supplies, connecting clients to help, providing clients with a sense of support and helping them to change their substance use and health behaviours.

Opioid overdose prevention strategies

Opioid overdose deaths often occur in the presence of other people (Marlatt & Witkiewitz, 2010) and can therefore be prevented. Naloxone, known as an opioid antagonist, is able to temporarily reverse the effects of an opioid overdose[16] by having a greater affinity for opioid receptors in the central nervous system. Naloxone is relatively inexpensive sub-stance with no potential for abuse and, historically, has been generally available in health-care facilities and administered by health-care providers. In 2012, a community-based pilot program gathered data on naloxone that was used to reverse opioid overdose (Dong et al., 2012). The study reported no adverse reactions or fatalities after naloxone use, indicating its potential to reduce morbidity and mortality. Community-based naloxone programs have also shown promising outcomes in other jurisdictions, including B.C., where a take-home naloxone program has operated since 2012 (Deonarine, Amlani, Ambrose, & Buxton, 2016). Statistics from Toward the Heart show that, as of mid-May 2017, B.C.'s take-home naloxone program distributed nearly 43,000 kits, with 8,236 being used to reverse an opioid overdose (Toward the Heart, 2017).

Initially in the U.S., and now Canada, we see an increase in the number of programs that provide education for people who use substances on how to prevent an overdose (including its signs and symptoms) and for their peers on how to administer naloxone. Overdose prevention education includes information on early intervention and can be an important aspect of peer education.

In 2016, Health Canada set out to make naloxone more widely available to Canadians in support of efforts to address the growing number of opioid overdoses. Its proposed amendment to the prescription drug list would allow for a non-prescription use of naloxone, specifically for emergency opioid overdoses outside the hospital setting. Health Canada also suggested simpler product labelling and compulsory training for those who would potentially administer naloxone. If the evidence supports these amend-ments, Health Canada intends "to waive the usual six-month implementation period [to enable a] change in status . . . as quickly as possible" (Health Canada, 2016, para. 4).

Methadone use as an opioid agonist therapy

As a type of opioid agonist therapy, methadone is a widely studied treatment, proven to be safe and effective, for opiate addiction. In 2007, methadone was added to the WHO Model List of Essential Medicines (WHO, 2015). Methadone can be used to relieve withdrawal symptoms during detoxification, or it can be used as a maintenance

[16] Depending on the amount of opioid in the person's system, multiple doses of naloxone may be required.

supervised injection sites receive education on safer injection, which can also reduce HIV risk behaviours (Wood, Tyndall, Stoltz, Small, Zhang, et al., 2005). At Insite, one in three users of the facility received education on safer injection (Wood, Tyndall, Stoltz, Small, Zhang, et al., 2005). Nurses play a key role in such education and are reaching almost half the users at this facility (Wood, Wood, et al., 2008).

A survey found that 75 per cent of Insite clients reported changes in their injecting behaviours, including fewer rushed injections, public injections and unsafe syringe disposal, and a greater likelihood of using clean water, a clean injection site and proper syringe disposal after use.

INCREASED ACCESS TO HEALTH AND ADDICTION CARE

Evaluations of supervised injection sites in Sydney, Australia, and Vancouver included assessments of staff referrals as indicators of increasing contact between site users and health service providers. At the Vancouver site, Tyndall et al. (2006) reported 2,171 referrals between March 2004 and April 2005, the most frequent (37 per cent) being referrals for addiction counselling. Other referrals by Insite nurses were to community health centres (16 per cent), hospital emergency departments (11.3 per cent), detoxification facilities (11.7 per cent), other community services (9.4 per cent), housing services (9.0 per cent), methadone maintenance programs (3.7 per cent) and recovery house programs (2.7 per cent). It is not known how many clients made contact with the agencies they were referred to. In a further analysis of Insite data, Wood, Tyndall, Zhang, et al. (2006) reported that weekly use of the supervised injection site and contact with the site's addictions counsellor were associated with a more rapid entry into detoxification programs. After analyzing data linked to residential treatment databases, Wood, Tyndall, Zhang, Montaner and Kerr (2007) reported that Insite's opening was associated with a 30 per cent increase in use of detoxification services which, in turn, was associated with initiating longer-term treatment and less frequent use of the supervised injection site. In an evaluation of the Sydney supervised injection site, van Beek (2003) reported that of more than 1,800 referrals to health and social services in the first two years 44 per cent were for substance treatment and rehabilitation services, and 31 per cent were for nearby primary medical care services. A retrospective, population-based study on Insite's effect on overdose fatalities (Marshall, Milloy, Wood, Montaner, & Kerr, 2011) found a 35 per cent decrease in local fatalities after the site opened, compared to a 9 per cent decrease in the rest of Vancouver.

Among Insite's improvements to public disorder are (1) less frequent public injecting; (2) reductions in the public discarding of syringes and other substance-related paraphernalia; and (3) having no observed increase in substance dealing in the area around the site.

IMPROVING PUBLIC ORDER

The impact of supervised consumption sites on public order has been studied in relation to the frequency of open public injection, littering and loitering, substance-related crime and substance use in the community. Over 40 peer-reviewed articles evaluating Insite have shown that its harm reduction program has had a positive effect — both for those who use the facility and for the surrounding community. Among the site's improvements to public disorder are (1) less frequent public injecting; (2) reductions in the public discarding of syringes and other substance-related paraphernalia; and (3) having no observed increase in substance dealing in the area around the site (Wood, Kerr, et al., 2004; Wood, Tyndall, Lai, Montaner, & Kerr, 2006). At the Sydney facility, a time-series analysis (Freeman et al., 2005) found no evidence of a positive or negative impact on substance-related crime and no increase in substance-related loitering near the site. A survey of people who used supervised consumption sites in Rotterdam, the Netherlands, Van der Poel, Barendregt and van de Mheen (2003) reported less frequent public sub-stance use and some decrease in substance use. Similarly, Petrar et al. (2007) found that 71 per cent of Insite users injected less often outdoors, and 56 per cent reported less unsafe syringe disposal. Factors which limited the use of the facility included having to travel to Insite, its limited operating hours (18 hours/day) and wait times for access to the site. While a survey of 39 substance consumption rooms in the Netherlands, Germany, Spain and Switzerland (Kimber, Dolan, & Wodak, 2005) found six facilities with increased substance dealing in the vicinity (two of which also reported a higher frequency of petty crime or aggressive incidents among clients), Hedrich (2004) has noted that such problems seem more likely to occur when the service is not meeting local needs (e.g., when wait times are long or when the service lacks the capacity to monitor activity outside the site).

PROFESSIONAL AND PUBLIC OPINION

Results from a stratified random sample of Ontario residents suggested that "individuals who support other harm reduction strategies, more liberal substance policies and who view illicit substance users as deserving of social and health assistance, are significantly more likely to support SIFs [supervised injection facilities] and HAT [heroin-assisted therapy]" (Cruz, Patra, Fischer, Rehm, & Kalousek, 2007, p. 59). In both Canada and Australia, public opinion concerning the sites has been found to be positive (Angus Reid Institute, 2010; Salmon, Thein, Kimber, Kaldor, & Maher, 2007). Numerous health professionals and community organizations have endorsed Insite, including the B.C. Nurses' Union, the Canadian Medical Association, CNA, and the College of Family Physicians of Canada (B.C. Nurses' Union, 2008; Canadian Medical Association, 2010; Dooling & Rachlis, 2010; Hwang, 2007; National Specialty Society for Community Medicine, 2009; Smadu, 2008).

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EXTERNAL EVALUATION OF EVIDENCE FROM INSITE

In 2008, an external advisory committee of experts appointed by Health Canada (2008b) released a comprehensive review and evaluation of the evidence related to Insite and other supervised injection sites. After its review of published and unpublished research on Insite, as well as evidence on facilities in Australia and certain European countries, the panel concluded that Insite has had a positive impact on the health of the community, the health of the people who use it, residents, service providers and local business owners. They also found strong support for Insite among neighbourhood business owners, service providers and residents, and showed that the facility produced (significant) cost savings for taxpayers, decreased risk behaviours associated with the spread of HIV, reduced the (subsequent) costs of HIV treatment and prevented overdose deaths. In addition, no adverse effects from Insite were found regarding substance use patterns, crime or public disorder. Two limitations of the research, as noted by the expert panel, were the lack of comparison studies on other methods (e.g., outreach) that might increase referrals and the lack of a comparison or control group to assess differences in risk behaviours (e.g., needle sharing).

SUPERVISED CONSUMPTION SITE MODELS AND NURSING

Internationally, there are a range of models for supervised consumption sites, with variations in the hours of operation, staffing, facilities, services and rules (Kimber Dolan, & Wodak, 2005; Potier et al. 2014). On the basis of a survey of 15 drug consumption rooms, Kimber, Dolan and Wodak (2005) reported that social workers were the type of professional most frequently employed at these sites, followed by nurses. In Canada, Insite's injection room is staffed by RNs who provide essential health services "to a highly marginalized population, using a comprehensive nursing framework that is rooted in client-centred relationship building and primary nursing care activities that are guided by a harm reduction philosophy and core principles of health promotion" (Lightfoot et al., 2009, p. 19). Regarding the site in Sydney, van Beek (2004) and Potier et al. (2014) also outlined and highlighted the role of nurses. Although in descriptions of services offered at supervised injection sites nurses' roles centre around wound care and vein maintenance, there is limited evidence on the processes and outcomes of nursing care within such settings. Wood, Wood, et al. (2008) and OHTN (2014) reported that nurses provided almost half of Insite users with education on safer injection. In examining the characteristics of people receiving such education, the authors found that Insite's nurses were most likely to educate those at highest risk (e.g., women and people who had trouble injecting). In Vancouver, the Dr. Peter Centre provides an

integrated model of supervised injection as part of its nursing services (Wood, Zettel, et al., 2003). In evaluating the harm reduction room at the Dr. Peter Centre, Krüsi, Small, Wood and Kerr (2009) found that staff increased client access by building more open and trusting relationships, although shame and a fear of judgment limited some clients' use of the supervised injection service.

The panel concluded that Insite has had a positive impact on the health of the community, the health of the people who use it, residents, service providers and local business owners.

Safer crack smoking and supervised inhalation rooms

Since the 1990s, there have been indications that the prevalence of crack smoking is increasing in both urban and rural settings (Fischer, Rehm, Patra, et al., 2006; Fischer et al., 2010). Safer crack kits provide the equipment and hardware for crack smoking, including glass pipes, tubing and lubricant, along with information about harm reduction. Sharing of crack pipes has been associated with increased risk of exposure to HCV and other communicable diseases (Macias et al., 2008; Tortu, McMahon, Pouget, & Hamid, 2004; Tortu, Neaigus, McMahon, & Hagen, 2001). DeBeck et al. (2009) found that smoking crack was an independent risk factor for HIV seroconversion among injection substance users.

Malchy, Bungay and Johnson (2008) found considerable evidence of unsafe crack smoking practices in Vancouver and recommended the implementation of education and programming using safer crack kits to reduce the negative consequences of substance use as part of disease prevention and health promotion programming. Strike et al. (2006) recommended that safer crack use equipment be included in established needle distribution and recovery programs. In an evaluation of programs to distribute safer crack kits, Leonard, DeRubeis and Birkett (2006) found that such distribution was associated with a decrease in risk behaviours associated with transmission of HIV and HCV. They concluded that distributing safer crack-smoking materials to crack smokers contributes to smokers' transition to safer methods of substance consumption and significantly reduces disease-related risk practices. Larger-scale studies and systematic evaluations are needed to determine the effectiveness of safer crack kits in reducing disease transmission and modifying risk behaviours. Similar to needle distribution and recovery programs, safer crack kit programs could have the potential to facilitate access to other harm reduction, health and social services. More recently, the case has been made to expand supervised injection sites to include supervised consumption (Collins et al., 2005) to reduce some of the harms associated with crack smoking.

Housing First

Housing programs often require abstinence from substance use as a condition of housing (Tsemberis, Gulcur, & Nakae, 2004). In contrast, Housing First programs place people who are homeless directly into housing without requiring their involvement in substance use treatment (Padgett, 2007). Harm reduction is therefore one of its key principles. At the same time, Housing First is often combined with intensive health services provided by assertive community treatment teams.

Evaluations of Housing First programs have found that participants achieved increased housing tenure, with at least 70 per cent remaining housed for four years or longer. In addition, participants in Housing First programs experienced no increase in substance use, psychiatric hospitalizations or acute care hospital use, and they perceive themselves as having greater choice (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Padgett, Gulcur, & Tsemberis, 2006; Stefancic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004). An identified research limitation on Housing First programs is that the majority of study participants were recruited on the basis of a severe mental health diagnosis and appear to have had limited problematic substance use or addiction issues (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009).

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In an analysis of the health, social and policing service costs of Housing First programs, Larimer et al. (2009) found that participants had decreased their alcohol use (in comparison with a control group), the costs for those with high health and social service usage were reduced. Using a before-and-after design, Podymow, Turnbull, Coyle, Yetisir and Wells (2006) found that a shelter-based-managed alcohol program led to decreasing trends in the mean number of ambulance calls, emergency room visits, hospital admissions and police encounters, which also lowered service costs for those in the program. In 2014, the Mental Health Commission of Canada (MHCC) launched its At Home/Chez Soi program to examine Housing First as a means of ending homelessness for people living with mental illness. In following more than 2,000 participants over a two-year period, it became the world's largest Housing First trial. Key findings showed that participants "across all cities . . . obtained housing and retained their housing at a much higher rate" than those in the treatment-as-usual group (MHCC, 2014, p. 5). Most "were actively engaged in support and treatment through to the end of [the followup period, while many] with previously unmet needs were able to access appropriate and needed services

during the study" (p. 5). Other outcomes included more positive housing stability, quality of life and community functioning (MHCC, 2014).

Criticisms of harm reduction

Harm reduction as a response to illicit substance use has been the focus of considerable controversy, and numerous criticisms of harm reduction have emerged (Christie, Groarke, & Sweet, 2008; Hunt et al., 2003; Magura, 2007). It may be useful to highlight some of these criticisms and outline responses based on the definitions and evidence previously reviewed in this paper. Frequently heard criticisms, several of which have been identified by Hunt et al. (2003), include but are not limited to the following points:

- Harm reduction keeps "addicts" stuck.
- Harm reduction fails to get people off illicit substances.
- Harm reduction encourages substance use.
- Harm reduction sends the wrong message.
- Harm reduction does not encourage personal responsibility.
- The evidence for harm reduction is inadequate.

The first three criticisms highlight the tension between abstinence-based approaches, which seek to prevent or discontinue substance use, and harm reduction, which seeks to reduce the harms associated with substance use. Evidence from Switzerland, where a large-scale open substance use scene thrived in a number of cities in the 1980s, showed that substance treatment programs that required abstinence for entry (i.e., high- and medium-threshold treatment programs) reached only 20 per cent of people actively using illicit substances. Harm reduction programming is designed to reach the other 80 per cent — many of whom may not be dependent or addicted — through needle distribution and recovery programs, street outreach, supervised consumption sites, programming in prisons, and low-threshold methadone and diacetylmorphine programs (MacPherson, 1999). Treatment for substance dependence is often assumed to be highly effective, but this assumption is not borne out by scientific evidence. In an abstinence-seeking context, harm reduction is seen as enabling substance use. However, treatment programs might have a success rate of only three per cent when abstinence is used as the benchmark of success after repeated cycles of treatment and relapse. Further, many people in Canada's inner cities need access to replacement and/or substitution therapy in the end stages of a chronic, relapsing illness (S. Burgess, personal communication, June 26, 2007).

Harm reduction strategies can be viewed as part of a continuum of prevention and treatment strategies. While criticized for not reducing substance use, reducing substance use and treating addiction are not among its stated goals. Therefore, if

someone fails to strive for or achieve abstinence, it does not necessarily mean the harm reduction approach has failed. Since its goal is to reduce the harms of substance use and manage addiction, these goals are the standard by which the harm reduction approach should be judged. Bearing that in mind, evidence shows that outreach programs and the referral process associated with supervised injection sites do not increase substance use (e.g., Wood, Tyndall, Montaner, & Kerr, 2006).

Harm reduction strategies can be viewed as part of a continuum of prevention and treatment strategies. Therefore, if someone fails to strive for or achieve abstinence, it does not necessarily mean the harm reduction approach has failed.

The fourth criticism is that harm reduction sends the wrong message to youth about substance use. However, there is no evidence that harm reduction services encourage substance use among youth. Supervised consumption sites such as Insite have been shown to attract long-term substance users (Kerr, Tyndall, et al., 2007), and many harm reduction programs have specific policies that restrict access based on age. The prevention of substance use harms can refer to preventing the onset of substance use or reducing the harms of all use or just non-problematic use. Thus, harm prevention can encompass a range of meanings (Tupper, 2008a, 2008b). A failure to promote health out of fear that such information will exacerbate use could make nurses feel conflicted about their ability to ensure the health and safety of youth.

The fifth criticism is that harm reduction does not encourage personal responsibility for substance use. In a society where individual liberty and personal responsibility are highly valued, an inability to discontinue substance use is seen as a personal failure. Yet, this view does not account for the social or structural factors (e.g., poverty, violence and abuse) that shape substance use, whereas harm reduction principles emphasize the importance of informed decision-making. In fact, governments may be viewed as responsible for safer substance use through their regulation of the production and distribution of psychoactive substances — as they already are with other potentially harmful items such as children's toys, automobiles, food, prescribed pharmaceuticals and alcohol.

Harm reduction efforts have also been criticized as creating a new social order and form of surveillance, as in the case of supervised injection sites (Fischer, Turnbull, Poland, & Haydon, 2004). Nurses recognize that personal responsibility is contextualized by life situations. According to the CNA code of ethics (2008), RNs should be committed to eliminating social inequities. The code recognizes the importance of advocacy to change the social conditions that affect health, such as poverty, violence and food insecurity, and to change policies that exacerbate inequities, such as drug policies that criminalize substance use.

There is substantial evidence that harm reduction strategies have achieved a range of positive health and social outcomes, including increased referrals and access to services, fewer transmissions of blood-borne diseases, a reduced number of overdose deaths and less public disorder and crime.

Finally, some authors have outlined criticisms of harm reduction in relation to evidence of its effectiveness, effects and intentions (Christie et al., 2008; Hunt et al., 2003), which describe it as ineffectual and without adequate evidence to support it. However, as the present literature review shows, there is substantial evidence that needle distribution and recovery programs, opioid maintenance therapy, take-home naloxone, supervised consumption sites and outreach services have achieved a range of positive health and social outcomes, including increased referrals and access to services, fewer transmissions of blood-borne diseases, a reduced number of overdose deaths and less public disorder and crime. As stated previously, many organizations (e.g., WHO, UNODC and UNAIDS) have endorsed harm reduction strategies as a public health measure on the basis of a well-established body of evidence (Wodak, 2009).

V. LEGAL AND ETHICAL PERSPECTIVES IN NURSING AND HARM REDUCTION

Because harm reduction strategies associated with illicit substance use raise difficult legal and ethical questions for nurses in relation to federal, provincial and organizational policies, this section looks at legal issues and ethical perspectives that are relevant to nursing.

Legal Issues

Distribution of harm reduction supplies

Needle distribution and recovery and safer crack use programs often prompt questions about the legalities of distributing harm reduction supplies and possessing used supplies. The legal opinion of the Canadian HIV/AIDS Legal Network (2008) is that distributing new or unused safer crack use kits and syringes is not a crime. The primary reasoning is that, under the Criminal Code of Canada, while an instrument designed primarily to consume a substance is illicit, safer crack kits and syringes are considered devices intended to prevent disease transmission through reduced sharing of equipment; thus, they would be regulated under the *Food and Drugs Act*. As the network notes, however, "no court in Canada has ruled on this interpretation of the law, neither for NSPs [needle syringe programs], nor for programs that distribute safer crack use kits" (2008, p. 3).

Possession of a controlled substance is prohibited under the CDSA. According to the Canadian HIV/AIDS Legal Network, in at least one case in Canada possession of a used crack pipe was "considered as providing reasonable grounds for arrest" (2008, p. 4). However, the network argues that arresting someone for such possession is contrary to the purpose of distributing safer crack kits. If people carrying a used crack pipe run the risk of being arrested, they will be less likely to use their own crack pipes and more likely to share and publicly discard them. It sees at least two reasons why "the federal government should make it clear that is it not illegal to possess used crack pipes (or needles used for injecting drugs)" (2008, p. 4). First, when public health services distribute crack supplies or needles, the purpose is to reduce harms such as preventing disease and ensuring safer use. Second, a ministerial exemption from criminal prosecution is possible under the CDSA for people in possession of used harm reduction supplies. Insite is able to operate because it has been granted this type of exemption.

Supervised consumption services

Three approaches have been identified to support the operation of supervised consumption services without concern for criminal liability: administrative agreements, regulatory or ministerial exemptions, and amendments to substance laws (Elliott, Malkin, & Gold, 2002). Insite was able to begin operation in March 2003 because the federal minister of health, under section 56 of the CDSA, exempted users and staff from the provisions of the act. Exemptions may be granted for medical, scientific or any other purposes deemed to be in the public interest (*PHS Community Services v. Attorney General of Canada*, 2008). The initial three-year exemption for Insite, granted on September 12, 2003,[18] was for scientific purposes. In 2008, a constitutional challenge was presented to the B.C. Supreme Court to keep Insite's doors open. The court ruled in favour of the exemption stating that existing laws that prohibit possession and trafficking of illicit substances are unconstitutional, since they deny access to health services offered to substance users at Insite (*PHS Community Services v. Attorney General of Canada*, 2008). Justice Ian Pitfield gave the federal government until the end of June 2009 to amend the CDSA and align it with constitutional principles embodied in the Canadian Charter of Rights and Freedoms. Further to this ruling, the B.C. Supreme Court granted Insite immediate exemption from the law, along with legal grounds to continue operations (*PHS Community Services v. Attorney General of Canada*, 2008).

If Insite's ability to operate had depended on the exemption without further extensions, it would have had to close its doors on June 30, 2008. However, before its extension expired, the Portland Hotel Society[19] sought relief from the ongoing series of

[18] The exemption was subsequently extended to December 31, 2007, and then to June 30, 2008.

[19] The Portland Health Society operates Insite in partnership with the Vancouver Coastal Health Authority, along with a number of other plaintiffs in the case.

extensions, launching a court case in the Supreme Court of British Columbia based on the position that Insite was a health-care facility and therefore under provincial jurisdiction. The Vancouver Area Network of Drug Users also filed suit, arguing that closing Insite would deprive injection substance users of access to health care and violate their Section 7 right to security of person under the Canadian Charter of Rights and Freedoms (*PHS Community Services v. Attorney General of Canada*, 2008). In court, witnesses testifying in support of the case made the following arguments:

- A review of evidence clearly indicates that Vancouver's Downtown Eastside has faced a public health crisis for several years, with increasing rates of HIV and HCV infection and an explosion of overdose deaths in the 1990s.
- Addiction is an illness that is chronic in nature and can be progressive, relapsing and fatal.
- Addiction has neurochemical, genetic, psychological and social determinants (e.g., stress, trauma and abuse).
- Unsafe injection practices increase the rate of HIV and HCV transmission.
- Supervised injections reduce morbidity and mortality.
- The introduction of the four-pillars approach (MacPherson, 2001) and Vancouver Coastal Health Authority's continuum of services (which include Insite) are intended to reduce overdose deaths, increase safer injections and provide points of entry to health and social services.

In his ruling, Justice Ian Pitfield determined the following:

> While users do not use Insite to directly treat their addiction, they receive services and assistance at Insite which reduce the risk of overdose that is a feature of their illness, they avoid the risk of being infected or of infecting others by injection, and they gain access to counselling and consultation that may lead to abstinence and rehabilitation. All of this is health care. (*PHS Community Services v. Attorney General of Canada*, 2008, p. 51)

Justice Pitfield ruled that to close Insite would violate human rights, specifically in Section 7 (risk to life) of the charter, on the following grounds: regardless of the circumstances of entry into substance use, the result is an illness of addiction, and failure to manage addiction may lead to death from overdose or other illnesses. "If the root cause of death derives from the illness of addiction," he said, "then a law that prevents access to health care services that can prevent death clearly engages the right to life" (*PHS Community Services v. Attorney General of Canada*, 2008, p. 53).

Justice Pitfield ruled that to close Insite would violate human rights.

With regard to risks to security, Justice Pitfield determined the following: "Society cannot condone addiction, but in the face of its presence it cannot fail to manage it, hopefully with ultimate success reflected in the cure of the addicted individual and abstinence" (*PHS Community Services v. Attorney General of Canada*, 2008, p. 54). He did not agree with denying people with an addiction access to health-care services that would reduce the effects of their condition: "Simply stated, I cannot agree with Canada's submission that an addict must feed his addiction in an unsafe environment when a safe environment that may lead to rehabilitation is the alternative" (*PHS Community Services v. Attorney General of Canada*, 2008, p. 55).

Justice Pitfield further determined that a failure to protect Insite's staff from prosecution for possession and trafficking would be a violation of the charter because it would restrict access to health care. As a result of this case, Insite was granted a constitutional exemption to sections 4(1) and 5(1) of the CDSA, and the federal government had until June 2009 to revise sections of the act. Justice Pitfield did not agree that it was a matter of provincial jurisdiction.

The federal government, however, sought redress in the B.C. Court of Appeal. In the January 2010 Court of Appeal decision the lower court ruling was upheld. Two of the three judges ruled that Insite was a health service and a provincial jurisdiction but refrained from ruling on the charter issue. The third judge disagreed that it was a provincial jurisdiction yet agreed it was a charter issue. The federal government then appealed to the Supreme Court of Canada, which agreed to hear the case.

Although not as well known as Insite, the Dr. Peter Centre in Vancouver — operated by a not-for-profit society, the Dr. Peter AIDS Foundation — has provided supervised injection services as part of its integrated health-care model since 2002 (Wood, Zettel, et al., 2003). Supervised injection services are part of registered nursing and registered psychiatric nursing practice in both the day health program and the 24-hour skilled nursing care residence. Many Dr. Peter Centre clients live with multiple illnesses, disabilities and social inequities in addition to HIV/AIDS.

The centre's RNs became increasingly concerned about overdose events on site and recurrent but preventable soft-tissue infections associated with non-medical injection substance use. The centre's executive director and its RNs approached the Registered Nurses Association of British Columbia (RNABC)[20] with the following question: "Is providing clients with evidence-based information to safely give themselves intravenous injections within the scope of registered nursing practice?"

[20] The predecessor of the College of Registered Nurses of British Columbia.

In 2002, RNABC answered yes:

> Assessing clients' knowledge and skill to safely give themselves intravenous injections is within the scope of nursing practice. Teaching and promoting evidence-based self-care activities prevents illness and promotes health, especially in relation to high risk client behaviours. Providing this information to these clients fosters the therapeutic alliance between the registered nurses and the clients and can facilitate promoting healthier client activities. . . . Employers have an obligation to provide essential support systems so that registered nurses are able to meet the Standards for Nursing Practice in British Columbia. The essential support systems include the necessary policies and resources to assist nurses to provide competent, evidence-based and ethical care. (M. Aldersberg, RNABC, personal communication to M. Davis, Dr. Peter Centre, February 19, 2002)

In 2005, RNABC became CRNBC under the new *Health Professions Act of British Columbia*. Two years later, CRNBC re-confirmed that supervised injection was part of RN practice for the purposes of preventing illness and promoting health. It also reiterated the employer obligation to support nursing practice (M. Aldersberg, CRNBC, personal communication to M. Davis, Dr. Peter Centre, December 11, 2007).

Unlike Insite, the Dr. Peter Centre did not have a Section 56 exemption to the CDSA. It stated that it was upholding provincial law and is doing everything reasonably possible to uphold federal law: nurses do not touch, inject or supply the substances.

The Dr. Peter AIDS Foundation was granted intervener status in Insite's B.C. Court of Appeal case. In her written summary of judgment, Justice Carol Huddart stated:

> The evidence [provided by the foundation] established how and why the decision in this case will have significant effect on registered nurses seeking to comply with the professional and ethical standards to which they are held by their governing body. That concern is at the root of the division of powers issue and the evidence will be helpful to a full understanding of that issue. (*PHS Community Services Society v. Canada (Attorney General)*, 2010, para. 188)

The federal government appealed the B.C. ruling to the Supreme Court of Canada. In its decision, on September 29, 2011, the Supreme Court of Canada ruled unanimously (9-0) — in *Canada (Attorney General) v. PHS Community Services Society* — that the federal minister's decision to withdraw Insite's exemption under the CDSA was

> arbitrary, undermining the very purposes of the CDSA, which include public health and safety. It is also grossly disproportionate: the potential denial of health services and the correlative increase in the risk of death and disease to injection drug users outweigh any benefit that might be derived from maintaining an absolute prohibition on possession of illegal drugs on Insite's premises. (Canada v. PHS Community Services Society, 2011, para. 136)

The court then ordered the federal health minister to grant an indefinite exemption to Insite. Following the ruling, the Conservative government tabled the bill that would

become the *Respect for Communities Act* (passed into law in March 2015), which sought a federal regulatory framework for supervised injection sites, along with provisions for certification and inspections. The act also tried to ensure that provincial health and public safety ministers would supply the federal health minister with support letters before the minister might grant an exemption to existing substance laws. The act outlined 26 criteria for applicants to meet before a site could be licensed. These criteria meant arduous delays in many areas where there was a demonstrated need for supervised consumption services. The act would require Insite and any future supervised injection sites to meet specific requirements for continued operation while providing regular reports on the facility, on crime rates in the surrounding area and on health outcomes. Then, in December of 2016, concurrent with the release of the Canadian Drugs and Substances Strategy (CDSS), the Liberal government introduced Bill C-37 into parliament. The bill, which supports the CDSS, proposes to amend the *Controlled Drugs and Substances Act* and repeal the *Respect for Communities Act*, reducing barriers and streamlining the process for communities in Canada who wish to apply for supervised consumption sites (Government of Canada, 2016b).

The Pitfield decision (*PHS Community Services v. Attorney General of Canada*, 2008), the B.C. Court of Appeal decision (2010), and the experience of the Dr. Peter Centre, followed by the 2011 Supreme Court of Canada ruling, provide important legal perspectives on supervised injection services. Among the implications for nurses are that:

- Addiction is understood to be a chronic disease.
- Harm reduction services are core health-care services for managing problematic substance use.
- It is unconstitutional to deny access to health-care services because of illicit substance use.
- Supervised injection education is within the scope of nursing practice.
- Managers and employers should support practice on the basis of current research.
- Managers and employers should support the development of organizational policies that are consistent with a harm reduction approach.

Ethical issues

In relation to the response to illicit substance use, at least two conflicts have particular relevance for nurses in Canada. The first is between evidence and policy; the second, between harm reduction and health equity, fairness and social justice.

While nurses have an ethical responsibility to promote health and well-being and a responsibility to base their practice on current evidence, they may work in organizations that do not support harm reduction or may endorse or follow an abstinence-based

model. In essence, the illicit status of many substances, along with current prohibitionist drug policies, create a concern about the very nature of ethical practice in the care of people who use illicit substances. To examine ethical nursing practice in this context, a discussion of the professional values that underpin nursing practice is helpful.

The values of harm reduction are consistent with the values of professional nursing presented in the code of ethics: the provision of safe, ethical, competent and compassionate care; the promotion of health and well-being; the promotion of and respect for informed decision-making; the preservation of dignity, in which care is provided on the basis of need; and the promotion of justice.

The ethical commitments of nurses are outlined in CNA's code of ethics (2008), which highlights important values that guide nursing practice and the delivery of care to all Canadians. The values of harm reduction are consistent with the values of professional nursing presented in the code of ethics: the provision of safe, ethical, competent and compassionate care; the promotion of health and well-being; the promotion of and respect for informed decision-making; the preservation of dignity, in which care is provided on the basis of need; and the promotion of justice (Lightfoot et al., 2009; Pauly, Goldstone, et al., 2007). In particular, in providing safe, competent and ethical care, nurses have a duty to base their practice on the best evidence available. The evidence reviewed previously in this paper suggests that harm reduction strategies, including needle distribution and recovery services, supervised consumption sites, peer outreach, distribution of safer crack kits, and opioid agonist treatments such as methadone, buprenorphine/naloxone, or diacetylmorphine, are associated with reducing risk behaviours and promoting the health and well-being of people who use illicit substances.

Nurses have a duty to base their practice on the best evidence available.

In some situations, the lack of a harm reduction policy in a health-care organization can contribute to and reinforce the existing societal stigmas of a culture permeated by negative attitudes toward illicit substance use. In this context, nurses may be concerned about legal and organizational censure if they take a harm reduction approach in their practice. Although legal prosecution appears unlikely (Pauly, Goldstone, et al., 2007), it is nonetheless possible that a nurse working under such conditions may face organizational censure if he or she departs from the organization's norms of practice.

National and provincial professional nursing associations have a key role in this regard. In Canada, CNA and CANAC (2012) have developed a joint position statement on harm reduction as part of the response to addressing health inequities. The creation of a national position on harm reduction is particularly important. At the provincial level, existing nursing policy (e.g., the definition of nursing practice, professional standards

and the CNA code of ethics) may be applied and interpreted to highlight important directions for nurses that are caring for people who use substances.

Fry, Cvetkovski and Cameron (2006) observed that questions of "microethics," or everyday ethics, abound in the operation and evaluation of supervised injection sites and supervised consumption sites, even though these "applied ethical issues (e.g., maintenance of client privacy and confidentiality, consent in the case of intoxicated clients, staff role boundaries and duty of care in the case of self-harm through injection) may be considered by some as second-order compared to other clinical and empirical concerns" (p. 465). They argue that reflecting on and discussing these issues is how to make values more explicit and enhance nursing practice. For example, concerns have been raised about the increased risk of HIV infection for people who require assistance with injecting (Wood, Spittal, et al., 2003). Individuals who are unable to inject themselves because of decreased mobility or lost limbs present ethically challenging cases for nurses who are at the front line of providing service in such situations. Within supervised injection sites and supervised consumption sites there is limited understanding of these issues and, more generally, issues related to poor health and inequities in access to health care for the individuals who use such facilities. Of key concern to nurses are the many ethical issues related to implementing harm reduction interventions (Pauly, Goldstone, et al., 2007).

The second conflict for nurses is the degree to which harm reduction is aligned with the fundamental commitments to equity and social justice outlined in CNA's code of ethics (2008). While harm reduction has been identified as "value-neutral" on the question of illicit substance use (Keane, 2003), it is not value-free. Some have therefore argued for a more ethically invested understanding of harm reduction, one that acknowledges its underlying values and fosters ethical engagement as a means of enhancing research, treatment and policy (Fry, Treloar & Maher, 2005). There are differing views on the extent to which the harm reduction approach should include strategies to change the policy and political context that shapes the harms of substance use (Fry et al., 2005; Hunt, 2004). Historically, the depoliticization of substance use has been promoted as a means of reducing judgments associated with substance use. Yet others have pointed out the limitations of depoliticizing harm reduction and the importance of explicitly addressing the social factors that magnify the harms of illicit substance use (Fischer, Rehm, Kim, & Kirst, 2005; Hathaway, 2001, 2002; Miller, 2001). Some have criticized the harm reduction movement for not doing enough to address social harms or the root causes of substance-related harms, such as homelessness and poverty (Miller, 2001). Increasingly, the movement has highlighted the relationship between current international substance control regimes and human rights violations (Barrett, Lines, Schleifer, Elliot, & Bewley-Taylor, 2008). HRI's (n.d.) principles have clearly embraced the need to challenge policies and practices that contribute to criminalization, discrimination and

social inequities as germane to harm reduction. This positioning is particularly relevant to the practice of nursing and the goals of social justice. For example, education on safer substance use will never end the homelessness that contributes to the harms of substance use (Hardill, 2007). Harm reduction can be seen as a way to partially address inequities in health and health care for people who are experiencing marginalization as a result of substance use (Pauly, 2008a).

VI. CONCLUSIONS

- Nurses play an important role in mitigating the health-related harms associated with illicit substance use. Nurses can also act as a primary point of access to health care for people who use illicit substances, and can link individuals to housing and social services to decrease some of the other harms of substance use. The organizational factors that shape access to health care, housing and social services need to be improved. For example, the potential for services not culturally or gender sensitive to further traumatize people who use illicit substances is of serious concern. There is an urgent need to critically analyze access to health and social services and to develop and refine their structures, particularly harm reduction, counselling and trauma-care services.
- Including "social harms" in the definition of the harms of substance use holds significant implications for the way harm is perceived and for nursing practices and policies associated with substance use. As Rhodes (2002) highlights, it is important to consider social harms because housing, economic and employment policies contribute to the risk of poor health for people affected by substance use. Nursing goals and commitments are consistent with a comprehensive definition of harm reduction, which recognizes the intersections of social determinants of health with illicit substance use and is based on an understanding of the underlying social conditions that shape inequities. Nurses are well placed to extend understanding of the root causes of the harms of illicit substance use as a means to address health inequities, and such efforts are consistent with the nursing mandate as set out in CNA's code of ethics (2008).
- Legal perspectives on the supply of harm reduction equipment and supervised consumption are consistent with pre-existing standards of professional and ethical practice in nursing. The legal opinion of the Canadian HIV/AIDS Legal Network is that distribution of safer crack kits and syringes is unlikely to result in prosecution. The Pitfield decision and the experience at the Dr. Peter Centre support the provision of supervised injection as part of nursing practice in primary health-care services. However, there is limited development and often a gap or absence of official nursing policies in relation to these issues in the majority of health-care settings. To date, there has been limited examination of micro-ethical issues in

harm reduction and nursing practice. More consideration of the ethical concerns associated with caring for people who use illicit substances is needed.

- There is substantial evidence of the benefits of several targeted harm reduction strategies. Needle distribution and recovery programs have been shown to be safe, effective and cost-saving in reducing HIV risk behaviours and increasing access to health and social services for people who use injected substances. Outreach strategies are a low-cost and effective means of reaching people who use illicit substances and are particularly effective if they incorporate peer-based outreach. Supervised consumption sites reduce HIV risk behaviours and overdose deaths, increase access to substance use treatment and reduce public disorder. Opioid agonist treatments such as methadone, buprenorphine/naloxone, or diacetylmorphine (prescription heroin) are safe and cost-effective, with initial evidence indicating that diacetylmorphine is more effective than methadone for people who have failed previous treatment approaches. Initial studies of diacetylmorphine have found that it improves health outcomes and reduces illicit substance use and crime without any negative impacts on the community. Newer research also cites possible improved safety of buprenorphine/naloxone (Suboxone) over methadone.
- Although there is considerable evidence concerning various harm reduction strategies such as needle distribution and recovery programs, opioid agonist treatments such as methadone, buprenorphine/naloxone, or diacetylmorphine, supervised consumption sites, distribution of safer crack use kits and peer outreach, assessments of the role and impact of nursing in these strategies have been limited. Most of the nursing literature on harm reduction consists of descriptive accounts of nursing practice. Although these accounts provide important insight into the role of nurses in reducing the harms associated with illicit substance use, research by or with nurses is also needed to monitor and evaluate nursing processes and outcomes.
- While international and provincial drug policies have shifted to support harm reduction strategies consistent with a public health approach to illicit substance use, federal policies have increasingly embraced abstinence and a "war on drugs" approach. There is a patchwork of policies at the organizational level that may support or discourage efforts to reduce the harms of illicit substance use. In the absence of nursing policy on harm reduction, nurses are often caught between evidence and policy. Research on risk environments as a framework for understanding social factors that produce harms that influence illicit substance use (Rhodes, 2002; Rhodes et al., 2005) points to the need for nurses to focus their attention not simply on drug policies, but also on policies related to social housing and income that contribute to these harms. In addition, histories of gender inequality, colonization and ethnic disparities strongly point to the need to

develop policies through a gendered and culturally appropriate lens that pays attention to the conditions that create inequities associated with illicit substance use. Challenging policies and practices that contribute to harms is consistent not only with the principles of harm reduction but with the CNA code of ethics (2008), in which commitments to equity and social justice include addressing unfair or unjust policies.

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