

Non-injection drug use within supervised consumption services

What is known about including non-injection drug use within supervised consumption services?

Supervised consumption services (SCS) that allow non-injection drug use (e.g., oral, intranasal, inhalation) have similar design and operational features as supervised injection services. Notable differences include dedicated spaces and time limits for non-injection drug use. Some evidence shows that these types of SCS can save money, promote safer use, and improve the health and safety of people who smoke drugs.

Background

Canada is experiencing an ongoing drug poisoning emergency. Between 2016 and 2021, there were more than 24,000 drug toxicity deaths in Canada¹. SCS, which are facilities where people can use drugs under the supervision of trained staff who respond to overdoses and provide connections to health and social services, are a core component of Canada's response to the drug poisoning emergency. However, most available research on SCS



Want more information on SCS? See *Supervised Consumption Services: The Basics* evidence brief and infographic on whyscs.ca for more details.

¹ Government of Canada. Opioid-related harms in Canada: June 2021 [Internet]. 2021 [cited 2022 Jan 06]. Available from: <https://health-infobase.canada.ca/substance-related-harms/opioidsstimulants/>



focuses on injection drug use². Little is known about using drugs orally, intranasally, or through inhalation within SCS.

Although injecting typically carries higher overdose risk than other routes of drug use, the relative risks associated with each route of drug use are changing in light of increased toxicity and contamination of illegal drugs, and other drug use trends³. For example, some Canadian regions have reported rising deaths related to inhalation⁴. People who use drugs through non-injection routes also experience blood-borne infections and adverse health outcomes related to specific routes of drug use (e.g., burns, mouth sores, and respiratory conditions associated with inhalation)^{2,3}. Including non-injection drug use within SCS may support subpopulations of people who use drugs that are typically underserved or excluded from existing services.

To learn more about SCS that include non-injection drug use, we searched the available literature that specifically discussed including at least one route of non-injection drug use within SCS. We published two academic articles summarizing the available evidence^{2,3}, including: 1) SCS characteristics (e.g., layout, service hours, staffing, rules, and challenges)²; 2) characteristics of participants using non-injection drug use within SCS²; and 3) the feasibility and outcomes of including inhalation and other non-injection routes of drug use within SCS³.

What did we find?

We identified 48 existing SCS that allowed non-injection drug use, most of which included inhalation and were located in Germany². SCS that allow non-injection drug use are similar to SCS that only allow injection, except in these noteworthy ways.

Layout

Generally, the physical layout of SCS including non-injection drug use is similar to those designed for injection³. However, SCS that allowed non-injection drug use included dedicated spaces to accommodate inhalation. For example, inhalation was offered in separate, often ventilated, rooms, while other SCS offered inhalation in outdoor settings². Moreover, evidence suggests that a welcoming physical environment and dimmer lighting is particularly important for inhalation within SCS³. Regardless, most SCS had



Want more information on the design and operational characteristics of SCS including non-injection drug use? See *To what extent do supervised drug consumption services incorporate non-injection routes of administration? A systematic scoping review documenting existing facilities* by Speed et al².

² Speed KA, Gehring ND, Launier K, O'Brien D, Campbell S, Hyshka E: To what extent do supervised drug consumption services incorporate non-injection routes of administration? A systematic scoping review documenting existing facilities. *Harm Reduct J*. 2020; Oct 7;17(1): 72.

³ Gehring ND, Speed KA, Launier K, O'Brien D, Campbell S, Hyshka E: The state of science on including inhalation within supervised consumption services: A scoping review of academic and grey literature. *Int J Drug Policy*. 2022; Apr;103589

⁴ British Columbia Coroners Service. (2020). Illicit drug toxicity deaths in BC knowledge update: Mode of consumption. Ministry of Public Safety & Solicitor General [Internet]. 2020 [cited 2022 Mar 13]. Available from: <https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/mode-of-consumption.pdf>

more spaces available for injection than inhalation². Although intranasal use could occur separately, it often occurred in inhalation or injection spaces.

Rules

Most of the SCS including non-injection drug use had restrictions on sharing drugs, reusing supplies, types of drugs that could be consumed, routes of drug use allowed, time limit for drug use, and prohibiting violence². Non-injection drug use typically had a shorter time limit than injecting.

Challenges

Research suggests that inhalation tends to be more social than consuming through other routes. Thus, special attention is needed to avoid drug and inhalation equipment sharing while allowing participants to smoke drugs together within SCS³. Evidence also suggests that providing education and building relationships are limited in inhalation spaces due to potential staff exposure to second-hand smoke². Moving these interactions to other spaces like the waiting or post-consumption area may address this challenge³.

Who uses them?

Similar to participants of supervised injection services, typical users of SCS that allow non-injection drug use were men over the age of 30 and structurally vulnerable (e.g., experiencing unstable and/or lack of housing)². This is consistent with our research indicating a high willingness to use SCS for inhalation amongst people who use drugs and experience structural vulnerabilities (e.g. experiencing unstable and/or lack of housing, identifying as a sexual or racial minority)³. Some SCS target specific populations, like women engaged in sex work or people experiencing homelessness, through dedicated service hours or entry criteria

Who uses the SCS is largely dependent on who is allowed to access the service. Most of the identified SCS including non-injection drug use had entry criteria, including a minimum age, having a history of illegal drug use, not being intoxicated at entry, and/or requiring to be registered with the site². Some also excluded people on addiction treatment, people who were not residents in the city of the SCS, or people with children or current pregnancy.

What impact do they have?

Improve health and safety

SCS including non-injection drug use may improve the health and safety of people who use drugs³. Studies found that using SCS including inhalation increased participants' physical or overall health (e.g., by preventing

infections, providing basic necessities), reduced their exposure to violence (e.g., by providing a safer location), and increased their access to health and social services (e.g., housing support, substance use treatment).

Promote safer drug use practices

Some evidence on SCS including non-injection drug use suggests that these types of SCS may reduce public drug use, equipment sharing, and improperly discarded drug use equipment³. Some research also suggests that including non-injection drug use within SCS may support the transition from injection to inhaled drug use.

Cost savings

SCS allowing non-injection drug use may also save money, although the evidence is limited. One study found that healthcare cost savings outweighed the operational costs of a SCS including inhalation³.



Want more information on the impact of SCS including non-injection drug use?

See *The state of science on including inhalation within supervised consumption services: A scoping review of academic and grey literature* by Gehring et al³.

What do we still need to learn about SCS including non-injection drug use?

Compared to injection, literature on non-injection drug use within SCS is limited^{2,3}. Among research on SCS including non-injection drug use, inhalation receives the most attention. Research documenting and evaluating other non-injection drug use within SCS (e.g., intranasal, oral, rectal) is needed. The level of reported detail about site and participants' characteristics varies considerably between SCS². Standardizing vocabulary and reporting to describe SCS and participants may facilitate understanding the different models, and determining which characteristics are most relevant for specific contexts, which would help researchers and those seeking to implement a SCS.

More research is needed on how access is limited for certain people who use drugs. For example, women tend to use drugs via inhalation more frequently than men, while also likely to experience violence or bloodborne virus infections. Similarly, youth who use illegal drugs are at an increased risk of exposure to bloodborne viruses. However, hours of operation and entry criteria that exclude minors and people who are pregnant or have children with them exclude these populations from accessing SCS².

Future research may also focus on the impact of allowing non-injection drug use within SCS on mitigating overdose morbidity and mortality, viral transmissions, public nuisance, and service use. Similarly, specific health outcomes related to inhalation (e.g., respiratory conditions) are yet to be examined. Future research should use more robust designs, examine different outcomes over time, study larger samples, and consider the geographic impacts of these services³.

Conclusion

Many studies have discussed SCS that include non-injection drug use, as well as the need for, and feasibility of these types of SCS. Fewer have evaluated the outcomes of including non-injection drug use within SCS. Overall, there is a high willingness to use drugs through non-injection routes within SCS among structurally vulnerable people who use drugs. Distinct considerations should be addressed when including non-injection drug use within SCS, especially the social nature of inhalation and potential exposure to second-hand smoke. Additionally, SCS that allow non-injection drug use support a broader population of people who use drugs. Current evidence shows positive impacts of SCS including non-injection drug use; however, these types of SCS should undergo more research to better understand the benefits of these services while facilitating their implementation and evaluation.

Authorship and Citation

Juan Ocampo, Kelsey Speed, Nicole Gehring, Elaine Hyshka; Last updated May 2022

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