HARM REDUCTION SERVICES IN SAN FRANCISCO

ISSUE BRIEF

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SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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TABLE OF CONTENTS

ACRYONYMS

ARCHES	Applied Research, Community Health Epidemiology & Surveillance
CDC	Centers for Disease Control and Prevention
CSA	Controlled Substance Act
DCR	Drug Consumption Rooms
DOPE	Drug Overdose Prevention and Education
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
MSM	Males who have Sex with Males
NHBS	National HIV Behavioral Surveillance
PWID	People Who Inject Drugs
SFDPH	San Francisco Department of Health
SCF	Safe Consumption Facilities
SCS	Supervised Consumption Services
SIF	Supervised Injection Facilities
SIS	Safe Injection Services
US	United States
USC	Unites States Code (USC)

HARM REDUCTION SERVICES IN SAN FRANCISCO

SECTION I: FRAMING THE ISSUE

There are an estimated 22,500 people who inject drugs (PWID) in San Francisco. Between 2006 and 2014, opioid overdose deaths in San Francisco remained relatively constant at between 110 to 120 per year. In 2015, saw a decline with 98 deaths due to opioids (prescription and heroin) and 81 deaths due to stimulants. Approximately 69 percent of PWID report living on the street, using homeless shelters or living in single room occupancy (SRO) hotels. The lack of stable housing opportunities has increased the public consumption of drugs and increased the nuisance of publicly discarded syringes.

Part of the continuum of harm reduction services for PWID, safe injection services (SIS) allow individuals to inject illicit drugs in a hygienic environment under the supervision of trained staff and have opportunities to engage in other health and social services. In April 2017, the Board of Supervisors passed resolution #123-17, introduced by Board President London Breed, urging the San Francisco Department of Public Health (SFDPH) to convene a Safe Injection Services (SIS) Task Force to make recommendations to the Mayor, the Board of Supervisors, and City departments regarding the potential opportunities and obstacles associated with safe injection facilities, the community need for such facilities, and the feasibility of opening and operating such facilities.

SECTION II: INFORMATION ON PEOPLE WHO INJECT DRUGS IN SAN FRANCISCO

DEMOGRAPHICS & GEOGRAPHY

SFDPH estimates the local population of PWID at approximately 22,500 individuals. In 2015, the majority of PWID were male (71.4%), ages 41-60 (55.1%), homeless (68.6%), and primarily injecting heroin (49.5%) and methamphetamine (33.8%) The population most often resided in Tenderloin (31%), South of Market (24%), Mission (9%), and Bayview-Hunters Point (8%) neighborhoods.

SECTION III: PUBLIC HEALTH CONCERNS AMONG PWID

PWID have multiple health needs that must be addressed in order to support their health and well-being, including how the use of drugs can lead to substance use disorder, transmission and acquisition to blood borne pathogens, exposure to communicable diseases and other unsanitary conditions, and overdose death.

SUBSTANCE USE DISORDER

Substance use disorder is a medical disorder that is: a primary, chronic disease of brain reward, motivation, memory and related circuitry; reflected in an individual pathologically; pursuing reward and/or relief by substance use and other behaviors; characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response; and often characterized by cycles of relapse and remission.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

In San Francisco, PWID and PWID who are homeless: account for 21 percent of people living with HIV; report injecting drugs (8.1%) in the prior 12 months among patients receiving HIV care; are less likely to be virally suppressed and more likely to transmit HIV; and have the lowest five-year survival rate of those living with HIV.

HEPATITIS C VIRUS (HCV)

In San Francisco, there are an estimated 23,000 residents with antibodies to HCV, and, approximately, 70 percent of active HCV infections are among PWID.

OVERDOSE

Recently in San Francisco, deaths due to heroin and methamphetamine have been increasing, and the largest percentage of deaths (approximately 33%) occurred in Tenderloin and South of Market. Most deaths occurred in single room occupancy hotel units where people tend to use in isolated settings.

SECTION IV: HARM REDUCTION IN SAN FRANCISCO

San Francisco's continuum of substance use disorder services are based on the principles of harm reduction. Harm reduction is a public health philosophy that promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors that impact individuals and their community. Harm reduction methods are free of judgment and directly involve clients in setting their own health goals.

The City formally sanctioned syringe access in 1993, and began funding programs as an essential structural component of HIV prevention services. A local study showed that San Francisco syringe programs reduced drug use and drug-related harms without increasing drug use among PWIDs. Additional studies have also found use of syringe services to be associated with reduced syringe sharing and other injection-related risk reduction behaviors.

Today, methadone and buprenorphine (medication-assisted treatment for opioid addiction) are available on demand for people who want to stabilize their illness. Additionally, the Homeless Outreach Team has embedded street medicine specialists who initiate medication-assisted treatment and treat abscesses and injection wounds. All of these programs provide linkages to medical care and treatment services. In 2003, San Francisco was the first city in the US to make Naloxone readily available to members of the public. This service has drastically reduced the number of overdose deaths from injection drug use, and 2016 saw 877 reported reversals of overdoses.

SECTION V: ABOUT SAFE INJECTION SERVICES

BACKGROUND

Safe injection services are a part of the continuum of harm reduction services that were developed to promote safer drug injection practices, enhance health-related behaviors among PWID, and connect PWID with external health and social services. Globally, these facilities are professionally supervised facilities where drug users can consume drugs in safer conditions.

SAFE INJECTION SERVICES AROUND THE WORLD

Data are available on 10 countries that provide SIS:

- Five countries (Spain, Switzerland, Germany, the Netherlands, and Denmark) reported having multiple locations (ranging from five to 37) with varying services at each. Spain and Denmark each reported having one mobile drug consumption room in addition to fixed sites.
- Five countries (Australia, Canada, Luxemburg, Norway, and France) reported having only one location. Australia, Luxemburg, and Norway restrict eligibility to person 18 years or older. All five are in fixed locations using an integrated model with a mix of services and linkages to other community services.

In January 2017, officials in Seattle and King County, Washington approved opening safe consumption facilities sites in their jurisdiction and developed a document entitled *Safe Consumption Facilities: Evidence and Models*. The document reviews three different services delivery models (integrated, specialized, and mobile) that differ in staffing, size, and organizational structure with features and staffing levels based on local circumstances.

SECTION VI: POTENTIAL BENEFITS AND RISKS OF SAFE INJECTION SERVICES

BENEFITS

Studies indicate that SIS are associated with an array of benefits, including: attracting the most marginalized PWID; promoting safer injection conditions; enhancing access to primary health care and other services; reducing the overdose frequency; reducing public drug injections; and reducing dropped syringes and hazardous litter

SIS are not found to increase drug injection, drug trafficking, or crime in the surrounding environments. Implementing SIS would not necessarily require any significant or fundamental changes in public policy or law. Additionally, they require the same working agreements with social service providers and the police that needle exchange, street-outreach, drug treatment and similar health programs for injectors already receive.

COST BENEFIT

In 2017, Amos Irwin and colleagues published an article titled *A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA*. At an estimated cost of $2.6 million annually to operate a facility based on the Vancouver program InSITE, the researchers found that each dollar spent on SIS would generate $2.33 in savings, for total annual net savings of $3.5 million for a single 13-booth SIS site. They further found that a SIS site in San Francisco would not only be a cost-effective intervention but also a significant boost to the public health system.

RISKS

Federal and State Controlled Substances Laws

Currently, the possession of controlled substances, without the prescription of a licensed health professional, is prohibited by both state and federal law, in addition to prohibitions on building owners and operators from allowing the manufacturing, storing, or distributing controlled substances. On May 12, 2017, Attorney General Jeff Sessions directed all federal prosecutors to pursue the maximum penalties under the law for all crimes, including mandatory minimum sentences.

Government Contracting Requirements

Another risk is the standard boiler plate language used in federal, state and local funding agreements where contractors and subcontractors agree to maintain a drug free work place.

SECTION VII: CONSIDERATIONS FOR SAN FRANCISCO REGARDING SAFE INJECTION SERVICES

LOCATION

A key consideration for implementing SIS is identifying locations where PWID already access services. Research conducted in San Francisco in 2008 found that 85 percent of study participants reported they would use SIS if they were convenient for them. Focusing on existing locations already serving PWID increases the likelihood that PWID will use SIS. The survey further found that nearly three-quarters of respondents (72%) would be willing to walk up to 20 minutes to a SIS site.

COMMUNITY

Engagement of the communities surrounding any proposed SIS location will be critical. One study that conducted in-depth interviews with 20 sampled stakeholders found concern about the implementation of SIS, including how they would impact a community struggling with safety and cleanliness, and the efficacy of harm reduction strategies to address drug use. Still, they were open to dialogue about how a SIS site might support neighborhood goals; and they stressed the importance of respect and collaboration between stakeholders and those potentially implementing SIS.

PROGRAM DESIGN

The programmatic design of any contemplated SIS location would need to ensure acceptability by and support of PWID. Identifying locations where PWID are already being served, as noted above, is one key element of program design. Additionally, the presence of other onsite support services, the accessibility of services, and the structure of the rules governing the program would also be critical.

LEGAL

It will be important for any proposed SIS provider to fully understand the associated legal risks.

SECTION I

FRAMING THE ISSUE

There are an estimated 22,500 people who inject drugs (PWID) in San Francisco. Between 2006 and 2014, opioid overdose deaths in San Francisco remained relatively constant at around 110 to 120 per year. In 2015, the City saw a decline with 98 deaths due to opioids (prescription and heroin) and 81 deaths due to stimulants. Approximately 69 percent of PWID report living on the street, using homeless shelters or living in single room occupancy (SRO) hotels. The lack of stable housing opportunities has increased the public consumption of drugs and increased the nuisance of publicly discarded syringes.

Part of the continuum of harm reduction services for PWID, safe injection services (SIS) allow individuals to inject illicit drugs in a hygienic environment under the supervision of trained staff and have opportunities to engage in other health and social services. In April 2017, the Board of Supervisors passed resolution #123-17, introduced by Board President London Breed, urging the San Francisco Department of Public Health (SFDPH) to convene a Safe Injection Services (SIS) Task Force to make recommendations to the Mayor, the Board of Supervisors, and City departments regarding the potential opportunities and obstacles associated with safe injection facilities, the community need for such facilities, and the feasibility of opening and operating such facilities. The resolution requested that the report included the following information:

1. Information on individuals who inject drugs in San Francisco;
2. Information on supervised injection services in other jurisdictions, including program models, effectiveness, and outcomes;
3. Potential risks and benefits of supervised injections services;
4. Considerations for San Francisco regarding supervised injection services, including legal, community, and operational; and
5. Policy recommendations for consideration.

This report has been compiled in response to this request. The health department recognized that nationally and globally there are many reports and articles that have reviewed these key considerations. This report draws on this expertise and is a summary of key findings that San Francisco can use to have a deliberative dialogue regarding this topic.

SECTION II

INFORMATION ON PEOPLE WHO INJECT DRUGS IN SAN FRANCISCO

DEMOGRAPHICS

SFDPH estimates the local population of PWID at approximately 22,500 individuals.[1] Using data from National HIV Behavioral Surveillance (NHBS), which conducts interviews with PWID due to their increased risk for HIV, Table 1 provides data on PWID in San Francisco. In **2015, the majority of PWID were male (71.4%), ages 41-60 (55.1%), homeless (68.6%) and primarily injected heroin (49.5%) and methamphetamine (33.8%).**

TABLE 1: DEMOGRAPHICS AND OTHER DATA ON PEOPLE WHO INJECT DRUGS, NATIONAL HIV BEHAVIORAL SURVEILLANCE, SAN FRANCISCO, 2005-2015

	2005 n = 565 N (%)	**2009** n = 535 N (%)	**2012** n = 570 N (%)	**2015** n =479 N (%)
Age				
<=20	2 (0.4)	0 (0.0)	3 (0.5)	1 (0.2)
21-30	29 (5.1)	37 (6.9)	38 (6.7)	62 (12.9)
31-40	126 (22.3)	88 (16.5)	74 (13.0)	103 (21.5)
41-50	224 (39.7)	182 (34.0)	184 (32.3)	118 (24.6)
51-60	157 (27.8)	191 (35.7)	215 (37.7)	146 (30.5)
61-70	26 (4.6)	35 (6.5)	56 (9.8)	45 (9.4)
70+	1 (0.2)	2 (0.4)	0 (0.0)	2 (0.4)
Gender				
Male	411 (72.7)	355 (66.4)	396 (69.5)	342 (71.4)
Female	142 (25.1)	165 (30.8)	166 (29.1)	131 (27.4)
Other	12 (2.1)	15 (2.8)	8 (1.4)	6 (1.3)
Race/Ethnicity				
White	231 (40.9)	227 (42.4)	207 (36.3)	226 (41.2)
Black	191 (33.81)	170 (31.8)	229 (40.2)	131 (27.4)
Latino	58 (10.3)	74 (13.8)	45 (7.9)	66 (13.8)
Mixed/other	85 (15.0)	64 (12.0)	89 (15.6)	56 (11.7)
Education				
Never attended school	2 (0.4)	1 (0.2)	1 (0.2)	0
Grades 1 through 8	34 (6.0)	18 (3.4)	23 (4.4)	20 (4.2)
Grades 9 through 11	128 (22.7)	112 (20.9)	117 (20.5)	96 (20.1)
Grade 12 or GED	242 (42.8)	219 (40.9)	222 (39.0)	187 (39.1)
Some College	130 (23.0)	152 (28.4)	170 (29.8)	152 (31.8)
College	20 (3.5)	27 (5.1)	25 (4.4)	12 (2.5)
Post-Graduate	9 (1.6)	6 (1.1)	12 (2.1)	11 (2.3)
Income				
$0 – 9,999	426 (75.4)	265 (49.5)	229 (40.2)	195 (40.8)
$10,000 – 29,999	109 (19.3)	236 (44.1)	286 (50.2)	234 (48.9)
$30,000 – 49,999	13 (2.3)	25 (4.7)	29 (5.1)	17 (3.5)
$50,000 – 74,999	6 (1.1)	6 (1.1)	15 (2.6)	10 (2.1)
$75,000+	4 (0.7)	3 (0.6)	9 (1.6)	8 (1.7)

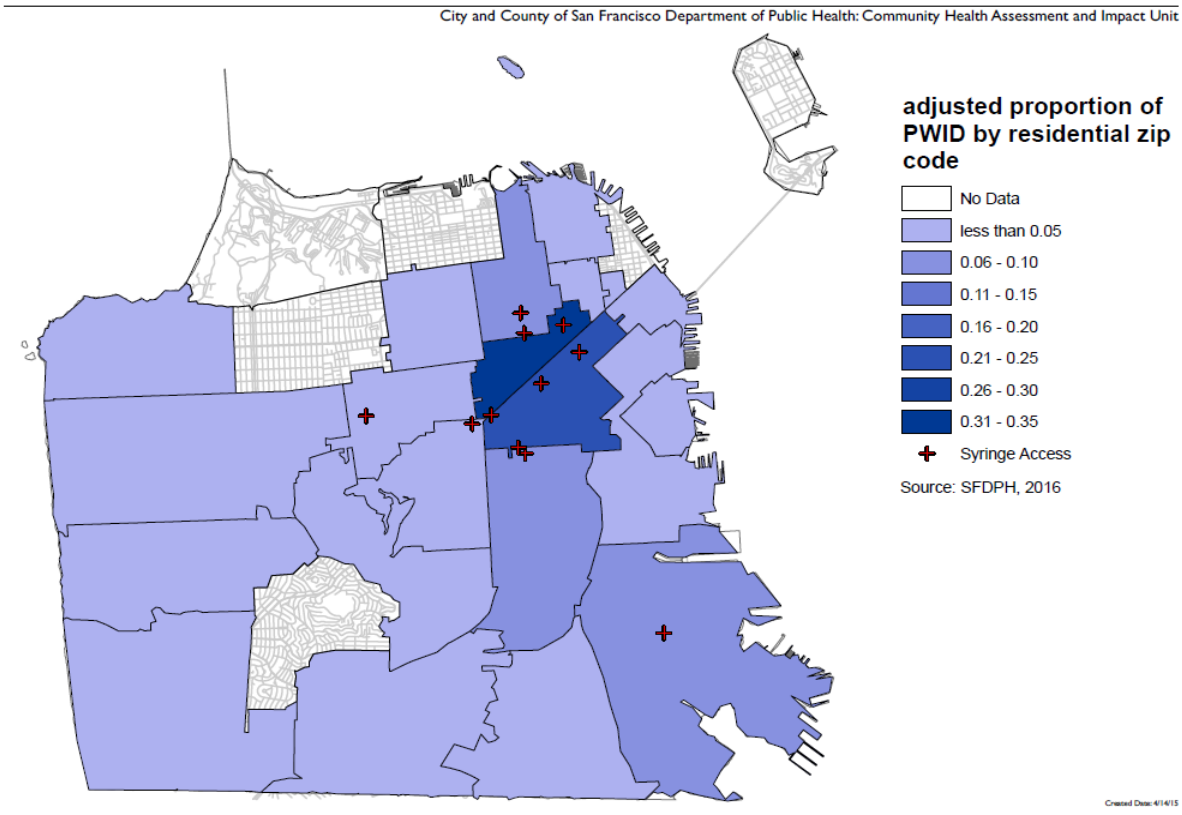
TABLE 1: DEMOGRAPHICS AND OTHER DATA ON PEOPLE WHO INJECT DRUGS, NATIONAL HIV BEHAVIORAL SURVEILLANCE, SAN FRANCISCO, 2005-2015				
	2005 n = 565 N (%)	**2009** n = 535 N (%)	**2012** n = 570 N (%)	**2015** n =479 N (%)
Currently homeless	319 (56.5)	299 (55.9)	345 (60.5)	327 (68.6)
Primary drug injected**				
Heroin	427 (75.6)	379 (70.8)	350 (61.4)	237 (49.5)
Cocaine	148 (26.2)	9 (1.7)	10 (1.8)	1 (0.2)
Speedball	202 (35.8)	27 (5.1)	37 (6.5)	37 (7.7)
Crack	46 (8.1)	1 (0.2)	2 (0.4)	2 (0.4)
Methamphetamine	260 (46.0)	103 (19.3)	157 (27.5)	162 (33.8)
Other	38 (6.7)	16 (3.0)	14 (2.5)	40 (8.3)

***Drug injected was asked as "check all" for 2005 and only "primary drug" for 2009/2012/2015.*

GEOGRAPHIC LOCATION

The NBHS data also show that PWID reside primarily in the **94102 (31%) and 94103 (24%)** zip codes. The next highest zip codes are 94110 at 9 percent followed by 94124 at 8 percent. Figure 1 shows the estimated percent of population size by San Francisco zip codes.

FIGURE 1: IDU POPULATION SIZE (2015)



SECTION III

PUBLIC HEALTH CONCERNS AMONG PEOPLE WHO INJECT DRUGS

PWID have multiple health needs that must be addressed in order to support their health and well-being. There are several health issues that are a particular concern to public health, including how the use of drugs can lead to substance use disorder, transmission and acquisition of blood borne pathogens, and deaths due to overdoses.

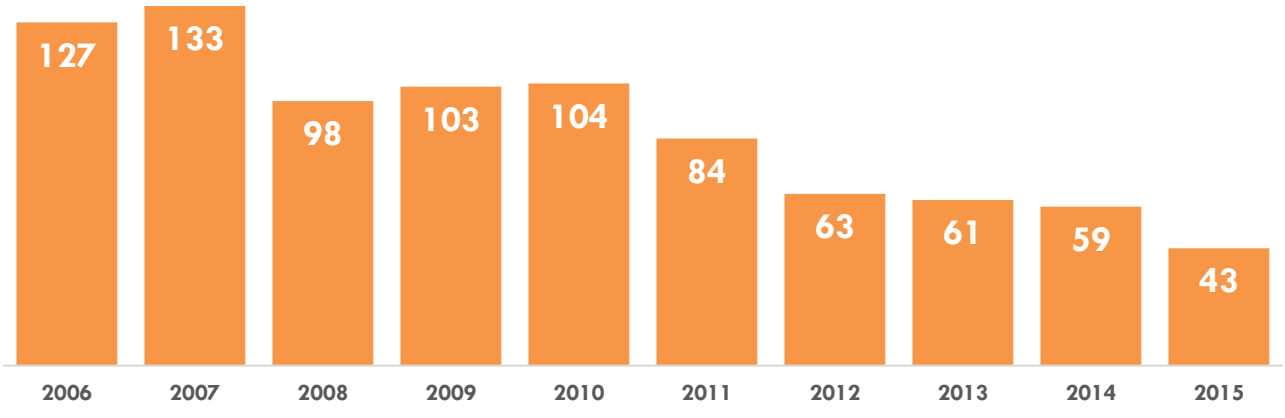
SUBSTANCE USE DISORDER

It is important to note that substance use disorders are a medical disorder. "Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."[2] Injecting drugs on the streets is also harmful to PWID due to the potential exposure to communicable diseases and other unsanitary conditions.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

People who inject drugs account for 21 percent of people living with HIV in San Francisco. Overall, both diagnoses of HIV infection and HIV related deaths in San Francisco have seen major decreases. Figure 2 shows the trend in PWID newly diagnosed with HIV infection from 2006-2015.[3] Data for the Medical Monitoring Project found that among patients receiving HIV care, 8.1 percent reported injecting drugs in the prior 12 months. Among both newly diagnosed people

FIGURE 2: PWID YEAR OF INITIAL HIV DIAGNOSIS



and people already living with HIV, PWID are less likely to be virally suppressed than the overall populations living with HIV. Viral suppression reduces the likelihood of HIV transmission.

Despite overall declines in the number of newly diagnosed HIV infections among PWID, people newly diagnosed with HIV who are also homeless in San Francisco are much more likely to be PWID. In 2015, SFDPH reported that PWID have the lowest viral suppression among living people living with the virus. PWID also have the lowest five-year survival out of all others living with HIV, 83 percent compared to 93 percent among men who have sex with men (MSM) who do not inject drugs.[4]

HEPATITIS C VIRUS (HCV)

The Hepatitis C Virus (HCV) is also a major public health concern in San Francisco. Until recently, limited epidemiological data has inhibited the health department's ability to understand the local epidemic. Mandated laboratory reporting of HCV began in July 2007, and, since then, more than 16,000 people with past or present HCV infections have been reported to the SFDPH. However, HCV transmission risk is not yet reportable, highlighting a need to better understand how HCV is transmitted through communities in San Francisco. End Hep C SF is a multi-sector collective impact initiative aiming to eliminate the virus in San Francisco. End Hep C SF estimates that there are 23,000 residents who have antibodies to HCV and that approximately 70 percent of active HCV infections are among PWID.[5]

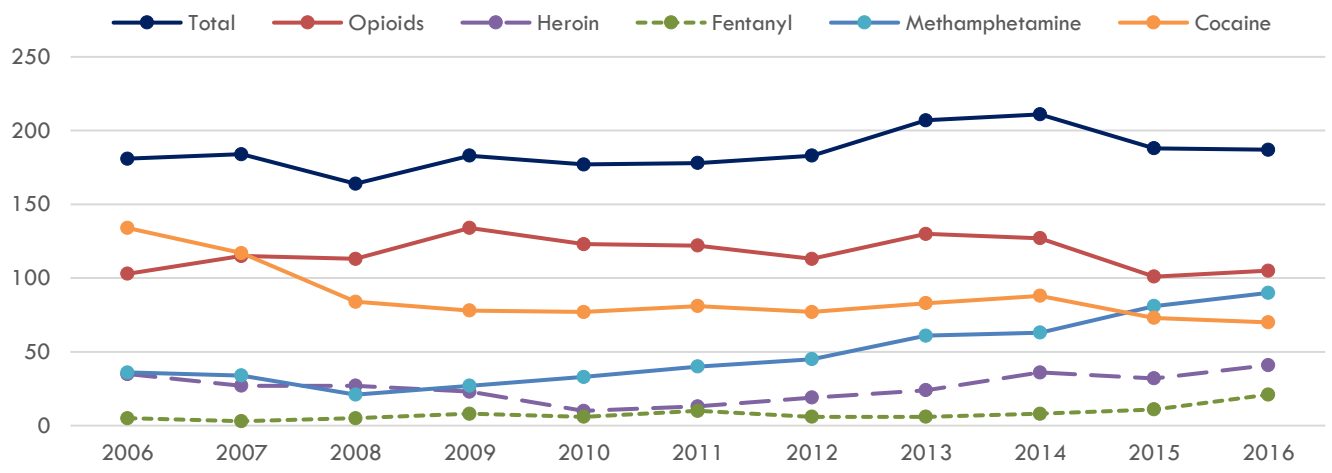
OVERDOSE

While drug injection is a known risk factor for opioid overdose, and most opioid overdose deaths are believed to involve injection of the causal drug, mortality data does not easily establish the role of injection in a death. From 2006-2012, a review of medical examiner records shows that at least 42 percent of opioid deaths during this period were due to heroin, had evidence of drug injection on the scene, or occurred among persons with a history of heroin use or drug injection.

Following a substantial reduction in opioid overdose mortality in the early 2000s, overdose deaths from opioids and stimulants in San Francisco have been fairly stable since 2006 (range 164-207 per year). In more recent years, the number of deaths due to opioid analgesics has been declining, while deaths due to heroin have been increasing (to 41 in 2016); there has also been a more recent increase in fentanyl deaths.[6] Deaths due to methamphetamine have increased substantially during this time, whereas deaths due to cocaine have slowly declined. Figure 3 shows the number of drug overdose deaths by drug type over the last decade.[7]

Among 1,758 unintentional opioid or stimulant deaths from 2005-2015 that had geographic information regarding place of death, the largest percentage of deaths (approximately 33%) occurred in the Tenderloin and South of Market, and most of these occurred in single room occupancy hotel units where people tend to use in isolated settings.

FIGURE 3: DRUG OVERDOSE DEATHS IN SAN FRANCISCO (2006-2016)



SECTION IV

HARM REDUCTION IN SAN FRANCISCO

San Francisco's continuum of substance use disorder services are based on the principles of harm reduction. Harm reduction is a public health philosophy that promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors that impact individuals and their community. Harm reduction methods and treatment goals are free of judgment or blame and directly involve clients in setting their own health goals.

GUIDING PRINCIPLES OF HARM REDUCTION SERVICES

- Clients are responsive to culturally competent, non-judgmental services, delivered in a manner that demonstrates respect for individual dignity, personal strength, and self-determination.
- Service providers are responsible to the wider community for delivering interventions which attempt to reduce the economic, social, and physical consequences of drug- and alcohol-related harm and harms associated with other behaviors or practices that put individuals at risk.
- Because those engaged in unsafe health practices are often difficult to reach through traditional service venues, the service continuum must seek creative opportunities and develop new strategies to engage, motivate, and intervene with potential clients.
- Comprehensive treatments need to include strategies that reduce harm for those clients who are unable or unwilling to modify their unsafe behavior.
- Relapse or periods of return to unsafe health practices should not be equated with or conceptualized as "failure of treatment".
- Each program within a system of comprehensive services can be strengthened by working collaboratively with other programs in the system.
- People change in incremental ways and must be offered a range of treatment outcomes in a continuum of care, from reducing unsafe practices to abstaining from dangerous behavior.

SYRINGE ACCESS

The City and County of San Francisco formally sanctioned syringe access in 1993, when Mayor Frank Jordan declared a public health state of emergency. This gave Mayor Jordan the power to legalize syringe programs, and the City began funding programs as an essential structural component of HIV prevention services. Cities that were early adopters of syringe access had significantly lower rates of HIV infection among PWID than cities that did not address this health need.[8] Local progress and advancements in polices for syringe access have resulted in California and the federal government allowing funds to be used for costs associated with operating a syringe services without having to declare a state of emergency.

A San Francisco study showed that from December 1986 through June 1992, San Francisco syringe programs reduced drug use and drug-related harms. Injection frequency among PWIDs in the community decreased from 1.9 injections per day to 0.7, and the percentage of new individuals initiating injection drug use decreased from 3 percent to 1 percent.[9] Moreover, this same study found that the syringe

access services did not increase drug use among PWID. Additional studies have also found use of syringe services to be associated with reduced syringe sharing and other injection-related risk reduction behaviors.[10,11]

The California legislature has also removed barriers to the purchasing of sterile syringes in pharmacies in the state. In 2004, SB 1159 (Vasconcellos), was passed establishing a five-year pilot program in select counties to allow pharmacies, when authorized by a local government, to sell up to 10 syringes to adults without a prescription. In 2011, the passage of SB 41 (Yee), authorized a county or city to allow licensed pharmacist across the entire state to sell or furnish 10 or fewer hypodermic needles or syringes to a person 18 or older without a prescription. Assembly Bill 1743 (Ting) further expanded this in 2014 to allow for unlimited number of syringes that could be purchased without a prescription.

TREATMENT ON DEMAND

In 1997, SFDPH launched its *Treatment on Demand* initiative to increase the availability of publicly-funded substance use disorder treatment, including medication-assisted treatment. Medication-assisted treatment is a harm reduction approach that combines behavioral therapy and medications to treat substance use disorders.[12] Methadone and buprenorphine are two of the main drugs used for opioid detoxification and to treat heroin dependence. Methadone treatment lasts a minimum of 12 months and must be dispensed by a SAMHSA-certified opioid treatment program.[13] It is taken orally and relieves withdrawal, blocks cravings, and prevents euphoria if other opioids are used.[14] Buprenorphine treatment occurs in three phases (Induction, Stabilization, and Maintenance) and can be prescribed or dispensed in a physician's office. It is a daily tablet that relieves withdrawal symptoms, decreases cravings, and also prevents euphoria if other opioids are used.[15, 16]

Today, methadone and buprenorphine are a part of the City's medication assisted treatment for opioid addiction, and are available on-demand for people who want to stabilize their illness. Additionally, the City's Homeless Outreach Team has embedded street medicine specialists who initiate medication-assisted treatment and treat abscesses and injection wounds. All of these programs provide linkages to medical care and treatment services.

NALOXONE

In 2003, San Francisco became the first city in the US to use public funds to make Naloxone, a medication designed to rapidly reverse opioid overdose, readily available to members of the public, drastically reducing the number of overdose deaths from injection drug use. These efforts began with the leadership of the Harm Reduction Coalition's Drug Overdose Prevention and Education (DOPE) Project. In December 2001, the DOPE Project began piloting training of community and government partners on the recognition, management, response, and prevention of overdoses. In 2003, with the results of the successful pilot, SFDPH expanded this training and also began to provide prescriptions for Naloxone.

In 2008, the California legislature also began to remove the policy limitations on the prescriptions of opioid antagonists. Since then, several bills have been passed to expand access to the drugs used to reverse an overdose as well as who can legally administer the opioid antidote. Due to the widespread availability of Naloxone, in 2016, there were 877 reported reversals of overdoses by drug users who have been trained by community partners in San Francisco.

SECTION V

ABOUT SAFE INJECTION SERVICES

BACKGROUND

Safe injection services, part of the continuum of harm reduction services, were developed to promote safer drug injection practices, enhance health-related behaviors among PWID, and connect PWID with external health and social services. Globally, different terms are used to describe the facilities that provide safe injection services: Supervised Injection Facilities (SIFs), Safe Consumption Facilities (SCFs), Drug Consumption Rooms (DCRs), and Supervised Consumption Services (SCS). According to the European Monitoring Centre for Drugs and Drug Addiction, these facilities are "professionally supervised facilities where drug users can consume drugs in safer conditions. They seek to attract hard-to-reach populations of drug users, especially marginalized groups and those who use drugs on the streets or in other risky and unhygienic conditions. One of their primary goals is to reduce morbidity and mortality by providing a safe environment for more hygienic drug use and by training clients in safer drug use. At the same time, they seek to reduce drug use in public and improve public amenity in areas surrounding urban drug markets. A further aim is to promote access to social, health and drug treatment facilities."[17]

SAFE INJECTION SERVICES AROUND THE WORLD

Data are available on 10 countries that provide SIS.

1) Eight countries (Netherlands, Germany, Spain, Switzerland, Denmark, Canada, France, and Norway) reported having multiple locations (ranging from two to 31) with varying services at each.[18] Spain and Denmark each reported having one mobile drug consumption room in addition to fixed sites. Norway and Switzerland reported restricting eligibility to person 18 years or older, while Spain and the Netherlands reported that eligibility differed based on the location.

   In recent years, the Netherlands, Switzerland, and Spain have closed drug consumption rooms either due to cost, or as a result of reductions in drug use and the associated need for these services.[19]

2) Two countries (Australia and Luxemburg) reported having only one location.[20] These countries restrict eligibility to person 18 years or older. All are in fixed locations using an integrated model with a mix of services and linkages to other community services.

Australia, Canada, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland

In 2012 the International Drug Policy Consortium released a briefing paper entitled *Drug consumption rooms. Evidence and practice.*[21] The data for the report were provided by staff from each of the safe injection services sites around the world. They noted that Australia, Canada, Luxembourg, the Netherlands, Norway, and Spain were able to provide country-wide data for the report. For Germany and Switzerland, only regional or local data were available. The report provides a profile of each of the eight countries featured.

Table 3 is adapted from the report with the updated number of locations in each country through June 2017 based on the most recent available data. The table also provides a summary of the report's findings.

TABLE 3: WORLD OVERVIEW OF DRUG CONSUMPTION ROOMS				
COUNTRY	**DCR**	**ELIGIBILITY & SERVICES**	**CLIENT PROFILES**	**RESULTS**
Australia	**Location** • 1 in Sydney **Staff** • 1 in injecting room • Training: At least 1 nurse, 3 officers with health training	**Eligibility** • 18 years and over • Already drug dependent • Not pregnant nor with child • Not intoxicated • No dealing of drugs on premises **Services** • Stage 1: Waiting room/assessment area • Stage 2: Injecting room with 8 booths • Stage 3: After care room • Resuscitation room • Links to health, legal, housing, welfare services	• 12,050 clients between May 2001 and April 2010 • 3 new clients a day on average • 74% men / 26% women • 33 years of age on average • 13 years of average time injecting **Principal substances used** • Drop in heroin use (40% in 2005) • Increase in other opioid use (60% in 2012) • Decline in cocaine use (15% in 2012) • 10% methamphetamines • 1-2% buprenorphine	• Cost-effective • Contacts vulnerable groups – • 9,500 referrals to health and social welfare services • 4,400 overdose interventions (no fatalities) • Reduced risk of blood-borne virus transmission • Reduced public injecting and injection-related litter • No adverse impact on local community (e.g. increase in drug-related crime in area)
Canada	**Location** • 2 in Vancouver called 'InSITE' • 3 in Montreal[22] **Staff** • 9 staff • Training: nurses, program workers (PHS), peer support workers	**Eligibility** • No admission criteria **Services** • Low-threshold, anonymous service with 12 drug consumption booths • Supply of clean injection equipment • Safer use counselling • Primary healthcare services • Voluntary detox (Onsite) • Links to longer-term drug dependence treatment programs • Links to housing and community support	• 1.8 million visitors since 2003 Between 1st Jan 2010- 31st Dec 2010: • 312,214 visits by 12,236 clients • 855 average daily visits • 587 average daily injections • 74% men / 26% women • 17% identified as Aboriginal **Principal substances used** • 36% heroin • 32% cocaine • 12% morphine	• 221 overdose interventions (no fatalities) • 3.383 clinical treatment interventions • 5,268 referrals to other social and health services • 458 admissions to Onsite detox program (completion rate in 2010: 43%) • Reduced risk of blood-borne virus transmission • Reduced public injecting and injecting-related litter • No adverse impact on local community

TABLE 3: WORLD OVERVIEW OF DRUG CONSUMPTION ROOMS				
COUNTRY	**DCR**	**ELIGIBILITY & SERVICES**	**CLIENT PROFILES**	**RESULTS**
Germany	**Location** • 24 in 15 cities country-wide **Staff** • Number of staff variable according to size of DCR and financial constraints • Training: Doctors, nurses, educators, qualified student assistants and freelancers	**Eligibility** • Age eligibility varies according to state regulation • Already drug dependent • Not under OST (except in Hamburg) • Not intoxicated **Services** • DCRs integrated with harm reduction facilities • Open between 3.5 and 12 hours a day • 3 to 20 drug consumption booths • Links to medical and social services	• In Frankfurt from 2003 to 2009: Up to 4,700 visitors per year • 26-35 years of age on average • 85% men / 15% women **Principal substances used** • 82% heroin • 36% crack	• Since 1994, no drug-related deaths recorded in Germany Increased client awareness of safer use techniques • Less drug-related health problems (e.g. fewer abscesses) • Data from North Rhine Westphalia (2001-2009): 3,271 drug emergency cases 710 CPRs
Luxembourg	**Location** • 1 in the City of Luxembourg called 'Abrigado' **Staff** • 23 multilingual staff • Training: Medical staff, psychologists social workers, educators, sociologists	**Eligibility** • 18 years and over • Already drug dependent • Not under OST • Not pregnant or with child • Not intoxicated • No dealing of drugs on premises • Sign a 'terms of use' contract **Services** • Integrated in low-threshold center with 7 injection booths • Pilot project 'Blow room' with 3 inhalation booths • Open 6 days a week, 6h a day) • Night shelter (42 beds) and nursery Drop-in center (Kontakt Café) with primary medical care • On-site HIV/hepatitis C testing • Needle exchange Program • Safer use counselling	• 170,000 supervised drug consumptions (since 2005) • 26,929 visits to DCR in 2011 • 207 average visitors per day (Kontact Café) • 96 average visitors per day (DCR) • 25-34 years of age on average 80% men / 20% women **Principal substances used** • 87% heroin • 8% cocaine • 5% mixtures	• 1,025 overdoses successfully managed (no fatalities) • General decrease in overdose deaths and proportion of people who inject drugs in newly diagnosed HIV infection cases since the opening of the DCR Citizens hotline established to encourage public acceptance of DCR • A few complaints from neighboring communities recorded

TABLE 3: WORLD OVERVIEW OF DRUG CONSUMPTION ROOMS				
COUNTRY	**DCR**	**ELIGIBILITY & SERVICES**	**CLIENT PROFILES**	**RESULTS**
The Netherlands	**Location** • 31 in 25 cities country-wide **Staff** • 3 staff members • Training: Medical staff, social workers, former drug users, security staff	**Eligibility** • Registered in city where DCR is located • Sign a 'terms of use' contract • No dealing of drugs on premises • Different admission criteria according to each DCR **Services** • 5 'stand-alone' DCRs, others are integrated within low-threshold services • Separate rooms for injectors and smokers • 15 booths for smokers, 5 for injectors • Medical • safer use counselling	• 24 clients per day on average • 90% clients are non-injectors • 45 years of age on average • 90% men / 10% women **Principal Substances used** • Heroin • Crack/coke base	• Decrease in needle sharing Only 4% of new diagnoses of HIV, Hepatitis B and C among people who use drugs • HIV incidence rates among people who inject drugs dropped from 8.6% in 1986 to • 0% in 2000 • 94 acute drug-related deaths in 2010 with 20 non-municipal registered people • Significant decrease in public disturbance • High acceptance of DCRs (80%) by social/health providers, neighborhoods and police
Norway	**Location** • 2 in two cities **Staff** • Minimum of 5 staff on duty during opening hours, including at least 1 Nurse. • Training: Nurses, auxiliary nurses and social workers	**Eligibility** • Heroin only substance allowed • 18 years and over • Sign a 'terms of use' contract • Long term history of injecting heroin **Services** • Limited to one dose of heroin per client per visit • Integrated with harm reduction services • Links with social and health services • Links to drug dependence treatment programs	• 2,480 registered clients since 2005 • 1,500 clients per year • 109 clients per day on average (2011) • 37 years of age on average • 70% men / 30% women **Principal substances used** • Heroin is the only substance allowed to be used in the DCR	• Reduced perception of social exclusion among the user group • Increased access to professional assistance in overdose situations • Increased access to health and social services

TABLE 3: WORLD OVERVIEW OF DRUG CONSUMPTION ROOMS				
COUNTRY	**DCR**	**ELIGIBILITY & SERVICES**	**CLIENT PROFILES**	**RESULTS**
Spain	**Location** • 13 in 7 cities country-wide, including 1 mobile DCR **Staff** • Number of staff variable according to each DCR • Training: multidisciplinary, with at least 1 nurse	**Eligibility** • 18 years and over • Sign a 'terms of use' contract (in the Barcelona DCRs) **Services** • 3 DCRs allow smoking • Links to social and health services • Links to drug dependence treatment programs • In Barcelona: HIV testing and counselling, health care and social, psychological and legal support	• 105,804 visits from 5,063 clients (2009) • 34 years of age on average • 80% men / 20% women **Principal substances used** • Cocaine most popular (except in Bilbao and Sala Balaurd in Barcelona, 2009) • Heroin most popular (Barcelona, 2011) • Speedball most popular (Madrid, 2011)	• Decrease in overdose deaths from 1,833 in 1991 to 773 in 2008 • Decrease in new HIV infections among clients from 19.9% in 2004 to 8.2% in 2008 • High acceptance and demand for DCRs • Reduced injection-related litter in public spaces • Community awareness about DCRs as a public health strategy • Development of common guidelines on harm reduction and DCRs
Switzerland	**Location** • 12 in 8 cities country-wide **Staff** • No country-wide data In Berne • Training: nurses and social workers.	**Eligibility** • 18 years and over Already drug dependent • Have official documentation • No dealing of drugs on premises • No consumption tolerated outside the DCR itself (e.g. cafeteria, toilets) **Services** • Booths for intravenous use, smoking and sniffing (numbers vary according to the DCR) • Cafeteria with food and non-alcoholic beverages • Medical treatment • Consultations for social problems Hygiene services (showers, provision of clothes) • NSP • Links to drug dependence treatment programs and clinics	• No country-wide data In Berne: • 38 years of age on average • 992 registered clients a year • 200 clients a day • 74.1% men / 25.9% women **Principal Substances Used** • No country-wide data In Berne: Heroin Cocaine • Benzodiazepines • Cannabis Substitutes • Alcohol	• Decrease in drug-related deaths Increased client awareness of safer use techniques • Reduces risk of blood-borne virus transmission

Denmark and France

In addition to the findings from the countries profiled in the table above, experience from Denmark and France provide further information. Denmark has five facilities currently operating. Four are fixed sites using an integrated model, typically part of a shelter with additional services such as counselling, laundry and shower facilities and a health clinic. These sites are financed through provisional governmental funds and managed by non-governmental organizations. Denmark also has one mobile DCR, which is directly financed and run by the Municipality of Copenhagen.[23] France launched two drug injection facilities in 2016 as part of their 6-year national strategy to address the spread of infection and drug overdoses.[24]

Belgium, Ireland, Scotland, and Slovenia

Slovenia recently revised their penal code to allow for the opening of supervised consumption facilities, and a planned pilot project is pending. HIV outbreaks among PWID in Scotland and Ireland have led to discussions about the introduction of supervised drug consumption facilities. In 2016, Belgium initiated a study to explore the feasibility of drug consumption facilities in five major cities in Belgium.[25]

Massachusetts, New York, Maine, Seattle, and King County, WA

While SIS are not yet legal in the US, at least several states are exploring legislation similar to California's that would remove prohibitions on operating SIS and allow for pilot projects, including Massachusetts, New York, and Maine.[26, 27, 28]

In January 2017, officials in Seattle and King County, Washington approved opening safe consumption facilities in their jurisdiction. The development of pilot "Community Health Engagement Locations" were recommended by the Heroin and Prescription Opiate Addiction Task Force Final Report released in September 2016. In preparation for the facilities, the County developed a document entitled *Safe Consumption Facilities: Evidence and Models.*[29] The document provides a review of the different services and delivery models. Models differ in staffing, size and organizational structure. Features and staffing levels are based on local circumstances. The document summarizes three basic models that they refer to as Integrated, Specialized, and Mobile. Information in Table 4 below is taken directly from the report and provides a summary of each of the models and some of the key advantages and disadvantages that were identified.

While the recommendation has support from the Mayor, health department and other key stakeholders, it has recently been met with major opposition by some members of the community who are seeking to pass an initiative to ban heroin injection sites in King County.[30] Washington State Senator Mark Miloscia, supports the ballot initiative and has written a letter to Attorney General Jeff Sessions urging him to intervene and asserting that if a site is allowed to open in King County "they will continue to spread to other parts of our state, and eventually to other communities across our nation."[31]

TABLE 4: DESCRIPTION OF SAFE CONSUMPTION FACILITY (SCF) MODELS AND SOME OF THE KEY ADVANTAGES AND DISADVANTAGES THAT WERE IDENTIFIED

MODEL	DESCRIPTIONS	KEY ADVANTAGES AND DISADVANTAGES
Integrated	Integrated SCFs are the most common type. The SCF is part of a broader and interlinked network of services housed in the same facility. Examples of services offered include: drop-in center with showers and laundry facilities, counseling and testing for blood borne viral infections, needle and syringe exchange, psychosocial care, employment programs, medical services, wound care, medication-assisted treatment.	**Advantages:** "One-stop-shop" offers convenient access to other important health and social services; consistent with current emphasis on offering integrated and coordinated care for persons with complex medical conditions. **Disadvantages:** Integrating a drug consumption space with medication-assisted treatment (MAT) places a burden on individuals picking up their medication. These individuals may be trying to stay away from areas of active drug use; complexity, cost.
Specialized	Specialized SCFs focus on providing a safe place for hygienic consumption of drugs in a non-judgmental environment, while providing referrals to other services. The SCF is usually located in close proximity to other services and near an open-air drug market.	**Advantages:** Single focus requires less operational complexity. Referrals to other services are available, just not in house; less expensive to site and operate then more comprehensive models. **Disadvantages:** Access to additional services is not as convenient as an integrated model, creating a potential barrier to accessing services.
Mobile	Mobile SCFs are specially outfitted vans that provide space for 1-3 injection booths inside. They offer a limited range of other services such as syringe and needle exchange and blood borne virus testing and are able to provide referrals to other services not available directly on the van.	**Advantages:** Able to reach populations outside the service range of stationary SCFs. **Disadvantages:** Low throughput capacity, limited services offered.

Note: Adapted from Wright, N. M. (2004). Supervised injecting centres. British Medical Journal, 328(7431), 100-102. doi:10.1136/bmj.328.7431.100

SECTION VI

POTENTIAL BENEFITS & RISKS OF SAFE INJECTION SERVICES

BENEFITS

Potier and colleagues conducted a systemic review of seventy-five articles that were published on these facilities. "The article found that SIS were effective in attracting the most marginalized PWID, promoting safer injection conditions, enhancing access to primary health care, and reducing the overdose frequency. SIS were not found to increase drug injecting, drug trafficking or crime in the surrounding environments. SIS were found to be associated with reduced levels of public drug injections and dropped syringes. Of the articles, 85 percent originated from Vancouver or Sydney."[32]

In 2002, Brodhead and colleagues published a comprehensive evaluation of the operations and benefits of Safe Injection Facilities (SIFs). The authors visited 19 SIFs in Germany, Switzerland, the Netherlands and Sydney, Australia. Based on their findings, the authors concluded:

> "Our review suggests that SIFs target several public health problems that municipalities in North America may wish to consider, problems largely unaddressed by needle exchange, street-outreach, education campaigns, HIV counseling, and other conventional services. SIFs target injectors' use of public spaces to inject drugs in order to reduce the many risks associated with the practice. Compared to conventional services, SIFs provide greater opportunities for health workers to connect with injectors, and to move them into primary care, drug treatment, and other rehabilitation services. Finally, SIFs target the 'nuisance factor' of drug scenes -- the hazardous litter and intimidating presence of injectors congregating in city parks, public playgrounds and on street corners -- by offering them an alternative, supervised 'public' space. Our review also suggests that, for municipalities considering SIFs in order to address these problems, their implementation would not necessarily require any significant or fundamental changes in public policy or law: SIFs require the same working agreements with social service providers and the police that needle exchange, street-outreach, drug treatment and similar health programs for injectors already receive."[33]

COST BENEFIT

San Francisco

In 2017, Amos Irwin and colleagues published an article titled *A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA*.[34] Using a number of studies and local health data, the researchers developed a mathematical model to create an estimate of the financial cost and benefits that a SIS can provide to San Francisco. The researchers found that each dollar spent on SIS would generate $2.33 in savings, for total annual net savings of $3.5 million for a single 13-booth SIS site. They further found that a SIS site in San Francisco would not only be a cost-effective intervention but also a significant boost to the public health system.

They first developed an estimation of the cost of operating a facility based on the Vancouver program InSITE. They estimate that it would cost San Francisco $2.6 million annually to operate a similar facility. They also acknowledged SFDPH

TABLE 5: HEALTH CONDITIONS AND THE POTENTIAL HEALTH BENEFIT AND SAVINGS	
HEALTH CONDITION	**POTENTIAL HEALTH BENEFIT AND SAVINGS**
HIV	A prediction that one site would help avert 3.3 HIV cases per year, with a lifetime treatment cost of over $402,000, this translates to annual savings of $1.3 million.
HCV	A prediction that one site would help prevent 19 cases per year, with a lifetime cost of $68,000, this translates to annual savings of $1.3 million.
Skin and Soft Tissue Infection	A prediction that one site would reduce hospital stays by 415 days per year, which translates to savings of roughly $1.7 million.
Overdose prevention	A prediction that one site with overdose prevention services will save an average of 0.24 lives per year, which translates to $284,000 in financial benefit.
Medication-Assisted Treatment	A prediction that one site would assist 110 PWID to enter treatment, resulting in an annual financial benefit of $1.5 million.

Note: Summary from Irwin, A., Jozaghi, E., Bluthenthal, R. N., & Kral, A. H. (2017). A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA. *Journal of Drug Issues, 47*(2), 164-184. doi:10.1177/0022042616679829

would need to reevaluate the cost associated with operating a facility based on the model and protocols prioritized by the department.

Table 5 is a summary of the benefits and savings identified in the article. It is important to also note that the estimation of health benefits and costs are based on providing this as an additional service over and above the current levels of services offered in the San Francisco, not replacing existing services. In personal communication with one of the co-authors, he also noted that the predication of the financial benefits for overdose prevention may also be under-estimated as the calculation of the savings was conducted a few years ago when the overdoses were at the lowest levels in San Francisco.

Vancouver, Canada

In 2008, researchers in Canada conducted a study on the cost-effectiveness of the Canadian supervised injection facility. InSITE is North America's first legal supervised injection site that was opened in 2003 by Vancouver Coastal Health. Below is an excerpt from the study published in the Canadian Medical Association Journal.

"**Results:** Focusing on the base assumption of decreased needle sharing as the only effect of the supervised injection facility, we found that the facility was associated with an incremental net savings of almost $14 million and 920 life-years gained over 10 years. When we also considered the health effect of increased use of safe injection practices, the incremental net savings increased to more than $20 million and the number of life-years gained to 1,070. Further increases were estimated when we considered all 3 health benefits: the incremental net savings was more than $18 million and the number of life-years gained 1,175."[35]

RISKS

Federal and State Controlled Substances Laws

Currently, the possession of controlled substances, unless the possession is with the prescription of a licensed health professional, is prohibited by both state and federal law. State and federal law also prohibits building owners and operators from allowing the manufacturing, storing, or distributing controlled substances.

Specifically, at the federal level, there are two major statutory considerations under Title 21 of the United States Code (USC) Controlled Substance Act (CSA) that need to be taken into account when discussing the operations of a SIS in San Francisco. Under section 844 (c) of the CSA, the term "Drug, narcotic, or chemical offense is

defined: drug, narcotic, or chemical offense means any offense which proscribes the possession, distribution, manufacture, cultivation, sale, transfer, or the attempt or conspiracy to possess, distribute, manufacture, cultivate, sell or transfer any substance the possession of which is prohibited under this subchapter."[36] This means individuals arriving at a SIS, who are bringing their own drugs, would be violating the federal law.

Further, CSA Section 856, 'Maintaining drug-involved premises' (also known as the Crack House Statute) states the following under (a) Unlawful acts:

> "Except as authorized by this subchapter, it shall be unlawful to—
>
> (1) knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or using any controlled substance;
>
> (2) manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance."[37]

Section 856 outlines the criminal penalties, violation as offense against property, and civil penalties that may be imposed on all the parties engaged in the property.

These federal laws are enforced by the US Attorney General. On May 12, 2017, Attorney General Jeff Sessions directed all federal prosecutors to pursue the maximum penalties under the law for all crimes, including mandatory minimum sentences. Most mandatory minimum sentences apply to drug offenses.[38]

Mirroring federal law, California law also prohibits the possession of controlled substances and provides for criminal penalties and fines to the individual(s) that has the illegal substance on their person and also to building owners and operators that allow manufacturing, storing, or distributing controlled substances on their premises.[39] Assembly Bill 186 is currently being considered by the California Legislature to remove the penalties for violation of these laws when associated with the operation of a safe consumption services program authorized by the local government entity.

Government Contracting Requirements

Another risk that has been identified is the standard boiler plate language used in federal, state and local funding agreements regarding maintaining a drug free work place. Please note that this matter is separate from the federal laws under the CSA. Below is an example of language that is part of the boiler plate for Medi-Cal and (i.e., Medicaid) and the federal block grant from the Substance Abuse and Mental Health Services Administration:

> "**No Unlawful Use or Unlawful Use Messages Regarding Drugs**
> Contractor agrees that information produced through these funds, and which pertains to drug and alcohol- related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol- related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Contract, Contractor agrees that it will enforce, and will require its Subcontractors to enforce, these requirements."[40]

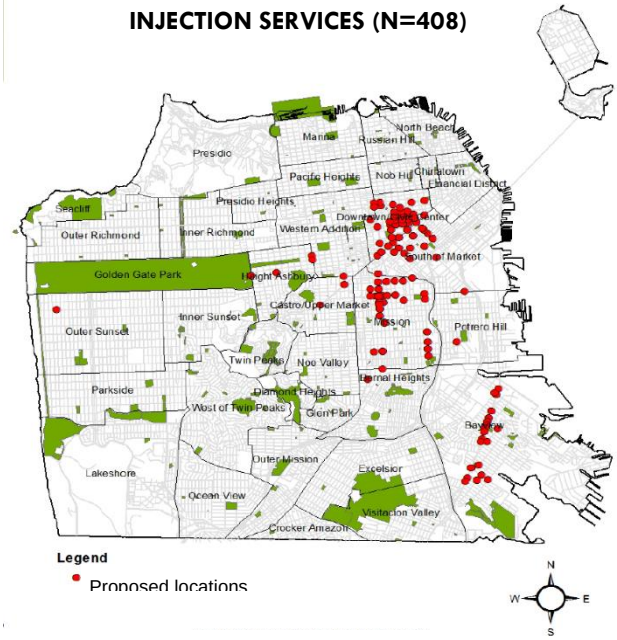
SECTION VII

CONSIDERATIONS FOR SAN FRANCISCO REGARDING SAFE INJECTION SERVICES

LOCATION

A key consideration for implementing SIS is identifying locations where PWID already access services. Research conducted in San Francisco in 2008 found that 85 percent of study participants reported they would use SIS services if they were convenient for them.[41] Researchers further found a correlation between PWID who reported having injected in a public place and their intent to use SIS services. The survey further found that nearly three-quarters of respondents (72%) would be willing to walk up to 20 minutes to a SIS site. Figure 3 depicts locations that PWID suggested for SIS locations. Suggested locations were clustered in the Tenderloin, South of Market, Mission, and Bayview neighborhoods.

FIGURE 3: INJECTION DRUG USERS' SUGGESTIONS FOR LOCATIONS OF SAFE INJECTION SERVICES (N=408)



Source of Data: RTI Urban Health Program, 2008

These suggested locations correspond with neighborhoods within which PWID reside. Approximately 55 percent of PWID are in 94102 (Tenderloin/Civic Center, 31%) and 94103 (South of Market, 24%). The next highest zip codes are 94110 (Mission, 9%) followed by 94124 (Bayview, 8%). Figure 1 shows the estimated percent of population size by zip codes. While data is available only at the zip code level, PWID populations may cluster in particular corridors within a zip code with limited movement outside those corridors. Thus, placing one SIS location in 94102 may combat public drug use in the blocks surrounding this location, but will likely not impact public use in other areas.

COMMUNITY ENGAGEMENT

Engagement of the communities surrounding any proposed SIS location will be critical. One study that conducted in-depth interviews with 20 sampled stakeholders, including representatives from neighborhood and business associations, politicians, law enforcement, religious leaders, school officials, community activists and service providers, found concern about the implementation of SIS.[42] Specifically, stakeholders were concerned about how SIS would impact a community struggling with safety and cleanliness and questioned the efficacy of harm reduction strategies to address drug use. Stakeholders indicated that they were open to dialogue about how a SIS site might support neighborhood goals; and they stressed the importance of respect and collaboration between stakeholders and those potentially implementing SIS. The researcher noted that government protection and political leadership will be necessary to implement a SIS.

PROGRAM DESIGN

The programmatic design of any contemplated SIS location would need to ensure acceptability by and support of PWID. Identifying locations where PWID are already being served, as noted above, is one key element of program design. Additionally, the presence of other onsite support services, the accessibility of services, and the structure of the rules governing the program would also be critical. Of the 85 percent of PWID surveyed in San Francisco who said they would use SIS services if they were convenient for them, over two-thirds reported that they would accept many potential rules and regulations.[43] Three-quarters of respondents said they would use SIS services at least three days per week and the majority (62%) indicated their preferred time of operation would be 8am to 4pm.

Availability of on-site supportive services would be essential to promoting recovery and wellness for PWID. SIS integrated with other on-site services and supports is the predominant model of SIS across the world. Research shows that SIS can provide opportunities for health workers to connect PWID to primary care, drug treatment, and other substance use disorder services and that access to such services improve the general health, stability, and level of functioning of PWID.[44]

LEGAL

It will be important for any proposed SIS provider to fully understand the associate legal risks. While legislation is currently pending to address some of the state-level risks, federal legal risks remain.

SECTION VIII

CONCLUSION

This issue brief provides background information and highlights important policy considerations to support the SIS Task Force as it develops its recommendations to the Mayor, the Board of Supervisors, and City Departments in accordance with Board of Supervisors Resolution #123-17.

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