

An Introduction to Safer Injecting Facilities

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1. Introduction

What are Supervised Injection Facilities?

Supervised Injection Facilities (SIFs) are controlled health care settings in which participants can more safely inject illicit drugs under clinical supervision. They are legally sanctioned facilities designed to reduce the negative health and public order issues often associated with public injection drug use by providing a safe, hygienic, and supervised space for consumers to inject pre-obtained drugs. In addition, SIFs serve as points of referral for consumers into health and social services including medical treatment, detoxification services, and substance abuse treatment. The primary aims of SIFs are to reduce personal health risks and public disturbance associated with injection drug use and to increase engagement of injection drug users (IDUs) in medical and social services through appropriate referrals. SIFs are designed to complement—not replace—existing prevention, harm reduction, and treatment interventions.

A Brief History of SIFs Worldwide

There are currently 92 SIFs operating within 63 cities and 8 different countries worldwide (Switzerland, Germany, the Netherlands, Norway, Luxembourg, Spain, Australia, and Canada.)

The first SIF of the current type opened in Switzerland in June of 1986. It was officially granted legal exemption in July of 1988 on the recommendation of a working group of judges and the General Prosecutor. During the late 1990s SIFs were piloted in Germany and the Netherlands and by the mid 2000s had spread to Spain, Australia, Canada, Norway, and Luxembourg.⁹ As of November 2012, Denmark and France have also adopted legislation to permit SIFs.^{8, 21}

2. Establishment and Legality of SIFs Worldwide: A Precedent for the U.S.

The primary legal barriers related to the establishment and regulation of SIFs are national laws which classify and prohibit the possession and use of controlled substances. In each of the 8 countries currently operating SIFs exemptions from relevant national drug laws have been granted in order to offer legal protection to SIF programs, staff, and participants.

The examples of Australia and Canada

In both Australia and Canada SIFs have been established as scientific pilot projects granted legal exemption from criminalization of drug consumption.

Australia's Sydney Medically Supervised Injection Centre (MSIC), which opened in 2001, is run as a non-government organization. The center was initially granted permission to open under a trial amendment of the Drug Misuse and Trafficking Act. This exemption was extended 3 times allowing the MSIC to operate under 'trial' conditions for nearly a decade until October 2010, when legislation was passed to end the facility's trial status and incorporate MSIC as a permanent health service.¹⁹

In 2003, Canada's federal government granted permission to the Vancouver Coastal Health Authority, under section 56 of the Controlled Drugs and Substances Act, to operate and evaluate a medically supervised injection facility.

Canada's Controlled Drugs and Substances Act (CDSA) grants authority to the federal Minister of Health to issue an exemption to "any person or class of persons" if "the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest."¹⁹ The only SIF operating in North America, InSite was granted several extensions of this exemption by the Canadian Supreme Court until September of 2011 when the court reached a unanimous decision that InSite should remain open.¹⁷

The federal legislation that allows InSite to operate was directly influenced by a group of stakeholders led by local, grassroots activists and community organizers. Formed in 1997, the Vancouver Area Network of Drug Users (VANDU) led this harm reduction coalition that grew to include then Mayor of Vancouver Philip Owen, then Chief Medical Health Officer of Vancouver Dr. John Blatherwick, the Vancouver Health Authority, the PHS Community Services Society, and 'From Grief to Action,' a grassroots organization for parents of children struggling with addiction or lost to overdose. As a direct result of the actions of this coalition, harm reduction was officially included as one of the four pillars of a new anti-drug strategy outlined in the Vancouver Agreement and ratified by federal, provincial, and municipal governments in 2000.⁶

Legal Barriers to Establishing SIFs in the United States

In the United States, manufacture, importation, possession, use, and distribution of certain substances is regulated under the federal Controlled Substances Act (CSA). There are at least 2 sections of the CSA that may be interpreted to prohibit the establishment of SIFs. Section 844 prohibits drug possession, and so is necessarily violated by every client who arrives at the SIF with pre-obtained drugs. Section 856, known as the 'Crack House Statute,' makes it illegal to "knowingly open or maintain or manage or control any place for the purpose of unlawfully using a controlled substance."² Although U.S. states and municipalities do have some authority to regulate SIFs, federal agencies reserve the right to intervene under the CSA, which supersedes all state and local laws.

The least politically and legally obtrusive way to launch a SIF would be to cast it as an incremental extension of a syringe exchange program (SEP) already authorized by state law. In this way, the program could avoid the SIF label and instead portray itself as a response to community concerns about public injecting and improperly discarded syringes. While this approach avoids the necessity of state legislation directly challenging federal drug law, it requires agreement from police to turn a blind eye to the consumption of drugs on SEP premises (as many local police forces already do with regards to possession of drugs and paraphernalia on SEP premises.) Unfortunately, without extremely robust community and police support, this approach leaves clients and staff of the SIF vulnerable to prosecution.²

Most local governments have some police power to protect public health as well as the discretion to implement programs that are supported by reasonable evidence of effectiveness. Syringe exchange programs (SEPs) have successfully operated in several cities in Pennsylvania, California, and Ohio without state authorization.² Following that model, SIFs may be authorized at the local level by a mayor, local health commissioner, county agency, or city council. However, a locally authorized SIF would be on the weakest footing in relation to a federal challenge and may also be vulnerable to challenge at the state level.²

It can be argued that, because public health initiatives remain a state power, states have a clear legal authority to authorize SIFs through the legislative process just as they can legalize the possession and use of medical marijuana.² In one example, the state of Oregon demonstrated its right to enact health policy conflicting with federal law by legalizing physician-assisted suicide through the Death With Dignity Act of 1994. Then Attorney General Janet Reno determined that the CSA did not authorize her to “displace the states as the primary regulators of the medical profession, or to override a state’s determination as to what constitutes legitimate medical practice.”² In 2000, when Reno’s successor John Ashcroft arrived at the opposite conclusion and attempted to challenge the Death With Dignity Act, the matter was ultimately decided by the US Supreme Court which upheld the Oregon state law.²

Alternatively, a state government might authorize a SIF through administrative action by the executive branch. For example, the New York State Health Commissioner is authorized to enact regulations exempting classes of persons from needle prescription laws, a power that has been used to authorize state-wide syringe exchange programs.² Additionally, governors may have the power to authorize SIF by executive order. However, a 2004 executive order by New Jersey Governor James McGreevey to allow SEPs was challenged and eventually overturned in the appellate court for violating existing state drug laws.²

In all cases, federal inaction would likely be sufficient to allow a local- or state- authorized SIF to proceed following instruction from the Attorney General to federal law enforcement to ignore the SIF in the exercise of ‘prosecutorial discretion.’

3. Implementation and Evaluation of SIFs

What concerns are cited by opponents of SIFs?

Opponents of SIF programs cite concerns that SIFs may promote drug use, increase drug trafficking, and/or lead to degradation of the neighborhoods in which they operate. In France, recent legislation authorizing SIFs was opposed by the conservative Union for a Popular Movement (UMP) Party on grounds that such programs “trivialize[e] drug use and legaliz[e] the use of the hardest drugs at the taxpayer’s expense.”²¹ The International Narcotics Control Board (INCB), the UN body responsible for monitoring the implementation of UN drug conventions, has expressed concerns over SIF on the basis that tolerating, for any reason, drugs obtained through illegal means supports trafficking.²¹ In 2000, establishment of SIF in Vancouver was

opposed by the Community Alliance, a group of local business and property owners in downtown Vancouver concerned about public disorder in the neighborhood⁶

What are the primary aims of SIFs? How are they evaluated?

The primary aims of SIFs are to reduce personal and public health consequences associated with injection drug use (primarily HIV, HCV, and overdose), to reduce public order consequences associated with injection drug use (public injection and publicly discarded syringes), and to increase utilization of medical and social services by IDUs.

A wealth of independent studies has evaluated the efficacy of SIFs in reaching the objectives above. Vancouver's InSite alone has been the subject of more than 30 peer-reviewed studies. The sections that follow will provide a summary of many of these evaluations.

4. Evaluating the Impact of SIFs on Health Issues Faced by IDUs

SIFs aim to reduce overdose mortality among IDUs as well as to decrease the incidence of blood-borne infection (HIV and HCV) within the IDU population by decreasing risky injection practices. SIFs aim to accomplish these goals without encouraging or increasing drug use.

Overdose Mortality

Between March 2004 and August 2005 336 overdoses were reported at InSite, none of them fatal. In most cases (87%) IDUs who overdosed were treated with oxygen and never required treatment in emergency medical facilities.³ A qualitative study consisting of in-depth interviews with 50 InSite participants revealed that InSite addresses many of the environmental factors that drive the high rate of overdose among IDUs. By making it possible for IDUs to inject under medical supervision, with enough time to carefully and safely inject in a safe environment with no risk of assault, robbery, or police confrontation, InSite plays an important role in reducing overdose risk and in safely managing those overdoses that do occur.¹⁰

HIV and HCV Risk Behavior

Blood-borne transmission of HIV and HCV among IDUs occurs through the sharing of personal injection equipment (syringes, cookers, cottons, and mixing water.) One study of a randomly selected cohort of InSite participants found a baseline HIV seroprevalence rate of 17%.²⁴ Another study of 691 randomly selected InSite participants found that 87.6% tested HCV positive.²⁶

Among 400 IDUs surveyed prior to the opening of InSite, 178 (45%) later began using the SIF. When compared to IDUs who do not utilize InSite, regular InSite participants are younger, more likely to inject in public, to be homeless or to live in unstable housing, to be daily heroin or cocaine users, and to have recently experienced a non-fatal overdose. Research demonstrates that IDUs with these characteristics are at higher risk of practicing risky injection behaviors and

therefore of becoming infected with HIV, HCV, or other blood-borne infections.²⁸

From July 2004 through July 2005, injecting practices were compared between participants who consistently used InSite (for 25% or more of their injections) and those who used the facility inconsistently (less than 25% of their injections.) Compared with those IDUs who used InSite inconsistently, consistent InSite users were almost 3 times more likely to use sterile water, 2.8 times more likely to swab injection sites, and 2.8 times more likely to cook or filter their drugs. They were also 2.8 times more likely to not rush during injections and more than twice as likely not to share syringes.³ The results of these studies suggest that SIFs such as InSite reduce risky injection practices among those drug users who are at highest risk of contracting and spreading HIV and HCV.

SIFs and Rates of Injection Drug Use

The drug use behaviors of 871 IDUs were observed in the one year period before the opening of InSite and again in the one-year period after the opening of InSite. Investigators examined the rates of relapse into injection drug use among former users as well as the cessation of injection drug use among current users. The study found that the opening of InSite had no significant impact on the rates of relapse into injection drug use among former users (17% prior to the opening vs. 20% afterwards.) Additionally, the study found no significant decrease in the rate of injection drug use cessation among current users (17% prior to the opening vs. 15% afterwards).¹¹ In a separate study examining personal histories of injection among InSite participants, investigators learned that the average InSite user had been injecting for 16 years at the time of the study. Only one person out of 1,065 reported performing their first injection at InSite.¹³ These results strongly suggest that SIFs such as InSite do not promote illicit drug injecting but rather attract individuals with long histories of injection drug use.

SIFs and Medical/Social Services

One aim of SIFs is to act as a point of entry for marginalized and isolated IDUs into further medical and social services, especially detoxification and rehabilitation programs. One study following 1,000 InSite participants found that 18% began a detoxification program at some point during the 16-month study period. The same study found that individuals who injected at InSite weekly were 1.7 times more likely to enroll in a detox program than were those who visited the center less frequently.³⁰ Moreover, clients who entered detox were 1.6 times more likely to enroll in methadone treatment and 3.7 times more likely to enroll in other forms of addiction treatment. Individuals who entered detox visited InSite less frequently in the month after enrolling in detox services than in the month prior to their enrollment.²⁹ These results strongly suggest that SIFs such as InSite increase referrals to detoxification and rehabilitation services and eventually decrease participants' need to utilize the SIF.

5. Evaluating the Impact of SIFs on Public Order and Law Enforcement

SIFs and Public Injection

Individuals who are homeless or unstably housed often have no choice but to inject drugs in public areas such as public restrooms, abandoned buildings, cars, stairwells, parks, and alleyways. Even individuals who are stably housed may choose to inject drugs in public when doing so presents the fastest means by which to avoid the immediate onset of withdrawal symptoms. Risks associated with public injection include robbery and assault by street predators, confrontation with police, risky injection practices including sharing and re-using of syringes, and overdose.⁴

SIFS attract IDUs who are likely to inject in public locations. In the month prior to registering at the MSIC in Sydney, 39% of clients reported injecting in a public space; among those registering at the SIF in Geneva, 20% reported that they had made their last injection in a public location.⁹ Investigators in Vancouver measured injection-related public order problems during the six weeks prior to the opening of InSite and the 12 weeks after its opening. The report found a significant decrease in public injection following the facility's opening as well as significant decreases in the amounts of publicly discarded syringes and other injection-related litter. After accounting for seasonal weather variations, variations in police presence, and other factors, the study concluded that the improvement in public order was a direct result of the presence of InSite.²⁵

SIFs and Crime Rates

Opponents of SIF programs cite concerns that centralizing services for injection drug users may lead to local increases in drug trafficking and related crimes. Investigators in Vancouver compared crime rates (drug trafficking, assaults, robberies, vehicle break-ins, and thefts) in the full calendar year immediately before and after InSite's opening. The report found no statistically significant changes in rates of drug trafficking, assaults, or robberies but found a significant decrease in rates of vehicle break-ins and vehicle thefts.²⁷ Studies of SIFs in Groningen, Biel, Geneva, and Sydney show no evidence of increased crime in the areas surrounding these facilities.⁹

Relationships Between SIFs and Local Law Enforcement

Critics of SIFs have argued that implementing such programs will lead to increased crack downs on open drug scenes and undermine cooperative efforts between law enforcement and public health initiatives.⁵ However, one study conducted for the Canadian Expert Advisory Committee on Supervised Injection Site Research found that the majority of local Vancouver police officers interviewed supported the Vancouver SIF as a means of improving public order. In fact, 17% of InSite participants surveyed reported having been referred to the SIF by Vancouver Police Officers when found injecting in public.⁵ These results suggest that Vancouver's SIF is providing local police with a mechanism to address public injection drug use in a manner that promotes

public safety while resolving some of the existing tensions between public health and public order initiatives.

A report by the European Monitoring Centre for Drugs and Drug Addiction analyzed study results from several European cities in which SIFs operate and found that the frequency of reported nuisance problems in the vicinity surrounding SIF sites is related to the quality of cooperative arrangements between police and drug user services. Fewer problems were reported in cities where a political consensus about the need for SIFs and their public health and public order advantages existed (e.g. Frankfurt, Saarbrücken) than in other cities where this was not the case (Hannover, Hamburg).⁹ Cities with successful SIF programs have established direct cooperation between local police and drug user services, supported by coordination bodies of local stakeholders including not only law enforcement and public health workers but also business and property owners as well as local residents.⁹

In general, public nuisance problems were reported when the capacity or location of the SIFs did not meet local need. For example, a study of 18 SIF locations across Germany found that 38% of clients interviewed admitted having used drugs in public during the previous 24 hours. Half of this group gave as their reason the fact that the SIF had been closed, with another third citing long wait times in over-burdened SIFs.⁹ While SIFs struggle to meet the full demand for drug user services public injection may be reduced but never entirely eliminated.

6. Evaluating the Cost-Effectiveness of SIFs

Several studies of Vancouver's InSite have suggested that SIFs are both practical and cost-effective as public health initiatives. A study published in the Canadian Medical Association Journal developed several computer-generated models for evaluating InSite's cost-effectiveness. One model operated under the assumption that the introduction of a local SIF decreases needle sharing between IDUs, increases the use of safer injection practices, and increases referrals to methadone treatment. This model predicted that, over 10 years of operation, the SIF would prevent 1,517 new HIV infections and 68 new HCV infections, resulting in a total of 1,695 life-years gained.¹ The health care costs averted per case were estimated at \$20,100 for HIV infection and \$444,500 for HCV infection. Total, this model predicted a net savings of \$18 million and 1,175 life-years over 10 years of facility operation.^{1,6} The model showed net cost savings if the facility was used regularly by only 3.8% of injection drug users in the region.¹

An alternative model assumed that decreased needle sharing would be the only effect of the SIF on health-related behaviors of IDUs. Even under this conservative model the SIF was associated with improved survival and net societal cost savings.¹

7. Logistical Operation of SIFs

Location and hours of operation are the most important factors determining whether a SIF will be regularly attended by a significant portion of a region's IDUs. SIFs need to be physically located in or near neighborhoods with large numbers of injectors and prominent centers of drug trafficking. Additionally, SIFs should be located on or near major routes of public transportation.

SIF staffing and operating hours should be determined based on need which may require some facilities to operate 24/7.

Most facilities restrict usage of the SIF to individuals who are already drug-dependent (not new injectors.) Some SIFs require clients to be registered and show an I.D. before admission to the injecting room and/or to demonstrate that they are injectors, city residents, and/or of minimum age (typically 18 years.)

Clients are expected to bring their own pre-obtained drugs to the site. Some SIFs allow clients to divide up the drugs they bring into the SIF and to assist one another in injecting; other SIFs enforce strict rules against sharing, preparing, or injecting drugs with other clients. In all cases clients are prohibited from dealing drugs on-site, or from injecting anywhere except in specifically designated injection rooms.

SIFs employ a queuing system to regulate client flow in and out of designated injection rooms. Clients have a limited time to use the injection room (typically 30-45 minutes) but are allowed to return to the facility several times throughout the day or evening. Each injection room provides all necessary injection equipment and supplies as well as the means for proper syringe disposal. Clients are required to clean up after their use of an injection space and to dispose of all used materials in appropriate biohazard or garbage containers before leaving. Additionally, clients are encouraged to assist in keeping the SIF clean and to collect drug-related debris within the vicinity of the SIF.

At least one SIF staff member supervises the injection room at all times. In general, SIF staff is prohibited from assisting clients in preparing or injecting their drugs although some SIFs allow medical professionals to provide clients with safer injection training. SIF staff is trained to respond to medical emergencies and some SIFs have direct phone lines to police and ambulance services.

7. Establishment of SIF in the United States: Looking Forward

San Francisco

The Drug Policy Alliance has targeted San Francisco as one of the most promising cities to host the nation's first pilot SIF. More than 12,000 San Francisco residents are living with Hepatitis C; as a result, the city is home to the nation's highest rates of liver cancer.²³ Since at least 2007 members of the San Francisco Mayor's Hepatitis C Task Force have been advocating for the establishment of a supervised injection site.²³ Supporters of SIF in San Francisco include the San Francisco AIDS Foundation, the San Francisco Drug Users' Union, the Mission Neighborhood Resource Center, and San Francisco General Hospital's Opiate Treatment Outpatient Program.¹⁴

Ed Lee, Mayor of San Francisco, opposes the idea of establishing a SIF in the city claiming that the city already has ample tools for attacking the problem of injection drug use, including syringe exchange programs.¹⁵

New York City

Several groups in New York City are advocating for the establishment of a supervised injection facility. Citiwide Harm Reduction in the South Bronx, which operates its own fully functional primary care health center, plans to build a full-scale model of a SIF at its 144th St. location. Citiwide Executive Director Robert Cordero explains that the model is educational in purpose and aims to change the public's "grisly misconception of what a safe injection site would be like."²²

In May of 2009, the John Jay College of Criminal Justice in New York City hosted a 1-day Safe Injection Facilities in New York Conference as part of the budding movement to expand harm reduction services statewide. The conference was sponsored by the college, the Harm Reduction Coalition, and a coalition of 17 different New York City needle exchange and harm reduction programs known as the Injection Drug User Health Alliance (IDUHA).²⁰

New Mexico

In February of 2012 the New Mexico Senate, with endorsement from public health agencies and the governor, passed a memorial to fund a University of New Mexico study to evaluate harm reduction approaches, including supervised injection facilities.²² This interest in expanding public health approaches to injection drug use arose in response to a CDC finding that New Mexico ranks #1 in the nation for prescription pain killer overdoses per capita (27 per 100,000 deaths.)¹⁶ The memorial, sponsored by Senator Richard Martinez, passed the senate with a 43-0 vote and has also been endorsed by the New Mexico Public Health Association.²²

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