My Place, Your Place, or a Safer Place

The Intention Among Montréal Injecting Drug Users to Use Supervised Injecting Facilities

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ABSTRACT

Background: Supervised injection facilities (SIF), a harm reduction intervention, may reduce several risks of public injection drug use. The prospect of conducting a scientific, multi-site pilot project of these facilities is being explored at federal and local levels in Canada. Experiences with SIF in Europe and Australia indicate that successful outcomes for the community ultimately hinge upon the responsiveness and relevance of the facilities to the needs of their primary target group: people who inject drugs in public places. Consideration of the factors and conditions found to influence a potential user's uptake of SIF, therefore, is imperative. This study sought to assess the acceptability of SIF and to determine factors associated with willingness of injecting drug users (IDU) to use SIF in a city considering their establishment.

Methods: From April 2001 to February 2002, following key informant interviews, a cross-sectional study was conducted among publicly injecting IDU participating in an ongoing HIV surveillance study in Montréal. Univariate and bivariate analyses preceded logistic regression.

Results: Participants were 11 key informants and 251 publicly injecting IDU. Key informants generated the Montréal-specific SIF model subsequently presented to IDU. 76% of IDU were willing to use at least one of three proposed SIF sites. Exploratory multivariable models indicated drug-use characteristics and SIF attributes as determinants of outcome: predominant cocaine injection, history of overdose, knowing about SIF, relieving and empowering feelings toward using SIF, and comfort with disclosure of one's injecting drug use.

Conclusion: User consultations are essential to assess relevance and plan SIF acceptable to IDU.

La traduction du résumé se trouve à la fin de l'article.

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Supervised Injecting Facilities (SIF) are "legally sanctioned and supervised facilities that…enable the consumption of pre-obtained drugs in an anxiety- and stress-free atmosphere, under hygienic and low-risk conditions."[1] Potential benefits reported by more than 40 established SIF include: 1) improved access and uptake of health and other services by injecting drug users (IDU); 2) reduced public injecting and drug-related public nuisance; 3) reduced opioid-related overdose risk; and 4) decreased risk of bloodborne virus transmission.[2] Other measures of SIF impact are expected from the scientific evaluation of a recently concluded Australian SIF trial.[2,3]

Within Canada's framework for harm reduction strategy,[4] guidelines for cities planning pilot SIF were recently announced by the Federal Health Minister.[5] In 2002, a Health Canada task group examined the feasibility of establishing a scientific, medical research project of SIF.[6] Their recommendations reiterate evaluations by the Canadian HIV/AIDS Legal Network and others calling for a multi-site pilot project.[7-14] One potential site, Montréal, currently offers its approximately 12,000 IDU access to several public health programs to promote safer injecting practices and facilitate reducing injection frequency or giving up injecting drugs (e.g., needle exchange programmes (NEP), pharmacy-sold syringes, low-threshold methadone maintenance). Yet, HIV thrives at 16.8% prevalence among Montréal IDU;[11] the frequency of sharing syringes among Québec IDU persists without decline;[15] and need exceeds supply of focussed public health interventions in Montréal.[11,15,16] The predominant injecting of cocaine, with its short half-life driving higher frequency of injections, further exacerbates this predicament.[17] Well-designed SIF can reach hard-to-reach IDU populations, while reducing the number of infections and overdose risk. Nevertheless, no research to date documents the components of SIF interventions that would enhance acceptability of SIF to publicly injecting Montréal IDU, a population at high risk of harm to their community and themselves, most likely to access future SIF, and thus the target population. Findings from Australian studies suggest important factors that should be considered when planning SIF, but differences in injecting behaviours and community relations caution against generalizing their results to Canada.[18,19]

This study sought to determine the acceptability of SIF and to identify IDU characteristics and SIF features associated with the intention of IDU to use SIF in a city considering their establishment.

METHODS

Key informant interviews

Since SIF do not yet exist in Canada, description of a realistic model was sought through key informant interviews. Informants were identified through contacts with the Montréal Regional Public Health Department, through an IDU-HIV surveillance study, and by using snowball techniques. Eligibility criteria included: current professional contact with IDU, knowledge of services in Montréal available to IDU, and interest in contributing to the study. Using a standardized guide, interviews were conducted in English (by TCG) or French with a translator (DP) and audio-taped by permission. The interviews were analyzed for consensus, with specific elements used to inform subsequent questionnaire development.

Quantitative data collection

IDU who had injected recently in public or semi-public spaces were recruited for this component. Public spaces included parks, parking lots, public toilets, bus stations, and alleys, whereas restaurants, malls, laundry rooms, cars, stairwells, disused buildings, and shooting galleries were considered semi-public. Eligible IDU were identified, recruited, and interviewed through the SurvUDI Study, a province-wide HIV surveillance project.[17,20] In the SurvUDI Study, individuals who injected drugs during the previous six months answer a short behavioural questionnaire, give a saliva sample, and are assigned a unique identifier for detecting multiple visits over time. SurvUDI respondents at 12 recruiting sites in Montréal who had injected publicly in the last month were invited to participate in the SIF Study. The SIF questionnaire first gauged the level of SIF knowledge before providing a standardized definition and visual aids depicting several SIF in Europe, to familiarize participants with the intervention. Questions focussed on the intention of IDU to use the model SIF, solicited feedback including the importance of specific services and factors that would affect their use of the sites (e.g., staffing), then concluded with enquiries on drug-use characteristics and health problems that may influence a publicly injecting IDU's intention to use SIF. The questionnaire was piloted and necessary modifications incorporated. Bilingual, trained interviewers from the SurvUDI Study administered the questionnaires and participants were remunerated $15 Canadian (SurvUDI $10, SIF $5).

All subjects gave informed consent prior to data collection. The McGill University School of Medicine's Institutional Review Board approved this study.

Analyses

Descriptive statistics are reported as proportions (%) for categorical and nominal data, and as means for continuous data. The outcome, intention to use SIF, was measured on a 5-point Likert scale from very unwilling (1) to very willing (5) to attend any proposed SIF, and was dichotomized to unwilling (1-3) and willing (4-5) based on the distribution of the first 50 responses. Chi-square or Fisher's exact tests and Student's *t*-tests are reported for bivariate differences between IDU willing and those unwilling to attend SIF. Tests of significance were two-sided and performed at the α=0.05 level. Using a parameter-estimating model-building approach,[21] we employed backward stepwise logistic regression to explore factors associated with intention to use SIF. In the final model, variables with p<0.10 were retained[22] and a goodness-of-fit test was applied to support the model.[22]

TABLE I

Characteristics of the SIF Study Participants

Characteristic	SIF Study Participants, N=251 N (%)
Male sex	205 (82)
Mean age (standard deviation, range)	32.0 (9.1, 16-54)
Francophone	212 (85)
Caucasian	224 (90)
Unstable source of income†	178 (71)
Unstable living situation‡	122 (49)
Cocaine as drug most frequently injected*	192 (78)
Frequency of injections > once per week*	189 (75)
NEP use > once per week*	128 (51)
Sought help to stop drug use*	110 (44)
Used needles already used by another IDU*	108 (43)
Used injecting equipment already used by another IDU*	124 (49)
Public/semi-public place most frequent injecting location	163 (65)
Would prefer a private place to inject	147 (59)
HIV positive status (result from SurvUDI Study saliva test)	52 (21)
History of overdose (cocaine or heroin)	100 (40)
History of abscess	60 (27)

* In the last 6 months
† Income derived mainly from sex work, unemployment, illegal activities, etc. in the past 6 months
‡ Lived mostly in the street, in a shelter, etc. in the past 6 months

RESULTS

From April to May 2001, 11 key informant interviews were conducted with public health workers, IDU service providers, outreach workers, former and current IDU, and a shooting gallery operator. Consensus was reached on most elements of the SIF model (detailed elsewhere[20]), and the majority (10 of 11) agreed that SIF should be incorporated into one or more existing NEP. Three different NEP sites were suggested in areas of Montréal with public injecting problems. Situated at these sites, SIF could provide nearly 24-hour access under existing opening hours. Operational aspects and SIF rules, including the management of cocaine injecting on-site, that achieved questionable consensus were left out of the model and instead raised separately with IDU in the questionnaire.

For the cross-sectional study of IDU participating in the SurvUDI Study from June 2001 to February 2002, 368 (57%) were eligible and, of these, 251 IDU answered the SIF questionnaire (68% response rate). Recruitment was accomplished primarily at CACTUS Montréal, the NEP located downtown (93.6%; N=235). Non-participants and participants were similar in most respects, but participants were more likely to be Francophone (85% vs. 71%, p<0.005), Caucasian (90% vs. 77%, p<0.005), and to report recent unstable housing (i.e., lived mostly in the street, in a shelter, etc. in the past 6 months) (49% vs. 35%, p<0.01). Table I notes the study sample characteristics.

TABLE II

Participant Characteristics and SIF Site Attributes Significantly Associated with a Willingness to Use SIF*

Variable	Willing to Use SIF N (%)	Group Total	Odds Ratio [95% Confidence Interval]
Study participant characteristics			
Overdoses experienced			
Ever	83 (83.0)	100	2.0 [1.1-3.7]
Never	107 (71.3)	150	1.00
Frequency of injections in the last 6 months			
≥Once per week	151 (79.9)	189	2.2 [1.2-4.1]
<Once per week	40 (64.5)	62	1.00
SIF site attributes			
SIF exposure			
Have heard of SIF			
Yes	78 (83.0)	94	1.9 [1.0-3.6]
No	113 (72.0)	157	1.00
The Injecting Room			
Able to tolerate injecting with other IDU around			
Yes	141 (81.0)	174	1.7 [0.9-3.25]
No	50 (71.4)	70	1.00
Staff composition			
Easy to use SIF with nurses on staff	182 (80.5)	26	4.1 [1.55-11.03]
Difficult to use SIF with nurses on staff	9 (50.0)	18	1.00
IDU's views on the importance of certain SIF entry criteria			
Exclusion of pregnant women			
Important to me	150 (80.7)	186	2.4 [1.31-4.54]
Not important/does not matter to me	41 (63.1)	65	1.00
Injecting drug users only (no other forms of drug use)			
Important to me	115 (83.3)	138	2.4 [1.34-4.42]
Not important/does not matter to me	76 (67.3)	113	1.00
Age restriction of 14 years and older			
Important to me	170 (81.0)	210	4.0 [2.0-8.17]
Not important/does not matter to me	21 (51.2)	41	1.00
Rules			
People can split their drugs but must self-inject			
Acceptable	169 (80.9)	209	2.5 [1.16-5.38]
Unacceptable	22 (62.9)	35	1.00
Nurses check for abscess prior to injecting room use			
Acceptable	183 (80.6)	227	4.7 [1.71-12.82]
Unacceptable	8 (47.1)	17	1.00
Situations that may be barriers to an IDU's use of SIF†			
Disclosure of injecting status ("People knowing you are a drug user.")			
Yes, would be a barrier for me	38 (64.4)	59	0.38 [0.20-0.73]
No, would not be a barrier for me	153 (82.7)	185	1.00
Location of SIF too far from drug source			
Yes, would be a barrier for me	118 (74.2)	159	0.47 [0.23-0.96]
No, would not be a barrier for me	73 (85.9)	85	1.00
Being in too much of a hurry			
Yes, would be a barrier for me	131 (74.4)	176	0.39 [0.18-0.89]
No, would not be a barrier for me	59 (88.1)	67	1.00
Feelings about use of SIF			
Relieving	147 (88.6)		6.1 [3.17-11.79]
Stressful	43 (55.8)	77	1.00
Empowering	136 (86.6)	157	3.8 [2.0-7.10]
Useless	55 (63.2)	87	1.00

* All variables $p<0.05$ by Chi-square or Fisher exact test.

† The absence of a barrier to SIF use (i.e., 'No, would not be a barrier for me') is the desired, positive effect. For convention, however, a 'Yes' response was given the score of 1 and a 'No' response received the score of 0. Hence, in interpreting the odds ratios for these variables, values less than 1.00 (OR<1.00) indicate an association between the absence of a barrier to SIF use and a willingness to use SIF.

Overall, 94% of IDU surveyed favoured SIF as a harm reduction tool. Reasons included concerns about personal safety (33%, e.g., fear of police, safer and cleaner place to inject, confidentiality), health (30%, e.g., care in the case of cocaine or heroin overdose, less stress, prevention of infections), and community (22%, e.g., fewer needles in the environment, protection of citizens).

SIF acceptability was high: 76% of respondents were willing to use one or more proposed SIF. Generally, willingness to use SIF was similarly strong across all socio-demographic and drug-use variables, however, public injectors with histories of cocaine or heroin overdose and IDU who injected drugs at least weekly were significantly more likely to be willing to use SIF (Table II). Table II also exhibits certain attributes of SIF significantly associated with the outcome of interest. Since many SIF attributes were highly correlated, the variables selected represent those of statistical and substantive importance.

Table III presents multivariable logistic regression models. In constructing the base model, multicollinearity was detected among several key variables, manifesting itself in poor precision and warranting exclusion of redundant variables. The base model consists of the remaining significant variables and those that augmented model fit and precision; it acted as an intermediary step in exploring relationships in the data.

Finally, through inspection of the data and additional trivariate analyses by age group, the effect of several factors appeared to be modified depending on an IDU's age. The sample was divided at age 25 because Montréal has a sizeable drug-injecting street youth population that is defined as 25 and younger. Two distinct trends in intentions and associations among these subpopulations were apparent. For example, younger IDU who injected most of the time in public places were significantly more willing to use SIF than younger IDU who injected mostly in private locations (87.8% public vs. 62.5% private, OR 4.3 [1.41-13.1]). However, among IDU aged 25 and older, quite the opposite was found: older IDU who injected mostly in private locations were more willing to use SIF than their counterparts who injected most of the time in public (85.7% private vs. 70.2% public, OR 0.39 [0.17-0.92]). Hence exploratory logistic regression models by age group were constructed (Table III).

DISCUSSION

We found high degrees of SIF acceptability, consistent with other studies conducted in cities considering SIF establishment.[23-25] IDU were concerned about health and safety problems related to publicly injected drug use not only for themselves, but also for the community. The Montréal-specific SIF model generated through consensus of 11 key informants was endorsed by a majority of public injectors.

Since injection of drugs in Montréal is cocaine-centred, it is not surprising that predominant cocaine injection was highly associated with intention to use SIF. Most SIF opened and continue to operate in

TABLE III

Factors Associated with the Willingness of Publicly Injecting Drug Users in Montréal to Use SIF: Multivariable Logistic Regression Results

Variable	Base Model Adjusted OR* [95% CI] N=238	Age ≤25 Years Adjusted OR* [95% CI] N=81	Age >25 Years Adjusted OR* [95% CI] N=170
Drug most frequently injected (cocaine vs. other drug)	3.08 [1.24, 7.63]	†	–
Most frequent injecting location (public/semi-public vs. private)	–	11.45 [2.14, 61.20]	0.28 [0.09, 0.89]
Feelings about use of SIF (relieving vs. stressful)	5.06 [2.27, 11.28]	11.33 [2.34, 54.79]	3.37 [1.23, 9.18]
Feelings about use of SIF (empowering vs. useless)	4.01 [1.79, 8.95]	–	4.57 [1.57, 13.32]
Overdoses experienced (ever vs. never)	2.49 [1.07, 5.80]	–	–
Have heard of SIF (yes vs. no)	2.43 [1.02, 5.79]	–	2.88 [1.01, 8.17]
Frequency of injections per week (≥once vs. <once)	–	4.60 [1.08, 19.61]	–
Nurses on staff (easy vs. difficult to use SIF)	3.27 [0.95, 11.20]	–	–
IDU's views on the importance of SIF entry criteria			
Age restriction of 14 years and older (important vs. unimportant/doesn't matter)	2.41 [0.92, 6.29]	–	3.57 [1.05, 12.11]
Rules			
People can split their drugs but must self-inject (acceptable vs. unacceptable)	2.70 [0.97, 7.51]	–	5.52 [1.40, 21.72]
Situations that may be barriers to an IDU's use of SIF‡			
People knowing that you are a drug user (yes, would be a barrier vs. no, would not be a barrier)	0.33 [0.14, 0.77]	0.20 [0.04, 0.91]	0.29 [0.10, 0.86]
Being in too much of a hurry (yes, would be a barrier vs. no, would not be a barrier)	–	–	0.21 [0.05, 0.87]
Location of SIF (yes, would be a barrier vs. no, would not be a barrier)	0.47 [0.20, 1.13]	–	–

* Adjusted for the variables listed in the respective model

† Predominant drug injected and place of injection were highly collinear (i.e., almost perfectly confounded by one another) among younger IDU. Predominant place of injection was chosen for inclusion in the model to compare with findings among older injectors, but a model using the drug variable returned identical predictors for younger IDU.

‡ The odds ratios less than 1.00 for these variables suggest that IDU who indicated that certain situations would not be barriers to their using SIF (i.e., 'No, not a barrier') were more willing to use SIF.

places where heroin is the drug of choice; hence there is no precedent for SIF operation in predominantly cocaine-injecting settings. Attention to such potential operational challenges and to the lessons learned from Australia's SIF trials is warranted in future SIF studies.

Similar to other findings, IDU who had overdosed were more likely to be willing to use SIF.[23] Multivariable analyses also pointed to the significance of SIFs' image among IDU. Emphasis on empowerment (i.e., control over one's drug use) and stress relief, both of which are perceived to be associated with using SIF, are important in strategizing outreach efforts. Moreover, awareness of SIF alone was predictive of willingness to use them, underscoring the relevance of social marketing of SIF to this hidden population. The association between disclosure of one's injecting ("People knowing you are a drug user.") and intention to use SIF is not entirely clear but one interpretation hypothesizes that it represents readiness to seek help and initiate treatment entry.

Location and injecting circumstances were key factors in the intention of IDU of any age to use SIF. Other studies emphasize the importance of distance from drug supply source, specific attributes (e.g., confidentiality), and SIF environment (e.g., cleanliness).[23,24,26] At the planning stage of SIF, it is crucial to consider such features in implementing pilot sites, given issues of civil liability and changes to the Canadian legal and regulatory drug policy that may be required.[14]

Age differentiates publicly injecting IDU. Comparable to other characterizations in the literature,[12,27,28] the majority of older IDU in this study were male, and 90% reported injecting cocaine both predominantly and frequently, whereas younger users were 39% female and reported significantly more heroin use (48%). The age-specific findings suggest that Montréal public health planners might consider incorporating SIF into existing points of service for street youth, in addition to the proposed SIF needle exchange sites, to address differences in needs and potential uptake of SIF services.

This study has several strengths. No previous study of SIF acceptability has exclusively consulted public injectors, nor sought to determine factors related to willingness of IDU to use SIF by multivariable methods. Key informant interviews created the description of the tailored, realistic SIF model, which was presented to IDU resulting in an action-oriented proposal to public health and political representatives. Prior SIF acceptability studies provided either a limited or no definition of SIF to study participants, which calls their findings into question. Acceptability once people actually experience SIF may differ from acceptability based on theoretical concepts. This study made a concerted attempt to mitigate problems of hypothetical acceptability by using a standardized SIF definition, visual aids, and a Montréal-specific model based on services known to participants. Study recruitment was facilitated by remunerating participants; building upon the rapport of the SurvUDI Study with the affected community, with its network of study sites and established interviewers who are trusted by IDU and on-site intervention workers, to gain access to IDU; and launching the study at a politically desirable time of increasing public debate over SIF. Feedback from IDU involved in this study was overwhelmingly positive: whether willing to use SIF or not, IDU expressed strong appreciation for being sought out to share "expert" views on and need for SIF.

There are also limitations to this study. The illegality of drug use and hidden nature of IDU populations make for challenging research. It is neither possible to assess the representativeness of the study sample nor to conclude the extent of generalizability of the results, even with precautions taken such as multi-site recruitment. The high proportion of subjects recruited from NEP may suggest further limitations on generalizability, though, alternatively, this figure could reflect the distribution of public injecting in the city (i.e., the presence of an 'open scene' downtown[26]). The key informant-created SIF proposal was viewed as an initial, harm-reducing, and politically viable model; however, IDU other than public injectors may seek out future SIF, especially if additional services are made available there (e.g., voluntary counselling and HIV testing). The use of monetary incentives to solicit participants may create selection

bias. By necessity, modest remuneration is widely used to recruit transient, homeless, and drug-using populations for research. A more fundamental shortcoming is the lack of variability across subgroups in the data, which limited the interpretation of the outcome of interest. Finally, splitting the data by age group reduces the power and precision of multivariable models, in exchange for exploring the observed differences between age groups. Despite these limitations, the findings return a data-rich profile of potential SIF users.

This study contributes to the growing research on SIF and IDU and to public health planning of SIF. The next step in establishing pilot SIF should survey relevant parties such as the police and community around proposed SIF sites. By identifying a set of predictors of willingness to use SIF, other cities in North America considering establishing SIF may find guidance in these results and initiate city-specific feasibility studies. Initial user consultations are integral to assessing relevance and to designing SIF that are meaningful, acceptable, and most likely to be used by IDU.

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RÉSUMÉ

Contexte : Les piqueries supervisées, une mesure de réduction des méfaits, peuvent réduire plusieurs des risques liés à l'utilisation de drogues injectables en public. Au Canada, on étudie aux paliers fédéral et local la possibilité de mener un projet pilote scientifique dans plusieurs installations à la fois. L'expérience des piqueries supervisées a été tentée en Europe et en Australie et semble indiquer que des résultats favorables à la collectivité dépendent en bout de ligne de la polyvalence des installations et de leur adaptation aux besoins de leur principal groupe cible : les personnes qui s'injectent des drogues dans des lieux publics. Il est donc impératif de prendre en considération les facteurs et les conditions connus pour influencer la bonne réaction de cette clientèle à ces installations. La présente étude visait à évaluer l'acceptabilité des piqueries supervisées et à déterminer les facteurs associés à la volonté des utilisateurs de drogues injectables (UDI) d'y recourir dans une ville qui songe à établir de telles installations.

Méthode : Entre avril 2001 et février 2002, à la suite d'entretiens avec des informateurs clés, nous avons mené une étude transversale auprès d'UDI qui s'injectaient dans des lieux publics. Ces UDI participaient déjà à une étude de surveillance du VIH à Montréal. Des analyses univariée et bivariée ont été suivies d'une analyse de régression logistique.

Résultats : Onze informateurs clés et 251 UDI s'injectant dans des lieux publics ont participé à notre étude. Les informateurs clés ont produit le modèle montréalais des piqueries supervisées, que nous avons ensuite présenté aux UDI. Soixante-seize p. cent des UDI étaient disposés à utiliser au moins une des trois piqueries supervisées qui leur étaient proposées. Des modèles multivariables préliminaires ont mis au jour des profils de consommation de drogues et des attributs des piqueries supervisées qui pourraient avoir un effet déterminant sur les résultats, à savoir : l'injection prédominante de cocaïne; les antécédents de surdose; le fait d'avoir entendu parler des piqueries supervisées; les sentiments de soulagement et de renforcement de l'autonomie liés à l'utilisation des piqueries supervisées; et la facilité à divulguer sa propre consommation de drogues injectables.

Conclusion : La consultation des utilisateurs est un élément essentiel lorsqu'on veut évaluer la pertinence des piqueries supervisées et planifier des installations acceptables aux yeux des UDI.