

APA Resource Document

Resource Document on Safe Consumption Facilities

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Prepared by the Council on Psychiatry and Law and the Council on Addiction Psychiatry

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INTRODUCTION

In 2019, there were nearly 72,000 U.S. overdose deaths, a new record high. Most of these overdose deaths involved opioids, with rising involvement of fentanyl and fentanyl analogues, which are increasingly found in street heroin and other opioids and often without the knowledge of the user. Even more concerning, it appears that the coronavirus pandemic is further worsening the overdose crisis.¹ In the context of this ongoing crisis, psychiatrists must be aware of the full range of policy, organizational, and public health strategies impacting the lives of people who use drugs (PWUD). This document aims to inform psychiatrists about one such strategy: Safe Consumption Facilities (SCFs, also known as “supervised consumption sites”), an approach that has long been a feature of harm reduction efforts in certain countries and that has attracted increasing attention in the United States.

Traditionally, addiction treatment has been marginalized within general psychiatry, and there is a continuing need for psychiatrist education on this topic. A survey from 1986 found that even among psychiatrists who expressed an interest in Substance Use Disorders, almost one-third of respondents did not agree that alcohol and drug problems were psychiatric disorders.² While attitudes have improved somewhat in the interceding decades, there remain significant shortcomings in attitudes, treatment, and workforce education.³ Increasingly, psychiatrists will be called upon to become involved not only in treatment planning but also in programmatic and organizational efforts to address the overdose crisis. SCFs are one such example of a cross-cutting intervention that goes beyond obvious medical relevance to implicate legal and cultural issues. As such, in addition to a discussion of public health outcome research, this document will also give a brief cultural and legal history of SCF implementation, describe

the varieties of SCFs, and discuss some of the broader challenges in SCF implementation, including both benefits and harms.

HISTORY, IMPLEMENTATION, AND LEGAL CONTEXT OF SCFS

In the 1980s, amid various developments — the rapid emergence of a “zero-tolerance” and abstinence-only approach to drug problems, as well as the rise of crack cocaine and gun violence — repressive criminal justice reforms contributed to mass incarceration, poverty and racial disparities. It quickly became apparent that criminal justice efforts alone were not sufficient to combat, and in many ways exacerbated, drug use and drug trafficking. There was also a slowly growing acceptance among treatment professionals that many PWUD were not ready to achieve abstinence and would benefit from interventions to “meet them where they were.” An approach which has since been labeled “harm reduction” emerged from this context, with the goal of reducing the direct and indirect social and medical consequences of substance use.^{4,5}

Harm reduction has been controversial and often misunderstood from its inception, so a clarification in terms is in order. Harm reduction can be conceptualized as simply a set of practical strategies, such as peer education, naloxone distribution, drug-checking services, public health monitoring and alert systems, and syringe service programs. Generally, those strategies are oriented toward “any positive change;” seeking to reduce negative effects of drug use and improve the conditions of PWUD. But harm reduction can also be conceptualized as a philosophy and movement that seeks to shift power and resources to PWUD (and more, broadly anyone at risk of structural violence).⁶ In other words, debates about harm reduction are often confused by a certain fluidity between concrete, quantified arguments about efficacy versus broader social, political, and moral considerations. At the level of public health evidence, many if not most harm reduction interventions have robust evidence for reducing morbidity and mortality. Harm reduction is perhaps more commonly critiqued on its broader social implications, such as concerns that harm reduction interventions are “sending the wrong message” or otherwise condoning drug use.^{7, Page 178} These various meanings of harm reduction can interact and complicate the debates around implementation, which are apparent in the history of SCFs.

SCFs are “supervised facilities designed to reduce the health and public order problems associated with illegal injection drug use.”⁸ The first legally sanctioned SCF was opened in 1986 in a café in Bern, Switzerland (though before that, there had long been for-profit, illegal “shooting galleries,”

which often operated without concern for health and safety). Swiss SCFs have generally followed this model: a café, a counseling room, a clinic for medical care, and injecting rooms. Injecting rooms were small discrete sterile rooms with tables and injecting supplies. Healthcare workers provide linkage to other care, education on reducing the harms associated with injection drug use, and are available to respond to any adverse events from drug use.⁹

While there is significant variability in the structure of SCFs, as discussed below, this early example demonstrates the overarching goals of most SCFs: to reduce overdose deaths and other possible harms of drug use, to reduce the spread of infectious diseases (e.g., HIV, viral hepatitis C), to improve access to medical and social services, and to increase public safety and reduce public disorder (i.e., discarded syringes).

In the 1990s, more SCFs were established throughout Europe, and in 2001, the first Australian SCF was opened in Sydney. In 2003, Insite Vancouver, Canada, was the first SCF to open in North America. There are currently approximately 120 SCF's in operation in Europe, Australia, and Canada, operating legally in 10 countries (Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland). The Netherlands has the greatest number of SCFs at nearly 40 throughout the country. None exist in low or middle-income countries, despite a high burden of harm related to injection drug use in these countries.¹⁰ There are currently no legal SCFs in the U.S., although several cities have proposed opening sites.

In the U.S., efforts to open SCFs have been thwarted by substantial political opposition. In California, Assembly Bill 186 would have allowed San Francisco to pilot the first full-scale SCFs in the U.S. The bill passed both houses of the state legislature in August 2018 but was vetoed by the state governor after substantial national controversy, and subsequent bills appear to have stalled.^{11,12} In Philadelphia, a 2017 committee convened by the mayor as part of a response to the opioid overdose crisis recommended opening SCFs in the city. Subsequently, a nonprofit organization called Safehouse, supported by the mayor and health commissioner, began working toward this goal. In early 2019, the U.S. attorney for the Eastern District of Pennsylvania sued in federal court, arguing that Safehouse would violate the so-called "crack house" provision of the Controlled Substances Act, which states that "it shall be unlawful to...manage or control any place...for the purpose of unlawfully...using a controlled substance." U.S. District Judge Gerald McHugh initially rejected this argument in October 2019, seemingly paving the way for Safehouse to open,¹³ but community opposition then caused the plan to

be put on pause, and Judge McHugh subsequently halted Safehouse’s opening in the face of the COVID-19 pandemic and protests for social justice reform in June 2020.^{14–16}

While Safehouse’s history has been particularly contentious, it is not uncommon for SCFs to require years of work on the part of their advocates before they can open. INSITE, Vancouver’s SCF, is one such example. It was initially approved as a relatively restricted pilot study in 2003, then faced continuing legal challenges, ultimately requiring a 2011 decision from the Supreme Court of Canada to receive an operating exemption. In the meantime, and in part motivated by the condition that its effects be thoroughly evaluated, INSITE has accumulated a substantial body of public health evidence in its favor (e.g., significant reductions in overdose deaths in its immediate surroundings). INSITE has grown to offer a wide array of services, connecting PWUD to treatment services, counseling, and medical help.^{17–}

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STRUCTURE OF SCFs

There are more than 120 SCFs worldwide, but they operate across various models, with an array of additional structures, services, and focuses. The most basic functional definition of an SCF is a managed space where people can use substances hygienically and where the immediate after-effects of substance use can be monitored— primarily for risk of overdose—but beyond that basic definition, diversity is the rule.

One useful categorization of SCFs, first used in a European Union report from 2004, divides SCFs into three categories:²⁰

- “Integrated:” an SCF that also provides other health, substance use, and social services, such as showers, counseling, drug safety testing, syringe service programs, or connection to medical services such as medications for addiction treatment (MAT). Integrated SCFs are most common, as they have frequently emerged as just one component of a more comprehensive network of services, often functioning as an early entry point in a system of care for people with substance use disorders.
- “Specialized:” an SCF focused exclusively on providing consumption room services. Specialized SCFs are less common than integrated SCFs and are usually established close to drug markets with concentrated open drug scenes.

- “Informal:” SCFs that are run by PWUD; they operate either without official approval but tolerated by authorities, or by simply evading detection.

A fourth, more recent variation is the “mobile” SCF, used in settings farther away from larger population centers. For example, one SCF retrofitted recreational vehicles to bring the SCF to rural clients living in less densely populated areas. Recent studies of the mobile SCF model suggest it is a viable model for delivering SCF services to such populations. However, the service providers expressed concerns that the limited space hampers their ability to respond to overdose events and to have private conversations with clients.²¹

Of the “integrated” SCFs that provide additional services, several model elements vary across sites. Staffing is variable; one survey of 31 European SCFs found most were staffed by social workers (97%) and nurses (87%), but many also included students (42%), guards (29%), and people who formerly used drugs (23%) among their staff.²²

All SCFs can vary by entry criteria. Some facilities are “low-threshold,” with low (or no) barriers to service access, allowing drug use practices such as assisted injection and drug sharing. “Low-threshold” SCFs are often staffed by peer workers and volunteers.²³ In contrast, more formal SCFs have specific requirements for entry and restrictions on substance use, such as minimum age requirements, limits on the number of doses, and enrollment requirements (e.g., signing a contract detailing the rules of the facility).²⁴ In one survey of 33 European SCFs, 70% required signing a contract, 24% required registration with the local authorities, and 15% required clients to be residents in the vicinity of the SCF.²² SCFs also vary by inclusion and exclusion criteria. Some require clients to be already physiologically dependent on drugs. In contrast, others have exclusion criteria: not on agonist therapy (e.g. buprenorphine or methadone), not pregnant, or not intoxicated.²⁴

Integrated SCFs often provide a wide range of additional social and medical services. Some provide showers, laundry facilities, and housing (e.g., night shelter on-site). They often provide links to medical services, such as office hours with a physician or nurse. Some provide infectious disease services such as screening for viral hepatitis and HIV on site. Additional services include vocational training and other social support and case management. General harm reduction services are often provided, such as syringe service programs or drug checking, and overdose reversal through the opioid antagonist naloxone is usually available.²⁴

It is important to note that for decades, “informal” SCFs have run on an “underground” basis. For-profit “shooting galleries” have acquired a reputation for operating with little regard for users’ health and safety.⁹ On the other hand, more recent accounts of informal sites suggest that at least some are now run with more of a sense of social mission, organized around a philosophy of providing a needed service to PWUD that is not available through official channels. A recent journalistic account documented three underground spaces in Seattle, WA, all of which were “members-only,” and some had volunteers providing additional harm reduction services such as teaching safe injection practices and offering syringe service programs.²⁵ The long history of such “informal” SCFs suggest that legal prohibitions can never truly eradicate consumption sites; such prohibitions only force those efforts underground, into less regulated and less medically integrated spaces.

SCF OUTCOMES

With approximately 120 SCFs established in ten countries worldwide, there is an abundance of outcome data from many of these facilities.²⁶

1. Effect on fatal overdoses:

A geographical analysis of overdose data since the opening of INSITE, the first Vancouver SCF, demonstrated a 35% reduction in fatal overdoses in the neighborhood surrounding the site location (within 500 m [1640 ft] of the site), compared to 9.3% in the rest of the city.¹⁹ This finding is consistent with Australian data showing that following the opening of an SCF in Sydney, the number of ambulance calls for suspected opioid-related overdoses decreased by nearly 80%.²⁷ The impact of the SCF on these changes was further demonstrated by the fact that the reduction was most significant during the site’s operating hours and in the neighborhood closest to the facility.

2. Effect on risky drug-use behaviors:

Outcomes studies from the Vancouver SCF found that people who use injection drugs who used the SCF consistently engaged in fewer risky injecting behaviors compared to those who only occasionally used the facilities.²⁸ Specifically, they were found to be less likely to reuse syringes, rush the injections, or inject in public. They were also more likely to use sterile water in their injections, swab injection sites, cook or filter the drugs, and safely dispose of the used syringes.

3. Effect on access to non-mental health medical treatment services:

Qualitative data collected from people who inject drugs using the Vancouver SCF indicate that program participants reported increased use of mental health and other medical treatment services.²⁹ SCF participants found that on-site medical services and referral opportunities increased the likelihood of seeking and receiving primary care services. Further, the availability of on-site nursing services increased the likelihood that SCF participants submitted to professional assessment and care of infectious processes caused by the injections.³⁰ In that sense, the nursing oversight bridged, albeit partially, some of the gaps in access to care resulting from social and structural barriers facing people who inject drugs.

Similarly, quantitative data from the Vancouver SCF showed that program participants with infectious complications of injection drug use were more likely to be referred to hospital-based medical services.³¹ The hospital stay for participants was significantly shorter compared to non-SCF using people who inject drugs. Data from Spanish SCFs in Madrid and Barcelona demonstrated that SCF participants tended to be more socially marginalized, positive for HCV, and to report injecting more frequently at baseline than non-SCF people who inject drugs.³² Their engagement with SCF facilities, however, resulted in using sterile needles more frequently and to experience bacterial infections less frequently than people who inject drugs who did not access an SCF. Moreover, participation in an SCF was found to reduce HIV and HCV transmission.³³ In Vancouver's SCF, retrospective data analysis demonstrated that it prevented at least 35 new HIV infection cases and approximately three HIV-related fatalities annually.

4. Effect on access to mental health, including SUD treatment services:

Data from a Sydney SCF demonstrated that most SCF participants were referred to SUD treatment services and had attended an intake assessment.³⁴ This finding parallels Canadian SCF survey data showing increased rates of medically supervised withdrawal management and SUD treatment facilities among SCF participants.³⁵

Another study from Vancouver found that SCF engagement was associated with higher participation in methadone maintenance and other SUD treatment services.³⁶ Furthermore, more frequent SCF participation, such as regular contact with SCF counselors, was also associated with cessation of drug use.

5. Effects on access to psychosocial support programs:

SCF participation provides a safe haven and increases access to social services for minority populations and marginalized groups. A qualitative study of women participating in a Vancouver SCF found that SCF participation served as a refuge from violence and gendered norms associated with drug preparation and consumption practices associated with street-based drug use among women who inject drugs.³⁷ A quantitative study of at-risk youth in Vancouver similarly found that among those adolescents and young adults who engaged in frequent injection drug use, a local SCF was able to attract high-frequency young drug users who would have otherwise injected publicly, and thus it provided an alternative to the often unsanitary and rushed public injections that pose a high risk of blood-borne infections, overdose, violence, and victimization.³⁸

6. Effects on drug-related healthcare costs:

SCFs can have a significant financial impact on the surrounding communities. An economic analysis of a Vancouver SCF demonstrated annual healthcare savings of up to \$3.5 million from reduced costs associated with preventing new HIV and HCV cases and up to \$1.8 million from averted overdose deaths.^{33,39}

7. Effects on criminal behaviors:

A common concern raised by communities considering opening an SCF is that these facilities could lead to increased crime rates. Outcome studies from the Sydney SCF do not support such fears. Indeed, following the facilities' opening, the local communities did not see any increase in rates of drug trafficking, assault, or robbery.^{40,41} In fact, it appears that SCFs might have the opposite effect on communities. While the primary purpose of SUD treatment is not to reduce criminal behaviors, it is often a common and welcome side-benefit. Indeed, following the opening of the Vancouver SCF, the rates of drug-related crimes, including trafficking and injecting in public, decreased in the nearby neighborhoods.⁴² This finding is consistent with studies of the Sydney SCF, which showed SCF participation was associated with fewer drug-related crimes, fewer publicly discarded needles, and less negative public perception of persons with SUD who inject drugs.⁴³ These effects extended beyond the direct neighborhoods where SCFs were established: communities surrounding a Sydney SCF had fewer auto break-ins and theft.^{40,41}

8. Safety of injecting at an SCF:

While injecting drugs carries inherent safety risks, it appears that SCF use, by virtue of the on-site available clinical oversight, protects against some of the immediate potential consequences. We were unable to identify any documented reports of fatal drug overdoses resulting from drug use within a facility.⁴⁴

9. Effects on drug use initiation:

There is no evidence to support the claim that SCF opening is associated with increased drug use rates or the initiation of injection drug use. In fact, it appears that the majority of SCF participants did not recently initiate injection drug use. Instead, most have been injecting drugs for an average of 16 years in the community.⁴⁵ Similarly, SCF participation is associated with reductions in the numbers of publicly discarded syringes, further reducing the local communities' exposure to drug use, as demonstrated in Canadian and Spanish SCFs.^{46,47} Finally, there is no published evidence substantiating the fear that SCF opening will increase drug use, including injection drug use among youth. Most SCFs are accessible only to persons over the age of 18.

CONCLUSION: CHALLENGES AND CONSIDERATIONS

The establishment, implementation, and management of SCFs present challenges on several levels, often stretching beyond the medical sphere into legal and other domains. It is not our intention to lay out a general roadmap for implementation (other authors have already done so at greater length and with the necessary attention to their own legal and cultural contexts; see, for example, the comprehensive New York City report from 2018 cited below).⁴⁸ Rather, this section focuses on a narrower set of concerns more directly relevant to the practicing psychiatrist. Psychiatrists might encounter SCFs because of clinical practice or because of their organizational or leadership work. Psychiatrists might encounter SCFs at the individual, advocacy, or organizational levels, and they may engage with SCFs through planning, implementation, management, or treatment provision. If so, what are the most salient challenges and how best to mitigate against any possible harms?

Below, we group the challenges and considerations along several levels: clinical, legal/political, regulatory, financial, structural/environmental, and social/cultural.

Clinical

One clinical challenge for SCFs is the changing landscape of drug supply and use. SCF models were primarily designed to address the use of heroin or prescription opioids, but new trends in drug use

may present novel clinical challenges. Over the past several decades, opioid supply and use patterns have shifted from heroin to prescription opioids, back to heroin, and now to synthetic opioids consisting primarily of more potent fentanyl/fentanyl analogs. Much of the existing data on SCF impacts and outcomes were collected and reported before the widespread advent of fentanyl and fentanyl analogs, which may present a higher risk of overdose death and require higher staff support levels. Also, changing trends in substance use may require different management strategies. There are indications that benzodiazepine use, stimulant use, and fatal overdoses associated with both those substances are rising.^{49–51} Stimulant intoxication, in particular, including possible agitation and paranoia, could present unique challenges for the behavioral management of the SCF space. Clinicians involved with SCFs will have to carefully consider the local context and needs of their drug-using population.

Legal/Political Challenges

Political and policing considerations will significantly impact the management and operation of SCFs. Prior evaluations of European SCFs have emphasized the importance of obtaining local police support for these initiatives. Street-level crackdowns can displace people who use drugs away from harm reduction programs and undermine public support for SCFs. In contrast, connections and partnerships with local police can strengthen SCF operations. For example, one study of the Vancouver SCF found that coordinating efforts among police, service providers and other stakeholders helped promote the use of the SCF, including police referrals to the SCF rather than arrests.¹⁸

However, studies from Vancouver also found that approximately 5% of Vancouver residents who inject drugs were deterred from using the SCF because of police presence around the facility, which raises the question: is it possible that a client's decision to attend an SCF might make them vulnerable to arrest? The federal finding in Philadelphia's Safehouse's case was that SCFs do not violate the Controlled Substances Act. Nevertheless, an individual's possession of illicit substances would still be a crime. Any individual using an SCF to consume an illegal substance would be easily identifiable for arrest given their use of the SCF. It remains to be seen whether U.S. authorities would use SCFs as an opportunity to surveil and arrest people who use drugs. Still, there is a relevant historical analogy: in the early years of Narcotics Anonymous in the United States, undercover narcotics enforcement agents frequently surveilled those meetings, leading to an attitude of fear and distrust.^{52, (page 343)}

On a provider level, the nature of possible legal implications for working in an SCF is unclear and may depend on ongoing case law. For example, if a medical director is overseeing an SCF, might they become targets of law enforcement attention, and could their license to practice be challenged?

Regulatory Challenges

Regulations regarding licensure and permitting/use authorizations will vary widely between municipalities and states. Without local or state precedent, it can be unclear how to license such a facility and under whose supervision/responsibility the facility would lie (though syringe exchange and other existing harm reduction interventions may provide a model). Some local questions that might arise include: Do these facilities require licensure and certification as healthcare facilities? Do they require a medical director? Do they require licensed staff with a particular level of professional training?

Furthermore, from a regulatory standpoint, who would they answer to: local emergency medical service administrators, local public health agencies, the Joint Commission? Finally, there may be regulatory requirements dictating who, administratively, can own and operate the SCF. For instance, could they be independently owned and operated under business licensure, or must they be a subsidiary of an existing organization/entity? Must they be local government-administered (such as county mental health plans, as in California)?

Financial Challenges

Funding is a critical challenge faced by SCFs. Cost-benefit analyses of SCFs have demonstrated that these facilities more than make up their costs by preventing infectious diseases and deaths. For example, a 2008 study of the Vancouver SCF found a societal benefit of over \$6 million (Canadian) per year after the program costs were taken into account, translating into an average benefit-cost ratio of 5.12 to 1.³³ Nonetheless, start-up and operating costs would still need to be raised; for example, New York estimated that the annual cost for a co-located facility could be on the order of \$250,000 annually vs. \$2-3 million annually if freestanding.⁴⁸ Whether the capital needed would come from private philanthropy, local tax coffers, or state/federal grant sources is an open question. Sustainability is challenging if services and activities remain non-reimbursable through commercial insurance, Medicaid, or Medicare. Many of the existing SCFs are privately funded, which leaves these SCFs relatively financially vulnerable.

Structural/Environmental Challenges

A significant challenge for SCFs has been, and remains, site selection. SCFs require a physical location, and as was the case in Philadelphia, neighborhood and local political concerns can play a major role in feasibility. Aside from political and community opposition, zoning rules may require complex variance proceedings to allow SCF operations. Additionally, facilities may be accountable for retrofitting requirements to meet ADA or other facility space requirements to comply with the demands commensurate with the overall regulatory body. Such requirements would create additional costs that would need to be factored into planning and operation budgets.

There are additional challenges related to community education and public relations. Engaging local stakeholders in conversations regarding the advantages, disadvantages, and operations of a proposed SCF can be understandably delicate. Concerns about policing and public safety may be of particular concern to local stakeholders. For example, in New York City, extensive community outreach and education campaigns have been a cornerstone of their (ongoing) implementation plan. Again, the prior practices of syringe exchange programs and other harm reduction interventions may serve as a useful model for best practices.

A final environmental challenge relates to COVID-19 and infectious disease management. The traditional SCF has been a designated site in which individuals congregate to use substances more safely. In the era of COVID-19, such “congregated” substance use may not be safe owing to the risk of disease transmission, and it may be outright prohibited by public health or other governmental edict. On the other hand, COVID-19 has motivated some harm reduction interventions; for example, some homeless individuals have been provided with small amounts of alcohol and nicotine to encourage people with SUDs to remain in quarantine.⁵³

Social/Cultural

A common concern voiced by opponents of SCFs is whether they — and harm reduction measures in general — “send the wrong message” by condoning drug use. This is both an empirical and a normative question, in the sense that there are data on the effects of harm reduction interventions on rates of substance use and related disorders, but also that the social and cultural meaning of SCFs impinges on questions of values and community norms. Regarding empirical data, one line of loosely analogous research suggests that the legalization of cannabis for medical and recreational use has impacted perceptions of harm of cannabis use (especially in youth),⁵⁴ raising the question that SCFs might similarly communicate a harmful message about the appropriateness and safety of substance use.

On the other hand, as noted above, research on SCFs has failed to find any association between SCFs and increased rates of drug use or drug injecting initiation. Instead, such research has found reductions in the local community's exposure to drug use, such as fewer publicly discarded syringes.

Regarding the normative questions, there has been a longstanding tension between harm reduction and abstinence-only forms of treatment.^{7, page 295} This tension has been portrayed as a fundamental philosophical conflict regarding the proper goals of care and the best form of recovery from substance use disorders. On one level, the conflict seems obvious in the case of SCFs—clearly, these are not abstinence-based interventions. However, in recent years, scholars have noted that—at least in some quarters—there has been a relative easing of social tensions between these supposedly diametrically opposed viewpoints. An alternative perspective has arisen that aims to provide “recovery support services” that are not fully abstinence-based, with harm reduction services provided as just one facet of a holistic and pragmatic approach to recovery. For instance, one such example is Pennsylvania’s RASE Project, which employs peers in long-term recovery who are dedicated to a “drug-free lifestyle,” but which also provides medications for addiction treatment and peer education on harm reduction measures. In this view, harm reduction need not be in conflict with recovery as such. Whether SCFs can be seen in this framework in the U.S. is an open question.

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