Councilmember Nikki Fortunato Bas CITY OF OAKLAND
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AGENDA MEMORANDUM

To: Rules & Legislation Committee

From: Mayor Libby Schaaf and Councilmember Nikki Fortunato Bas

Date: April 25, 2019

Subject: Resolution in Support of AB 362 (Overdose Prevention)

Colleagues on the City Council and Members of the Public,

We respectfully urge your support for the attached Resolution, which we have submitted with the attached Fact Sheet, text of the bill and other supporting material:

RESOLUTION IN SUPPORT OF AB 362 – OVERDOSE PREVENTION PROGRAMS (EGGMAN) AND REQUEST THAT, IN ADDITION TO THE CITY AND COUNTY OF SAN FRANCISCO, THE BILL BE AMENDED TO GIVE THE CITY OF OAKLAND DISCRETION TO AUTHORIZE QUALIFIED ENTITIES TO OPERATE OVERDOSE PREVENTION PROGRAMS IN THE CITY OF OAKLAND

Respectfully submitted,

Libby Schaaf, Mayor

Nikki Fortunato Bas, Councilmember

ASSEMBLY BILL No. 362

Introduced by Assembly Member Eggman
(Principal coauthor: Senator Wiener)
(Coauthor: Assembly Member Friedman)

February 4, 2019

An act to add and repeal Section 11376.6 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 362, as introduced, Eggman. Controlled substances: overdose prevention program.

Existing law makes it a crime to possess specified controlled substances or paraphernalia. Existing law makes it a crime to use or be under the influence of specified controlled substances. Existing law additionally makes it a crime to visit or be in any room where specified controlled substances are being unlawfully used with knowledge that the activity is occurring, or to open or maintain a place for the purpose of giving away or using specified controlled substances. Existing law makes it a crime for a person to rent, lease, or make available for use any building or room for the purpose of storing or distributing any controlled substance. Existing law authorizes forfeiture of property used for specified crimes involving controlled substances.

This bill would, until January 1, 2026, authorize the City and County of San Francisco to approve entities to operate overdose prevention programs that satisfy specified requirements, including, among other things, the provision of a hygienic space supervised by healthcare professionals, as defined, where adults who use drugs can consume preobtained drugs, sterile consumption supplies, and access to referrals

to substance use disorder treatment. The bill would require the City and County of San Francisco, prior to authorizing an overdose prevention program in its jurisdiction, to provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The bill would require any entity operating a program to provide an annual report to the city and county, as specified. The bill would exempt a person from, among other things, civil liability, professional discipline, or existing criminal sanctions, solely for actions or conduct on the site of an overdose prevention program for adults authorized by the city and county.

This bill would make legislative findings and declarations as to the necessity of a special statute for the City and County of San Francisco.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 11376.6 is added to the Health and Safety Code, to read:

11376.6. (a) Notwithstanding any other law, the City and County of San Francisco may approve entities within their jurisdiction to establish and operate overdose prevention programs for persons 18 years of age or older that satisfy the requirements set forth in subdivision (c).

(b) Prior to approving an entity within their jurisdiction pursuant to subdivision (a), the City and County of San Francisco shall provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The notice of the meeting to the public shall be sufficient to ensure adequate participation in the meeting by the public. The meeting shall be noticed in accordance with all state laws and local ordinances, and as local officials deem appropriate.

(c) In order for an entity to be approved to operate an overdose prevention program pursuant to this section, the entity shall demonstrate that it will, at a minimum:

(1) Provide a hygienic space supervised by healthcare professionals where people who use drugs can consume preobtained drugs. For purposes of this paragraph, "healthcare professional" includes, but is not limited to, a physician, physician assistant, nurse practitioner, licensed vocational nurse, registered

nurse, psychiatrist, psychologist, licensed clinical social worker, licensed professional clinical counselor, mental health provider, social service provider, or substance use disorder provider, trained in overdose recognition and reversal pursuant to Section 1714.22 of the Civil Code.

(2) Provide sterile consumption supplies, collect used hypodermic needles and syringes, and provide secure hypodermic needle and syringe disposal services.

(3) Administer first aid, if needed, monitor participants for potential overdose, and provide treatment as necessary to prevent fatal overdose.

(4) Provide access or referrals to substance use disorder treatment services, medical services, mental health services, and social services.

(5) Educate participants on the risks of contracting HIV and viral hepatitis.

(6) Provide overdose prevention education and access to or referrals to obtain naloxone hydrochloride or another overdose reversal medication approved by the United States Food and Drug Administration.

(7) Educate participants regarding proper disposal of hypodermic needles and syringes.

(8) Provide reasonable security of the program site.

(9) Establish operating procedures for the program, made available to the public either through an internet website or upon request, that are publicly noticed, including, but not limited to, standard hours of operation, a minimum number of personnel required to be onsite during those hours of operation, the licensing and training standards for staff present, an established maximum number of individuals who can be served at one time, and an established relationship with the nearest emergency department of a general acute care hospital, as well as eligibility criteria for program participants.

(10) Train staff members to deliver services offered by the program.

(11) Establish a good neighbor policy that facilitates communication from and to local businesses and residences, to the extent they exist, to address any neighborhood concerns and complaints.

(12) Establish a policy for informing local government officials and neighbors about the approved entity's complaint procedures, and the contact number of the director, manager, or operator of the approved entity.

(d) An entity operating an overdose prevention program under this section shall provide an annual report to the city and county, that shall include:

(1) The number of program participants.

(2) Aggregate information regarding the characteristics of program participants.

(3) The number of hypodermic needles and syringes distributed for use onsite.

(4) The number of overdoses experienced and the number of overdoses reversed onsite.

(5) The number of persons referred to drug treatment.

(6) The number of individuals directly and formally referred to other services and the type of service.

(e) Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, and clients or participants, shall not be arrested, charged, or prosecuted pursuant to Section 11350, 11364, 11365, 11366, 11366.5, or 11377, or subdivision (a) of Section 11550, including for attempt, aiding and abetting, or conspiracy to commit a violation of any of those sections, or have their property subject to forfeiture, or otherwise be penalized solely for actions or conduct on the site of an overdose prevention program approved by the City and County of San Francisco pursuant to subdivision (a).

(f) Notwithstanding any other law, a person or entity, including, but not limited to, property owners, managers, employees, volunteers, and clients or participants shall not be subject to civil, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability solely for actions or conduct on the site of an overdose prevention program approved by the City and County of San Francisco pursuant to subdivision (a).

(g) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

SEC. 2. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California

Constitution because of the unique needs of the City and County of San Francisco.

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AB 362 – Overdose Prevention Programs

SUMMARY

This bill allows the Board of Supervisors of San Francisco the discretion to authorize overdose prevention programs where adults may use controlled substances under supervision of staff trained to prevent and treat overdose, prevent HIV and hepatitis infection, and facilitate entry into drug treatment and other services. This law would be repealed January 1, 2026.

BACKGROUND

According to the California Department of Public Health, drug overdose is a leading cause of accidental death in California. In 2013, California hospitals treated roughly one overdose every 45 minutes, while heroin and opiate use continue to rise.

According to the federal Centers for Disease Control and Prevention, in 2010 nearly 4,000 new cases of HIV were attributed to unsafe injections, and heroin overdose mortality in the United States nearly tripled between 2010 and 2014. Many of the most marginalized and high-risk drug users, who lack housing and other supports, inject in public spaces without clean equipment or a readily accessible method of syringe disposal.

Overdose Prevention Programs, or Supervised Consumption Services, have been utilized in Vancouver, Sydney, and approximately 100 other cities around the world to reduce overdose death and injury, decrease public health concerns like discarded syringes and public injection, reduce the transmission of infectious diseases, and provide entry to treatment for this most marginalized group.

In addition to these benefits, research has shown that these programs ***do not*** encourage additional drug use or increase crime in the surrounding area, and potentially save millions of dollars in healthcare and incarceration costs. For these reasons, the American Medical Association endorsed piloting these sites in June 2017.

THIS BILL

AB 362 would allow, pursuant to a vote of the Board of Supervisors of San Francisco, exemptions from state controlled substance offenses for employees, staff, volunteers, and clients of health facilities intended to reduce drug overdose death and to facilitate entry into drug treatment.

AB 362 requires any such program to provide access to drug treatment and other services, maintain specified safety and security protocols, and to be accountable to local governments for data collection and reporting.

This bill only allows for authorization of programs for adults, aged 18 years and older, in San Francisco, and requires the local government to hold a public hearing with input from law enforcement, public health, and the general public.

It has a sunset date of January 1, 2026.

CO-SPONSORS

CA Association of Drug Program Executives
California Society of Addiction Medicine
Drug Policy Alliance
Harm Reduction Coalition
Healthright 360
Project Inform
San Francisco AIDS Foundation
Tarzana Treatment Center

SUPPORT

FOR MORE INFORMATION

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Supervised Consumption Services

August 2018

We are the Drug Policy Alliance.

Overview

Supervised consumption services (SCS) – also called overdose prevention programs (OPPs), safer injection facilities (SIFs), drug consumption rooms (DCRs), supervised drug consumption facilities (SCFs) or safer drug use services (SDUS) – are legally sanctioned facilities designed to reduce the health and public order issues often associated with public injection. These facilities provide a space for people to consume pre-obtained drugs in controlled settings, under the supervision of trained staff, and with access to sterile injecting equipment. Participants can also receive health care, counseling, and referrals to health and social services, including drug treatment.

There are approximately 120 SCS/OPP currently operating in ten countries around the world (Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland) – but none in the U.S.[i] In the past two years, Canada, and especially the city of Vancouver, has grown from two authorized sites to thirty, plus multiple smaller Overdose Prevention Sites –a temporary site set up to address the immediate need in a community.

There are plans for the opening of SCS/OPP in Portugal, Belgium, Ireland and the UK. In the United States, Seattle, San Francisco, Philadelphia and New York City have committed to opening sites, but none are in operation yet.[ii] There is, however, one underground site in the U.S., according to researchers.[iii]

SCS/OPP can play a vital role as part of a larger public health approach to drug policy. SCS/OPP are intended to complement – not replace – existing prevention, harm reduction and treatment interventions.

SCS Improve Safety and Health

Numerous evidence-based, peer-reviewed studies[iv] have proven the positive impacts of supervised injection services, including:

- Increasing use of substance use disorder treatment, especially among people who distrust the treatment system and are unlikely to seek treatment on their own;
- Reducing public disorder, reducing public injecting, and increasing public safety;
- Attracting and retaining a population of people who inject drugs and are at a high risk for infectious disease and overdose;
- Reducing HIV and Hepatitis C risk behavior (i.e. syringe sharing, unsafe sex);
- Reducing the prevalence and harms of bacterial infections;
- Successfully managing hundreds of overdoses and reducing drug-related overdose death rates;
- Saving costs due to a reduction in disease, overdose deaths, and need for emergency medical services;
- Providing safer injection education, subsequently increasing safer injecting practices;
- Increasing the delivery of medical and social services.

In areas surrounding existing SCS, there has been no evidence of increased community drug use, initiation of injection drug use, or drug-related crime. A 2017 systematic review concluded: "*Consistent evidence demonstrates that SCFs mitigate overdose-related harms and unsafe drug use behaviours, as well as facilitate uptake of addiction treatment and other health services among people who use drugs (PWUD). Further, SCFs have been associated with improvement in public order without increasing drug-related crime. SCFs have also been shown to be cost-effective.*"

And a previous review concluded: *"All studies converged to find that SIFs were efficacious in attracting the most marginalized people who inject drugs, promoting safer injection conditions, enhancing access to primary health care, and reducing the overdose frequency. SIFs were not found to increase drug injecting, drug trafficking or crime in the surrounding environments. SIFs were found to be associated with reduced levels of public drug injections and dropped syringes."* [v]

Vancouver's *InSite*

Vancouver, Canada's supervised injection facility, *InSite*, has been the most extensively studied SIF in the world, with over 60 peer-reviewed articles published examining its effects on a range of variables, from retention to treatment referrals to cost-effectiveness.[vi] These reports are in agreement with reviews of Australian and European SIFs, which show that these facilities have been successful in attracting at-risk populations, are associated with less risky injection behavior, fewer overdose deaths, increased client enrollment in drug treatment services, and reduced nuisances associated with public injection.[vii] For example, one study found a 30 percent increase in the use of detoxification services among *InSite* clients.[viii]

InSite has proved to be cost-effective in terms of overdose and blood borne disease prevention as well.[ix] One cost-benefit analysis of *InSite* estimated that the facility prevents 35 cases of HIV each year, providing a societal benefit of more than $6 million per year.[x]

"InSite saves lives. Its benefits have been proven. There has been no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation."

- Supreme Court of Canada, 2011. [xi]

A survey of more than 1,000 people utilizing *InSite* found that 75 percent reported changing their injecting practices as a result of using the facility. Among these individuals, 80 percent indicated that the SIF had resulted in less rushed injecting, 71 percent indicated that the SIF had led to less outdoor injecting, and 56 percent reported less unsafe syringe disposal.[xii] InSite has produced a "large number of health and community benefits...and no indications of community or health-related harms."[xiii]

Several Cities on the Verge of Opening First SCS in U.S.

In 2012, New Mexico adopted a proposal to study the feasibility of a safer injection facility in the state -- becoming the first state in the nation to consider this potentially life-saving intervention.[xiv]

In 2016, the city of Ithaca launched the "The Ithaca Plan" -- a comprehensive municipal drug strategy which included a proposal for a safer injection site.[xv]

In January 2017, Seattle and the surrounding King County announced a plan to establish several SCS in the area as a pilot test to address overdose and drug use in the community.[xvi] And in 2018, city officials in Philadelphia, San Francisco, and New York City announced their plans to open sites in their cities.[xvii] Momentum for SCS has also emerged in cities such as Boston and Baltimore. Additionally, legislation has been introduced in California, Colorado, Maryland, Massachusetts, Missouri, New York and Vermont to allow SCS.

Recommendations

SCS are a vital part of a comprehensive public health approach to reducing the harms of drug misuse. Local, state and national governments should explore the implementation of legal SCS (at least at the pilot level) staffed with trained professionals to reduce overdose deaths, increase access to health services and further expand access to safer injection equipment to prevent the transmission of HIV and Hepatitis C.

DPA supports the efforts of local communities in the U.S. to pursue SCS programs.

Though SCS cannot prevent all risky drug use and related harms, evidence demonstrates that they can be remarkably effective and cost-effective at improving the lives of people who inject drugs as well as the public safety and health of their communities.

[i] European Monitoring Centre for Drugs and Drug Addiction, "Drug consumption rooms: an overview of provision and evidence," (2018) http://www.emcdda.europa.eu/system/files/publications/2734/POD_Drug%20consumption%20rooms.pdf; Government of Canada, "Supervised consumption sites: status of applications," https://www.canada.ca/en/health-canada/services/substance-abuse/supervised-consumption-sites/status-application.html;

[ii] K. Stone and G. Sander, "The Global State of Harm Reduction 2016" (Harm Reduction International, 2016) https://www.hri.global/contents/1739; Heroin and Prescription Opiate Addiction Task Force: Final Report and Recommendations (September 15, 2016) http://www.kingcounty.gov/~/media/depts/community-human-services/behavioral-health/documents/herointf/Final-Heroin-Opiate-Addiction-Task-_Force-Report.ashx?la=en.

[iii] Alex H. Kral and Peter J. Davidson, "Addressing the Nation's Opioid Epidemic: Lessons from an Unsanctioned Supervised Ijection Facility," Americal Journal of Preventive Medicine, Volume 53, Issue 6 (2017) 919-922, doi: https://doi.org/10.1016/j.amepre.2017.06.010.

[iv] C. Potier et al., "Supervised injection services: What has been demonstrated? A systematic literature review," *Drug Alcohol Depend* 145C(2014): 48-68; S. Semaan et al., "Potential role of safer injection facilities in reducing HIV and hepatitis C infections and overdose mortality in the United States," *Drug Alcohol Depend* 118, no. 2-3 (2011): 100-10; Mary Clare Kennedy et al., "Public Health and Public Order Outcomes Associated with Supervised Drug Consumptions Facilities: a Systematic Review," *Curr HIV/AIDS Rep* (2017) 14: 161-183.

[v] Potier et al., "Supervised injection services: What has been demonstrated? A systematic literature review," 48 Mary Clare Kennedy et al., "Public Health and Public Order Outcomes Associated with Supervised Drug Consumptions Facilities: a Systematic Review," *Curr HIV/AIDS Rep* (2017) 14: 161-183.

[vi] T Kerr et al., "Findings from the Evaluation of Vancouver's Pilot Medically Supervised Safer Injection Facility—Insite," (Vancouver, BC: Urban Health Research Initiative, BC Centre for Excellence in HIV/AIDS, 2009) http://uhri.cfenet.ubc.ca/images/Documents/insite_report-eng.pdf.

[vii] See KPMG, *Further evaluation of the Medically Supervised Injecting Centre 2007-2011*, http://www.health.nsw.gov.au/resources/mhdao/pdf/msic_kpmg.pdf; European Monitoring Centre for Drugs and Drug Addiction, "Drug consumption rooms: an overview of provision and evidence."

[viii] E Wood et al., "Rate of detoxification service use and its impact among a cohort of supervised injection facility users," *Addiction* 102(2007): 918.

[ix] M. A. Andresen and N. Boyd, "A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility," *Int J Drug Policy* 21, no. 1 (2010): 70-76; AM Bayoumi and GS Zaric, "The cost-effectiveness of Vancouver's supervised injection facility," *Can Med Ass J* 179, no. 11 (2008): 1143-51; SD Pinkerton, "Is Vancouver Canada's supervised injection facility cost-saving?," *Addiction* 105(2010): 1429-36.

[x] Andresen and Boyd, "A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility."

[xi] Brandon DL Marshall et al., "Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study," *The Lancet* 377, no. 9775 (2011): 1429-37.

[xii] S Petrar et al., "Injection drug users' perceptions regarding use of a medically supervised safer injecting facility," *Addict Behav* 32(2007): 1088-93.Steven Petrar et al., "Injection Drug Users' Perceptions Regarding Use of a Medically Supervised Safer Injecting Facility," *Journal of Addictive Behaviors* 32, no.5 (2007):1088-1093.

[xiii] E Wood et al., "Summary of findings from the evaluation of a pilot medically supervised injecting facility," *Can Med Assoc J* 175, no. 11 (2006): 1399-404.

[xiv] 50th Legislature, State of New Mexico, Senate Memorial 45 (2012) http://www.nmlegis.gov/Sessions/12%20Regular/memorials/senate/SM045.pdf

[xv] Drug Policy Alliance, "Ithaca to Release Groundbreaking Plan to Address Over-Incarceration and Skyrocketing Overdose Deaths, While Creating Comprehensive Health-Based Approach to Drug Policy," February 21, 2016 http://www.drugpolicy.org/news/2016/02/ithaca-release-groundbreaking-plan-address-over-incarceration-and-skyrocketing-overdose

[xvi] Heroin and Prescription Opiate Addiction Task Force: Final Report and Recommendations (September 15, 2016) http://www.kingcounty.gov/~/media/depts/community-human-services/behavioral-health/documents/herointf/Final-Heroin-Opiate-Addiction-Task-_Force-Report.ashx?la=en

[xvii] Elana Gordon, "What's Next For 'Safe Injection' Sites In Philadelphia?," *NPR*, January 24, 2018, https://www.npr.org/sections/health-shots/2018/01/24/580255140/whats-next-for-safe-injection-sites-in-philadelphia; Heather Knight, "SF safe injection sites expected to be first in nation open around July 1," *San Francisco Chronicle*, Feb 6, 2018, https://www.sfchronicle.com/news/article/SF-safe-injection-sites-expected-to-be-first-in-12553616.php; William Neuman, "De Blasio Moves to Bring Safe Injection Sites to New York City," *New York Times*, May 3, 2018, https://www.nytimes.com/2018/05/03/nyregion/nyc-safe-injection-sites-heroin.html.

Establishing Sanctioned Safe Consumption Sites in the United States: Five Jurisdictions Moving the Policy Agenda Forward

Alene Kennedy-Hendricks, Ph.D., Jenna Bluestein, B.A., Alex H. Kral, Ph.D., Colleen L. Barry, Ph.D., M.P.P., Susan G. Sherman, Ph.D., M.P.H.

Objective: Safe consumption sites enable use of preobtained drugs in hygienic settings where trained staff are available to respond to overdoses and connect individuals with health and social services. This study examined efforts to advance policies to establish safe consumption sites in the United States, where no sanctioned sites exist.

Methods: Between April and July 2018, the authors conducted 25 telephone interviews with a purposive sample of key informants in five communities considering safe consumption site implementation. Participants included organizers and advocates, government officials, and personnel with social service and health organizations. Interview notes were analyzed by using hybrid inductive-deductive coding.

Results: Key strategies for organizing support for safe consumption sites included involving people who use drugs, engaging diverse partners, supporting allies in related causes, and using various tactics to garner support from policy makers. Major barriers to adoption included identifying the right locations, uncertainty about the federal response, mistrust arising from racial injustice in drug policy, and financing. Participants identified facilitators of progress toward safe consumption site adoption, such as building on existing harm reduction programs, securing political champions, and exposing community officials to programs operating internationally.

Conclusions: A window of opportunity may be opening to advance policy related to safe consumption sites; whether sanctioned sites become part of the broader policy strategy for addressing drug use and overdose in the United States will depend on the experiences of the first sites. Organizing around this issue may facilitate engagement among people who use drugs in broader conversations about drug policy.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.201800398)

The United States is facing a sustained addiction and overdose epidemic that is historic in magnitude and pervasiveness. Drug overdose deaths in 2017 surpassed 70,000 (1). Reversals in life expectancy gains have been attributed in part to rising drug overdose mortality rates (2). Fentanyl, a synthetic opioid that is significantly stronger than heroin, has become increasingly prevalent, escalating the lethal risk of drug consumption (3, 4). In addition, growing incidence of hepatitis C virus (5) and recent regional HIV outbreaks have been traced to injection drug use (6). The federal government and a number of states have declared public health emergencies (7, 8).

Despite efforts to curtail the epidemic, the rates of addiction and overdose deaths continue to escalate. In this context, jurisdictions are searching for new approaches. One proposal involves safe consumption sites, also known as supervised injection facilities and overdose prevention sites, among other related terms. These are places where people can use preobtained drugs in a hygienic setting, with supervision by trained staff, and connect to other health and social services (9). Creating safe consumption sites is one of many harm reduction strategies, including syringe services programs, overdose education, and naloxone distribution.

HIGHLIGHTS

- In the context of a sustained and increasingly lethal drug overdose crisis in the United States, several jurisdictions are engaged in efforts to change local and/or state policy to establish sanctioned safe consumption sites.
- Communities seeking to implement sanctioned safe consumption sites report employing various strategies to garner political and public support, resolve logistical barriers, and navigate federal opposition.
- Organizing around safe consumption sites may be one pathway to include people who use drugs in broader conversations around U.S. drug policy.

By facilitating access to respectful and relevant services, harm reduction programs enable people who use drugs to make positive changes. Proponents view safe consumption sites as one element of a multifaceted strategy to shift the drug policy paradigm away from criminalization and toward interventions emphasizing the health and well-being of people who use drugs. Over 100 sanctioned safe consumption sites exist in cities in Canada, Australia, Mexico, and Europe (9).

Insite, which opened in 2003 in Vancouver, Canada, was the first safe consumption site in North America. Evaluations of the facility suggest that safe consumption sites can produce important benefits for people who use drugs, including reducing fatal overdoses (10, 11), facilitating safer injection and less sharing of syringes (12, 13), and increasing connection to addiction treatment (14, 15). Research also indicates that the surrounding neighborhood experienced a decline in public drug use and syringe debris (16), with no increase in drug-related crime (17). Systematic reviews of research conducted in a wider range of geographic settings found that safe consumption sites were associated with positive outcomes (18, 19). Cost-benefit analyses focused on San Francisco and Baltimore point to the potential cost savings of this intervention through reduced spending on medical complications of unsafe drug consumption (20, 21).

To date, no sanctioned safe consumption site exists in the United States. An underground site has been operating in the United States since 2014 (9, 22), and some syringe services providers have pushed legal boundaries by operating quasi-safe consumption sites in their facility bathrooms (23). By the end of 2018, legislation to establish safe consumption sites had been introduced in at least six states (California, Colorado, Massachusetts, Maryland, New York, and Vermont). California's state legislature was the first to pass a safe consumption site bill, although it was vetoed by the governor (24). On the local level, Philadelphia announced plans to facilitate the establishment of safe consumption sites and the Seattle city council allocated funding for safe consumption sites (25), but so far neither city has opened a site.

Few studies have explored the processes currently underway to facilitate adoption of policies that would permit the use of safe consumption sites (26–28). Furthermore, we are unaware of research that has examined the growing movement to establish these sites in the United States. Through interviews with key informants in five locations across the country, we describe the local context related to drug use that these sites aim to address, characterize the organizing strategies employed by advocates, and consider barriers to and facilitators of adoption of sanctioned safe consumption sites.

METHODS

Data Collection Efforts

Of the eight states with active, ongoing efforts at the state or local level to change safe consumption site policy, we purposively recruited interviewees from five states in which advocates have secured support from key elected officials (e.g., public mayoral support) or have built significant momentum in advancing policy to establish sanctioned sites (e.g., advancing legislation out of committee). We identified an initial set of study participants through the networks of two study authors (A.H.K. and S.G.S.) with ties to the harm reduction community and used snowball sampling to recruit additional participants. To maintain confidentiality, we have not identified the location of the participants included in our sample.

Between April and July 2018, we conducted 25 telephone interviews with a purposive sample of four to six key informants from each location until we reached data saturation. We determined saturation had been achieved when new themes were no longer emerging during interviews conducted within the same jurisdiction. Participants included organizers and advocates, local government officials, and personnel with social service and health organizations, including organizations considering operating a safe consumption site. Interviews ranged from 45 minutes to 1 hour. The study team drew on the literature and team member expertise on this topic to develop a semistructured interview guide. One study team member took detailed notes during each interview. According to the Johns Hopkins Bloomberg School of Public Health Institutional Review Board, the study was not designated as human subjects research.

Analysis

Analysis of interview notes employed a hybrid inductive-deductive coding process. All study team members reviewed the interview notes, identifying important themes. Using this initial set of themes to develop codes, one author (A.K.-H.) systematically analyzed the data by using NVivo 12 Pro qualitative analysis software (29). Segments of the text were initially coded for the a priori themes identified during the group review of interview notes, and the text was then coded iteratively to capture new themes emerging during the coding process. Related coded text segments were then categorized into overarching themes.

RESULTS

Defining the Problem

Interview participants reported that safe consumption sites were eliciting interest because of the following problems: overdose deaths, development-induced displacement and homelessness, and publicly visible drug use and syringe debris. Many participants identified all three problems as driving interest in sanctioned safe consumption sites. However, the salience of these issues varied by geographic region. Participants suggested that rising overdose death rates were playing a greater role in driving policy discussions in areas where overdose mortality rates are rising rapidly. However, even in areas of the country where death rates have increased more slowly, there was a sense that the

broader national narrative about the overdose epidemic had contributed to a greater willingness to consider a policy in support of safe consumption sites.

In several locations, participants noted that interest in safe consumption sites appeared to be driven more by concern about public drug use and syringe debris than about the well-being of people who use drugs. Participants viewed the issues of development and displacement, homelessness, visible drug use, and syringe debris as interrelated. In cities experiencing rapid gentrification, people who previously used drugs in more hidden settings (e.g., abandoned buildings) were now using drugs in the street or in public bathrooms. In some cities, people congregated in tents or other visible encampments. Most participants characterized safe consumption sites as a critical but incomplete policy response to the issues affecting people who use drugs and the neighborhoods in which they live.

Becoming Part of the Policy Agenda

Four of five locations had established government-sponsored committees that formally recommended adoption of safe consumption sites. Three jurisdictions organized these committees around a broader topic (e.g., the opioid crisis) and included sanctioned safe consumption sites as one of several recommendations. The reports generated by these committees attracted media attention, raised the profile of safe consumption sites among the general public, catalyzed organizing efforts, and provided political cover for supportive elected officials.

Participants in two locations described efforts as exclusively focused on changing policy at the local level (see online supplement). They reported that state politics drove this decision but also felt that state-level policy action was not necessary to establish a safe consumption site. Among the three jurisdictions that had introduced state legislation to establish safe consumption sites, all were pursuing other mechanisms for achieving legal sanction as well, including authorization of a research pilot, city ordinance, or health department action.

Organizing and Coalition Building

Efforts to organize around safe consumption sites were heterogeneous in terms of the groups leading the movement, the extent to which the advocates constituted an organized coalition, the level of involvement from people who use drugs, and the tactics employed by advocates to engage relevant groups and garner political support (Box 1). Participants in all jurisdictions emphasized the importance of engaging those with diverse perspectives on safe consumption sites and diverse motivations for supporting them. Engaging diverse voices enabled organizers to build a broader coalition and more successfully lobby policy makers. Participants emphasized the importance of supporting potential allies on other issues, or "showing up," as they built a coalition, illuminating both the transactional nature of organizing and the extent to which allies often share a wider set of political goals. Although participants in all jurisdictions emphasized the importance of including and elevating people who use drugs in advocacy efforts, there was variation in the extent to which this goal had been achieved. People who use drugs were more involved in places that had established drug user unions, whereas in other jurisdictions, organizing around safe consumption sites drove efforts to mobilize this population. Political strategy involved initially targeting policy makers who were anticipated to be receptive to the issue, educating policy makers and connecting them to information, pressuring key policy makers who resisted publicly supporting safe consumption sites, engaging in acts of civil disobedience, and positioning safe consumption sites as a campaign issue on which candidates were forced to comment.

Community Engagement

A key element of organizing was community engagement (Box 2). Some jurisdictions viewed community engagement as part of a long-term process of building relationships and engaging the community around drug policy more broadly. Most participants viewed early engagement of the community as critical to building public understanding of the concept of safe consumption sites and quelling potential opposition. In one jurisdiction, community engagement mostly occurred after the local government announced support for safe consumption sites and community opposition had emerged as a roadblock. The majority of jurisdictions engaged with the community through public meetings, often involving local government representatives and members of the task force. Many participants felt that smaller meetings enabled more productive discussions about how to address community concerns and led to less fraught public meetings.

One key theme was the importance of taking community concerns seriously. In describing their approach to engaging the community, participants evoked the harm reduction philosophy of meeting people where they are and not reflexively attributing concerns raised about safe consumption sites to intractable stigma or NIMBY-like attitudes. Advocates also emphasized the importance of finding trusted members of the community to champion the cause and to ensure transparency in the process of building support for safe consumption sites.

Challenges

One of the challenges mentioned most commonly involved finding the right location (Box 3). This theme encompassed neighborhood resistance and identifying the right physical space. The issue of physical space overlapped with uncertainty about the enforcement of 21 USC Section 856, the so-called Crack House Statute, which prohibits operation of spaces for the use of illegal substances (30, 31). Participants anticipated reluctance by property owners to rent space for use as a safe consumption site, limiting options. Also related to the Crack House Statute were concerns that the federal

BOX 1. Key dimensions of organizing and coalition building identified by stakeholders involved in efforts to establish safe consumption sites

Engaging partners with diverse perspectives
"Support is challenging because it sometimes comes from people who just want these individuals to disappear, but they are vocal about the need for safe consumption sites because of syringes on the street."
"Diverse coalition seems very critical . . . geographically diverse across the state, and we also mean racially diverse and diverse in how you arrive at this work. [It's] critical for the coalition and for the legislators we engage."

Focus of organizing efforts
"[Location X] has a good ground game. . . . They've been putting together a concerted grassroots community education and mobilization campaign. In [another location], there isn't really a ground game and media strategy. . . . There's more behind-the-scenes meeting to educate legislators and convene community stakeholders."
"[Location X] is challenging because there's an emerging dynamic of gentrification in which a class of highly educated white professionals are moving in and are seen as 'new [name of locality]' and they tend to be easier to convince on things like [safe consumption sites], but you don't want them to be the face of your grassroots movement."

Showing up for allies
"[W]e built a strong relationship with a [local peer recovery group] and [think about] how we can show up for them and integrate advocacy more into their work, and that's a long-term process that is an intensive and important piece of this work."

Organizing people who use drugs
"[A new advocacy organization] coalesced around . . . service provision under the [city's] bridges to build trust . . . with people with lived experience to build social capital and make sure people know we are not just advocates but service providers. We hoped that the [organization] would become an auxiliary to the union of people who use drugs."
"Our members identify more or less as drug users. But the truth is that some are active drug users and some are fully in recovery but identify as drug users for political reasons. . . . For us, what's most important is, 'Are you a victim of the drug war?' We don't organize 'Wall Street' drug users."

Learning from previous policy change efforts
"A lesson learned from LEAD [law enforcement–assisted diversion] was bringing in people to build consensus who have different motivations. . . . It was really clear that there was never going to be agreement on a wide range of issues, so we focused on a couple things we could agree on and leave disagreements at the door."

Targeting friendly policy makers first
"[We] focused on solid, traditional allies."
"We used comprehensive syringe exchange supporters to target for potential safe consumption site support. It became more acceptable over time, and we have about 30 cosponsors on the safe consumption site bill now. A lot of members were moved by targeted advocacy, lobbying, and testimony."
"[We are] planning to meet with city council members, first with folks who are likely to support [safe consumption sites]."

Educating policy makers
"We do a lot of education with elected officials, helping them work through questions with constituents."
"[The local police chief] met with the previous chief [in Vancouver] about law enforcement impact research from Vancouver, and he was really enthusiastic because he saw it as a solution to a lot of the problems his department is dealing with, namely public syringes."

Publicly pressuring policy makers
"We took to publicly attacking [key elected official]. We did a number of demonstrations and public confrontations and civil disobedience actions that got a lot of attention."
"We're keeping the pressure on, recognizing that [movement on safe consumption sites] may not happen until after the November election."

Making safe consumption sites a campaign issue
"We're working on . . . identifying candidate stances on harm reduction for the election year, seeing if people can ask harm reduction questions at town halls."
"[A candidate in a local election] raised safe consumption sites as an issue, and it became part of a campaign conversation so all the candidates had to comment on it. The [local political group] does candidate forums and endorses candidates, so every politician has been asked their opinion on this topic."

government might seize assets from established providers or withhold funding from local jurisdictions if they opened a safe consumption site.

Several participants identified challenges in building trust among communities of color that have been disproportionately affected by the "War on Drugs" and its punitive drug policies. These participants felt strongly that efforts to advocate for safe consumption sites should either be preceded by or clearly framed as part of a broader effort to confront the racially unjust impact of punitive drug policy. Without this framing, safe consumption sites appeared to some community members as privileged treatment of white communities, which have experienced high rates of opioid addiction and overdose (32). Other challenges included financing; bureaucratic delays; reluctance by incumbents to endorse safe consumption sites in an election year; and other

BOX 2. Key elements of community education and engagement identified by stakeholders involved in efforts to establish safe consumption sites

Engaging early
"My favorite thing about [advocacy group X] is that they don't start on [safe consumption sites] when doing community engagement. . . . [Advocacy group X] is intentional about building trust in the community before going in with a hard ask on [safe consumption sites], though the downside is that it takes a long time."
"Need to make sure community engagement is part of the process from the beginning."

Convening community members
"Held [public] meeting with [various stakeholders] to give opportunity for people in the community to come and comment on safe consumption sites. . . . [We] had almost zero opposition. [We] had already laid some groundwork by talking to nonprofits, faith-based groups, and school groups in the area."
"I think the best way that could occur would be not having a public forum where everyone just rails on [public officials] about NIMBY issues, but . . . have smaller groups of people together to say what are the conditions in which people could endorse [safe consumption sites], and [local officials] could meet some of those conditions."

Taking community concerns seriously
"We approached things from a place of thinking it was reasonable that people had questions, which engendered good will from people and communities."
"Not meeting people with anger or frustration, realizing that people don't know the principles of harm reduction, and treating the outward community with the tools we practice—meeting people where they're at and listening to concerns."

Activating community voices
"It's hard to go into a community you've never been a part of and try to advocate, so that's an interesting dynamic. . . . You need to show it's not 'big public health' trying to put policy on the community."
"[Community group X] is doing an intensive set of conversations with business owners, labor unions, tenants' organizations, and community organizations doing presentations and getting support. They've done a great deal of work addressing people's concerns."
"Identify community leaders to be champions of the project who are trusted."

Transparency
"[We have] done a lot of work through a transparent process. Provided many opportunities for the larger public to give comment. . . . Even people who weren't in favor of safe consumption sites wouldn't say that the process wasn't fair."
"The general perception from the public is that they're being lied to from the government. . . . It's hard because residents are also incorrect in their interpretations . . . but advocates also misrepresent what information is out there."

legal issues, such as protecting the professional licensure of providers who might work at these facilities.

Facilitators

At least three locations had considered safe consumption sites before the acceleration of the drug epidemic, and participants felt that these conversations were a helpful foundation for current efforts. Participants identified a variety of existing policies, programs, or partnerships as having laid the groundwork for adoption of safe consumption sites (Box 4). These included decades-long efforts to implement syringe services programs (33), the provider type most frequently identified by participants as a potential operator of safe consumption sites; overdose education and naloxone distribution programs (34); other interventions targeting people who use drugs and people experiencing homelessness (e.g., Housing First initiatives) (35); activism around HIV/AIDS; organizing to end punitive drug policy; and broad diffusion of a harm reduction orientation throughout a jurisdiction or service system.

Other key facilitators included having political champions who actively engage in advocacy around safe consumption sites, public support, and favorable media coverage. Another facilitator, exposure to Insite, either through visits to Vancouver or meetings with key Vancouver officials, often was effective in persuading key public officials and community groups. However, several participants also noted that some visitors were confused about the causal relationship between neighborhood conditions and Insite, not realizing that conditions in the surrounding high-poverty neighborhood predated Insite. Several participants mentioned that the anticipated opening of a sanctioned site in the United States would catalyze their own efforts. Finally, research was identified as a facilitator, including research on the unsanctioned U.S. site (9) and the cost-effectiveness of these sites in U.S. cities (20, 21). Participants also cautioned that research was not sufficient to move policy adoption, and some also noted that community distrust of research diluted its power as a persuasive tool.

DISCUSSION

In this study, we considered the strategies being employed to advance the policy agenda on safe consumption sites in the United States. Political scientist John W. Kingdon (36) theorized that policy entrepreneurs can take advantage of windows of opportunity to enact meaningful policy change. These windows occur when a problem appears on the

BOX 3. Key barriers to policy adoption and implementation identified by stakeholders involved in efforts to establish safe consumption sites

Location or siting

"The challenges that we are continuing to work through here relate to the siting of one of these facilities, which comes back to this idea of community acceptance and understanding and stigma."

"We don't want a nonprofit to lose a building unless it's completely stand-alone and provides no other services."

"The Crack House Statute makes it complicated when a lot of possible locations are rental locations, so you'd need approval from landlords, which is unlikely."

Uncertainty about federal government response

"The risk of federal interference is high because it's a poor city reliant on [federal] funding."

"Other cities are interested, but we haven't answered the key question of how to protect them from federal intervention."

Mistrust and racial justice

"We've heard time and time again from the community, 'Great that you want to do this but it's because now it's affecting a predominantly white population. Why should we support this until you're willing to let our families out of prison for low-level drug offenses?' We need to address this head on."

"If there was a space legalized tomorrow, it wouldn't be successful because people wouldn't trust or know about it, so its success is reliant on communities being behind it and rooting it in racial justice and an understanding of the war on drugs."

Financing

"It's a frustrating point of view that [jurisdiction] knows it's a good option but won't pay for it. They know that it won't happen without funding from [jurisdiction]. We need an institutional commitment for this."

"We've talked to a number of funders, and a number have given us a positive response, but many are loathe to commit any type of money at this point to an idea that, at this point, is simply an idea."

political agenda, a policy exists to address this problem, and the political climate is favorable. Drug use and addiction are present on the political agenda in the five locations we studied, and in many cases, sanctioning safe consumption sites is increasingly viewed as a valuable component of a multifaceted policy response. The local political climate in the locations considering safe consumption sites may be conducive to change, given that policy makers—including mayors, city council members, health agencies, and state legislators—have endorsed the establishment of these sites.

Nevertheless, jurisdictions face both logistical (e.g., locating a site) and political (e.g., opposition from key political officials) obstacles to establishing these sites. Some jurisdictions lack the support necessary from key policy makers to move forward, but community advocates are hopeful that the results of upcoming elections will alter the political climate. In the meantime, participants reported working to establish policies and procedures for safe consumption sites, identifying partners for service provision, and exploring potential funding opportunities so that when official sanction of safe consumption sites occurs, they can act quickly. Some participants also have engaged in civil disobedience by establishing quasi-safe consumption sites to force the hands of political officials while also addressing the current needs of people who use drugs. Advocates in other countries, such as Australia, Denmark, and Canada, also practiced civil disobedience prior to safe consumption policy change (27, 37).

A major uncertainty looming over efforts in all jurisdictions is the potential federal response to implementation. Following the completion of these interviews, the Deputy Attorney General of the United States published an opinion piece strongly opposing safe consumption sites (38). It is unclear how this public statement may affect efforts moving forward. Participants reported being well aware of the legal obstacles to implementation and had undertaken legal analyses to prepare and mitigate liabilities (30). Although not all localities had champions at the state level, state intervention appeared to be of lesser concern than the potential federal response.

An important theme emerging from these interviews was the essential role of people who use drugs in organizing around safe consumption sites. Schneider and Ingram's (39) work suggests that the social construction of target populations is an important determinant of the policy agenda and design. According to this theoretical framework, strategies must be put in place to counteract the lack of political power among people who use drugs. Otherwise, policy makers enact punitive policies targeting this group as a default position. Organizing this community is one approach advocates have pursued to strengthen the political influence of people who use drugs on the policies that affect them.

This study had several limitations. Our sample lacked representation from people who currently use drugs, although three participants described themselves as in recovery. Attitudes toward safe consumption sites among people who use drugs have been explored in prior research (40). To our knowledge, there has been little research on the role of this group in driving policy change in the United States (41–43); this topic should be explored further. Another limitation of the study was its generalizability. Although we focused on five localities that have made measurable progress in advancing policy, there may be other places that have made similar progress. Another limitation was that most study participants represented urban, politically progressive settings. Their experiences may be less generalizable to rural settings, where the availability of

BOX 4. Facilitators of progress toward policy adoption identified by stakeholders involved in efforts to establish safe consumption sites

Predecessor programs and harm reduction exposure
"We have a long history of doing this work with respect to syringe exchange."
"[Locality X] is the best example where there is a long-standing [law enforcement–assisted diversion] program and a lot of movement on safe consumption sites, but it's a lot of the same people involved on both things, so it's clearly linked. The link is less obvious in other cities."
"[We] have a long history of harm reduction that's woven into the philosophy of the work that the [government health agency] does."

Political champions
"Political champions willing to go to bat, especially law enforcement and/or prosecutors willing to stand behind this."
"It's really important to have healthy relationships with [local political] leadership. Those conversations are important because it won't get done without political will."

Public support
"Politically, it is very difficult for politicians to come out in support of [safe consumption sites]. Constituents and public opinion are key here."
"Of course, the high-level people need the information, but they will ultimately respond to public opinion."

Favorable media coverage
"The big opportunity came when [reporter X at news outlet X] did a big long story on [syringe services provider] and essentially showed that they were all but operating as [a safe consumption site], and it was a favorable story."
"[Local news outlet] has offered great coverage of the issue even before this became the focus, talking about the opioid crisis locally. They were able to provide several informative reports around the role of safe consumption sites."

Exposure to existing safe consumption sites in other countries
"A group of them ended up being funded by [organization X] to go to Vancouver on a tour of Insite, and they came back talking about it in religious-conversion terms."
"People who don't understand addiction attribute all negative aspects of drug use in Vancouver to the facility itself. But other officials with knowledge of drug use . . . see the positive aspects and it helps gain support."

Opening of a sanctioned safe consumption site in the United States
"If [legislation X] passes, it will be a game changer for this issue for the . . . country."
"If [locality X] moves forward and [politicians] can go visit those sites, then that would build momentum."

Research—although insufficient to shift views
"The science is settled around safe consumption, but the political battle is the hard part. Just going to them with the literature reviews does not work."
"Using the data makes it clear that safe consumption sites work and are needed. The only tool the opposition has is fear, so in any structured conversation, like department board meetings, there is clear evidence pitted against unsubstantiated fears."

services on which to build safe consumption sites—such as addiction treatment and syringe services programs—is more limited (33, 44) and where the political environment differs.

CONCLUSIONS

Although the people and organizations driving progress on safe consumption site policy vary across the country, interviews illuminated many common themes. The success of organizers in positioning the sanctioning of safe consumption sites as a politically viable policy option has involved responding to questions and concerns with openness; engaging a diverse set of allies; organizing people who use drugs and involving them in advocacy efforts; urging politicians to support safe consumption sites with behind-the-scenes and public pressure; and addressing mistrust in the community, particularly concerns about racial injustice in drug policy. As localities independently engage in efforts to move safe consumption site policy forward, they are closely watching one another's progress, which has important implications for their own likelihood of success. As one participant noted, the "X factor . . . will be if another city actually implements [a site]."

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AMA

AMERICAN MEDICAL ASSOCIATION

AMA Wants New Approaches to Combat Synthetic and Injectable Drugs

For immediate release: Jun 12, 2017

[SNIP—second half of press release re: safe consumption services]

In an effort to consider promising strategies that could reduce the health and societal problems associated with injection drug use, the AMA today voted to support the development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision.

Studies from other countries have shown that supervised injection facilities reduce the number of overdose deaths, reduce transmission rates of infectious disease, and increase the number of individuals initiating treatment for substance use disorders without increasing drug trafficking or crime in the areas where the facilities are located.

"State and local governments around the nation are currently involved in exploratory efforts to create supervised injection facilities to help reduce public health and societal impacts of illegal drug use," said Dr. Harris."Pilot facilities will help inform U.S . policymakers on the feasibility, effectiveness and legal aspects of supervised injection facilities in reducing harms and health care costs associated with injection drug use."

The examination of this issue by physicians at the AMA Annual Meeting was greatly assisted by the Massachusetts Medical Society and its recently completed comprehensive **study** of the literature associated with supervised injection facilities.

amfAR The Foundation for AIDS Research
MAKING AIDS HISTORY

June 2017
ISSUE BRIEF

The Case for Supervised Consumption Services

In the United States, people who use drugs (PWUD) continue to be at elevated risk for HIV, according to the Centers for Disease Control and Prevention.[1] At the same time, a surging epidemic of overdoses from heroin and prescription painkillers (i.e., opioids) claimed nearly 50,000 lives in 2014 alone.[2] To save lives, there is a pronounced need to implement scientifically validated harm reduction programs, which reduce the risks associated with drug use and facilitate access to addiction treatment and medical care. Among the newest and most innovative interventions to reduce overdoses are supervised consumption services.

What are supervised consumption services?

Supervised consumption services (SCS)* are a public health intervention that provide a hygienic space for people to use illicit drugs under the supervision of trained staff. SCS are designed to reduce the risk of HIV/hepatitis C virus (HCV) transmission, prevent overdose fatalities, and connect PWUD with addiction treatment and other social services. SCS may also decrease drug use in public places, reduce improperly discarded syringes, and diminish crime sometimes associated with open-air drug scenes.

> A surging epidemic of overdoses from heroin and prescription painkillers (i.e., opioids) claimed nearly 50,000 lives in 2014 alone.

Other well-established harm reduction interventions include opioid substitution treatment (OST) and syringe services programs (SSPs), which, along with clean injecting equipment, generally provide outreach, peer education, and health promotion services. SCS evolved primarily as one of several responses designed to address health and public order concerns associated with public drug use. The first SCS facility was established in Switzerland in 1986, and currently almost 100 are operating in Europe, Australia, and Canada.

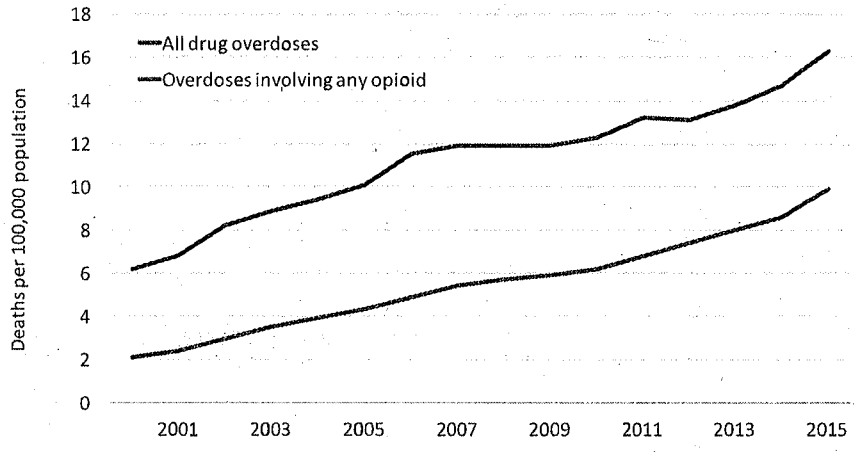
IN THIS ISSUE BRIEF

- Drug overdose fatalities have reached epidemic proportions in the U.S., the majority associated with opioids, particularly prescription painkillers and heroin.
- In addition, people who inject drugs account for 11% of all men and 23% of all women living with HIV, but many lack access to sterile injection equipment to keep them from acquiring HIV. The vast majority of Hepatitis C (HCV) cases in the U.S. are also associated with injection drug use.
- The absence of private, secure, and hygienic spaces often drives people who inject drugs to do so in public, with discarded syringes posing a health hazard, and overdose fatalities increasingly occur in bathrooms in fast food restaurants, hospitals, public libraries, and churches.
- Supervised consumption services (SCS) provide a hygienic space for people to use illicit drugs under the supervision of trained staff. SCS are designed to reduce the risk of HIV/HCV transmission, prevent overdose fatalities, and connect people who use drugs with addiction treatment and other social services.
- Research has shown that SCS are associated with greater access to medical and social services and reduced public drug use. Moreover, there are no persuasive data to suggest that SCS increase drug use or the frequency of injecting, or that they result in higher rates of local drug-related crimes.

*Over the past three decades, a variety of terms have been used to describe SCS, including safe(r) injection facilities (SIF), drug consumption rooms (DCR), and others. The term SCS acknowledges both evolving drug use patterns and the prevalence of polydrug use.

Opioid overdoses driving increase in drug overdoses overall

Age-adjusted rate of drug overdose deaths and drug overdose deaths involving opioids, United States, 2000-2014



SOURCE: Centers for Disease Control and Prevention. Increases in Drug and Opioid Overdose Deaths – United States, 2000 to 2014. MMWR 2015.

www.cdc.gov/drugoverdose

Most SCS target people who are homeless or in insecure housing, such as shelters, and have limited options for hygienic injecting without the risk of disease transmission or overdosing. Each functioning SCS typically provides staff as well as sterile injection equipment, counseling services, referrals to medical, addiction treatment, or social services, and emergency care in the event of overdose. Most restrict access to registered users who meet certain requirements, such as minimum age and local residency. The vast majority are integrated into low-threshold facilities that offer other services, such as food, showers, and clothing, along with harm reduction materials including 'sharps' containers and condoms. While most SCS target drug injectors, an increasing number also accommodate users who smoke or inhale drugs.

Making the case: The need for SCS in the United States

People who use drugs continue to be at high risk for HIV infection, but have low access to sterile syringes.
While the rate of new HIV transmissions associated with injection drug use decreased from 2010 to 2014, people who inject drugs (PWID) account for 11% of all men and 23% of all women living with HIV. Moreover, survival is lower among people diagnosed with HIV whose infection is attributed to injection drug use, compared to all other transmission categories.[3] But many PWID lack access to sterile injection equipment to keep them from acquiring HIV. For example, in the U.S., SSP coverage (the capacity to provide one sterile syringe per injection) is estimated to be minimal (only 3%).[4]

The vast majority of Hepatitis C (HCV) cases in the U.S. are associated with injection drug use.
Cases of acute HCV infection increased 2.5 times between 2010 and 2014, predominantly among young persons who are white, live in non-urban areas (particularly in Eastern and Midwestern states), have a history of injection drug use, and previously used opioid agonists such as oxycodone. Mortality among HCV-infected persons is increasing, and in 2007, the number of HCV-related deaths exceeded the number of HIV-related deaths for the first time.[5]

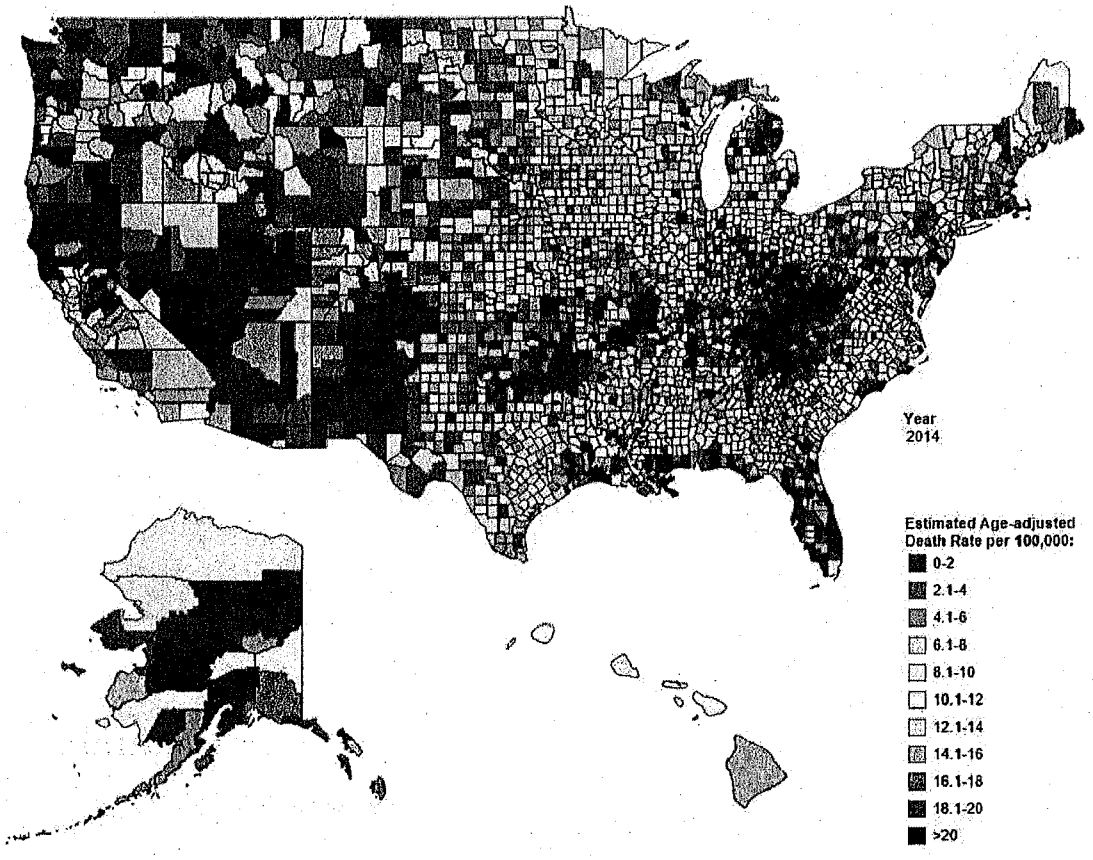
> In 2007, the number of HCV-related deaths exceeded the number of HIV-related deaths for the first time.

There is an epidemic of overdose fatalities among people who use drugs.
Overdose fatalities have reached epidemic proportions in the U.S. There were nearly 500,000 in the U.S. between 2000 and 2014—the majority (61%) associated with opioids, including prescription painkillers and heroin. During that time, drug overdose deaths

Drug Poisoning Mortality†: United States, 1999-2014

U.S. Trends: 1999-2014 | State Trends: 1999-2014 | County Estimates: 1999-2014

Estimated Age-adjusted Death Rates§ for Drug Poisoning by County, United States: 2014



Designed by L. Rossen, B. Bastian & Y. Chong. SOURCE: CDC/NCHS, National Vital Statistics System.

tripled, with 47,055 in 2014 alone, more than any previous year on record. The rise in overdose fatalities is driven by two distinct but interrelated trends: a 15-year increase associated with prescription opioids and a more recent surge driven largely by heroin.[6]

The large increase in heroin use across the country is closely related to prescription opioid misuse and dependence. In fact, past misuse of prescription opioids is the strongest risk factor for heroin initiation and use.[7] The increased availability of high-purity heroin, combined with its far lower price (compared to diverted prescription painkillers), appears to be driving the trend.[8] An influx of illicit fentanyl, a synthetic opioid that is often mixed with or sold as heroin, has further exacerbated the drug overdose fatality rate; deaths associated with synthetic opioids doubled from 2013 to 2014.[9]

Overdose fatalities represent only the worst possible outcome of a much larger problem—non-fatal overdoses may occur 20–30 times more frequently than fatal ones[10,11] and result in significant drug-related morbidities.[12]

Injection of drugs in public spaces is commonplace. Public injection has been associated with a greater risk of

LOCAL COMMUNITIES CAN BE AT PRONOUNCED RISK

Recently, HIV and overdose outbreaks among PWUD have raised public awareness of the need for interventions. In 2015, Indiana health officials diagnosed HIV infection among 135 people in a community of 4,200, the majority associated with the injection of oxymorphone, a powerful opioid painkiller.[13] Immediately following the outbreak, Indiana permitted the implementation of SSPs for the first time—and the chain of HIV transmission ceased.

The increase in drug overdoses, in particular, is dramatically illustrated by local outbreaks. For example, in June 2016, there were 16 overdoses in a single night in New Haven, CT; at least two were fatal.[14] In August 2016, Huntington, WV, police responded to 26 heroin overdose cases in a span of four hours.[15] That same month, Cincinnati health officials reported 174 overdoses associated with adulterated heroin in six days.[16] In September 2016, local authorities recorded 21 overdoses in a single Friday night in Akron, Ohio, one day after four people in the city died from overdoses.[17]

overdose and HIV transmission. Many PWUD are homeless or in insecure housing and are forced to inject in public settings, such as streets, parks, or mass transit, or in semi-public spaces, such as bathrooms, abandoned buildings, methadone clinics, or hospitals. Furthermore, the lack of privacy compromises the health, well-being, and safety of the injection drug user and the surrounding community.[18] For example, the absence of private, secure, and hygienic spaces often drives PWUD to inject in public, with discarded syringes posing a health hazard, and overdose fatalities increasingly occur in bathrooms in fast food restaurants, hospitals, public libraries, and churches.[19] In a survey conducted by the Injection Drug Users Health Alliance, among 447 SSP participants in New York City who reported injection drug use in the past three months, nearly half (49.9%) reported injecting in a public bathroom and more than a third (35.6%) reported injecting in a street or park. For 13.6% of participants, a public bathroom was their most frequent location for injecting.[20]

Are SCS effective? What does the research say?

The most thoroughly studied programs, as well as systematic reviews of programs, have shown that the implementation of SCS is associated with safer and more hygienic drug use among regular clients, greater access to medical and social services, and reduced public drug use. Moreover, there are no persuasive data to suggest that SCS increase drug use or the frequency of injecting, or that they result in higher rates of local drug-related crimes.[21,22,23] A wealth of credible scientific research has been generated from SCS programs that have been operating for a decade and a half in Sydney, Australia (the Uniting Medically Supervised Injecting Centre [MSIC], established in 2001), and Vancouver, Canada (Insite, established in 2003). Both were initially implemented as pilot projects and have incorporated numerous modifications based on extensive evaluations.

> The implementation of SCS is associated with ... greater access to medical and social services and reduced public drug use.

SCS are effective at reducing overdose fatalities.
During an 18-month study at Insite in 2004–2005, there were 336 overdoses—none fatal.[24] In an examination of all overdose deaths in Vancouver between 2001 and 2005, 89 occurred within 500 meters of Insite; after Insite opened, fatal overdoses within this area decreased by 30%, compared to 9% in the rest of Vancouver.[25] In another study in Sydney, fewer overdoses were reported to emergency response services at times when the MSIC was open.[26] Most often, SCS are implemented in settings with significant numbers of PWUD who are at high risk for overdoses.

SCS contribute to lower rates of syringe sharing, sharply reducing the risk of HIV/HCV transmission.[27,28]
SCS reduce syringe sharing and thus HIV/HCV transmission by providing sterile injection equipment and promoting safer injection techniques. For example, among 431 Insite participants, use of the facility was independently associated with a decline in needle sharing.[29] Because the reduction of HIV and HCV transmission among SSP participants has been well documented,[30,31,32,33,34] it is likely to hold true for SCS, which also attract populations at elevated risk for HIV or HCV. For example, among 904 Insite participants who were tested for HCV, 88% were HCV positive. Among other factors, those participants with a previous history of borrowing syringes were more likely to have acquired the hepatitis C virus.[35]

SCS are an effective strategy to reach people at greatest risk of overdose or blood-borne infections,[36] and may improve access to HIV care.
In the Vancouver Injection Drug User Study, participants who were at elevated risk of HIV infection, including younger daily cocaine users, or those at increased risk because of unstable housing, frequent heroin injection, non-fatal overdose, or public drug injection, were significantly more likely to use SCS.[37] In qualitative interviews, participants and staff reported that the program enhanced access to HIV care by building open and trusting relationships and facilitated delivery of treatment.[38]

SCS promote safer and hygienic drug use, thus preventing adverse health outcomes, such as abscesses and infections.[39]
At Insite, consistent participants were more likely to make positive changes in injecting practices, including less reuse of syringes, increased use of sterile water, swabbing injection sites with alcohol, cooking/filtering drugs prior to injection, and less rushed injecting, all of which may reduce the risk of infection and/or overdose.[40]

SCS help to reduce public injecting and the inappropriate discarding of syringes.[41]
For example, there were significant reductions in public order problems (public drug use, discarded syringes, and injection-related litter) following the opening of Insite, independent of law enforcement activities and changes in rainfall patterns.[42]

SCS provide an effective referral mechanism to detoxification and addiction treatment.[43]
Among a cohort of 1,031 PWID in Vancouver, there was a 30% increase in the use of detoxification services following Insite's opening, compared to the previous year, after controlling for age, gender, years injecting, and prior year injection drug use. Detoxification service use was also associated with increased use of methadone and reduced injecting.[44] Among Sydney MSIC participants, those who used the facility frequently were more likely to be referred to drug treatment than non-regular clients.[45] In a subsequent analysis of Insite participants, regular SCS use and having contact with a counselor were associated with treatment enrollment, which was positively correlated with injection cessation.[46]

Do SCS promote drug use or increase drug-related crime?

Like SSPs, since SCS were first proposed as a harm reduction intervention more than 30 years ago, critics have argued that they will inadvertently increase drug use among current users, initiate new users, and increase drug-related crime in the areas in which they operate.

There is no evidence that SCS encourage increased drug use or initiate new users.[47]
Most Insite participants, for example, are longtime injection drug users. In a study conducted among 1,065 participants, the median number of years of injection drug use was 15.9, higher than among non-participants from a community cohort. Furthermore, there was no evidence to suggest that the SCS facility prompted drug use in the community.[48] Another study conducted before and after the opening of Insite found no substantial increase in the rate of relapse among those who had stopped injection drug use.[49]

There is no evidence that operation of SCS leads to an increase in drug-related crimes.[50]
The opening of the MSIC in Sydney was not associated with an increase in the proportion of drug use or supply offenses.[51] In a follow-up study five years later, there was no evidence that robbery, property crime, or drug offenses had increased in the immediate vicinity.[52] Similarly, in the year following the opening of Insite, no increases in drug trafficking, assault, or robbery were detected, while vehicle break-ins decreased compared to the previous year.[53]

What does public opinion say about SCS?

As the rate of overdose fatalities has escalated in the U.S., local communities have been increasingly open to new interventions. In Ithaca, NY, Mayor Svante Myrick proposed implementing SCS in the context of *The Ithaca Plan: A Public Health and Safety Approach to Drugs and Drug Policy,*"[54] which was extensively covered by CNN's *Fareed Zakaria GPS*.[55] Similarly, in Seattle, the mayor's Heroin and Opioid Task Force recently included SCS among its recommendations to confront a heroin and opioid epidemic,[56] and a pilot SCS is underway.[57] In New York, State

As the rate of overdose fatalities has escalated in the U.S., local communities have been increasingly open to new interventions.

Assemblymember Linda B. Rosenthal, Chair of the Committee on Alcoholism and Drug Abuse, recently endorsed SCS, the first state-level official to do so, and announced her plans to draft legislation to permit the services in the state.[58] Soon after, the New York City Council approved the study of SCS,[59] and a proposal is underway to establish a SCS site in Buffalo.[60] And on June 2, 2017, the California State Assembly became the first state body to pass a bill approving the establishment of SCS in the state.[61]

In-depth articles exploring the implementation of SCS to address overdose fatalities have appeared prominently in *The Washington Post*[62] and *The New York Times*,[63] while the editorial boards of *The Boston Globe*[64] and *The Seattle Times*[65] have endorsed the approach. In 2016, *The Baltimore Sun* urged the Maryland General Assembly to thoroughly examine a bill to legalize SCS.[66] (The bill was subsequently defeated.)

Many HIV organizations have endorsed SCS. For example, the AIDS United Public Policy Committee recently called for the local implementation of SCS as part of a comprehensive public health approach to reducing overdose deaths, preventing the transmission of HIV and HCV, and improving quality of life among PWID.[67]

What are the policy implications of SCS?

In the U.S., there is increasing recognition of the need for a non-punitive, comprehensive approach to drug use and misuse to save lives. Following the 2015 Indiana outbreak, Congress reversed the longstanding prohibition on states and local communities from using federal funds to support SSPs, though still under fairly limited circumstances.

Based on public health imperatives, states and some municipalities have the authority to sanction the operation of SCS to address the risks posed by injection drug use. A similar rationale has underpinned authorizations of SSPs since the 1980s. However, the federal government could impede the implementation of SCS by enforcing provisions of the Controlled Substances Act.[68] Ultimately, state legislation authorizing SCS would be desirable, but it is not required. Still, implementing SCS anywhere in the U.S. will require at least tacit acceptance from the federal government.

Aside from the legal issues regarding SCS, support among stakeholders is critical. The 30-year success of SCS in Europe, Canada, and Australia has been dependent on local support and cooperation among key stakeholders, including health workers, law enforcement, businesses and commercial interests, and advocates. In most cases, champions from academia, medicine, and sometimes government played a key role.[69]

In Sydney, local residents and business operators have perceived significant improvements in public nuisance indicators (e.g., reduced publicly discarded injecting equipment and fewer reports of public injecting) since the opening of the MSIC and are cognizant of both the public health and public order benefits.[70] In a survey conducted among neighborhood residents and business owners, the proportion who agreed with the establishment of the King's Cross MSIC increased steadily from 2000 (before the MSIC opened) to 2010, from 68% to 78% and 58% to 70%, respectively.[71]

Are SCS cost-effective?

While the efficacy of SCS in improving health outcomes among participants and reducing public order nuisances has been well demonstrated, the savings associated with averted HIV and other drug-related medical costs must still be sufficient to offset operating costs. In the case of Insite, a number of studies have shown that the benefits far exceed the costs, even using conservative estimates of efficacy.[72,73] A 2010 study concluded that benefits surpass $6 million per year, after accounting for program costs.[74] It is important to note that because all of these studies measure only a limited number of variables, usually HIV infection and overdose fatalities, they do not account for other outcomes that are harder to judge monetarily, including reductions in public drug use, improvements in public order, or increased uptake into detox or opioid substitution treatment.[75]

The evidence is clear that supervised consumption services are a remarkably effective and cost-effective approach to improving the lives of people who use drugs and the health and security of the communities in which they live.

Conclusion: The time for SCS is now

With the capacity to reach and maintain contact with PWUD, reduce and prevent adverse health outcomes including overdose fatalities, facilitate entry into addiction treatment or medical care, and diminish the consequences of public drug use, supervised consumption services are an important component of a comprehensive harm reduction strategy. Local and state governments should actively explore the implementation of SCS to complement existing drug prevention and treatment interventions, in consultation with stakeholders, including PWUD, affected communities and businesses, healthcare and addiction treatment professionals, and law enforcement. The evidence is clear that supervised consumption services are a remarkably effective and cost-effective approach to improving the lives of people who use drugs and the health and security of the communities in which they live.

This brief was prepared by Derek Hodel.

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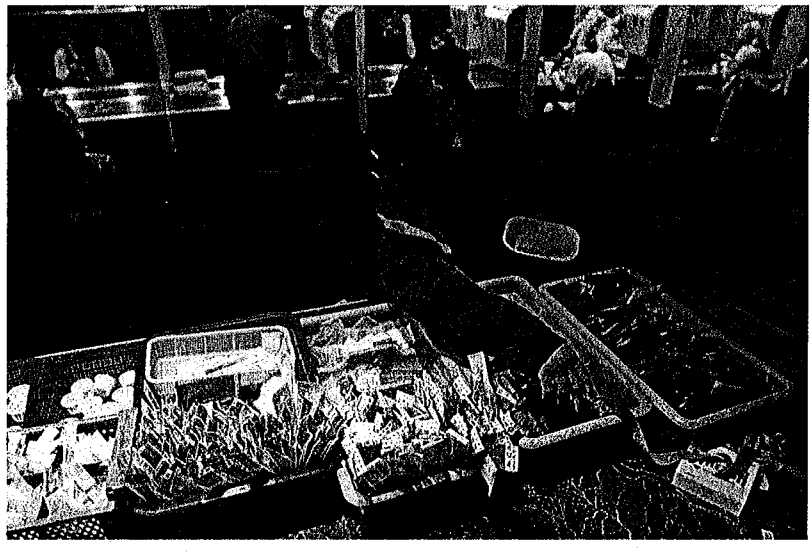
The New York Times

The Opinion Pages

Injecting Drugs, Under a Watchful Eye

Tina Rosenberg JAN. 18, 2017



A client at the Insite supervised injection center in Vancouver, Canada. Credit Laurent Vu The/Agence France-Presse — Getty Images

It has been nearly 30 years since the first needle exchange program opened in the United States, in Tacoma, Wash., in 1988. It was a health measure to prevent injecting drug users from sharing needles, and therefore spreading H.I.V. and hepatitis.

The idea was controversial, to say the least. Many people felt — and still feel — that it enables drug use and sends a message that drug use is O.K. and can be done safely.

Today the evidence is overwhelming that needle exchange prevents disease, increases use of drug treatment by winning users' trust and bringing them into the health system, and does not increase drug use. Its utility has won over some critics. When Vice President-elect Mike Pence was governor of Indiana, he authorized needle exchange programs as an emergency response to an H.I.V. outbreak. "I do not support needle exchange as antidrug policy, but this is a public health emergency," he said at a news conference in 2015.

Needle exchange saved New York City from a generalized H.I.V. epidemic. In 1990, more than half of injecting drug users had H.I.V. Then in 1992, needle exchange began — and by 2001, H.I.V. prevalence had fallen to 13 percent.

America has another epidemic now: overdose deaths from opioids, heroin and fentanyl, a synthetic opioid so powerful that a few grains can kill. A thousand people died of overdose in the city last year — three times the number who were killed in homicides. Nationally, drug overdose has passed firearms and car accidents as the leading cause of injury deaths.

If there is a way to save people from overdose death without creating harm, we should do it. Yet there is a potent weapon that we're ignoring: the supervised injection room. According to a report by the London-based group Harm Reduction International, 90 supervised injection sites exist around the world: in Canada, Australia and eight countries in Europe. Scotland and Ireland plan to open sites this year. In the United States, state officials in New York, California and Maryland, and city officials in Seattle (where a task force recommended two sites), San Francisco, New York City, Ithaca, N.Y., and elsewhere, are discussing such facilities.

Do you think needle exchange sends the wrong message? Boy, are you going to love this.

A supervised injection facility is a walk-in center where drug users can get clean equipment and use (their own) drugs under the watchful eye of staff armed with naloxone, the antidote that instantly reverses overdose. Some facilities are open to people who inhale drugs as well.

These facilities, like all harm reduction measures, are always part of a larger antidrug strategy. The response to America's opioid crisis requires legal crackdowns on the supply chain, especially fentanyl shipped from China; intensive prevention measures; and no-waiting, locally available long-term treatment, especially the most effective treatment, which uses Suboxone or methadone.

The government response lags far behind the problem; only a tiny percentage of people who need treatment have been able to get it so far.

Supervised injection sites save lives. There has yet to be a single overdose death in a site anywhere in the world, said Rick Lines, executive director of Harm Reduction International. A recent survey of scientific studies found that the sites — which serve the most hard-core, marginalized users — do many things. They get people into health care. They do not increase drug injecting. They don't increase trafficking or crime in the surrounding neighborhoods — their neighborhoods, in fact, saw less public injecting and fewer dropped syringes. And by averting H.I.V. and Hep C infections and reducing ambulance use and hospitalizations, they save money.

Like all harm reform measures, this idea assumes that people who are addicted to injecting drugs will do so *somewhere*. It's better for them — and for everyone — if that place is not an alley, playground or Burger King bathroom. They should not be alone. You can't enter treatment if you're dead.

The only sites in North America are in Vancouver. But Canada is seeing record overdose deaths and the spread of fentanyl, so Ontario's government just announced it would fund three sites in Toronto and one in Ottawa. Montreal plans to open some, too. "There is no higher priority in the health ministry," said Adam Vaughan, a member of Parliament from Toronto, The Globe and Mail reported.

The largest and oldest Vancouver clinic is Insite, established in 2003 in the city's Downtown Eastside neighborhood, where drug use is concentrated. Most of its funding comes from the province government.

"Insite is for long term, serious IV drug users," said a spokeswoman, Anna Marie D'Angelo. Peer counselors, doctors and nurses screen out novices or minors, she said. Clients average around 30 years old, and some clients are in their 70s and have been shooting heroin for decades.

Clients pick up clean injecting equipment and go to one of 13 clean, well-lit carrels — mirrored, so staff can watch. After they inject, they can go to a chill room to talk with peer counselors and nurses. These conversations build trust between clients and a determinedly nonjudgmental staff. The "no lecture" part of harm reduction bothers a lot of people, but clients must trust staff if they are to accept help.

Insite says that the vast majority of referrals it makes are to treatment or detox — many to Onsite, the detox center right upstairs. Researchers found that Insite was associated (pdf) with a 30 percent increase in use of detox services, which in turn increased the use of long-term treatment and decreased injecting drug use.

Randy Fincham, a staff sergeant at the Vancouver Police Department, said that Insite was not an easy sell with police. "It's hard for police officers to look the other way if someone's going to consume," he said. But Insite's record was convincing, he said — clients have overdosed about 5,000 times and were revived in every single

case. "It's not the be-all and end-all. It's a Band-aid for opioid consumption until other solutions are introduced. It's taken a few years, but now our members are fully supportive — because of the need."

To measure Insite's impact on overdose deaths, researchers tallied deaths in Insite's neighborhood in the two years before it opened and then in its first two years of operation, and compared them to deaths elsewhere in the city. Within roughly a third of a mile of Insite, overdose deaths dropped by 35 percent. In the rest of Vancouver, deaths dropped by 9.3 percent.

Researchers also found no increase in crime, and a decrease in public injecting and discarded needles. It has made the neighborhood better, not worse. The same is true in Sydney. Australian researchers found that three-quarters of residents and businesses in the area around Sydney's facility support it (pdf). "SIFs cannot be expected to solve all of the drug-related problems within a particular area, but can contribute to their reduction or minimization," said Australia's Salvation Army — an organization normally focused on abstinence.

A caution: Small is not beautiful. Insite's 13 carrels are not enough — each day starts off with a line around the block. This is bad for the neighborhood, and counterproductive for drug users. It's very hard to stand in line for an hour with a bag of heroin in your pocket.

And to make a difference, sites must be near the clients. Vancouver is unusual in the concentration of its drug injecting in one neighborhood — which is also why there are lines. This is a challenge for other cities where drug use is more disperse, and especially problematic in rural areas; people won't travel to go inject safely.

In New York, Linda Rosenthal, who represents Manhattan's Upper West Side in the State Assembly, is preparing to introduce legislation laying the legal groundwork that would allow cities to establish the sites. She believes the facilities should go into buildings that already serve injecting drug users with services such as needle exchange, detox, counseling and connections to social programs.

The New York City Council is funding a $100,000 study by the Department of Health and Mental Hygiene that will look at the feasibility and possible impact of sites in New York City. The money came out of an already budgeted sum designated for H.I.V.-prevention, so the council has not yet debated the issue.

It's a first step — given the politics, possibly the only step. The idea came from City Councilman Corey Johnson, who heads the health committee. He thinks that if the scientific evidence doesn't convince council members, the financial argument might help. "We can centralize a point of outreach to heroin addicts that actually does save significant money and resources in our fight against multiple epidemics," he said.

"I'm not sure we've been able yet to have the larger, substantive conversation that would hopefully educate people," he said. "At first glance, it's 'why are we going to set up facilities to allow people to inject really lethal drugs?' It's hard to comprehend why a government would do that."

Correction: January 18, 2017

An earlier version of this article misspelled the name of the city in Washington State that opened the first needle exchange program. It is Tacoma, not Takoma.

Tina Rosenberg won a Pulitzer Prize for her book "The Haunted Land: Facing Europe's Ghosts After Communism." She is a former editorial writer for The Times and the author, most recently, of "Join the Club: How Peer Pressure Can Transform the World" and the World War II spy story e-book "D for Deception." She is a co-founder of the Solutions Journalism Network, which supports rigorous reporting about responses to social problems.

APRIL 2019

OVERDOSE PREVENTION PROGRAMS FOR OAKLAND

In 2018, the HIV Education Project of Alameda County (HEPPAC), Harm Reduction Coalition, and Research Triangle Institute (RTI) conducted an assessment of people who use drugs in Oakland to explore the potential impact of an overdose prevention program, also known as supervised consumption services, on community health.

WE KNOW THAT...

1 THEY PREVENT FATAL OVERDOSE

Overdose prevention programs are places where people can bring pre-obtained drugs to use under the supervision of trained workers in a hygienic space where signs of overdose are quickly identified and naloxone is administered to prevent fatal overdose.

2 THEY REDUCE HIV AND HCV

Overdose prevention programs provide harm reduction supplies onsite so that people use sterile equipment, preventing the chances of re-using contaminated equipment or sharing with others. This reduces the likelihood of transmission of HIV, viral hepatitis, and bacterial infections that can be very costly to treat.

3 THEY SAVE MONEY

Study after study has shown that by averting potential bloodborne infections that usually end up with costly county emergency room visits or long term chronic infections, they ultimately save a lot of money.

4 THEY CONNECT PEOPLE

Overdose prevention programs serve as hubs for people who may have a variety of competing health and social concerns to services, including drug treatment, housing, and medical care.

5 THEY'RE EVIDENCE-BASED

Overdose prevention programs have been operating for over 30 years and have decades worth of evidence. There are over 130 sites operating across 12 countries.

WHAT DO PEOPLE WHO USE DRUGS THINK ABOUT THESE PROGRAMS?

Of the 138 people who were surveyed, 87% reported that establishing overdose prevention programs should be a priority for Oakland.

Of the survey respondents, 67% of all respondents, and 75% who injected drugs, reported that they would use an overdose prevention program if it existed in Oakland.

Of the respondents that reported they would use an overdose prevention program...

80% of respondents said they would do so to protect themselves from dying from an overdose,

70% would do so to gain access to drug treatment,

83% would do so to prevent being arrested, and

84% would do so to be able to see a health professional.

Preferred sites for overdose programs included a tent next to a syringe access program (75%) or to host the services within a building of an existing syringe access program (72%)

Two thirds of respondents reported that inhaling, smoking, or sniffing drugs should be acceptable at the site.

Community Assessment

In 2018, we conducted a community assessment to explore interest in overdose prevention programs among participants of syringe access program in Oakland. We conducted 138 interviewer-administered surveys to assess interest, perceived benefits and barriers, and willingness to use the services among people who use drugs. We followed up with three different sites in Oakland to conduct focus groups for deeper understanding about neighborhood dynamics, safety, and confidentiality.

Number & Percentage of People with Different Characteristics Saying They Would Use an Overdose Prevention Program

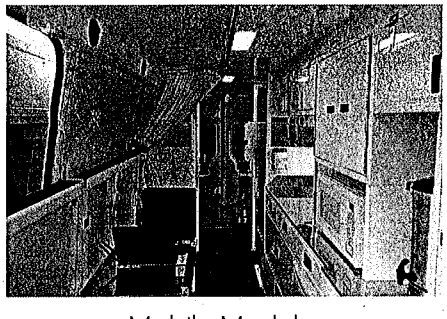
	N	%
Gender		
Female	35	59
Male	51	71
Non-conforming	2	100
Latinx	13	65
Race		
White	27	75
Black	42	62
Asian	2	100
Pacific Islander	1	25
Native American	6	86
Mixed Race/Other	10	59
Homeless	72	69
Stimulant Use in past 30 days	81	68
Opioid Use in past 30 days	49	75
Injected Drugs in past 30 days	48	75
Injected in Public in past 30 days	17	71
Injected Alone in past 30 days	27	75

Focus Group Key Findings

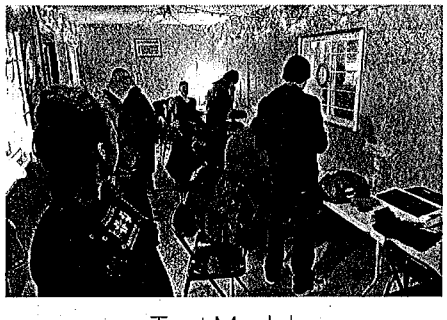
- **Safety not Surveillance-** Spaces should be free from law enforcement and surveillance. Safety should be created through staffing and peer structures.
- **Trust in Staff is Critical-** It's important to be able to trust the staff overseeing consumption sites, to have trained medical staff but also familiar peers
- **Nothing About us Without Us-** Participants stated they would be more likely to use services when they played a role in developing them
- **A Space for All People Who Use Drugs -** Sites should be Inclusive of smoking or other non-injection forms of drug consumption

What do Overdose Prevention Sites look like?

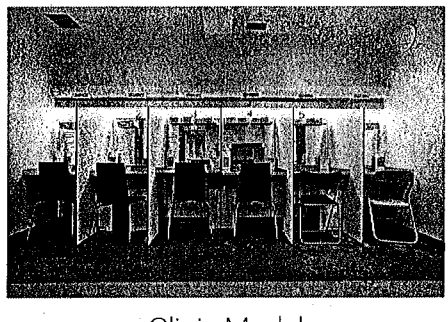
There are many different models used across the world. Here are examples of some that Oakland participants believe will work best in their community.



Mobile Model



Tent Model



Clinic Model

For more information, visit www.yestoscscalifornia.org

We are the Drug Policy Alliance.

HEPPAC

harm reduction COALITION

RTI INTERNATIONAL

Approved as to Form and Legality

City Attorney's Office

OAKLAND CITY COUNCIL

RESOLUTION NO. _____ C.M.S.

INTRODUCED BY MAYOR LIBBY SCHAAF AND COUNCILMEMBER NIKKI FORTUNATO BAS

RESOLUTION IN SUPPORT OF AB 362 – OVERDOSE PREVENTION PROGRAMS (EGGMAN) AND REQUEST THAT, IN ADDITION TO THE CITY AND COUNTY OF SAN FRANCISCO, THE BILL BE AMENDED TO GIVE THE CIT Y OF OAKLAND DISCRETION TO AUTHORIZE QUALIFIED ENTITIES TO OPERATE OVERDOSE PREVENTION PROGRAMS IN THE CITY OF OAKLAND

WHEREAS, in 2016, an estimated 5.6 percent of people ages 12 years and older (79,186 people) misused opioids in Alameda County and one percent of people (14,254 people) had an opioid use disorder (OUD), defined as opioid abuse or dependence; and

WHEREAS, according to the California Department of Public Health, drug overdose is a leading cause of accidental death in California, and in 2013, California hospitals treated roughly one overdose every 45 minutes, while heroin and opiate use continue to rise; and

WHEREAS, deaths from accidental overdose in Alameda County disproportionately occur among African American residents; and

WHEREAS, according to the federal Centers for Disease Control and Prevention, in 2010 nearly 4,000 new cases of HIV were attributed to unsafe injections, and heroin overdose mortality in the United States nearly tripled between 2010 and 2014; and

WHEREAS, many of the most marginalized and high-risk drug users are homeless or in insecure housing and are forced to inject in public or semi-public spaces, such as streets, parks, mass transit, or bathrooms, and the lack of privacy compromises the health, well-being, and safety of the injection drug user and the surrounding community, with discarded syringes posing a health hazard, and overdose fatalities increasingly occur in public or semi-public spaces; and

WHEREAS, Overdose Prevention Programs, or Supervised Consumption Services (SCS), have been utilized in Vancouver, Sydney, and approximately 120 other cities around the world to reduce overdose death and injury, decrease public health concerns like discarded syringes and public injection, reduce the transmission of infectious diseases, and provide entry to treatment for this most marginalized group; and

WHEREAS, in 2017, Seattle and the surrounding King County announced a plan to establish several SCS in the area as a pilot test to address overdose and drug use in the community; in 2018, local government officials in Philadelphia, San Francisco, and New York City announced plans to open sites in their cities; and additionally, legislation has been introduced in California, Colorado, Maryland, Massachusetts, Missouri, New York and Vermont to allow SCS; and

WHEREAS, research has shown that these programs ***do not*** encourage additional drug use or increase crime in the surrounding area, and potentially save millions of dollars in healthcare and incarceration costs, and for these reasons, the American Medical Association endorsed piloting these sites in June 2017; and

WHEREAS, the Oakland Fire Department and Emergency Ambulance Services reported utilizing over 800 Narcan opioid overdose treatment interventions since 2013; and

WHEREAS, in 2018 the OAK 3-1-1 system recorded 569 service requests for needle collection/disposal and $143,000 was expended on the biohazard contract for collection of needles and human waste; and

WHEREAS, existing California state law makes it a crime to possess specified controlled substances or paraphernalia, to use or be under the influence of specified controlled substances, to visit or be in any room where specified controlled substances are being unlawfully used with knowledge that the activity is occurring, or to open or maintain a place for the purpose of giving away or using specified controlled substances, and existing law also makes it a crime for a person to rent, lease, or make available for use any building or room for the purpose of storing or distributing any controlled substance; and

WHEREAS, California State Assembly Bill 362 (Overdose Prevention Programs) introduced by Assembly Member Eggman and co-authored by Assembly Members Weiner, Friedman, Chiu, and Wood, would authorize the City and County of San Francisco Board to approve qualified entities to operate overdose prevention programs where adults may use controlled substances under supervision of staff trained to prevent and treat overdose, prevent HIV and hepatitis infection, and facilitate entry into drug treatment and other services; and

WHEREAS, Assembly Bill 362 prescribes minimum requirements for operation of overdose prevention programs; now, therefore, be it

RESOLVED: That the City of Oakland hereby endorses AB 362 and urges the California State Legislature and Governor Gavin Newsom to support its enactment into law; and be it

FURTHER RESOLVED: That the City Council of the City of Oakland requests that the authors amend the bill to include that the same discretion granted to the City and County of San Francisco be granted to the City of Oakland to authorize overdose prevention programs in the City of Oakland; and be it

FURTHER RESOLVED: That the following public agencies and community organizations support this legislation including the California Association of Alcohol and Drug Program Executives, California Society of Addiction Medicine, Drug Policy Alliance, Harm Reduction Coalition, HealthRIGHT 360, San Francisco AIDS Foundation, American Academy of HIV Medicine's California/Hawaii Steering Committee, American Civil Liberties Union of California, California Psychiatric Association, California State Council of the Service Employees International, City and County of San Francisco, Coalition on Homelessness, San Francisco, Ella Baker Center for Human Rights, Glide Foundation, Health Officers Association of California, Larkin Street Youth Services, San Francisco Public Defender, and Service Employees International Union California among others; and be it

FURTHER RESOLVED: That The Oakland City Council hereby directs the City Clerk to convey a copy of the Resolution to the State Legislature and Governor Gavin Newsom.

IN COUNCIL, OAKLAND, CALIFORNIA,

PASSED BY THE FOLLOWING VOTE:

AYES - FORTUNATO BAS, GALLO, GIBSON MCELHANEY, KALB, REID, TAYLOR, THAO AND PRESIDENT KAPLAN

NOES –

ABSENT –

ABSTENTION –

ATTEST:_____
LATONDA SIMMONS
City Clerk and Clerk of the Council of the
City of Oakland, California

2733603v2