Evaluation Report:
Vancouver Coastal Health
Safer Smoking Pilot Project
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Purpose

The purpose of the Vancouver Coastal Health (VCH) Safer Smoking Pilot Project is to assess whether the provision of free safer smoking supplies and related education reduces health risks associated with using makeshift supplies and sharing supplies to smoke crack cocaine (such as transmitting communicable diseases and experiencing mucosal cuts and burns), and engages people to access health services and addiction treatment.

The objectives of the VCH Safer Smoking Pilot Project are to:

1. Determine if the provision of safer smoking kits and associated education reduces the risk factors associated with the transmission of communicable diseases, such as mucosal cuts and burns, and sharing smoking supplies with others;
2. Estimate the demand for safer smoking supplies in the Downtown Eastside of Vancouver (DTES);
3. Evaluate the effectiveness of the distribution of safer smoking supplies as an engagement strategy to encourage people who smoke crack to access health services, including addiction treatment; and
4. Determine how best to coordinate and standardize the distribution of safer smoking supplies and education in the DTES.

Rationale

VCH initiated the Safer Smoking Pilot Project because:

1. Crack smoking has increased in Vancouver in recent years;
2. People who use makeshift supplies or who share supplies to smoke crack are at an increased risk of transmitting and acquiring communicable diseases, as well as experiencing injuries, such as mucosal cuts and burns;
3. Safer smoking supplies which reduce the likelihood of these harms are not consistently available in Vancouver; and
4. The distribution of safer smoking supplies represents an opportunity to educate people on their correct use and to engage people so as to facilitate access to health and addiction services.

1. Prevalence of crack smoking

Research has found that there has been a substantial increase in crack smoking in Vancouver since the mid-1990s.

- Research conducted by the BC Centre for Excellence in HIV/AIDS found that, while 3.5 per cent of a long-term cohort of adults who use injection drugs in the DTES smoked crack daily in 1996, 41.7 per cent of this cohort were smoking crack daily by 2007\(^1\).
- Research conducted by the Centre for Addictions Research of BC (CARBC) found that, “crack has continued to be the most prevalent drug used by Vancouver street-involved adults. Consistently dating back to 2009 about 80% of those... interviewed reported using crack in the past month”\(^2\).

\(^1\) Werb D, et al. 2010. VIDUS: Crack cocaine use among IDUs 1996-2005

Research from other Canadian jurisdictions has also found a significant prevalence of crack smoking among people who use drugs.

- The 2006 I-Track research study conducted by the Public Health Agency of Canada surveyed 3,031 injection drug users (IDUs) in seven sites across Canada. This study found that 65 per cent of IDUs reported smoking crack at least once a week\(^3\). Of the participants from Ontario, 24 per cent reported smoking crack daily and 78 per cent reported sharing smoking supplies. IDUs who reported smoking crack also reported that they smoked it an average of 24 times per day\(^4\).

Certain populations may be more vulnerable to experiencing harms related to smoking crack.

- Research conducted by the BC Centre for Excellence in HIV/AIDS and the University of British Columbia found that women who smoke crack and inject drugs in the DTES reported trading sex for crack; experiencing sexual assault, assault, and robbery related to crack use\(^5\); and being forced or coerced into sharing their smoking supplies\(^6\).

- Respondents to surveys of people who smoke crack conducted by the BC Centre for Excellence in HIV/AIDS and the University of British Columbia were more likely to be of Aboriginal descent when compared to the census profile of the DTES\(^7,8,9\).

- Research conducted by the University of British Columbia found that 60 per cent of youth aged 14 to 19 in youth custody centres in Burnaby, Prince George, and Victoria reported using crack\(^10\). Additionally, research from

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CARBC found that twenty to thirty per cent of street involved youth interviewed in Vancouver since 2008 reported using crack in the past 30 days.\(^{11}\)

2. Harms from using makeshift supplies and sharing supplies

- The use of makeshift supplies to smoke crack (such as metal pipes, glass pipes, or pop cans) is associated with an increased risk of experiencing burns, cuts, and other injuries on the lips, mouth, hands, or face.\(^{12}\) These injuries are subsequently associated with an increased risk of acquiring infections such as hepatitis B, hepatitis C, tuberculosis, and pneumococcal disease. Sharing supplies can also increase the risks of transmitting and acquiring these infections.
  - For example, in 2006, an outbreak of invasive pneumococcal disease, an infection of Streptococcus pneumoniae bacteria that is spread by mucosal contact with salivary droplets and can result in meningitis and sepsis, occurred among residents of the DTES; many of these residents were admitted to hospitals and intensive care units in the Vancouver Coastal region. Epidemiological analysis of the outbreak determined that smoking crack cocaine was the risk factor most strongly associated with contracting S. pneumoniae.\(^{17}\)
  - A study of a subset of injection drug users determined that smoking crack cocaine is an independent risk factor for HIV infection;\(^{18}\) however, further research is needed to determine the mechanism for this increased risk, as this study did not control for high risk sexual behaviour among people who smoke crack.
  - Crack use has been associated with an increased risk of sexually transmitted infections.\(^{19}\)
  - The use of makeshift or non-recommended smoking supplies and the incorrect use of supplies have been associated with the inhalation of hot steel wool fragments and glass shards.\(^{20}\)

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3. Availability of safer smoking equipment

- The use of clean, safer smoking supplies identified by best practices, including vinyl mouthpieces\(^{21}\), wooden push sticks\(^{22}\), brass screens\(^{23}\), and heat-resistant borosilicate (also known by the trade name Pyrex\(^{6}\)) stems (pipes)\(^{24}\), may reduce the likelihood of experiencing health risks, such as transmitting or acquiring communicable diseases and injuries to the face, mouth and lungs\(^{25}\).

- In BC, the provincial Harm Reduction Strategies and Services Committee (BC HRSS) approves and coordinates the distribution of harm reduction supplies, including supplies to support safer sex, safer injection, and safer smoking, to harm reduction service providers throughout the province. The BC Ministry of Health and the Provincial Health Services Authority fund the provision of these supplies to harm reduction service providers\(^{26}\).

- Prior to the start of the VCH Safer Smoking Pilot Program in November 2011, the BC HRSS was already providing mouthpieces and push sticks to harm reduction service providers. In the 2009-10 fiscal year, the BC HRSS distributed:
  o Mouthpieces and push sticks to over 21 harm reduction service providers in the DTES;
  o 156,700 bags of 100 wooden push sticks to harm reduction service providers in the DTES; and
  o 35,400 boxes of 100’ mouthpiece tubing to harm reduction service providers in the DTES. Of these, 19,100 were ¼”-wide tubing and 16,300 were 5/16”-wide tubing\(^{27}\).

- In January 2012, the BC HRSS began to provide brass screens to harm reduction service providers.

- While the BC HRSS best practice document supports the distribution of safer smoking supplies\(^{28}\), BC HRSS does not currently receive adequate funding to provide borosilicate stems to harm reduction service providers in BC.

- The provision of borosilicate stems to people who smoke crack is not a new idea; prior to the start of the VCH Safer Smoking Pilot Project, at least thirteen other rural and urban centres in Canada were distributing stems to people who smoke crack in their communities.

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\(^{21}\) Goodman D. 2005.


\(^{27}\) Suggested mouthpiece length is at least four inches.

• At least six harm reduction service providers in Vancouver were also distributing borosilicate stems and/or safer smoking kits prior to the start of the VCH Safer Smoking Pilot Project\(^{29}\). All of these service providers reported that the demand for stems exceeded their supply. Additionally, these service providers decided how to distribute supplies and what supplies to distribute independent of each other; therefore, the distribution of their supplies and the contents of their safer smoking kits were not centrally coordinated nor standardized.

  o Despite some distribution of borosilicate stems in Vancouver in 2010, harm reduction service providers reported that makeshift pipes were being sold for $5-6 per unit in the DTES\(^{30}\). Because these makeshift pipes may not conform to best practice (for example, they may not be made of borosilicate and often have sharp ends), people who use these makeshift pipes may be at an increased likelihood of experiencing health risks.

  o Additionally, people who do receive a borosilicate stem or a safer smoking kit anecdotally reported experiencing barriers to using them. Researchers from the University of British Columbia, the University of Victoria, the BC Centre for Disease Control, and the Safer Crack Use Coalition of Vancouver found that 19 per cent of respondents to a survey conducted between 2005 and 2008 of people who smoke crack in Vancouver reported confiscation of a stem by police, 43 per cent of respondents reported having a stem smashed by police, and 32 per cent of respondents reported being told by police to smash a stem\(^{31}\).

4. Educate and engage people who smoke crack

• Lack of knowledge of the correct use of safer smoking supplies can also increase the risk for injury and communicable disease transmission. Because research suggests that people who smoke crack learn safer smoking best practices when they are provided by both harm reduction service providers and by their peers\(^{32}\), educating and training people who smoke crack to provide safer smoking education to their peers was an important component of the VCH Safer Smoking Pilot Project.

• The distribution of harm reduction supplies presents an opportunity to engage with people who use drugs; this engagement increases the likelihood that people will then access critical health and social services, including referrals to addiction treatment services\(^{33}\). Research conducted at Insite, a supervised injection service in Vancouver, found that the distribution of safer injection supplies facilitated access to health and addiction services by people who use drugs\(^{34, 35}\).

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29 Including the Back Lane Harm Reduction team, DAMS, Lookout Emergency Aid Society, Portland Hotel Society, and Vancouver Area Network of Drug Users.

30 Several verbal reports from DTES service providers and peers at VCH Harm Reduction Service Providers meetings.


• The VCH Safer Smoking Pilot Project also presented an opportunity for VCH to expand and coordinate the distribution of safer smoking supplies and education in the DTES. Expanding the distribution of supplies may reduce harms associated with sharing smoking supplies; research conducted by the BC Centre for Excellence in HIV/AIDS, the University of British Columbia, and VCH found that expanding access to safer injecting supplies in the DTES by, among other policies, increasing the number of service providers offering supplies reduced sharing of supplies by people who inject drugs\(^{36}\). Expanding and coordinating safer smoking supplies distribution also provides VCH with the opportunity to provide a standard set of educational materials and information on best practices for using safer smoking supplies.

Because of the increased prevalence of crack smoking in Vancouver, the health risks associated with using makeshift supplies and sharing supplies to smoke crack, the insufficient quantity and coordination of borosilicate stem distribution in the DTES, and the opportunity to educate and engage with people who smoke crack, the VCH Office of the Chief Medical Health Officer initiated the Safer Smoking Pilot Project in November 2011. The VCH Office of the Chief Medical Health Officer initially purchased 60,000 borosilicate stems, brass screens and bags with which to assemble safer smoking kits for distribution to people who smoke crack in the DTES; however, based on the early positive reports from harm reduction service providers and people who smoke crack, as well as the need for further evaluation, the VCH Office of the Chief Medical Health Officer purchased an additional 90,000 stems for distribution until March 2013.

**Project Overview**

The VCH Safer Smoking Pilot Project included the assembly and distribution of safer smoking kits and additional stems in the DTES, coupled with the provision of educational materials, drop-in groups, and safer smoking workshops. Participating VCH teams employed qualitative and quantitative methods to evaluate the objectives of the Project.

The VCH Safer Smoking Pilot Project included a number of distinct components, which are discussed in the report and outlined in the project timeline (Appendix 1):

1. Consultation;
2. Baseline surveys;
3. Project training for partner agencies;
4. Kit distribution and loose supply distribution;
5. VANDU drop-in Rock Users Group (RUG);
6. Follow-up surveys;
7. Interviews with service providers;
8. Focus groups with people who smoke crack;
9. Delivery of VANDU RUG Safer Smoking Workshops; and
10. Evaluation of VANDU RUG Safer Smoking Workshops.

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Contributing Organizations

The VCH Safer Smoking Pilot Project was a collaborative project; the following VCH teams participated in the Project’s development, implementation, and evaluation:

- The Office of the Chief Medical Health Officer;
- The Vancouver Community of Care;
- The Public Health Surveillance Unit; and
- Mental Health & Addictions.

VCH’s Regional Harm Reduction Coordinating Committee then reviewed and approved this Evaluation Report and its recommendations.

Rather than assemble safer smoking kits and distribute these kits, stems and other safer smoking supplies, VCH chose to contract the assembly of kits and to engage harm reduction service providers who had previous experience with safer smoking kits and supplies to do the distribution. VCH contracted with the Vancouver Area Network of Drug Users (VANDU) to assemble safer smoking kits and to coordinate the peer education and training components of the VCH Safer Smoking Pilot Project. VCH then provided the kits and supplies to the following harm reduction service providers for distribution to people who smoke crack in the Downtown Eastside:

- The Back Lane Harm Reduction team: a small, independent team of peers who distribute harm reduction supplies in the DTES;
- DAMS: a VCH-contracted program which supports women and trans-women in the DTES;
- Lookout Emergency Aid Society downtown shelter;
- The PHS Community Services Society (Portland Hotel Society), which operates a VCH-contracted mobile harm reduction van and the Washington needle depot, a fixed-site harm reduction service provider in the DTES; and
- The Vancouver Area Network of Drug Users (VANDU).

VCH incorporated the vinyl mouthpieces, wooden push sticks, brass screens, and alcohol swabs already provided by the BC HRSS into its safer smoking kits.

VCH notified the provincial BC HRSS Committee and the Vancouver Police Department of the VCH Safer Smoking Pilot Project and solicited feedback from these organizations throughout the Project. These organizations did not participate in the implementation or evaluation of the Project.

Safer Smoking Kits and Supplies

Each safer smoking kit assembled by VANDU for the VCH Safer Smoking Pilot Project included supplies identified by best practices as reducing harms associated with the use of makeshift supplies. VANDU placed these supplies in a clear plastic bag, based on feedback provided by the Vancouver Police Department (as opposed to a black bag that was preferred by people who smoke crack). VANDU then attached a sticker to the kit to identify it as part of a VCH research project and to explain the purpose of the kit.
Each safer smoking kit contained the following supplies (see Appendix 2 for supply cost and further information):

- One borosilicate stem;
- Two vinyl mouthpieces;
- Two packages of brass screens to be used as filters;
- Two wooden push sticks;
- Four alcohol swabs; and
- One educational insert\(^{37}\).

In addition to the safer smoking kits, harm reduction service providers received additional units of the above supplies to distribute to people who smoke crack\(^{38}\) if they did not need all the supplies in a kit each time they accessed supplies. Though harm reduction service providers later reported that safer smoking kits were popular among people who smoke crack, both people who smoke crack and service providers recommended distributing both safer smoking kits and separate supplies prior to the start of the Safer Smoking Pilot Project so as to reduce drug litter in the community and wasted supplies.

**Distribution of Safer Smoking Kits and Supplies**

One of the objectives of the VCH Safer Smoking Pilot project was to determine how best to coordinate and standardize safer smoking supplies distribution and education in the DTES. Because the distribution of safer smoking kits and stems in the DTES was not coordinated or standardized prior the start of the VCH Safer Smoking Pilot Project, VCH met with each harm reduction service provider that had been distributing safer smoking supplies to review guidelines and best practices for the distribution and use of the safer smoking kits and stems. VCH provided each harm reduction service provider with a project binder and reviewed its contents with each service provider’s staff. The binder included the following resources:

- Data collection forms and procedures;
- Posters advertising kit distribution locations and times;
- VCH and partner project contacts;
- Best practices for supply distribution (Appendix 3);
- Project communications and VCH updates;
- Safer Smoking project Youth Guidelines and Resource list; and
- VCH Addictions Services information.

**Peer Education and Training Components**

VCH contracted VANDU to coordinate the peer education and training components of the VCH Safer Smoking Pilot Project. These components included:

- Peer-based Educators: VANDU provided one-to-one peer-based education on best practices for using safer smoking supplies and for reducing health harms. Specifically, peer educators provided instruction on loading

\(^{37}\) The educational insert described best practices for the use of supplies, provided information on overdose prevention, and provided information on recognizing and seeking treatment for levamisole-related harms.

\(^{38}\) Except for stickers, bags and educational inserts.
brass screens into stems, as improper loading can result in drug loss and thus shift people towards the use of unsafe alternatives (such as steel wool pads).

- ‘Rock Users Group’ (RUG): The RUG is a bi-weekly support and education group for people who use crack. RUG meeting topics included:
  - Best practices for using safer smoking supplies;
  - Proper use of brass screens, so as to discourage the use of steel wool pads;
  - Presentations from local researchers on harms associated with crack use;
  - Education on overdose prevention and intervention; and
  - Education on levamisole, a potentially lethal de-worming pharmaceutical often added to crack to serve as a bulking agent.

- Safer Smoking Workshops: The RUG also developed participatory workshops to educate people who smoke crack on safer smoking practices and reducing health harms, such that attendees could then disseminate these best practices to their peers. In addition, RUG members developed their capacity to educate their peers by facilitating these workshops in the DTES community (See Appendix 4 for workshop outline).

Evaluation of the RUG and associated workshops is ongoing as of February 2013, and not yet complete.

Project Evaluation

Evaluation methods

VCH used both quantitative and qualitative methods to evaluate the VCH Safer Smoking Pilot Project.

Count of safer smoking supplies distributed and referrals/ education provided

- Each harm reduction service provider that distributed VCH’s safer smoking kits and stems collected the following measures daily:
  - the number of safer smoking kits and stems\textsuperscript{39} distributed;
  - the number of new recipients of safer smoking kits\textsuperscript{40};
  - the number of visits to a harm reduction service provider for safer smoking supplies\textsuperscript{41};
  - the number of brief intervention referrals provided\textsuperscript{42}; and
  - the number of one-to-one safer smoking education interventions provided\textsuperscript{43}.

\textsuperscript{39} This category also includes separate stems distributed in addition to a safer smoking kit.

\textsuperscript{40} Defined as a person who, when asked if they had ever received a VCH safer smoking kit or stem since December 2011, answered ‘no’.

\textsuperscript{41} Defined as the number of times a harm reduction service provider distributed a safer smoking kit or supplies.

\textsuperscript{42} Defined as the number of referrals provided to primary health services (including community health centres, immunization services, wound treatment, emergency care, etc.), addiction services (including detoxification services, addictions counseling, supervised injection services, etc.), and other services (including housing, shelter, food, etc.).

\textsuperscript{43} Defined as each time a harm reduction service provider offered education to people relating to best practices for using safer smoking supplies and reducing harms associated with smoking crack and incorrect use of supplies.
Pre- and Post-Project surveys

- VCH contracted CARBC to conduct two cross-sectional surveys of people who smoke crack in the DTES, with one survey conducted prior to the distribution of VCH’s safer smoking kit and one survey conducted six months after the start of distribution. Trained facilitators administered a standard questionnaire to drop-in clients at each of the harm reduction service providers distributing VCH’s safer smoking kits and stems, as well as to people on the street; VCH provided both facilitators and respondents with a $10 voucher as compensation for their time. One hundred thirty-two respondents completed the “pre-survey” (Appendix 5a) prior to kit distribution, and 139 respondents completed the “post-survey” (Appendix 5b) six months following the start of kit distribution. Nine per cent of respondents to the post-survey, which was similar in length and content to the pre-survey, indicated that they had been approached to participate in both surveys.

- The survey included questions related to the following issues:
  - User demographics;
  - Frequency and quantity of crack use;
  - Crack pipe supply access;
  - Access and use of safer smoking supplies;
  - Sharing practice;
  - Health issues possibly related to crack cocaine use; and
  - Access to resources and treatment.

- VCH analyzed responses from each survey separately to examine the prevalence of these issues both before and after VCH started to distribute safer smoking kits and stems.

Centre for Addictions Research of BC (CARBC) street adults survey

- Since 2008, CARBC has conducted semiannual cross-sectional surveys of street-involved Vancouver adults who use drugs. Survey questions are related to alcohol and drug use, user demographics and health outcomes. The survey is conducted in two waves, six months apart. Starting with the 2012 Wave 1 survey and continuing in future surveys, CARBC included sixteen questions from the VCH pre- and post-survey, so as to continue monitoring the effect of the distribution of safer smoking supplies.

Focus groups

- In July 2011, prior to its distribution of safer smoking kits and stems, VCH conducted three focus groups with people who smoke crack in the DTES. These were held at VANDU and DAMS, as each harm reduction service provider had distributed safer smoking supplies for several years. Staff at VANDU and DAMS informed people who smoke crack of the focus groups by word-of-mouth and handbills, and people self-selected to participate in the groups. Each focus group had six to eight participants; harm reduction service providers offered participants safer smoking kits and food vouchers for participating. VCH used the results of these focus groups to estimate the volume of safer smoking kits and supplies to allocate and to clarify the preferences for specific safer smoking supplies (see Appendix 6 for focus group questions).

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44 CARBC. Alcohol and Other Drug Monitoring Project, High Risk Populations Component: http://www.carbc.ca/AODMonitoring.aspx
Harm reduction service provider interviews

- In July 2012, VCH conducted four interviews and two focus groups with the contact people at each harm reduction service provider distributing safer smoking kits and stems, so as to obtain feedback on the VCH Safer Smoking Pilot Project and the supplies and educational materials being distributed. The interviewees also provided VCH with information regarding current and estimated demand for safer smoking supplies in the DTES, as well as with further recommendations for reducing smoking related harms (see Appendix 7 for interview questions).

Evaluation results

Count of safer smoking supplies distributed and referrals/ education provided

VCH allotted each harm reduction service provider a specified number of safer smoking kits and stems per month. VCH based these allotted amounts on the demand for safer smoking kits and stems estimated by the harm reduction service providers prior to the start of the VCH Safer Smoking Pilot Project. From December 2011 to March 2012, VCH, via the harm reduction service providers, distributed approximately 3,750 safer smoking kits and 3,750 stems per month in the DTES (Figure 1). Based on feedback from harm reduction service providers that the demand for safer smoking kits and stems continually exceeded supply, VCH increased distribution to 4,250 safer smoking kits and 4,250 stems per month for April and May 2012 (Figure 1). From June 2012 onward, VCH further increased distribution to 4,750 kits and 4,750 stems per month in the DTES. In total, harm reduction service providers distributed at least 100,400 safer smoking kits and stems during at least 65,299 visits from at least 4,213 unique individuals from December 2011 to November 2012.

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45 VCH conducted interviews with the contact person at the Portland Hotel Society mobile van, the Washington Needle Depot, DAMS, and Lookout Emergency Aid Society.

46 VCH conducted two focus groups with five participants each from the VANDU RUG. The RUG and VANDU recruited the focus group participants based on their experience with both distributing and accessing safer smoking supplies.

47 VCH did not interview the Back Lane Harm Reduction team, as their contact person was not available. However, VCH did receive feedback and input from the Back Lane Harm Reduction team throughout the Project.

48 VCH initially funded the provision of brass screens, as they were not yet available from the BC HRSS at the start of the VCH Safer Smoking Pilot Project; the BC HRSS approved brass screens for provision to harm reduction service providers in January 2012. The BC HRSS was providing wooden push sticks and mouthpieces to harm reduction service providers prior to the start of the VCH Safer Smoking Pilot Project.

49 One harm reduction service provider estimated the number of unique clients who accessed safer smoking kits and stems from their services for nine of the twelve months of the VCH Safer Smoking Pilot.
From December 2011 to November 2012, harm reduction service providers offered 11,470 brief intervention referrals to people who smoke crack, including 721 referrals to health services, 1,280 referrals to addictions services, and 9,469 referrals to other services; during this time, harm reduction service providers also engaged in 11,949 instances of safer smoking education with people who smoke crack. The provision of referrals and education to people who smoke crack is important, as, historically, harm reduction service providers have focused on providing referrals and education to prevent harms associated with injection drug use, which may have resulted in people who smoke crack but do not use injection drugs not receiving referrals and education.

Pre- and post-Project surveys, and CARBC street adults survey

Respondent demographics

A total of 250 unique individuals responded to VCH’s pre- and post-surveys; there were no statistically significant differences in the demographics of the pre-survey and the post-survey respondents. Respondents to these surveys represented a particularly marginalized population. When comparing the survey respondents to the census profile of the DTES, the survey respondents were more likely to be female, five times more likely to be of Aboriginal descent, seven times more likely to be unemployed and twice as likely to receive government payments; when comparing this population


to the Vancouver census profile, the differences are even more apparent. Almost half of respondents also reported living in a single room occupancy (SRO) hotel room or a boarding room (see Table 1).

Table 1. Demographics of all VCH Safer Smoking Pilot Project survey respondents, combined pre- and post-survey respondents.

<table>
<thead>
<tr>
<th></th>
<th>Pilot Surveys (n=250)</th>
<th>DTES core profile (n=18,020)</th>
<th>Vancouver (n=583,690)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Gender</td>
<td>48%</td>
<td>60%</td>
<td>49%</td>
</tr>
<tr>
<td>Average Age</td>
<td>42.5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>19-67 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Born in Canada</td>
<td>93%</td>
<td>61%</td>
<td>54%</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>47%</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>DTES Resident</td>
<td>91%</td>
<td>100%</td>
<td>3%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>84%</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>Receive government payments</td>
<td>89%</td>
<td>43%</td>
<td>10%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No certificate, diploma, or degree</td>
<td>58%</td>
<td>30%</td>
<td>10%</td>
</tr>
<tr>
<td>Completed high school</td>
<td>22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some or completed university</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rented house or apartment</td>
<td>19%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SRO/ hostel/ boarding room</td>
<td>49%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter or refuge</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No fixed address</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: DTES core profile based on 2006 Census data.

Survey respondents reported using crack on average 18 (pre-survey) to 24 (post-survey) times during a typical week – not a statistically significant difference. Individual respondents ranged in their weekly use from less than one time a week to 280 times a week. These respondents also reported using a median of 10 crack rocks per week in both the pre- and post-survey, with individual respondents reporting using between one and 500 rocks a week. 35% of pre- and post-survey respondents also reported injecting drugs in the past 30 days; however, less than 20% of respondents indicate that they inject crack if they cannot find the supplies to smoke it (Table 2). Differences between pre and post-survey respondents were not statistically significant.
Table 2. Frequency of crack smoking and injecting drugs reported by survey respondents.

<table>
<thead>
<tr>
<th></th>
<th>Pre-survey</th>
<th>Post-survey</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of times</td>
<td>18</td>
<td>24</td>
<td>0.140</td>
</tr>
<tr>
<td>participants reported smoking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>crack per week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median number of rocks</td>
<td>10</td>
<td>10</td>
<td>0.940</td>
</tr>
<tr>
<td>participants reported smoking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>crack per week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of participants who</td>
<td>30%</td>
<td>40%</td>
<td>0.309</td>
</tr>
<tr>
<td>injected drugs in past 30 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of participants who</td>
<td>17%</td>
<td>12%</td>
<td>0.316</td>
</tr>
<tr>
<td>inject crack if they cannot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>find supplies to smoke it</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: No statistically significant differences between pre- and post-survey responses.

Stem usage

Most survey respondents reported using "a few pipes" per week, and that pipes lasted, on average, 14 days (median of 7 days). More than half of post-survey respondents (59%) reported smoking with a broken or cracked pipe in the past year. Among those respondents, 37% smoked a broken pipe without a mouthpiece; however, the post-survey did not discern whether these pipes were safer smoking stems provided by VCH or pipes obtained from other sources. The majority of post-survey respondents reported disposing of their pipes in garbage bins (41%) or in sharps containers (17%).

Pipe sharing

There was no statistically significant decrease in pipe sharing from the pre-survey to the post-survey, although there was a small, non-significant decrease (Figure 2); surveys conducted by CARBC also showed a small, non-significant decrease in pipe sharing from 2009 to 2012. Among pre- and post-survey respondents who reported sharing in the past 30 days (54%), 20% shared one to two times in that period and 14% shared 3 to 5 times. Respondents who reported sharing also reported smoking with used supplies an average of 5 times in the past 30 days. Post-survey respondents who reported sharing were also more likely to share both the mouthpiece and the pipe, rather than share only one item.
Health issues

After the VCH Safer Smoking Pilot Project, there was a statistically significant decrease in the proportion of respondents who reported they had experienced a burn from smoking crack in the past 30 days compared to pre-survey respondents (Figure 3). For other health issues examined, no statistically significant increase or decrease was observed in the short time period between the pre- and post-survey, though a non-significant decrease in cuts and other injuries (e.g., blisters, sore throats, etc.) from smoking crack was observed (Figures 3 and 4).
Figure 3. Injuries in the past 30 days reported among people who smoke crack in the DTES.

Data source: VCH Safer Smoking Pilot Project surveys, administered November 2011 and May 2012.
Prepared by: Public Health Surveillance Unit, Vancouver Coastal Health, October 2012.
Figure 4. Health issues reported among people who smoke crack in the DTES.

![Health issues chart]

**Data source**: VCH Safer Smoking Pilot Project surveys, administered November 2011 and May 2012. Canadian Adult Sentinel Survey of Illicit Drug Use from the Centre for Addictions Research of BC (CARBC).

**Prepared by**: Public Health Surveillance Unit, Vancouver Coastal Health, October 2012.

**Access to and use of safer smoking kits and supplies**

Prior to the distribution of VCH safer smoking kits, 43% of pre-survey respondents stated that they had difficulty accessing new stems. Responses from the post-survey indicated this had significantly decreased.

- Only 22% of post-survey respondents stated that they had difficulty accessing new stems, a statistically significant decrease ($p < 0.05$) (Table 3). Among respondents who reported difficulty accessing new stems in the pre- and post-survey, the most reported reasons were difficulty accessing at night and limited supplies available.
- 87% of post-survey respondents stated that they had used a VCH safer smoking kit (Table 3).
- There was a statistically significant decrease in the proportion of respondents who reported obtaining smoking supplies on the street, including both used and new supplies (Figure 6). There was also a decrease among people obtaining supplies from friends and making homemade supplies (Figure 6).
- There was a statistically significant increase in the proportion of respondents who reported obtaining stems without having to trade anything for them (Figure 5).
- There were no statistically significant changes among post-survey respondents with regard to specific supplies used, although there were small, non-statistically significant increases in the proportion of post-survey respondents who reported using brass screens, educational materials, and alcohol wipes following the distribution of safer smoking kits (Table 3).
There was also a small, non-statistically significant increase in the proportion of survey respondents reporting enrollment in any form of drug or alcohol treatment or support group.

There was a statistically significant decrease in the proportion of post-survey respondents (14%) reporting confiscation of pipes by the Vancouver Police Department (VPD) compared to pre-survey respondents (26%). VCH had informed the Vancouver Police Department of the Safer Smoking Pilot Project prior to its start and continued to engage in discussions with and solicit feedback from the VPD during the Project.

Table 3. Access to pipes and safer smoking supplies used in past 3 months.

<table>
<thead>
<tr>
<th></th>
<th>Pre-survey</th>
<th>Post-survey</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported it was hard to find pipes</td>
<td>43%</td>
<td>22%</td>
<td>*0.027</td>
</tr>
<tr>
<td>Used a VCH Safer smoking kit</td>
<td>n/a</td>
<td>87%</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Safer smoking supplies used in past 3 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pyrex pipe/ glass stem</td>
<td>97%</td>
<td>97%</td>
<td>0.983</td>
</tr>
<tr>
<td>Brass screen</td>
<td>40%</td>
<td>44%</td>
<td>0.545</td>
</tr>
<tr>
<td>Mouthpiece</td>
<td>76%</td>
<td>75%</td>
<td>0.085</td>
</tr>
<tr>
<td>Educational materials</td>
<td>31%</td>
<td>42%</td>
<td>0.078</td>
</tr>
<tr>
<td>Alcohol swabs and hand wipes</td>
<td>60%</td>
<td>65%</td>
<td>0.426</td>
</tr>
<tr>
<td>Wooden push sticks</td>
<td>89%</td>
<td>82%</td>
<td>0.071</td>
</tr>
<tr>
<td>Reported being in a drug and/or alcohol treatment/support program</td>
<td>14%</td>
<td>19%</td>
<td>0.374</td>
</tr>
</tbody>
</table>

Note: A * indicates a statistically significant difference between pre- and post-survey respondents. All other differences between pre- and post survey respondents are not statistically significant.
Figure 5. Trading for pipes among people who smoke crack.

Among those who traded, what did they trade for pipes?

Data source: VCH Safer Smoking Pilot Project surveys, administered November 2011 and May 2012.
Prepared by: Public Health Surveillance Unit, Vancouver Coastal Health, October 2012.

The pre- and post-surveys also identified how respondents obtained safer smoking supplies:

- Most post-survey respondents picked up safer smoking supplies from VANDU or a mobile needle van (Figure 6). Respondents cited convenience as the primary reason for their choice of pick-up location.
- In the pre-survey, 31% of respondents picked up supplies once per week, and 23% of respondents picked up supplies a few times per week. In the post-survey, 26% of respondents picked up supplies a few times per week, and 22% of respondents picked up supplies once a week.
- Almost half of respondents (41% pre-survey, 46% post-survey) reported picking up supplies for someone else.
- Almost a quarter of post-survey respondents reported providing a safer smoking kit to people living outside of the DTES, including to people living in Surrey, Richmond, New Westminster, Langley, Mission, and North Vancouver.
Figure 6. Sources of smoking supplies from past three months.

Prepared by: Public Health Surveillance Unit, Vancouver Coastal Health, October 2012.

Focus groups and harm reduction service provider interviews

Safer smoking kits and supplies

Feedback from focus group participants and harm reduction service providers regarding the safer smoking kits and supplies was mostly positive. Focus group participants reported that they preferred the standardized stems, mouthpieces, and push sticks in the VCH safer smoking kits when compared to other supplies available prior to the VCH Safer Smoking Pilot Project or from other harm reduction service providers. Focus group participants and service providers reported that some people who smoke crack preferred to use steel wool pads (also known by the trade name Brillo®) as a filter rather than brass screens; however, the harms associated with the use of steel wool pads preclude their distribution as a

51 Focus group participants expressed a preference for borosilicate stems that were 8mm wide and 10cm long; participants also observed that 8mm wide stems were compatible with the 5/16” mouthpiece tubing currently provided to harm reduction service providers by the BC HRSS.

52 Focus group participants also expressed a preference for the slightly thicker wooden push stick with flat ends that the BC HRSS approved for provision to harm reduction service providers in 2012. Compared to the thinner push stick previously distributed by the BC HRSS, the thicker push stick is less breakable and fits more easily into the 8mm stem.
safer smoking supply. Focus group participants and harm reduction service providers also provided other recommendations related to supplies (see Appendix 8).

**Access to and use of safer smoking kits and supplies**

Despite the increased provision of safer smoking kits and stems, harm reduction service providers continued to report that the supply of safer smoking kits and stems did not meet the demand. As a result, these service providers either ran out of safer smoking kits and stems well before the end of each month, or restricted safer smoking supply distribution so as to ensure their allotment of supplies lasted the entire month (see Appendix 9). However, harm reduction service providers reported that restricting access to the safer smoking kits and stems frustrated the people requesting these supplies, and contributed to verbal abuse of staff and at least three reported instances of physical aggression.

Harm reduction service providers also observed that demand for makeshift pipes either remained the same or increased during the VCH Safer Smoking Pilot Project. One service provider reported that the street value of makeshift pipes had decreased from $5 at the beginning of the Safer Smoking Pilot Project to $2 a year later, while another service provider reported no price change. That these makeshift pipes continue to have value on the street, given that focus group participants stated a preference for the supplies distributed in VCH safer smoking kits, suggests that the supply of free safer smoking stems does not currently meet the demand in the DTES.

Anecdotal evidence also indicates unmet demand for safer smoking supplies outside of the DTES. One harm reduction service provider estimated that 10% of people accessing safer smoking supplies in the DTES lived outside of the DTES. Additionally, VCH staff at the Pacific Spirit Community Health Centre in Vancouver’s Kerrisdale neighbourhood distributed 17 safer smoking kits to people who smoke crack between October and December 2012. Furthermore, the VCH needle recovery program in Vancouver found at least 39 used stems and mouthpieces discarded in areas outside of the DTES during this period.

**Safer smoking education**

Harm reduction service providers reported that education, including demonstrations, of the various methods for using brass screens was the most frequently requested piece of safer smoking education. Service providers reported that demonstrating the proper use of brass screens and discussing experiences of harms from the use of steel wool pads with people who smoke crack was effective in encouraging the transition to screen use. Service providers suggested that additional safer crack smoking workshops, including further information about the health effects of crack use, and information about safe stem disposal would provide the most benefits for people who smoke crack.

Harm reduction service providers also reported advising people who smoke crack not to use supplies openly or in parks, playgrounds and other sensitive community areas, so as to reduce the likelihood of seizure of their safer smoking supplies. Focus group participants reported that the VCH sticker on the safer smoking kits further reduced the likelihood of kit seizure or destruction.

Harm reduction service providers also reported the greatest barrier to people who smoke crack adopting safer smoking practices was the inadequate distribution of free safer smoking supplies.

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53 A ‘filter’ is used to hold crack in place at the tip of the stem while it is heated, vapourized, and inhaled. Without a filter, the crack would liquefy and run through the stem. When heated, steel wool pads can break apart and be accidentally inhaled into the mouth and lungs, causing burns and lung damage. Brass screens do not break apart and therefore reduce the risks associated with the use of steel wool pads.

54 Previously evaluated safer smoking kit distribution in the DTES recommended providing both supplies and associated education to encourage safer smoking practices. See Malchy L, et al. 2011.
Harm reduction service provider recommendations

Harm reduction service providers also made the following recommendations regarding safer smoking supplies distribution and education, based on their observations throughout the VCH Safer Smoking Pilot Project:

- Continue to provide free safer smoking supplies, as people who smoke crack continue to use non-recommended supplies when safer smoking supplies are not free and available;
- Expand safer smoking supply distribution beyond the DTES, involving a diversity of service providers;
- Develop instructional videos for screen loading;
- Expand one-to-one education and safer smoking workshop opportunities, as both contributed to greater uptake of safer smoking practices by people who smoke crack;
- Provide safer smoking supplies for crystal methamphetamine;
- Establish a safer smoking facility or services;
- Provide additional training for harm reduction service providers, as lack of knowledge about safer smoking creates barriers to accessing services; and
- Improve communication between harm reduction service providers, so that service providers have accurate information regarding the availability of safer smoking kits and supplies from specific harm reduction service providers.

Project Outcomes

The objectives of the VCH Safer Smoking Pilot Project were to:

1. Determine if the provision of safer smoking kits and associated education reduces the risk of transmission of communicable diseases, including mucosal cuts and burns, as well as sharing smoking supplies with others;
2. Estimate the demand for safer smoking supplies in DTES;
3. Evaluate the effectiveness of the distribution of safer smoking kits as an engagement strategy to encourage people who smoke crack to access health services, including addiction treatment; and
4. Determine how best to coordinate and standardize the distribution of safer smoking supplies and education in the DTES.

Objective #1: Determine if the provision of safer smoking kits and associated education reduces the risk factors associated with the transmission of communicable diseases, such as mucosal cuts and burns, and sharing smoking supplies with others

A survey of people who smoke crack in the DTES conducted in May 2012 found a statistically significant decrease in the proportion of respondents reporting burns in the previous 30 days when compared to those surveyed before the start of the Pilot Project. There were also statistically significant reductions in high risk behaviour reported in May 2012, including obtaining used stems from the street or trading anything for stems. While there were no significant differences in other health issues, the evaluation methods were not designed to demonstrate differences in infection rates for hepatitis C, HIV, or other infections.

Objective #2: Estimate the demand for safer smoking supplies in the DTES

Harm reduction service providers distributed at least 100,400 safer smoking kits and stems to at least 4,213 unique individuals in the DTES from December 2011 to November 2012. In the latter months of the VCH Safer Smoking Pilot
Project, harm reduction service providers distributed 9,500 safer smoking kits or stems in the DTES per month. However, harm reductions service providers reported that this supply was not sufficient to fully meet demand. Additionally, survey responses and other evidence suggests that there is also unmet demand for safer smoking supplies outside of the DTES; survey respondents indicated that people obtained safer smoking kits and stems to give to people living outside the DTES, survey respondents indicated that convenience was an important factor in determining where they accessed supplies, and the VCH needle recovery program in Vancouver found at least 39 used stems and mouthpieces discarded outside of the DTES during the Safer Smoking Pilot Project.

Objective #3: Evaluate the effectiveness of the distribution of safer smoking supplies as an engagement strategy to encourage people who smoke crack to access health services, including addiction treatment

From December 2011 to November 2012, harm reduction service providers received at least 65,299 visits for safer smoking kits and supplies from at least 4,213 unique people who smoke crack in the DTES. During those visits, harm reduction service providers engaged in at least 23,419 interactions with people who smoke crack to provide at least 11,949 instances of safer smoking education, at least 721 referrals to health services, at least 1,280 referrals to addiction services, and at least 9,469 referrals to other services. These interactions suggest that harm reduction service providers are engaging with a group of people to provide education and referrals to health and addiction services who may not have received them in the past. While there was no significant difference reported after the pilot in the proportion of survey respondents who accessed drug or alcohol treatment, the VCH Safer Smoking Pilot Project may not have been long enough to observe such differences.

Objective #4: Determine how best to expand, coordinate and standardize safer smoking supplies distribution and education in the DTES

After the pilot, 87% of survey respondents stated that they had used a VCH safer smoking kit. Additionally, there was a statistically significant reduction in the proportion of those who reported difficulty in accessing new stems (22%) when compared to those surveyed before the Pilot Project (43%). Among survey respondents who reported difficulty accessing new stems, the most reported reasons included difficulty accessing at night and limited supplies available.

The VCH Safer Smoking Pilot Project also provided education based on best practices to people who smoke crack via print materials in each safer smoking kit, one-to-one interactions with harm reduction service providers, workshops, and peer groups; ensured safer smoking kits and supplies met best practices and the preferences of people who smoke crack so as to maximize the likelihood that supplies would be used appropriately; and established processes with which to collect data on crack use and demand for safer smoking supplies and services throughout the Downtown Eastside. Additionally, through its connection with the BC HRSS, the VCH Safer Smoking Pilot Project had the opportunity to provide feedback collected from focus groups and interviews on the safer smoking supplies directly to the BC HRSS.

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Recommendations

Recommendation 1

The BC Harm Reduction Strategies and Services Committee (BC HRSS) should be adequately funded to provide all safer smoking supplies recommended in its best practices document\(^{56}\), including borosilicate stems, to harm reduction service providers across the province.

- The BC HRSS should update its best practices document to align with the best practices to be outlined in the forthcoming pan-Canadian harm reduction best practices document.

Recommendation 2

VCH should expand the provision of safer smoking supplies, including borosilicate stems, vinyl mouthpieces, brass screens, and wooden push sticks, to multiple harm reduction service providers throughout the Vancouver Coastal region.

- The availability of these supplies should meet the demand and preference of people who smoke crack, where possible;
- The supplies should be of a standard size and type where possible, so as to ensure they can be easily assembled;
- However, as borosilicate stems are not currently among the provincially funded harm reduction supplies, cost constraints will limit VCH’s capacity to provide these stems to harm reduction service providers.

Recommendation 3

VCH should provide both pre-packaged safer smoking kits and individual supplies, along with safer injection supplies, safer sex supplies, and referrals to other services upon request.

- Safer smoking kits should contain, at minimum, a borosilicate stem, vinyl mouthpieces, brass screens, wooden push sticks, and education or referral information;
- Connecting people who smoke crack to health, addictions, and other health and support services should continue to be a key goal for VCH’s harm reduction programs.

Recommendation 4

VCH should educate people who smoke crack about the best practices for using safer smoking supplies and the risks of sharing supplies.

- VCH should develop a range of education interventions, including visual material, one-to-one education, and screen-loading demonstrations.

Recommendation 5

VCH should complete an evaluation of the peer-based components of the VCH Safer Smoking Pilot Project, including the Rock Users Group and Safer Smoking Workshops.

Acknowledgements

The VCH Safer Smoking Pilot Project was a collaborative project, with the following VCH teams participating in its development, implementation, and evaluation:

- The Office of the Chief Medical Health Officer;
- The Vancouver Community of Care;
- The Public Health Surveillance Unit; and
- Mental Health & Addictions.

VCH’s Regional Harm Reduction Coordinating Committee and the VCH Chief Medical Health Officer then reviewed and approved this Evaluation Report and its recommendations.

The following harm reduction service providers distributed the safer smoking kits, stems, and other supplies to people who smoke crack:

- The Back Lane Harm Reduction team;
- DAMS;
- The Lookout Emergency Aid Society downtown shelter;
- The PHS Community Services Society (Portland Hotel Society); and
- The Vancouver Area Network of Drug Users (VANDU).

VCH contracted with the Centre for Addictions Research of BC (CARBC) to assist with the development of the tools used to collect the data needed to evaluate the VCH Safer Smoking Pilot Project.

VCH incorporated vinyl mouthpieces, wooden push sticks, brass screens, and alcohol swabs that are provided as in-kind resources by the BC HRSS into its safer smoking kits.

VCH notified the BC HRSS and the Vancouver Police Department of the VCH Safer Smoking Pilot Project, and solicited feedback from these organizations before and during the Project.

VCH thanks all of the study participants and harm reduction service providers for their willingness to participate in the Safer Smoking Pilot Project, and to share their information, experiences, and data.
Appendices

Appendix 1: Project Timeline

October - December 2010

- VCH Open Board Meeting: the Back Lane Harm Reduction Team presents their observations of health harms related to the lack of safer crack smoking supplies in the DTES. Shared supplies and the use of hazardous crack smoking supplies are their main concerns.
- Dr. Patricia Daly, Chief Medical Health Officer, with support from the VCH Board of Directors, initiates discussions about the VCH Safer Smoking Pilot Project.
- VCH consults with and receives feedback from the Vancouver Police Department, BC Harm Reduction Strategies and Services Committee, and other organizations.
- VCH conducts focus groups with people who smoke crack to determine safer smoking kit contents.

November 2011

- VCH, with support from Centre for Addictions Research BC, conducts baseline surveys in the DTES.
- VCH trains staff at harm reduction service providers to provide supplies, collect data, be aware of protocols for providing services and supplies to youth, and refer people to other services and supports.
- VANDU begins manufacturing safer smoking kits for distribution to the other harm reduction service providers involved in the VCH Safer Smoking Pilot Project

December 2011

- VCH begins coordinated kit and stem distribution in the DTES.

January 2012

- VANDU Rock Users Groups begin, initially meeting weekly.

May 2012

- CARBC conducts post-surveys in the DTES.

July 2012

- VCH conducts project evaluation interviews with harm reduction service providers.
- VCH conducts Rock Users Group evaluation focus groups with group members.

August 2012 – ongoing

- VANDU Safer Smoking Workshops begin at partner agencies.
- VCH conducts focus group evaluation of Safer Smoking Workshops.
## Appendix 2: Kit Contents Summary

<table>
<thead>
<tr>
<th>Supply</th>
<th>Cost / kit</th>
<th>Funder</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 stem (borosilicate glass, e.g., Pyrex)</td>
<td>$0.30\textsuperscript{57}</td>
<td>VCH</td>
<td>Replace metal pipes, pop cans, inhalers, light bulbs, non-heat resistant glass, and homemade borosilicate stems, which can cause harms</td>
</tr>
<tr>
<td>2 packages brass pipe screens</td>
<td>$0.15\textsuperscript{58}</td>
<td>VCH</td>
<td>Replace steel wool, which causes lung damage when inhaled</td>
</tr>
<tr>
<td>1 baggie</td>
<td>$0.04</td>
<td>VCH</td>
<td>For kit supplies</td>
</tr>
<tr>
<td>1 sticker for bags</td>
<td>$0.05</td>
<td>VCH</td>
<td>Indicate that the VCH kit intends to prevent disease transmission and injury</td>
</tr>
<tr>
<td>1 info / education card</td>
<td>$0.06</td>
<td>VCH</td>
<td>Educate about reducing harms from smoking crack. Include Detox hotline</td>
</tr>
<tr>
<td>2 mouthpieces</td>
<td>In Kind</td>
<td>MoH (HRSS)</td>
<td>Reduce disease transmission that might result from sharing. Reduce oral cuts and burns</td>
</tr>
<tr>
<td>2 wooden push sticks</td>
<td>In Kind</td>
<td>MoH (HRSS)</td>
<td>Assist with screen loading and decrease stem damage caused by metal push sticks</td>
</tr>
<tr>
<td>4 alcohol swabs</td>
<td>In Kind</td>
<td>MoH (HRSS)</td>
<td>Use for wiping stems, mouthpieces, hands</td>
</tr>
</tbody>
</table>

\textsuperscript{57} The first 60,000 stems purchased were $0.32 each. The next delivery of 90,000 stems were $0.29 each. The price of safer smoking kits and stems decreased because VCH ordered a larger volume of supplies in its second purchase.

\textsuperscript{58} Brass screens were purchased by VCH for the first year of the project, and were provided to all BC harm reduction service providers through the BC HRSS after January 2012.
Appendix 3: Best practices for kit distribution

- Determine whether the client has been documented as a ‘new’ client of the safer smoking pilot; ask “has anyone offered you a VCH crack kit before?”
- Give up to 2 stems or kits / person / visit.
- As per VCH consultation with the Vancouver Police Department, advise clients not to use safer smoking supplies openly in parks, playgrounds or other sensitive community spaces.
- Encourage disposal of used mouthpieces and broken stems in sharps containers 59.
- Provide safer smoking education & instruction.
- Provide appropriate referrals, including to Health services and Addictions Treatment.
- Record required supply distribution and referral information and report this data to VCH.
- Order 5/16th tubing, alcohol swabs, wooden push sticks, and screens regularly from the BC HRSS.

**Stems (heat and shatter resistant glass)**
Prevent cuts, burns, HIV, hepatitis C, infections and other harms.
- Give up to 2 stems per visit.
- Encourage single-person use of stems.
- Distribute stems with mouthpieces, screens, wooden push sticks and alcohol swabs.
- Encourage disposal in sharps container.

**Screens**
Prevent burns and lung damage from inhaled ‘brillo’ and other metals.
- Give 2 packages of screens per stem.
- Show how to load screens into pipe.
- Show alternative methods for using screens.

**Mouthpieces**
Prevent cuts and burns, allow smoke to cool and prevent inhaled ‘brillo’; may prevent transmission of hepatitis C, pneumonia, and other infections.
- Cut to 3 or 4 inches long.
- Give 2 per stem.
- 5/16th tubing fits the 8mm stems.
- Educate people on the risks of sharing supplies.

59 Service providers report seeing very few stems or mouthpieces disposed of on ground, though they do occasionally see smashed pipes. Service providers remind clients to dispose of their used stems in a sharps container in order to prevent others from using them. Service providers report that people will pick up used pipes, or try to get them out of sharps containers to use or in an attempt to recover drug residue.
**Alcohol Swabs**
- Clean hands before assembling a pipe.
- Clean mouthpiece:
  - Before you put it on.
  - Between uses.

**Wooden Push Sticks**
Prevent pipe damage from metal push sticks.
- Provide two or more per stem.
Appendix 4: RUG Workshops

The VANDU Safer Smoking Workshop included 6 Learning activities with associated learning outcomes, as follows:

Section 1: Safer Smoking Supplies, Safer Practices

1. Overview and open discussion of the supplies in a safer crack smoking kit.
   a. Participants are able to identify the contents of a safer smoking kit
   b. Participants can explain the function of each supply in the kit
   c. Participants can identify how the kit contents reduce crack-related harms

2. Loading a crack pipe with screens: discussion of the risk of harms from using brillo, and how screens can be used to reduce harms. Participatory activity of putting screens into the stem using the ‘VANDU’ method.
   a. Participants are able to identify that there are harms associated with using brillo and will be able to demonstrate several methods of using screens.

3. How to stay safe—avoiding drug acquisition harms: activate experiential knowledge regarding how you keep yourself safe in the illegal drug market. Generate discussion by compiling a 'top 10 list'.
   a. Participants will share ‘best practices’ in avoiding illegal drug market harms, including lateral, drug dealer and enforcement, addiction, withdrawal and other drug-related harms.

4. Top Chef VANDU—removing harmful cuts. Group discussion about ‘cooking’ crack cocaine to remove harmful substances. Discussion of what can and can’t be removed. Discussion of the harms associated with levamisole.
   a. Participants will understand the benefits of cooking rock before smoking, and understand that levamisole can not be cooked out.
   b. Participants will be able to identify levamisole-related health issues and when / how to seek related healthcare

Section 2: Stimulant Overamping

1. Mapping adverse reactions on the body: participants will brainstorm adverse effects of smoking and facilitators will mark these on a large outline of the human body - for example paranoia (the head), limb jerking (limbs), and heart distress (heart).
   a. Participants will be able to distinguish between psychological and physical overamping and take appropriate measures (know when to call 911 and when to provide support and comfort) for someone ‘overamping’ or overdosing
   b. Participants will be able to demonstrate how to deal with overamping, including creating conditions for safer use (staying hydrated and rested, frame of mind, safe place, comfortable with the people you are with, etc.)

Section 3: Where do the harms come from and how can we address them?

1. Identifying and Classifying Harms: brainstorm some of the harms that people who use drugs face, including violence, enforcement harms, incarceration, heart attack, endocarditis, HIV, hepatitis C, homelessness, child apprehension, lateral violence, etc.
a. Participants will develop an analysis of which harms can be mitigated through safer practices, and which harms are associated with the prevalent policy framework and social structure.
Appendix 5a: Pre-survey
Socio-demographic questions

1. What is your age in years?
   ________ years

2. What is your gender?
   - Male
   - Female
   - Transgender
   - Other (specify) __________________________

3. Where you born in Canada?
   - Yes (skip to question 6)
   - No
   - Refused

4. Which country were you born in?
   Specify __________________

5. What year did you come to Canada?
   Specify __________________

6. Do you identify yourself as Aboriginal (e.g. Métis, First Nations, Inuit)?
   - Yes
   - No

7. What type of accommodation do you currently live in? (select one only)
   - Owned house/apartment (alone/shared)
   - Rented house/apartment (alone/shared)
   - Parents’/carers’ family home
   - Boarding house/hostel/single room occupancy hotel (SRO)
   - Student residence
   - Shelter/refuge
   - Drug treatment residence
   - Squat
   - No fixed address/couch surfing/staying with friends
   - Street
   - Other (specify) __________________________
   - Refused

8. Do you live in the DTES?
   - Yes
   - No: If no, where do you live? ______________

9. Are you currently in paid employment?
   - Yes: If yes, how many hours per week? _____hrs
   - No
10. Are you receiving any welfare or benefit payments?
   - Yes
   - No
   - Refused

11. What is the highest level of education you have completed? (select one only)
   - No schooling
   - Some elementary schooling
   - Completed elementary schooling
   - Some high school
   - Completed high school
   - Some university
   - Completed university
   - Don’t know
   - Refused

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### Health related questions

12. Do you smoke crack?
   - Yes
   - No (terminate questionnaire)

13. In a typical week, how OFTEN have you smoked crack?
    Specify __________ times

14. In a typical week, how MANY rocks have you smoked?
    Specify __________ rocks

15. Have you ever been told by a physician or other health care provider that you have HIV?
   - Yes
   - No

16. Have you ever been told by a physician or other health care provider that you have hepatitis C?
   - Yes
   - No
17. a. In the past 30 days have you experienced any of these injuries due to crack smoking?

b. And have you seen a community health care provider or have been to the hospital for these problems?

(circle Y or N for each)

*Note: Please distinguish between health care providers in the community such as walk-in clinics vs hospital emergency room visits*

<table>
<thead>
<tr>
<th>Injury</th>
<th>Health care provider</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sores</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Burns</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Cuts</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>Y N</td>
<td>Y N</td>
</tr>
</tbody>
</table>

18. a. In the past 12 months have you experienced any of these injuries due to crack smoking?

b. And have you seen a community health care provider or have been to the hospital for these problems?

(circle Y or N for each)

*Note: Please distinguish between health care providers in the community such as walk-in clinics vs hospital emergency room visits*

<table>
<thead>
<tr>
<th>Injury</th>
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<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
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<td>Burns</td>
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<td>Y N</td>
</tr>
<tr>
<td>Cuts</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>Y N</td>
<td>Y N</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Y N</td>
<td>Y N</td>
<td></td>
</tr>
</tbody>
</table>
19. In the past 3 months, have you been to a community health care provider or have been to the hospital for any of these problems?

(circle Y or N for each)

*Note: Please distinguish between health care providers in the community such as walk-in clinics vs. hospital emergency room visits*

<table>
<thead>
<tr>
<th>Problems</th>
<th>Health care provider</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia (lung infection)</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Inhaled piece of filter (brillo), glass, screen or steel from crack pipe</td>
<td>Y N</td>
<td>Y N</td>
</tr>
</tbody>
</table>

20. In the past 12 months, have you been to a community health care provider or have been to the hospital for any of these problems?

(circle Y or N for each)

*Note: Please distinguish between health care providers in the community such as walk-in clinics vs. hospital emergency room visits*

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Health care provider</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia (lung infection)</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Inhaled piece of filter (brillo), glass, screen or steel from crack pipe</td>
<td>Y N</td>
<td>Y N</td>
</tr>
</tbody>
</table>

21. Have you received information about health, addictions and other supports from service providers/peers at this site:

- [ ] Washington
- [ ] VANDU
- [ ] DAMS
- [ ] Mobile van
- [ ] Lookout Shelter
- [ ] Other (specify) ________________________
Use and access of crack, crack pipes and other drugs questions

22. Where did you get your crack smoking supplies from in the past 3 months? And were they free or did you purchase them? (select all that apply)

<table>
<thead>
<tr>
<th>Location</th>
<th>Free</th>
<th>Purchased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street (new pipes)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Street (used pipes)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Corner store</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>DAMS drop-in</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>DAMS outreach</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lookout Shelter</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>VANDU</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Washington</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Mobile van</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Friend/partner</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Homemade</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

23. Where do you get your crack smoking supplies from the most and why? (choose from list above)

Location: ______________ Why? ____________

24. Do you find it hard to get pipes when you need them?

☐ Yes
☐ No (skip to question 26)

25. Why do you find it hard to get them? (select all that apply)

☐ Difficult to find pipes at night
☐ No one has them
☐ Can’t get to distribution site
☐ Can’t afford them
☐ Other (specify) _________________________

26. In the past 30 days how many times have you shared a crack pipe (either without a mouthpiece or without changing the mouthpiece)?

☐ Not in the past 30 days
☐ Once or twice
☐ 3-5 times
☐ 6-10 times
☐ 11-20 times
☐ 21-50 times
☐ More than 50 times
☐ Don’t know
27. In the past 12 months, how often have you shared a crack pipe (either without a mouthpiece or without changing the mouthpiece)?

- Not in the past 12 months
- Less than once a month
- Once a month to once a week
- More than once a week but less than daily
- Once a day
- More than once a day
- Don’t know
- Refused

28. How many times have you given someone used crack pipe equipment in the past 30 days?

__________ times

29. How many times have you smoked with used crack pipe equipment in the past 30 days?

__________ times

30. How many pipes do you use in a month?

- One every day
- A few a week
- One a week
- A few a month
- One a month
- Less than one a month

31. How long does each pipe last in days?

__________ days

32. How often do you pick up crack supplies?

- Once every day
- A few times a week
- Once a week
- A few times a month
- Once a month
- Less than once a month

33. When you pick up crack supplies, do you also pick them up for other people?

- Yes
- No

34. Which safer smoking supplies have you used in the past 3 months? (select all that apply)

- Pyrex pipe/glass stem
- Brass screen
- Mouthpiece
- Educational materials
- Alcohol swabs and hand wipes
- Wooden push sticks
35. What did you trade in order to obtain crack pipes and/or mouthpieces in the past 30 days? (select all that apply)

☐ Money
☐ Sex
☐ Other products or services
   Specify _______________________________
☐ Nothing

36. In the past 12 months, what did you trade in order to obtain crack pipes and/or mouthpieces? (select all that apply)

☐ Money
☐ Sex
☐ Other products or services
   Specify _______________________________
☐ Nothing

37. Have you injected drugs in the past 30 days?

☐ Yes: If yes, how many times? __________ times
☐ No

38. If you can’t find supplies to smoke crack, do you inject instead?

☐ Yes
☐ No

39. What drugs other than crack, have you used in the past 12 months? (select all that apply)

☐ Cannabis (marijuana, hashish, etc.)
☐ Cocaine powder (coke, blow)
☐ Crack (rock)
☐ Heroin (down)
☐ Amphetamine (speed powder or pills)
☐ Crystal meth (tina, jib, gak)
☐ Ecstasy (“E”, MDMA/MDA/MDEA)
☐ Hallucinogens (LSD, mushrooms, etc.)
☐ Methadone (juice)
☐ Pain killers (morphine, oxycodone, etc.)
☐ Other prescription drugs
☐ Other (specify) __________________________

40. Are you currently in any form of drug or alcohol treatment or support group? (e.g. methadone, 12-step, detox, outpatient day program, individual counsellor, etc.)

☐ Yes
☐ No

41. Have your crack pipes or mouth pieces been confiscated or broken by the police in the past 30 days?

☐ Yes
☐ No

42. Have your crack pipes or mouthpieces been confiscated or broken by the police in the past 3 months?
43. Is there anything else you would like to see in the safer crack kit?

☐ Yes: If yes, specify ________________________
☐ No

Thank you!
Socio-demographic questions

44. What is your age in years?

__________ years

45. What is your gender?

☐ Male
☐ Female
☐ Transgender
☐ Other (specify) __________________________

46. Where you born in Canada?

☐ Yes (skip to question 6)
☐ No
☐ Refused

47. Which country were you born in?

Specify __________________

48. What year did you come to Canada?

Specify __________________

49. Do you identify yourself as Aboriginal (e.g. Métis, First Nations, Inuit)?

☐ Yes
☐ No

50. What type of accommodation do you currently live in? (select one only)

☐ Owned house/apartment (alone/shared)
☐ Rented house/apartment (alone/shared)
☐ Parents’/carers’ family home
☐ Boarding house/hostel/single room occupancy hotel (SRO)
☐ Student residence
☐ Shelter/refuge
☐ Drug treatment residence
☐ Squat
☐ No fixed address/couch surfing/staying with friends
☐ Street
☐ Other (specify) __________________________
☐ Refused

51. Do you live in the DTES?

☐ Yes
☐ No: If no, where do you live? ________________

52. Are you currently in paid employment?

☐ Yes: If yes, how many hours per week? _____hrs
☐ No
53. Are you receiving any welfare or benefit payments?
   □ Yes
   □ No
   □ Refused

54. What is the highest level of education you have completed? (select one only)
   □ No schooling
   □ Some elementary schooling
   □ Completed elementary schooling
   □ Some high school
   □ Completed high school
   □ Some university
   □ Completed university
   □ Don’t know
   □ Refused

55. Did you participate in a similar survey during November to December 2011?
   □ Yes
   □ No
   □ Don’t know

Health related questions

56. Do you smoke crack?
   □ Yes
   □ No (terminate questionnaire)

57. Have you used the safer smoking crack pipe kit?
   □ Yes
   □ No
   □ Don’t know

58. In a typical week, how OFTEN have you smoked crack?
   Specify __________ times

59. In a typical week, how MANY rocks have you smoked?
   Specify __________ rocks

60. Have you ever been told by a physician or other health care provider that you have HIV?
   □ Yes
   □ No

61. Have you ever been told by a physician or other health care provider that you have hepatitis C?
62. Have you ever been told by a physician or other health care provider that you have tuberculosis?

- Yes
- No

63. a. In the past 30 days have you experienced any of these injuries due to crack smoking?

b. And have you seen a community health care provider or have been to the hospital for these problems?

(circle Y or N for each)

*Note: Please distinguish between health care providers in the community such as walk-in clinics vs hospital emergency room visits*

<table>
<thead>
<tr>
<th>Injury</th>
<th>Health care provider</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Sores</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>☐ Burns</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>☐ Cuts</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>☐ Other (specify)</td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td></td>
<td>Y N</td>
<td>Y N</td>
</tr>
</tbody>
</table>

64. a. In the past 12 months have you experienced any of these injuries due to crack smoking?

b. And have you seen a community health care provider or have been to the hospital for these problems?

(circle Y or N for each)

*Note: Please distinguish between health care providers in the community such as walk-in clinics vs hospital emergency room visits*

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<td>Y N</td>
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<td>☐ Cuts</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>☐ Other (specify)</td>
<td></td>
<td>Y N</td>
</tr>
<tr>
<td></td>
<td>Y N</td>
<td>Y N</td>
</tr>
</tbody>
</table>

65. In the past 3 months, have you been to a community health care provider or have been to the hospital for any of these problems?

(circle Y or N for each)
66. In the past 12 months, have you been to a community health care provider or have been to the hospital for any of these problems?

(circle Y or N for each)

67. Have you received information about health, addictions and other supports from service providers/peers at this site:

☐ Washington  
☐ VANDU  
☐ DAMS  
☐ Mobile van  
☐ Lookout Shelter  
☐ Other (specify) ________________________

Use and access of crack, crack pipes and other drugs questions

68. Where did you get your crack smoking supplies from in the past 3 months? And were they free or did you purchase them? (select all that apply)
<table>
<thead>
<tr>
<th>Location</th>
<th>Free</th>
<th>Purchased</th>
</tr>
</thead>
<tbody>
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<td>☐</td>
</tr>
<tr>
<td>VANDU</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Washington</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Mobile van</td>
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</tr>
<tr>
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<td>☐</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

69. Where do you get your crack smoking supplies from the most and why? (*choose from list above*)

Location: ______________ Why? ____________

70. Do you find it hard to get pipes when you need them?

☐ Yes  ☐ No (*skip to question 26*)

71. Why do you find it hard to get them? (*select all that apply*)

☐ Difficult to find pipes at night  ☐ No one has them
☐ Can’t get to distribution site  ☐ Can’t afford them
☐ Other (specify) _________________________

72. a. In the past 30 days how many times have you shared a crack pipe (either without a mouthpiece or without changing the mouthpiece)?

☐ Not in the past 30 days  ☐ Once or twice
☐ 3-5 times  ☐ 6-10 times
☐ 11-20 times  ☐ 21-50 times
☐ More than 50 times  ☐ Don’t know
☐ Refused

b. If shared a crack pipe: Did you share?

☐ A stem  ☐ A mouthpiece  ☐ Both
Don’t know

73. a. In the past 12 months, how often have you shared a crack pipe (either without a mouthpiece or without changing the mouthpiece)?

☐ Not in the past 12 months
☐ Less than once a month
☐ Once a month to once a week
☐ More than once a week but less than daily
☐ Once a day
☐ More than once a day
☐ Don’t know
☐ Refused

b. If shared a crack pipe: Did you share?

☐ A stem
☐ A mouthpiece
☐ Both
☐ Don’t know

74. How many times have you given someone used crack pipe equipment in the past 30 days?

__________ times

75. How many times have you smoked with used crack pipe equipment in the past 30 days?

__________ times

76. How many pipes do you use in a month?

☐ One every day
☐ A few a week
☐ One a week
☐ A few a month
☐ One a month
☐ Less than one a month

77. How long does each pipe last in days?

__________ days

78. How do you dispose your used crack pipes? (select all that apply)

☐ Return them to an agency that distributes stems
☐ Throw them in the garbage
☐ Place them in a container and throw them in the garbage
☐ Give them to someone else to discard
☐ Put them in outdoor needle drop box
☐ Put them in a biohazard (sharps) container
☐ Throw them in the street/alley/sewer/park
☐ Other (specify) __________________________

79. In the past 12 months, have you smoked with a broken or cracked crack pipe?

☐ Yes, with a mouthpiece
☐ Yes, without a mouthpiece
80. How often do you pick up crack supplies?

- Once every day
- A few times a week
- Once a week
- A few times a month
- Once a month
- Less than once a month

81. When you pick up crack supplies, do you also pick them up for other people?

- Yes
- No

82. Which safer smoking supplies have you used in the past 3 months? (select all that apply)

- Pyrex pipe/glass stem
- Brass screen
- Mouthpiece
- Educational materials
- Alcohol swabs and hand wipes
- Wooden push sticks

83. Have you ever taken and given the safer smoking crack pipe kit to others outside of DTES?

- Yes: If yes, where? _______________________
- No

84. What did you trade in order to obtain crack pipes and/or mouthpieces in the past 30 days? (select all that apply)

- Money
- Sex
- Other products or services
  - Specify _______________________________
- Nothing

85. In the past 12 months, what did you trade in order to obtain crack pipes and/or mouthpieces? (select all that apply)

- Money
- Sex
- Other products or services
  - Specify _______________________________
- Nothing

86. Have you injected drugs in the past 30 days?

- Yes: If yes, how many times? __________ times
- No

87. If you can't find supplies to smoke crack, do you inject instead?

- Yes
- No
88. What drugs other than crack, have you used in the past 12 months? (select all that apply)

☐ Cannabis (marijuana, hashish, etc.)
☐ Cocaine powder (coke, blow)
☐ Crack (rock)
☐ Heroin (down)
☐ Amphetamine (speed powder or pills)
☐ Crystal meth (tina, jib, gak)
☐ Ecstasy ("E", MDMA/MDA/MDEA)
☐ Hallucinogens (LSD, mushrooms, etc.)
☐ Methadone (juice)
☐ Pain killers (morphine, oxycodone, etc.)
☐ Other prescription drugs
☐ Other (specify) __________________________

89. Are you currently in any form of drug or alcohol treatment or support group? (e.g. methadone, 12-step, detox, outpatient day program, individual counsellor, etc.)

☐ Yes
☐ No

90. a. Have your crack pipes or mouth pieces been confiscated or broken by the police in the past 30 days?

☐ Yes
☐ No

b. If yes, were they used crack pipes?

☐ Yes
☐ No

91. a. Have your crack pipes or mouthpieces been confiscated or broken by the police in the past 3 months?

☐ Yes
☐ No

b. If yes, were they used crack pipes?

☐ Yes
☐ No

92. Is there anything else you would like to see in the safer crack kit?

☐ Yes: If yes, specify _______________________
☐ No

Thank you!
Appendix 6: Baseline Focus group Questions

Participants participated in building a safer smoking kit and commented on the materials provided.

Bags
- What do you like / not like about these bags?
- Do you have other suggestions for bags?

Stems and Mouthpieces
- What do you like / not like about these stems?
- How long does a stem last?
- Which size mouthpiece do you like?
- Which mouthpieces should we put in the kits? How many?

Screens
- Do you use screens? Why and why not?
- How many?
- Do you have tips and tricks for using them? What are they?
- What would help people use them more?
  - peer education
  - print education
  - instructional video
    - online
    - at drop in
    - other ways
  - different methods
  - different supplies

Pushsticks
- Do you use these?
- What do you like / not like about these?
- How many / kit?

Alcohol Swabs
- Do you use them?
- Why and why not?
- How many / kit?

Should we include other supplies?
- Condoms, lube, lighters, gum, etc.
Kits vs Individual supplies

- How often do you want a kit vs. how often do you want just supplies?

Education and Information:

- What do you want in your kit?
  - How to use the supplies (screens, mouthpieces, push sticks)
  - Where to get safer smoking supplies
  - Health information (like levamisole warning)
  - OD information
  - Detox information
  - Dates and times of support groups
  - Information about health clinics
- Which format? (Cards, pamphlets, little booklet, sheet of paper)

Where do you want to get your stems from?

DAMS, VANDU, WND, PHS van, Lookout, Main/ Hastings outreach, other place?
Appendix 7: Interviews with Service Providers

Section 1: Review and comments on kit contents:

- Who are your clients who access safer smoking supplies (demographics: age, gender, ethnicity, area of residence, etc.)
- Do you have specific feedback or comments about the supplies in the kit? (quality, size, durability, compatibility with other materials, number / kit)
  1. Stems
  2. Mouthpieces
  3. Screens
  4. Educational materials
  5. Push Sticks
  6. Alcohol swabs
- What about the kits in general? Is there anything you would add to or remove from future kits? (Prompt: kits vs. loose supplies?)
- Can you estimate how many kits did your organization distribute / month?
- Can you estimate how many additional stems from VCH?
- Can you estimate how many days your supply of kits and stems from VCH last each month?
  o Did this change from month to month, or was it constant? Did demand increase, decrease or stay the same over the project?
- How many additional kit or stems from your organization did you distribute per month? Did you do this before, after, or at the same time as you were distributing VCH kits?
- Were any of these supplies different from what VCH provided? How? Was there a client preference?
- Did you ever run out of kits and stems? Why/why not?
- What is the maximum number of kits or stems you could distribute each month?
- Should the distribution of publicly-funded stems and kits continue? Why or why not?
- If distribution continues, how could it be improved?

Section 2: Client Engagement, Referrals and Education

- What were the most common referrals to other services requested by people accessing the safer smoking supplies?
- Did you provide education about safer smoking? What types? What were the most common pieces of education you discussed with clients?
- Were the VCH safer smoking education inserts effective?
- How could safer smoking education be improved?
- What are some of the barriers to using safer smoking supplies for your clients?
- What makes it easier for people to use safer smoking supplies and practices?
- Do you think people dispose of their stems in a proper sharps container? Why or Why not?
- How could proper stem disposal be improved?
Section 3: Interactions with police

- Did you receive reports of police seizing, confiscating or making people smash their stems? How many / month?
- Did you report these in writing to VCH? If not, can you give us details of these incidents now? (Or email Sara Young at sara.young@vch.ca later)
- Has this changed since December and the start of VCH kit distribution? How?

Section 4: Final Comments

- Is there any other information you think VCH needs to know related to crack stem or kit distribution (service provider, community agency, client issues?)
## Appendix 8: Supply Feedback

<table>
<thead>
<tr>
<th>Supply</th>
<th>Description</th>
<th>Source</th>
<th>Service Provider Comments</th>
</tr>
</thead>
</table>
| Stems           | 8mm x 10 cm Borosilicate glass tubing                                       | VCH            | • Are the most sought after safer smoking supply  
• Most people prefer the 8mm, some prefer the 10mm  
• Are of good quality supply  
• Pipes do break sometimes |
| Mouthpieces     | 100-foot lengths of vinyl tubing, available in 3 diameters                  | BC HRSS        | • A variety of lengths are preferred by clients  
• 4” is a good length for the kits  
• 2-3 foot lengths are requested and should be provided  
• Most people prefer the 5/16”, but all three sizes are requested |
| Wooden Push sticks | BC HRSS Wooden craft dowel                                                   |                | • There were several types of push stick available from BC HRSS over the course of the pilot  
• The current stick is sturdy with blunt ends, and fits easily into the stem  
• The current stick is preferred |
| Alcohol Swabs   | BC HRSS                                                                     |                | • Service providers unsure about whether clients use these  
• Clients not sure what these are for  
• Clients use these to clean hands, rather than stems |
| Educational Inserts | Series of 5 small education cards. One card included in each kit    |                | • Clients may not be interested / able to read them  
• Verbal and 1:1 education is more effective than written materials  
• Service providers do not see the print materials discarded, so clients may be keeping them  
• People may get the same educational materials repeatedly  
• Insert cards not effective for clients – need posters, large font, etc  
• Inserts educated service providers |
| Screens         | Brass pipe screens                                                          | BC HRSS        | • Many clients prefer brillo  
• Service providers hear reports of inhaled brillo and other health harms from using brillo  
• Clients reluctant to use screens because of previous experiences with ‘losing dope’ when using them  
• Service providers report that screens poke and cut people |
| Additional supplies | Partner agencies | • Loading the screens is difficult and time-consuming  
• Transitioning to a new supply is difficult, but people are getting used to using the screens  
• Demonstrating how to load the pipe is sometimes an effective way to promote transition to screen use  
• Pre-packed pipes would ensure people use screens more  
• Multiple techniques for loading screens exist and should be taught  
• Service providers and clients recommend researching other options, such as stainless steel brillo  
| One site includes small Blistex lip balm packs  
One site includes lighters, as matches and lighters are often requested by clients |
Appendix 9: Approaches to demand vs. supply issues

<table>
<thead>
<tr>
<th>Service Provider Agency</th>
<th>Restricted or Unrestricted Distribution</th>
<th>Supply shortage indicators</th>
<th>Demand Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agency 1</strong></td>
<td>Receives kits and stems twice per month. Distributes only 1/15 of their 15-day allotment per day</td>
<td>Has usually distributed all supplies for the day within 2 hours</td>
<td>They estimate they could distribute all of their 15-day allotment within 2-3 days if they did not restrict distribution</td>
</tr>
<tr>
<td><strong>Agency 2</strong></td>
<td>Receives kits and stems twice monthly. Distributes only 1/15 of their 15-day allotment per shift, and restricts distribution to one stem/kit per person when on outreach</td>
<td>Staff report an average of 61 people turned away for supplies each month</td>
<td>They estimate that distribution could double through their agency</td>
</tr>
<tr>
<td><strong>Agency 3</strong></td>
<td>Receives kits and stems twice monthly. Does not restrict or stagger distribution</td>
<td>Distributes their 15-day allotment within 2-3 days of receiving it</td>
<td>This service estimates they alone could distribute 10,000 kits per month throughout Vancouver. Mobile van distributed thousands of additional non-VCH kits and stems throughout the project</td>
</tr>
<tr>
<td><strong>Agency 4</strong></td>
<td>Receives kits twice monthly. Distributes only 1/15 of their 15-day allotment per day, and only during daytime hours</td>
<td>Before switching to restricted distribution, their 15-day allotment was distributed within 5 days</td>
<td>See approximately 500 clients per day and 75% ask for a pipe (=11,437 requests for stems / month).</td>
</tr>
<tr>
<td><strong>Agency 5</strong></td>
<td>Distributes 100 stems / day (50 in the morning and 50 in the afternoon) in order to ensure their allotment of stems lasts until they receive their next allotment</td>
<td>Often run out of stems within a couple of hours</td>
<td>They estimate that distribution could be at least doubled in the DTES</td>
</tr>
</tbody>
</table>