

# Safe Injection Sites and Needle Exchange Programs: An Important Part of Ensuring Health to Injection Drug Users

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Stephanie AUBIN\* <sup>1</sup>

<sup>1</sup> Student, University of Ottawa, Canada

\* *Auteur(e) correspondant | Corresponding author: N/A*

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## Introduction

When one thinks of current epidemics, surely HIV/AIDS is one of the first to come to mind. Although one perhaps thinks of it as mostly an epidemic associated with developing countries and in particular Africa, it is a problem here in Canada as well. In the 1990's Vancouver had the highest infection rate of all developed nations (BC Partners for Mental Health). This infection rate was largely driven by addicts (Ball, 2007), as HIV/AIDS can be transmitted through sharing of injecting equipment (Tyndall et al., 2006). In fact, the spread of HIV/AIDS by injection drug use is reportedly responsible for a third of new infections outside of sub-Saharan Africa (Ball, 2007). To try and slow the spread of infection through sharing of injecting equipment, needle exchange programs (NEPs) were developed (BC partners for Mental Health). The idea behind these programs is to provide injection drug users with safe equipment for injecting, but they serve also to reduce drug associated litter in the community as one is required to exchange a used needle to obtain a clean one (BC Partners for Mental Health). Following the example of European countries, Canada's first needle exchange programs were opened in the 1980's – in Toronto unofficially in 1987 and in Vancouver officially in 1989 (BC Partners for Mental Health). More controversial are safe injection sites (SISs). On top of supplying safe injection equipment, these sites provide the user with a safe place to inject as well as access to medical care on the premises (Canadian Centre on Substance Abuse, 2009, Bayoumi & Zaric, 2008). SISs and NEPs both fall under the term harm reduction: programs with the goal of reducing harm associated with drug use (and other unhealthy behaviours) by means other than reducing the behaviour itself (Weatherburn, 2009). Harm reduction strategies are important when the costs of the behaviour are great, and eradicating the behaviour poses many challenges (Weatherburn, 2009)

In 2002 Larry Campbell ran for mayor of Vancouver and his platform called for the immediate opening of a safe injection site to help combat Vancouver's AIDS epidemic (Kerr, Oleson, & Wood, 2004). When he won, and no SIS was opened, local activists opened a user-run SIS (Kerr, Oleson & Wood, 2004). This site was opened for 181 days before being shut down and was the first SIS in operation in Canada (Kerr, Oleson & Wood, 2004). In 2003 the pilot safe injection site called "Insite" began in Vancouver (Garmaise, 2005). Since its opening there has been ongoing research to establish its costs and benefits, and whether it should stay open on legal and ethical grounds.

This paper argues that harm reduction strategies such as needle exchange programs and safe injection sites are an important part of ensuring that injection drug users are afforded health equity. Despite the inappropriateness of drug use, the harms associated, such as contracting HIV, are disproportionate to the fact that drug use is illegal (Kleinig, 2006). There are criticisms to this point of view. First, some believe that the primary aim of any program funded by the government should be treatment, as opposed to reducing harm (Collier, 2008). Second, there are concerns that needle exchange programs promote drug use, as opposed to recovery from addiction. Third, there are concerns that needle exchange programs and safe injections sites will increase drug use and therefore increase associated crime.

In fact, safe injection sites do promote treatment and recovery and are not associated with an increase in drug use or crime. Therefore, despite the controversy surrounding safe injection sites, needle exchange programs and harm reduction strategies in general, drug users have a right to the health equity that can be obtained through these programs.

## Counterargument

There are many counterclaims to the argument that Safe Injection Sites are beneficial to the addict and the community. In an address to the Canadian Medical Association's 141st annual general council, Health minister Tony Clement summed up many of the criticisms. One point stated was that the money used to run this safe injection site, an estimated \$3 million a year, should be used on programs with the primary aim of treatment (Collier, 2008). Clement implied safe injection sites were a so-called band-aid as opposed to a cure, using smoking as an example and saying, "doctors tell patients to quit, not smoke less" (Collier, 2008). The Journal of Global Drug Policy and Practice takes a similar stand, highlighting that the risk of infection rises with each subsequent injection; hence abstinence is preferable (Voth, 2008). In a paper on needle exchange programs and ethics, Kleinig (2006) states that some see needle exchange programs as a "counsel of despair". One other person who has aligned himself with those staunchly against harm reduction is former president of the United States George W. Bush, who was quoted as saying:

I do not favour needle exchange programs and other so-called "harm reduction" strate-

gies to combat drug use. I support a comprehensive mix of prevention, education, treatment, law enforcement, and supply [prohibition] to curb drug use and promote a healthy, drug-free America, not misguided efforts to weaken drug laws. [...] America needs a President who will aim not just for risk reduction, but for risk elimination that offers people hope and not a dead-end approach that offers despair and addiction (Kleinig, 2006, p. 818).

As Ball (2007) brings to our attention, a type of dichotomy has been set up: treatment versus harm reduction. Critics seem to believe it is all or nothing and that a focus on both cannot exist simultaneously.

A second point of concern for Clement was the extent to which recovery was promoted at the safe injection site, let alone that treatment was not the primary goal (Collier, 2008). More and more needles are being handed out by the needle exchange program in Vancouver; in fact there has been a tenfold increase in the last decade (BC Partners for Mental Health). Could this indicate that there is in fact no recovery by the injection drug users using the needle exchange program? It has even been hypothesized that safe injection sites may have a negative effect on recovery. The theory goes that with medical supervision a user may be more likely to inject higher doses of the drug, seeing as the medical personnel create a sense of security, a sense that if ill consequences do follow, the user need not worry as they will be attended to (Canadian Centre on Substance Abuse, 2009).

Lastly, of concern is the link between safe injection sites and crime. Clement put forth the question: is it ethical for doctors to be involved in the administration of illegal substances (Collier, 2008)? Critics have also noted that injection drug users often commit crimes to obtain drugs, and therefore the link is made that safe injection sites promote crime (Canadian Centre on Substance Abuse, 2009). This has been a particular concern to conservative religious groups (Wynia, 2005). They worry that, “harm-reduction efforts provide tacit social approval of risky, and ‘immoral,’ behaviours” (Wynia, 2005). Kleinig (2006) also notes that the effectiveness of a needle exchange program does not eliminate the need to meet ethical requirements. In a discussion forum on supervised injection sites it was noted that because of Insite’s association with illegal substances and illegal practices, the site is being evaluated much more

harshly than other public health initiatives (Canadian Centre on Substance Abuse, 2009).

## Position argument

Although research is ongoing, so far studies have pointed to needle exchange programs and safe injection sites as having a positive influence on injection drug users individually and on the community collectively. Treatment would be ideal, as would full recovery of all substance abusers; however currently, with respect to certain drugs in certain countries, harm reduction is a much more realistic proposition (Ball, 2007). Meanwhile, unrecovered substance abusers are deserving of a life without AIDS or Hepatitis C. As Dr. Bonnie Cham, chair of the CMA’s Committee on Ethics points out, “IV drug users have the right to compassion and access to care that has proven to be beneficial,” (Collier, 2008). Kleinig (2006) notes:

Even a minimally humane society does not leave by the roadside those whose reckless driving has resulted in an accident, and we cannot ignore the medical conditions of those whose drug use has resulted in their contraction of serious disease (p. 821).

In fact the Canadian Charter of Rights and Freedoms, and the Canadian Human Rights Act protect the rights of drug users as a group, giving them legal entitlement to “reasonable personal safety” (BC Partners for Mental Health). It would appear that harm reduction strategies have played a role in ensuring such safety. A study conducted in the U.S. highlighted that drug users with access to a needle exchange program are up to six times less likely to become infected with HIV/AIDS as compared with drug users who had no access (BC Partners for Mental Health). In a U.S. study conducted from 1994 to 2004, it was found that those using NEPs were less likely to share needles and therefore NEPs had an indirect effect on the reduction of Hepatitis C among injection drug users (Holtzman et al., 2009). In France, after the introduction of a needle exchange program in 1994, HIV prevalence decreased from 40% to 11% (Carrieri, 2008). This is not to say that treatment and recovery should be ignored. Needle exchange programs and safe injection sites are a useful way to come into contact with the drug using population and expose them to treatment options (Wynia, 2005). In fact, during twelve months of supervision of Vancouver’s safe injection site, 2171 referrals were made, and 37% of these were for

addictions counselling (Tyndall et al., 2004). Despite this achievement, it must not be ignored that treatment and recovery are secondary aims of the safe injection site pilot project in Vancouver; the primary aim is reducing transmission of HIV/AIDS (Canadian Centre on Substance Abuse, 2009). In this respect the site would again seem to be successful: in the last five years incidence has decreased from 310 new cases to 163. And although there has been a tenfold increase in needles handed out, there has been a 110% return rate, indicating a decrease in needles disposed of inappropriately in the community (BC Partners for Mental Health). As for safe injection sites causing IV drug users to inject higher doses, to date there is no evidence to support this claim (Canadian Centre on Substance Abuse, 2009). To reinforce the utility of needle exchange programs and safe injection sites it must be noted that Clement and Voth are correct: harm reduction is not a cure and drug injection is dangerous; however SISs and NEPs help injection drug users on the road to recovery (although not its primary aim) and meanwhile reduce the danger of contracting AIDS and Hepatitis C through injection.

Another point the health minister brings up is the cost of Insite. Would this money be better spent elsewhere? The above paragraph argues that Insite is money well spent, however it should be noted that a case study of an unsanctioned user-run safe injection site suggests that the program could be run quite economically (Kerr, Oleson, & Wood, 2004). In 2003, a group of volunteers opened a safe injection site in Vancouver in response to a police crackdown on drugs as well as in response to the mayor's failure to fulfill his campaign promise to open a sanctioned safe injection site. Over 181 days the site was able to support 9000 visits and 3000 injections despite having limited financial support and being run by volunteers and users of the facility (Kerr, Oleson, & Wood, 2004). Another study estimated that if one looks only at the impact on health of using non-contaminated injection equipment, the health care system saves \$14 million and 920 years of life lost over a ten year period (Bayoumi & Zaric, 2008). Another study found that by conservative estimates Insite prevents thirty-five new cases of HIV and three deaths each year (Andresen & Boyd, 2009). This is further proof that government funds used on safe injection sites are well spent.

Another concern voiced by critics is that needle exchange programs and safe injection sites appear to condone the use of illegal substances and therefore the use of illegal substances may increase, and we would subsequently see a rise in crime rates. To date, there is no evidence that safe

injection sites increase drug use (Health Canada releases report, 2008). As for the implication that safe injection sites condone crime, NEPs convey no positive regard for non-dependent drug dealers (Kleinig, 2006).

Secondly it has been found that the opening of Insite had no visible effect on drug trafficking and assaults and robbery, whereas the breaking and entering of vehicles and vehicle theft diminished in the neighbourhood in which Insite operates (Wood, Tyndall, Lai, Montaner & Kerr, 2006). Similar results were also found upon evaluation of a safe injection site in Australia: there was no increase in theft, robbery, or drug-related loitering after the opening of the site (Freeman, Jones, Weatherburn, Rutter, Spooner, & Donnelly, 2005). In another study evaluating a SIS in Australia the public was surveyed. It was found that 90% of the public surveyed listed at least one benefit of the SIS, indicating their awareness of the necessity of the site. Also there was a significant reduction reported in the amount of public injections witnessed (Salmon, Thein, Kimber, Kaldor, & Maher, 2007).

The health minister was also concerned with the ethical implications of physicians and other medical personnel being involved with the administration of banned substances. A study printed in the *Annals of Internal Medicine* and conducted by Temple University School of Law found there were no ethical concerns with physicians prescribing safe injecting equipment (Burriss, Lurie, Abrahamson, & Rich, 2000). There is a standard of care for patients who inject drugs, and it is in fact unethical not to meet this standard. Their study also notes:

Prescribing sterile injection equipment is certainly appropriate from a clinical perspective. Many injection drug users cannot or will not abstain; others may be willing to try but cannot gain access to drug treatment services. Health care providers are well acquainted with the notion of setting intermediate goals in caring for patients. For example, a physician might suggest that a two-pack-a-day smoker reduce his or her daily tobacco consumption to a single pack because predictable benefits result from even a reduction in smoking (Burriss, Lurie, Abrahamson & Rich, 2000, p. 219).

Furthermore, an analysis of the relevant laws in 50 states in the U.S. and in Puerto Rico found that physicians prac-

ting in these states were well within the law to prescribe sterile injection equipment with the aim to reduce disease transmission (Burriss, Lurie, Abrahamson, & Rich, 2000).

In response to the concerns of religious groups, Kleinig (2006) notes the dangers of public policy being directed by religious beliefs. He suggests that their idealistic principles for the drug user population should be proven as possible of effecting some change before being adopted. Another point Kleinig brings up is the belief that reducing NEPs and SISs will reduce drug use. As Kleinig put it, it is “a serious misunderstanding of the dynamics of drug use as well as the drug-injecting population.” In essence there is little evidence that NEPs increase drug use or crime rates in the surrounding area in which they are established and in some cases may appear to diminish certain types of crime. Also, medical practitioners are not behaving unethically when working with safe injection sites. As for the place of religious beliefs in this debate, they do have a place, but the safety of the drug users must be put first.

## Conclusion

Injection drug users are a part the Canadian population and therefore deserve health equity. This was taken into consideration when Justice Ian Pitfield of the BC Supreme Court ruled that the federal government could not close Insite (Vancouver Coastal Health, 2009). His decision was based on the fact that Insite is a public health initiative to which users have a constitutional right. There have been over 30 peer reviewed studies evaluating Insite in particular, and many more evaluating safe injection sites in general. According to Kerr, one of these researchers, the academic debate concerning the medical utility of Insite is over (O'Connor, 2009). Although the health minister has expressed many concerns, these concerns have been more political and moral in nature as opposed to viewing the matter from a strictly academic standpoint. The health minister wonders if government funds should be spent on harm reduction as opposed to strict treatment and detoxification programs, whether SISs promote recovery, and whether it is ethical for the government to fund a program associated with illegal substances and practices (Collier, 2008). In fact these questions have been answered in the literature. Treatment and recovery are promoted at safe injection sites, and if we look at the impact that these sites have on the user, we know the sites are an appropriate use of government funds. Further, safe injection sites and nee-

dle exchange programs are not associated with any increase in illegal activity, whether it is drug use or criminal acts to obtain such drugs. But the bottom line is this: the availability of safe injection equipment through safe injection sites and needle exchange programs reduces the rate of contraction of HIV and Hepatitis C among injection drug users. Public health initiatives such as Insite are important if all socio-economic segments of the population are to be afforded health equity.

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