jor reason that safe injection rooms are needed.

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[Evan Wood and colleagues respond:]

The answers to the questions raised by Gordon Brock and Vydas Gurekas are quite straightforward. We would hope that safer injecting rooms could operate on a 24-hour basis every day. After all, these are precisely the operating hours of the alleyways and shooting galleries where the public health crisis has emerged. Clients would bring their own drugs and would have access to sterile injecting equipment, which would be disposed of safely on site rather than in parks and schoolyards. Overdoses would be addressed sooner on site by staff, rather than later in ambulances and emergency departments. It is noteworthy that although British Columbia has had an average of 300 overdose deaths per year, there has never been a fatal overdose in any of the 42 safer injecting sites operating across Europe.[1]

If a safer injecting room only provided sterile injecting equipment and a place to inject where staff could respond to overdoses, it would represent a substantial improvement over the present situation. However, we further propose that referrals to detox, addiction treatment, counselling and primary health care be available for these difficult-to-reach populations. The legal issues have been fully considered by experts in the field and are not insurmountable.[2]

William Campbell and Nady el-Guebaly rightly point out that the provision of addiction treatment is woefully inadequate in Canada. Access to methadone must be improved, but it will ultimately not reach a significant proportion of opiate users[3] or cocaine addicts.[4] For these reasons, we concur that novel treatments such as heroin prescription must be explored.[5] For those not ready for treatment, programs such as safe injection sites should be implemented to prevent irreversible harms to these people and the health care system while they continue to inject.

Such sites should obviously be located close to where injection drug users presently congregate, such as Vancouver's Downtown Eastside. Brock and Gurekas wonder about the open-mindedness of neighbours, whose reaction may present the largest barrier to implementation of safer injection rooms. Although community concerns will have to be addressed, experience has shown that groups initially opposed to safer injection rooms often later become their strongest supporters, because they find the presence of a safer injecting room more acceptable than the intense open-drug scenes that preceded them.[1,6] Why would a neighbour oppose a safer injection room in their backyard, when they currently have unsafe injection scenes in their back alley?

We do indeed live in an era of intense pressures on constrained health care resources. For example, the lifetime direct medical costs associated with each case of HIV infection are in the range of $150 000.[7] The costs of hepatitis C infection are also extremely high, and the burden of in-patient care for patients with endocarditis, abscesses, nonfatal overdoses and other drug-related harms is crippling our inner-city hospitals.[8] Approximately $300 000 is spent annually on ambulance services to respond to overdoses in Vancouver alone.[9]

"How can we afford to pay for safe injection sites?" A better question might be, How can we afford not to?

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tion Action Society; 2000. Available: www.cfdp.ca/safei.pdf (accessed 2002 Jan 18).

[Thomas Kerr and Anita Palepu respond:]

Although we agree that there is need for an expansion of treatment services in Canada, evidence from Germany, the Netherlands and Switzerland suggests that a continuum of services that includes low-threshold services (e.g., safe injection facilities) constitutes the most effective means of reducing drug-related harm.[1,2] No intervention, be it abstinence-based treatment, methadone treatment or safe injection facilities, can stand alone as a panacea.[2] We believe that safe injection facilities could serve a purposeful and complementary role in our continuum of services, and therefore a rigorous trial and evaluation of safe injection facilities is warranted.

With respect to the complementary effects of safe injection facilities, research from Switzerland has shown that low-threshold services such as safe injection facilities serve to increase the number of injection drug users entering treatment.[1] During the mid-1980s Swiss medium- and high-threshold services (e.g., methadone and drug treatment) only contacted 20% of active injection drug users.[1] Following the implementation of safe injection facilities and other low-threshold services, the number of injection drug users entering treatment increased to 65%, and by necessity, treatment services were expanded.[1] According to Swiss reports, the remaining 35% of injection drug users were in regular contact with low-threshold services, which in turn served to minimize harm among people who continued to inject while reducing the impact of drug use on communities.[1]

Safe injection facilities have contributed to higher rates of referral to drug treatment. This can in part be attributed to increased opportunities for sustained contact between health care professionals and street-based injection drug users.[3] Although needle exchange and street-outreach workers make frequent contact with injection drug users, the great majority of these interactions tend to be cursory and on-the-run.[4,5] Safe injection facilities place trained staff in direct proximity with injection drug users while they are waiting to consume their drugs, as well as after they have done so and have returned to the waiting room. Moreover, safe injection facilities offer many needed services on-site: needle exchange, counselling, primary medical care, drug treatment, shower and laundry, and other services, depending on resources. There is substantial research that indicates that injection drug users will avail themselves of drug treatment and other services at much higher rates if they are offered on-site rather than externally.[6,7] Although Gordon Brock and Vydas Gurekas may question the transferability of these effects, we can conceive of no reason why Canadian drug users would be less likely to avail themselves of these services when similar referral mechanisms are implemented.

Discussions concerning the costs and interventions associated with injection drug use should not be limited to health service budgets and the associated priorities. As the Auditor General pointed out in a recent report, the total cost of illicit drug use in Canada is estimated to be $5 billion.[8] Of the $500 million devoted to enforcement, prevention, treatment and harm reduction, $475 million is used for enforcement. Perhaps what is needed is a redistribution of funds rather than increased investment in only one component of the health system. Clearly, a more comprehensive approach is needed to reduce the health, social and economic consequences of injection drug use in Canada.

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[Wayne Weston responds:]

Mark Latowsky applies the concept of informed and shared decision-making to physicians' work with a challenging group of patients, injection drug users, and suggests that we have a moral obligation to treat them with respect, as people with a disease rather than as bad people deserving punishment. Finding common ground[1] with these patients is often difficult because we want them to change too much, too fast and we become frustrated and judgmental when they do not follow our advice. Finding common ground does not mean coercing, cajoling or even coaxing our patients to agree with our treatment guidelines. Rather, it means seeking to understand the patient's world and their illness experience well enough that we can empathize with their plight and appreciate the difficult and sometimes unhealthy choices they feel compelled to make. We need to stick with them so that they know we care and they learn to trust us. Then, together we can tackle their problems.[2]

Two concepts help physicians to be more helpful and less pessimistic. Motivational interviewing methods are based on the theory of stages of change[3,4]: peo-