Supervised Injection Facilities: A Logical Progression in Harm Reduction or a Bridge Too Far?

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The scourge of opiate abuse continues to rage unabated. It claimed 42,000 lives in 2016, more than in any previous year (U.S. Department of Health and Human Services, 2018). That's 115 human lives per day. Five of our brothers and sisters are lost each hour. One of our parents, spouses, sons or daughters passes every 12 minutes. An additional life will surely have vanished in the time it has taken me to compose this paragraph. This is universally recognized as the most pressing public health crisis of our time, and clarion calls for action emanate from the afflicted, the advocates and the corridors of power. Such seemingly concerted efforts have failed to staunch its progression, however. Centers for Disease Control and Prevention data reveal a 29% increase in drug-related deaths in New York State between 2015 and 2016, the largest annual increase in the 2010-2016 period (Rockefeller Institute of Government, 2018). Cities, states and municipalities struggle to contain this epidemic and the existential threat it poses, and some have turned to a potential solution that would be politically infeasible (if not altogether unthinkable) in the absence of such a crisis: Supervised Injection Facilities (SIFs).

SIFs, also known as Drug Consumption Rooms (DCRs) or Supervised Consumption Services (SCS), provide safe spaces where individuals may ingest illicit substances under the supervision of specially-trained personnel. These facilities emerged from a Harm Reduction paradigm that aims to mitigate risks associated with substance use among individuals who are not able or willing to abstain altogether. SIFs differ from other Harm Reduction approaches, however, inasmuch as they permit recipients to utilize illegally-procured substances on facility premises and under the direct supervision of their personnel. As such, they may easily run afoul of laws and regulations governing the possession and use of illicit substances. They also challenge prevailing philosophies on recovery and engender resistance from a variety of stakeholders. Some view supervised consumption as tantamount to sanctioned substance use and fear it will condone or encourage it. Others are wary of its potentially adverse impact on the communities in which they operate. We do not need to speculate, however, about the ramifications of SIFs for individuals and communities. A robust network of these facilities has been in operation throughout Europe, Canada and Australia since the late 1980s and we have a wealth of data from which to draw some informed conclusions.

Switzerland, Germany and The Netherlands have operated SIFs for the past 30 years. Canada and Australia established sites in the early 2000s and Spain, Luxembourg and Norway followed suit shortly thereafter (International Drug Policy Consortium, 2012). These facilities were established to serve a similar mission and purpose but they operate according to disparate guidelines, recipient eligibility criteria and legislative authorities. Moreover, public sentiment toward SIFs naturally varies in accordance with political, cultural and other contextual factors, so it is difficult to generalize research findings from each facility to the international network of which it is a part. Nevertheless, the findings have converged on certain conclusions that may be reasonably applied to most SIFs irrespective of differences in operational standards or the communities in which they are situated:

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• SIFs reduce drug overdoses and drug-related fatalities. An evaluation of a Vancouver-based facility revealed a 35% decrease in drug-related overdose deaths within the vicinity of this facility compared to a 9.3% citywide reduction (Otter, 2012). A SIF in Sydney, Australia had a similarly favorable impact on overdose deaths according to a comprehensive evaluation by KPMG. Between 2007 and 2010 this facility managed (i.e., supervised) 3,426 overdose events and successfully intervened to avert fatalities in each of them (KPMG, 2011). The study authors reasonably concluded at least some of these events would have resulted in death had they occurred in other public or private spaces or in the absence of supervision by specially-trained personnel. They also found a marked decrease in the incidence of drug overdoses in proximity to the facility (KPMG, 2011). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reached similar conclusions in its analysis of several European facilities (EMCDDA, 2018.) Most astonishingly, the research literature reports only one drug-related fatality on the premises of a SIF since their inception 30 years ago, and this was attributed to anaphylactic shock (Otter, 2012).

• SIFs reduce blood borne disease transmission rates. Intravenous drug users (IDUs) frequently experience significant life challenges (e.g., poverty, poor physical and mental health, etc.) and are at elevated risk of other hazardous behaviors including the sharing of used syringes with fellow IDUs. Consequently, rates of Hepatitis C (HCV) and Human Immunodeficiency Virus (HIV) infection are disproportionately high among this population. Needle exchange programs pioneered in the U.S. in the late 1980s and early 1990s have been proven to reduce the transmission of blood borne pathogens among IDUs (Government Accountability Office, 1993), so it is not surprising that SIFs have had a similarly beneficial impact inasmuch as they customarily furnish clean needles to their recipients. Analyses of SIFs in Australia, Canada, The Netherlands, Spain and Switzerland found reductions in the rates of blood borne disease transmission among their users (Otter, 2012). Another study confirmed these findings and also revealed an increase in condom use among SIF users (Milloy & Wood, 2009). The authors of this study concluded SIFs may play a more comprehensive role in preventing disease transmission through a variety of preventive, educational and ancillary support services.

• SIFs do not produce an increase in crime or other deleterious effects in the communities in which they operate. Public sentiment toward the siting and operation of SIFs is naturally mixed, and many stakeholders have expressed concern such facilities would encourage drug-related crime and other undesirable activities in their communities. Research findings do not validate such concerns. Examinations of the Canadian and Australian facilities revealed no increase in drug trafficking, violence or other crimes in their vicinities following their establishment (Otter, 2012). Other studies also described a marked decrease in publicly observable indicators of drug consumption in proximity to SIFs. A study of an Australian facility reported a consistent decline in both public drug use and the improper disposal of drug paraphernalia (i.e., used syringes) within its vicinity during the survey period (KPMG, 2011). An analysis of a Spanish SIF yielded a similar conclusion. It revealed a fourfold decrease in the volume of disposed syringes in proximity to the facility during an eight-year survey period (Vecino et al., 2013).

• SIFs promote recipients' engagement in drug treatment and other health and social services. Examinations of SIFs confirm they generally adhere to a Harm Reduction model of intervention that aims to

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support recipients through various stages of change. Of the various "types" of SIFs described in the research literature the "integrated" type is the most common. An integrated SIF generally provides an array of services that may include showers and laundry facilities, counseling and testing for blood borne viral infections, needle and syringe exchange, psychosocial care, employment programs, medical services, wound care, and medication-assisted treatment, among others (Otter, 2012). Perhaps not surprisingly, recipients of such facilities often receive education, preventive care and referrals to a variety of support services designed to reduce the harm associated with drug use and to promote lasting recovery (KPMG, 2001; Milloy & Wood, 2009; Otter, 2012). The Vancouver facility is the only officially sanctioned SIF in North America and it has been subject to extensive research and evaluation since its inception in 2003. A meta-analysis of this research concluded its users were significantly more likely than non-users to enter detoxification or addiction treatment services following their engagement with the facility (Radcliffe, 2018).

SIFs remain exceedingly controversial within the United States and no officially sanctioned sites have yet emerged here. Nevertheless, a comprehensive review of an unsanctioned (i.e., "underground") site currently in operation in an urban area within the U.S. concluded it produced the same benefits as its counterparts abroad (Davidson, Lopez & Kral, 2018). Several American cities have explored the development of sanctioned sites, and San Francisco and New York have commissioned comprehensive feasibility studies to guide their deliberations. Other cities have followed suit, but many policymakers and other stakeholders fear repercussions of violating federal drug laws, especially in view of Attorney General Sessions' pledge to prosecute violations of the Controlled Substances Act. Divergent opinions and philosophies and deeply entrenched political sensibilities will surely influence the national discussion as well. In these respects, SIFs are not unlike other interventions that once challenged conventional wisdom but ultimately proved useful to the recovery movement.

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