



# Inpatient supervised consumption services: A nursing perspective

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## Abstract

Harm reduction reduces the risk of negative effects of health behaviours. Supervised consumption services (SCS) provide clean, safe and supervised locations for substance use. They are one strategy to reduce unintentional overdose and spread of infectious disease. The first in-hospital SCS in Edmonton, Alberta continues to offer services to inpatients. Nurses provide supervision of substance use, health promotion and education to clients. SCS staff also provide education to hospital nursing staff who refer clients for SCS. Despite existing community and hospital SCS, nursing frameworks for the services and federal and provincial policies that support them, implementation of SCS in hospitals is uncommon. Nurses should be informed about SCS and their potential for further implementation. Existing programs can be useful templates for future implementation in hospitals. Nurses can be advocates for harm reduction strategies in their workplace that include SCS.

*Keywords:* supervised consumption, acute care, inpatient, substance misuse

It would be antagonistic to one's ethical obligations as a healthcare provider to refute an intervention that could save a patient's life. Harm reduction saves lives, yet harm reduction often has a weak reception by healthcare providers, government, and communities alike. Harm reduction aims to reduce the risk of negative effects associated with health behaviours, but does not necessarily aim to stop behaviours (Hawk et al., 2017). Harm reduction can include a variety of interventions, from wearing a

seatbelt, to wearing a procedure mask, to supervised consumption services (SCS). It is also a social justice movement built on the belief in, and respect for, the rights of people (National Harm Reduction Coalition, n.d.).

SCS provide a hygienic space where people can consume their own drugs under supervision of trained staff, aiming to reduce accidental overdose and spread of infectious diseases (Government of Canada, 2021b). For the purposes of this report, the focus for harm reduction will be substance use, illicit or otherwise, via SCS. We will describe a current hospital SCS, evidence for further implementation, federal and provincial policies that inform harm reduction, a nursing care model in support of inpatient supervised consumption, and challenges to implementation.

## Supervised Consumption Services (SCS)

Access to harm reduction services in hospitals reduces overdose, overdose related deaths, untreated pain, withdrawal associated with involuntary discharge, and concealed use in patient care areas (Dong et al., 2020). The SCS have been shown to reduce infectious disease transmission, public disorder, and contribute to health promotion service referral (Kerr et al., 2017). SCS access increases connections to social services, reduces public drug use, improper discarding of drug paraphernalia, reduces strain on emergency medical services, and connects people to staff and peers to promote pursuing treatment (Government of Canada, 2021b). Implementation of SCS in hospital settings can improve patient compliance with care, improve hospital experience, enhance identification of individuals who require addiction treatment and ensure evidence-based treatment of substance use disorders (Dong et al., 2020). The SCS contribute to efforts to address the opioid crisis that is currently a significant draw on hospital and community resources.

The first in-hospital supervised consumption site in North America opened at the Royal Alexandra Hospital (RAH) in Edmonton, Alberta in 2018. This ground-breaking program continues to provide inpatients with 24-hour staffed SCS access, sterile supplies, safer use education, and resources regarding opiate agonist treatment, detoxification, and addictions services. The SCS had 7,856 visits in its first year and responded to 27 emergency situations, none resulting in death (Dong et al., 2020). The RAH SCS demonstrate the potential for further widespread benefits that could be achieved with implementation in other hospital sites, including harm reduction for patients, healthcare providers, and surrounding communities.

### **Nursing experience in an inpatient SCS**

The supervised consumption nursing team at the RAH, including the author (DM), has observed that being present during consumption allows SCS staff to encourage health promotion and safer use in real time. The SCS staff can step in at critical moments and respond to emergency events, further building trusting relationships. The SCS staff proactively engage clients to establish a unique relationship in which clients are seen and heard, safe to ask questions and are more engaged in their care planning when they do not feel they need to hide their substance use. SCS rapport with clients builds confidence that accurate and adequate answers to their care questions are provided.

### **What happens in the SCS?**

At the RAH, SCS do not provide substances to clients. SCS staff are present throughout client self-administration of substances. Staff can assist with safe preparation up to the action of needle to vein, including skin preparation and vein finding. Clients have a 45-minute window to use within the supervised consumption booth and 45 minutes in the post-consumption area where they engage in care conversations and rapport building. Timeline boundaries encourage the client to return to their nursing unit for required medical treatment and continued engagement in care. Clients visit SCS for purposes beyond use, such as resource information and safe supplies.

The SCS staff provide education to hospital nursing staff on pain management in substance use disorder, opioid agonist treatment, harm reduction approach and supplies. Hospital nursing staff may have reservations about substance use, feelings regarding ethics and 'enabling' substance use, and providing pain medication alongside SCS access. After four years in operation, the SCS is more accepted by staff, but nurse turnover necessitates ongoing education. Unit staff refer clients to SCS, avoiding patient substance use in the nursing unit. Overall, SCS is uniquely situated in the acute care client's journey, meeting clients where they are at and providing care where gaps have previously been identified.

### **How could more hospitals implement SCS?**

Federal and provincial policies and funding exist to facilitate SCS implementation in hospitals. Health Canada promotes the "Harm Reduction: Canadian Drugs and Substances Strategy", a collaborative and comprehensive harm reduction strategy to reduce harmful effects of substance use (Government of Canada, 2018). Federally, SCS must operate by exemption under section

56.1 of the Controlled Drugs and Substances Act, available to hospitals (Government of Canada, 2018). Health Canada's Substance Use and Addictions Program contributes funding to harm reduction initiatives across the country, including in hospitals (Government of Canada, 2021a, 2021c). Alberta Health Services (AHS) expresses provincial commitment to supporting a "recovery-oriented approach inclusive of numerous interventions such as prevention, harm reduction, addiction treatment and supports for recovery" (Alberta Health Services, 2020). The AHS policy specific to SCS in-hospital includes accessibility, equity, fairness, minimizing harm, promoting patient safety, providing access to addiction counselling, peer support and addressing social determinants of health (Alberta Health Services, 2022). Thus, cohesive support is readily available through federal and provincial policies and funding for harm reduction via SCS implementation in hospitals.

### **Resistance to inpatient SCS**

Despite the success of SCS implementation at the RAH, resistance to further implement hospital SCS remains. Hawk et al. (2017) suggested "harm reduction stands in opposition to the traditional medical model of addiction which labels any illicit substance use as abuse, as well as to the moral model which labels drug use as wrong and, therefore, illegal" (p. 1). Ambivalence about the value of harm reduction and unease about encouraging risky behaviours contribute to the stigma surrounding harm reduction practices (Knaak et al., 2019). Conflicting medical paradigms and moral obligations, combined with disapproving government stakeholders, provides layers of complexity to SCS implementation. Historically, Conservative governments and their advocates are not in support of harm reduction strategies, resulting in under-funding of SCS and under-serving people with substance use disorder (Kerr et al., 2017). The complex interplay of government, policy makers, communities, and stigma present challenges to further implementation of SCS in hospitals despite convincing evidence of positive outcomes.

### **Nursing advocacy for SCS**

Inpatient harm reduction and supervised consumption is congruent with existing nursing care models. For example, the Insite nursing framework endorses a client-centred approach to care that encompasses harm reduction philosophies, and health promotion principles in the context of community SCS settings. This framework appreciates building culturally safe, nonjudgmental, and trusting relationships, encouraging nursing staff to recognize the client first, which is especially important to those who feel stigmatized by their situation (Lightfoot et al., 2009). The nursing framework also applies to inpatient harm reduction. Access to SCS, safe supplies, and addiction service resources, all in support of meeting the patient where they are at on their addiction recovery journey is possible in hospitals. The model is upheld through referrals to addictions, social or mental health services, partnerships with community addictions services and promoting health within the broader context of the patient's social system (Lightfoot et al., 2009). Incorporating harm reduction and supervised consumption alongside inpatient nursing care promotes continuity of services and progress toward immediate and long-term addiction recovery goals, in a nonjudgmental, holistic, and supportive environment.

Implementation of SCS within the hospital setting is supported by evidence. The SCS at RAH is a remarkable example of how SCS can promote successful patient outcomes and provide harm reduction regardless of admitting diagnosis. Emergency nurses must be informed about harm reduction and health promotion in-hospital to provide cultural, intersectional and trauma safe care for clients to access SCS. National and provincial policies and funding are available to support SCS in hospitals across the country. Nurses can uniquely support SCS in the hospital setting, taking guidance from existing programs. Foreseeable challenges exist for implementation, but nurses are well positioned to persist moving forward with social action to promote harm reduction in hospitals, which benefit patients, healthcare providers, and communities.

### Implications for emergency clinical practice

- Emergency nurses and their leadership must be informed about harm reduction and health promotion possibilities in hospital settings.
- National and provincial policies and funding are available to support SCS in hospital across the country.
- Emergency nurses are well positioned to advocate for harm reduction in hospitals to benefit patients, healthcare providers, and communities.

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### Conflicts of Interest

None

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