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Review

Supervised injection services: What has been demonstrated? A systematic literature review☆

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ABSTRACT

Background: Supervised injection services (SISs) have been developed to promote safer drug injection practices, enhance health-related behaviors among people who inject drugs (PWID), and connect PWID with external health and social services. Nevertheless, SISs have also been accused of fostering drug use and drug trafficking.
Aims: To systematically collect and synthesize the currently available evidence regarding SIS-induced benefits and harm.
Methods: A systematic review was performed via the PubMed, Web of Science, and ScienceDirect databases using the keyword algorithm [("SUPERVISED" OR "SAFER") AND ("INJECTION" OR "INJECTING" OR "SHOOTING" OR "CONSUMPTION") AND ("FACILITY" OR "FACILITIES" OR "ROOM" OR "GALLERY" OR "CENTRE" OR "SITE")].
Results: Seventy-five relevant articles were found. All studies converged to find that SISs were efficacious in attracting the most marginalized PWID, promoting safer injection conditions, enhancing access to primary health care, and reducing the overdose frequency. SISs were not found to increase drug injecting, drug trafficking or crime in the surrounding environments. SISs were found to be associated with reduced levels of public drug injections and dropped syringes. Of the articles, 85% originated from Vancouver or Sydney.
Conclusion: SISs have largely fulfilled their initial objectives without enhancing drug use or drug trafficking. Almost all of the studies found in this review were performed in Canada or Australia, whereas the majority of SISs are located in Europe. The implementation of new SISs in places with high rates of injection drug use and associated harms appears to be supported by evidence.

Contents

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1. Introduction

Injection drug use represents a source of numerous harmful effects on both the health conditions of people who inject drugs (PWID) and their social environment. Drug injection is one of the main factors in the dissemination of blood-transmissible viral infections such as human immunodeficiency virus or the hepatitis B and C viruses (EMCDDA, 2008; Joint United Nations Programme on HIV/AIDS, 2002; WHO, 1997). In addition, numerous other physical problems can result from drug injection, including other viral and bacterial infections, cutaneous lesions, locomotive disorders, and hepato-gastroenterological pathologies (INSERM, 2010; Klee and Morris, 1995; Palepu et al., 2001). Psychiatric disorders are also more frequent in PWID (EMCDDA, 2008), who are subject to reduced access to medical services (Kerr et al., 2005b). Moreover, PWID exhibit enhanced marginalization from society, which increases their exposure to social precariousness, unemployment, homelessness, crime, and prostitution (DeBeck et al., 2007; EMCDDA, 2008). Thus, injection drug use induces considerably higher mortality. Partly because of its illegal nature, injection drug use is also responsible for numerous societal consequences, e.g., violence, traffic, crime, and public space degradation (Kerr et al., 2005a; Renn and Lange, 1996; Singer et al., 2001). For these reasons, injection drug use places a heavy burden on society.

During the early 1980s, PWID had to face the HIV epidemic. Preventing viral infection became crucial, and, therefore, care professionals had to consider the damage caused by drug use rather than focusing on drug use itself. Moreover, in face of the failure of public policies that aimed to eradicate drug use and drug trafficking (Drucker, 1999) and in consideration of the number of PWID who were not ready to enter into classical abstinence care, new prevention and care paradigms emerged, constituting the 'harm reduction' approach (MacPherson, 2001; Wodak and Owens, 1996). The first aim of these new care systems was to reduce the social and medical consequences of injection drug use and to stop the marginalization spiral to which PWID were exposed (Berridge, 1999; MacPherson, 2001). In this context, the first syringe exchange programs and the development of opiate maintenance therapies were implemented (WHO, 1998).

Similarly, new facilities emerged at the end of the 1980s, and the first objective was to allow PWID to inject self-provided drugs within a supervised framework in enhanced aseptic conditions with medical monitoring and no risk of police control (EMCDDA, 2008; Jozaghi, 2012; Semaan et al., 2011). These facilities have had different appellations, including 'safer injection facilities,' 'supervised injecting centers/sites/rooms/facilities,' 'drug consumption rooms,' and 'supervised injection services' (SISs) (Hedrich, 2004; Noël et al., 2009). Throughout the present article, we will indistinctly use the term 'SISs' to designate these facilities. The concept of SISs rapidly spread in Western countries, and in 2010, there were more than 90 identified SISs in Canada, Australia, Norway, Germany, Switzerland, Spain, the Netherlands and Luxembourg (Semaan et al., 2011).

SISs were implemented complementarily to other harm reduction measures for the following purposes (EMCDDA, 2009; INSERM, 2010; Noël et al., 2009): (1) to reach the most marginalized populations of PWID, who are least likely to obtain access to medical and social support, and connect them with health and social services; (2) to reduce overdose-induced morbidity and mortality; (3) to educate PWID to enhance their health behaviors; (4) to reduce injection-related risks by promoting the prevention and education of safe self-injecting practices; (5) to improve the global health conditions of PWID by promoting the prevention, screening and medical orientation of viral infections; (6) to foster the initiation of dependence care programs among PWID; and (7) to reduce the nuisances triggered by injection drug use in public spaces, e.g., urban violence and crime, drug trafficking and drug-use waste.

SIS access is usually restricted and regulated (Hedrich, 2004; INSERM, 2010). Most SISs are forbidden to subjects under 18 years of age, pregnant women, irregular or unidentified PWID, and individuals who wish to experience their first drug injection. Internal rules also forbid violence and drug selling. Moreover, many SISs prohibit drug sharing or helping other users with drug injection. However, SISs have endured criticism. Some official organizations have argued that "*any national, state or local authority that permits the establishment and operation of drug injection rooms or any outlet to facilitate the abuse of drugs (by injection or any other route of administration) also facilitates illicit drug trafficking*" (INCB, 1999). The detractors of SISs often argue that SIS implementation is equivalent to the tacit acceptance of injection drug use by public authorities, which will foster drug use, attract drug traffickers and increase drug-related consequences in the surrounding area (Boyd, 2013; Elliott et al., 2002; Gandey, 2003; Parliament of New South Wales, 1998). This perception has often been shared by groups of local residents and politicians in cities where new SISs were implemented (Elliott et al., 2002) and has sometimes led to long court procedures (Health Canada, 2006; Small, 2010; Wodak et al., 2003; Wood et al., 2007).

Twenty-eight years after the first legal opening of an SIS (Zobel and Dubois-Arber, 2004), we have performed a systematic review of the literature to collect the published data currently available on SISs and to synthesize these data to determine whether SISs have achieved their objectives and whether the fears raised against them are justified.

2. Materials and methods

A systematic search for relevant articles was conducted and is presented herein according to the PRISMA statement (Liberati et al., 2009). The research was performed using the PubMed, Web of Science, and ScienceDirect databases. To avoid selection bias, an inventory of the different English appellations for SIS was conducted, which led to our use of the following keyword algorithm: ("SUPERVISED" OR "SAFER") AND ("INJECTION" OR "INJECTING" OR "SHOOTING" OR "CONSUMPTION")

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