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Research Paper

Arguments supporting and opposing legalization of safe consumption sites in the U.S.

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ABSTRACT

Background: Safe consumption sites are spaces where people can legally use pre-obtained drugs under medical supervision and are currently in operation in Canada, Australia and Western Europe. These sites are effective in reducing opioid overdose mortality and other harms associated with opioid use, such as HIV infection, and increasing drug treatment entry. Various U.S. communities are considering establishing safe consumption sites, however, only 29% of U.S. adults support their legalization. This purpose of this study is to assess what types of arguments resonate with the public in support of and opposition to legalizing safe consumption sites to combat the opioid epidemic.

Methods: A public opinion survey of U.S. adults in July-August 2017 (N = 1004) used a probability-based sample of respondents from a large, nationally representative online panel. The survey examined the public's perception of the strength of common arguments offered in support of and opposition to legalizing safe consumption sites. Arguments were identified through a detailed scan of news media coverage, public reports, and advocacy materials.

Results: The national sample of U.S. adults rated all arguments opposing legalization of safe consumption sites as stronger than any of the arguments supporting legalization. The most highly rated opposing arguments were that public funds were better spent on addiction treatment, and that sites were allowing illegal activity and encouraging people to use drugs. The highest rated arguments supporting legalization were that safe consumption sites were a better alternative than arresting people for using drugs, they would reduce HIV and hepatitis C by encouraging safe injection practices, and that they would lower emergency department admission and hospitalization costs.

Conclusion: Legalization of this evidence-based harm reduction approach in U.S. communities will be difficult to advance without public education to confront persistent myths that safe consumption sites encourage drug use and do not facilitate treatment access.

Introduction

Overdose death rates in the U.S. have been rapidly rising with over 63,600 overdose deaths in 2016. The age-adjusted rate of drug overdose deaths was 19.8 per 100,000 in 2016, 21% higher than the rate of 16.3 per 100,000 in 2015 (Hedegaard, Warner, & Miniño, 2017). The medical and health policy communities in the U.S. have attempted to reverse the epidemic using various approaches, including the release of clinical prescribing guidelines, dosing regulations, establishment of prescription drug monitoring programs, pill mill crackdowns, insurance and regulatory changes to broaden access to evidence-based addiction treatment, and others. To date, increasing overdose death rates suggest that these varied approaches have not altered the course of the epidemic. Meanwhile, the nature of the problem has evolved. Although prescription opioids drove overdose deaths in earlier years of the epidemic, in recent years, heroin and synthetic opioids, such as fentanyl, have become increasingly important contributors to overdose deaths (Hedegaard et al., 2017; O'Donnell, Halpin, Mattson, Goldberg, & Gladden, 2017). Heroin overdose deaths more than tripled between 2010 and 2015 in the U.S. (Centers for Disease Control & Prevention, 2017) and fentanyl deaths increased by more than 500% between 2014 and 2016 (O'Donnell et al., 2017).

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The recent rise in heroin and fentanyl-related overdose deaths in the U.S. suggests that new approaches, beyond those targeting the flow of prescription opioids, are needed to combat the epidemic. The emergence of illicit fentanyl in particular has complicated efforts to control overdose deaths. A number of features of fentanyl contribute to its devastating public health consequences including its high potency, its comparatively low production costs and its growing number of analogues. The financial incentive to mix fentanyl with other drugs means that many individuals are not aware that they are consuming fentanyl (Amlani et al., 2015). Additionally, the rapid lethality of fentanyl means that the traditional approach to overdose rescue with naloxone may no longer be sufficient. When the overdose involves fentanyl, naloxone requires quicker administration and often multiple doses, compared with rescue from overdose of other prescription opioids or heroin (CDC, 2015).

In this context, it is worthwhile considering policy approaches that have worked well in other countries. Safe drug consumption sites constitute one evidence-based harm reduction approach that might be adopted in the U.S. to reduce the toll of the opioid crisis. Safe consumption sites are spaces where people can legally use pre-obtained drugs under medical supervision and are currently operating in Canada, Australia and Western Europe. Safe consumption sites have been shown to decrease the harms of opioid use including reducing overdose deaths, decreasing HIV and hepatitis C infection, and lowering rates of public syringe disposal, and have not led to increases in crime or drug use in the neighborhoods where they are located (Marshall, Milloy, Wood, Montaner, & Kerr, 2011; Potier, Laprevote, Dubois-Arber, Cottencin, & Rolland, 2014; Wood et al., 2004; Wood, Tyndall, Zhang, Montaner, & Kerr, 2007). These sites offer opportunities to connect individuals to health care and social supports, including detoxification services, addiction treatment, HIV and hepatitis C treatment, primary health care, housing, and other services. No facility with legal sanction currently exists in the U.S., although one unsanctioned facility has been in operation by a community organization since 2014 (Davidson, Lopez, & Kral, 2018). Various U.S. communities are considering establishing safe consumption sites, including the cities of Baltimore MD, Seattle WA, San Francisco CA, Philadelphia PA, New York City and Ithaca NY. While states and some municipalities have the power to authorize safe consumption sites, federal authorities could still challenge these facilities under the Controlled Substances Act, creating ongoing legal uncertainty (Beletsky, Davis, Anderson, & Burris, 2008).

Evidence supports the notion that public policies are more likely to pass when public support is high (Jacobs & Shapiro, 2000; Stimson, MacKuen, & Erikson, 1995, 2004). A number of studies have gauged attitudes among the general public, and among residents, business owners and other stakeholders located in close proximity to safe consumption sites in non-U.S. settings in Canada (Bardwell, Scheim, Mitra, & Kerr, 2017; Strike et al., 2014; Cruz, Patra, Fischer, Rehm, & Kalousek, 2007; Strike, Watson, Kolla, Penn, & Bayoumi, 2015; Kolla et al., 2017) and Australia (Salmon, Thein, Kimber, Kaldor, & Maher, 2007). However, only one prior study has examined public views in the U.S. about safe consumption sites. McGinty and colleagues conducted a nationally representative survey of support among U.S. adults for safe consumption sites and found that only 29% supported their legalization (2018). Respondents who had negative views about this strategy also tended to have very negative views about people who use opioids.

Importantly, this study and most other prior research has not explored the underlying arguments for and against safe consumption sites that characterize individuals' views on the advisability of legalizing safe consumption sites. Prior research suggests that strategic communication efforts have the potential to alter public attitudes, even on controversial topics (Bachhuber, McGinty, Kennedy Hendricks, Niederdeppe, & Barry, 2015). Shifts in policy preferences in response to choice of arguments or language are known as framing effects. Arguments or 'message frames' provide cognitive shortcuts for individuals (Fiske & Taylor, 1991) and influence how individuals perceive policy issues (Iyengar, 1991; Nelson, Clawson, & Oxley, 1997). Only one prior study by Strike et al. (2014) delved into a more detailed exploration of public agreement with arguments for (but not against) safe consumption sites among Canadians. This study gauged attitudes among the general public and among residents and business owners located in proximity to a safe consumption site in Ontario before (2003) and after (2009) a safe consumption site was established. Researchers found that relative to 2003, respondents surveyed in 2009 were more likely to agree that these sites reduced neighborhood problems, increased contact for people using drugs with health and social services, reduced overdose deaths and infectious diseases and encouraged safer drug injecting. Attitudes about arguments for and against legalizing safe consumption sites have not been examined in a U.S. context.

The purpose of this study was to better understand how the American public thinks about the potential benefits and risks associated with safe consumption sites. While safe consumption sites are one of the most common terms to describe these facilities in the U.S., it is important to note that they are also sometimes known, particularly outside the U.S., as supervised injecting facilities (Kerr, Mitra, Kennedy, & McNeil, 2017), overdose prevention sites (Tait & Woo, 2017), or drug consumption rooms (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2017)). We fielded a web-based national public opinion survey in July 2017 to examine agreement with 17 different arguments in support of and in opposition to legalization of safe consumption sites in the U.S. among a representative sample of 1004 U.S. adults.

Data and methods

We fielded a web-based survey in July-August 2017 using the survey research firm GfK, which maintains a probability-based online panel of 50,000 U.S. adult members and includes people living in cell phone–only households. GfK recruits panel members using an equal-probability sampling method with a published sample frame of residential addresses that covers approximately 97% of U.S. households. GfK provides sampled non-Internet households with a web-enabled device so they may participate as online panel members. Individuals agreeing to participate complete a demographic profile and then respond to surveys via the Internet in exchange for various incentives (i.e., small cash awards, gift prizes, raffles).

To identify the pro- and anti- legalization arguments used in the survey instrument, we conducted a detailed scan of news media sources, public reports, and advocacy group materials in the spring of 2017 to identify the most commonly used arguments. We used the following five search terms to identify arguments about sites: safe consumption site, safe consumption room, supervised injecting facilities, overdose prevention sites, and drug consumption rooms. One study author [SL] conducted an online scan to review sources and extract arguments over a period of three weeks until thematic saturation was achieved, meaning that no novel pro- and anti- arguments emerging from the search process. Once arguments were identified, the full study team participated in an iterative process to standardize arguments around a set of agreed-upon principles. These principles were that: (1) arguments must be of a similar length; (2) no supporting data or statistics should be included; (3) no jargon, stigmatizing terminology or colloquial terms should be included, and (4) an identical stem (i.e., 'safe consumption sites should be legal/illegal because…") should be used for each argument. Arguments appeared in the instrument in random order to avoid item order effects. The survey instrument was pilot-tested for length and formatting. Respondents read a three-sentence introduction describing the opioid epidemic and the purpose of these sites. Next, respondents rated their agreement with 10 arguments favoring and 7 arguments opposing legalizing safe consumption sites on five-point Likert scales (1 = strongly disagree, 5 = strongly agree).

A total of 1004 respondents completed the survey, with a 70% completion rate (defined as the proportion of GfK panel members

Table 1
Agreement among U.S. Adults with Arguments Opposing and Supporting Safe Consumption Sites, 2017 (N = 1004).

Anti-Safe Consumption Site Arguments	% Agree (95% CI)	Pro-Safe Consumption Site Arguments	% Agree (95% CI)
Fund Treatment: Safe consumption sites should be illegal because funding should be spent instead on opioid use treatment and recovery.	57.6 (54.3, 60.8)	**Better Alternative:** Safe consumption sites should be legal because they are a better alternative to dealing with opioid use than arresting people, which does not address their substance use.	42.7 (39.5, 46.0)
Opioids are Illegal: Safe consumption sites should be illegal because use of heroin and other opioids is illegal.	56.3 (53.1, 59.5)	**Reduce Infectious Diseases:** Safe consumption sites should be legal because they would reduce HIV and hepatitis C by encouraging safer injection practices, such as using sterile syringes for each injection, among people who use opioids.	41.8 (38.7, 45.0)
Allow Continued Use: Safe consumption sites should be illegal because they allow people to continue using opioids.	53.7 (50.4, 57.0)	**Decrease Costs:** Safe consumption sites should be legal because they would reduce opioid-related emergency room visits and hospital admissions, which would decrease healthcare costs.	41.6 (38.5, 44.8)
Increase Drug Use: Safe consumption sites should be illegal because they would increase illegal drug use by making it easier for people to use opioids.	51.9 (48.6, 55.1)	**Connect to Treatment:** Safe consumption sites should be legal because they would reduce opioid use by connecting people who use opioids to drug treatment.	41.5 (38.3, 44.7)
Increase Illegal Activity: Safe consumption sites should be illegal because they would lead to more illegal activities in the neighborhoods where they are located.	51.0 (47.8, 54.2)	**Law Enforcement Focus:** Safe consumption sites should be legal because they allow law enforcement to focus more on violent crime instead of low-level drug offenses.	40.2 (37.0, 43.4)
Encourage Harmful Behavior: Safe consumption sites should be illegal because medical professionals would be encouraging harmful health behaviors like opioid use.	50.1 (46.8, 53.3)	**Reduce Fatal Overdoses:** Safe consumption sites should be legal because they would reduce fatal opioid overdoses by providing a place for people to have medical supervision while they use opioids.	39.4 (36.3, 42.6)
Government Tolerance: Safe consumption sites should be illegal because the government should not tolerate illegal activities such as opioid use.	49.0 (45.7, 52.2)	**Reduce Public Use:** Safe consumption sites should be legal because they would reduce the use of opioids in public places.	36.1 (33.1, 39.3)
		Helped in Other Countries: Safe consumption sites should be legal because they have helped to reduce fatal opioid overdoses in other countries.	34.0 (31.0, 37.1)
		Safe Site: Safe consumption sites should be legal because they would provide a place for people who use opioids to stay safe while they are using drugs.	33.2 (30.2, 36.3)
		Dignity and Respect: Safe consumption sites should be legal because they would create a space where people who use opioids are treated with dignity and respect.	27.3 (24.5, 30.3)

randomly selected for the study who completed the survey). GfK provided measures of the socio-demographic characteristics of the sample. We calculated the proportion of respondents agreeing with each argument. We present results using survey weights constructed by GfK to adjust the sample for known selection deviations and survey non-response so that the resulting estimates are representative of the U.S. population. All respondents for both surveys were 18 or older. To report the proportion of respondents in agreement with each argument for and against safe consumption sites, we created dichotomous measures coding strongly agree and somewhat agree as supporting the argument. The research protocol was determined exempt by the Johns Hopkins Bloomberg School of Public Health Institutional Review Board.

Results

The demographic characteristics of the study sample parallel those of the U.S. population (Appendix Table). Respondents rated all 7 arguments opposing legalization of safe consumption sites higher than any arguments supporting legalization (Table 1). The most popular arguments in opposition to legalization were that public funds are better spent on improving opioid addiction treatment (58%) and that drugs used at these sites are illegal (56%). All of the other arguments in opposition to safe consumption sites were endorsed by a majority or near majority of respondents including: sites encourage people to continue using drugs (53%), they make it easier for people to use drugs (52%), they would lead to more illegal activity in the neighborhoods where they are located (51%), medical professionals would be encourageing harmful health behaviors like opioid use (50), and government should not tolerate illegal activity (49%).

Less than half of respondents agreed with any arguments supporting legalization, and most arguments were in a relatively narrow range of support – with agreement among 39%–43% of respondents. These arguments were that these sites were a better alternative than arresting people (43%), would reduce HIV and hepatitis C by encouraging safe injection (42%), would decrease cost through lower emergency department admissions and hospitalizations (42%), would connect people using opioids to treatment (42%), would allow law enforcement to focus on violent crimes instead of low-level drug offenses (40%) and would reduce fatal overdoses by providing a place for people to have medical supervision while using opioids (39%). The other four arguments were endorsed by a somewhat lower share of respondents. These were that safe consumption sites should be legal because they would reduce the use of opioids in public places (36%), they have helped reduce fatal overdoses in other countries (34%), they would provide a place for people using opioids to stay safe while using drugs (33%) and they would create a space where people using opioids are treated with dignity and respect (27%).

Discussion

This study assessed how arguments put forth in news media reports and public documents by advocates and opponents of legalization of safe consumption sites to combat the opioid epidemic resonate with the U.S. public. This harm reduction approach is being considered in multiple jurisdictions in the U.S., but widespread adoption is hampered in part due to low levels of public support for establishing these sites. Respondents rated all arguments opposing legalization of safe consumption sites above arguments supporting legalization; the most highly rated opposition arguments were that public funds were better spent on addiction treatment, and that sites were allowing illegal activity and encouraging people to use drugs. These results are helpful in understanding what underlies the finding from a recent public opinion study that only 29 percent of U.S. adults supported legalization of safe consumption sites (McGinty et al., 2018).

These findings point to a larger set of questions about why so many Americans are resistant to arguments in support of this evidence-based

harm reduction response to the opioid epidemic, and what options exist for changing views. One possible explanation for resistance to pro safe consumption arguments is the pervasive and persistent level of stigma toward people who use drugs (Barry et al., 2016). In the U.S., social stigma – measured as public desire for social distance from individuals using drugs or a reported willingness to accept discriminatory housing and employment practices toward people who use drugs – is higher even than the levels of public stigma reported toward individuals with mental illness (Barry, McGinty, Pescosolido, & Goldman, 2014). Stigma can influence attitudes about appropriate responses to public health programs. For example, one study found that high stigma ratings are associated with lower support for public health-oriented policies and higher support for punitive policies aimed at individuals using drugs (e.g., prosecuting women if there is evidence of narcotic use during pregnancy) (Kennedy-Hendricks et al., 2017). In this context, it is perhaps not surprising that the pro-safe consumption site argument that rated the lowest among respondents was the item endorsing creating a space where people using opioid are treated with dignity and respect. This implies that communication strategies to augment support for safe consumption sites should incorporate evidence-based messaging shown to reduce stigma toward people who use drugs.

One promising approach was suggested by Buchanan, Shaw, Ford, and Singer (2003). The authors examined the question of how public health advocates might make a better case for this evidence-based approach to preventing spread of disease, and observed that syringe exchange advocates tended to define the issue strictly in empirical, scientific terms while opponents defined the question primarily in normative, ethical terms. The authors suggest that public health advocates would benefit from acknowledging their own moral values underlying their position to counter the ethical concerns of opponents. Specifically, advocates can counter opponents' ethical argument that syringe exchange tacitly encourages illegal drug use by making a counter argument, for example, about how the "inequitable burden of AIDS and addiction violates our sense of the most basic moral norms of a just society" (p.438). This hypothesis might similarly be tested in the context of arguments over safe consumption site legalization. Indeed, two of the top three most popular argument in opposition to safe consumption sites were that these spaces would allow illegal activity and would encourage people to use drugs. Only one of the pro-safe consumption arguments we tested explicitly framed the issue in moral or ethical terms – in this case – in terms of dignity and respect toward people using drugs; however, this item received the lowest rating of public agreement. This is an important area for future study.

Unfortunately, this study does not allow us to directly assess the specific factors underlying public attitudes about arguments for and against safe consumptions sites or how such factors compare with those of other harm reduction approaches. This is a critical area for future work. It is worth noting that many of the arguments that emerged for and against establishing safe consumption sites are quite similar to those that have been used previously in discourse over syringe services programs. This suggests that persuasion strategies that were successfully employed to increase support for syringe services could provide clues for how best to raise support for safe consumption sites. Nonetheless, there are important differences between these two harm reduction approaches – most prominently the nature of the legal hurdles that must be overcome – potentially limiting the extent to which lessons learned from one context might be applied to the other.

In addition, our results suggest that many members of the public do not make the connection that safe consumption sites can be an important entry point to treatment. In fact, the number one reason respondents opposed these sites was due to a belief that funds should be spent instead on opioid use treatment and recovery. The notion that an investment in legalization of safe consumption sites was an investment in treatment is not well-understood among the broader public. This is another area where messaging about the links between harm reduction and treatment might make a difference in public views.

Findings from this study should be considered in light of certain study limitations. First, although our study sample is national, these sites are being considered within specific local jurisdictions. Respondents' opinions are likely influenced by whether they have been exposed to policy debate in their communities or affected by other issues such as personal experiences with opioid addiction or overdose. Second, this study reports on a set of arguments used commonly in recent news media and public reports. However, while we attempted to be as systematic as possible in our process of searching for and identifying pro- and anti- safe consumption site arguments, there are likely to be important arguments in policy discourse on this topic that were missed. In addition, given the fluid policy environment around the epidemic, new messages will certainly emerge if the crisis around opioid deaths persists unabated. Third, we note that the language we used to construct the 17 arguments has the potential to affect the interpretation of items by study participants. Extensive prior research has documented the importance of question wording in the manner in which information is interpreted and valued by the public, especially on topics like drug use that trigger strong underlying values. In a systematic review of surveys gauging support for syringe services programs, for example, Vernick and colleagues found that levels of public support for these programs were highly sensitive to question wording and the use of value-laden or stigmatizing language (e.g., reference to "drug addicts"). We have attempted to minimize these sources of bias.

Our findings indicate that it will be critical to bolster support for this harm reduction approach, but our study does not elucidate the best strategy for doing so. Increased support could be achieved, for example, by countering opposing arguments, by increasing the salience of pro-legalization arguments, or by finding new arguments or message frames to persuade the public. Moving forward, advancing communication research should be considered as a strategy for identifying more effective ways of transmitting the value of legalizing safe consumption sites to the American public, especially those living in communities hardest hit by the epidemic.

Declarations of interest

None

As corresponding author, I certify that none of the authors have any conflicts of interests to report. Colleen L. Barry

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Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:https://doi.org/10.1016/j.drugpo.2018.10.008.

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