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Perceptions about supervised injection facilities among people who inject drugs in Philadelphia

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ABSTRACT

Background: People who inject drugs (PWID) are at high risk for infectious diseases, skin and soft tissue infections, and overdose. However, these harms are all avoidable when sterile injection equipment, hygienic places to inject, and medical care are accessible. Unfortunately, many PWID in the U.S lack these resources. The most vulnerable are forced to inject in public spaces, where individual risks are high and communal harms are sometimes many. Supervised Injection Facilities (SIFs) are an established intervention for reducing these harms. Despite positive experiences in other countries, little research explores how PWID in the U.S. perceive the value of such facilities.

Methods: We conducted a freelisting exercise with PWID (n = 42) and healthcare providers (n = 20) at a syringe exchange program (SEP) that provides comprehensive clinical and social services in Philadelphia to inform in-depth semi-structured interviews with PWID (n = 19) at the same location.

Results: Participants expressed support for a potential SIF as a valuable public health intervention. They suggested that an SIF would improve PWID health while reducing the public disorder associated with injecting drugs in public. The latter was especially important to participants without stable housing, whose decision to inject furtively in secluded places was often motivated by desire not to upset community members, and particularly children. These participants acknowledged that such seclusion elevated the risk of fatal overdose. Despite similarly positive perceptions about an SIF, participants with stable housing reported that they would prefer to continue injecting at home.

Conclusion: Results both confirm and extend prior research about PWID and SIFs. Participants expressed support for SIFs as in prior survey research in the U.S. and in other countries. Facility location and housing status were identified as important determinants of facility use. Results extend prior research by illuminating PWID perceptions in the U.S. including motivations grounded in concern for public order.

Background

Injection drug use is a longstanding source of population harm. Despite considerable progress expanding harm reduction interventions, people who inject drugs (PWID) remain at high risk for infectious diseases such as HIV and hepatitis C (HCV) (Van Handel et al., 2016; Wejnert et al., 2016). Injection-related skin and soft tissue infections (SSTI) are common, and when medical care is delayed, costly and difficult to treat. With observed prevalence rates just over 30% among active PWID, these wounds are a primary driver of Emergency Department visits, hospitalizations, and readmissions among PWID (Binswanger et al., 2008; Palepu et al., 2001; Smith et al., 2014). Injection drug use also accounts for a substantial portion of the surging opioid overdose epidemic. In the last decade, fatal heroin overdoses have more than tripled in the U.S. (Hedegaard et al., 2015); fatal overdoses involving fentanyl have increased over 70% over one recent two year period (Rudd et al., 2016).

Many of these harms are avoidable. With sterile injection equipment and hygienic places to inject, PWID can dramatically reduce their risk of HIV, HCV, and SSTI (Bluthenthal et al., 2000; Kinnard et al., 2014; Phillips et al., 2012). When naloxone is readily available and medical care is accessible, fatal overdoses are prevented and safely managed (Kerr et al., 2008; Walley et al.,

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2013). Unfortunately, many PWID in the U.S. lack these resources (Cooper et al., 2016). The most vulnerable are forced to inject in public spaces, where individual risks are high and communal harms such as injection related litter are sometimes many (Rhodes 2002; Small et al., 2007).

Supervised Injection Facilities (SIF) are an established intervention for reducing the harms associated with injection drug use (Potier et al., 2014). These facilities provide a safe, hygienic space where individuals can inject controlled substances under clinical supervision. Most facilities also offer drug counseling and other social services (Kerr et al., 2007). Despite established benefits in other countries, there are only two studies exploring whether PWID in the U.S. would utilize such facilities. In both surveys, one in San Francisco and the other in Rhode Island, most PWID expressed support and willingness to use a SIF (Bouvier et al., 2017; Kral et al., 2010). Our study is the first, to our knowledge, to explore perceptions of SIF among PWID in the U.S. using qualitative methods. Given prior research documenting stigma and fear among PWID, we approached these inquiries through a broader investigation about where participants currently inject and the factors that motivate that decision.

Methods

Data collection began with a freelisting exercise with PWID (n = 42) and healthcare providers (n = 20), who were all recruited from a syringe exchange program (SEP) that provides clinical and social services in the Philadelphia area. Freelisting is an ethnographic tool used to explore individuals' notions of health practices or conditions, and differences between healthcare providers and lay person's perceptions. The approach identifies salient domains among people who have a shared experience, often in preparation for subsequent exploration with other qualitative methods (Brewer, 2002; Quinlan, 2005; Schrauf & Sanchez, 2008; Weller & Romney, 1988). In this instance, PWID and healthcare providers at the SEP were asked to create lists of terms associated with the causes, risks, and treatment of SSTI. Analysis of resultant lists was facilitated by Anthropac 4.98 software and revealed salient terms related to injection practices ("dirty works," "missing the shot," and "rushing"), injection risk environments ("unsanitary conditions," "abandoned houses") and injection stigma ("being treated as a junkie," "fear of law enforcement"). These findings, along with policymaker interest in SIFs, informed the development of our semi-structured interview guide which explored whether PWID believe that SIFs would improve the prevention and treatment of injection-related problems, particularly SSTI. More details about the findings relating to abscess knowledge, self-care, and barriers to healthcare for SSTI are published in a companion piece (Harris et al. 2018). Participants in the semi-structured interviews (n = 19) were approached during operating hours at the same SEP or were referred to the study by staff. Participants were compensated with $20 at the end of the interview. The interviews, which lasted between 30 and 50 min, were audio-recorded and transcribed verbatim.

Analysis of the transcripts was facilitated by NVivo11 software. First, the study team developed a code-book in two ways: a priori (informed by the literature and interview guide) and through line by line reading of a subsample of interview transcripts. Each code was given an explicit definition to ensure coding accuracy then each transcript was coded by two members of the study team. The full research team participated in resolving coding inconsistencies, and schema refinement. Resultant codes were organized into thematic categories, which were explored in the context of individual transcripts and stratified by groups (e.g., those reporting home versus public injection). Institutional review boards at the University of Pennsylvania and the SEP approved the study.

Results

Qualitative interview participants identified as male (n = 9) and female (n = 10). Fifteen (n = 15) identified as White (n = 15); the remainder identified as Latino (n = 1), and Black (n = 3). Median age was 39 years (range: 27–59 years). Median time injecting drugs was 14 years (range: 2.5–20 years). Although not systematically elicited, in unstructured discussion, access to housing emerged as an important factor in participant decision-making and perceptions, with just over half of the participants reporting access to stable housing (n = 10).

Preference for home injection

Participants with stable housing almost exclusively injected drugs in their homes. They explained this preference in terms of security and the ability to control their surroundings. Protection from the fear of assault or arrest facilitated routinized injection practices predicated on security and comfort. Being inside also afforded these participants access to adequate light and heat and running water, as well as stores of clean injection equipment and sharps containers to safely discard used paraphernalia, obtained from the SEP.

> Most of the time I try to grab my shit the night before. . You know what I'm (getting high) before I get my kids up, because I wake up an hour before I have to wake my kids up. This way, by the time they get up, I'm already up and functioning. We're not waking up at the same time and I'm hearing, "Mom, Mom," because I'm drowsy . . . They get up, brush their teeth, come downstairs, eat. I already did my bag, everything's already out. I ain't got to worry about nothing. (Participant 6)
>
> [N]umber 1 is safety. [If you are] outside injecting, and you go into your nice phase, anybody can get you. . [the next is] access of water. Um. The electricity as far as light's concerned . . . If it's in the wintertime, the heat. (Participant 13)

When asked why PWID choose to inject in abandoned houses and other secluded locations, one participant noted simply "Because they're homeless. Where else are they going to shoot up?" (Participant 20).

Most participants with housing did not think they would use a SIF, if available, still preferring to inject at home, especially if they could do so with other trusted family and friends. However, about half of the participants with stable housing (n = 5) suggested that they have or would inject away from home during severe withdrawal.

> You know some people they get so sick they just like, you know what screw it, I'm going there. (Participant 16)
>
> I had to go far to get it, the heroin, and I was so sick that I just couldn't walk back . . . so I went in an alley. (Participant 6)

Although injecting alone at home may decrease the risk of that an overdose will be reversed, access to stable housing otherwise provides a reasonably safe, sanitary, and comfortable environment in which to inject. Those lacking access to housing face a series of challenging decisions about where best to inject for the health and safety of themselves and their communities.

A dual imperative for PWID without stable housing

For participants without stable housing, the decision of where to inject was driven by two opposing imperatives. The first imperative was avoiding attention. PWID sought places to inject where they would not be observed by police, by those who mightrob or otherwise injure them, or by the community. Fear of arrest and violence are both well-established in the literature. The