PILOT PROJECT REPORT

SURVEY ON DRUG USE AMONG HARM REDUCTION CLIENTS, BC, 2012

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September 2012

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EXECUTIVE SUMMARY

Objective

The primary objectives of this surveillance project were: 1) to develop a simple tool for the collection of basic indicators on drug use among harm reduction clients in BC and 2) to pilot the tool and the process in order to assess feasibility for ongoing use and utility for regional targeting of harm reduction activities.

Background

This was a stakeholder driven process. Each Health Authority (HA) representative on the Harm Reduction Strategies and Services (HRSS) committee is responsible for bringing the perspectives of those involved in harm reduction activities in their region and for keeping their region informed on the work of the HRSS. Concerns were raised that drug use trends in Vancouver and Victoria may not be the same as in other parts of BC. A better understanding of drug use trends by region would inform regional interventions that could make a difference. BC has an established network of over 200 sites across all 5 geographic Health Authorities[1] that distribute supplies ordered from the provincial harm reduction programme (Appendix A: Needle Distribution Map). This network could be leveraged to collect needed data.

Methods

A 2-page survey tool was developed with extensive input from the HA stakeholders. Twenty-eight harm reduction distribution sites in the 5 geographic health authorities were identified by the HA representative to participate in the pilot project (Appendix B and C: Pilot Site Map and Pilot Site List). The pilot sites administered the 10 minute survey to their clients (N=743). Sites were provided with some funding and participants were given a small stipend in recognition of their time, as determined by the site (value=$5). Data was returned to BCCDC and analyzed with a focus on frequency of type of drug use by region, polydrug use, and comparing major centres with communities ≥50km from the major centre. The survey process was evaluated using an acceptability questionnaire completed by participating harm reduction groups. The survey tool was further refined by interviewing a sample of those who had administered it to clients during the pilot for their feedback and suggestions for improvement.

Results

Acceptability (process):

- Pilot sites report it is feasible to administer a survey once per year
- The data collection process is acceptable to the site staff and peers
- The data collected was valued by the sites for gaining knowledge and service planning
- As a measure of client acceptability, refusal and non-completion rate was reported to be low (5%)
- Some issues were identified for lower volume HR sites (e.g. time of year and duration of data collection period)

[1] Abbreviations: HA – Health Authority (referring to 5 geographic Health Authorities as follows: FHA – Fraser Health Authority; IHA – Interior Health Authority; NHA – Northern Health Authority; VCH – Vancouver Coastal Health Authority; VIHA – Vancouver Island Health Authority

Simplicity (tools):

- Based on feedback from interviewers (peers and staff) and from the data analysis, the survey requires revisions.
- The utility of the user guide would be improved if provided in a video format

Data Analysis:

743 respondents completed demographics and supply usage portion of survey (page 1of 2 page survey):

- 45 (6%) reported no drug use in the prior 7 days; 698 (94%) completed current drug use portion of survey
- 6% of all respondents reported drinking non-beverage alcohol
  61% male; similar age distribution in men and women (mean approximately 40 years)

698 respondents reported using one drug or more in the prior 7 day period (page 2):

- Crack (50%), heroin (44%), morphine (30%) and cocaine (26%) were the most frequently reported drugs
  - Crack use predominates in VCH, VIHA, and NHA HR pilot sites
  - In IHA pilot sites, heroin and morphine use are slightly higher than crack use
  - Heroin use predominates in FHA pilot sites; low levels of cocaine and morphine use
  - NHA pilot site clients were the only group in which cocaine use exceeds heroin use
- Polysubstance use[2] is common among HR clients surveyed in all health authorities (mean 71%)
  - VIHA pilot site clients had the highest prevalence of polysubstance use (81%)
  - VIHA pilot site clients had the highest reporting of four or more substances in prior 7 days (37%)
- There were differences in use among HR clients in the HA major centre[3] vs. clients from ≥50km away
  - major centre clients had higher use of crack and heroin
  - non-major centre clients had higher use of cocaine and morphine
- 90% of those respondents disposing of needles reported a safe disposal method

Limitations and Strengths

This survey was administered by a convenience sample of HR sites from each health authority which may lead to underrepresentation or overrepresentation of particular groups within the sample. To improve sampling, the desired representation requires further development and articulation by stakeholders. This survey is also subject to recall bias and social desirability bias, albeit in a low barrier environment. Finally, participant incentives may influence willingness to participate with unknown impact on responses.

This survey's key strength was excellent stakeholder engagement. Peer involvement and opportunities for motivational interviewing were some other benefits reported outside of data

[2] *For the purposes of this survey, polysubstance use is defined as two or more substances used in the prior 7 day period*

[3] *Health Authority Major Centres (by population): VCH=Vancouver; VIHA=Victoria; IHA=Kelowna; NHA=Prince George; Fraser Health Authority=Surrey; HR sites were assessed as being <50km or ≥50km from centres*

collection itself. The systems (network, process, database, analysis) developed through this pilot are now in place for use annually. Surveillance of drug use trends may be possible as long as core drug use questions remain consistent. Expanding to more HR sites may be possible to provide more data for regional trends. The process is flexible (e.g. region specific questions).

Summary

This survey provides some basic indicators of drug use among a sample of active drug users from each BC health authority using a simple survey tool. The HA level data are valuable to HR service providers and the process is acceptable to repeat annually. The survey resulted in measurable regional differences in drug use useful for Health Authority level harm reduction planning. Leveraging of the existing harm reduction network was useful and feasible. Inclusion of smaller and/or more rural harm reduction sites is possible, with appropriate supports and considerations.

General Recommendations for future survey

- Refine survey questions and wording based on pilot site feedback and data analysis
- Create survey administration guide in video format
- Repeat survey annually with consistent core drug questions
- Consider recruiting more suburban and rural HR sites to survey; reduce number of surveys collected per site; allow more lead time and data collection time
- Plan a period each year when all HR sites record their client volumes (to provide weighting)
- Continue to refine the goal of survey representation and sampling strategy

ABSTRACT

Background

In British Columbia (BC), understanding of high-risk drug use trends is largely based on survey and cohort study data from two cities, Vancouver and Victoria. Harm reduction (HR) stakeholders from the five geographic BC health regions identified a need for indicators on drug use across BC in order to inform regional HR activities. Using an existing HR supply distribution network, we piloted a drug use survey, evaluating the survey tool and acceptability of the process to front-line HR stakeholders.

Methods

A survey focusing on current drug use was developed with stakeholders and piloted among HR clients at 28 HR supply distribution sites across BC by existing staff and peers. Data were collated and analyzed at the BC Centre for Disease Control with a focus on types of drug use by region. A post-pilot questionnaire to the sites evaluated the survey and acceptability of the process.

Key Findings

Crack cocaine, heroin, and morphine were the most frequent drugs used with notable regional differences. Polydrug use was common (71%) with one region identified as having 81% polydrug use. Those surveyed in major cities were more likely to use crack cocaine and heroin while those residing more than 50 km from an urban centre were more likely to use morphine and cocaine (powder). Stakeholders valued the information and found the process acceptable. Recommendations were made to improve the survey for future use.

Conclusions

This survey provides an indicator of drug use among a sample of active drug users from each BC health authority using a simple survey tool. The provincial and regional data are valuable to HR stakeholders and the process is acceptable to repeat annually. We will continue to recruit more suburban and rural sites to improve our understanding of drug use in these regions.

INTRODUCTION

Drug information systems are particularly important in the contemporary context of changing drug trends, including new and re-emerging substances, among increasingly diverse populations in an expanding range of settings [1]. In Norway and Australia, systems have been developed to monitor trends in alcohol, illicit drugs and the street use of prescription drugs and used to report back to policy makers and practitioners for early intervention[1]. In the Canadian context, concerns have been raised about the adequacy of surveillance of drug trends for timely response to drug-related hazards [2].

In BC we are fortunate to have several indicators of illicit drug use trends and harms experienced among high risk populations. The Canadian Community Epidemiologic Network on Drug Use (CCENDU) collates and reports on drug use trends and other data relevant to the health of individuals who use illicit drugs from various data sources at participating sites across Canada. Vancouver was such in the past and the report included relevant provincial, including mortality indicators (vital statistics, BC Coroners Service), crime statistics (provincial and Vancouver Police Department), population surveys, hospital and ambulance data, cohort studies, drug use surveys, harm reduction supply and laboratory data [3]. While there are limitations with each source, the multiple sources provide context for an overall picture.

BC's Harm Reduction Programme was transferred to the BC Centre for Disease Control (BCCDC) from the Ministry of Health Services in 2003. The Harm Reduction Strategies and Services Committee of BC (HRSS) has representation from each of the geographic health authorities across BC and is responsible for harm reduction service delivery in British Columbia [4]. Indicators including supply distribution, communicable disease rates and local initiatives are monitored by the BCCDC, Health Authorities and other health system partners for annual reporting [5]. More recently (2011), the BC Drug Overdose and Alert Partnership was struck to focus on timely identification of increased overdoses and emerging harms related to substance use and effective dissemination of alerts [6]. Data from the Health Authorities, BC Coroner's Service, law enforcement, and other partners is shared to detect and respond to risks to drug users.

The M-Track survey of the Public Health Agency of Canada is a regularly repeated survey conducted at different sites across Canada providing enhanced surveillance of HIV, sexually transmitted and blood-borne infections, and associated risk behaviours among Men Who Have Sex with Men [7]. In BC, this is conducted in Victoria. Similarly, I-Track is the national, second-generation HIV sentinel surveillance system focused on IDU in Canada [8]. I-Track is conducted at 10 sites across Canada, 3 in BC. Both surveys cover drug use and are conducted in phases (e.g.: 2004 to 2007) then the collated data is analyzed and published.

The Vancouver Injection Drug Use Study (VIDUS) is a long running cohort study, under the Urban Health Research Initiative (UHRI), a programme of the BC Centre for Excellence in HIV/AIDS, which assesses factors on the health of injection drug users in Vancouver [9]. The At-Risk Youth Study (ARYS) is another UHRI cohort study focusing on Vancouver youth aged 14-26 deemed at risk based on a variety of factors [10]. The ACCESS study follows individuals who are identified with HIV and include participants who were in VIDUS and ARYS. These studies provide valuable assessment of risk factors for communicable disease and other harms as well as some drug use information but may or may not be generalizable to other parts of BC.

The *High Risk Populations* survey component of the Alcohol and Other Drug Monitoring Project of The Centre for Addictions Research of British Columbia (CARBC) is a comprehensive survey providing indicators of patterns of use and substance-related problems within at-risk populations. This is a rolling survey consisting of two data collection waves per year at both Vancouver and Victoria sites and is designed to monitor specific trends of illicit drug use among club attendees, street involved youth and street involved adults [11]. While the CARBC survey provides timely and relevant data for understanding drug use trends in Vancouver and Victoria, it is unclear how well this represents drug use in other BC communities. In addition, the street involved youth and adults surveyed may not fully represent the clients served by the HR sites of the HRSS network. CARBC also makes available and/or interprets other data on overdose, population surveys, policy, among other topics [12].

Thus, the impetus for this pilot project derived from identification of a gap in our understanding of what illicit drugs are currently being used in other parts of BC, outside of Vancouver and Victoria, coupled with an interest in better understanding the needs of clients of harm reduction sites in BC. The survey tool for this pilot project was designed to collect information from current drug users on basic demographics and site use, what drugs are being used and the methods of use, with a focus on developing an effective process for understanding current drug use among HR clients on a regular, sustainable, and province-wide basis, with representation including, but also outside of, Vancouver and Victoria.

Goal: To design and implement a drug-use survey that will provide indicators on high risk drug use among HR clients in BC. The data needs to be useful for regional planning of HR activities and the process needs to be feasible for ongoing implementation.

Pilot Project Objectives

1. To review and learn from surveys designed for use among persons who use illicit substances that are currently being implemented in BC, other provinces and countries

2. In consultation with HR stakeholders, to develop a survey tool and process for survey administration with a focus on its feasibility for use at front line harm reduction sites

3. To pilot the survey tool and process among a sample of harm reduction sites from the overall existing network of harm reduction sites in BC

4. To evaluate the system for simplicity of the survey tool and acceptability of the process, as assessed by HR stakeholders (including HR survey staff, peers, and clients)

5. To refine the survey and process for ongoing use based on experience at pilot sites

METHODS

Pilot Project Development

Project stakeholders included HRSS Health Authority representatives, their front-line public health staff engaged in harm reduction, and community harm reduction partners, including peers. These groups were asked to provide their perspective on the project objectives and design.

Further development included the recruitment of supply distribution sites from each HA to participate in the pilot project. This was a convenience sample as sites were put forward for contact by regional representatives based on capacity and willingness to participate. A 2-page survey tool was created which included a guide for staff and peers for obtaining informed consent, tracking of those clients who declined to participate or did not complete the survey (to determine refusal/non-completion rate), and instructions on how to administer the survey questions to clients and complete the paper survey with an emphasis on obtaining informed consent in a low barrier environment. These tools were reviewed by HR committee representatives and several HR site staff.

HR sites were contacted to discuss capacity and process for undertaking the pilot and to provide an estimate of weekly client volume. The survey materials were mailed out and a two week period of data collection was designated. HRSS provided $8/client surveyed to allow for a participant incentive and some general cost defrayal. The logistics of survey administration and handling of the participant incentive/stipend were determined at the site level. Peer and staff interviewers were identified and provided the user guide and other materials to assist with training on survey administration. Table 1 below summarizes the timeline of project development.

Table 1. HR Client Illicit Drug Survey Pilot Project Timeline, 2011-2012

March - May, 2011	environmental scan of data sources with a focus on surveys among active drug users
April - June, 2011	stakeholder identification and consultation on project objectives and development
April – December, 2011	create survey tool for use by local communities
January – May, 2012	pilot tool and refine plans for data collation, interpretation, and feedback to stakeholders

Analysis of Drug Use Data

Completed surveys were returned to the BCCDC and data was entered in an ACCESS database. Tracking forms were used to calculate refusal/non-completion rates. Demographics and site use was described. The focus of the analysis was health authority level comparisons of drug use by type, polysubstance use[4], and other geographic comparisons of proportion of respondents reporting particular types of drug use in the prior 7 day period. Basic descriptive statistics, histograms, tables, and graphs were produced.

Evaluation

Pilot Site staff were asked to identify criteria for feasibility for biannual or annual survey participation. From this, an acceptability questionnaire was developed to be administered to site groups after the survey was complete. Additionally, staff and peers administering the survey to clients were contacted after the pilot to provide specific input on how individual questions were received by clients and feedback on how to improve the wording and administration of the survey. The process was open to all feedback on an ongoing basis during and after the survey period.

[4] *For the purposes of this survey, polysubstance use is defined as two or more substances used in the prior 7 day period and includes the drugs specified from the list on Page 2 of the survey as well as responses to the 'other drugs not listed here' question at the bottom of page 2 (See Appendix D).*

RESULTS

Pilot Project Implementation

Health Authority representatives identified a minimum of 4 HR sites in each health authority that could participate in the pilot (See Appendix B and C: Map and List of Pilot Sites).

Stakeholders identified the need for the survey to be both anonymous and very short (less than 10 minutes) to maintain the low barrier harm reduction site environment (See Appendix D: Pilot Survey). Although survey self-administration was discussed, HR stakeholders opted for administration by staff and peers for the pilot to maintain data quality. Each site determined the form of the participant incentive; many opted for a $5 cash stipend for client participation in the survey while others provided $5 gift cards to local food establishments.

Larger volume sites were able to meet their target estimates of surveys completed in the two week period while smaller volume sites often needed additional time. Sites in Northern BC found the time of year (early February) problematic. During cold weather clients tend come in and stock up on supplies and not return for some time, so client volumes were especially low.

Analysis of Drug Use Data

743 clients participate in the survey, completing Page 1. Of these 743 participants, 698 went on to complete Page 2, in which drugs used in the last 7 days were disclosed. Thus, 45 individuals (6.1% of all respondents) did not report any drug use in the last 7 days. Reasons for this varied and were not systematically collected. 60% of those respondents that did not go on to complete the drug use portion of the survey were from Northern Health where some participants were recruited upon entry to a treatment programme, with a higher proportion of persons abstaining from drug use in the prior 7 day period. Figures 1 thru 5 summarize Page 1 Data and the remaining figures and tables summarize the drug use data from Page 2 of the survey.

Table 2: Number of Harm Reduction Client Survey Respondents Completing Pages 1 and 2 of the Pilot Survey, by Health Authority, BC, 2012 (N=743)

	Interior	Fraser	Vancouver Coastal	Vancouver Island	Northern	Total
Number of Respondents Completing Page 1 (row %)	188 (25.3%)	163 (21.9%)	145 (19.5%)	129 (17.4%)	118 (15.9%)	743 (100%)
Number of Respondents Completing Page 2 (row %)	178 (25.5%)	161 (23.1%)	141 (20.2%)	127 (18.2%)	91 (13.0%)	698 (100%)
Difference (row %)	10 (22.2%)	2 (4.4%)	4 (8.8%)	2 (4.4%)	27 (60.0%)	45 (100%)

Figure 1. Question 1: Is this the first time you have used this supply pick up site? (N=743)

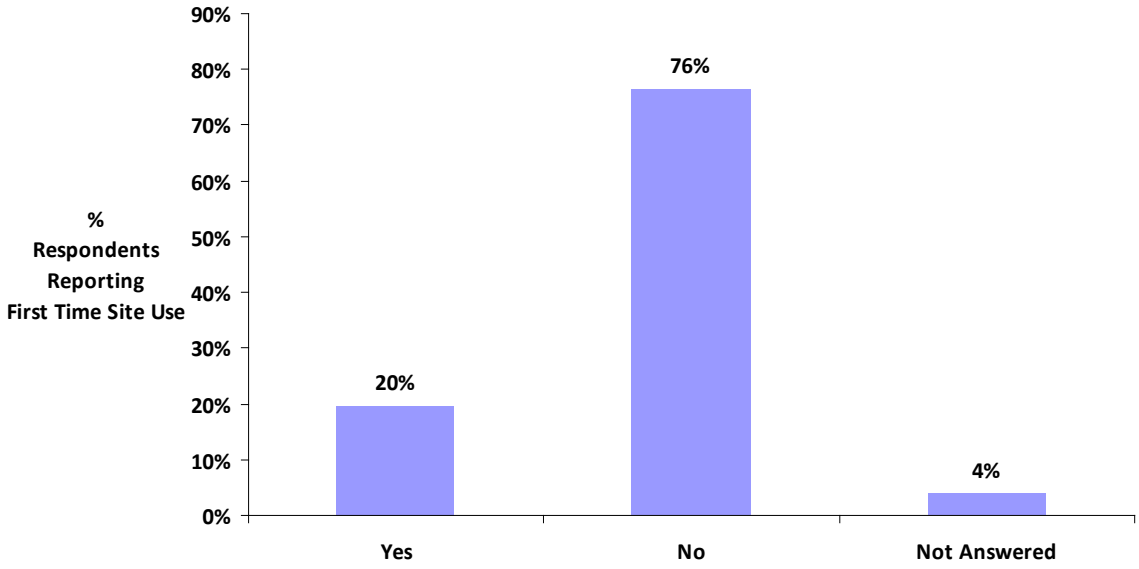
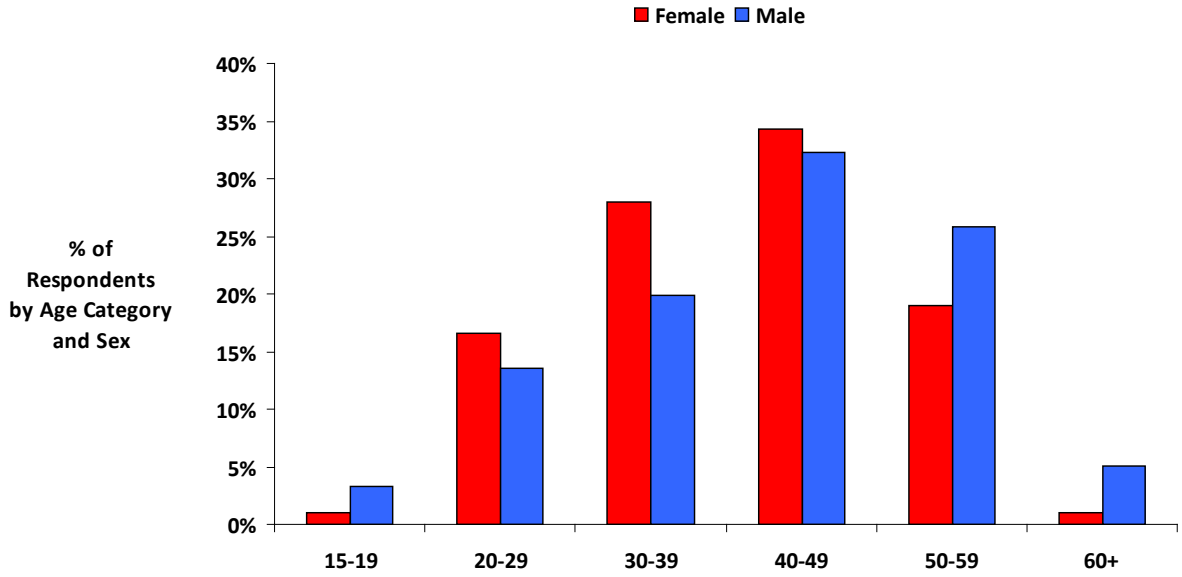


Figure 2. Question 2 and 3: Sex and Age Distribution of Pilot Survey Respondents (N=739)



	Female (n=289)	Male (n=449)	Transgender (n=1)	Overall (N=739)
Age (years)				
Mean	40.0	42.6	-	41.6
Median	39.5	42.0	-	42.5
Range	15-80	15-74	37	15-80

Figure 3: Question 4: Who are the supplies for? (N= 743)

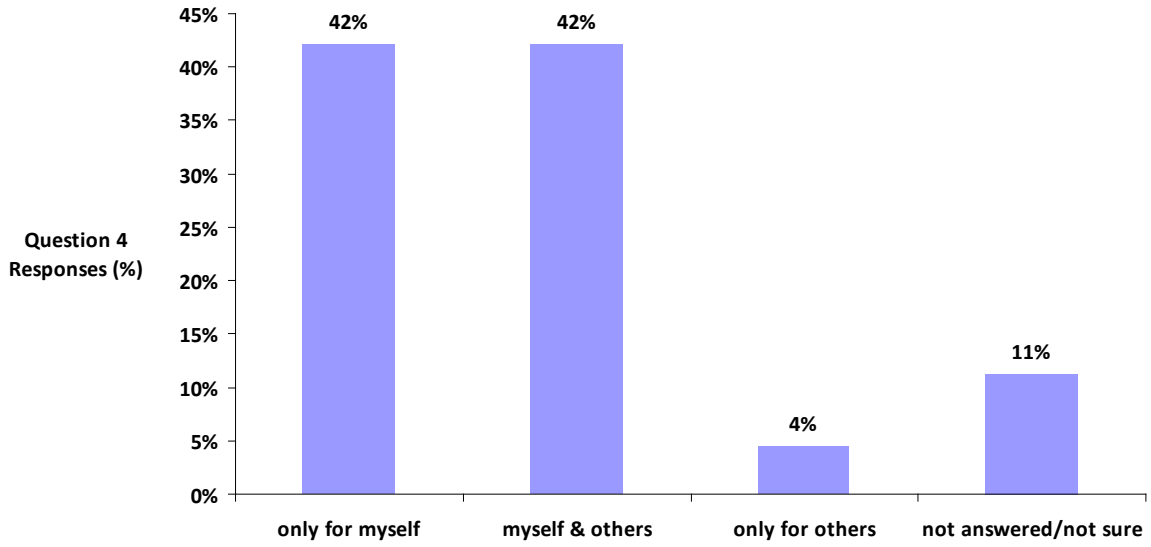


Figure 4. Question 6: Consumption of Non-Beverage Alcohol (N=743)

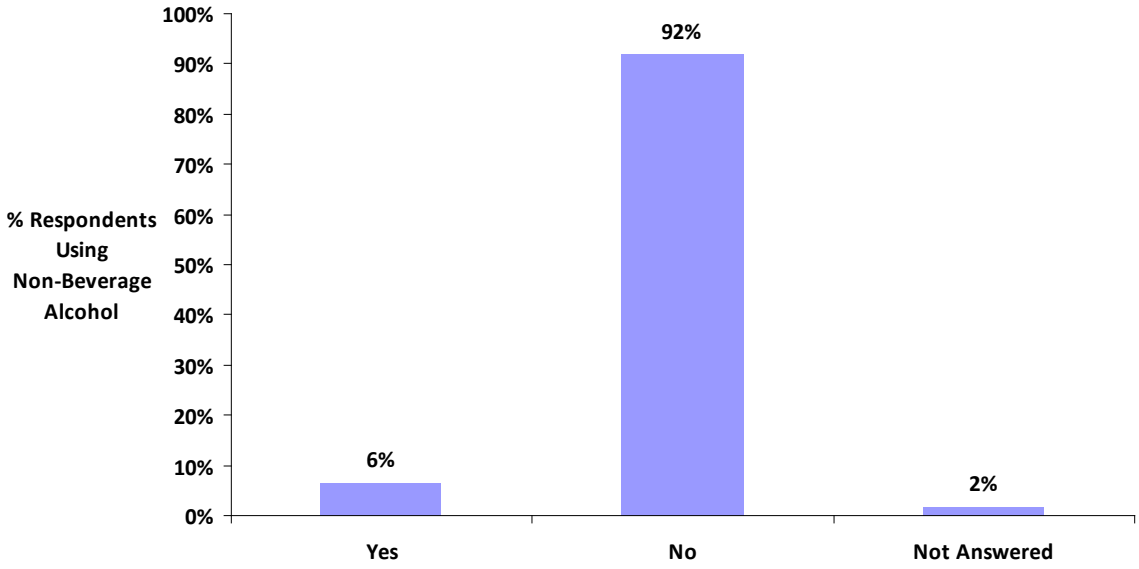


Figure 5: Level of Safety of Reported Needle Disposal Method (N=299)

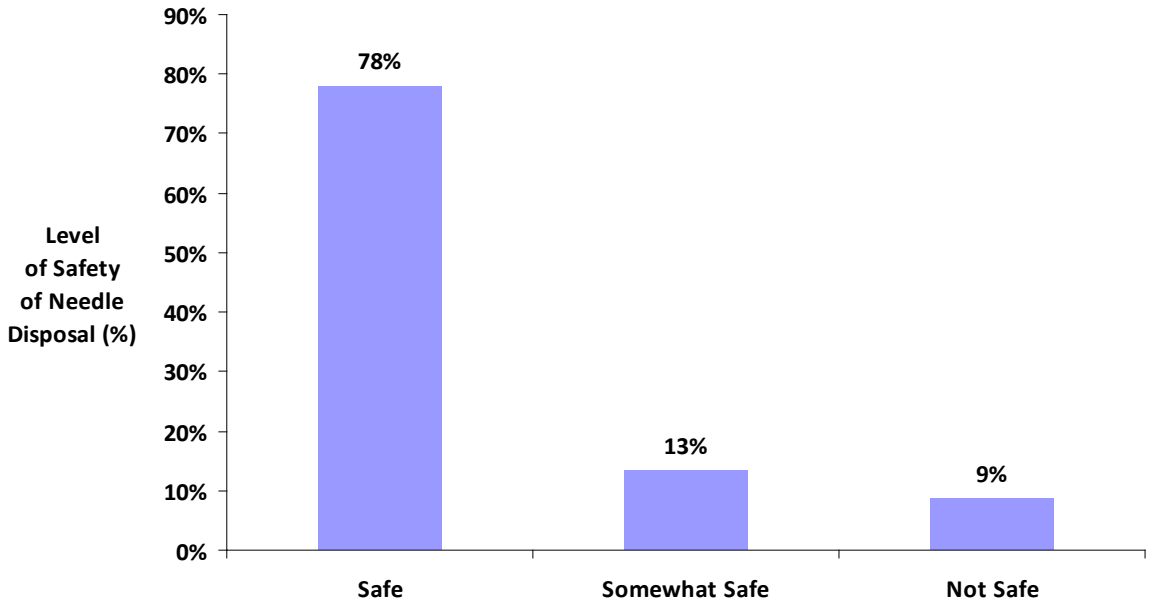


Figure 6. Percent of Respondents Reporting Illicit Drug Use in the Prior 7 Day Period (N=698), BC, 2012.

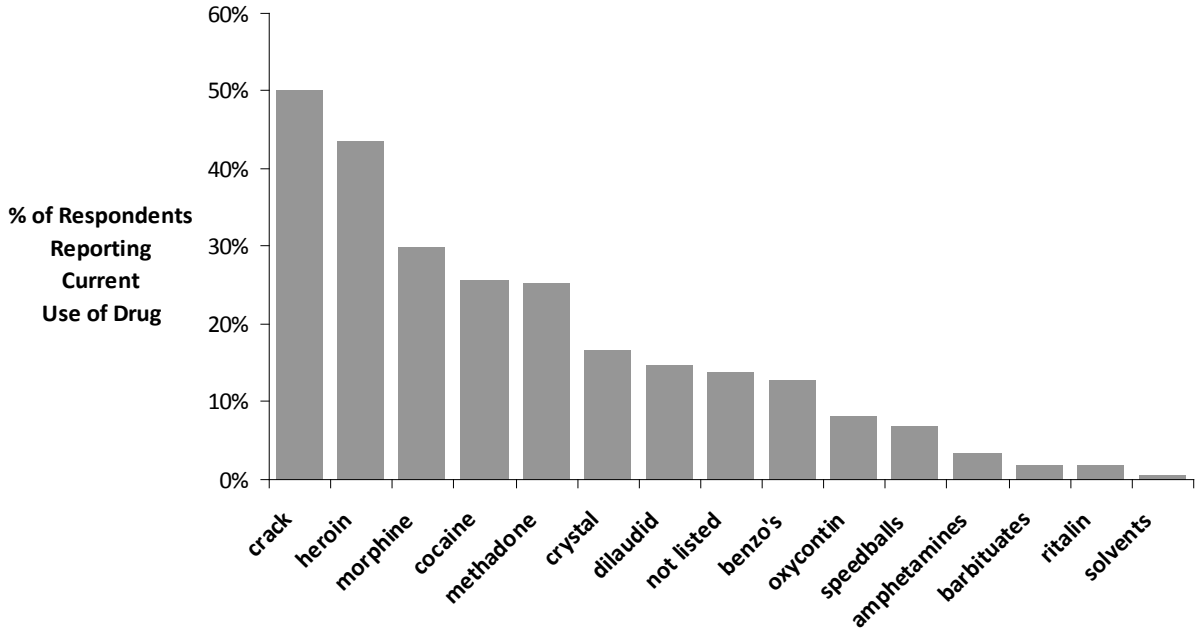


Figure 1 shows drug frequencies reported on the survey among the total sample, allowing for multiple responses. Among 698 respondents, 50% reported use of crack, 44% Heroin, 30% Morphine, and 26% Cocaine.

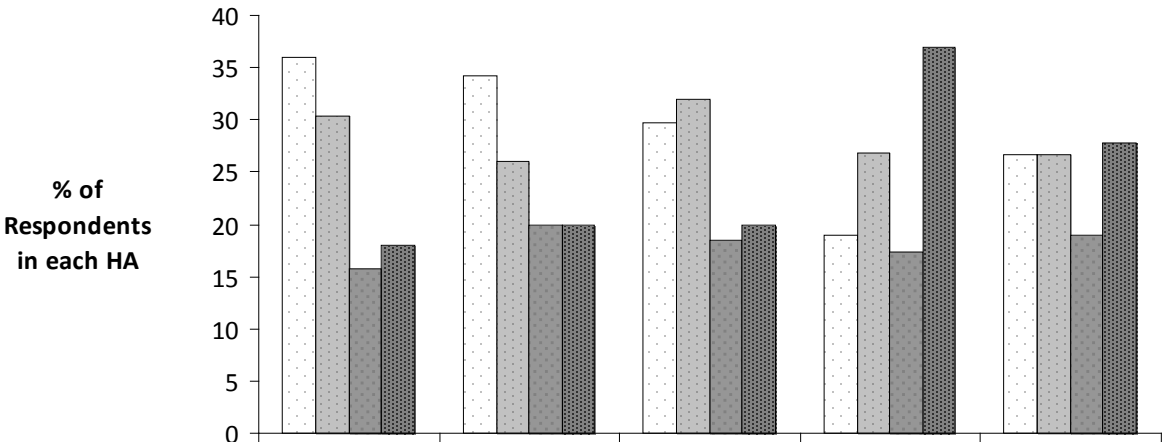
In Table 3, we have combined drug categories to make more direct comparisons with recently presented results from the CARBC Vancouver/Victoria High Risk Drug Survey among street involved adults. However, we asked clients about drug use in the prior 7 days which is difficult to compare to those asked about drug use in the prior 30 days.

Table 3. Comparison of 2010 CARBC with 2012 HR Pilot Project Drug Use Prevalence

	CARBC 2010 (W2)[5] High Risk Drug Survey Street Adult Drug Use **Last 30 Days**	2012 HR Pilot Project **Last 7 Days**
Crack	76.3%	50.1%
Opioids (methadone, morphine, dilaudid, oxycodone & codeine)	56.0%	78.1%
Cocaine	33.8%	25.6%
Heroin	31.3%	43.6%
Crystal Meth	19.4%	16.6%

[5] W2 refers to second data collection wave of 2010. Results presented at AOD Steering Committee Meeting, March 10th, 2011.

Figure 7. Polysubstance Use among Survey Respondents, by Health Authority, BC, 2012



	Interior	Fraser	Van Coastal	Island	Northern
single drug	36.0	34.2	29.8	18.9	26.7
two drugs	30.3	26.1	31.9	26.8	26.7
three drugs	15.7	19.9	18.4	17.3	18.9
> three drugs	18.0	19.9	19.9	37.0	27.8

or the purposes of this survey, polysubstance use is defined as two or more substances used in the prior 7 day period. For the pilot survey, this refers to two or more substances identified on the 'main' list of drugs (page 2 of the 2 page survey) and not the 'Other Drugs Not Listed Here' section. While polysubstance use was common among HR clients surveyed in all health authorities (average 70.9%, range 64.0% - 81.1%), Vancouver Island had the highest prevalence of polysubstance use (81.1%) and notably prevalent reporting of greater than three substances used in the last 7 days (37.0%). Northern had the second highest prevalence of more than three substances used within last 7 days (27.8%).

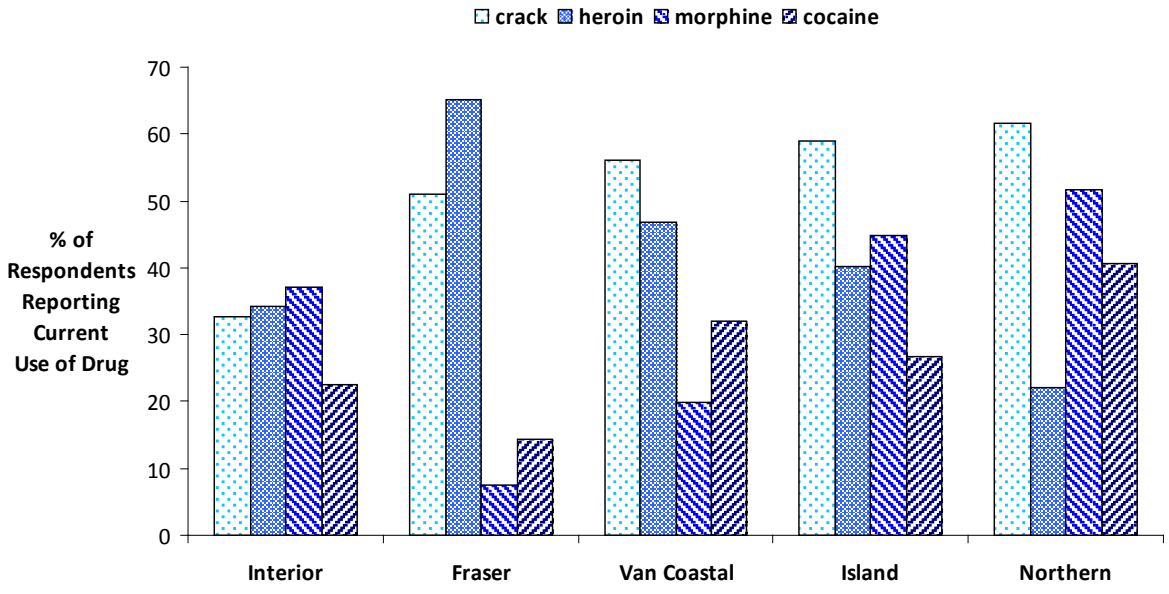
Respondents were asked about whether they took 'other drugs not listed' in the prior 7 days. A key purpose of this question was to assess if any frequently taken drugs were excluded from the main list. 98 individuals responded 'yes' to this question and 97 provided at least one drug name. Marijuana and Alcohol were the top two reported (Table 4).

Table 4. Number of Respondents Reporting 'Other Drugs Not Listed Here' in the Prior 7 Day Period, BC, 2012 (N=97)

Other Drugs Used in Last 7 Days	# Reporting Use
Marijuana	72
Alcohol	11
Tylenol (various forms)	4
Seroquel	3
Gabapentin	3
Antidepressants	2
Codeine	1
Fentanyl	1
MDMA (Ecstacy)	1
Suboxone	1
Arthritis meds	1
Muscle relaxants	1
Mushrooms	1
Gravol	1

Among the 304 respondents who reported use of heroin in the prior 7 day period, 84% also used another substance in the same 7 day period: 54% also reported use of crack, 31% reported use of methadone, 24% and 23% reported use of cocaine and morphine, respectively.

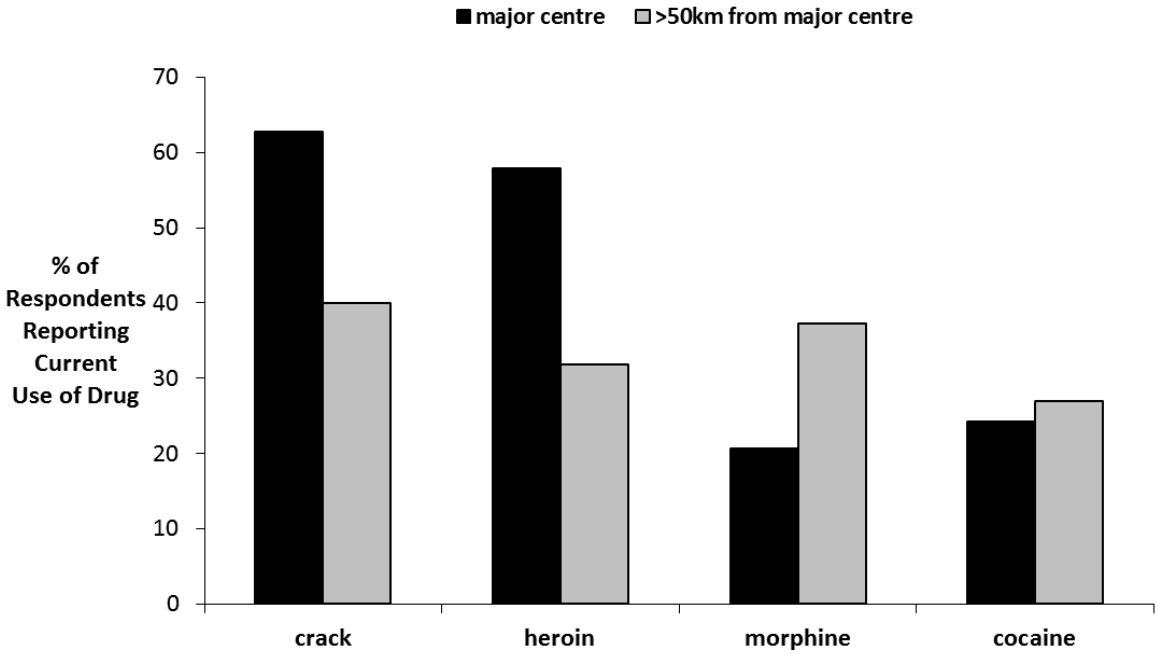
Figure 8. Percent of Respondents Reporting Current Use of Crack, Heroin, Morphine, and Cocaine, by Health Authority, BC, 2012 (N-698)



In Vancouver Coastal, Vancouver Island, and Northern Health Authorities, crack use is highest while in Interior Health, heroin and morphine use are slightly higher than crack use. A high proportion of the Fraser respondents report heroin use, followed by crack, with comparatively low levels of

cocaine and morphine use. Northern has the highest proportion of morphine use and is the only health authority in which cocaine use outstrips heroin use.

Figure 9. % of Respondents Reporting Use of Crack, Heroin, Morphine, and Cocaine from the Major Centre [6]



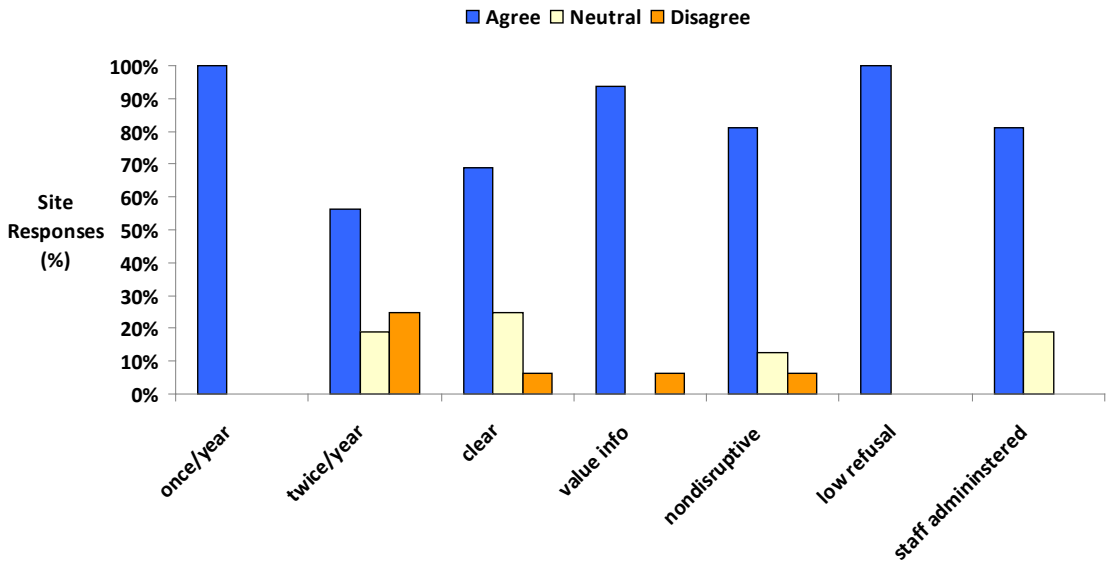
While methods of assessing rural and urban status of communities vary [13], most of BC is generally considered urban. Among the participating pilot sites, one had a 'rural' postal code. Most were urban with a small number categorized as urban fringe depending on the methodology. We opted to categorize respondents as to whether they lived in their Health Authorities major centre (VCH=Vancouver, VIHA=Victoria, IHA=Kelowna, NHA= Prince George, FHA=Surrey), or up to 50km from city centre, versus those living >50km from the city centre. Using this categorization, we see slightly more crack and heroin use among the respondents from the major centre and more morphine and cocaine use among those respondents >50km away.

[6] *Health Authority Major Centres (by population): VCH=Vancouver; VIHA=Victoria; IHA=Kelowna; NHA=Prince George; Fraser Health Authority=Surrey; HR sites were assessed as being ≤50km or >50km from city centres*

Evaluation

Of the 28 participating pilot sites, 26 were able to complete the post-pilot acceptability questionnaire (See Appendix E: Post- Pilot Acceptability Questionnaire). Figure 6 depicts sites responses to the 7 questions.

Figure 10: Pilot Site Responses to 7 Likert Scale Questions (N=26/28 Pilot Sites)



Pilot sites were in agreement with running the survey once each year but more mixed on the feasibility of offering it twice per year. Approximately 70% of the sites found the survey wording of questions clear; those sites that did not find the wording of all questions clear were asked for further input to improve clarity. Over 90% of the sites stated they valued the information covered by the survey questions for their own knowledge and planning. Over 80% of the sites found the process non-disruptive while others provided input into making the process less disruptive. Sites with low supply distribution volumes and staff numbers generally found it more challenging to administer the survey but this also depended on the service model. Subjective refusal and non-completion levels were universally felt to be very low and acceptable and this was attributed to the stipend offered to clients for their participation. Over 80% of sites reported that survey administration by site staff or peers (versus self-administration by clients) was necessary for both data quality and to maintain other benefits such as rapport-building with clients.

The questionnaire included three open-ended questions: what went well, what didn't go so well, and suggestions for improvement. Below is a summary of responses:

What went well:

- Many sites reported the survey process offered an opportunity for engagement and rapport-building with clients as well as a way for staff to learn more about what is going on at street level and to identify areas of need
- The anonymous nature of the survey was important and helpful to obtaining accurate responses
- Peer administration of survey was very productive and appreciated by sites
- The survey asked timely and relevant questions and can be used to ask questions of local interest

What didn't go so well:

- Administering the survey in winter (Jan/Feb) in Northern when client volumes were low (stocking up on supplies is more common when travel is restricted)
- Estimating the amount of drug used 'per hit' was problematic (columns 4-5 of page 2 drug table)
- Sites with a small number of staff found addition of survey administration challenging, needed to leverage students and volunteers
- Advance monies slow to arrive

Suggestions for Improvement

- Ask about concurrent use of alcohol and drugs re: OD risk
- Ask about barriers to access of supplies
- Include ethnicity
- Increase time for smaller sites to collect (i.e.: a month if needed)
- Continue to use peers to improve wording of survey
- Create a video on how to administer survey

Feedback was solicited on wording of survey and survey was revised (See Appendix F: 2013 Draft Survey).

DISCUSSION

The 2012 Harm Reduction Client Drug Use Pilot Survey went well in terms of logistics, feasibility, and the utility of the data collected. Front line staff and management at participating sites found the process generally acceptable, feasible to administer annually, and useful for understanding and responding to client needs. Other benefits of offering the survey, such as building rapport with clients, were also identified. There were many lessons learned from the pilot experience. In particular, it highlighted important issues we must consider and plan for when running the survey in smaller sites and in Northern Health Authority.

The analysis of the pilot data suggests that drug use trends in Vancouver and Victoria may not be representative of HR clients in other BC regions. Compared to drug use data collected in other surveys primarily from Vancouver and Victoria, our sample had less crack cocaine use and higher use of opioids. Morphine use may be a much bigger concern in BC communities than the Vancouver/Victoria data would suggest. In addition, notable regional differences were found. Based on our sampling frame, Vancouver Island and Northern have the highest concern regarding polysubstance use. It is important to note that the convenience sample in this pilot project is very different from other surveys and findings must be interpreted and compared with caution. However, the main goal of our sampling, to represent our BC harm reduction clients as fully as possible by Health Authority, including but not limited to our major metropolitan centres, seems to be shared by stakeholders and, thus, can be improved upon in future surveys.

In the post-pilot evaluation several weaknesses were identified, including the need to refine the survey tool for clarity through further evaluation by peers and the inability to assess the concurrent use of drugs (e.g. heroin and alcohol). As we are asking clients about their drug use in the recent past, recall bias and social acceptability bias may play roles in underreporting of certain drug use. The use of incentives, while agreed by stakeholders to be important in respecting clients time and willingness to participate, may have varying effects on data quality that are difficult to assess. This pilot also confirmed that this process will not provide a lead indicator or ‘snapshot in time’, as different sites will need different lengths of time to collect data.

The key strength of the survey pilot was excellent stakeholder engagement. All stakeholders were enthusiastic contributors from the inception to the implementation of the pilot. Willingness of the pilot sites to participate is reflected in the exceptional peer and client participation levels. There is good potential to recruit more sites for 2013 with the 2012 pilot sites acting as supports. Finally, the systems developed in 2012 are now in place for the 2013 survey and, thus, we can anticipate a more streamlined roll out of future surveys. This network of committed stakeholders, who are best positioned to assess and respond to client needs, has good potential for this and other collaborations in the future.

CONCLUSIONS

This survey provides an indicator of drug use among a sample of active drug users from each BC health authority using a simple survey tool. The provincial and regional data are valuable to HR stakeholders and the process is acceptable to repeat annually. We will continue to recruit more suburban and rural sites to improve our understanding of drug use in these regions.

RECOMMENDATIONS

Practical:
- Maintain budget for annual survey, send startup monies earlier
- Expand number of sites participating in each Health Authority
    - Consider reducing the number of surveys collected per site
    - Consider setting cap for the number of surveys collected per site (e.g. 25)
    - Consider collecting site volumes secondarily as a means of calculating provincial weighting, if desired
    - Discuss with 2012 pilot sites if they can champion process with other nearby sites for 2013 (both sites that order from HRSS as well as sites that redistribute supplies)

Tools:
- Create video to train interviewers
- Continue revising and testing survey tool with stakeholders, particularly peers

Communication:
- Disseminate full report or abbreviated report directly to pilot sites as able

Other:
- Consider HSDA level analysis in future

ETHICS

This project is designed as surveillance and programme evaluation, as opposed to research. Due to on the vulnerable populations being surveyed, ethics review was sought. This project was approved by:
UBC Behavioural Research Ethics Board (BREB), certificate H07-00570
Vancouver Coastal Health Research Institute, certificate V07-00570
BCCDC internal review process

ACKNOWLEDGEMENTS

We are deeply grateful to the following participants, contributors and supporters:

28 HR Pilot Sites:	**Staff, Peers, and Clients**
HRSS:	**HA Representatives and Committee Members**
BCCDC:	**Mei Chong, Erin Gibson, Erica Li, Faye Low, Sunny Mak, Lily Zhou**
CARBC:	**Clifton Chow and Andrew Ivsins**

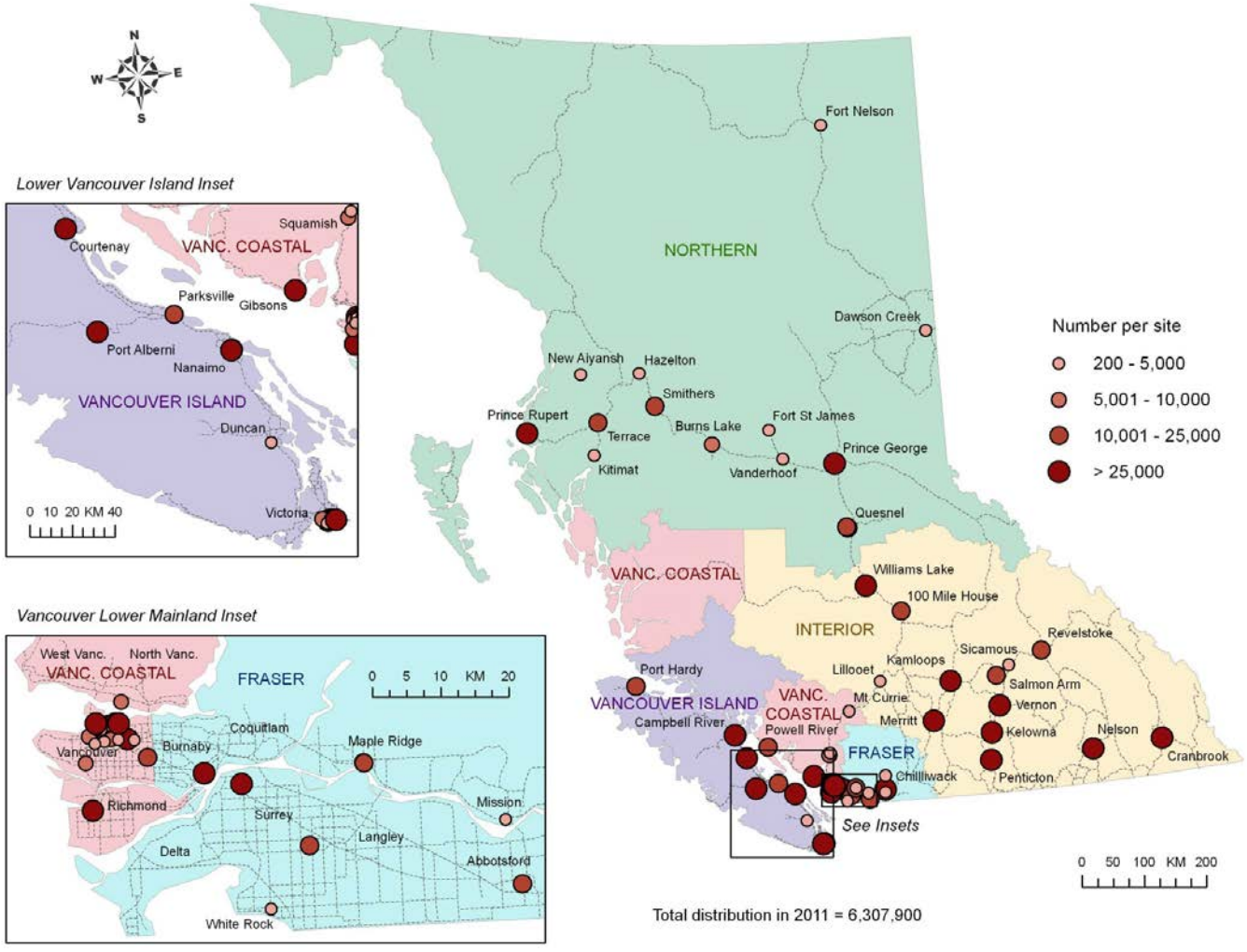
REFERENCES

1. Mounteney J & Haugland S. Earlier warning: a multi-indicator approach to monitoring of trends in the illicit use of medicines. 2009. International Journal of Drug Policy; 20:161-69.
2. Fielden SJ & Marsh DC. It's time for Canadian community early warning systems for illicit drug overdose (commentary). 2007. Harm Reduction Journal; 4:10. Retrieved 17-Aug-2012 at: http://www.harmreductionjournal.com/content/4/1/10
3. Canadian Community Epidemiology Network on Drug Use (CCENDU). Vancouver Site Report for the Canadian Community Epidemiology Network on Drug Use. June 2007. Retrieved 17-Aug_2012 at: http://www.ccsa.ca/2007%20CCSA%20Documents/CCENDU-Vancouver-highlights-2007-e.pdf
4. BC Harm Reduction Strategies and Services Committee. Terms of Reference. 2009. Retrieved 17-Aug-2012 at: http://www.bccdc.ca/NR/rdonlyres/ED341A02-9FA3-428A-BB71-AF0302A7B5B8/0/Epi_HarmReduction_Guidelines_BCHRSSTermsofReferenceJan2009_20090508.pdf
5. BC Harm Reduction Strategies and Services Policy Indicators Report. March 2012. Retrieved Aug-17-2012 at: http://www.bccdc.ca/NR/rdonlyres/B39C410C-F5D1-467B-A92F-B46715583404/0/BCHRSSPolicyIndicatorsReportMarch162012.pdf
6. BC Drug Overdose and Alert Partnership. Terms of Reference. July 2012. Available upon request from the BC Harm Reduction Strategies and Services Committee.
7. Public Health Agency of Canada. M-Track: Enhanced Surveillance of HIV, Sexually Transmitted and Blood-borne Infections, and Associated Risk Behaviours among Men Who Have Sex with Men in Canada, Phase 1 Report. 2011. Project Overview: http://www.phac-aspc.gc.ca/aids-sida/about/mtrack-eng.php#phase1. Report found at: http://orders.catie.ca/product_info.php?cPath=14_53&products_id=25916

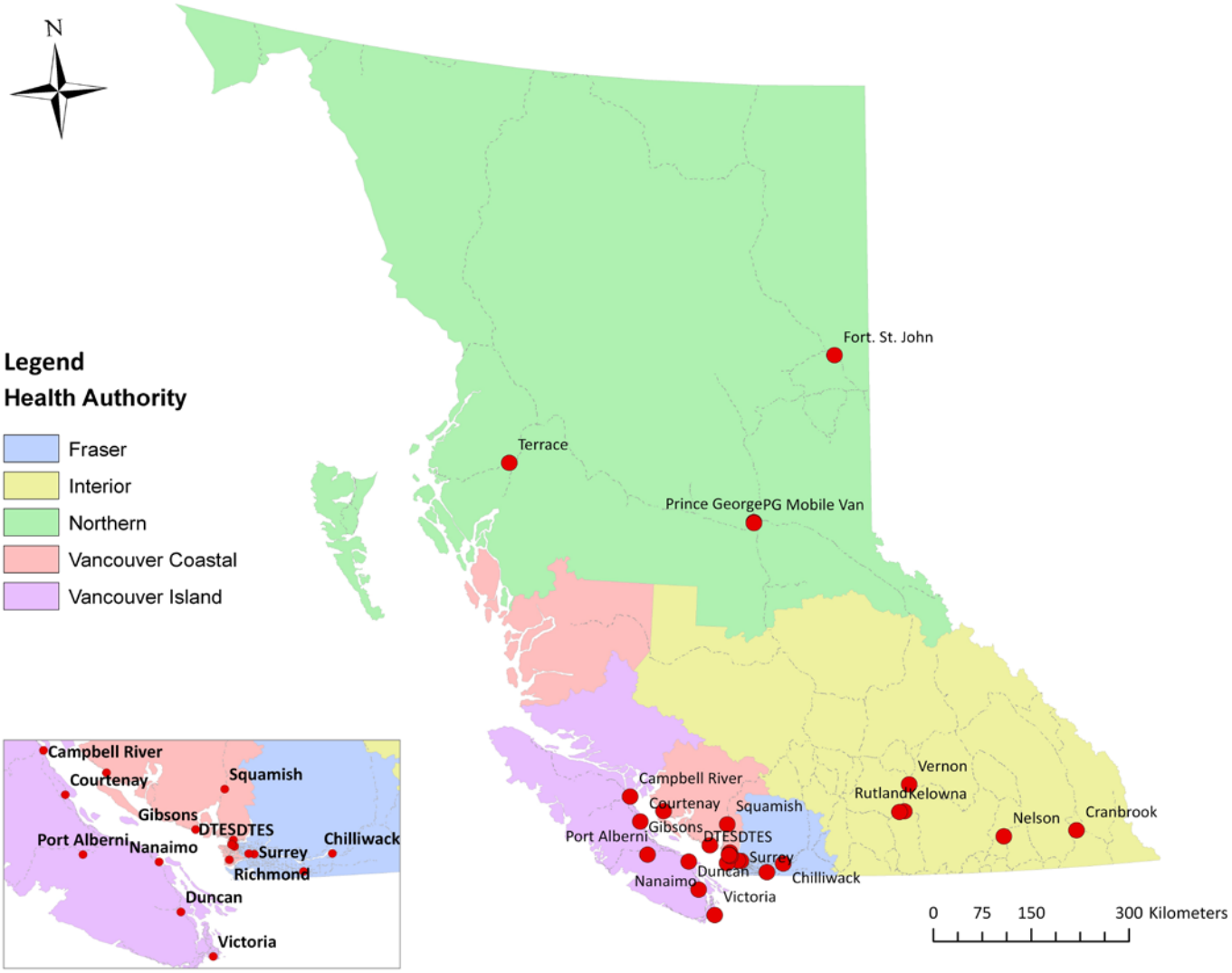
8. Public Health Agency of Canada. I-Track: Enhanced Surveillance of Risk Behaviours Among Injection Drug Users in Canada. August 2006. Project Overview: http://www.phac-aspc.gc.ca/i-track/sr-re-1/index-eng.php. Report found at: http://www.phac-aspc.gc.ca/i-track/sr-re-1/pdf/itrack06_e.pdf
9. BC Centre for Excellence in HIV/AIDS. Vancouver Injection Drug Users Study (VIDUS): http://cfenet.ubc.ca/research/vidus
10. BC Centre for Excellence in HIV/AIDS. Urban Health Research Initiative. At-Risk Youth Study (ARYS): http://cfenet.ubc.ca/research/arys
11. University of Victoria. Centre for Addiction Research of BC (CARBC). Alcohol and Other Drugs Monitoring Project (AOD Project). High Risk Populations: http://www.carbc.ca/AODMonitoring/ProjectComponents/HighRiskPopulations.aspx
12. University of Victoria. Centre for Addiction Research of BC (CARBC). Alcohol and Other Drugs Monitoring Project (AOD Project). Other Data and Interpretations: http://www.carbc.ca/Home.aspx
13. Statistics Canada. Rural and Small Town Canada Analysis Bulletin: Definitions of Rural. 2001; 3(3). Catalogue no. 21-006-XIE: http://www5.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=21-006-XIE&lang=eng

APPENDICES

Appendix A: Distribution of Needles and Syringes in British Columbia, 2011



Appendix B: Distribution of Harm Reduction Sites Participating in Pilot Survey (N=28)



Appendix C: List of Harm Reduction Sites Participating in Pilot Survey (N=28) by Health Authority

Site Name	Community
Interior Health Authority	
ANKORS	Nelson
ANKORS	Cranbrook
Living Positive	Rutland
NOYFSS	Vernon
Outreach Urban Health	Kelowna
Vancouver Island Health Authority	
SOLID	Victoria
AIDS Vanc Island	Courtenay
AIDS Vanc Island	Campbell River
NARSF	Nanaimo
NARSF	Duncan
NARSF	Port Alberni
Fraser Health Authority	
Pacific Community Resources Society	Chilliwack
The Warm Zone, Women's Resource Society of the Fraser Valley	Abbotsford
South Fraser Community Services	Surrey
The Lower Mainland Purpose Society for Youth and Families	New Westminster
Northern Health Authority	
Terrace Public Health	Terrace
Fort St. John Mental Health and Addictions	Fort. St. John
PG AIDS Prevention Programme - fixed site	Prince George
PG AIDS Prevention Programme - mobile site	Prince George
Vancouver Coastal Health Authority	
North Shore	North Shore
Sunshine Coast and Powell River - mobile unit	Gibsons and Sechelt
Sunshine Coast and Powell River - fixed site	Powell River
Harm Reduction Distribution Site in Richmond (Public Health Needle Exchange)	Richmond
Sea-to-Sky	Squamish
Robert and Lily Lee Family Community Health Centre harm reduction kiosk - fixed peer site	Vancouver
Robert and Lily Lee Family Community Health Centre harm reduction kiosk - evening outreach	Vancouver
The Washington	DTES
DTES Mobile Van	DTES

Appendix D: 2012 Pilot Survey

SITE ID:

DATE:

PAGE 1 of 2

Interviewer Initials: _____

Anonymous Client Survey

Please take a moment to complete this ***confidential*** survey. The information will be used to improve harm reduction services in your area. (Only complete if you have not done it before or it has been at least 14 days) ***Thank you.***

BC Harm Reduction Services and Strategies (HRSS)

1. Is this the first time you have used this supply pick-up site? Yes ❑ No ❑

2. What is your gender? Male ❑ Female ❑ Transgendered ❑

3. What is your age? _____ years old

4. If you picked up supplies today, who are the supplies for?

   only for myself ❑ myself & others ❑ only for others ❑

5. Have you ever used the services of any other supply pick-up site?

   (includes mobile, outreach) Yes ❑ No ❑

6. In the **PAST 7 DAYS**, have you consumed alcohol not sold in a liquor store?

   Some examples are rubbing alcohol, hand sanitizer/microsan, mouthwash, aqua velva, hairspray, vanilla extract, Lysol.

   No ❑ Not Sure/Don't Know ❑ Yes ❑

If Yes, what kind? : _____

7. If you used rigs in the **PAST 7 DAYS**, how did you get rid of them? (check all that apply)

   ❑ street/park/alley (onto ground)

   ❑ garbage cans/dumpsters

   ❑ returned to supply pick-up site

   ❑ gave to others to discard

   ❑ not sure/don't know

   ❑ put in container (i.e.: shampoo bottle, personal sharps container, ...)

Please describe type of container and where usually dispose of container:

_____

❑ other If other, please explain: _____

Please complete other side and give to service provider

Anonymous Client Survey

Please indicate how much of each of the following you used ***IN THE PAST 7 DAYS***.
It doesn't matter whether or not there was a prescription. **Thank you, *HRSS***

*(Remember, this is **confidential** and if we understand what people are using and how, we can provide better services!)*

Drug Type	# days you used in PAST 7 DAYS? (write 0—7)	The way you took it? (circle all that apply)	How many hits per day? (# or $)	How much per hit? (amount or $)
Cocaine (powder)		Swallow/ Smoke/ Inject / Snort Other:		
Crack		Swallow/ Smoke/ Inject / Snort Other:		
Heroin		Swallow/ Smoke/ Inject / Snort Other:		
Crystal Meth		Swallow/ Smoke/ Inject / Snort Other:		
Amphetamines dexedrine, preludin		Swallow/ Smoke/ Inject / Snort Other:		
Ritalin		Swallow/ Smoke/ Inject / Snort Other:		
"Speedballs"		Swallow/ Smoke/ Inject / Snort Other:		
Methadone		Swallow/ Smoke/ Inject / Snort Other:		
Benzo's		Swallow/ Smoke/ Inject / Snort Other:		
Morphine		Swallow/ Smoke/ Inject / Snort Other:		
Oxycontin/codone		Swallow/ Smoke/ Inject / Snort Other:		
Dilaudid		Swallow/ Smoke/ Inject / Snort Other:		
Barbituates		Swallow/ Smoke/ Inject / Snort Other:		
Glue or Solvents glue ,gas, Lysol, Pam		Sniff/ Inhale / Other:		

Are there any other drugs not listed here that you used **IN THE PAST 7 DAYS**?
(please name drug and the way you took it):

Thank You!!!

Appendix E: 2012

Post-Pilot Acceptability Questionnaire

Acceptability Indicators

After participating in the pilot survey:

1. We would be willing to do the survey again next year (once per year)

   ☐ strongly agree ☐ agree ☐ neutral ☐ disagree ☐ strongly disagree

2. We would consider doing the survey twice per year

   ☐ strongly agree ☐ agree ☐ neutral ☐ disagree ☐ strongly disagree

3. The questions were easy to understand and answer

   ☐ strongly agree ☐ agree ☐ neutral ☐ disagree ☐ strongly disagree

4. The staff and peers involved with the survey felt it was valuable information

   ☐ strongly agree ☐ agree ☐ neutral ☐ disagree ☐ strongly disagree

5. The administration of the survey to clients was minimally disruptive to our regular activities

   ☐ strongly agree ☐ agree ☐ neutral ☐ disagree ☐ strongly disagree

6. We estimate the decline/refusal rate was within acceptable limits (under 15%)

   ☐ strongly agree ☐ agree ☐ neutral ☐ disagree ☐ strongly disagree

7. Administration of the survey to clients by staff or peers is preferred over self-administration

   ☐ strongly agree ☐ agree ☐ neutral ☐ disagree ☐ strongly disagree

A. What went well for us: B. What didn't go so well: C. Suggestions for improvement:

Appendix F: 2013 Draft Survey

SITE ID:

DATE:

PAGE 1 of 2

INTERVIEWER INITIALS:

Anonymous Client Survey

Please take a moment to complete this ***confidential*** survey. The information will be used to improve harm reduction services in your area. (Only complete if you have not done it before or it has been at least 30 days) ***Thank you.***

BC Harm Reduction Services and Strategies (HRSS)

1. Is this the first time you have visited this harm reduction site? Yes ❑ No ❑

2. Did you pick up supplies here today? Yes ❑ No ❑

   If Yes, who are the supplies for?

   only for myself ❑ myself & others ❑ only for others ❑

3. What is your gender? Male ❑ Female ❑ Transgendered ❑

4. What is your ethnicity? Aboriginal ❑ Caucasian ❑ Other ❑

5. What is your age? _____ years old

6. Do you use crack pipes? Yes ❑ No ❑

   If Yes, how often you do get a new crack pipe? (in weeks): _____

   _____

   If Yes, how do you usually dispose of your crack pipe? _____

   _____

STOP— Go to Page 2

If you answered yes to 'other drugs not listed above' on page 2, please complete below:

remember PAST 7 DAYS ONLY

Drug Type	# days used	The way you took it?	Did you have

Final Question: Have you taken two drugs within 6 hours of each other **IN THE PAST 7 DAYS**? Yes ❑ No ❑

If Yes, what drug combination? _____

Please complete both sides

Anonymous Client Survey

Have you used drugs (prescription or non-prescription) **IN THE PAST 7 DAYS?**

Yes ❑ No ❑

If Yes, please indicate drugs from the list below you used **IN THE PAST 7 DAYS**

Thank you, *HRSS*

*(Remember, this is **confidential** and if we understand what people are using and how, we can provide better services!)*

Drug Type	# days you used drug in PAST 7 DAYS? (write 1—7)	The way you took it? (circle all that apply)	Did you have a prescription? (write YES or No)
Cocaine (powder)		Swallow/ Smoke/ Inject / Snort Other:	
Crack		Swallow/ Smoke/ Inject / Snort Other:	
Heroin		Swallow/ Smoke/ Inject / Snort Other:	
Alcohol		Swallow/Drink: Other:	
"Speedballs"		Swallow/ Smoke/ Inject / Snort Other:	
Amphetamines dexedrine, preludin		Swallow/ Smoke/ Inject / Snort Other:	
Marijuana		Smoke / Swallow Other:	
Barb's phenobarb, amobarb		Swallow/ Smoke/ Inject / Snort Other:	
Benzo's valium, ativan		Swallow/ Smoke/ Inject / Snort Other:	
Crystal Meth		Swallow/ Smoke/ Inject / Snort Other:	
Methadone		Swallow/ Smoke/ Inject / Snort Other:	
Morphine		Swallow/ Smoke/ Inject / Snort Other:	
Oxycontin/codone		Swallow/ Smoke/ Inject / Snort Other:	
Dilaudid		Swallow/ Smoke/ Inject / Snort Other:	
Ritalin		Swallow/ Smoke/ Inject / Snort Other:	

Are there any **other drugs NOT LISTED ABOVE** that you used **IN THE PAST 7 DAYS**?

Yes ❑ No ❑

If Yes, go back to bottom of page 1

Thank You!!!