alberta

Nick Bok
Edmonton Police Service
Edmonton, Alberta

Dawn Bucharski
Birth Control Center
Capital Health Authority; Public Health Services
Edmonton, Alberta

Richard Butler
Native Justice Initiatives
Edmonton, Alberta

Lyne Callan
Alberta Alcohol and Drug Abuse Commission
Calgary, Alberta

Ione Challborn
Capital Health Authority; Public Health Services
Edmonton, Alberta

Yvonne Chiu
Capital Health Authority; Public Health Services
Edmonton, Alberta

Phyllis Craig
Provincial AIDS Program
Edmonton, Alberta

Dave DesJardins
Feather Of Hope Aboriginal AIDS Prevention Society
Edmonton, Alberta

Charlotte Dion
Boyle Street Co-op
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