POSITION STATEMENT:
ILLICIT DRUG EXPOSURE

April 9, 2025

Harm Reduction Nurses Association

Association des infirmiers et infirmières en réduction des méfaits

Now more than ever it is important to prioritize evidence-informed practices to shape the future of the Canadian healthcare system. Fear-based and reactionary approaches and policies towards drug use are aging poorly in Canada's current state of public health, putting patients and healthcare workers at risk. It is time that we prioritize the protection of healthcare workers, communities, and people who use drugs (PWUD) without perpetuating the harms of stigma and bias. We must correct our current course to stay true to the values and ethical commitments we hold sacred as healthcare providers: safety, respect, autonomy, and justice.

BACKGROUND

There is uncertainty about the safety risks to healthcare workers in BC and Canada associated with secondary exposure to illicit drugs and the smoke they produce. Everyone has the right to a safe workplace and to exist safely in public spaces, however, our perception of what is safe or unsafe is often influenced by the amplified uninformed opinions of influencers and lobbyists, and media misinformation. Evidence-informed policies that reflect actual, rather than perceived risks, are essential for mitigating this bias.

The question of whether secondary exposure to illicit drugs is safe has received widespread attention in BC (British Columbia Government News, 2024a). These stories and subsequent media attention led the BC government to frame this problem as one of "public safety" and subsequently to abandon their decriminalization pilot project to recriminalize drug possession in public spaces, such as hospitals (British Columbia Government News, 2024). Notably, decriminalization and exposure are two different problems, and while exposure was the purported issue, the BC government rescinded decriminalization. We know that criminalizing possession and use compels people to use drugs alone out of fear of being arrested (British Columbia Centre for Disease Control, n.d.), and is one factor that has contributed to overdose deaths of, on average, six people a day in BC since 2014 (BC Government News, 2024b).

POSITION

The Harm Reduction Nurses Association (HRNA) firmly opposes punitive and reactive policymaking that penalizes patients for illicit drug use in hospitals. While we acknowledge healthcare workers' fears related to illicit drug exposure, we highlight the lack of available resources and accurate information regarding their safety and the safety of their patients. We believe that policies prohibiting illicit drug use in healthcare settings also fails to protect PWUD and ultimately compromise their health, well-being, and access to life saving healthcare. In Canada, all people have the right to access healthcare and should not be persecuted for substance use by healthcare providers. We urge decision makers to respond with pragmatic and evidence-informed information and solutions that respect both patient and healthcare worker safety. More specifically, we call for the dissemination of accurate information on drug exposure risks and rapid implementation of overdose prevention sites (OPS) in health services such as hospitals and re-implementation of harm reduction vending machines at hospitals in the province.

THE HARMS OF PUNITIVE POLICIES

British Columbia has implemented punitive and reactive policies that have raised concerns about the safety and well-being of both patients and healthcare workers in response to purported increased use of illicit drugs in hospital settings. This includes:

- **Increasing police presence to "ensure safe and comfortable communities"** (British Columbia Government News, 2024). Such policies can cause PWUD to be more apprehensive in accessing healthcare services due to a history of over policing and fear of being arrested for a health concern (substance use disorder) (Alang et al., 2020). This is a barrier to access to healthcare.

- **Recent news reports of nurses' exposure to illicit drugs in hospitals has sparked Adriane Gear, the president of BC Nurses Union, to highlight that nurses should not be made to "enforce safety measures while in the workplace"** (Kulkarni, 2024). As a profession, we recognize the inherent danger in over-surveilling our patients. This is particularly true for patients who live at the intersections of stigma and systemic harms, where over-surveillance has damaged community relationships, patient-provider trust, and ultimately compromised patient health outcomes (Greene et al., 2022). Surveillance and punitive measures are not aligned with the core values of patient agency and autonomy. Anticipation of being subjected to these harms in healthcare settings poses yet another barrier to accessing healthcare.

- **Many hospitalized PWUD rely on drugs to manage withdrawal and distress** (Cleveland Clinic, 2024), particularly when they are not provided prescribed alternatives or opioid agonist treatment options. Punitive hospital policies, often rooted in stigma, can exacerbate harm and hinder recovery (Martin et al., 2022).

EVIDENCE OF RISK ASSOCIATED WITH SECONDARY EXPOSURE

Misconceptions about the dangers of secondary exposure to illicit drugs, like fentanyl, are widespread. A study by Persaud and Jennings (2019) found that 79.7% of first responders falsely believed brief contact with fentanyl can cause harm. However, a retrospective study of 168 overdose responses reported zero adverse effects from exposure through smoke, dermal contact, or ingestion (White et al., 2022). We conducted a brief review of evidence on this topic, and research consistently shows there is negligible risk from accidental secondary exposure to commonly used substances:

- **Fentanyl:** A systematic review (Adams et al., 2023) and a case study (Feldman, 2022) concluded that brief dermal exposure poses minimal risk of rapid absorption. In terms of inhalation risk, it takes around 200 minutes of continuous secondary exposure to ingest a 100 mcg = 0.1 mg dose (Moss et al., 2017). This is 20 times less than what is generally thought is needed to cause overdose (2 mg) (Drug Enforcement Administration, n.d).

- **Cocaine:** Studies conducted in the late 1990s (Cone et al., 1995; Mieczkowski, 1997) found no pharmacological effects from secondary inhalation or dermal exposure, even with chronic exposure, as it was undetectable in hair samples.

- **Methamphetamine:** Research (Abe et al., 2021) showed no detectable levels of methamphetamine in urine samples after secondary exposure. Among U.S. law enforcement officers who reported dermal contact with fentanyl or methamphetamine, no evidence of toxic effects were found (Chiu et al., 2019).

Reports of adverse effects are often anecdotal and likely influenced by the nocebo effect, where expected harm leads to perceived symptoms (Herman, 2020; Brascher et al., 2017; Witthoft & Rubin, 2013). This has been amplified by media coverage, which frequently presents subjective symptoms as facts. Between 2015 and 2019, over 550 misleading news articles on accidental opioid exposures were shared widely, reaching as many as 70 million people and reinforcing false beliefs with misinformation (Beletsky et al., 2020). There is currently no research on the long-term health effects of routine secondary exposures. Rigorous research is required in this area.

SUPPLEMENTAL DATA

St. Paul's hospital in Vancouver, BC, serves as a leading example of integrating on-site drug consumption services to support people who use drugs (PWUD). These services

allow PWUD to receive necessary healthcare without the risk of being discharged for leaving the facility to use substances. The hospital provides a clean, safe, and supportive environment where individuals can use drugs under supervision, ensuring their safety and reducing harm. Peer workers play a central role in creating a welcoming and non-judgemental space, fostering trust, and encouraging PWUD to seek care without fear of stigma or discrimination – something that regulated healthcare providers alone cannot achieve. This model, echoed by similar programs like the one offered at Royal Alexandra Hospital in Alberta, has demonstrated profound positive impacts, as highlighted by interviews with staff at St. Paul's Hospital which have informed this position statement. Expanding these services nationwide could significantly improve access to care, reduce harm, and save lives (Dong et al., 2020).

RECOMMENDATIONS

Overdose prevention sites (OPS) within or adjacent to hospitals are crucial for providing a safe space for patients to inject and inhale drugs, reducing the risk of overdose death. Implementation of these sites offer several key benefits that include:

- **Providing a safe and supervised space for people to consume drugs to manage withdrawal symptoms while admitted to hospital;**
- **Reducing safety risks through increased environmental and relational controls;**
- **Allowing patients who use substances to remain in hospital, ensuring continued access to medical care and support services;**
- **Reducing the need for over-surveillance by directly addressing patient needs;**
- **Accommodating various methods of drug consumption, including injection and inhalation, addressing diverse needs;**
- **Promoting a harm reduction approach that prioritizes the health and well-being of individuals who use drugs.**

We also believe that PWUD and worker safety are not mutually exclusive. Staff have the right to a safe work environment, which is achievable through specific evidence-informed, person-centred strategies that include:

- **Providing sterile equipment to PWUD, either directly or through the implementation of harm reduction vending machines, and ensuring staff are trained to work with clients on safe methods of administration, in line with established harm reduction knowledge and evidence;**
- **Situating OPS in or adjacent to hospitals with the capacity to support inhalation. This would allow PWUD to consume their substances safely and decrease the need for consumption in common or public areas;**
- **Avoiding making healthcare workers de facto enforcers of public safety. This leads to moral distress and moral injury when enforcing prohibitionist policies that are not patient-centred.**

CONCLUSION

Existing evidence suggests that risks to healthcare professionals from secondary illicit drug exposure can be mitigated. Rigorous research and evaluations on exposure risks would bolster the current literature and inform decision makers. Punishing PWUD fails to address stigma, fails to mitigate safety risks, and is ultimately a barrier to accessing healthcare. Instead of focusing on criminalization and compounding surveillance measures, there is an urgent need to embrace evidence-informed policies that foster collective safety for patients and providers. By shifting away from punitive policies and aligning with a harm reduction approach and evidence-informed practices, a healthcare system that upholds all individuals' dignity, safety, and well-being regardless of their substance use status or professional roles can exist. Harm reduction is healthcare.

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