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Chapter

An Examination of Safe Injection Sites and Ethical Issues in Philadelphia, United States

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Abstract

The opioid epidemic in the United States has been an ever-increasing public health crisis. Despite being a major issue in the United States for decades, relatively little action has been taken to address the opioid crisis. To mitigate the harm the opioid epidemic has caused in the United States, safe injection sites have emerged as a promising solution. Despite the exhaustive benefits of safe injection sites, including the reduction in the number of opioid overdose deaths, safe injection sites have faced opposition in the United States. Most of these concerns in the United States question the legality of safe injection sites, along with potential community implications. Through examining the ethics of safe injection sites from a Catholic social teaching perspective and performing an integrative literature review, safe injection sites are clearly ethical and would aid in respecting the dignity and life of people who inject drugs (PWID). With safe injection sites being ethical and recommendations in this paper to overcome concerns about safe injection sites, safe injection sites are a viable option to combat the opioid crisis in the United States.

Keywords: safe injection sites, opioid epidemic, opioids, opioid-related disorders, harm reduction

1. Introduction

1.1 Ethical principles from a catholic social teaching perspective

While public health crises, such as the COVID-19 pandemic, have received tremendous attention and resources, one public health crisis has seemingly been forgotten for decades: The opioid epidemic. With nearly half a million Americans dead from opioid use in the past few decades and no foreseeable stop to the increasing number of opioid overdose deaths, the United States is in need of immediate solutions to the opioid crisis. One emerging solution to combat the opioid crisis is facilities known as safe injection sites. Safe injection sites allow people who inject drugs (PWID) to safely inject addictive substances in the presence of healthcare professionals. While safe injection sites have been successful in countries across the world for decades as a solution to the opioid crisis, they have recently been a topic of debate in the United States. Especially in cities, such as Philadelphia, where the opioid crisis is one of the worst in the nation, safe injection sites are an extremely promising solution.

Before safe injection sites are able to be discussed in detail, this paper will first provide a background to the opioid epidemic, highlighting the role of...
pharmaceutical companies, physicians, the Drug Enforcement Agency (DEA), and the Food and Drug Administration (FDA) in exacerbating the opioid crisis in the United States. The three stages of the rise in opioid deaths will also be discussed in this section, showing the transition from predominately prescription opioid overdose deaths to heroin overdose deaths, and then the more recent transition to synthetic opioid overdose deaths. In addition, the impact of the COVID-19 pandemic on the opioid epidemic will be described, especially its role in exacerbating the opioid crisis in the United States.

With an understanding of the background of the opioid epidemic, this paper will then provide an analysis of a case study regarding the opioid crisis in the Kensington region of Philadelphia, which is one of the most impacted areas by the opioid epidemic in the country. Furthermore, this paper will then provide a detailed breakdown of the history of safe injection sites, along with their respective risks and benefits. The implications of safe injection sites for the United States will especially be emphasized in this section, along with the recent legal battle to bring safe injection sites to Philadelphia and other areas of the country. An ethical analysis of safe injection sites will then be provided from a Catholic social teaching perspective using the principles of the respect for human dignity, solidarity, the common good, and the stewardship of resources, and the relationship of safe injection sites to the harm reduction theory will also be discussed. The ethical analysis will provide an argument as to why safe injection sites should be implemented in the United States. Lastly, we will make seven recommendations for the successful and effective implementation of safe injection sites in the United States, highlighting legal, medical, educational, social, and financial aspects.

2. Opioid epidemic background

Since the 1990s, the opioid epidemic has been a devastating problem in the United States. According to the Centers for Disease Control and Prevention (CDC), between 1999 and 2019, nearly 500,000 people in the United States died from a drug overdose involving opioids, which accounts for nearly two-thirds of the total drug overdose deaths [1]. In 2019 alone, nearly 70% of the 70,630 drug overdose deaths involved opioids, and the total number of deaths from drug overdoses was four times higher in 2019 as compared to 1999 [1]. While the opioid epidemic has ravaged the United States for decades, it has not always been at the forefront of public health concerns. In 2015, Anne Case and Angus Deaton, two extremely well-known economists with the latter being a Nobel Prize winner, brought the opioid epidemic to the spotlight. While investigating morbidity and mortality rates for men and women from the CDC, Case and Deaton discovered a puzzling trend: There was a striking increase in the morbidity and mortality of middle-aged white non-Hispanic individuals between 1999 and 2013 [2]. According to Case and Deaton, between 1978 and 1998, the mortality rate for middle-aged (45–54 years old) white non-Hispanics in the United States fell by 2% per year on average [2]. However, beginning in 1999, the mortality rate for middle-aged white non-Hispanics in the United States rose by an average of half a percent a year until 2013 [2]. At the same time mortality rates were increasing for non-Hispanic whites, morbidity rates experienced a direct increase as well. In a self-reported assessment of health status from 1997 to 1999, there was a 6.7% decrease in middle-aged non-Hispanic whites from the United States reporting excellent or very good health and a related 4.3% increase in middle-aged US non-Hispanic whites reporting an increase in fair or poor health. At the same time, mortality and morbidity were increasing in the United States between 1999 and 2013 for middle-aged US non-Hispanic Whites,
self-reported declines in health, mental health, increases in chronic pain and inability to work, ability to conduct daily activities of living, and clinically measured deteriorations in liver function [2]. All of these factors interestingly coincide with the increased availability of prescription opioids for pain during the 1990s [2].

The prevalence of different types of opioids has fluctuated throughout the epidemic in three distinct waves, with the first wave of the opioid epidemic involving the increased prescription of opioids. Prescription opioids, such as OxyContin and Vicodin, are frequently used to treat moderate-to-severe pain after surgery and chronic pain [3]. While the use of prescription opioids was originally intended for chronic pain from diseases, such as cancer, or for short-term use for recovering after surgery, in the 1990s medical professionals began expanding the use of opioids [4]. Physicians began to increase the long-term use of opioids in treating chronic nonmalignant medical conditions, which include conditions, such as sciatica and low-back pain [4]. Physicians were especially influenced and encouraged to increase the usage of prescription opioids, such as OxyContin, through aggressive marketing tactics from drug companies [4]. For the physicians, the message to “be proactive with pain and treat it aggressively,” seemed to make perfect sense, and promoted the use of prescription opioids, such as OxyContin [4]. In 1995, OxyContin, a prescription opioid-containing the highly addictive compound oxycodone produced by Purdue Pharmaceutical, was approved by the United States Government. OxyContin was initially approved as an extended-release reformulation of oxycodone that was intended to reduce abuse and addiction [5]. Since opiates at the time were being used recreationally and it was widely believed that individuals with chronic pain needed more help, OxyContin was readily approved [6]. However, Purdue Pharmaceutical clearly lied and deceived the public by claiming that OxyContin’s delayed absorption ability reduced the “abuse liability of the drug” [7].

Even though OxyContin was advertised to be less abusive than other opioids, Purdue Pharmaceutical had actually conducted a study in 1995 showing that 68% of oxycodone could be extracted from an OxyContin tablet when crushed [6]. Evidently, Purdue Pharmaceutical knew how highly addictive OxyContin was, but continued to lie about their product to increase sales. With this completely false claim of reducing potential abuse of OxyContin and the unwavering message to alleviate pain whenever possible, Purdue Pharmaceutical was able to successfully market their drug to physicians, which resulted in sales increasing from $48 million in 1996 to approximately $1.1 billion in 2000 [8]. For the next 20 years after 1995, prescription opioids, such as OxyContin, experienced a 10-fold increase in medical use. Interestingly, family medicine physicians with no expertise in pain management prescribed more opioids than any other type of physician, even pain specialists. In 2012, 18% of all opioid prescriptions were written by family medicine physicians, 15% were written by internists, and only a mere 5% were written by pain specialists [4].

Despite the rapid increase in the use of prescription opioids, such as OxyContin, in the United States beginning in the late 1990s, OxyContin was not even more effective than alternative drugs. For example, a randomized double-blind study showed that giving OxyContin every 12 hours produced comparable efficacy and safety results when treating chronic back pain as giving immediate-release oxycodone four times daily [9]. In addition, when treating patients with moderate to severe cancer-related pain, a randomized double-blind study showed that OxyContin given every 12 hours was as effective as immediate-release oxycodone given four times daily [10]. Even during the FDA’s review of OxyContin in 1995, the FDA’s medical review officer concluded that OxyContin had no significant advantages over immediate-release oxycodone [6]. Along with not producing a significant advantage over other alternatives, there have been no studies affirming the
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long-term effectiveness of OxyContin [3]. Moreover, in 2006, a Danish study with a national random sample of over 10,066 individuals that compared opioid users to non-opioid users revealed that opioid usage was significantly associated with reports of moderate/severe or very severe pain, poor self-rated health, unemployment, increased use of the health care system, and a lower quality of life [11]. With OxyContin seeming to have more negative effects on patients than positives, it is evident that its producer, Purdue Pharmaceutical, is at fault. As Oxycontin became one of the most prescribed opioids in America, it had also become one of the most abused drugs in America by 2004, resulting in an increasing number of opioid overdose deaths [12]. From 1999 to 2017, the number of opioid overdose deaths involving prescription opioids increased from 3,442 to 17,029 deaths [13].

While Purdue Pharmaceutical did nothing to inform the public about these harms, physicians are not infallible for their propagation of the opioid epidemic. Even after the addictive nature of opioids has become apparent in the past two decades, prescription opioids are still heavily utilized. In 2017 alone, over 191 million opioid prescriptions were dispensed to American patients [3]. In addition, the long-term use of prescription opioids by an individual is connected to the prescribing patterns of the original physician they encountered [14]. For example, researchers discovered that doctors they marked as “high-intensity” prescribers sent one out of four patients home with opioids, while “low-intensity” prescribers gave opioids to one out of 14 patients, and patients that saw a “high-intensity” prescriber were over 30% more likely to become long-term users of prescription opioids [14]. While physicians played a role in starting the opioid epidemic, they can continue to exacerbate it if prescription opioids continue to be prescribed at high frequencies.

Along with physicians and large pharmaceutical companies, such as Purdue Pharmaceutical, the Drug Enforcement Administration (DEA), further worsened the opioid epidemic. For example, in 2019, the Justice Department’s inspector general criticized the DEA’s decision to authorize manufacturers to tremendously increase the production of prescription opioid painkillers between 2003 and 2013 while opioid-related deaths in the United States surged [15]. The DEA directly oversees access to opioids, regulates opioid production quotas, and investigates illegal diversions of opioids [15]. However, the DEA failed to adequately respond to the opioid crisis as it increased the production quotas for oxycodone production by nearly 400% between 2002 and 2013, even though there was significant evidence that opioids were being abused and overprescribed [15]. The DEA also further did not capture proper data on opioid abuse and other drug trends between 2002 and 2013, thereby further handicapping their ability to properly mitigate the opioid crisis [15].

Along with the DEA, the Food and Drug Administration (FDA) further failed to deal with the opioid epidemic properly. For example, in 2019, the FDA failed to use its policing powers by providing no oversight or measure of effectiveness for a safety training program that aimed to reduce the improper prescription of opioids [16]. In 2007, Congress explicitly gave the FDA the power to require the manufacturers of opioids to give training to physicians so that they could properly prescribe opioids, and the FDA was allowed to monitor the performance of these drug companies [16]. With this power, in 2011, the FDA asked producers of OxyContin and other addictive long-term opioids to pay for safety training for nearly 320,000 physicians prescribing their drugs, and also asked these entities to track the effectiveness of this training and measure other factors, such as reducing addiction, overdoses, and deaths [16].

Even though the safety program sounded good in theory, in practice it was doomed from the beginning. For example, the FDA never determined if the program worked as the opioid manufacturers were not properly collecting the right type of data, and the FDA made the critical mistake of leaving the monitoring of
these safety programs in the hands of the drug manufacturers. In 2010, the FDA advisory committee of experts was aware of these potential flaws in the program’s design and voted 25–10 against its implementation; however, the FDA still implemented the flawed program [16]. In addition, in 2013, a report by the inspector general of the Department of Health and Human Services showed that only 14% of the safety programs that the FDA reviewed actually met their goals, and that the FDA had no enforcement actions against companies that did not provide enough information about their safety program for it to be reviewed [16]. Hopkins researchers discovered that even though the FDA was aware of these problems after performing their own review process, they still did nothing to change it, and ultimately failed to regulate the opioid manufacturers [16]. This improper decision-making seemed to be driven by a conflict of interest between opioid manufacturers and the FDA staff responsible for opioid oversight [17]. Shockingly, the two FDA reviewers that originally approved Purdue Pharmaceutical’s oxycodone application joined Purdue after leaving the FDA [17]. With a conflict of interest and the lack of action, the FDA made no progress in limiting the devastating impacts opioids were having in the United States, and ultimately played a critical role in exacerbating the opioid crisis.

While prescription opioids started the opioid epidemic in the United States, the second wave of the opioid crisis, starting in 2010, saw a rapid increase in the number of opioid overdose deaths using heroin. According to the CDC, between 2010 and 2018, opioid overdose deaths involving heroin increased by a factor of 5 from 3,036 deaths in 2010 to 14,996 deaths in 2018 [18]. In 2018, it was estimated that over 808,000 individuals had used heroin in the United States [19]. While heroin use only started to spike around 2010, it has accounted for nearly a third of all opioid overdose deaths contributing to the death of over 115,000 Americans between 1999 and 2018 [18]. Furthermore, heroin is often combined with other drugs and alcohol, leading to a greater chance of overdose. In 2013, it was reported that over 96% of heroin users use another drug, while 61% report using at least three different drugs [20]. Since heroin is typically injected using needles, heroin users are also at risk of contracting HIV, Hepatitis B, and Hepatitis C. In 2017, the CDC reported that almost 9% of the 38,738 diagnoses of HIV in the United States resulted from the injection of drugs, such as heroin [21].

Despite the devastating impact that heroin and prescription opioids have had on the United States during the opioid epidemic, the third wave of the opioid epidemic, starting in 2013, has been characterized by the development of deadly synthetic opioids. The use of synthetic opioids, such as fentanyl and Tramadol, is currently the leading cause of opioid deaths. For example, in 2018, over 31,000 people died from overdoses involving synthetic opioids excluding methadone, which was a 10% increase from 2017 [22]. From 2010 to 2013, the national rate of synthetic opioid overdose deaths was approximately 1 per 100,000 individuals, while this rate tripled from 2013 to 2015 to nearly 3.1 synthetic opioid overdose deaths per 100,000 individuals [23]. Fentanyl is particularly problematic as it is 50–100 times more potent than morphine, and is often mixed with heroin and cocaine without the knowledge of the user, as it can increase the euphoric effects [22].

With the increased usage of synthetic opioids in recent years, the opioid epidemic began to emerge as a public health crisis. On October 26, 2017, President Trump officially declared the opioid epidemic a “public health emergency” [24]. With this declaration, President Trump instructed the Health and Human Services (HHS) secretary, Eric D. Hargan to declare the opioid epidemic a public health emergency [24]. With Hargan’s declaration, HHS was allowed to allocate resources and personnel to face the opioid epidemic [25]. In particular, on March 20, 2018, a National Health Emergency Dislocated Worker Demonstration Grant became available to individuals who experienced economic and workforce-related impacts.
caused by the opioid crisis [26]. Through providing this grant, training opportunities for skilled professions were encouraged to help those struggling with addiction to have a path back to the workforce.

While progress in mitigating the opioid epidemic has occurred in recent years, the development of COVID-19 has exacerbated the crisis. Before COVID-19, between 2017 and 2018, opioid-involved deaths decreased by 2%, prescription-opioid involved death rates decreased by 13.5%, and heroin involved deaths decreased by 4% [3]. With drug overdose mortality declining for the first time in over two decades, there was room for optimism in 2018 that the opioid epidemic was finally starting to become under control [27]. However, between 2018 and 2019, drug overdose deaths climbed once again up to 70,000 deaths [27]. This increasing trend in drug overdose deaths starting before the COVID-19 pandemic, has only continued to increase as a result of the pandemic. For example, provisional drug overdose deaths experienced an increase of 2,146 deaths from 75,696 deaths in the 12-months ending in March 2020 to 77,842 deaths in the 12-months ending in April 2020, and drug overdose deaths experienced a 3,388 death increase from the 12-months ending in April 2020 to 81,230 deaths in the 12-months ending in May 2020 [28]. What makes these numbers so alarming is that the increase of 2,146 provisional drug overdose deaths and 3,388 provisional drug overdose deaths mark the largest monthly increases since provisional 12-month estimates began to be calculated in January 2015 [28]. Even more alarming is the fact that in a 12-month period ending in September 2020, more than 87,000 Americans died from drug overdoses, which was the highest number ever recorded since the start of the opioid epidemic in the 1990s [29]. Moreover, the opioid crisis has even caused more devastation than COVID-19 in cities, such as San Francisco, where in 2020, the number of drug overdose deaths skyrocketed to 713 deaths as compared to the 257 individuals who died of COVID-19 that year [30].

With record-breaking monthly and annual surges in drug overdose deaths recorded at the start of COVID-19’s declaration as a national emergency, it is clear that the pandemic has been responsible for increasing the number of drug overdose deaths. While we know this is happening, why is the pandemic increasing drug overdose deaths? First of all, while social distancing has been critical in mitigating the COVID-19 pandemic, it has also unfortunately been extremely problematic for those recovering from drugs or for individuals that use drugs. For example, access to essential treatments and community groups has been disrupted, as individuals have been instructed to stay away from others during the pandemic [27]. While recommendations to avoid individuals have been generally seen as positive, an unintended consequence of these recommendations is that they conflict with the harm reduction theory’s principle of never using alone [27]. Furthermore, the pandemic is tremendously increasing the reasons people have to use drugs, such as opioids, as it has increased unemployment, feelings of loneliness and hopelessness, poverty, and a general desire to escape [27]. As people lose their jobs and experience economic and social turmoil, drugs like opioids are readily being seen as a remedy for these troublesome issues.

With the devastation that the pandemic has caused to the lives of so many individuals, it is not a surprise that heroin and synthetic opioids usage and deaths have seen tremendous rises. In a study of over 150,000 urine samples ordered by health professionals 4 months before the national emergency declaration (November 14, 2019, to March 12, 2020) and after (March 13, 2020, to July 10, 2020), fentanyl prevalence increased from 3.80% to 7.32% and heroin prevalence increased from 1.29% to 2.09% [31]. In addition, in a study of over 500,000 definite drug test results from Millennium Health in the periods before and after the national emergency for COVID-19 was declared, the national findings revealed a 31.96% increase in
non-prescribed fentanyl, 19.69% for methamphetamine, 10.06% increase in cocaine, and a 12.53% increase for heroin [32]. Along with the rise in heroin and synthetic drug usage, drug overdose deaths from both of these types of opioids have increased as well. For example, between the 12-months ending in June 2019 and the 12-months ending in May 2020, the 12-month count of synthetic opioid deaths increased by over 38.4% [28]. The increase in drug overdose deaths from heroin is co-linked with drug overdose deaths, as overdose deaths from cocaine typically combined with heroin increased by 26.5% [28]. While COVID-19 has resulted in the death of over 530,000 individuals in the United States as of March 2021, the COVID-19 pandemic has only accelerated the usage and drug overdose deaths from opioids, and has pushed the opioid epidemic out of the concern of the public eye [33].

3. Case study

Philadelphia is home to the worst opioid crisis in the United States. Of the 10 most populous counties in the United States, Philadelphia has the highest overdose rate [34]. In addition, according to the Philadelphia Department of Public Health, in 2019, over 1,150 people died from drug overdoses in Philadelphia with 80% of these overdose deaths involving opioids [35]. The COVID-19 pandemic has further caused an 11% increase in the number of drug overdose deaths in Philadelphia in the first three quarters of 2020 compared to the same period in 2019 [36]. The pandemic has been especially devastating for Black and Hispanic Philadelphians, as drug overdose deaths in the first three quarters of 2020 increased by over 40.3% for Black Philadelphians and increased by 5.9% for Hispanic Philadelphians while decreasing by 7.3% for white residents [36]. These discrepancies have been accounted for by explanations of systemic racism experienced by Black and Hispanic individuals that result in less access to treatment, education, and economic resources [36].

Even though the number of deaths is troubling, the number of Philadelphians addicted to opioids is even more problematic. In 2017, the Philadelphia Department of Public Health estimated that over 75,000 of its residents are addicted to heroin and other opioids [35]. At the center of the opioid crisis in Philadelphia is one main neighborhood: Kensington. The Kensington District is home to one of the largest open-air drug markets in the United States, with buyers and sellers of heroin and other opioids roaming the streets at all hours of the day [37]. Of the 1,217 people that fatally overdosed from drugs in Philadelphia in 2017, 236 individuals fatally overdosed in Kensington alone [35]. With high levels of opioid use and fatal drug overdoses, individuals in Kensington live in a perpetual state of suffering.

One resident of Kensington, Crystal, a 34-year-old mother of three children, is a devout heroin addict. Crystal is originally from the Kensington area and had several other of her relatives that were addicted to heroin [34]. After Crystal's husband lost his job, Crystal began to utilize heroin as a coping mechanism for this loss. As Crystal and her husband divorced, she continued to abuse heroin, and eventually found herself living on the streets of Kensington without her children. Through further suffering a broken ankle, Crystal continued to use heroin as a means to escape. Crystal would constantly need to be revived by Narcan, as she was heavily addicted to heroin. The heroin in Kensington, known as “Philly dope,” is especially more dangerous as it is often laced with the dangerous synthetic opioid, fentanyl [34]. The heroin is also extremely cheap in Kensington at only $5 a bag making it accessible to numerous individuals. With these factors, Crystal remained in a state of a constant dependency on heroin. When she was
without it, she would experience tremendous episodes of withdrawal. Crystal described this lifestyle as “playing Russian roulette with your life,” but sadly like many other Kensington residents, she was too addicted to leave this lifestyle behind [34].

Although heroin users from Kensington like Crystal can grow up in Kensington, many users are drawn to the area for its reputation as “the Walmart of heroin” [34]. One middle-aged woman named Jax migrated to Kensington to start shooting up heroin. Jax was originally a college student that started using opioids in college but eventually became a prostitute after shooting up heroin in Kensington. Jax tried to remain sober by checking herself into rehab centers but could never escape the addiction. Despite having the initial support of her boyfriend, Jax’s boyfriend eventually left, leaving Jax alone to continue her heroin use. Like many women in Kensington, Jax turned to prostitution to pay for bags of heroin. Prostitutes in Kensington have been raped, tied up, and abused but are often afraid to tell police about their abuse due to their previous drug or prostitution charges. After becoming pregnant in 2009, Jax used heroin for the whole nine months, and her resulting son currently does not live with her. In 2018, Jax spent 24 days in jail, but after being released, she overdosed nine times in two weeks. Despite being saved from death on numerous occasions, Jax simply wishes that people would “just let me die” [34].

As shown through the examples of Crystal and Jax, individuals from all different backgrounds can be drawn into devastating opioid addictions. Crystal inevitably became a product of her own environment, while Jax was attracted to Kensington for its powerful opioids [34]. Although each woman experienced unique life challenges, their current lives are plagued by a constant presence of overdosing and dependence on heroin. While these women could potentially benefit from rehab centers, it is evident through cases like Jax that these rehab centers are simply not enough. Even when Philadelphia mayor Jim Kenney attempted to clean up the streets of Kensington in 2017, displaced residents from his projects continued to refuse the city’s offer of treatment [34]. While rehab centers are unlikely to benefit Crystal and Jax, safe injection sites could potentially allow these individuals to slowly escape their heroin addiction, and at least mitigate the harm of abusing heroin.

4. Consequences of safe injection sites

4.1 Benefits of safe injection sites

While safe injection sites have been a recently new topic of discussion in the United States, they have benefited other countries for decades. Canada decided to become the first North American country to implement safe injection sites in 2003. Leading up to their decision, Canada had been experiencing health-related and social harms with injection drug use, especially in Vancouver [38]. In the mid-late 1990s, Vancouver’s health authorities declared a public emergency after trends showed over 300 annual fatal overdoses occurring in the province of British Columbia, along with an annual new HIV infection rate of approximately 19% among local people who inject drugs [38]. As a result, the first legally sanctioned safe injection site opened in Vancouver in 2003 [38]. The Portland Hotel Society (PHS), a non-government organization, was responsible for the creation of the first sanctioned site, which initially began by members quietly building the safe injection site in a seemingly boarded up vacant building [38]. The regional health authority decided to work with PHS to open the site after its development in the form of a scientific pilot known as Insite, and the site received a federal exemption under Section 56 of the Controlled Drugs and Substances Act by the federal Health Ministry [38].
In the years since the creation of Insite, the results have been extremely promising. Since 2003, there have been over 3.6 million visits to inject drugs under the supervision of nurses, with 6,440 overdose interventions, and zero fatalities [39]. Along with preventing any overdose deaths, since 2003, there have been approximately 48,798 clinical treatment visits from users of illicit drugs. Furthermore, in the most recent data from 2019, Insite had 170,731 visits by 5,111 individuals, with 1,314 overdose interventions, and 3,158 clinical treatment interventions [39]. An average of 312 injections occurred at Insite per day in 2019, with 60% of these injections involving only opioids, 15% of injections involving stimulants only, and approximately 24% of injections involving a mix of opioids and stimulants [39]. Moreover, after the opening of Insite, the overdose mortality rate of all persons living within 500 m of the facility (70% of safe injection site users) decreased from 253 to 165 per 100,000 person-years, and one overdose death has been prevented for every 1137 users [40]. However, there was no change in overdose mortality elsewhere around the city of Vancouver, indicating the importance of Insite in inducing these changes. After the opening of Insite, there were also 67% fewer ambulance calls for treating overdoses, along with a decrease in HIV infections with an estimated 6–57 HIV infections being prevented per year in Vancouver [40].

Along with the tremendous benefits provided by Insite, the model has proved to be cost-effective. Insite’s operating costs are approximately $3 million per year, but the value of the benefits of Insite is much greater [41]. Without Insite, it is estimated that yearly HIV infections in Vancouver would by 83.5 infections increase from 179.3 to 262.8 infections [41]. Using the value of 83.5 preventable HIV infections, Insite has been estimated to save approximately $176 million in lifetime HIV-related medical costs [41]. In addition, based on more conservative estimates, Insite has been estimated to prevent around three deaths per year and approximately 35 new cases of HIV [42]. Using these values, Insite has been estimated to have a societal benefit in excess of $6 million after yearly operating costs are factored in, thereby producing an average benefit-cost ratio of 5.21:1 [42]. Moreover, another study projected that over 54 cases of hepatitis C infections would be prevented over ten years with the presence of Insite [43]. The amount of cost averted per case was estimated to be $444,500 for each hepatitis C virus infection [43]. Through these estimates, it is clear that Insite is an effective use of public health resources when analyzing the measurable benefits of HIV infection and drug overdose deaths.

With the continued success of safe injection sites in Vancouver and around the world, it is evident that safe injection sites provide clear benefits to their communities. A summarized list of the benefits of safe injection sites is as follows:

1. Successfully managing on-site overdoses and reducing drug-related overdose death rates
2. Saving costs due to reducing disease, overdose deaths, and the need for emergency medical services
3. Reducing the risk behavior associated with HIV and other blood illnesses, such as Hepatitis C
4. Increasing the entry into substance use disorder treatment
5. Reducing the amount and frequency individuals use drugs
6. Increasing the delivery of medical and social services [44].
4.2 Bringing safe injection sites to the United States

Based on the success of Insite and other safe injection sites facilities, the number of safe injection site facilities has continued to grow. As of 2021, there are approximately 120 safe injection sites operating in ten different countries throughout the world: Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland [44]. Despite the opioid epidemic ravishing the United States, there are currently no safe injection sites in the country. However, in the past few years, several cities in the United States have been trying to change that. With the worst opioid crisis in the nation, in January 2018, the city of Philadelphia began to look toward implementing a safe injection site in the form of Comprehensive User Engagement Sites (CUES) [45]. CUES was developed with Insite as a model and adopted many of its services, such as monitoring user injection of drugs for on-site overdose care, recovery/detoxification services, referrals to treatment, and other health services, such as wound care, immunizations, and pregnancy tests [46]. CUES was also structurally similar to Insite by providing a reception area for PWID and giving each PWID a card with an anonymous identification number [46]. The purpose of the card is not to collect personal information, but rather to provide PWID the address and phone number of the facility, phone number of counseling and rehabilitation programs, and also contacts to emergency services in case of an overdose [46]. At the reception center, PWID are also asked where they heard about the site from, their age and ethnicity, along with their interest in services, such as rehabilitation, psychiatric services, wound care, and clean needle exchanges [46]. After the reception, PWID can safely inject at separate benches in a large room under the supervision of healthcare professionals, and can then briefly relax in a separate lounge area for 30 minutes. During the lounge period, educational material, counseling, and rehabilitation services are offered to PWID [46]. Unlike Insite, CUES offers additional services, such as fentanyl screenings, Hepatitis-C/HIV screenings, a needle exchange program, Narcan distribution and education, early education, and counseling for rehabilitation and detoxification done by individuals in recovery who have actually experienced drug addiction [46].

The services provided by CUES also have extremely promising impacts on population health. For example, in December 2017, SCF-averred HIV infections were estimated to range from 1 to 18 annually with the low range assuming a receptive needle sharing of 2% with the upper range assuming a receptive needle sharing of 28.3% [47]. In addition, SCF-averred hepatitis C virus (HCV) infections were estimated to range from 15 to 213 annually assuming the same receptive needle sharing ranges as used in the HIV estimates [47]. While the low ranges are possible for both averted HIV and HCV infections, the Philadelphia Department of Health estimates that the actual rate of needle sharing is closer to 28.3%, thereby suggesting that true values for averted infections should be closer to the upper limits [47]. Along with HIV and HCV infections, the estimated number of annual overdose deaths averted within 500 meters of a SCF would be between 27 and 48 deaths annually, while the number of averted overdose deaths from opening a SCF would be between 24 and 76 deaths annually [47].

Along with the health impacts, the estimated financial impacts of SCFs are quite striking. For example, the estimated total value of overdose deaths averted in Philadelphia would be between $12,462,213 and $74,773,276 annually [47]. In addition, the estimated annual savings due to SCF skin and soft tissue infection (SSTI) reductions would be between $1,512,356 and $1,868,205 annually [47]. Furthermore, estimates predict that SCF will result in savings due to a reduction in emergency room visits, hospital stays, and ambulance calls. For example, the estimated annual savings due to SCF reducing ambulance calls for an overdose

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is $123,776 [47]. The estimated annual savings from keeping PWID out of the emergency room is $280,683, while the estimated annual savings on hospitals for PWID who overdose would be $247,941 [47]. With these estimates, SCFs are expected to produce tremendous benefits to the health and financials of individuals in the city of Philadelphia.

With the promising impacts of safe injection sites in Philadelphia, numerous individuals in Philadelphia saw developments, such as CUES as an opportunity to successfully combat the opioid epidemic. In 2018, the Mayor of Philadelphia, Jim Kenney, and Philadelphia District Attorney Larry Krasner, both strongly supported the implementation of CUES. Instead of combating drug addiction through the criminalization of drugs by claiming a “War on Drugs,” both Kenney and Krasner wanted to approach drug addiction from more of a harm reduction standpoint [48]. Through the opioid epidemic driving violence in Philadelphia and stressing the EMS system, both Kenney and Krasner realized that immediate action was needed that focused on saving lives “in a way that research has shown to be successful” [48]. For Kenney and Krasner, CUES provides not only a place where PWID can be safely injected under supervision, but also provides a direct link to treatment, resources for housing and meals, and the ability to save lives [48]. Krasner also expressed that he would not prosecute anyone involved in bringing safe injection sites to Philadelphia [48]. Moreover, safe injection sites, such as CUES, have the support of Philadelphia’s Health sector. In 2018, Dr. Thomas Farley, Philadelphia’s Health Commissioner and co-chair of the city’s opioid task force, also expressed his support for safe injection sites [49]. Farley described how there are “many people who are hesitant to go into treatment, despite their addiction, and we do not want them to die” [49]. Instead of letting individuals die, Farley continued to reiterate the sentiment that safe injection sites save lives and connect individuals to treatment [49]. Based on the support of numerous public officials, as of early 2018, the message for safe injection sites was clear: CUES have the greenlight to be implemented. Although, instead of paying or operating any of the safe injection sites, the city of Philadelphia would simply be a facilitator and connector with the organizations that provided addiction services [49].

4.3 Legal barriers to safe injection sites in the United States

With the city of Philadelphia not directly funding safe injection sites, other organizations became responsible for the implementation of safe injection sites. Within a year, a privately funded, 501 tax-exempt, Philadelphia nonprofit corporation named Safehouse, attempted to address the opioid epidemic crisis by its plan to open the United States’ first safe injection site in Philadelphia [50]. However, Safehouse’s plan was met with immediate legal resistance. In February 2019, Bill McSwain, the U.S. Attorney for the Eastern District of Pennsylvania filed a civil lawsuit that asked a federal court to declare supervised consumption sites, otherwise known as safe injection sites, illegal under 21 U.S. Code 856, which is a section of the Controlled Substances Act known as the “Crack House” Statute [50]. The Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, known as the Controlled Substances Act, had the main goal of improving the manufacturing, importation, exportation, distribution, and dispensing of controlled substances [51]. To create a “closed system” for controlled substances, the Controlled Substances Act further mandated that manufacturers, distributors, and dispensers of controlled substances must register with the Drug Enforcement Administration (DEA) [51]. In addition, the Controlled Substances Act categorized controlled substances into five schedules based on their abuse potential to further aim to mitigate the potential harms of these substances [51].
In terms of safe injection sites, the Controlled Substances Act, has tremendous legal implications. For example, Section 856(a) of the Controlled Substances Act, otherwise known as the “Crack House Statute,” contains a potential barrier to establishing safe injection sites. Subsection (a) regarding the unlawful acts of Section 856 of the Controlled Substances Act is as follows:

1. Knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or using any controlled substance;

2. Manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance [52].

Based on the Crack House Statute, it is illegal to run a facility where controlled substances, such as opioids, are used. With this statute, operating these facilities is considered a federal crime and individuals can be subject to a felony with imprisonment of up to 20 years, and hundreds of thousands of dollars in fines [52]. With McSwain's civil lawsuit against Safehouse, it now became up to the federal courts to decide if safe injection sites indeed violate the Crack House Statute. McSwain in conjunction with the Justice Department argued that the plain language of the law was clear, and if advocates of Safehouse wanted to change the law to open safe injection sites, they would have to lobby Congress [53]. On the other hand, advocates for Safehouse argued that the Crack House Statute does not apply to safe injection sites as the law only intended to impact the owners and tenants of drug dens at a time when the crack-cocaine epidemic was at its height [53]. Despite McSwain's appeal, in October 2019, U.S. District Judge Gerald A. McHugh did not believe the Crack House Statute applied to safe injection sites, such as Safehouse, as he did not believe that lawmakers had safe injection sites in mind when creating the Controlled Substances Act [53]. McHugh further argued that the goal of safe injection sites, such as Safehouse, is to “reduce drug use, not facilitate it, and that it was up to Congress to amend the statute if it wanted to deem safe injection [53].

After this initial victory defending the implementation of safe injection sites, the battle over the legality of safe injection sites has continued. On February 25, 2020, McHugh issued a Final Declaratory Judgement for Safehouse which declared that the proposed safe injection site did not violate any of the federal drug laws [50]. Safehouse asked for this judgment to be assured that they could proceed with their plans to open a proposed safe injection site [54]. With this reaffirmation of the legality of safe injection sites, Safehouse was ready to bring the first safe injection site inside the Constitution Health Plaza at the corner of Broad and McKean Street in South Philadelphia [54]. However, McSwain adamantly continued his argument against the implementation of safe injections sites under the current law, and appealed McHugh's decision to the U.S. Court of Appeals for the Third Circuit a few days after McHugh's final judgment [55]. McSwain also asked for an Emergency Motion of Stay, which would prevent safe injection sites from opening until the Third Circuit court made its decision [50]. Along with McSwain, community residents in South Philadelphia resisted the idea of safe injection sites. Residents argued that crime would be brought to their neighborhoods, and that safe injection sites were not going to solve the opioid epidemic [56].
Despite the resistance, Safehouse did not want to slow the progress they had made. On March 10, 2020, in response to McSwain’s order for a stay to be issued, Safehouse requested that a stay not be issued on the case [50]. However, during the following week, the city of Philadelphia went into lockdown due to the COVID-19 pandemic, resulting in the closure of courts across the Philadelphia area [57]. Along with the COVID-19 pandemic, protests against police brutality swept across the nation after the killing of Mr. George Floyd in late May 2020 [58]. With city and country officials being overwhelmed with the challenges associated with COVID-19 and the outrage over police brutality, McHugh ultimately decided to approve McSwain’s emergency stay on June 25, 2020 [58]. Even though McHugh did not change his original verdict on safe injection sites, he believed it was the “wrong moment for another change in the status quo” [58]. After a long delay, a three-member panel of the Third Circuit Court of Appeals eventually started hearing oral arguments on November 16, 2020 [50]. At the conclusion of the case hearing, the Third Circuit Court of Appeals agreed with the Government that supervised safe injection sites are illegal under federal law on January 13, 2021 [59]. In a 2-1 decision, the appeals court decided to change to the decision of the federal district court as it argued that Safehouse “knows and intends that visitors to its consumption room will have a significant purpose of using illegal drugs” [59]. With this decision, Safehouse suffered a massive blow, as opening safe injection sites became declared to be illegal in the United States. On February 24, 2021, Safehouse filed a Petition for Rehears ing En Banc, which requested a rehearsal in front of the entire panel, but this request was denied on March 24, 2021, despite three judges issuing strong dis-sents to the denial [50]. Safehouse still has options to appeal to the Supreme Court of the United States.

With the promise of a ruling on safe injection sites going to the Supreme Court of the United States, several states have continued to lobby for state laws that support the implementation of safe injection sites. For example, after first introducing the idea of Harm Reduction Centers in 2019, lawmakers revised two versions of a bill known as H 5245 and S 0016, which focus on the creation of a harm reduction center advisory committee and pilot program [60]. The Senate version of the bill, S 0016, which was passed on February 23, 2021, would result in the establishment of an advisory committee that makes recommendations to the state’s Health Department Director on the regulation of safe injection sites. Unlike the house version, the Senate version of the bill provides liability protection that prevents “property owners, managers, employees, volunteers, clients, or participants, and state, city, or town government employees acting in the course and scope of employment” from being arrested or prosecuted [60]. If the house version of the bill, H 5245, is passed by the house and approved by Rhode Island Governor Gina Raimondo, Rhode Island could be the first state to legalize safe injection sites [60].

Along with Rhode Island, on March 2, 2021, the New Mexico House passed HB 123, a bill authorizing counties to establish and operate OPPs (Overdose Prevention Programs) following guidelines that will be created by the New Mexico Department of Health by October 1 [61]. In the argument for the creation of OPPs, lawmakers took a similar legal stance to the proponents of Safehouse and argued that the purpose of these sites is to protect the health of people who do drugs, not to facilitate drug use [61]. If the legislation passes through the New Mexico State Senate, OPPs will be established in New Mexico. Despite the ruling against Safehouse in January 2021, state legislatures remain optimistic that their versions of safe injection sites will be federally legal, as President Biden has strongly emphasized the key component of harm reduction in his National Drug Control Policy. The Biden-era Office of National Drug Control Policy (ONDCP), places a great emphasis on “confronting racial equity issues related to drug policy” and “enhancing evidence-based harm
reduction efforts” [62]. With strong support for harm reduction in combating drug abuse by the President, the legal approval of safe injection sites seems to be on the horizon.

4.4 Potential risks of safe injection sites

While safe injection sites carry tremendous potential benefits, there are also some important risks. Outside of the legal issues previously discussed, one main potential risk of safe injection sites proposed by critics is that they can encourage drug use and disincentive drug cessation by sending out the message that drug use is legally tolerable [46]. One study on Insite in Vancouver measured changes in drug use among PWID in Vancouver both one year before and after Insite was opened. This study showed that there were no significant differences in rates of relapse into injected drug use (17% versus 20%), or stopping injected drug use (17% versus 15%) [63]. In addition, the study showed that there were no significant differences in crack cocaine smoking (12% versus 14%), rates of stopping methadone use (11% versus 7%) or starting methadone use (13% versus 11%), and rates of stopping binge drug use (58% versus 63%) [63]. The opening of Insite clearly did not significantly affect community drug use or drug cessation. In addition, another study examined drug injection cessation between December 2003 and June 2006 in Vancouver after the opening of Insite with a sample of over 1090 participants, and it was found that 46% of participants entered into treatment [64]. Based on this study, drug injection cessation does not appear to decrease or be disincentivized as a result of opening up safe injection site facilities, such as Insite, as PWID entered treatment to stop drug use.

Along with potential increases in drug use and the disincentivizing of drug cessation, another potential risk of safe injection sites voiced by critics is that these sites increase crime and neighborhood disorder. In a study comparing annual periods before and after the opening of Insite in Vancouver, it was found that rates of drug trafficking, assaults, and robbery were similar after Insite’s opening [65]. Based on this study, neighborhood crime rates have not significantly increased or decreased as a result of opening safe injection sites, such as Insite. Similar to the trends in crime rates, there has been no evidence to show that safe injection sites increase neighborhood disorder. In a study comparing public injection drug use and public syringe disposal before and 12-weeks after the opening of Insite, there were statistically significant reductions in the daily mean number of injecting drug users injecting in public from approximately 4.3 users to 2.4 users and significant reductions in publicly discarded syringes from a daily average of 11.5 to 5.3 syringes [66]. This study also showed that there was a statistically significant reduction in injection-related litter for Insite as the pre/post daily mean count of injection-related litter decreased from 601.7 to 305.3 [66]. Based on this study, safe injection sites do not appear to increase neighborhood disorder. Moreover, critics of safe injection sites have also feared that these sites will promote drug tourism from outside of the community [46]. Despite the evidence showing that increases in crime rates and neighborhood disorder are unlikely, no studies are currently available that have analyzed the potential problem of drug tourism. However, scholars have pointed out that the majority of PWID users are residents in the area surrounding the safe injection Insite, so it would be unlikely that after the implementation of Insite people would travel long distances just to use drugs in a dangerous and impoverished area of Vancouver [46].

While crime rates, neighborhood disorder, and drug tourism seem unlikely to increase as a result of safe injection sites, continued potential risk of safe injection sites is the lack of community support for them. For example, South Philadelphia
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Residents felt “blindsided” by Safehouse’s decision to plan a safe injection site in South Philadelphia, and accused Safehouse of never soliciting the community’s support [49]. Many residents located near potential safe injection sites fear the potential for increases in crime and neighborhood disorder with some completely rejecting the notion that safe injection sites can even mitigate the opioid epidemic. However, one study analyzing community perceptions of neighborhood disorder 5 years after the opening of the Uniting Medically Supervised Injecting Centre (MISC) in Australia, showed that the fears of residents seem to dissipate over time [67]. In this study, business owners and residents in the surrounding area of MISC noted that they had witnessed lower instances of public injecting and publicly discarded injecting equipment [67]. Over 90% of participants in this study also reported at least one advantage of MISC in their area [67]. Even though community support of safe injection sites tends to increase over time, it appears to be important to consult the community of proposed safe injection site locations to educate the members about the benefits and potential risks. This education could potentially make residents more understanding of safe injection sites from the start of their implementation.

According to critics, another potential risk of safe injection sites is that they will fail as PWID do not even want to quit injecting drugs to begin with. Scholars have argued that critics who have this viewpoint presuppose that PWID are “completely void of any desire to quit the drug habit, or that the PWID evaluate their desire to stay addicted so positively that the desire to quit is an insignificant element in their decision-making process” [46]. In a scenario like Insite where drug addiction is strong for users, it is false that PWID are completely void of any desires as addicted people experience a conflict between the desire to stay addicted and the desire to do away with drugs and start a normal life [46]. In addition, scholars believe that the view that the desire to quit is an insignificant element for PWID is false, as it implies that PWID enjoy a low quality of life along with the drug-induced euphoria they experience [46]. It is unreasonable to think that PWID enjoy their low quality of life filled with homelessness and violence in many cases. In a study of 42 PWID evaluating their perceptions of safe injection sites, several participants felt that safe injection sites would improve their neighborhoods through a lessened community exposure to drug use and less injection equipment on the streets [68]. Clearly, many PWID want to escape their life of drugs but need a facility, such as a safe injection site, to help overcome their addiction.

Along with the risk of safe injection sites failing based on the belief that PWID do not want to stop injecting drugs, safe injection sites also have financial implications. Unlike Canada where the operating costs of Insite have been provided by the British Columbia Ministry of Health Services and additional funding has been provided by Health Canada, cities in the United States are not currently funding safe injection sites [69]. Since the city of Philadelphia is not funding safe injection sites, many individuals rightfully question how these facilities will be funded and maintained. Before the potential opening of Safehouse in February 2020, Safehouse only had $200,000 in the bank, which was tremendously less than the estimated annual $1 million operating costs of the facility [54]. However, recently in March 2021, the $1.9 trillion American Rescue Plan Act was enacted, which allocated $4 billion to address the overdose crisis in America and face the challenges of substance use disorder and mental health [70]. Of the $4 billion, $30 million was allocated to “support community-based overdose prevention programs, syringe service programs, and other harm reduction services” [50]. This commitment to harm reduction may set the stage for funding for safe injection sites in the long term, although the funding of safe injection is still currently in the hands of private donors in the case of safe injection sites, such as Safehouse.
5. Ethical analysis from a catholic social teaching perspective

The development of safe injection sites as a solution to the devastating opioid crisis in the United States has caused a tremendous debate amongst individuals from a wide variety of backgrounds. As previously discussed, the advantages of safe injection sites are extensive. Safe injection sites have been shown to successfully manage on-site overdoses, reduce drug-related overdose death rates, reduce the risk behavior associated with HIV and Hepatitis C, increase the delivery of medical and social services, and increase the number of individuals entering into substance use disorder treatment. In addition, further advantages of safe injection sites include reducing the amount and frequency individuals use drugs, along with saving costs via reducing the prevalence of diseases, overdose deaths, and the need for emergency medical services. While safe injection sites, such as Insite, have clearly been shown to be cost-effective and successful in combating the opioid crisis in Vancouver, safe injection sites are not without their concerns. Critics of safe injection sites highlight concerns of increased drug use, crime, neighborhood disorder and drug tourism, reduced drug cessation, and the notion that safe injection sites will fail as PWID do not even want to quit drugs to begin with. Furthermore, critics have concerns about the potential lack of community support, how safe injection sites will be funded, and the legality behind them.

While these concerns have been previously discussed, one notion of the argument that seems to be missing is the ethical implications of safe injection sites. Are safe injection sites even ethical to begin with? Clearly, it would not be advisable to support a project that is unethical in nature, even despite the end result of the means. Even if safe injections sites provide the end result of mitigating the opioid crisis, they simply cannot be unethical in nature if they are to be successfully instituted in the United States. To determine if safe injection sites are ethical, the Catholic social teaching principles of respect for human dignity, solidarity, the common good, and the stewardship of resources will be applied to safe injection sites. The relationship of safe injection sites to the harm reduction theory will also be elaborated on to evaluate the ethics of safe injection sites.

5.1 The principle of human dignity

The principle of human dignity is known as the foundational principle for Catholic social teaching. The United States Conference of Catholic Bishops describes the principle of human dignity as the following:

“Every human being is created in the image of God and redeemed by Jesus Christ, and therefore is invaluable and worthy of respect as a member of the human family” [71].

As expressed in this principle, every human being, from their conception to their death has inherent dignity and right to life based on that dignity. In practice, every human being, regardless of their personal race, religion, sex, age, national origin, sexual orientation, economic status, health, intelligence, or any other characteristic that differentiates individuals from one another, is worthy of respect [72]. Despite differing characteristics between individuals, simply being a human being confers one this dignity. As a result of this dignity, the human person is always seen as an end in the Catholic view, not as a means. The presence of human dignity further guarantees every human person a claim of membership in a community known as the human family.
Applying the respect for human dignity to safe injection sites, all individuals, especially PWID, have an inherent value to their lives that must be respected. Despite using drugs, PWID are equal to every other human person in that their dignity must be safeguarded at all times. PWID are part of the vulnerable group of individuals across the world known as the invisible and dispensable minority. As a result, PWID are often stereotyped as less valuable members of society, and their dignity is overlooked. Safe injection sites respect the dignity of PWID by directly reducing drug use, drug overdose deaths, and diseases, all of which if left unattended would directly threaten the inherent value of each PWID’s life. By helping to encourage PWID into substance use disorder treatment and giving them medical and social services, safe injections sites actually enhance the respect for human dignity for PWID by protecting these individuals’ lives. Safe injection sites ultimately accept PWID for who they are and where they are at the present moment.

5.2 The principle of solidarity

The principle of solidarity at its core functions is to promote peace and justice for all, along with protecting the common good. The United States Conference of Catholic Bishops describes the principle of solidarity as the following:

“Catholic social teaching proclaims that we are our brothers’ and sisters’ keepers, wherever they live. We are one human family .... Learning to practice the virtue of solidarity means learning that ‘loving our neighbor’ has global dimensions in an interdependent world” [71].

As evident by this principle, every human being is part of one family known as the human family. Despite our national origins or any social, political, or economic barriers that separate us, every human being is interconnected with one another. Promoting solidarity for all involves a commitment to every human being that you will seek peace and justice for everyone and promote the common good. The principle of solidarity is grounded in the Gospels’ calls for human beings to be peacemakers, and Pope Paul VI has elaborated on this notion by stating that “if you want peace, work for justice” [73]. Solidarity ultimately facilitates peace, justice, and the common good for all.

Despite this sense of togetherness across the globe, solidarity has been threatened by the lack of concern for the poor and the most vulnerable individuals in society. The United States Bishops have even promoted the notion that more attention should be provided to “the needs of the poor, the weak, and the vulnerable, in a debate often dominated by more powerful interests” [71]. In terms of PWIDs, these individuals are part of the vulnerable, poor, and weak in society. PWIDs often lack social support and financial resources to overcome their addiction to the drug, leading them to continue in a constant cycle of addiction. Safe injection sites promote solidarity by emphasizing a preferential option for the poor and vulnerable by giving them adequate care and resources to overcome their addiction. While others may look down upon PWIDs, safe injection sites graciously accept them for the human beings they are and seek to invoke unity to overcome their addiction together. Safe injection sites are a direct commitment to the global community to reduce human suffering and ensure the value of human dignity for all.

5.3 The principle of the common good

The principle of the common good is an essential ethical imperative in Catholic social teaching. The United States Conference of Catholic Bishops describes the principle of the common good as the following:
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“The common good is understood as the social conditions that allow people to reach their full human potential and to realize their human dignity” [71].

Based on this definition, the common good is inevitably linked to solidarity and human dignity. The social conditions that promote the common good presume the “respect for the person,” “the social well-being and development of the group,” and the maintenance by a public authority that promotes the ideals of peace and justice [72]. Without the foundational pillars of solidarity and human dignity, there would be no common good. In addition, the common good implies the good of all and every individual, which should be sought together collectively. However, this notion of the common good directly contrasts with utilitarianism’s promotion of the greatest good for the greatest number. This utilitarian belief accepts the presence of a minority group always being injured, while the common good promotes equal treatment for all human persons. Since we are a global family of brothers and sisters, we all have a right and a duty to participate in society to seek the common good and well-being of all, especially for the poor and the most vulnerable individuals in society [71]. The Catholic Church emphasizes that the major role of governments and institutions is to protect human life and human dignity and to promote the common good [71].

With the presence of global interdependence in contemporary times, the principle of the common good emphasizes the “need for international structures that can promote the just development of the human family across regional and national lines” [72]. Since it is the government’s duty to promote the common good for all, including PWID, the creation of safe injection sites would support the goal of addressing the needs of the most vulnerable and poor in society. As a community with inherently valuable lives, we have a duty to support PWID. Reducing drug use, drug overdose deaths, and disease are all clear components of the common good that promote the inherent value of human life and are a preferential option for the poor and vulnerable. The common good could easily be promoted by governments in this case with the development of facilities, such as safe injection sites, that seek to combat the devastation of drug use, which affects the human person, and as a result, the global human community.

5.4 The principle of stewardship

The principle of stewardship is one that emphasizes the value of management, not ownership. The United States Conference of Catholic Bishops describes the principle of stewardship as the following:

“The Catholic tradition insists that we show our respect for the Creator by our stewardship of creation” [71].

Using this definition of stewardship, it is evident that a key role in Catholic social teaching is to protect the people and planet that God created. Since we are all created in the image of God, we not only have a moral responsibility to the environment, but also to our personal talents, personal health, and our use of the private property [72]. The principle of stewardship, therefore, contains the stewardship of resources, which in itself emphasizes a just allocation of resources in the world. This requirement for the just allocation of resources has tremendous implications for safe injection sites. For example, safe injection sites fulfill the duty of the stewardship of resources by providing a just allocation of healthcare resources. Safe injection sites, such as CUES discussed above, provide health care services, such as wound care, pregnancy tests, immunizations, recovery/detoxification services, referrals to treatment, and on-site overdose care to PWID, who are some of the
most vulnerable individuals in society. By justly allocating healthcare resources to PWID, the principle of the stewardship of resources is effectively and adequately promoted. Furthermore, safe injection sites, such as CUES, provide the vulnerable with equitable access to food and housing, which PWID would not have adequate access to without these facilities. Providing basic necessities and rights to individuals, such as the right to healthcare and safe injection sites, are improving the lives of individuals, which in turn improves the overall well-being of the interconnected global community. Moreover, the more general principle of stewardship is applicable to safe injection sites through their ability to reduce waste in the environment. As previously described, safe injection sites reduce the number of drug injecting equipment waste present in the community, which further fulfills the goal of stewardship in promoting respect for God’s creation.

5.5 Ethical justification using the harm reduction theory

The driving ethical force behind the push for safe injection sites like CUES to be made available as a viable option for PWID is their potential to be used under the harm reduction idea. Harm reduction is an approach focused on minimizing the negative results that go hand-in-hand with drug abuse [74, 75]. Harm reduction techniques have both a medical and ethical impact on the individual and society as a whole. Harm reduction techniques accept the individuals as they are, while also tailoring that person’s treatment to fit his or her needs [76]. Furthermore, there are certain principles that are quintessential to an understanding of harm reduction, as listed by the Harm Reduction Coalition:

• Accepts, for better and/or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.

• Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence and acknowledges that some ways of using drugs are clearly safer than others.

• Establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.

• Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live to assist them in reducing attendant harm.

• Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

• Affirms drugs users themselves as the primary agents of reducing the harms of their drug use and seeks to empower users to share information and support each other in strategies that meet their actual conditions of use.

• Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.

• Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use [74].
The CUES’ ability to allow PWID to have a safe environment to inject drugs gives itself the potential to be used as a harm reduction agent in and of itself. Furthermore, many individuals who die from opiate overdoses, such as heroin, did not receive the necessary medical treatment in time to save them; allowing PWIDs access to the CUES could possibly save many preventable deaths. If we, as a society, value human life as sacred, we must find a way to prevent these deaths. The CUES program, such as Insite in Vancouver, supervised by trained medical personnel as a harm reduction agent could present a viable alternative to address the growing heroin addiction epidemic and save thousands of lives. The heroin epidemic is growing, fatal overdoses are increasing, and people are becoming more and more frustrated by legal and political barriers to new forms of treatment being put in place to stop this problem. As shown above, SIFs like Insite have been shown to decrease heroin abuse, disease, and mortality rate in Canada and Europe. In the United States, overdoses have led to 45,000 opioid overdose deaths in a 12-month period that ended in September 2017. This number is unacceptable by any standards [77]. Therefore, the harm reduction initiatives like Insite and a CUES must be introduced.

6. Conclusion

Safe injection sites are emerging as both an effective and ethical solution to the opioid crisis in the United States. However, to deal with the various concerns about safe injection sites along with the potential for additional benefits, this article seeks to make a variety of recommendations concerning the implementation of safe injection sites. These seven recommendations include legal, medical, educational, social, and financial implications that seek to make safe injection sites as effective as possible in the United States.

1. Legal: Mobile and portable units like a van could be used as safe injection sites to overcome the Crack House Statute. Even McSwain himself, a staunch critic of safe injection sites, acknowledged that mobile units would not be a violation of the Crack House Statute [78]. Since mobile and portable units do not pertain to real estate, McSwain does not think the Crack House Statute applies to them. Prevention Point Philadelphia already uses vans effectively for their clean needle exchange program.

2. Educational: Provide medical residents, physician assistants, nurse practitioners, and medical students the opportunity to do rotations at safe injection sites. This would allow these medical professionals to be educated on communication skills with vulnerable populations, which is often not addressed in medical education programs. The opportunity to do rotations would also give medical professionals a better sense of cultural sensitivity, further allowing these individuals to have a more holistic understanding of medicine.

3. Medical: Mandatory fentanyl testing at all safe injection site facilities to protect PWID. As discussed previously, fentanyl is over 50–100 times more potent than morphine and is becoming increasingly prevalent in cities such as Philadelphia. If we really care about PWID and want to respect their human dignity and their lives, then we should seek to mitigate the extremely dangerous risk of injecting opioids laced with fentanyl.

4. Social: Safe injection sites should provide social support services such as housing, employment, and job development counseling. This would help PWID
escape their addiction lifestyle, and give them skills and knowledge to be successful and productive members of society.

5. Social: Create an advisory board to combat the concern of the lack of community involvement in the implementation of safe injection sites in various communities. This advisory board would be a diverse group consisting of medical professionals, community leaders, social workers, addiction counselors, and clergy.

6. Medical/Social: Preferably utilize addiction counselors who have been former addicts as they have a deeper relationality to PWID, which will allow them to treat PWID for who they are and where they are at in the present moment. These addiction counselors have walked the walked and talked the talk, which will enhance the rehab counseling experience.

7. Financial: No city funding should be put toward safe injection sites, as the use of tax dollars for safe injection sites would likely be extremely controversial. Instead, we recommend that safe injection sites rely on funding from grants and nonprofits, and potential partnerships with one to two local health systems. In Philadelphia, the five main health systems include Jefferson Health, The University of Pennsylvania Health System, Tower Health, Temple Health, and Trinity Health. Safe injection sites have been proved to be cost-effective and save medical resources by reducing the number of emergency room visits and the need for emergency services. As a result, partnering with safe injection sites could save healthcare systems money, and be a cheaper alternative than the expensive use of emergency medical resources.

With these recommendations, safe injection sites could legally and effectively open in cities across the United States with the aim of mitigating the devastation that the opioid epidemic has caused in the country for the last three decades.
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