

# LESSONS LEARNED FROM THE SCORE PROJECT:

A Document to Support Outreach and Education Related to Safer Crack Use

## SCORE



Safer Crack Use, Outreach,  
Research and Education



*Lessons Learned: Safer Crack Use*

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We acknowledge the incredible contributions of the many people who assisted with the SCORE project. Our deep gratitude is extended to the individuals who assisted with kit making circles and distribution. We are grateful to those working in the DTES who helped to arrange access to resources for the project. We also recognise the women and men who gave of their time and helped to improve our understanding of how to successfully develop harm reduction materials focussed on crack use.

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## **1. KEY ELEMENTS OF THE SCORE PROJECT**

### INTRODUCTION

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The aim of this report is to provide key findings related to the SCORE project. It is our hope that the insights that we have gained may be of benefit to others engaged in similar initiatives and to ultimately improve the health of individuals who use crack.

The SCORE project (Safer Crack Outreach, Research, and Education) grew out of the vision and hard work of the Safer Crack Use Coalition of Vancouver. Before the SCORE Project was funded, this coalition devoted much energy into raising awareness regarding the insufficient resources aimed at preventing the harms related to crack use. The SCORE project emerged as a way to address this issue in Vancouver's Downtown Eastside (DTES), specifically to facilitate a better understanding of the health concerns and service needs of people who use crack. The project ran for three years between 2005 and 2008.

The SCORE project team included both academic researchers and frontline workers associated with the University of British Columbia, the University of Victoria, the BC Centre for Disease Control, and the Safer Crack Use Coalition of Vancouver. Project team members consulted with women and men who use crack who participated in an advisory capacity and have informed much of this project.

The main components of the project were:

- Kit-making circles in which women came together and constructed safer crack use kits
- Kit distribution in which outreach teams distributed safer crack use kits and engaged in a harm reduction discussion with those receiving these kits.

We evaluated the project using a variety of techniques, including:

- Pre- and post-distribution surveys
- Qualitative interviews with kit recipients
- Qualitative interviews with those involved in kit distribution
- Field notes taken during kit-making circles
- Tally sheets recording the number of kits distributed

## THE CONTEXT OF THE SCORE PROJECT

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In order to understand the outcomes of the SCORE project, it is important to locate it within the political and social context.

### **Safer Crack Use Coalition of Vancouver**

Drawing on work done in Toronto, the Safer Crack Use Coalition's goals included education and advocacy, the distribution of mouthpieces, and the eventual production of safer crack use kits. A key goal was to actively involve people who use crack in the development of all activities. In 2005, the Coalition was facing a lack of funds. In partnership with researchers at UBC, funding was received through the Health Canada Drug Strategy Community Initiatives Fund and the SCORE project was established.

In the fall of 2007, a new National Drug Strategy was announced. This policy, now titled the "Anti-Drug Strategy," emphasized the need to "get tough on drug use" and proposed stricter enforcement. Although addiction services were emphasized in the strategy, harm reduction was not mentioned.

### **The National Context**

Political shifts at the national level affected the SCORE project. The 2005 federal election brought a minority neo-liberal Conservative party to power and harm reduction programs were placed in jeopardy. The Conservative Prime Minister made it clear that he did not support harm reduction programs; rather, his government favoured crime control initiatives. At the outset of the project, we were encouraged by Health Canada staff to keep the project "under the radar." It was clear that the funding for the project could be pulled if there was too much negative publicity.

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### **The Provincial Context**

Vancouver is the largest city in the province of British Columbia (BC). In 2002, the election of a neo-liberal provincial government led to cuts to services, welfare support, public housing, and community-based programs (e.g., legal aid and mental health services). The government eliminated the Ministry of Women's

In 2002, the election of a neo-liberal provincial government led to cuts to services, welfare support, public housing, and community-based programs resulting in limited service provision for those most marginalized: women and children, Aboriginal people, and the elderly.

Equality, the Minister's Advocacy Council on Women's Health, the Provincial Mental Health Officer, and the Human Rights Commissioner. These cutbacks and eliminated positions resulted in limited service provision for those most marginalized, namely women and children, Aboriginal people, and the elderly (Creese & Strong-Boag, 2005).

### **The Municipal Context: Vancouver and the Downtown Eastside**

The SCORE project took place in Vancouver's Downtown Eastside (DTES). It is one of the poorest neighbourhoods in Canada. It has been estimated that approximately 16,000 people live in the DTES and that women comprise 38% of this population (City of Vancouver, 2004). The DTES is a diverse neighbourhood: 40% of its residents are Aboriginal and 20% are East Asian or Latino/a (Robertson & Culhane, 2005). The DTES has a "high concentration of social problems, including poverty, mental illness, drug use, crime, survival sex work, high HIV/Hepatitis infection rates, unemployment and violence" (PIVOT Legal Society, 2006, p. 5).



The Carnegie Community Centre at Main and Hastings  
*Photo by Kris Krüg*

In 2007, the mayor of Vancouver initiated Project Civil City, a program to clean up "public disorder" before the 2010 Olympics. By-laws were passed and 15 activities were deemed subject to penalties: jay walking, smoking, noise, and urinating/defecating and expectorating in public. Many individuals living in the DTES have little

access to private spaces, homes or public washrooms; they faced the brunt of the mayor's Project Civil City initiative.

A number of local, national, and global factors shape the lives of people living in the DTES. The Olympics in Vancouver continues to be seen by many as diverting tax dollars for housing and social supports and contributing to gentrification in the area. Gentrification and the loss of low-income housing contribute to a growing problem of homelessness. It is estimated that by 2010 over 3,000 people in the DTES will be homeless (PIVOT, 2006).

Vancouver Police expressed concerns about the legitimacy of the SCORE project, and the legality of distributing safer crack use materials. They were concerned that the downtown streets would be "littered" with crack pipes, and that the SCORE project was enabling crack use.

Prior to 2005, harm reduction programs in the DTES had focused primarily on the reduction of blood borne infectious diseases such as HIV and HCV. For example, programming that supports safer injection drug use practices such as access to sterile needles, syringes and water and the implementation of a supervised injection site were implemented (Kerr et al., 2003; Wood et al., 2006).

Finally, it is important to note that during the course of the project the trial of Robert "Willy" Pickton, a man accused of being Canada's largest serial killer, took place. In 2007, Pickton was accused of 26 murders (and convicted of six murders) of women who lived and worked in the DTES. This illustrated the extent to which a lack of safety, violence, and grief coloured the lives of many who live in the DTES.

### **The Vancouver Police**

While the Vancouver Police were on record as being supportive of harm reduction in general and the Supervised Injection Site in particular, they were not supportive of the SCORE Project. The Canadian Association of Chiefs of Police had gone on record as opposing any safer crack initiatives. Early in the project, we met with Vancouver Police on two occasions. In both meetings they expressed concerns about the legitimacy of the SCORE project, and the legality of distributing safer crack use materials. Their concerns stemmed from a belief that the streets would be "littered" with crack pipes, and that we would be enabling crack use. It is interesting to note that over the course of the SCORE project, 14,000 kits were distributed and there were no official complaints about kit materials littering the DTES. To the

credit of the Vancouver Police, toward the end of the SCORE project, officers working in the DTES were familiar with the project and refrained from confiscating harm reduction materials associated with the project.



Police at Main and Hastings  
*Photo by anonymous Vancouver street photographer*

Safer crack kits were seen within the ***Food and Drug Act*** as a “Device” meaning any instrument represented “for use in the mitigation or prevention of disease.”

### **Legal Opinion**

Due to ambiguity in the law and controversy over the distribution of safer crack kits, the SCORE team contacted a lawyer for a legal opinion. We learned that if safer crack kit contents are viewed as being used for illegal use, they can be categorized under the ***Criminal Code*** as “instruments for illegal drug use.”<sup>1</sup> However, the contents in the kit can also be defined as “devices” within the ***Food and Drug Act***. “Device” means any instrument represented “for use in the mitigation or prevention of disease.” These two legal documents are equally relevant, yet they have conflicting meaning for safer crack kit initiatives in Canada. In brief, our legal position regarding safer crack kit initiatives was as follows:

- The area of law around the issue of possession of materials for use with illegal substances is vague and open to interpretation.

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<sup>1</sup> It is important to note that at the time of this study there were no documented cases of arrest or conviction of anyone involved in the distribution of harm reduction materials.

- Our project focuses on health promotion, harm reduction and access to health education about minimizing risk. Our intent is to reduce and prevent harm. We provide kits for these purposes.
- Our safer crack kits are a “harm reduction tool.” We are interested in reducing the harm from the consequences of crack use.
- We had no intent to be in possession of illegal drugs (i.e., used pipes) or to encourage crack use.
- We targeted existing users with the intent to reduce harm.

Thus it was concluded that there was no criminal offence associated with the aims and activities of the SCORE project.

Because there was ambiguity in the law, we took the following steps:

- In official documentation, we referred to the pipes as glass stems. This language is more suggestive of a “device” as per the ***Food and Drug Act***.
- We educated all persons involved in the project that Canadian law states that once the glass stems/pipes are used, their status changes from legal to illegal. If there is resin<sup>2</sup> of an illegal substance in the pipe, the individual who possesses the pipe can be arrested and charged.
- During kit distribution screens and glass stems were distributed separately (i.e., they were not assembled).

### **Other Safer Crack Use Initiatives**

The SCORE project is by no means the first safer crack use initiative in Canada. In Toronto, the Safer Crack Use Coalition pioneered the distribution of safer crack use kits. Ottawa had a program that was cancelled by Ottawa City Council in July 2007 because of the belief that the program condoned or encouraged drug use. Winnipeg has a program that was developed in 2004; it is now overseen by the public health department. Other small programs have existed in BC in Nanaimo, Prince George and on the Sunshine Coast.

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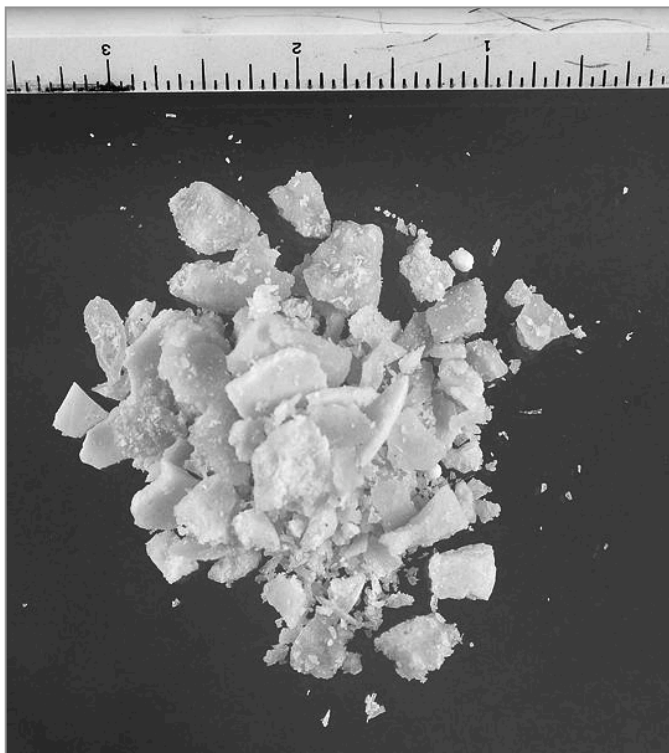
<sup>2</sup> The term “resin” refers to a concentrated and more potent form of crack cocaine which collects on the inside walls of the pipe while an individual is smoking crack.

## CRACK USE

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### **What is Crack?**

Crack is a form of cocaine made by processing powder cocaine with baking soda or ammonia and then crystallizing it into a salt. Few impurities are removed during the manufacturing of crack and it is possible to add other substances that include lidocaine, heroin, amphetamines, and kerosene (Goodman, 2005). Crack remains a relatively inexpensive form of cocaine, partially because it is sold in small quantities. Although crack use is not confined to any specific demographic, an increased prevalence of use has been associated with people who live in poverty and/or experience other forms of marginalization.



Crack cocaine "rocks"  
*Photo from USDEA*

### **How is Crack Used?**

Although crack may be injected, smoking is the most common route of use. Smoking crack involves several pieces of equipment including a pipe (metal or glass), filter, heat source, push stick, and in some instances a

piece of rubber tubing that acts as a mouthpiece. The filter, usually comprised of steel wool, is positioned at one end of the pipe with the aid of a metal or wooden push stick. The crystallized cocaine, commonly known as “rock” is placed on the filter. The pipe is then heated by consistently applying a flame up and down the pipe and the vapours are inhaled.

### **How Prevalent is Crack Use?**

Crack was first developed in the 1970s. Its use became popular in the mid-1980s and is the most common substance smoked worldwide after tobacco and marijuana. Crack is inexpensive and readily available in Vancouver; it produces an intense high, which is short-lived so that users must smoke repeatedly in order to maintain the high.

A number of surveys and studies in the DTES indicate that crack use has become increasingly common over the past 10 years. The actual prevalence of use depends on the population surveyed; in surveys where gender is reported, females appear more likely to smoke crack than do their male counterparts.

- The Vancouver Injection Drug Users Survey (VIDUS) found that crack use in a group of injection drug users in Vancouver almost doubled from about 32% in 1997 to over 60% in 2004 (Buxton, 2007a).
- In 2003-2004, the Community Health and Safety Evaluation project (CHASE) recruited over 3,500 people within the DTES to participate in a survey on health related questions. About 28% reported frequent crack use and over half of respondents had used crack (CHASE, 2005).
- In a study of youth in custody in BC aged 14-19 in 2006, 60% reported ever using crack with females significantly more likely than males to have used (Buxton 2007b).

Crack pipes are often split or cracked which increases the likelihood of cuts to the hands and lips.

### **Harms Associated with Crack Use**

Many factors contribute to the harms associated with smoking crack:

- Crack pipes are often split or cracked which increases the likelihood of cuts to the hands and lips.



## *Lessons Learned: Safer Crack Use*

Many people who smoke crack share their equipment, thereby increasing their risk for infection.

- Crack is often smoked using other receptacles (e.g., aluminum cans, broken bottles), all linked with sores, cuts and burns.
- When steel wool is heated, it often breaks apart and loose particles are inhaled. This results in burns to the lips, mouth, and upper respiratory tract.
- The use of metal push sticks to scrape the resin weakens the glass pipes, thereby increasing the potential for breakage or loose shards of glass being inhaled.
- Plastic push sticks (e.g., ball point pen, plunger from a syringe) melt inside the hot pipes and the toxic fumes from plastic are inhaled.
- Many people who smoke crack share their equipment, thereby increasing their risk for infection.

In September 2006, an outbreak of pneumonia was identified in the DTES. A substantial proportion of these cases were noted to be active crack users, leading to the proposition that sharing crack paraphernalia was an efficient means of spreading pneumonia.

Various infectious diseases have been associated with crack use. Hepatitis C (HCV) and Human immunodeficiency virus (HIV) have been associated with crack use in epidemiologic studies (Porter, 1993; Tortu, 2001; Tortu, 2004; Gyarmathy, 2002; Leonard, 2008). A recent study confirmed the plausibility of HCV transmission through sharing crack pipes when HCV was identified on a crack pipe (Fischer, 2008). In September 2006, an outbreak of pneumonia was identified in the DTES. A substantial proportion of these cases were noted to be active crack users, leading to the proposition that sharing crack paraphernalia was an efficient means of spreading pneumonia. (CCENDU, 2007). In 2007, there was an outbreak of tuberculosis in persons who use crack in BC (Times Colonist, 2007). Finally, sexually transmitted infections are linked with crack use.

## PRINCIPLES UNDERLYING THE SCORE PROJECT

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Peer involved – the perspectives of women and men who have drug use experiences in common with the target population are essential to effective programming.

Early on in the project, the need to articulate the principles underlying this initiative was identified. We believe that adherence to these principles was key to project success and include them below so that they can be adapted and used in future projects.

- **Harm Reduction** – to reduce the harms related to crack use and increase education within the context of its use.<sup>3</sup>
- **Remaining focused on the target population** – rather than responding to the needs of policy makers or external bodies, we remained committed to the people who were using crack. The project needs to be informed by people who use crack and be flexible enough to respond to what is occurring within the target population.
- **Peer involved** – the perspectives of women and men who have drug use experiences in common with the target population are essential to effective programming.
- **Respect** – honouring the integrity of the participants as well as the project team.
- **Truthfulness and honesty** – with regards to communication and sharing of information.
- **Safety** – recognizing vulnerabilities and ensuring that we do not jeopardize anyone's safety.
- **Women-centered** – this included the creation of a women's advisory group to guide and support the project as well as "women only"<sup>4</sup> kit-making circles in which self-identified women assembled the safer crack kits for this project.

### **Why a Women-Centered Approach?**

Given that the harms of crack use are experienced by women and men alike, some might wonder why we

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<sup>3</sup> "Harm reduction" aims to keep people safe and minimize death, disease, and injury from high-risk behavior. Harm reduction involves a range of support services and strategies to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier. In society, there are people who use substances. Dependent users may not want or be able to quit, or may continue to relapse into substance use. Harm reduction reduces the risk and spread of infections like hepatitis and HIV. Harm reduction creates opportunities for people to lead healthier lives (BC HealthFile #102, July 2007).

<sup>4</sup> We use the term women here to include all persons who identify as women (i.e., including transgendered women).

Crack use practices are gendered and women are disadvantaged in many ways (i.e., they lack their own equipment to use more safely, women are often second on the pipe and women often can not obtain their own supply of crack).

adhered to a women-centered approach. We maintain that:

- There are many women in the DTES who use crack and are subject to violence, disease and social stigma.
- Many of these women support themselves through the sex trade, and are expected to supply men (i.e., partners, pimps) with crack.
- Typically, women have fewer opportunities for involvement in projects and taking on leadership roles than do their male counterparts.
- Women require a safe place to speak freely about crack use and need a safe alternative to sex work.
- Crack use practices are gendered and women are disadvantaged in many ways (i.e., they lack their own equipment to use more safely, women are often second on the pipe and women often can not obtain their own supply of crack).

While there were components of this study that were focussed exclusively on women, we were dedicated to ensuring that women AND men who used crack had access to equipment and education that would promote safer use.



Attendees at the DTES women's memorial pay tribute to the missing and murdered women of Vancouver's DTES.

*Photo by Dawn Paley*

## SAFER CRACK KITS

We began by contacting harm reduction programs across Canada to learn about the contents included in safer crack kits. We then explored supply options, availability and costs and established a preliminary list of contents. We modified the original kit contents through a process of consultation with people who use crack in Vancouver and through members of the project advisory teams. This was a process that took place over several months and included discussion about type and quantity of items.

### **Safer Crack Use Kit Contents**

In the following section, we list the items included in the SCORE safer crack kit and provide the rationale for their inclusion.

- **Pyrex Stems**

Compared to conventional glass, Pyrex stems are stronger and less brittle; Pyrex is less likely to explode, break or chip. Pyrex stems last longer than glass stems. Pyrex stems were included in order to reduce the likelihood of the use of other less safe options.

- **Mouthpieces**

The kit included a 4-inch rubber mouthpiece cut from food grade tubing. The use of a rubber mouthpiece at one end of a stem prevents direct contact with broken or hot pipes. Providing individuals with their own mouthpiece allows individuals to protect themselves from exposure to communicable disease when a pipe is shared.

- **Push Sticks**

A wooden chopstick was included. Push sticks are used to pack and position the filter or screen inside the crack pipe. After crack has been smoked, the push stick is used to move the filter back and forth to recover the crack that has hardened on the inside of the pipe after it cools. Wooden push sticks do not chip stems, unlike metal ones that are used frequently (e.g., coat hangers, car antenna). We learned that the plungers of syringes were being used for push sticks. It was estimated that 1 in 5 syringes distributed through the harm reduction program in Vancouver may be used for the plunger alone and that the rest of the syringe including the attached needle is discarded. Including a push stick in the kit helped avoid the waste of syringes and littering of needles and syringes.

- **Condoms**

As the use of crack is associated with high-risk sexual behaviors (i.e., buying and selling sex), condoms were included to promote safer sex. Many women in the DTES who use crack support themselves through sex work. Although condoms are available elsewhere in the DTES, women need easy access to condoms.

- **Bandages**

Bandages were included to protect broken skin.

- **Alcohol Swabs**

Alcohol swabs were included to promote the use of clean equipment (e.g., pipes, mouthpieces) and to cleanse open wounds (e.g., sores on the fingers).

- **Screens**

Brass screens designed for tobacco pipes were provided. These screens are less likely to break apart than steel wool or “Brillo<sup>5</sup>.” As these brass filters are designed for tobacco smoking, they are not coated with potentially toxic substances as is the Brillo.

- **Lighter**

Each kit included one lighter. Smoking crack requires consistent heat applied to the pipe. Using matches is more likely to result in burns and the inhalation of sulphur. In addition, the lack of having one’s own “light” is associated with unsafe circumstances (i.e., being forced to share crack or harassment from others).

- **Information cards**

Two cards were included in the kits: the Tip card covered harm reduction information for crack users, and the Resource card included information with health and drug user services within the DTES.

The total cost of each kit was approximately \$1.66. A list of the items and their associated costs follows.

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<sup>5</sup> The term “Brillo” used here and in the remainder of the document is the street term for the steel wool used as a filter on the inside of the crack pipe

*Lessons Learned: Safer Crack Use*

ITEM	APPROX COST PER ITEM
Pipe	0.50¢
Rubber tubing	0.28¢
Lighter	0.17¢
Brass Screens (2 packages/kit)	0.08¢ per package of 5
Push stick	0.02¢
Band-Aid (2/kit)	0.04¢
Alcohol Swab	In Kind
Condoms	In Kind
Tip Card	0.21¢
Resource Card	0.21¢
Kit Bag	0.03¢
<b>Total:</b>	<b>\$1.66</b>



Safer crack kit contents

One of the facilitators explained that the kit-making circle was an opportunity for women to come together and share their knowledge and expertise with regards to women's concerns and resource needs.

### **Kit-Making Circles**

Kit-making circles were held to assemble kits and to provide a space to consult women about kit contents and distribution. Approximately 200 women participated in the kit-making circles and represented diverse social, cultural, and ethnic backgrounds. The women ranged from 20 to 60 years of age. Most women were living in extreme poverty and many experienced unstable housing. The women currently used or had used illegal drugs, some were selling drugs ("dealers") and others were engaged in treatment and recovery. Many of the women worked as street sex workers. Women who identified as Aboriginal were overrepresented in the group which is not surprising given the overrepresentation of Aboriginal people living in the DTES.

There were on average, twelve kit-making circles per month. Each circle was an hour long and involved four women from the DTES and one or two members of the SCORE team. There were two peer facilitators who worked consistently with the project. They were members of the local women's drug user group and had been selected by the group to act in this role. These two peer facilitators took turns being present at the group and co-led the kit-making circle alongside the SCORE research team project facilitator. This second facilitator was an experienced outreach worker with extensive experience working with women living in the DTES.

The circles took place in various locations throughout the DTES including drop-in centres, women's housing facilities, emergency shelters, and community health centres. The drop-in locations were chosen strategically to enhance women's access to services offered by these agencies. For half of the circles, women were recruited from outdoor locations such as the local park or the street. Women were approached by a peer facilitator and asked if they would like to participate in a project about harm reduction for women who use crack. For many of these women, participating in the kit circles was an opportunity for an alternative to sex work. For the other half of the circles, women were recruited by staff members from the specific agencies where the circles were occurring. In these instances, interested women received an invitation with their name on it and the time and location for the circle.

- **Station One**

Facilitator sits at this station; cuts rubber mouthpieces to put in the kits.

- **Station Two**

Participant picks up black plastic bags and inserts one Tip card, one Resource card, and one mouthpiece.

- **Station Three**

Insert one glass stem and one lighter.

- **Station Four**

Insert two bandages, two alcohol swabs and two condoms.

- **Station Five**

Insert two packages of brass screens and one wooden push stick.

- **Station Six**

Seal the bag, place in bin.

The kits were usually assembled in a separate room at each agency. The room was set up to contain a table with six chairs around it. On the table in front of each chair was a “station” with a plastic tray filled with specific harm reduction items. The kit was assembled as it was passed from station to station.

A “note taker” was also at the table and was responsible for recording field notes.

On a separate small table was a display poster with information cards that the women could take listing resources on a variety of topics from health care, advocacy and legal services, to housing, income assistance and safety tips written by and for women involved in sex work.

Once the women were seated around the table, one of the facilitators welcomed the women to the circle, and reviewed the purpose of the project. She explained that the kit-making circle was an opportunity for women to come together and share their knowledge and expertise with regards to women’s concerns and resource needs. She also outlined that everything discussed was confidential and that each woman had the right to request that a comment not be written down. Next, the peer facilitator explained the kit-making process by describing and demonstrating the task for each woman. The peer facilitator made it clear that everyone could work in a relaxed manner, and that there was no rush or quota of kits. Each participant received twenty dollars for her time and a certificate. The women appreciated the certificate because it specified that they were consultants.

### **Kit Distribution**

During the course of the SCORE project, two methods of distribution were used:

- **Peer<sup>6</sup> outreach** - teams were created that conducted on-foot outreach, patrolling the alleys and main areas of the DTES. The organization of these teams varied; some distribution teams used the same workers every week, while others rotated workers each month. Some

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<sup>6</sup> The term “peer” refers to individuals who are associated closely with the DTES community either in the context of living within the community or in the context of currently using crack.



teams specifically targeted women while others gave kits to both men and women.

- **Integrated outreach** - outreach was also combined with existing services in the DTES. In these situations, service providers distributed kits along with other activities. Some of this outreach took place on foot and one outreach team had access to a van and conducted mobile outreach.

All the teams had a limited number of kits, and gave out between 25 and 100 each time. The process of distribution included handing out kits and demonstrations of how to put the brass screens into the pipe and how to attach the mouthpiece properly. There was information provided on why screens were preferable to the use of Brillo. The teams also talked with people about the risks of sharing equipment and made referrals to health agencies when possible. The teams used a tally sheet to record how many kits were given out, the number of people who received demonstrations and education, what referrals were made and the gender of kit recipients.

## 2. EVALUATION OF THE SCORE PROJECT: WHAT WE LEARNED

In order to evaluate the SCORE project, we collected data from a variety of sources. These included the field notes taken during the kit-making circles, qualitative data collection with kit recipients, individuals involved with kit distribution and a pre-program/post-program survey with individuals who use crack. In the following section, we describe key learnings from the analysis of this data.

### KIT-MAKING CIRCLES

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The women who participated in the kit-making circles lived their day-to-day lives in an environment filled with threats where there was often “no place safe to go.”

The women who participated in the kit-making circles contributed to making 14,000 kits. Through the kit-making circles, we learned about the obstacles that prevent women from incorporating harm reduction practices. Many women were vocal about what they wanted in the kits and what worked and did not work. They also identified services and resources they needed, often outlining the gaps in services and the need for change in responding to women who use crack in the DTES.

The kit-making circles were described as valuable experiences that led to positive changes:<sup>7</sup>

*Since I seen that lady and we did that thing [kit-making circle] it's helped a lot of other girls too. Another girl, I see some changes in her, positive ones.*

*It's not just putting the kits together; it's also a way of networking and getting support. And you know, like around the kitchen table - I thought it was a great idea.*

Typically, these circles commenced with a discussion related to the kit contents. Often there were opportunities to explain why certain items were included and to provide information about harm reduction. As the circle progressed, the topics frequently switched to a more personal nature. Women began telling stories about their own experiences with violence, the challenges of finding safe and affordable housing and the efforts that women make to keep each other safe. In some instances, referrals

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<sup>7</sup> All italicized quotes denote data extracted from qualitative interviews and project focus groups.

were made to assist women to find appropriate counselling as well as housing and health care.

### **Creating a Safe Space**

The women who participated in the kit-making circles lived their day-to-day lives in an environment filled with threats where there was often “*no place safe to go.*” These kit-making circles provided a safe space for women to take a break from their everyday/night activities at both a physical and emotional level. For some women, this was a place where they could come and rest. There were times when some women fell asleep during these circles. The other women would often not disturb a sleeping woman; rather, her activities were automatically taken up by other women while she rested to ensure that the process of kit making continued. The awareness in the room was unmistakable: outside of this space, safety did not exist for that particular woman.

*“It means so much to get together like this and it means I didn’t have to do a date.”*



Simulation of kit-making circle at UBC.

The circles were also considered a safe place to earn money as they provided a legal way to be paid for their expertise and time. As one woman commented, “*It means so much to get together like this and it means I didn’t have to do a date.*”

There was emotional safety in being able to simply share stories about stress in each others lives and the women expressed how important it was for them to come together to do this. Often during the circles, claims would

be made like “*sisterhood is important*” and “*women’s issues are important.*”

Establishing the circle as a “*safe place to be*” was vital to its success and was facilitated mostly by the peer facilitators. As noted by one of the peer facilitators:

*Sometimes it helps having a peer there. It helps them, makes it a little more comfortable and lets the conversation sort of open up a little easier. So that they don’t think that there’s any ulterior motives out there then, you know, [it’s] for the best interest of themselves and for everybody else. So, for me I think a lot of it’s just the support and just sort of making them feel comfortable and opening up the doors for what you guys [SCORE researchers] do as well.*

### **Women Supporting Women**

There were many ways in which the women offered support to one another such as sharing information about services, resources and safer crack use and simply listening and being attentive. Unlike many of their day-to-day interactions, they made comments like “*The conversation is good, it is healthy conversation.*” The women emphasized that attending these circles provided a relaxed and safe atmosphere where they could enjoy “*just talking.*”

### **Support through the Sharing of Information**

Some of the older women saw their role as one of passing on information to the younger women. They shared information about services women could access. For example women advised others about their preferred “*clinics*” and “*doctors.*” One woman warned others about a service agency that was “*a little rough*” making it a place where you did not want to “*wait in the lobby.*”

The women asked questions and were provided with information about health issues. The kit contents naturally triggered opportunities for education and discussion. One woman asked, “*What’s with the condoms? What does smoking crack have to do with condoms?*” Another asked about female condoms<sup>8</sup> and admitted, “*I always wanted to know but I was too embarrassed to ask.*” In response to learning about disease transmission through sharing mouthpieces or pipes, one woman exclaimed: “*You just*

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<sup>8</sup> Female condoms were not distributed with the safer crack kit items but are widely available as part of a larger harm reduction strategy in many of the agencies in the DTES.

*“For me, it’s just helping the girls be aware. Like harm reduction to me is educating and making people aware of how it is that what they may be doing or not doing is safe or unsafe.”*

*made me a one pipe lady.”* This declaration seemed a transformative experience and modeled behaviour change for the other women. As one of the peer facilitators commented:

*For me, it’s just helping the girls be aware. Like harm reduction to me is educating and making people aware of how it is that what they may be doing or not doing is safe or unsafe.*



A woman smokes crack under her coat  
*Photo by anonymous Vancouver street photographer*

Through their stories, women shared and received encouragement from the other participants and the facilitators. In the process the women had an opportunity to grieve, to share frustration, and experiences of powerlessness, violence, and experiences of discrimination.

### **Support through Sharing Stories and Active Listening**

In each group, there were usually one or two women who needed to tell their stories. They were validated by sharing their ideas and having others listen, and support them. Through their stories, women shared and received encouragement from the other participants and the facilitators. In the process the women had an opportunity to grieve, to share frustration, and experiences of powerlessness, violence, and experiences of discrimination.

Women also shared empowering experiences, helping to inspire other women in moments of fear or isolation. For example, one woman talked about completing a university course and was congratulated by the other women. Another woman spoke about completing a three-year core training program about HIV. She is now able to speak publicly about HIV. She said, *“That’s my journey*

*in life, to prevent one person from going downtown, from tweaking<sup>9</sup> like I did.”*

Not all circles ran smoothly. Sometimes the lack of a sense of community or the rivalry between women surfaced as they competed with each other over dwindling resources targeting women specifically. Other times, the sharing of stories validated experiences which emphasized and enforced negative stereotypes and harmful behaviour or peer pressure to conform to social norms, such as the aggression of female drug dealers or the ways that women handle their drug use.

As women laughed and used humour to talk about the absurdity of their lives, they built a sense of community through releasing these shared experiences.

### **Providing Support “in the moment”**

The ways in which women explicitly supported one another “in the moment” was present in all circles. Often this occurred through words of encouragement or inclusion: *“It happens to the best of us, hon,”* said one participant to another in reference to her addiction to heroin. On another occasion, one woman noted how a participant was accomplishing the work at her station: *“You are doing a great job... I know it is hard to do this stuff when you are tired and this is probably the only chance you have had to sit still.”* Light-hearted teasing built a sense of familiarity and intimacy. As women laughed and used humour to talk about the absurdity of their lives, they built a sense of community through releasing these shared experiences.

### **Building Community**

The kit-making circles built a sense of community. Women stated that they felt supported as a woman within a community of women. Some recognized the connection that they had with other women.

*Hey, that could be any of us. It is OK if she wants to crash with me. I might lose some stuff, but what the hell. I would rather she be safe.*

Many indicated that they liked meeting and knowing other women who could serve as a resource for when they were outside of the group. For example, they shared information with one another about a particular women’s group that met every Saturday morning.

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<sup>9</sup> The term “tweaking” used here refers to smoking crack and its associated consequences.

By discussing the gaps in services and resources, women were often politicized making connections based on their common experiences, including their experience as women living in poverty.

### **Kit-Making Circles as Facilitating Change**

By discussing the gaps in services and resources, women were often politicized making connections based on their common experiences, including their experience as women living in poverty. As one participant commented, *“There are only 6 [detox] beds for women, that is not enough.”* Fresh ideas were shared, emphasising women’s safety and harm minimization, such as the need for *“self-defence classes.”*

Another idea was the creation of a *“bad dope<sup>10</sup> sheet”* to circulate so that people who use crack would be aware of current trends on the street and how to use crack more safely. The women talked openly about the need for testing strategies that would tell them what was in the *“dope”* so that adverse reactions could be avoided.



Pigeon Park  
*Photo by Mike*

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<sup>10</sup> The term “dope” is commonly used interchangeably with different types of street drugs. In the context, “dope” refers to crack.

## KIT CONTENTS

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*“It’s a safe thing, it’s a healthy thing. It says, ‘I care’ because other people care. It made me feel safe.”*

This next section focuses on the content of the kits. It is based on interviews with people who received at least one safer crack kit. In total, 27 interviews were conducted with 17 women, 1 transgendered individual and 9 men.

### **The Kits in General**

Many people we talked with shared their enthusiasm about the first time that they received the kit.

*It was like a breath of fresh air, it was everything you possibly need.*

*I was surprised, pleasantly surprised that there was so much in there and it sort of had everything covered in a little kit. And it was in a black bag which makes it more anonymous... I’m all about confidentiality. That right away struck me, first thing. I thought, hmmm, a black bag. Well nobody’s going to know what’s in it. And you know, it makes somebody feel more comfortable accessing it and carrying it around on them.*

In addition, their impressions of the kits were positive. As one woman reported, “they are what we need on the street.” Another participant said,

*Overall, I think it’s a wicked idea. It saves a lot of complication, a lot of looking for a pipe. You’ve got everything you need. You’ve got a lighter, you’ve got a pipe, you’ve got a screen, what more do you need?*

Some people we interviewed recognized and articulated how receiving the kit helped them minimize the risks involved with using crack. In the words of one person, it was “an incentive to do a safer method.”

*This is solving the problem because I see people using antenna [from] on top of cars. Well that can’t be healthy for you, right? Like this [smoking crack] is bad enough for your lungs, you start adding other stuff, right? It’s not good.*

*It enables you to have a new pipe almost every second day. And then you always have new hoses [mouthpieces], new screens, so...and the thing you know we have to worry about nowadays with all these diseases that we could contract with old pipes, or sharing.*



In addition, some felt that the distribution of the safer crack kits let people know that others care about them. As one woman pointed out, *“It’s a safe thing, it’s a healthy thing. It says, ‘I care’ because other people care. It made me feel safe.”* However, one person who received a kit had mixed feelings about the kit distribution, *“I think it’s good that they are giving them out for people to use, but the other part of me says it’s wrong, [it’s] condoning the smoking of rock.”* Nonetheless, this person’s view was the exception among the people that we interviewed.

## 1. Pipes

*“Oh, I love them. It’s a Pyrex pipe, or I don’t want it at all. They’re thicker and when you put heat on them they don’t crack as easy as the regular glass pipes. They [glass pipes] break way too easy and they crack. And you can only put so much pressure when you pack your Brillo, or you’ll break your whole pipe, it shatters, right?”*

## Individual Kit Items

The people who we spoke with were asked to comment on the kit contents. As it turns out, there was much variation in opinions. When asked, some believed that certain items were more important, usually the pipe and the lighter.

Here is some of what people had to say about the different kit items.

- **Pipes**

Nearly everyone we talked with gave positive feedback about the Pyrex pipes.

*The kind of pipe these are, they don’t crack as bad as some of them that you can buy on the street.*

Most individuals appreciated receiving a clean pipe. Some emphasized the link between having their own pipe and practices of harm reduction and safer crack use.

*I don’t really share pipes, I give them a totally different pipe if I share pipes. I have two pipes, one for the public and one for myself.*

*Well, it’s safer, instead of like people buying used ones. I used to buy used ones and it was black [charred with use].*

- **Lighters**

Most participants agreed that receiving a lighter was handy as well as a healthier alternative than using matches. Some people noted that having a lighter meant that it was no longer necessary to find a “light” elsewhere.

## 2. Lighters

*“But just having the light, you know what I mean? Because a lot of the time if women are on the street and they just want to have a toke and warm up, often they won’t have a lighter. And then you have to search around and find, hang out and put yourself at risk, legally having police see you borrowing somebody else’s lighter. And it costs money too when you can’t afford it, right?”*

## 3. Tip Card

*“I found them useful in explaining to people, because I used to do outreach. And I participated in the harm reduction conference, so I’m fairly knowledgeable. So by my saying a piece of information but then having it backed up [on the card], made it invaluable, right?”*

Another woman underlined how she could be more discrete about her crack use by having her own lighter. As she describes it, she was less likely to draw attention to herself.

*You’ve got a backup. At least you don’t have to run around going door to door in the middle of the night. ‘I’ve got to finish my toke<sup>11</sup>, anybody got a lighter?’ Yelling through the hall. ‘I need to borrow a lighter somebody.’ It’s embarrassing and plus, you’ll know if there are police in the building too. That happened to me one time.*

Although some people liked the brand of lighter because the flame was adjustable, others reported bad experiences with these lighters. One person noted that the lighters in the kits were *“worse than the ones I buy for a dollar at the store”* and anecdotally it was reported that some lighters had exploded.

- **Tip Card**

People had much to say about the Tip card. Some described them as *“informative”* and useful in working with others. Other comments about the Tip card were less favourable. For example, some people felt that they already knew this information. A few people had *“no use for them.”*

*Those [cards] are for rookies<sup>12</sup>, for those that don’t know how to use a pipe, that’s where you start learning because I’m not going to teach you. I didn’t read it, didn’t care because I already know how to use a pipe.*

*I didn’t read them because I’m a long-term user and I know all the ins and outs, right? That’s why I just left them in the bag.*

One person had another take on the Tip card and suggested that including it *“promotes”* crack use. Some pointed out that some people did not read these cards and one person stated that people may *“ignore that [information] because they are too high to take care. They’re well experienced and so they got their way in that and they go by that.”* Another person pointed out that it was *“too much information.”* One significant challenge with these cards

<sup>11</sup> The term “toke” is a street term used to describe the act of smoking crack (i.e., to take a toke means to inhale crack fumes).

<sup>12</sup> The term “rookies” is used here to describe individuals who are new to crack smoking and the rituals associated with using crack.

#### 4. Resource Card

*"I know a 19-year-old who almost committed suicide the other day. And I gave her that [resource card] and now she's gone into treatment. I talked to her today, she called the number and she did the detox in 2 days."*

#### 5. Push Sticks

*"Umbrella, twigs and needles? Yeah it [push stick] works way better. It doesn't break and it doesn't chip off. It was like the perfect size so your dope doesn't get all on your chop stick, you know what I mean?"*

was for those who were not able to read the information, either because they had difficulty reading, were unable to read or because they needed glasses.

- **Resource Card**

In general, people conveyed positive comments about the resource card which was considered beneficial and practical. As one person put it, *"everybody needs these numbers at some time, right?"* Other comments included:

*The resource card for people using crack is really great because a lot of people don't know about different resources.*

Not everyone focused on the usefulness of the card. In fact, one person found a completely different use for this card. *I usually use them [resource cards] just to put my caviar [resin] on.*

One person described why both the Tip and Resource cards were not used by some people. In her opinion, it was important for people *"to learn"* how to use the cards which then led to taking the extra time to be safer.

*But the cards, some people don't realize that they are safety cards as well as a resource card. They just kind of look at it and throw it out. If they took the time to actually check it out which is what I try to tell people, to take a little extra time and see that there are reasons why they put it in there. And if you don't think it's useful, then maybe you can tell me something else that I could suggest to them, that you would like in there, that would be more useful.*

- **Push Sticks**

People's comments on the wooden push sticks varied. Generally the push sticks were considered better than nothing.

*Push sticks are better, they're clean and it's better than picking something off the ground and using it.*

Nonetheless they were far from perfect. One person reported that the wooden push sticks were *"too skinny baby."* And those who did use the wooden push sticks noted its faults:

## 6. Mouthpieces

*“The 2 mouthpieces is really good because then they can keep one to use if people want to use their pipe and they do lend it out because a lot of women don’t have a lot of money. And if somebody is using their pipe, they get to keep their resin and that’s how they stay high all day, right? So if they lend their pipe out all day long and have an extra mouthpiece to put on for other people to use, then they can switch mouthpieces. I think that’s a great idea.”*

*You get the tendency to catch the edge of the pipe and get slivers once in a while.*

*I wish it wasn’t a stick because it doesn’t take the resin off as well because there is no kind of a curve on it.*

In addition, a number of people found the wooden push sticks to be too long. As one person pointed out, *“Because the pipe was 3 or 4 inches long, and the push stick is eight inches, it’s sort of over doing it.”* Another participant focussed on the importance of being discrete with paraphernalia.

*It is a bit long for somebody who’s trying to keep things out of sight. I noticed that if I am transporting some paraphernalia from one place to another and I have to get there fast and I don’t want anybody noticing, I don’t want the police to notice this stick hanging out of my pocket, it gets seen, right? So if it’s a little bit smaller, it would be good.*

Wooden push sticks were especially problematic when used in combination with Brillo, *“If you’re using Brillo, you’re going to get little [wood] slivers and stuff in there.”* For a variety of reasons, some participants preferred using metal pushers rather than the wooden variety.

*And with the metal, you could bend it to also make it look smaller and then bring it back out in length if you wanted a long stick. So that’s one advantage to a metal push stick.*

- **Mouthpieces**

Many supported the idea of supplying mouthpieces. While the actual practices associated with these mouthpieces were not consistent, people recognized their valuable role in reducing harm.

*I don’t use the mouthpiece, if I do, if I’m using somebody else’s [pipe], then I use a mouthpiece.*

One person observed that the use of mouthpieces was based on availability.

*Everybody uses mouthpieces if they’re there, pretty well, especially now people are starting to get more involved because it’s a lot of sharing of pipes.*

## 7. Alcohol Swabs

*“To me I think the alcohol swabs not only are good for killing off the germs but they are good for cleaning the pipe too in between, or if a person wants to put new Brillo in or whatever. The alcohol swab cleans that bacteria right out inside of it, like all the gunk and stuff builds up.”*

While many recognized the benefits to using mouthpieces that included cooling down the tip of the pipe and preventing burns, others were critical of using mouthpieces. As one person noted, *“Usually you get a lot of phlegm in the mouthpiece and you suck it right back in.”* A few people noted the mouthpiece was difficult to apply onto the pipe. One person complained, *“I always seem to break the pipe when I’m putting the mouthpiece on.”* One man noted that the diameter of the tubing was too small.

*The mouthpiece was too small for the pipe. If there’s a size just marginally bigger, then it would work fine. You can sort of force it on dry or heat it. And then as I said, you sort of place it on and work it on. If you step up the size, you can just take it and insert the pipe into it, and it fits well.*

One person observed that mouthpieces were rarely used because the residue was difficult to remove from it.

*A lot of people down here, very few of them actually use the mouthpiece because if it’s even only that long, like 2 inches long, if you get a piece of residue in there and you can’t scrape it or push on it, it drives you nuts.*

- **Alcohol Swabs**

A few people talked about using alcohol swabs as a part of their daily crack use.

For others, alcohol swabs were linked with IV drugs and therefore seen as not necessary for their crack use.

*Alcohol swabs help if you use needles, I don’t use needles very often. They’re good for cleaning up your fingers and cleaning up the pipe if you really want to sterilize your pipe. But I don’t because I’m the only one that uses my pipe. My girlfriend is the only one that uses my pipe so I don’t bother sterilizing it.*

Others used the swabs for different purposes. *“I use alcohol swabs for my face, under my eyes, I get black or whatever. I get my hands clean with them.”* In fact, some people were not sure why alcohol swabs had been included in the safer crack kit.

## 8. Bandages

*“The screens can cut you and so the Band-Aids are a good thing.”*

## 9. Condoms

*Well, I like the fact that a working girl is going to get condoms in there, that’s always a safety thing, right?*

*Well what’s the use [of alcohol swabs]? What are you going to do, put it on your lips? That’s not going to stop the burning I don’t think. And it would probably catch fire and then your lips would burn the top off.*

- **Bandages**

Most people appreciated receiving the bandages as a part of the kits. As one person noted, crack use was related to cutting oneself, *“The screens can cut you and so the Band-Aids are a good thing.”* One woman stressed their importance:

*Band-Aids are great because a lot of times people will be cutting themselves and/or they’re out there and they’ve got shoes [that hurt their feet]. And you know, they take care of their blisters and things like that, I think it’s a great idea.*

However, not everyone agreed that these were necessary items to include in the kits.

*Oh, I could care less about Band-Aids. I don’t want Band-Aids, like they’re always too tight or I can’t get it on right.*

- **Condoms**

Most often, it was the women we met with who supported including condoms in the kits. As one woman said it, *“Condoms are totally necessary.”* As such, condoms were viewed in the context of “safety” and considered important for personal relationships as well.

*A lot of people use condoms for their private/personal connections, not just being on the street. So to have them handy is a really good idea.*

However, another person saw no value in including condoms in the kits based on their personal circumstances.

*Yeah, that’s a totally different subject. That has totally nothing to do with smoking anything. I haven’t had sex in 20 years and I don’t really care about it anymore. I still smoke but I don’t have sex anymore. It’s a totally different concept.*

To another individual, including the condom in the kit was seen in a negative light.

## 10. Screens

*“The screens are good because they don’t burn like the other ones, like Brillo. And the Brillo, I’ve had caught in my throat I don’t know how many times. I’ve cut my fingers with it [Brillo] trying to break it apart.”*

*For one thing, this put me off right away because I don’t work the streets [survival sex work] so I thought this was kind of offensive for me. There are people in the East End that don’t work the streets. Yeah, they do say that is a good thing for some people. I don’t know if everyone thinks the same way.*

Finally, several women described using the condoms for other purposes. In so doing, they shared their stories with some humour. As one woman said, *“I use them for hair ties, I put stuff in them, I put lots of things in them.”* Another woman described another use for condoms.

*You know how people share it when they’re mouth to mouth blowing the smoke in, it’s the same thing with a condom. You blow the smoke in there and suck it back. Same thing, “seconds<sup>13</sup>”, that’s what I use the condoms for.*

- **Screens**

People had differing experiences and opinions regarding the use of the screens. During the interview, the use of screens was often compared to Brillo. As one woman noted, *“Yeah, screens are better because they make your dope taste better.”* Some participants preferred screens, noting that screens were less harmful than was Brillo.

*Screens are better for your lungs and then that’s harm reduction.*

Others did not like using screens supplied in the kits for different reasons. Many people commented on how screens were difficult and time consuming to insert compared to Brillo.

*In the last case scenario, I would use screens. But every time you heat them, they [the screens] get small so they run up and down your pipe every time.*

*I’ve used your screens. They are questionable because they do block easy, the drug, the oils do block the screens quicker. And so it’s very difficult to get your toke because the holes get blocked up.*

Although one person experienced challenges using the screens, he also noted that it was safer to use them.

<sup>13</sup> The term “seconds” refers to the act of “recycling” crack smoke fumes; the first inhalation is straight from the crack pipe, the second from someone else’s mouth or in this case, from the smoke fumes gathered from the inside of the condom.

### 11. The Bag

*“You can recycle and use the plastic bag again. And I’m about that too, so saving money.”*

*The screens when you use them and you heat them up, it cracks the pipe and especially in the cold, they heat up differently. The Brillo cools down kind of like that [snaps finger for effect]. You can take the screens out and wash them, or change them. People don’t like the screens. As I said, I’m not a proponent of it, but no more black things spitting up, no more black tongues, um, I’m sure it will let me keep my teeth a couple of years.*

A solution for some was therefore to use the screens and Brillo together.

*I’ve seen more and more people put a screen and then Brillo and then another screen. They’re still using Brillo but they’re using screens a bit. It is a good combination. I’ve used it so, it works quite well.*

- **The Bag**

A number of people had positive feedback on the bags used for the kits. Their comments were somewhat unexpected during the course of the interviews and point to the usefulness of the entire kit.

*You can put the resin on it or, I liked it because it’s like a, it has a mirror effect, it’s like a mirror effect, camera.*

A few people suggested using a different type of container for the kit contents. One person suggested a metal container as something “solid” that would prevent a pipe from breaking if dropped. Another person suggested,

*Actually like a cigarette package or a tin would be good. It’s so much safer. You have it in a plastic bag and if you put it somewhere, you could have put it in your pocket or whatever. And you might sit on it and break it [the pipe] and cut yourself or whatever, right?*



*“I know all the tips and that. I give them [cards] to other people that are outside or whatever.”*

### **What Happened to Items that Were Not Used?**

The kit items that were of no use to some people (e.g., condoms) ended up in the garbage. One woman said that she “left them [unused items] at my friend’s, that’s where I usually go, so I left them there.” Interestingly, there were no complaints about kit items littering the streets. People were encouraged to pass unwanted kit items to other people and some participants talked about giving certain items away.

*I know all the tips and that. I give them [cards] to other people that are outside or whatever.*

### **Suggestions about Modifying the Kits**

A number of people made suggestions about how the kits could be improved. Some offered their ideas about what else could be included in the kits. For example, one person believed that “a blue container of sterilized water<sup>14</sup>” would be good for people who burned themselves. Someone else questioned, “I didn’t understand why there wasn’t gum, even a mint or something because sometimes your mouth gets so dry afterwards.”

As for lubricant, there were opposing views about whether or not it should be included in the kits.

*You should have some lube [lubricant] in there, a couple of little containers. When you’re younger, you don’t produce as much lubrication as you would if you were a more mature woman, so that was part of the problem for me - I used a condom and it broke.*

This was in contrast to another participant who said,

*But you wouldn’t want that [lubricant] in there because it can damage rock. Because somebody had it on their hands one time and got it on the stuff [the dope]. And it just ruins it.*

Other participants suggested extra quantities of existing kit items. One person thought that including more than one pipe would be a good idea. Some ideas were based on personal experience of losing certain items or on having screens that were no longer useable.

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<sup>14</sup> The “blue container” mentioned here is a commonly distributed harm reduction outreach item for individuals who inject drugs.

*It should have more of that silver stuff [screens] because it only lasts a couple of times and that was really bothering me because once we run out, we have a hard time bumming Brillo in the middle of our session.*

*I think you should have another chop stick for emergency. I seem to always lose my chop sticks or push sticks. I was almost dying, 'where the hell did my chop stick go?'*

Another woman's suggestion focused on having extra copies of Resource cards in the kits to permit sharing a card with others.

*You should have duplicates [Resource card] so if they see somebody that's not necessarily open enough to even reach out and try and get a kit, that they can at least have the resources and stuff like that from someone that has an extra card.*

Several people suggested changes to the existing items such as adding instructions for screens onto the Tips card, making the print larger on the cards and modifying the shape of the screens to make them easier to insert. In addition, one woman had specific suggestions related to the resource cards:

*You've got to make sure you have more 1-800 numbers [on card] because a lot of the women don't have any money, they don't have a quarter for the phone. And there is not always a free phone. And also, I know you have activities groups, you should put the PWN [Positive Women's Network] on here. Because it is a women's only space, it is a women's safe space and they also have a food bank. They kind of work within the harm reduction ways as well, right?...You need to add some groups outside of this area [on card].*

In conclusion, consultation with women at the kit-making circles and interviews with people who use crack highlight once again how important it is to work with people who use crack in implementing service delivery decisions that directly affect them (e.g., decisions about what to provide in the crack kits).

## KIT DISTRIBUTION

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*“Also for some new user, it’s good to have a moment to sit down and spend a little bit of time with that person. When you are isolated that means you and that person have space to do it [engage] together.”*

In order to evaluate the distribution outreach process, we conducted focus groups and individual interviews with outreach workers.

It is clear from people’s comments that the kit distribution outreach had a positive impact on members of the community. One outreach worker pointed to how the kit distribution made it possible to connect with people, suggesting that this contact would not have happened otherwise.

*The good part is like sometime some people they never come to us before, but they have now because they need the kit and we have a chance to talk to them.*



*“You can’t force teaching, right?...It depends what group you are going into and it depends what time of day, what’s happening on the street, it depends on a whole bunch of things and it’s out of your control.”*

Homeless sleeping on church steps

*Photo by anonymous Vancouver street photographer*

### **Engaging Clients**

There was a sense among outreach teams that street engagement was most useful when it was a one-on-one encounter in a quiet setting that permitted a teaching moment:

*Also for some new user, it’s good to have a moment to sit down and spend a little bit of time with that person. When you are isolated that means you and that person have space to do it [engage] together,*

*“I was surprised that people that smoke for a long time, they don’t really know how to do it properly, but that is [a] good moment of teaching.”*

*maybe just one or two persons with one or two nurses, or outreach worker.*

Given that outreach teams received a limited number of kits to distribute, one outreach worker noted how engagement with his regular clients became problematic when he no longer had any kits. Another challenge of engagement was a lack of predictable teaching moments. Situations and people varied constantly. One outreach worker noted how teaching opportunities needed to be tailored based on individual interactions.

*Absolutely, you can’t force teaching, right? I think as [X] said, it depends what group you are going into and it depends what time of day, what’s happening on the street, it depends on a whole bunch of things and it’s out of your control. And so yeah, they may want to learn about Brillo one day and they don’t the other day.*

The outreach teams set out to engage with crack users about health behaviour and safer use. However, sometimes the distinction was blurred between the necessity of conveying health promotion messages and respecting personal choices. One peer outreach worker noted how drug use ritual was “*personal*,” and no one had the right to tell people how to use, “*To each his own, they just do whatever.*” Someone else added, “*It’s not my place to push my ideas on someone else.*” It was particularly difficult for some peers to suggest that others change their drug use behaviour.

Opinions varied among outreach workers regarding strategies of engagement. Some maintained that being introduced to the kits on one occasion was sufficient. One outreach worker did not support the idea of engaging with people, rather, felt kits should be given out “*with no questions asked.*” There was a sense that long time crack users were the experts. In contrast, one person noted the limited knowledge regarding safer use among some long term users.

*I was surprised that people that smoke for a long time, they don’t really know how to do it properly, but that is [a] good moment of teaching.*

### **Educational Challenges**

One significant obstacle experienced by outreach workers was in the area of passing on educational information. As

one outreach worker explained, there were assumptions based on people's level of knowledge.

*A lot of participants didn't ask how to insert the screens and they weren't necessarily explained how to insert the screens, if people that were giving out the supplies assumed that you knew about this.*

Encouraging people to change their crack use practice was seen as challenging by outreach workers given that many people were not receptive to much interaction.

*I think an honest and hard try is being made to supply people with a safer way to use. I really can't think of another [way], I mean, 'Would you like the package? Would you like me to show you how to use it?' You know, 'Can I help you with it? There's a little card in there' and stuff like that. People are like, 'No,' you know. 'Just give it to me, I'm gone.'*

### **Limited Availability**

It was often a challenge to limit the distribution to one kit per person as per the research protocol; many asked for more than one kit for a relative or partner, especially women with male partners.

*There's a ton of dynamics so how we work together in order that we don't be seen like this and we don't play the power game because we do have this bag of jewels here.*

The "one kit" strategy was not always possible when there were concerns for the outreach workers. Some teams went to great lengths to make sure each person only received one kit. There were strained dynamics in groups when some outreach workers followed the protocol and others did not.

The lack of availability of safer crack kits was one of the biggest challenges faced during distribution. Supplies were limited; kits were considered commodities and sometimes sold. Every team experienced a demand that far outweighed supply. As one person explained, "You give one person one and they come running."

### **Safety and Swarming**

The peer outreach workers were recognized (even on the days when they were not working on the project) by many in the DTES as associated with kit distribution. Once they were recognized, people would run towards them. In

these situations, it was difficult to engage in education, demonstrations, referrals, or collect data for the tally sheet. As one person noted, *“they just want the pipe and go.”* Someone else pointed out,

*One of the most important things that I used to do, if someone was really interested in using the pipe and the screens is to show him or her how to do that, but it takes like two or three minutes. So meanwhile, the outreach team is surrounded by people.*

At times, “swarming” occurred when outreach workers found themselves instantly surrounded by people wanting kits. One person described how “the word got out” about the kits, continuing that *“You have them for five minutes and sometimes they’re gone.”* For this reason, mobile outreach seemed preferable. As one outreach worker noted, *“we have the little bit of advantage that [we can], roll up the windows and drive to the next block.”*

*“One of the most important things that I used to do, if someone was really interested in using the pipe and the screens is to show him or her how to do that, but it takes like two or three minutes...So meanwhile, the outreach team is surrounded by people.”*



DTES Alleyway  
Photo by Campbell

The possibility of arrest cast a shadow of fear among some outreach workers, both providers and peers. For example, there were concerns about possible arrest by engaging with crack users during screen demonstrations and showing someone how to put kit items together while

*“Just when we were up by the Carnegie [community centre] in the alley there and this one guy was almost at the point where he was going to start throwing punches almost... You just need to be aware of that, any time you come up to people, you don’t know what they are going to do, we’re in a rough area.”*

using crack. In addition, some peer outreach workers felt unsafe having kits and pipes on them because of past bad experiences with the police: *“I feel safer in the alley ways than I do on the street. But that’s through all the years of [outreach] work I’ve done.”*

In addition to the dangers of the street in general, safety was further compromised by someone receiving a kit:

*Just when we were up by the Carnegie [community centre] in the alley there and this one guy was almost at the point where he was going to start throwing punches almost. You know in a case like that, you want to just get yourself away from there and you don’t want to stop, you keep going and he’s talking at you bitching, so just get out fast, then go back. But in a situation like that it seems like that’s the easiest way to handle it. You just need to be aware of that, any time you come up to people, you don’t know what they are going to do, we’re in a rough area.*

Street outreach at night time was especially dangerous and therefore was only offered by mobile outreach. This was the best time to reach more vulnerable and marginalized individuals.

*“The majority of people in this area are users, but without a doubt we have offered kits to people that were terribly offended by it. It was touch and go. It was back up, some people get offended easy, you know, you apologize.”*



New Brandiz Bar  
Photo by Mike

### **Reaching Clients**

Some teams spoke of accessing a wide range of people who were more isolated by going a few blocks from the core of the DTES or down side streets and back alleys. However, in some situations it was challenging for outreach workers to determine the appropriateness of

approaching people they saw on the street. Given that it is often not clear who uses crack, some people were extremely insulted when approached:

*The majority of people in this area are users, but without a doubt we have offered kits to people that were terribly offended by it. It was touch and go. It was back up, some people get offended easy, you know, you apologize.*

It was also clear that distribution was not reaching all crack users. One person elaborated,

*The guys that come into town just for the weekend or whatever, truck drivers or something like that. There are some people like the weekend warriors that just show up just that time, they're in and they're out.*

*"Peers trust peers. And that's what they look for, if they know you already. They've already got a certain amount of trust for you. People that they don't know, first thing that goes through their mind, they will think you are a cop, and it's hard."*

### **Peer Outreach**

A challenge for peer outreach workers was the ways the kits could trigger their own use. One outreach worker noticed the struggle some others had negotiating their outreach responsibilities and addiction saying, *"they were struggling with the desire of doing it [distributing kits] as fast as possible, getting this started and then getting high [competing with] the desire to do it well."*

The kit recipients who knew the peers were likely to trust them, making this one of the most positive aspects of peer outreach. As one peer outreach worker explained,

*Peers trust peers. And that's what they look for, if they know you already. They've already got a certain amount of trust for you. People that they don't know, first thing that goes through their mind, they will think you are a cop, and it's hard.*

*"I get a good feeling out of it myself, you know what I mean, I really do. For years I used to just take, take, take. And now, I feel like I'm giving back, it's not much but at least I'm giving back."*

In this way using peers to distribute the kits was a benefit, people receiving them felt safe. In addition, many of the peer outreach workers were already involved in working in the DTES. One peer emphasized, *"it's because we all do work down here, we know a lot of people, we're in the alleys a lot and it's our volunteer work that we do down here that make us recognizable and trusted."*

The peer outreach workers themselves often felt a personal benefit. For some peers, this work felt like *"giving back"* to their community. There was also a sense of pride and responsibility that came with working on the project for peers within the community.



*“For a while there you’re like this great nurse because you’ve got these great things. And then you’re a bad nurse because you won’t give them out.”*

*I get a good feeling out of it myself, you know what I mean, I really do. For years I used to just take, take, take. And now, I feel like I’m giving back, it’s not much but at least I’m giving back.*

### **Integrated Outreach**

Some outreach teams were associated with existing outreach services in the DTES. These teams were effective in teaching people who use crack about safer crack use, and there was consensus that giving out the kits not only helped make new contacts but also allowed them to reconnect with clients they already knew. At the same time incorporation of safer crack kit outreach presented unique challenges. For example, kit distribution went against some agency mandates while the kit often became the main focus of the outreach connection. As one outreach worker shared,

*When you have something and it’s a hot commodity... well people would come up and say ‘Do you have a crack kit,’ right? That’s all they want, all they want. And even if you try to, you know, ‘Well hey, how’s it going?’, introduce something else, it didn’t really fly, they want, they’re fixed on the crack kit.*

Other outreach workers agreed with this describing it as a “push-pull situation” with “interesting” dynamics. *“For a while there you’re like this great nurse because you’ve got these great things. And then you’re a bad nurse because you won’t give them out.”*

*“I think availability is [the] main issue because we just do it now...If they [were] available in more places even at Life Skills Centre and if it [was] available and accessible, there would be less pressure on us when we do outreach.”*

### **Future Suggestions for Distribution**

Many involved with outreach had suggestions for improving this process. The main issue was the limited availability of kits. One idea that came up frequently was to set up kit distribution as a “pipe depot” akin to the needle depot, in which users could get new pipes, dispose of the old used glass safely, as well as receive information. This was proposed as a solution for those who “have to scramble and scurry to get pipes” and who often ended up borrowing pipes.

*If it was something that was established and available, it would quite quickly become almost identical to needle distribution, where the counselling and teaching and nursing moments need to happen, happen, and when they don’t, they don’t.*

Underscoring the lack of kits available and the incredible need of this harm reduction service in the area, some

people suggested that making kits available at a variety of agencies in the DTES in combination with outreach would be preferable.

*I think availability is [the] main issue because **we** just do it now. But if every clinic had it, Downtown clinic, Pender clinic, if they have it there plus VANDU<sup>15</sup>, plus Contact Centre, plus Insite<sup>16</sup>. If they [were] available in more places even at Life Skills Centre and if it [was] available and accessible, there would be less pressure on us when we do outreach.*

Many people also had suggestions about how the kits could be made more useful. Some outreach workers suggested carrying individual supplies instead of the whole kit. As one person stated, “*Yeah I think things should be individualized because the pipes are by far the most popular thing.*”

### **Client Reactions**

Despite the challenges, the experience of distribution and outreach was a positive one. Many outreach workers told stories of how appreciative people were to be receiving the kits: “*They are ecstatic. They can’t believe that someone’s actually going to be giving out something like that for free.*”

Outreach workers indicated that they were surprised how much the kits meant to some recipients, “*It’s almost embarrassing when I hear people say ‘God Bless you!’...like you’ve given them a million dollars or something.*”

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<sup>15</sup> VANDU, Vancouver Area Network of Drug Users is a local drug user network involved in service provision as well as political activism in regards to the rights of people who use illicit substances.

<sup>16</sup> Insite is Vancouver’s Safe Injection Site, located in the DTES.

## CHANGING CRACK USE PRACTICES

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*“But now I make sure I carry my own mouthpiece with me. And if it’s ever an option, I usually try not to share other people’s pipes. If I absolutely cannot live without [sharing] it, then I’ll have my own mouthpiece at least to put on there.”*

A number of kit recipients talked about changes they had made in their practice of crack use as a result of receiving a kit. One person credited the information on the Tip card with being able to “slow down and not to use every day.” Another person noted the following change, emphasizing the use of a mouthpiece on a regular basis.

*I mean I’ve been guilty of using whatever pipe was convenient and closest, whoever had whatever. And I was just lucky that I didn’t catch anything from it. But now I make sure I carry my own mouthpiece with me. And if it’s ever an option, I usually try not to share other people’s pipes. If I absolutely cannot live without [sharing] it, then I’ll have my own mouthpiece at least to put on there. And I usually carry a couple of alcohol swabs with me actually too.*

*The safety tips gave me an idea on how to slow down and not to use every day.*

*“Because it’s almost like an insult to me because I’ve been smoking crack for 13 years...12 or 13 years. For somebody to demonstrate to me how to load a pipe would be disrespectful in a way.”*



Smoking crack on West Hastings street  
*Photo by anonymous Vancouver street photographer*

However, some individuals indicated that they had no intention of changing how they smoked crack. In particular, a number of people we talked with continued to use Brillo. As one person noted, “I’m used to one thing, I don’t change...don’t even ask me because I won’t change.” At the same time, there was recognition that others might be

receptive to changing. *“Yeah, some people are open to change, but I’m not one of them.”*

One person was adamant that he would not change his crack use practice after years of doing it a certain way. In fact, he was offended by the idea that others would show him *“how to.”*

*Because it’s almost like an insult to me because I’ve been smoking crack for 13 years... 12 or 13 years. For somebody to demonstrate to me how to load a pipe would be disrespectful in a way.*

Rather, some people preferred to rely on what they already know based on years of drug use. *“But I pretty much know like the do’s and don’ts.”* Another person stated, *“I know all that shit already anyways and you know, why would I need that?”*

For others, continuing to use Brillo was a matter of convenience and saving time. As one person stated, *“We’re not thinking about safety when we want [to use], we’re just thinking about our dope. We need a toke.”* Another person indicated that she was in too much of a hurry to get high and said, *“I didn’t want to play with it [inserting screens].”*

A number of people simply preferred Brillo. As one person explained, *“Brillo is still better than screens because it stops the oil from running through, whereas the screens, the oil runs right through it.”* Several people maintained that they planned to continue to use Brillo.

One participant’s first experience using the screens had been *“disappointing”* which influenced her plans about using screens in the future.

*I just, I didn’t get anything that I was hoping to get out of it. It was really disappointing. Because I didn’t do a lot of crack yesterday and to have, sometimes if you have some and you’re starting fresh with something you’ve never tried and you use it, and you don’t get what you are expecting, it’s even more disappointing, so I was a little bit bummed out by that. I won’t do that again because I’ve tried it with the screens and every time I’m disappointed.*

Yet another person was open to the idea of using screens instead of Brillo based on being told that it was safer:

## *Lessons Learned: Safer Crack Use*

*“Yeah, I know because I went home and I was like trying it [to use screens]. You’ve got to always try something new, right? And if it’s something that is better for me, then sure I’ll do it.”*

*Yeah, I know because I went home and I was like trying it [to use screens]. You’ve got to always try something new, right? And if it’s something that is better for me, then sure I’ll do it.*

Having a positive experience with the screens influenced an individuals’ choice to use them over Brillo. Some preferred the taste of using the screens. Nonetheless, this change from using Brillo and starting to use screens was gradual for some.

*I’ve always used Brillo but I’m finding that more people are using screens and they’re telling me, and they are showing me, ‘You should be doing it’ which I’m doing that more often than I used to...the screens are better for your lungs and I have emphysema, so I should be using the screens more often.*

*“I’m finding that more people are using screens and they’re telling me, and they are showing me... the screens are better for your lungs and I have emphysema, so I should be using the screens more often.”*



The Ovaltine Café, DTES  
*Photo by Mike*

Others reflected on what they had personally found helpful in order to make changes that resulted in safer crack use. One person emphasized how being “*aware*” of health issues related to crack use had played a role in his own safer crack use practices. For some, this involved incorporating what they knew about certain items, such as the screens. *“There is no such thing as safe crack, if I can minimize the damage, at least, then I’m on my way, right?”*

Several noted significant changes regarding their practice of sharing pipes. One person indicated that he was happy

to have “a nice pipe” and that he no longer shared his pipe with anyone. Another participant added to the benefits of receiving a pipe and subsequent changes in her use, stating, “*The benefit being that it’s safer, you know, you’re not using all broken up pipes and we’re not sharing. Often, I know myself now I’m not sharing my pipes like I used to because of availability, right?*”

Indeed key elements were mentioned frequently as essential to changing crack use practices: availability, repeated messages, and demonstrations. Availability of kit items was seen as a key component of changing practices.

*“The more times you’re told, the more times that people are encouraging you [to use more safely]. You have the van going around telling us, now that I have a concept, I will be telling people, you know, to make a change.”*

*Well, screens aren’t very available and how often does crack kits come around? I think once I got one off the street. So if they had screens available, then maybe they would be used more.*

Several people emphasized how important and helpful it was to hear the safer crack use message on a repeated basis from peers and outreach workers in order to change personal crack use practices. One participant noted how she shared the message about safer use with others.

*Well probably the more times you’re told, the more times that people are encouraging you [to use more safely]. You have the van going around telling us, now that I have a concept, I will be telling people, you know, to make a change.*

Demonstrations with pipes and screens were also described as beneficial in terms of changing practices. As one participant noted, this was a process that took time.

*She [outreach worker] showed me how to wrap, fold the screen, basically once she showed me that, I still didn’t listen and use it. But after that, I started to, question the Brillo more. And she showed me, and you know, she just showed me what was in there [the kit] and showed me how to use the screen and that it was better for you. And I took her advice in the end, it took me awhile.*

## THE SURVEYS: DOCUMENTING THE EFFECTS OF THE SCORE PROJECT

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We conducted two surveys, one prior to kit construction and distribution and one after the program had been running for one year when most of the kits had been distributed. The survey focused on crack use practices and knowledge about safer crack use. Findings from the first survey suggested the high incidence of daily and weekly crack smoking practices, highlighting the need for less harmful non-injection drug using equipment including: Pyrex stems, metal screens, mouthpieces and wooden push sticks. The lack of availability of mouthpieces coupled with the high incidence of sharing practices particularly among men confirmed the need for mouthpieces in the DTES as well as a more in-depth exploration of the dynamics of sharing practices.

After one year, individuals had modified their crack smoking practices in the direction of “safer crack use” (e.g., using a mouthpiece), (See Table 1). However “sharing practices” between users still persisted. For example, most participants reported they had shared a mouthpiece (61%) and a pipe (77%) with people they knew and over one third shared mouthpieces (37%) and pipes (45%) with people they didn’t know. One noteworthy change was an increase in the number of people who indicated that they preferred to use a mouthpiece. However, while use of “safer” items had increased at one year, shared use of these items also increased, pointing to the need for more education about sharing practices.

The inconsistent practice of safer crack use suggests that there is a need for more education and awareness about safer smoking practices as well as consistent messaging about these practices from credible sources, both health care providers as well as peers in the community.

While the use of metal push sticks remained the most common method of scraping crack resin, use of wooden sticks (safer) and plastic rig plungers (unsafe) had increased after one year. While 100% of the survey participants reported smoking crack, only 39% reported injection drug use, suggesting that over 60% of these individuals may not be reached by other harm reduction initiatives such as needle exchange.

While many participants engaged in safer practices such as buying from someone they trusted (95%) and letting their pipe cool down (91%) in order to decrease risks of burns and split pipes, individuals still reported smoking

**Table 1: Changed Practice**

<b>Smoking Practices</b>						
	<i><b>Never/ Almost Never %</b></i>		<i><b>Sometimes %</b></i>		<i><b>Usually/ Always%</b></i>	
	<b>Pre test</b>	<b>Post Test</b>	<b>Pre</b>	<b>Post</b>	<b>Pre</b>	<b>Post</b>
Use Brillo ®	2	3	7	6	91	91
Use Pyrex pipes*	8	5	33	13	59	82
Use screens	N/A	55	N/A	16	N/A	29
Use pipes with splits or cracks	52	45	30	37	18	18
Use mouthpiece*	25	15	22	15	53	69
Use a used mouthpiece*	63	55	28	24	8	20
Use a used pipe*	45	42	42	29	13	30
Pipe explode or break apart	59	52	29	27	12	21
Obtain own crack	4	5	7	3	89	91
Find pipe when needed*	8	3	16	8	76	89
Find mouthpiece when needed*	25	10	24	8	49	82
Prepare own pipe	5	2	8	5	86	93
Smoke with others*	18	11	34	21	48	68



outdoors in an alley putting them at higher risk for arrest, violence and manipulation.



The Balmoral hotel and pub  
*Photo by Mike*

The inconsistent practice of safer crack use suggests that there is a need for more education and awareness about safer smoking practices as well as consistent messaging about these practices from credible sources, both health care providers as well as peers in the community.

### **Safer Crack Kit Use**

Over half of survey respondents indicated that they had experienced trouble finding a kit. These results are not surprising in light of the reports from those involved in distribution about the difficulties of outreach with this population. Of those who had received a kit:

- People doing outreach (52%)
- Friends (18%)
- A group/workshop (17%)
- Street nurses (15%)
- Mobile outreach (15%)
- Kit-making circle (9%)
- Family member or partner (5%)

While approximately 10,000 kits had been distributed by one year, not everyone had received a kit, 29% of survey participants reported they had never received one.

We asked those who had received a kit which of the safer crack kit items they had used regularly. The percentage of people who used each item follows:

- Pipe (99%)
- Lighter (98%)
- Mouthpiece (79%)
- Condoms (59%)
- Wooden stick (58%)
- Alcohol swabs (58%)
- Bandages (53%)
- Screens (42%)

In addition, 74% of kit recipients found the safer crack kit Tip card useful, and 66% found the Resource cards useful. Again, these numbers reflect much of the sentiments reported in the interview data.

When asked about the types of services and supports that people believed they needed, the most common responses included counseling services (which incorporated alcohol and drug counseling services, emotional counseling, and mental health services), “a safe place to smoke” and smoking equipment.

### **Supports and Services**

After distributing more than 10,000 kits, the majority (65%) of individuals indicated that they had become aware of safer crack use compared with less than half of the sample at baseline (47.5%). This information about crack was obtained from various community agencies, community workers, educational posters or community meetings. We found an increase in the awareness of services geared towards crack users (up from 28.2% to 34%). Many participants (43%) reported that no one had ever reached out to offer them support or help. When asked about the types of services and supports that people believed they needed, the most common responses included counseling services (which incorporated alcohol and drug counseling services, emotional counseling, and mental health services), “a safe place to smoke” and smoking equipment.

### **Enforcement**

At one year, almost one fifth of the sample (19%) reported that they had had their kit taken away by the police. Almost one half of individuals surveyed (43%) reported that the police had smashed their pipe, (an increase from the beginning of the project) and one third (32%) reported that the police made them smash it themselves. Of those who had had the experience of having their kit taken or pipe smashed, 14% reported that their pipe or kit had not been used.

### **Limitations**

While these surveys documented noteworthy trends in crack use practices, there are limitations to interpreting the results in relation to the SCORE project. As this survey was a cross sectional snapshot of a population, it is difficult to attribute claims about changed practices in crack smoking behaviour. In addition, many of the individuals surveyed at year one had not received a crack use kit from the SCORE project. Despite the implications for the generalizability of our data, it is interesting to note that while 14,000 kits were ultimately distributed in the DTES, there were clearly populations within this jurisdiction who did not gain access to the kits.

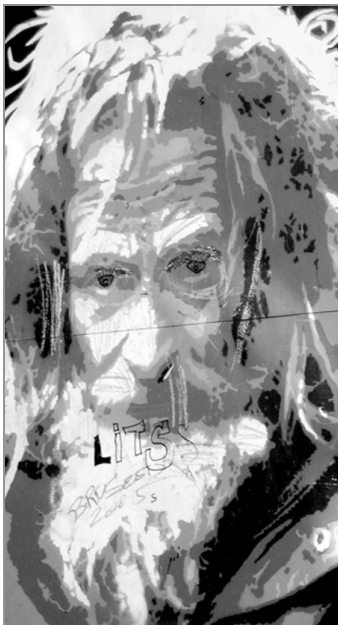
### **3. WHERE ARE WE AT NOW?**

Since the SCORE project began, the social environment in the DTES has worsened. Gentrification and lack of affordable and safe housing, and violence against street-involved women continues unchecked. As mentioned at the beginning of this report, while the Vancouver Police are on record as being supportive of harm reduction in general and the Supervised Injection Site in particular, they were not supportive of the SCORE Project. However, the new chief constable of the Vancouver Police Department, Jim Chu, may provide an environment of change. In November 2007 the Vancouver Police Department issued a formal apology to DTES residents. The apology stems from a series of complaints about abuse by police officers against poor people in the DTES. It remains to be seen whether or not the new chief constable will support ongoing and newly emerging harm reduction initiatives in the DTES.

Harm reduction services for crack users are under funded and scarce. There have been no comparable provincial initiatives for prevention, education, and harm reduction programs for crack in British Columbia.

On the provincial level, crystal methamphetamine continues to be flagged by the government of B.C. as the most important illegal drug to be addressed. Although “meth” rates are high for street-involved homeless youth in Vancouver, crack use is higher across the board in national, provincial, and local drug use rate surveys. Rather than contribute to ongoing debates about which drugs need to be more fully addressed at this time, we wish to point out that stemming from sensationalist media reportage from early 2000 to 2005 about meth use and production in British Columbia, a Crystal Meth Secretariat was established under the Ministry of Public Safety and Solicitor General and crystal meth task forces were established throughout B.C. as a Ministry of Health strategy. In November 2005, B.C. Premier Gordon Campbell also announced a new \$7 million dollar initiative in response to the perceived meth “epidemic.” Although we are not advocating that a crack Secretariat be established, we wish to point out that harm reduction services for crack users are under funded and scarce. There have been no comparable provincial initiatives for prevention, education, and harm reduction programs for crack in British Columbia.

On the federal level, the 2007 National Anti-Drug Strategy and budget eliminated federal funding for harm



“Old Man” mural in  
Pigeon Park, DTES, by  
The Dark  
*Photo by Degan Beley.*

reduction initiatives while increasing police budgets. Bill C-26 proposes the implementation of harsher laws and mandatory minimums for drug production and trafficking. Critics of harsher drug laws and mandatory minimums suggest that the line separating drug users and traffickers is illusory. People who are poor, visible, small-time street-involved users and dealers will be most vulnerable to arrest. Since the mid-1980s, harsh sentencing, including mandatory minimum sentencing for drug offences, especially for crack offences, in the United States led to an exploding prison population. The Pew Centre on the States reports that today the United States imprisons one out of every 100 adults, imprisoning a higher percentage of their population than any other nation in the world (Warren, 2008). Rising prison costs have led to cut-backs in education, social services, housing, and health care as tax dollars are diverted to criminal justice and prisons (Boyd, 2004). However, research demonstrates that mandatory minimums are ineffective deterrents in relation to drug offences and have little impact on drug use rates and drug-related crime (Canadian HIV/AIDS Legal Network, 2007). Furthermore, there is little scientific evidence to support enforcement-related efforts in Canada (DeBeck, et al., 2006).

On the global level, in 2007 the International Narcotics Control Board (INCB) annual report sternly reprimanded Canada for their harm reduction efforts. The INCB is an independent board that monitors the implementation of United Nations drug control conventions. Historically they have been law-and-order advocates of the global war on drugs and community and social programs created to reduce harm through public health programs have come under fire from them. In the 2007 report they claim:

In Canada, the supply of “safer crack kits”, including mouthpiece and screen components of pipes for smoking “crack”, has been authorized by the Vancouver Island Health Authority, in contravention of article 13 of the 1988 convention. Several other cities in Canada, such as Ottawa and Toronto, have also approved programmes for the distribution of paraphernalia, including crack pipes, to chronic drug users. The Board calls upon the Government of Canada to eliminate those programmes, as well as existing

programmes providing drug injections sites . . .  
(INCB, 2007: 60, 61).



Single room occupancy  
building, DTES  
*Photo by Kelly Nicoll.*

In keeping with attempting to present evidence rather than hearsay, it is worth noting that the INCB report is inaccurate in relation to safer crack kits and paraphernalia being distributed in Canada. The Vancouver Island Health Authority did not authorize the distribution of pipes or screens. The safer crack kit project in Ottawa was discontinued in July 2007 because it was mistakenly thought to condone drug use.

Canadian and international lawyers point out that the establishment of needle exchange, safer crack initiatives and safer injection sites does not contravene UN drug treaties. Many nations around the world have established similar harm reduction programs. The supervised injection site in Vancouver, B.C. has demonstrated its effectiveness as a harm reduction program. The researchers involved with the program have published over 20 peer-reviewed publications in leading medical journals outlining the reduction of public injections, transmission of blood-borne infections like HIV and HCV, injection-related infections and emergency room visits. They also note that not one single drug overdose death has occurred at the site even though there have been numerous overdoses. Over a two-year period, 40 percent of referrals were for addiction counselling and public disorder and crime in the area has not increased since the opening of the site (Vancouver Coastal Health, 2006). It appears that scientific evidence of success may mean little to the Federal Conservative government and the INCB.

Harm reduction and public health advocates have brought attention to ongoing political interference by drug control advocates who disapprove of the emergence of harm reduction and public health initiatives and who reject scientific evidence, basing national and local drug policy on ideology (Hwang, 2007). Yet harm reduction has proven to save lives and incarceration of illegal drug users has not. Nor does incarceration reduce drug use.

The SCORE project supports harm reduction initiatives for crack users at the local, provincial and federal levels. Drug use is a public health issue. Harm reduction initiatives such as needle exchange and supervised

Whereas needle exchange initiatives in Canada are widely accepted today as a disease prevention strategy, providing safer crack kits is still mired in controversy. Yet, we now understand that HIV and HCV can be transmitted via mouthpieces and crack pipes.

injection sites have proven to successfully reduce the transmission of disease and infection. Harm reduction services also provide a non-judgemental setting where drug users have access to health care and social service providers. Whereas needle exchange initiatives in Canada are widely accepted today as a disease prevention strategy, providing safer crack kits is still mired in controversy. Yet we now understand that HIV and HCV can be transmitted via mouthpieces and crack pipes. Misunderstandings about people who use crack have contributed to less societal concern about their lives and the effects of poverty. Little attention has been paid to disease prevention and harm reduction programs. Political interference continues to shape drug policy debates about crack and harm reduction in Canada.

Toronto pioneered the distribution of safer crack kits; the program is ongoing and is funded by the Health Authority. Another program worth mentioning is the Prince George, B.C. initiative. In 1991 the Native Friendship Centre in Prince George began to provide needle exchange in order to prevent the spread of HIV. In 2000 they handed their successful program over to the Health Authority. Today the Northern Health Authority AIDS Prevention Program and Needle Exchange provide multiple harm reduction and nursing services for drug users. They have both a permanent location and a mobile van. In the summer of 2003, responding to the needs of and the changing practices of people who use drugs, they began to provide mouthpieces and glass stems. The AIDS Prevention Program and Needle Exchange is considered to be an essential service. Close liaison with community representatives was essential. They have weathered criticism by vocal reporters and business representatives and the local RCMP superintendent is supportive of their efforts.



## RECOMMENDATIONS

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Based on the findings of the SCORE project, we offer the following recommendations:

- Provision of unlimited safer crack use supplies should be integrated into existing harm reduction services (e.g., provided at needle exchange, community health clinics, etc.).
- A variety of approaches (e.g., peer-led outreach teams, mobile van outreach and nurse-led outreach) must be employed as part of a continuum of outreach distribution. Efforts must be made to tailor strategies to the unique needs and circumstances of particular contexts. Education efforts must include demonstrations on how to use paraphernalia correctly, particularly screens.
- In order to address gaps in knowledge about safer crack use, comprehensive educational outreach programming is required. Special attention must focus on those who are most vulnerable and marginalized.
- Those who currently use crack must be involved in the development of programs.
- Concerted efforts are required to provide women who use crack with specialized services. In particular, women-only environments foster networking and emotional support.
- Given the increasing rate of crack use and the growing number of harm reduction initiatives across Canada, there is a need to bring together individuals involved in harm reduction policy and programming to share information and develop appropriate community and health programs.
- Public education about harm reduction and crack use is essential for civil society, politicians at all levels of government, law enforcement agencies and the press.
- Research is required to determine the feasibility and effectiveness of harm reduction strategies to assist people to use more safely (i.e., safe inhalation sites, stimulant maintenance programs).

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