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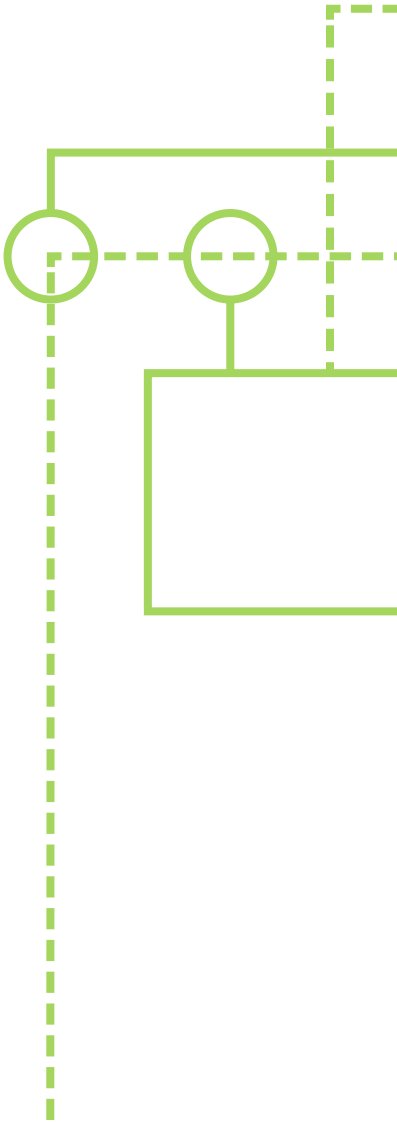
Establishing Sanctioned Safe Consumption Sites in the United States

FIVE JURISDICTIONS MOVING THE POLICY AGENDA FORWARD



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Colleen L. Barry, Susan G. Sherman

Fall 2018

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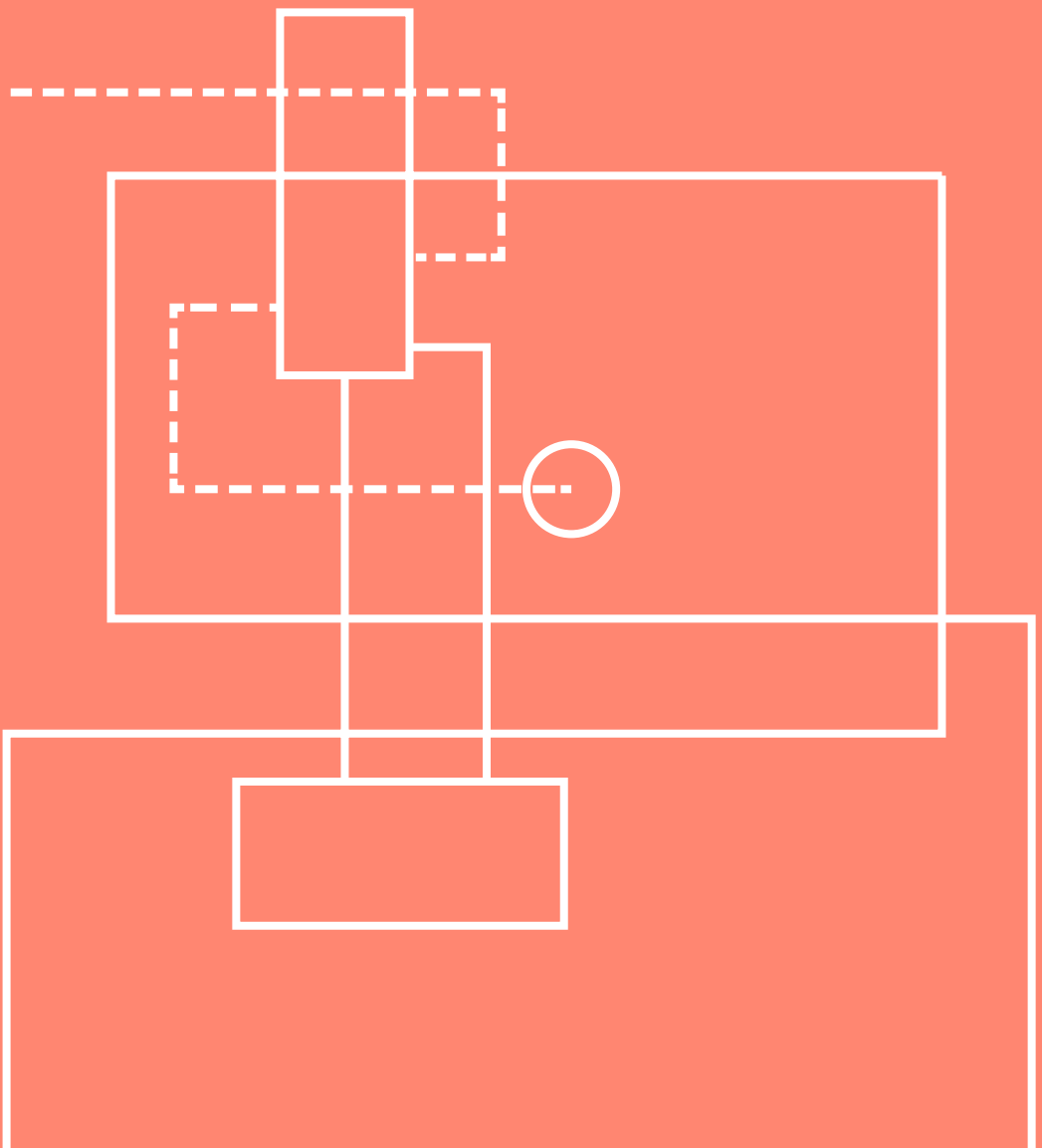

Dear Reader,

We are in the midst of the worst epidemic in generations and we continue to lose ground in terms of the annual number of people who overdose and die from opioids. There is an ever-growing sale of these substances, legal and illegal. Every day in the United States an estimated 142 people die from drug overdoses, and such deaths are surely underreported. Deaths from opioid overdoses have continued to rise, attributable to the increased use of heroin and fentanyl additives, with estimates of an increase of 22% in 2016. The recent rise in fentanyl-related overdose deaths suggests that new approaches are necessary to combat the opioid epidemic, including adoption of harm reduction strategies.

In recent years, major U.S. policy efforts have been aimed at combating the epidemic of opioid addiction and overdose deaths. In response to the epidemic, the medical community and policymakers at the federal, state, and local levels have intervened by using various approaches, including: the release of new clinical guidelines on opioid prescribing and regulations on opioid dosing; establishment of and regulations regarding use of prescription drug-monitoring programs; pill-mill crackdowns and enforcement efforts; insurance changes to broaden access to evidence-based addiction treatment; and regulatory changes to expand the supply of physicians trained in addiction medicine; and other approaches. However, they have done little to reverse the increase in mortality related to opioid overdose.

Now is the time to change public policies, service delivery and funding mechanisms to solve for this epidemic. This white paper focuses specifically on the sanctioned safe consumption sites as part of a broader harm reduction strategy. Currently no safe consumption site exists in the United States and there are few studies which have explored the processes facilitating policy adoption of sanctioned safe consumption sites. This paper further examines the growing movement to establish sanctioned safe consumption sites across five cities in the United States, with recommendations for the jurisdictions contemplating opening a safe consumption site.

We hope you use this paper to extend progress of the safe consumptions sites and avoid losing ground at a time of great need.

Sincerely,

Joseph Pyle, M.A.
President
Thomas Scattergood Behavioral Health Foundation

Rick Kellar, M.B.A.
President
Peg's Foundation

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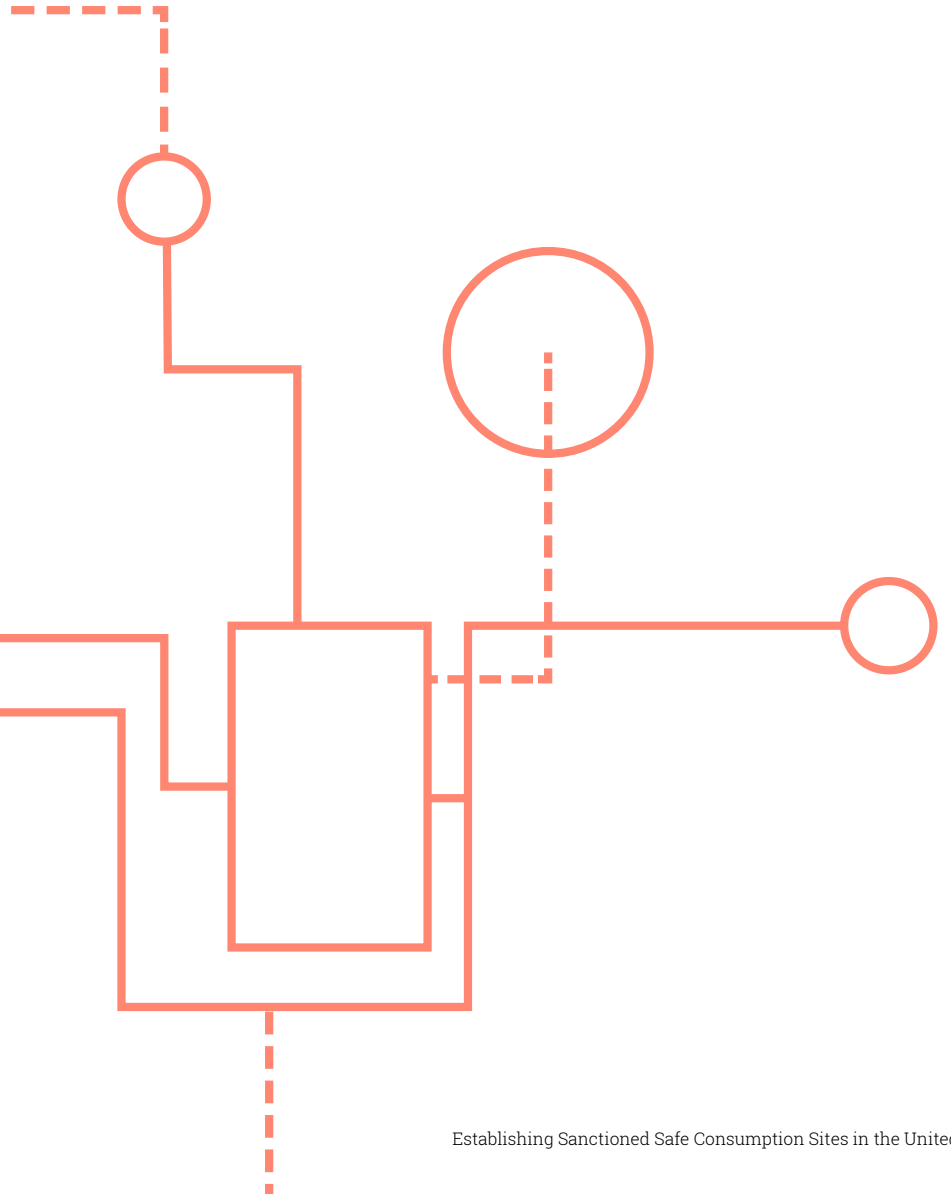

Establishing Sanctioned Safe Consumption Sites in the United States

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Fall 2018

Introduction

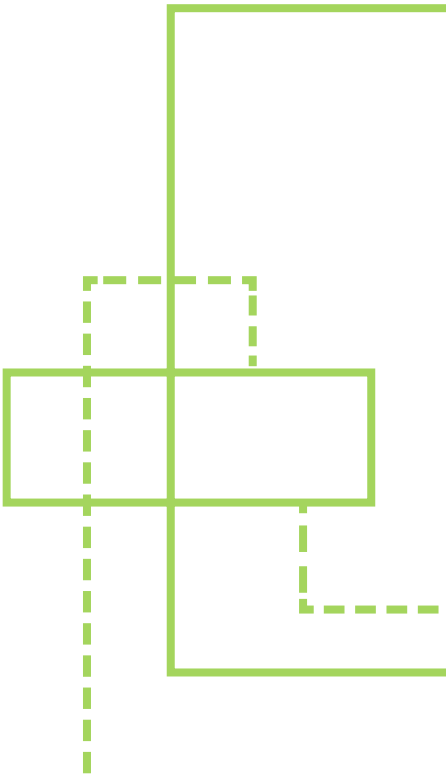
The United States is facing a sustained addiction and overdose epidemic that is historic in its magnitude, pervasiveness, and geographic reach. The provisional count of drug overdose deaths in 2017 surpasses 70,000.[1] Reversals in life expectancy gains in the U.S. have been attributed in part to rising drug overdose mortality rates.[2] Illicitly manufactured fentanyl, a synthetic opioid significantly stronger than heroin, has become increasingly prevalent, escalating the lethal risk of drug consumption.[3,4] In addition to overdose mortality, increasing incidence of hepatitis C virus[5] and recent localized HIV outbreaks have been traced to injection drug use.[6] The federal government and a number of states have declared the opioid epidemic a public health emergency.[7,8]

Despite implementation of numerous policies to curtail the drug epidemic, trends in addiction and overdose deaths are escalating. It is in this context that jurisdictions are searching for new policy solutions. One proposed approach involves establishing safe consumption sites (SCSs), also known as supervised injection facilities and overdose prevention sites, among other names. SCSs are places where people can use pre-obtained drugs in a hygienic setting with supervision by trained staff and connect to other health and social services.[9] More than 100 sanctioned SCSs exist in 66 cities in Canada, Australia, and Europe.9

Evaluations of InSite, the first North American facility, which opened in 2003 in Vancouver, Canada, suggest that an SCS can produce important benefits for people who use drugs, including reducing fatal overdoses,[10,11] increasing connection to addiction treatment,[12,13] and facilitating safer injection practices and less syringe sharing.[14,15] Research on the broader community impacts of InSite indicates reductions in public drug use and syringe debris,[16] with no increase in drug-related crime in the neighborhood.[17] Systematic reviews of research conducted in a wider range of geographic settings also have found SCSs to be associated with positive outcomes both for the people using these facilities and for the broader communities in which they are located.[18,19] Recent cost-benefit analyses in San Francisco and Baltimore have estimated that SCS implementation would generate cost savings by reducing spending on the medical complications of unsafe drug consumption.[20,21]

To date, no sanctioned SCS exists in the United States. One underground site has been operating since 20149,[22] and some syringe services providers manage quasi-SCSs in bathrooms that push the boundaries of legal sanction.[23] At the time of this writing, legislation to establish SCSs has been introduced in at least six states (CA, NY, MD, CO, VT, and MA), with varying degrees of success. In 2017, the California State Assembly passed a bill to establish SCSs, and the State Senate passed the bill in 2018.[24] On the local level, the Seattle City Council allocated funding for operating SCSs,[25] although the city has not yet opened a site.

Few studies have explored the processes facilitating policy adoption of SCSs,[26–28] and no research of which we are aware has examined the growing movement to establish SCSs in the United States. Through interviews with key informants in five locations across the U.S., we (1) describe the local context related to drug use and overdose that SCSs might help to address, (2) characterize the organizing strategies that advocates have employed to build momentum around SCSs, (3) consider the challenges to SCS adoption, and (4) identify factors that have facilitated progress toward SCS adoption. On the basis of these findings, we propose a set of recommendations for other communities to consider in the context of discussions about establishing SCSs.

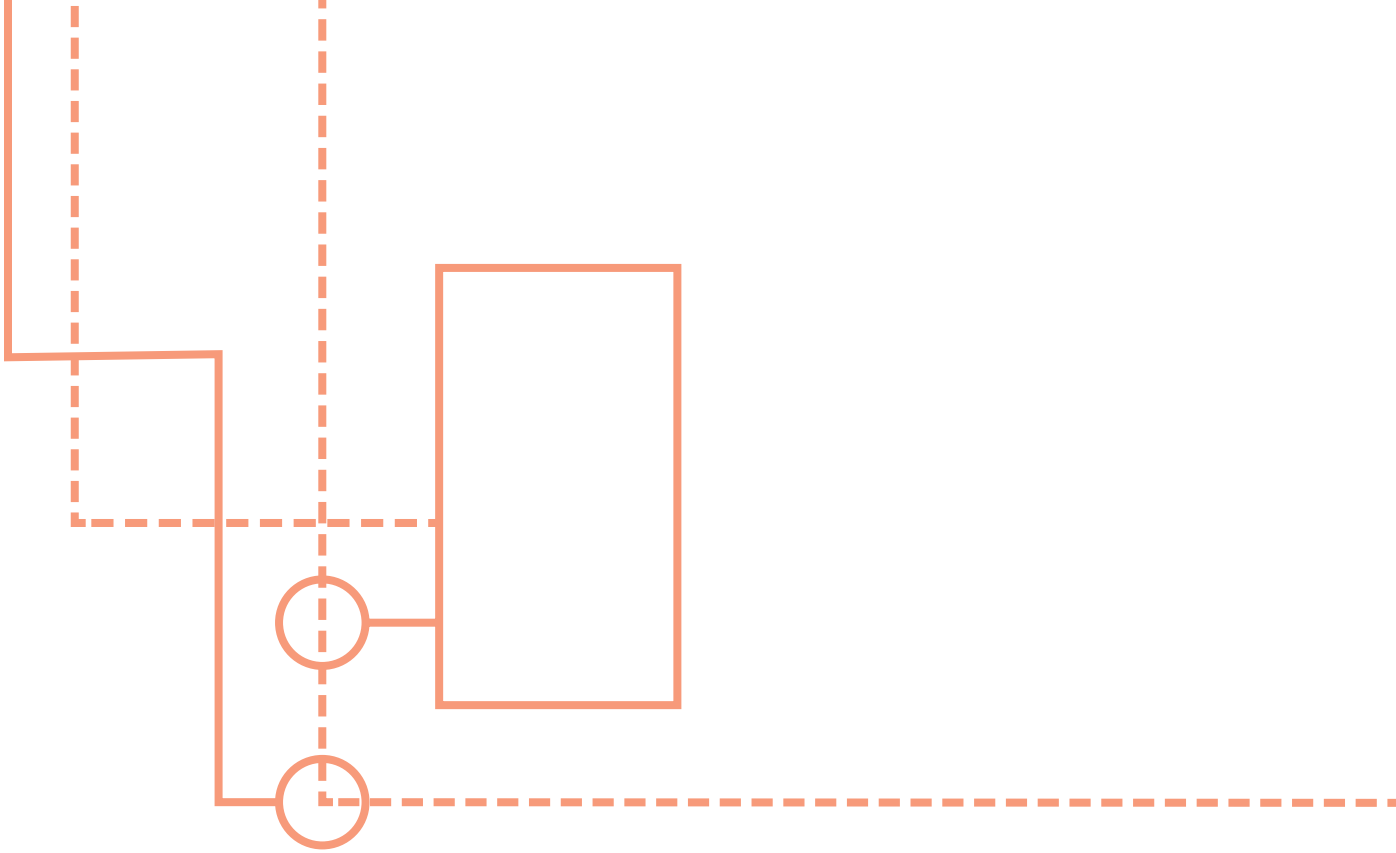


METHODS

Data Collection

Although movements to establish SCSs are growing around the country, we narrowed our focus to five locations in which advocates have secured support from key elected officials or have made measurable progress in advancing policy to establish sanctioned SCSs (e.g., advancing state legislation out of committee). We identified an initial set of study participants through the networks of two study authors (AHK and SGS) with ties to the harm reduction community and then used snowball sampling to recruit additional participants within each jurisdiction. To maintain the confidentiality of participants, we do not identify the five locations in our sample.

Between late April and early July 2018, we conducted 25 interviews with a purposive sample of four to six key informants from each location. Participants included members of the organizing and advocacy community, local government officials, and personnel with social service and health organizations, including organizations considering operating an SCS in the future. Interviews took place by telephone and ranged from 45 minutes to one hour. The study team drew on the literature and team member expertise on this topic to develop a semi-structured interview guide. One study team member took detailed notes during each interview. The Johns Hopkins Bloomberg School of Public Health Institutional Review Board designated the study not human subjects research.



Analysis

Analysis of interview notes employed a hybrid inductive-deductive coding process. All study team members reviewed the interview notes, identifying important themes. One study member (AK-H) then systematically analyzed the data using NVivo 12 Pro qualitative analysis software.[29] Segments of the text were initially coded for the a priori themes identified during the group review of interview notes and then coded iteratively to capture new themes emerging during the coding process. Related text segments were then categorized into overarching themes.

Results

Across the five locations, much of the effort to establish SCSs was concentrated in urban settings. Participants represented the organizing and advocacy community; social service and health providers, including syringe services programs; and local government.

Defining the Problem that SCSs Address

Study participants identified SCS implementation as a policy response to the following social problems: (1) overdose deaths, (2) economic development–induced displacement and homelessness, and (3) publicly visible drug use and syringe debris. Many participants identified all three problems as driving interest in SCSs. However, the salience of these problems varied by geographic region. Participants suggested that rising overdose death rates were playing a greater role in driving policy discussions around SCSs in parts of the U.S. where overdose mortality rates are rising rapidly. However, even in areas of the country where drug overdose death rates have risen more slowly, there was a sense that the broader national narrative about the overdose epidemic has contributed to a greater willingness to consider SCS policy.

In several locations, participants noted that interest in SCSs appeared to be driven more by concern about public drug use and syringe debris than the well-being of people who use drugs. Participants viewed the issues of economic development and displacement, homelessness, visible drug use, and syringe debris as inter-related. In cities experiencing rapid gentrification, people who previously used drugs in more hidden settings (e.g., low-cost housing and abandoned buildings) were now using in the streets or in public bathrooms. In some cities, people who use drugs congregate in visible encampments, including tents. Participants expressed that SCSs were a critical but incomplete policy response to the issues affecting people who use drugs and the neighborhoods in which they live.

Getting SCS on the Policy Agenda

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

> **"In [X state], the long game is to get legislation passed . . . if it passes, it will be a game changer on this issue for the state and the country."**

Exhibit 1 highlights strategies behind targeting efforts to obtain legal sanction. Participants in the two locations that were focused exclusively on the local government reported that state politics drove this tactical approach, but they also felt that state-level policy action wasn't necessary for establishing SCSs. Among the three jurisdictions that had introduced state legislation to establish SCSs, all were also pursuing other mechanisms for achieving legal sanction, including through the authorization of a research pilot, city council ordinance, or state or local health department action.

Exhibit 1 / Level of Government Targeted to Advance SCS Policy

	Description of Approach	Quotations Explaining Approach
City or County	All five jurisdictions were pursuing local government policy mechanisms to establish SCSs (e.g., health department approval, emergency declaration, city ordinance). Two jurisdictions focused exclusively on policy mechanisms available at the city/county level because state government level support was not feasible. Both had executive branch support (i.e., mayor, health department). One jurisdiction's city council had allocated funding for an SCS.	"We advocated not to do [state legislation] because we knew that it couldn't pass the legislature because of split control. . . . [There was] concern that having a bill fail can create the impression that without that bill, you can't do it, but that's not true. The public health department can do it without the bill so we were afraid of detrimental effects from a failed bill." "The mayor could declare a public health emergency. This is how they established syringe services. Another mechanism could be an ordinance from the city council that would be renewed in perpetuity."

	Description of Approach	Quotations Explaining Approach
State Legislation	In three of the five jurisdictions, state legislators had introduced bills authorizing SCSs. None had passed at the time of this study, but sponsors were planning to re-introduce bills in subsequent legislative sessions. Participants from the two jurisdictions in states that had not introduced legislation authorizing SCSs opted not to do so given the political composition of their state legislatures.	"In [X state], the long game is to get legislation passed . . . if it passes, it will be a game changer on this issue for the state and the country." "We could have introduced the [state] legislative package and tried to build movement in [X city], but I don't think [X city] is conducive to that. . . . [Other cities planning to implement SCS] are the biggest tax generators in their state. . . . [X city] can't do its own thing in the same way that those [jurisdictions] can."

	Description of Approach	Quotations Explaining Approach
Multiple pathways	In the three jurisdictions pursuing state legislation, the state legislation was part of a broader strategy that involved pursuing local-level policy change as well. Advocates in one jurisdiction also were working to push the state executive branch (i.e., governor and state health department) to authorize SCS adoption as pilot research.	"[T]he legislative push is supporting the [research] pilot push. . . . In our mind, of course we want to pass legislation. The legislation supports the pilot efforts and the pilot efforts support the legislation." "[There is a] whole other conversation to be had about the state legislation we're running—a state bill to create authorization for the city to create [SCSs] and protect the city from state law."

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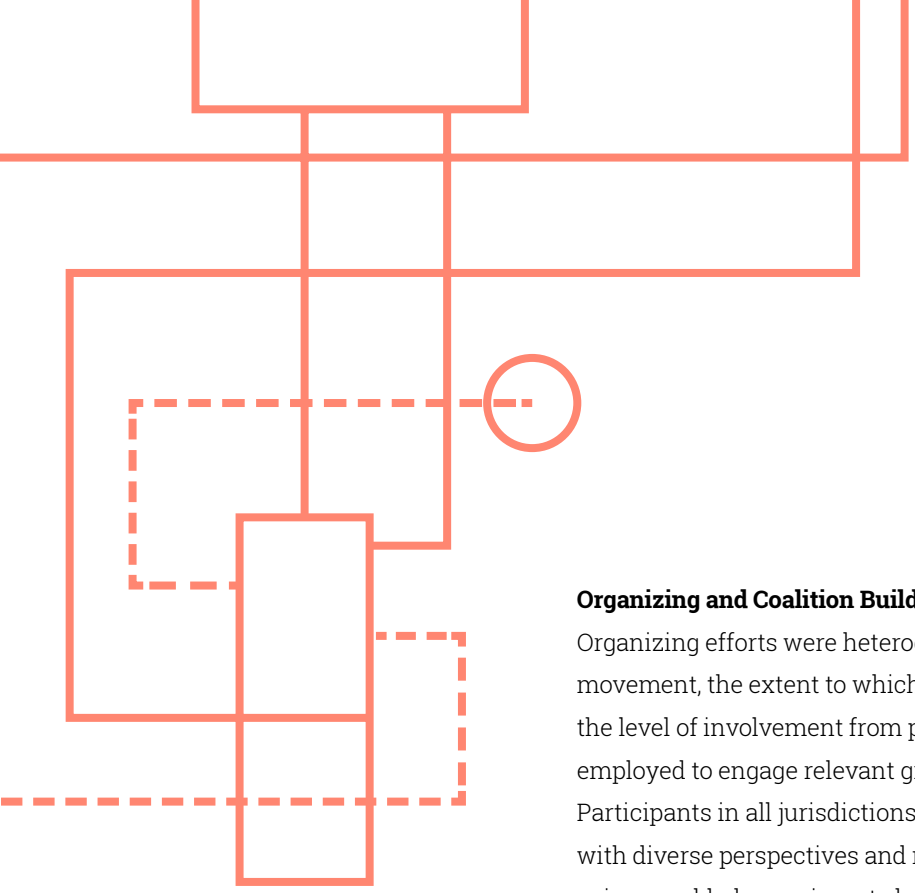

Organizing and Coalition Building

Organizing efforts were heterogeneous in terms of the groups leading the movement, the extent to which the advocates composed an organized coalition, the level of involvement from people who use drugs, and the tactics advocates employed to engage relevant groups and garner political support (see **Exhibit 2**). Participants in all jurisdictions emphasized the importance of engaging those with diverse perspectives and motivations for supporting SCSs. Engaging diverse voices enabled organizers to build a broader coalition and more successfully lobby policymakers. Participants emphasized the importance of supporting or "showing up" for potential allies as they built a coalition, illuminating both the transactional nature of organizing and the extent to which many allies often shared a wider set of political goals. Although participants in all jurisdictions emphasized the importance of including people who use drugs in advocacy efforts, there was significant variation in the extent to which they had achieved this goal. People who use drugs were more involved in places that had established drug user unions, whereas in other jurisdictions, organizing around SCSs was driving the organizing of this group. Political strategy involved initially targeting policymakers who were anticipated to be receptive to SCSs, educating policymakers and connecting them to information, pressuring key policymakers who resisted publicly supporting SCSs, committing acts of civil disobedience, and positioning SCS adoption as a campaign issue on which candidates had to comment.

"We used comprehensive syringe exchange supporters to target for potential SCS support. It became more acceptable over time, and we have about 30 cosponsors on the SCS bill now. A lot of members were moved by targeted advocacy, lobbying, and testimony."

Exhibit 2 / Organizing and Coalition Building

Engaging Partners with Diverse Perspectives

"Support is challenging because it sometimes comes from people who just want these individuals to disappear, but they are vocal about the need for SCSs because of syringes on the street."

"Diverse coalition seems very critical . . . geographically diverse across the state, and we also mean racially diverse and diverse in how you arrive at this work. [It's] critical for the coalition and for the legislators we engage."

Focus of Organizing Efforts

"[X location] has a good ground game. . . . They've been putting together a concerted grassroots community education and mobilization campaign. In [another location], there isn't really a ground game and media strategy. . . . There's more behind-the-scenes meeting to educate legislators and convene community stakeholders."

"[X location] is challenging because there's an emerging dynamic of gentrification in which a class of highly educated white professionals are moving in and are seen as 'new [name of locality]' and they tend to be easier to convince on things like [SCSs], but you don't want them to be the face of your grassroots movement."

Showing Up for Allies

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

Description of Approach

"[A new advocacy organization] coalesced around . . . service provision under the bridges to build trust . . . with people with lived experience to build social capital and make sure people know we are not just advocates but service providers. We hoped that the [organization] would become an auxiliary to the union of people who use drugs."

"Our members identify more or less as drug users. But the truth is that some are active drug users and some are fully in recovery but identify as drug users for political reasons. . . . For us, what's most important is: Are you a victim of the drug war? We don't organize 'Wall Street' drug users."

Learning from Previous Policy Change Efforts

"A lesson learned from LEAD [Law Enforcement Assisted Diversion] was bringing in people to build consensus who have different motivations. . . . It was really clear that there was never going to be agreement on a wide range of issues, so we focused on a couple things we could agree on and leave disagreements at the door."

Targeting Friendly Policymakers First

"[We] focused on solid, traditional allies."

"We used comprehensive syringe exchange supporters to target for potential SCS support. It became more acceptable over time, and we have about 30 cosponsors on the SCS bill now. A lot of members were moved by targeted advocacy, lobbying, and testimony."

"[We are] planning to meet with city council members, first with folks who are likely to support [SCSs]."

Educating Policymakers

"We do a lot of education with elected officials, helping them work through questions with constituents."

"[The current police chief] met with the previous chief [in Vancouver] about law enforcement impact research from Vancouver, and he was really enthusiastic because he saw it as a solution to a lot of the problems his department is dealing with, namely public syringes."

Publicly Pressuring Policymakers

"We took to publicly attacking [key elected official]. We did a number of demonstrations and public confrontations and civil disobedience actions that got a lot of attention."

"We're keeping the pressure on, recognizing that [movement on SCSs] may not happen until after the November election."

Making SCS a Campaign Issue

"We're working on . . . identifying candidate stances on harm reduction for the election year, seeing if people can ask harm reduction questions at town halls."

"[A candidate in a local election] raised SCSs as an issue, and it became part of a campaign conversation so all the candidates had to comment on it. The [local political group] does candidate forums and endorses candidates, so every politician has been asked their opinion on this topic."

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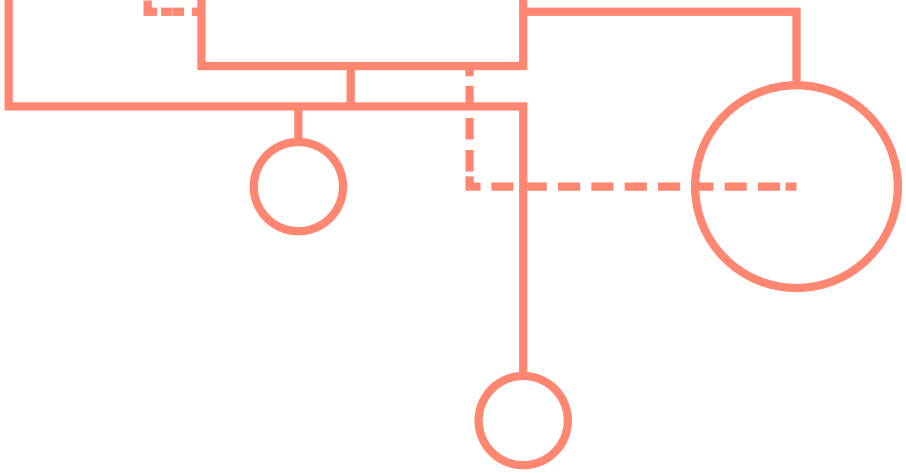

Community Education and Engagement

A key element of organizing was community engagement. **Exhibit 3** displays key themes related to community engagement efforts around SCSs. Some jurisdictions viewed community engagement as part of a long-term process of relationship building and engaging the community around drug policy more broadly. Most participants viewed early engagement of the community as critical to building public understanding of the concept of SCSs and quelling potential opposition. In one jurisdiction, community engagement mostly occurred after the local government announced support for SCSs and community opposition had emerged as a roadblock. The majority of jurisdictions had been engaging with the community through public meetings often involving local government representatives and members of the task force. Many participants felt that the smaller meetings enabled more productive discussions about how community concerns could be addressed and also led to less fraught public meetings.

> **"[We have] done a lot of work through a transparent process. Provided many opportunities for the larger public to give comment. . . . Even people who weren't in favor of SCSs wouldn't say that the process wasn't fair.**

One key theme was the importance of taking community concerns seriously. Participants evoked the harm reduction philosophy of meeting people where they are in describing their approach to engaging the community and not reflexively attributing concerns raised about SCSs to intractable stigma or not-in-by-backyard (NIMBY) beliefs. Advocates of SCSs also emphasized the critical importance of finding trusted members of the community to champion the cause of SCSs and to ensure transparency in the process of building support for SCSs.

Exhibit 3 / Community Education and Engagement

Engaging Early

My "favorite thing about [X advocacy group] is that they don't start on [SCSs] when doing community engagement. . . . [X advocacy group] is intentional about building trust in the community before going in with a hard ask on [SCSs], though the downside is that it takes a long time."

"Need to make sure community engagement is part of the process from the beginning."

Convening Community Members

"Held [public] meeting with [various stakeholders] to give opportunity for people in the community to come and comment on SCSs. . . . [We] had almost zero opposition. . . . had already laid some groundwork by talking to nonprofits, faith-based groups, and school groups in the area."

"I think the best way that could occur would be not having a public forum where everyone just rails on [public officials] about NIMBY issues, but . . . have smaller groups of people together to say what are the conditions in which people could endorse [SCSs], and [local officials] could meet some of those conditions."

Taking Community Concerns Seriously

"We approached things from a place of thinking it was reasonable that people had questions, which engendered goodwill from people and communities."

"Not meeting people with anger or frustration, realizing that people don't know the principles of harm reduction, and treating the outward community with the tools we practice—meeting people where they're at and listening to concerns."

Activating Community Voices

"It's hard to go into a community you've never been a part of and try to advocate, so that's an interesting dynamic. . . . You need to show it's not 'big public health' trying to put policy on the community."

"[Community group] is doing an intensive set of conversations with business owners, labor unions, tenants' organizations, and community organizations doing presentations and getting support. They've done a great deal of work addressing people's concerns."

"Identify community leaders to be champions of the project who are trusted."

Transparency

"[We have] done a lot of work through a transparent process. Provided many opportunities for the larger public to give comment. . . . Even people who weren't in favor of SCSs wouldn't say that the process wasn't fair."

"The general perception from the public is that they're being lied to from the government. . . . It's hard because residents are also incorrect in their interpretations . . . but advocates also misrepresent what information is out there."

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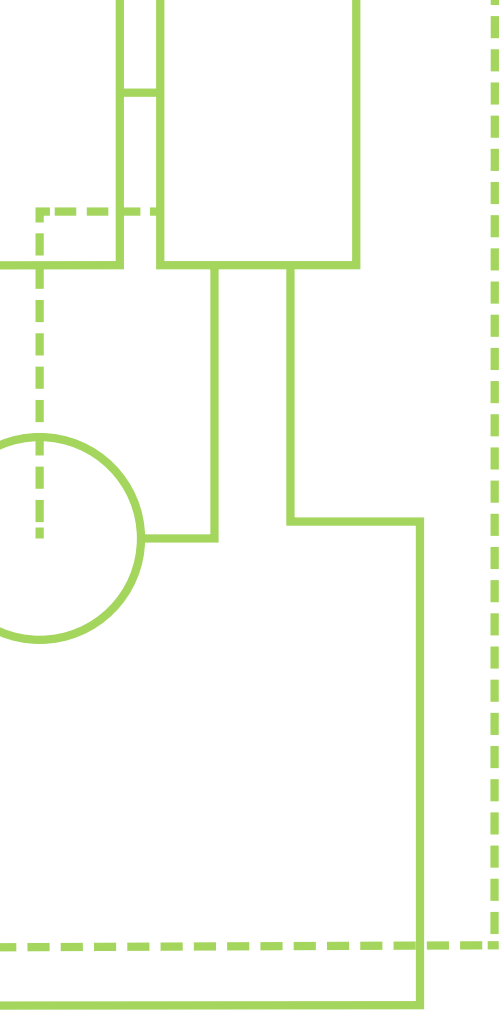

Challenges to Implementing SCSs

Exhibit 4 lists several of the major challenges to implementing SCSs identified by participants. One of the most commonly mentioned challenges involves finding the right location for an SCS. This theme encompassed neighborhood resistance and identifying the right physical space. The issue of physical space overlapped with uncertainty about the enforcement of 21 USC Section 856, the Crack House Statute, which prohibits operation of spaces for the use of illegal substances.[30,31] Participants anticipated landlord reluctance to rent to entities that would operate an SCS, limiting location options. Also related to the Crack House Statute were broader concerns about the federal response, including concern about the risk of asset seizure faced by established providers serving people who use drugs if they opened an SCS and the withholding of federal funding from local jurisdictions that sanction SCSs.

Several participants identified major challenges in building trust in communities of color that have been disproportionately affected by punitive drug policy through the War on Drugs. In three locations in which communities feel continuing effects of punitive drug policy, participants expressed strongly that efforts to advocate for SCSs should either be preceded by or clearly framed as part of an effort to confront the racially unjust impact of punitive drug policy. Without this framing, SCS adoption appeared to some community members as privileged treatment of white people who use drugs.[32] Other challenges identified by participants included financing the SCS, bureaucratic delays, reluctance of incumbents to endorse SCSs in an election year, and other legal issues, such as protecting the professional licensure of providers who might work at these facilities.

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

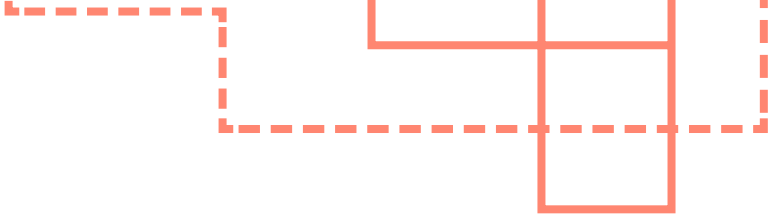

Exhibit 4 / Key Barriers to SCS Adoption and Implementation

Location/Siting

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

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

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

Uncertainty about Federal Government Response

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

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

Mistrust and Racial Justice

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

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

Financing

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

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

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Facilitators to Advancing SCS Implementation

At least three locations had considered SCS adoption previously, before the acceleration of the drug epidemic, and participants felt that these conversations were a helpful foundation for current efforts. Participants identified a variety of existing policies, programs, or partnerships as having laid the groundwork for SCS adoption (see **Exhibit 5**). These included decades-long efforts to implement syringe services programs,[33] which were the provider type most frequently identified as potential operators of SCSs, overdose education and naloxone distribution programs,[34] other interventions targeting people who use drugs and people experiencing homelessness (e.g., Housing First initiatives),[35] activism around HIV/AIDS, organizing to end punitive drug policy, and being in a jurisdiction that had diffused harm reduction into its service system more broadly.

> **"Using the data makes it clear that SCSs work and are needed. The only tool the opposition has is fear, so in any structured conversation, like department board meetings, there is clear evidence pitted against unsubstantiated fears."**

Other key facilitators included having political champions who actively engaged in advocacy around SCSs, public support, and favorable media coverage. Exposure to InSite, either through visits to Vancouver or meetings with key Vancouver officials, often was effective in persuading key public officials and community groups. However, several participants also noted that some visitors to InSite did not appreciate that conditions in the surrounding high-poverty neighborhood predated InSite and left Vancouver confused about the causal relationship between neighborhood conditions and SCS. An anticipated facilitator mentioned by participants was the opening of a sanctioned SCS in the U.S., which many felt would catalyze their own efforts. Finally, participants identified research as a facilitator, including research on the unsanctioned U.S. site[9] and the cost-effectiveness of SCSs in U.S. cities.[20,21] But participants also cautioned that research was not sufficient to move policy adoption, and some also noted that community distrust of research diluted its power as a persuasive tool.

Exhibit 5 / Facilitators of Progress

Predecessor Programs and Harm Reduction Exposure

"We have a long history of doing this work with respect to syringe exchange."

"[X locality] is the best example where there is a long-standing [Law Enforcement Assisted Diversion] program and a lot of movement on SCSs, but it's a lot of the same people involved on both things, so it's clearly linked. The link is less obvious in other cities."

"[We] have a long history of harm reduction that's woven into the philosophy of the work that the [government health agency] does."

Political Champions

"Political champions willing to go to bat, especially law enforcement and/or prosecutors willing to stand behind this."

"It's really important to have healthy relationships with [local political] leadership. Those conversations are important because it won't get done without political will."

Public Support

"Politically, it is very difficult for politicians to come out in support of [SCSs]. Constituents and public opinion are key here."

"Of course, the high-level people need the information, but they will ultimately respond to public opinion."

Favorable Media Coverage

"The big opportunity came when [X reporter at X news outlet] did a big long story on [syringe services provider] and essentially showed that they were all but operating as an [SCS], and it was a favorable story."

"[Local news outlet] has offered great coverage of the issue even before this became the focus, talking about the opioid crisis locally. They were able to provide several informative reports around the role of SCSs."

Exposure to Existing SCSs in Other Countries

"A group of them ended up being funded by [X organization] to go to Vancouver on a tour of InSite, and they came back talking about it in religious-conversion terms."

"People who don't understand addiction attribute all negative aspects of drug use in Vancouver to the facility itself. But other officials with knowledge of drug use . . . see the positive aspects and it helps gain support."

Opening of a Sanctioned SCS in the U.S.

"If [X legislation] passes, it will be a game changer for this issue for the . . . country."

"If [X locality] moves forward and [X politicians] can go visit those sites, then that would build momentum."

Research as Necessary but Not Sufficient to Shift Views

"The science is settled around safe consumption, but the political battle is the hard part. Just going to them with the literature reviews does not work."

"Using the data makes it clear that SCSs work and are needed. The only tool the opposition has is fear, so in any structured conversation, like department board meetings, there is clear evidence pitted against unsubstantiated fears."

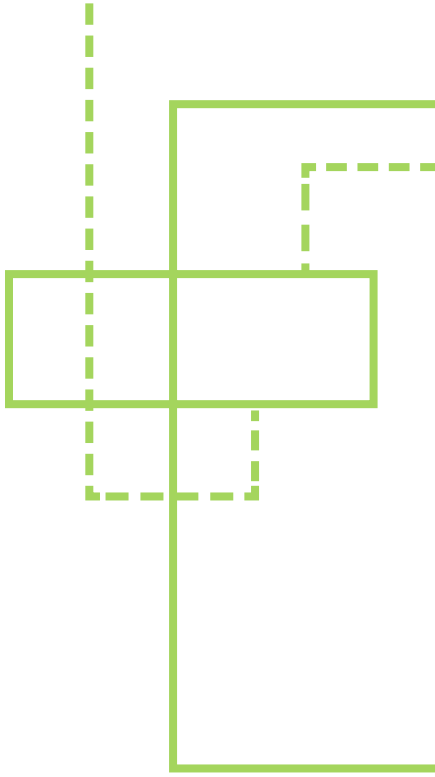
Bracketed text indicates editing by the authors either to clarify the context of the quotation or to substitute potentially identifying information with more generic language.

Discussion

In this study, we considered the strategies being employed to advance the policy agenda on SCSs in the United States. The political scientist John W. Kingdon theorized that when a problem appears on the political agenda, a policy exists to address this problem, and the political climate is favorable, policy entrepreneurs can take advantage of this window of opportunity to enact meaningful policy change.[36] Drug use and addiction are present on the political agenda in the five locations we studied, and in many cases, SCS adoption is increasingly viewed as one viable policy response. The local political climate in the locations considering SCS adoption may be conducive to change as policymakers, including mayors, city council members, health agencies, and state legislators, have endorsed SCS.

Nevertheless, U.S. jurisdictions face both logistical (e.g., locating a site) and political (e.g., opposition from key political officials) obstacles to establishing these sites. Some jurisdictions do not have the support they need from key policymakers to move forward, and community advocates are waiting on upcoming elections to change the political climate. In the meantime, participants reported working to establish policies and procedures for SCS implementation, identify partners for service provision, and explore potential funding opportunities so that when official sanction of SCSs occurs, they can move forward quickly. Some participants also have engaged in civil disobedience by establishing quasi-SCSs to force the hands of political officials while also addressing the current needs of people who use drugs. Advocates in other countries, such as Australia, Denmark, and Canada, also practiced civil disobedience prior to SCS policy change.[27,37] A major uncertainty looming over efforts in all jurisdictions is how the federal government will respond. Participants were well aware of the legal obstacles to SCS implementation, and most had undertaken legal analyses to prepare and mitigate liabilities.[30] Although not all localities had champions at the state level, state intervention appeared to be of lesser concern than the potential federal response.

An important theme emerging from these interviews was the essential role of people who use drugs in the organizing movement around SCSs. Schneider and Ingram's work suggests that the social construction of target populations is an important determinant of the policy agenda and design.[38] According to their theoretical framework, policymakers will default to enacting punitive policies targeting people



who use drugs unless strategies are put in place to counteract the powerlessness of this population in the political arena. Organizing this community is one approach SCS advocates have pursued to strengthen the political power of people who use drugs and improve the way that they are perceived in society.

This study has several limitations. Our sample lacked representation from people who use drugs. Although three participants shared that they had lived experience with a substance use disorder, all described themselves as in recovery. Attitudes toward SCSs among people who use drugs have been explored in prior research.[39] However, to our knowledge, there has been little research on the role of this group in driving policy change in the U.S.;[40–42] this topic should be explored further. Another limitation of the study is its generalizability, particularly in the context of a problem that encompasses non-urban areas of the country. Although two jurisdictions are aiming to establish non-urban sites, most study participants represented urban, politically progressive settings. This constitutes an important limitation given that the drug epidemic in the U.S. has had wide geographic reach and devastating effects in rural regions. The experiences shared by participants may be less generalizable to rural settings, where the availability of the types of services, such as pharmacologic treatment for opioid use disorder and syringe services programs, on which SCSs might build is more limited[33,43] and the political environment differs.

Although the people and organizations driving progress on SCS policy vary across the country, interviews illuminated many common themes. Organizers' success in positioning SCS implementation as a politically viable policy option has involved responding to questions and doubts about SCSs with openness, engaging a diverse set of allies, organizing people who use drugs and involving them in advocacy efforts, urging politicians to endorse SCSs with behind-the-scenes and public pressure, and addressing mistrust in the community, particularly as related to how SCS policy contrasts with the racial injustice of punitive drug policy in the context of the War of Drugs. As localities independently engage in efforts to move SCS policy forward, they are closely watching one another's progress, which has important implications for their own likelihood of success. As one participant noted, the "X factor . . . will be if another city actually implements SCS" and how the federal government responds.

RECOMMENDATONS FOR JURISDICTIONS CONSIDERING ESTABLISHING SCSs

The conditions that have driven momentum around SCSs in these five locations are not isolated problems. As other communities begin to consider SCS adoption, the early lessons learned from the five jurisdictions examined in this study can be informative. Based on findings from these interviews, we have developed eight initial recommendations for communities to consider in initiating public conversations around SCS adoption (see **Exhibit 6**).

Exhibit 6 / Recommendations for Communities Considering Safe Consumption Site Adoption

1. Initiate a public task force process to lay the groundwork for exploring safe consumption sites
2. Involve people who use drugs in the planning process
3. Engage in organizing and neighborhood outreach early
4. Pursue legal sanction of safe consumption sites through multiple avenues
5. Develop a legal strategy for operating the safe consumption sites
6. Frame the concept of safe consumption sites in the context of racial justice
7. Consider a wide range of partnerships
8. Build on past successes at the local level
9. Engage local researchers
10. Develop a media communication strategy

1. Initiate a public task force process to lay the groundwork for exploring SCS adoption.
The process should be transparent in its proceedings and provide opportunities for members of the community to contribute to and shape the conversation. A report produced through a task force process could provide a format for summarizing the evidence base on SCSs, outlining considerations for establishing SCSs specific to the local context, and serving as a reference point for public dialogue around SCSs.

2. Involve people who use drugs in the planning process. Communities with active drug user unions should involve these groups early in formal processes for considering SCS adoption, such as establishing task forces or initiating town hall meetings. Communities without active drug user unions should consider strategies for connecting with and organizing people who use drugs and to leverage SCS adoption as an opportunity to engage this group in broader community conversations about drug policy.

3. Engage in organizing and neighborhood outreach early.
If drug use and overdose are concentrated in certain neighborhoods, these neighborhoods inevitably become the candidates for locating an SCS. Neighborhood-level attitudes toward proposed SCSs will be a critical factor in the likelihood of SCS adoption. Engaging community members early in discussions about SCSs will enable advocates to proactively address community concerns, identify trusted partners, and avert organized opposition.

4. Pursue legal sanction of SCSs through multiple avenues. The political climate in the city or state considering SCS adoption will influence the level of government targeted for obtaining legal sanction and the specific policy mechanism, such as state legislation, city council approval, or executive branch authorization (e.g., authorization from the mayor, governor, or the local or state health department). If multiple governmental entities offer a feasible path forward, localities should pursue legal sanction through more than one avenue; these efforts can be mutually reinforcing.

5. Develop a legal strategy for operating the SCS.
Localities considering SCS adoption should develop a legal strategy for protecting the individuals, facilities, and organizations involved in operating the SCS. Developing a legal strategy will likely involve obtaining professional legal counsel.

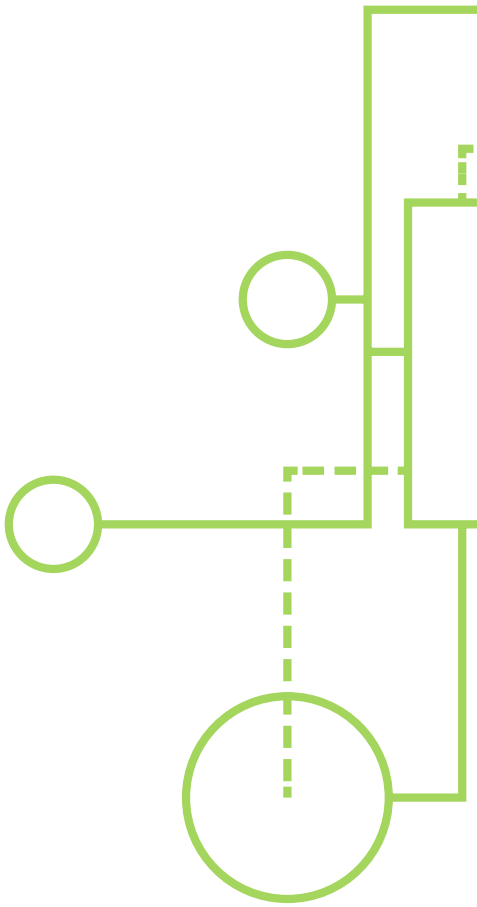
6. Frame the concept of SCSs in the context of racial justice.
In communities that have been disproportionately affected by punitive drug policy, conversations about SCSs should be framed within the broader context of the War on Drugs and strategies for reversing punitive drug policy and remedying the damage it has wrought on communities of color.

7. Consider a wide range of partnerships.
Organizers in localities considering SCS should engage diverse allies and be open to partnerships with groups that may have different motivations for supporting SCSs. Engaging partners with differing perspectives can quell potential opposition and facilitate support among groups that harm reduction organizers may not typically reach.

8. Build on past successes at the local level.
Within many communities, prior policy and/or organizing efforts might provide an existing infrastructure for jump-starting efforts to establish an SCS. Existing syringe services programs, law enforcement diversion efforts, or other initiatives in communities may have established prior partnerships around community action, legal precedent, and community buy-in regarding specific locations to site an SCS or another context that could be helpful in moving SCS efforts forward.

9. Engage local researchers.
Local researchers can contribute to the evidence base on SCS implementation in a U.S. context. Researchers should be included early in the process to ensure that there is sufficient opportunity to design a rigorous evaluation and to collect baseline data. In addition to generating evidence on SCS impacts in U.S. communities, researchers studying the implementation process can develop best practices to inform SCS implementation in other locations.

10. Develop a media communication strategy.
Be proactive in developing a strategy for communicating information about SCSs through the media. By engaging with the media early in the process, organizers can disseminate positive messages about the benefits of SCSs and counter misperceptions preemptively. Identify and train specific individuals to serve as the key media liaisons.



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3. Endorse the paper on social media outlets
4. Link to the paper on your organization's website or blog
5. Use the paper in group or classroom presentations
6. Frame the concept of safe consumption sites in the context of racial justice
   Reference the paper in your materials, and cite it as follows: "Establishing Sanctioned Safe Consumption Sites in the United States." Scattergood Foundation, Philadelphia, PA
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