



SAFE INJECTION FACILITIES: RESPONSE TO SENATE  
JUDICIARY COMMITTEE REQUEST

October 15, 2018

REVISED and Updated October 17, 2018

## Acknowledgements

The Council wishes to thank the members of the OCC Safe Injection Facilities Executive Team, and the contributors to this report, for dedication, effort and expertise they brought to this examination.

### Safe Injection Facilities Executive Team

**Tom Anderson**, Commissioner, Vermont Department of Public Safety

**Mark Levine**, Commissioner, Vermont Department of Health, Agency of Human Services

**Jolinda LaClair**, Director, Drug Prevention Policy and Governor's Opioid Coordination Council

**Christopher Herrick**, Deputy Commissioner, Vermont Department of Public Safety

**Rose Gowdey**, Community Engagement Liaison, Governor's Opioid Coordination Council

**John Searles**, Substance Abuse Research and Policy Analyst, Vermont Department of Health

**Teresa Randall**, Lieutenant, Vermont Department of Public Safety

**Eleanor Springer**, VISTA volunteer, Governor's Opioid Coordination Council

### Contributors

**Christina Nolan**, U.S. Attorney, Vermont

**Vermont League of Cities and Towns**

**Members of the Governor's Opioid Coordination Council**



**For information about the Opioid Coordination Council, contact:**

Jolinda LaClair, Director, Drug Prevention Policy

[Jolinda.LaClair@vermont.gov](mailto:Jolinda.LaClair@vermont.gov)

Rose Gowdey, Community Engagement Liaison

[Rose.Gowdey@vermont.gov](mailto:Rose.Gowdey@vermont.gov)

**Website:** [www.healthvermont.gov/opioid-coordination-council](http://www.healthvermont.gov/opioid-coordination-council)

# Table of Contents

<b>Acknowledgements</b> .....	2
<b>Executive Summary</b> .....	5
<b>Introduction</b> .....	6
Research Background.....	6
Questions from the Senate Judiciary Committee .....	8
<b>Efficacy and Outcomes of SIFs Worldwide (Questions 1, 2 and 7)</b> .....	9
<b>SJC Q1:</b> An examination of the experiences of places such as Seattle, WA; Philadelphia, PA; Ithaca, NY; New York City, NY; Montreal, Canada; and Vancouver, Canada where such facilities are either currently operating or in the authorization process.....	9
<b>SJC Q2:</b> The efficacy and outcomes of safe consumption facilities operating in other jurisdictions around the world. ....	12
<b>SJC Q7:</b> The public safety issues associated with such a facility as evidenced by experience in other jurisdictions and whether there is any evidence that safe consumption facilities in other jurisdictions have increased crime in those neighborhoods or created a new market for drugs. ....	14
<b>Costs and Benefits of SIFs to State and Local Governments and Communities (Questions 3 &amp; 4)</b> .	15
<b>SJC Q3:</b> The costs to local or state government if such a facility were operated in Vermont by an independent organization and whether such a facility can result in net savings with respect to a reduced need for health care, emergency services, and law enforcement. ....	15
<b>SJC Q4:</b> The appropriate methods and measures for determining the health-related and public safety outcomes for such a facility. ....	16
<b>Legal Obstacles to the Establishment of a SIF (Questions 6 &amp; 5)</b> .....	17
<b>SJC Q6:</b> The federal criminal and civil legal risks facing clients, staff, volunteers, and organizations associated with such a facility.....	17
<b>SJC Q5:</b> Whether there are legal risks or liabilities to the State in approving, but not operating, such a facility.....	18
<b>The Rights of Local Governments and Communities to Limit Establishment of a SIF (Question 8)</b> ....	19
<b>SJC Q8:</b> Whether local governments should have the ability to prohibit such a facility from locating in that community or whether restrictions should be limited to time, place, and manner.....	19
<b>Considerations</b> .....	20
<b>Conclusion</b> .....	22
<b>Appendix I:</b> Members and Staff of the Opioid Coordination Council .....	24
<b>Appendix II:</b> Glossary of Terms.....	25
<b>Appendix III:</b> Letter from the Senate Judiciary Committee.....	27
<b>Appendix IV:</b> Opioid Coordination Council Strategies on Syringe Services Programs and Naloxone	30
<b>Appendix V:</b> Literature Review by Vermont Department of Health .....	31

**Appendix VI:** Syringe Services Program Info Sheet ..... 43  
**Appendix VII:** Additional Vermont Information on the Cost of Endocarditis Associated with Injection Drug Use..... 44

## Executive Summary

The Vermont Senate Judiciary Committee (SJC) asked the Opioid Coordination Council (OCC) in January 2018 to review and provide input regarding the operation of Safe Injection Facilities (SIFs). This was a part of the SJC's consideration of legislation which would provide legal protection for the operation of SIFs in Vermont. Specifically, the SJC provided eight points of inquiry which guided this review. These points were organized by theme for this report, as follows:

- Efficacy and Outcomes of SIFs Worldwide (Questions 1, 2 and 7)
- Costs and Benefits of SIFs to State and Local Governments and Communities (Questions 3 and 4)
- Legal Obstacles to the Establishment of a SIF (Questions 6 and 5 in that order)
- The Rights of Local Governments and Communities to Limit Establishment of a SIF (Question 8)

The OCC has spent the last several months reviewing information, research and studies on SIFs. This report reflects the OCC's review of these materials and includes the input of a majority of OCC members, who participated in a meeting on August 1, 2018 designed to consider the frame and direction of this report. The report was also reviewed by the Council at its meeting on September 10, 2018 and has been provided to Governor Phil Scott.

Based on its review, the OCC concludes that the legal obstacles alone, including potential federal criminal prosecution and civil liability of anyone involved in the operation of a SIF, make the opening of a SIF in Vermont virtually impossible to accomplish legally. The OCC further concludes the efficacy of SIFs in reducing overdose deaths, providing a pathway to treatment, and reducing the spread of infectious disease is currently unproven and requires significantly more independent scientific study before their effectiveness can be determined, and a meaningful cost-benefit analysis can be completed. (See **Appendix V, p. 6.**) Finally, the OCC believes investment of Vermont's limited resources is more prudent when directed to proven harm reductions models, and in particular syringe service programs (SSPs), and in proven treatment models like the Hub and Spoke system.

An AHS proposal to devote \$1 million of the tobacco settlement funds to expand syringe services programs will be included as part of the FY 2019 budget adjustment in January 2019.

**Note:** The research upon which this report is based is provided in substantial detail in **Appendix V: Literature Review.**

## Introduction

Vermont has approximately 8,000 people in medication-assisted treatment (MAT) for opioid use disorder (OUD). Vermont estimates there are 15,000 – 20,000 people with OUD in the State, an estimate based on US, regional and Vermont data. This equates to approximately three percent of people in Vermont who suffer with OUD. Thus, between 7,000 and 12,000 people are not in treatment.<sup>1</sup>

The Opioid Coordination Council (OCC) honors the tremendous achievement of moving 8,000 people in to MAT through the State's Hub and Spoke system; and it works with a sense of urgency to improve intervention systems on behalf of Vermonters with OUD who are still in need of treatment.

That is the context in which the OCC has undertaken the Senate Judiciary Committee's request for input on particular issues raised by S.107 of 2018 and the possibility of a Safe Injection Facility (SIF)<sup>2</sup> in Vermont. The OCC has prepared this response by reviewing available research and to a limited degree, primary news sources. These resources relate to the health, public safety, legal, and community-based issues that inform whether SIFs should be considered as a program within Vermont's harm reduction model, which aims to mitigate opioid-related harms in the State of Vermont. This review includes an examination of the efficacy and impact, including neighborhood impacts of SIFs in locations where they operate; a review of scientific literature relating to SIFs; data points that might be used to measure health-related and public safety outcomes; legal and liability issues (state and federal) in connection with the operation of SIFs; and whether the operation of such facilities is cost-effective as compared to other prevention, treatment, and harm reduction programs designed to address the State's opioid epidemic.

### Research Background

The research upon which this report is based is provided in substantial detail in **Appendix V: Literature Review**. This review was performed by John Searles, Vermont Department of Health, and updated for this report. The OCC SIFs Executive Team recommends reading the Literature Review in full.

It is of note both in responses to items herein and in the Literature Review that the Vancouver SIF, InSite, is the primary source of data. It was established in 2003 by waiver of the Canadian government (Health Canada), and required to be studied by an independent research body. Even so, findings and interpretations of the data should be examined and questioned, given, for example, the absence of consideration of environmental factors that may have influenced findings on neighborhood impacts, and the reliance on simulated models where hard data may be available to more accurately assess cost-effectiveness. Challenges to the data or interpretations are explained in this report and in **Appendix V**.

---

<sup>1</sup> These figures are based on a) the number of people in MAT in Vermont at any point-in-time (approximately 8,000); b) 2017 National Survey on Drug Use and Health (NSDUH) estimates that nearly 55% of individuals with heroin use disorder and 30% of those with OUD have received treatment, c) Vermont has capacity or near immediate MAT, and d) Massachusetts estimates 4.4% OUD in ages 11+ (<https://www.mass.gov/files/documents/2017/08/31/legislative-report-chapter-55-aug-2017.pdf>). Vermont's population is older than MA (median age 43.1 vs MA's 39.5), and Vermont has among the highest treatment rates in the U.S., both of which would contribute to a rate lower than the MA rate. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504312/>

<sup>2</sup> Nomenclature for SIFs continues to evolve. **Appendix II: Glossary** includes several variations. The use of "Safe" here should not be construed as an assumption that injection of illicit drugs in an approved facility or elsewhere is "safe" under any circumstances.

Information on efforts to establish SIFs in the United States was gathered informally by the OCC SIFs Executive Team, and from primary news items.

Many news articles and broadcasts are available addressing a broad range of perspectives on the necessity, legitimacy, legal factors, public safety and health considerations relating to SIFs. These are referenced minimally in this report, when they bring useful data or information to the questions considered here.

The OCC's SIFs team also reviewed for this report the Chittenden County State's Attorney's Commission findings: A Public Health and Safety Analysis in Support of Supervised Injection Facilities (SIFs) (November 2017).

The OCC's review is in general agreement with the Commission's findings relating to syringe services programs as follows:

- Emergency access to low barrier MAT would serve to reduce risk of overdose, and would be likely to improve treatment access and retention.
- Improved capacity to provide counseling and case management for drug treatment options at SSPs would serve to increase treatment access and retention.
- Improved procedures to address on-site medical emergencies and overdoses would benefit outcomes.

However, the OCC's review does not support the Commission's findings encouraging movement toward the establishment of SIFs.

### Questions from the Senate Judiciary Committee

(See Appendix III: Letter from the Senate Judiciary Committee.)

**Note:** These points were reordered for this report, to allow content to be organized by theme. The Table of Contents reflects the organization of information.

1. An examination of the experiences of places such as Seattle, WA; Philadelphia, PA; Ithaca, NY; New York City, NY; Montreal, Canada; and Vancouver, Canada where such facilities are either currently operating or in the authorization process.
2. The efficacy and outcomes of safe consumption facilities operating in other jurisdictions around the world.
3. The costs to local or state government if such a facility were operated in Vermont by an independent organization and whether such a facility can result in net savings with respect to a reduced need for health care, emergency services, and law enforcement.
4. The appropriate methods and measures for determining the health-related and public safety outcomes for such a facility.
5. Whether there are legal risks or liabilities to the State in approving, but not operating, such a facility.
6. The federal criminal and civil legal risks facing clients, staff, volunteers, and organizations associated with such a facility.
7. The potential public safety issues associated with such a facility as evidenced by experience in other jurisdictions and whether there is any evidence that safe consumption facilities in other jurisdictions have increased crime in those neighborhoods or created a new market for drugs.
8. Whether local governments should have the ability to prohibit such a facility from locating in that community or whether restrictions should be limited to time, place, and manner.

## Efficacy and Outcomes of SIFs Worldwide (Questions 1, 2 and 7)

**SJC Q1:** An examination of the experiences of places such as Seattle, WA; Philadelphia, PA; Ithaca, NY; New York City, NY; Montreal, Canada; and Vancouver, Canada where such facilities are either currently operating or in the authorization process.

There are no sanctioned or operational SIFs in the United States. This may be in part due to the potential legal obstacles to their operation, the professional jeopardy for SIF staff and sponsoring organizations, and community opposition or lack of support. Accordingly, data or information are not available on any actual experiences of operating SIFs in the United States. However, as set forth below, several U.S. cities are considering or have approved SIFs. There also appears to be at least one, but likely several unauthorized SIFs operating covertly in large cities in the U.S. (See **Appendix V.**)

The experiences of SIFs currently being operated in Canada is included below and elsewhere in this report.

### **International**

Vancouver, British Columbia: InSite in Vancouver, BC has been operating since 2003, having been established under a waiver from Health Canada to prevent any federal, state, or local interference. InSite limits participants' stays to 30 minutes due to high demand. However, no documentation was found regarding how long a participant actually spends in the SIF on an average visit.

InSite appears to be the rare site that has data and published research results, and is therefore often cited, especially in support of SIFs.

Montreal, Quebec: Three permanent sites and one mobile site have been established under the same Health Canada waiver as Vancouver. One of the sites is apparently located near a school, which has caused some local concern.<sup>3</sup> According to SIF staff, the average time a participant stays at the facility is not tracked but staff suggested most stay much less than an hour, and some stay as little as ten minutes.<sup>4</sup>

Toronto, Ontario: Toronto SIFs operate under the same Health Canada waiver as Vancouver, with two permanent sites open and one moveable "pop-up" site open.

Sydney, Australia: As of August 2018, the only operational SIF in Australia is located in Sydney. The Uniting Medically Supervised Injecting Centre (MSIC) Kings Cross is operated by Uniting, the services and advocacy arm of the Uniting Church NSW & ACT. The site is also supported by the New South Wales Police, the New South Wales Department of Health, and the local community. The site is funded by a Confiscated Proceeds of Crime Account, as managed by the New South Wales Treasury. The SIF is open every day of the week, including public holidays. Because of its location opposite Kings Cross Station, the site is a short train ride from Sydney's central business district and other points of access.<sup>5</sup>

---

<sup>3</sup> According to CBC News, one the Montreal sites is located near a school, and some parents are advocating that the opening hours of the SIF be changed. The head of the elementary school's governing board felt that government officials had not properly consulted parents or the school before moving ahead with the project. <http://www.cbc.ca/news/canada/montreal/safe-injection-site-montreal-downtown-parents-1.4347727>

<sup>4</sup> This is based on informal conversation with Montreal SIF staff.

<sup>5</sup> <https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre>

Europe/EU: In Europe, where many countries legalized SIFs as a part of an effort to combat increasing HIV/AIDS infection rates, Drug Consumption Rooms were established with purely clinical intent, and little to no research has been published in English since 2004. The European Monitoring Centre for Drugs and Drug Addiction notes that, “Facilities for supervised drug consumption tend to be located in settings that are experiencing problems of public use and targeted at sub-populations of users with limited opportunities for hygienic injection (e.g. people who are homeless or living in insecure accommodation or shelters).” The map in Figure 1 demonstrates the density of SIFs in Europe, with, as of April 2018, 115 facilities in 64 cities across Europe.<sup>6</sup>

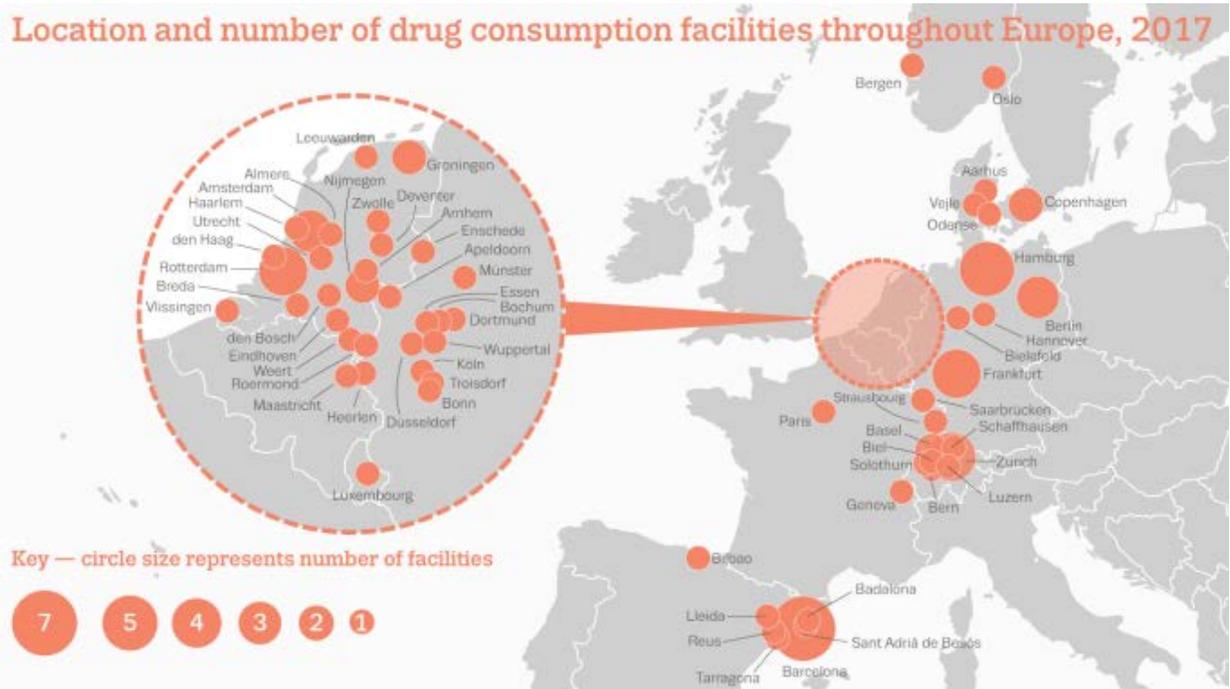


Figure 1

## United States

King County (Seattle), WA: King County approved a plan to establish two SIFs. Contact with Brad Finegood of the King County Department of Community and Health Services has provided insight into the obstacles they face even with this approval. When they selected a location to lease for the establishment of a SIF, the landlord retracted the lease offer due to concerns about federal forfeiture laws applied to individuals and the property they own where illicit drug activity is involved. They are now considering two alternatives: a mobile SIF (which does not subvert the forfeiture problem, but does reduce cost and exposure), or setting up a SIF within a faith-based property (i.e. a church). Whether the federal government would apply the forfeiture rules to such a property is unknown. (See **Appendix V, p. 3.**)

<sup>6</sup> European Monitoring Centre for Drugs and Drug Addiction. Updated 7/6/2018. Perspectives on Drugs: Drug Consumption Rooms: an overview of provision and evidence. [http://www.emcdda.europa.eu/publications/pods/drug-consumption-rooms\\_en](http://www.emcdda.europa.eu/publications/pods/drug-consumption-rooms_en). Figure 1 can be found at: <http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms>

Philadelphia, PA: In January 2018, city officials in Philadelphia approved the establishment SIF but, to date, no facility has been opened or is operating in Philadelphia.

New York City, NY: City officials in New York are currently discussing SIFs with Mayor DeBlasio in support of SIFs being operated in New York.<sup>7</sup> One article describes an attempt by researchers and clinicians to establish a pop-up SIF in the South Bronx area of New York City, an area identified because a nearby abandoned and partially underground rail line is a known congregation space for people who inject drugs. The SIFs were two high-end portable toilets modified by the researchers for safe injection space use. However, very few of the area residents used the SIFs, instead continuing to inject near the abandoned rail line.<sup>8</sup> (See Considerations section for results of a feasibility report out of New York.)

Ithaca, NY: A news item in The Ithaca Voice dated May 16, 2018 includes a letter from the mayor of Ithaca to New York Governor Cuomo asking that Ithaca be added to the list of SIF pilot sites. This pilot project was proposed by the City of New York, and has not been approved.<sup>9</sup>

San Francisco, CA: The California State legislature is on the verge of passing a bill like VT S.107 of 2018 to protect the employees and staff of a SIF, limiting that protection to San Francisco rather than statewide. The San Francisco Department of Public Health is set to implement policy and procedures (e.g., determining necessity of fire inspections, qualifications of staff, etc.). SIFs would be established in existing clinics (e.g., SSPs) and run by private agencies. For any organization operating a SIF, questions about federal funding and/or legal action must be considered. San Francisco is considering workarounds to avoid legal implications for staff, landlord and the organization operating the facility.

Boston, MA: Instead of pursuing the establishment of a SIF, the Boston Health Care for the Homeless Program has established an observation site, “Supportive Place for Observation and Treatment” (SPOT). This facility is a safe space for individuals who have consumed non-prescribed drugs to go for observation in a non-stigmatized, non-threatening environment.

---

<sup>7</sup> New York Times May 3, 2018. DeBlasio Moves to Bring Safe Injection Sites to New York City. (<https://www.nytimes.com/2018/05/03/nyregion/nyc-safe-injection-sites-heroin.html>)

<sup>8</sup> Wolfson-Stofko et al. (2016). The Portapotty Experiment: Neoliberal Approaches to the Intertwined Epidemics of Opioid-Related Overdose and HIV/HCV and Why We Need Cultural Anthropologists in the South Bronx. *Dialectical Anthropology*, 40, 495-410. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5130102/>)

<sup>9</sup> The Ithaca Voice, May 16, 2018. Svante Myrick wants Ithaca to be New York’s fifth pilot site for supervised injection facilities. (<https://ithacavoices.com/2018/05/svante-myrick-wants-ithaca-new-yorks-fifth-pilot-site-supervised-injection-facilities/>)

**SJC Q2: The efficacy and outcomes of safe consumption facilities operating in other jurisdictions around the world.**

The current research does not support whether or to what extent SIFs reduce fatal opioid overdose, reduce the spread of disease, or help to offer pathways out of drug misuse (i.e. by offering access to treatment, etc.). Vancouver is the only site worldwide that has published peer-reviewed research with information on its SIF. One of the conditions of the Health Canada waiver authorizing the InSite facility was to establish a continuing three-year independent evaluation group. The group is affiliated jointly with the British Columbia Centre for Excellence in HIV/AIDS and the Department of Medicine, University of British Columbia.

The peer-reviewed research published by this group suggests SIFs may result in positive harm reduction outcomes in a densely populated, urban area with a large known population of people who use intravenous drugs (i.e. reduced overdose deaths, reduced rates of transmission of blood borne diseases, increased access to treatment, reduced public drug injection use, reduced crime). (See **Appendix V.**)

Many of the published studies regarding the InSite SIF have been conducted by this one group. The two principal authors of the InSite research reports were also its chief advocates and had published research prior to the establishment of InSite promoting the creation of a SIF in Vancouver. Questions have been raised regarding whether these studies are truly independent, about the integrity of the reported data, and the actual impact of InSite on key outcomes.

For example, one report states there was a 35% decrease in overdose mortality rates in the 15 months after InSite opened (September 21, 2003) compared to the 33 months prior to the opening of the SIF, while a non-significant decrease was observed in the rest of the city. However, the report fails to mention that the Vancouver Police Department implemented a significant “crackdown” in this area in the same six-month period prior to InSite’s opening. (See **Appendix V, p. 4.**) The documented increased police presence was dramatic and operating 24 hours per day, seven days per week. One of the results of this heightened presence was a displacement of both the drug market and drug use from this area to an adjacent area. Thus, a 35% reduction in overdose deaths in the area immediately surrounding the SIF would not be due entirely to the opening of the SIF.

As shown in the heat maps below, between 2001 and 2017, the overdose death rate in the area surrounding the InSite facility consistently has the highest overdose death rate in the Vancouver area, which has steadily risen during this period.

## City of Vancouver Overdose Death Rate per 100,000, 2010-2017<sup>10</sup>

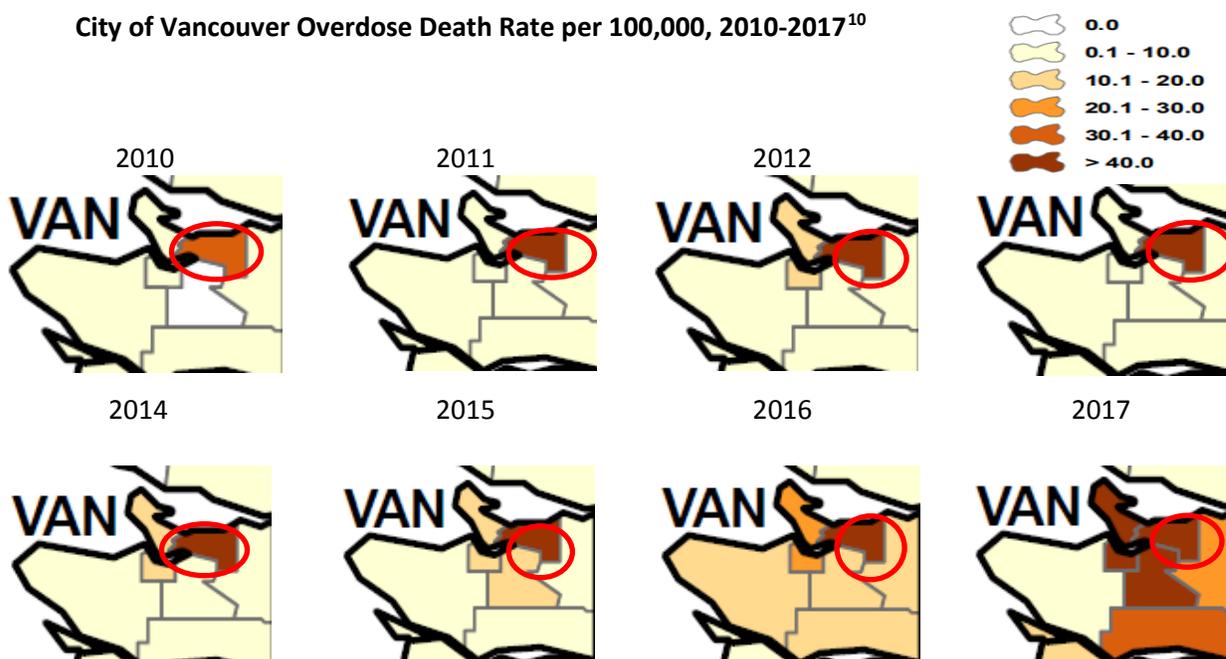


Figure 2: Vancouver's InSite program is in the neighborhood indicated by the red circle.

InSite data regarding frequency of use by participants is also instructive on the challenges of measuring and demonstrating efficacy. In 2017, 7,301 unique individuals made 175,464 visits to the site. People with advanced opioid use disorder and heavy heroin use inject multiple times daily – estimates range from five or six injections per day, to over ten. These are likely to be typical SIF participants. Based on this reported usage, many people use these sites infrequently – less than once per week. A calculated average would be 24 times per year.

InSite has collected no data on the overdose death rates of individuals who have utilized the facility as compared to the general population who inject drugs, which may be a more meaningful measure of whether InSite has reduced overdose deaths. In other words, does a SIF prevent overdose deaths or simply delay them? Other claimed benefits of the InSite facility, e.g., reduction in disease transmission and reduction of heroin use through treatment referrals, also lack supporting data despite InSite having been in operation for 15 years. Nonetheless, even assuming such benefits are being realized, they can be and are being realized in a far less controversial, and a more cost-effective and legal manner, through SSPs in Vermont and across the U.S.

In summary, there are no definitive long-term data showing a reduction in overdose deaths among those who use SIFs, or that SIF participants are successfully transitioning to treatment. (See **Appendix V, p. 6.**)

It is also important to note the available research on the efficacy of SIFs has been completed in areas of high population density in an urban setting. Even accepting as accurate the claimed benefits from such

<sup>10</sup> <http://www.bccdc.ca/resource-gallery/Documents/Statistics%20and%20Research/Statistics%20and%20Reports/Epid/Other/Illicit%20Drug%20Overdose%20Deaths%20by%20LHA%20-%20No%20Counts.pdf>

sites, it is far from clear whether the same results and benefits would translate to a rural and dispersed population, as found in Vermont.

**SJC Q7: The public safety issues associated with such a facility as evidenced by experience in other jurisdictions and whether there is any evidence that safe consumption facilities in other jurisdictions have increased crime in those neighborhoods or created a new market for drugs.**

There has not been adequate research into whether jurisdictions with operating SIFs experience an increase or decrease in crimes in or around the area the SIF operates.<sup>11</sup> That said, it is important to consider the potential negative effects a SIF may have on a neighborhood or community, including, among others, the following financial and public safety impacts:

- Increased possession and distribution of illegal drugs in the vicinity of the SIF (assuming that those using the SIF would make some of their purchases in the neighborhood, and that dealers may target such neighborhoods, unless law enforcement in the area is increased);
- Increased property crimes such as burglary and theft;
- Increased violent activity such as robbery;
- Increased disorderly conduct complaints; and
- Increased impaired driving after use of a SIF.

One study on the impact of Vancouver’s InSite facility on the surrounding community suggests that violent, drug-related crime was highly visible eight years after Insite opened.<sup>12</sup> This study was a qualitative and mapping report on gendered violence in the Downtown Eastside of Vancouver where Insite is located. Mapping data identified the area immediately surrounding Insite as “area avoided” by study participants due to the high risk of violence.

Regarding impaired driving, most SIFs around the world are located in urban, metropolitan areas. Public transportation, and the location of SIFs in high injection drug use areas, may minimize the number of participants who drive to the SIF. In Vermont, we know some use drugs in their vehicles – this is already an issue. Vermont’s rural nature increases the likelihood that participants will drive to and from a SIF, even in Burlington. One must consider, therefore, the public and roadway safety risks of an increased number of people driving away from a SIF under the influence of the drug they have used.

---

<sup>11</sup> Data on Vancouver’s SIF suggest a reduction in the local crime rate near the facility within the first years of operation. As noted in **Appendix V**, this was as likely a result of an intentional and substantial increase in police presence in the area.

<sup>12</sup> McNeil, et. al. (2014). Negotiating Place and Gendered Violence in Canada’s Largest Open Drug Scene. *International Journal of Drug Policy*, 25, 608-615.

## Costs and Benefits of SIFs to State and Local Governments and Communities (Questions 3 & 4)

**SJC Q3:** The costs to local or state government if such a facility were operated in Vermont by an independent organization and whether such a facility can result in net savings with respect to a reduced need for health care, emergency services, and law enforcement.

This section addresses primarily the information available regarding cost/benefit or cost-effectiveness of SIFs, noting that aside from Vancouver's InSite, available literature makes projections based on simulations.

First, it is important to note that the SJC question assumes that a hypothetical SIF in Vermont would not be directly operated or funded by state or local government. There would, however, be significant indirect costs to taxpayers resulting from the existence of a SIF.

That said, initial and on-going direct costs would be substantial. Health Canada allocates \$3 million (Canadian) per year to operate Vancouver's InSite SIF. A 2013 estimate of the cost of operating a SIF in Montreal is \$2.182 million (Canadian).<sup>13</sup> A CBC news report from June 2017 indicates that Health Canada had approved three sites in Toronto, at a cost estimate of \$1.6 million (Canadian) each annually.<sup>14</sup> Operational costs estimates from King County (Seattle) are projected to be approximately \$1.3 million.<sup>15</sup>

Indirect cost implications for local or state government may include:

- Increased need for law enforcement in the area of the SIF;
- Impact on local community-based costs, such as expenses for first responder and emergency department interventions for overdose cases;
- Need for regulatory and administrative oversight by the State of Vermont; and
- Addressing potential neighborhood complaints.

Advocates of SIFs suggest the costs are recouped by downstream health care savings and potential lives saved, and, in fact, it is difficult to either to affirm or deny such claims, given the lack of data supporting them and the difficulty of calculating avoided outcomes.

**Any cost-benefit analysis of SIFs, however, should include a comparison of potential SIF benefits to the benefits obtained by other services.** In Vermont, SSPs operated by regional healthcare providers address many of the same outcomes intended by SIFs. They provide clean supplies and instructions and refer for wound care when infection is suspected. They have also begun providing fentanyl testing kits to their participants, and report positive results. In addition, they have been collecting and analyzing data on overdoses, transitions to treatment, and other measures, and SSPs do not face the legal obstacles that apply to SIFs. SSPs can be expanded to reach more individuals across the State. (See **Appendix VI, Syringe Service Program Info Sheet** for data and comments. See also the Considerations Section, p. 21-22.; **Appendix VII: Additional Information**; and **Appendix II: Glossary**.)

---

<sup>13</sup> Jozaghi, E., Reid, A. A., & Andresen, M. A. (2013). A cost-benefit/cost-effectiveness analysis of proposed supervised injection facilities in Montreal, Canada. *Substance Abuse Treatment, Prevention, and Policy*, 8, 25.

<sup>14</sup> The Canadian Press, June 2, 2017. <https://www.cbc.ca/news/canada/toronto/toronto-injection-sites-1.4144096>

<sup>15</sup> <http://www.seattleweekly.com/news/seattle-and-king-county-officials-want-a-safe-injection-van/>

**SJC Q4: The appropriate methods and measures for determining the health-related and public safety outcomes for such a facility.**

The attached Literature Review describes the challenges in projecting outcomes for SIFs. (See **Appendix V, p. 7.**) No cost-benefit study to date has used real data in its analyses. The Vancouver report relies on estimated, hypothetical, and simulated data, despite having data based on their operations beginning in 2003. Desirable outcomes such as lives saved or overdoses and infections prevented can only be assessed through hypothetical modeling. This underscores the difficulty in evaluating health-related and public safety outcomes. While it is in theory possible to specify relevant outcomes, it is nearly impossible to ascribe these outcomes (positive or negative) to a particular program such as a SIF.

External factors often contribute to a particular measure, making it difficult to attribute the results to the program. The cost and availability of drugs, secular trends that affect drug use, and political will can have major effects that are difficult to measure. For example, in Vancouver, increased policing activities in the neighborhood during the early phase of InSite's opening and operation made it difficult to assess the SIF's role in crime reduction. Furthermore, people who inject drugs are a small percentage of the general population, and they tend not to use SIFs for most of their drug injections; tracking data and ascribing causality on a small population that infrequently utilizes a SIF is unlikely to point conclusively toward any particular outcome.

To accurately gauge outcomes and success, a credible research consultant would need to be engaged both to establish effective measures and to perform the research and analysis.

If Vermont were to establish a SIF, measures for consideration may include:

**Potential public health measures/outcomes, such as:**

- Increase/decrease in injection overdoses among SIF participants, at the SIF or outside the SIF;
- Increase/decrease in overdose deaths among SIF participants;
- Increase/decrease in overdose deaths in the area the SIF is located, before and after the SIF is operational;
- A comparison of HIV and HCV infection rates among SIF participants, before and after SIF opens
- Injection site infection rates (soft tissue damage);
- Comparison of infection rates and illnesses related to injection drug use before and after the opening of a SIF, and the costs of their treatment (endocarditis, etc.);
- Comparative costs of treatment of infections among participants and non-participants; and
- Number of referrals to treatment provided, and rate of successful transition to treatment; and

Increase/decrease in the frequency of SIF use (percentage of an individual's drug use at the SIF compared to outside the SIF).

**Potential public safety/local community measures/outcomes, such as:**

- Increase/decrease in the number and type of interactions with law enforcement, especially in the local area the SIF is located (and an analysis of the related costs for enforcement);
- Increase/decrease in the number and type of arrests in the area the SIF is located (drug trafficking, theft, assault, robbery, disorderly conduct, violence, etc.);
- Increase/decrease in drug trafficking activity in the area the SIF is located;
- Increase/decrease in the number of complaints related to SIF presence, compared to citizen complaints relating to drug activity prior to SIF presence; and
- An analysis pre/post-SIF of EMT/first responder resources and related costs.

## Legal Obstacles to the Establishment of a SIF (Questions 6 & 5)

### SJC Q6: The federal criminal and civil legal risks facing clients, staff, volunteers, and organizations associated with such a facility.

As set forth more fully below, the potential federal criminal and civil liability to those working in, supporting, or aiding the operation of a SIF is significant and likely would pose an insurmountable obstacle to the establishment of a SIF in Vermont regardless of any action of the Vermont Legislature might take. Indeed, the exposure to potential federal criminal and civil sanctions may be the main reason that no SIF has actually been opened or operated in the United States. In addition, the Deputy Attorney General of the United States has recently stated that the Department of Justice will “meet the opening of any injection site with swift and aggressive action.”<sup>16</sup> In addition, there are potential professional licensure consequences to individuals involved in this activity as well as likely denial of liability insurance for health care workers, and the potential loss of federal funding to any agency or department involved directly or indirectly with the operation of a SIF. (See **Appendix V.**)

Establishment of injection facilities would violate several provisions of federal criminal law. Those who operate and administer the facilities or own the properties on which the facilities are situated, could be subject to prosecution under several provisions of the federal criminal code, including 21 U.S.C. section 856, which makes it a felony, punishable by up to 20 years in prison, to maintain a premises for the purpose of drug use. It is also a felony under federal law to aid and abet the distribution of a controlled substance and to conspire to commit a violation of any federal drug law – that is, become a knowing member of an agreement to violate the federal drug laws. Thus, under federal conspiracy and aiding/abetting law, insurance underwriters, nurses, staff, and others involved in the operation of injection facilities could be subject to federal criminal prosecution. As the drug quantities involved in a crime increase, so too do mandatory minimum/statutory maximum penalties. For example, an offense involving 100 grams or more of heroin gives rise to a charge carrying a five-year mandatory minimum sentence, and a forty-year statutory maximum. The same is true for an offense involving at least forty grams of a mixture and substance containing a detectible amount of fentanyl. The penalties are 10 years to life where the offense involves a kilogram or more of heroin or at least 400 grams of fentanyl. Participants at a SIF also face federal prosecution for the illegal possession of a controlled substance. 21 U.S.C. § 844.

Additionally, under federal criminal and civil forfeiture law, the property that is used or intended to be used, in any manner or part, to commit or facilitate the commission of a felony violation of the federal drug code is subject to forfeiture to the United States.

Other potential civil enforcement actions against the facility operators/administrators could result if an agency or organization operating a SIF accepted/received federal funds or grants of any kind, and that money was used to violate federal law (or for any unapproved purpose). Such enforcement actions could include a lawsuit under the false claims act or a healthcare fraud action. The federal government could also take action on the administrative side, by potentially revoking licenses or permissions of operators/administrators/staff.

---

<sup>16</sup> Rosenstein, Rod, J. (2018). ‘Fight Drug Abuse, Don’t Subsidize It’. *New York Times*, Aug. 27, 2018.

**SJC Q5: Whether there are legal risks or liabilities to the State in approving, but not operating, such a facility.**

Generally, to determine the liability of the State with respect to a SIF, a determination must be made as to whether the State has waived sovereign immunity. *See Lane v. State*, 174 Vt. 219, 222 (2002).

(“Lawsuits against the State are barred unless the State waives its sovereign immunity.”)

The Vermont Tort Claims Act (VTCA) is a limited waiver of sovereign immunity. It provides, in pertinent part:

The State of Vermont shall be liable for injury to persons or property or loss of life caused by the negligent or wrongful act or omission of an employee of the State while acting within the scope of employment, under the same circumstances, in the same manner, and to the same extent as a private person would be liable to the claimant . . . 12 V.S.A. § 5601(a).

The statute also sets out a number of exceptions to the State’s waiver of sovereign immunity, *see* § 5601(e), and any analysis should consider whether an exception or any other provision of § 5601 applies. Thus, whether and to what extent the State may be held liable should it participate in the opening, approval, licensing, and/or operation of a SIF will depend on a number of factors.

A model under which the State is the primary operator of the SIF may expose the State to liability for a “negligent or wrongful act or omission” of State employees acting within their scope of employment. For instance, if the facilities employed State employees, a State employee’s negligent conduct may open up the State to liability in a situation where no exception applied. Again, the sovereign-immunity analysis would depend on the precise circumstances of the situation, including the nature of the claims brought against the State. *See, e.g., Earle v. State*, 180 Vt. 284, 289 (2006).

A different model, however, based on a State inspection-and-licensing approach for the facilities, may or may not lead to State liability under the VTCA. For example, the Vermont Supreme Court has not imposed liability on the State for a “generalized licensing and inspection scheme” in the context of licensed childcare facilities. *See Lafond v. Vt. Dep’t of Soc. & Rehab. Servs.*, 167 Vt. 407, 415 (1998); *cf. Johnson v. State*, 165 Vt. 588, 588 (1996) (entry order) (finding sovereign immunity a bar to a claim against the State in suit involving a license).

Still, it is unclear how the specifics of any given model may affect a sovereign-immunity analysis. For instance, would State “approval” consist solely of licensing and inspection? Would “approval” require more extensive State involvement than in the childcare context referenced above? Would the facilities employ State employees? Also, in providing some type of State oversight, would the State be rendering any services to the facilities? These questions, among others, may have a direct bearing on any sovereign immunity analysis.

Finally, in evaluating potential State liability in this context, it is also important to consider how legislation—or, possibly, existing law—could impact sovereign immunity or the VTCA’s waiver of such immunity. For instance, with respect to a negligence claim against the State, the Vermont Supreme Court has set forth four factors to assess when determining whether a governmental entity “has undertaken a duty of care towards a specific individual, as distinguished from its duty to the public at large.” *Earle*, 180 Vt. at 289. The first listed factor is “whether an ordinance or statute sets forth mandatory acts for the protection of a particular class of persons.” *Id.* Would new legislation authorizing these facilities in Vermont establish the “mandatory acts”? Or, perhaps, could one argue they already exist in some form? This may warrant review. Moreover, could new legislation seek to govern State

liability with respect to the facilities at issue here? See § 5601(e)(7) (excepting from the VTCA’s waiver “[a]ny claim for which a remedy is provided or which is governed specifically by other statutory enactment”); see also 20 V.S.A. § 2305(d), as amended by Act 94 of 2018 (“No State agency or department or State official shall be subject to any civil, criminal, administrative, or regulatory liability for any act taken or omission made in reliance on the provisions of this chapter.”).

Given the above, any action by the State to operate, authorize or approve the opening of a SIF raises many unanswered questions and issues regarding potential civil liability for the State.

### The Rights of Local Governments and Communities to Limit Establishment of a SIF (Question 8)

**SJC Q8:** Whether local governments should have the ability to prohibit such a facility from locating in that community or whether restrictions should be limited to time, place, and manner.

The OCC notes that it is the responsibility and authority of the State Legislature to determine the role of local government if the establishment of a SIF were to occur. With that in mind, we have solicited and received input from the Vermont League of Cities and Towns (VLCT), which provided the following:

The delegation of power that would allow cities and towns to determine whether a safe injection facility could be established by a provision added in statute. An example is medical marijuana: “Nothing in this subchapter shall be construed to prevent a municipality from prohibiting the establishment of a dispensary within its boundaries or from regulating the time, place, and manner of dispensary operation through zoning or other local ordinances” (18 V.S.A. § 4474l). In other cases, this power is enumerated in a specific listing under an ordinance, for instance according to 24 V.S.A. § 2291<sup>17</sup>. The zoning and planning authority also has the power to regulate such an establishment according to Title 24, Chapter 117.<sup>18</sup>

An additional note from the Vermont League of Cities and Towns: VLCT generally supports and advocates for local control. In this case, that would manifest as supporting and advocating for towns and cities to determine whether an approved SIF were the right fit for their communities, and how that SIF should be run under local police powers.

---

<sup>17</sup> <https://legislature.vermont.gov/statutes/section/24/061/02291>

<sup>18</sup> <https://legislature.vermont.gov/statutes/chapter/24/117>.

## Considerations

During consideration of the eight primary questions provided by the Senate Judiciary Committee, the OCC has identified themes common to several responses as well as topics not adequately addressed by those questions. These topics represent additional obstacles to the establishment of SIFs as well as opportunities and alternatives.

### Intervention through Syringe Services Programs (SSPs)

The following information suggests that outcomes sought through SIFs may be achieved by expansion of services already underway through SSPs in Chittenden County and available in other parts of the State. A proposal to utilize \$1 million in tobacco settlement funds to expand the SSPs will be presented by AHS as part of the budget adjustment in January 2019.

SSPs provide clean supplies including naloxone for overdose reversal, and instruction on safe use and disposal. They accept used supplies for safe disposal, and consult with participants regarding health, wellness and safety issues, including infection prevention (including HIV, HCV, and injection site infection). They may refer for treatment when infection is suspected. In the process of the above engagement with participants, SSP staff maximize opportunities to refer for SUD treatment, and continue such consultation through to treatment when the participant is responsive. Increasingly, they are able to provide fentanyl testing kits, and at one SSP location low-barrier access to medication assisted treatment (MAT) is being piloted.

These are all intervention services provided by SSPs, which are promoted as core to the harm reduction role SIFs are designed to play. They are legal to operate in the U.S. Howard Center's SafeRecovery SSP in Chittenden County, and VermontCares are the largest services in Vermont.

### Cost Considerations

One of the arguments advanced by proponents of SIFs is that they result in an overall savings by reducing the incidence of life-threatening infections such as endocarditis, an infection of the heart valves or heart lining, which is associated with injection site infections from drug use.<sup>19</sup> While there is lack of research supporting these claims, SSPs currently provide an effective way to reduce the spread of such diseases. In fact, analyses of Vancouver data suggest that 79% of the savings attributed to prevention of HIV and other blood-borne diseases are credited to the operation of their SSP, rather than the SIF.

For additional national and Vermont information on possible association between injection drug use and endocarditis, see recent information from the Centers for Disease Control, North Carolina study, and **Appendix VII: Additional Vermont Information on the Cost of Endocarditis Associated with Injection Drug Use.**<sup>20</sup> (See also response to Q3, p. 15.)

---

<sup>19</sup> The Howard Center syringe services program reports that in a survey of participants, 67% reported having experienced abscess or injection site infection. 88% indicate injection as their primary route of administration.

<sup>20</sup> Fleischauer, Aaron T. PhD, et.al. (2017). Hospitalizations for Endocarditis and Associated Health Care Costs Among Persons with Diagnosed Drug Dependence – North Carolina, 2010-2015. *Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report*. Vol. 66, No. 22.

## Population

Most SIF sites around the world are located in densely populated, urban environments.<sup>21</sup> For example, in 2017, the population of the greater Vancouver metropolitan area (where Insite is located) was approximately 2,571,262. The European Monitoring Centre for Drugs and Drug Addiction describes all of the operating SIFs in Europe to be in “cities.” (See Figure 1 above.) A cursory review of the populations of the European cities with SIFs show that almost all have populations of over 100,000.<sup>22</sup>

In contrast, Burlington’s population is approximately 42,260 with the population of the greater metropolitan area (Chittenden, Franklin and Grand Isle counties) estimated at 213,700 (one third of Vermont’s population).

The difference in population size, density and geography between Vermont and cities in which SIFs currently operate raises significant questions whether the experiences in these locations would be fully relevant to a SIF in Vermont. These differences also present Vermont with other challenges not currently faced by SIFs operating in an urban environment. These include proximity of potential SIF participants to the SIF, transportation to and from a SIF and the increased potential for drug impaired drivers on Vermont’s highways.

## Transportation

The OCC’s work has identified transportation as a significant barrier for individuals seeking treatment and working to sustain recovery, as they try to balance treatment appointments, childcare, jobs, and other scheduling, often with no vehicle, no license, or both. The OCC considers this a high priority need to be addressed by State agencies and in communities. These transportation barriers would apply with equal force to individuals seeking access to a SIF.

It is also not clear whether individuals with a substance abuse disorder would avail themselves of a SIF even if one were opened in Vermont. A recent report out of New York on the feasibility of SIFs determined that 80% of potential SIF participants would not travel more than two miles to use the facility. This raises questions about the viability of a SIF in a rural environment such as Vermont where many potential SIF participants would have to travel significant distances to a facility. (See **Question 1, New York, above.**)

Similarly, the approach taken in Boston – providing a safe space for individuals who have consumed non-prescribed drugs to go for observation – would also raise transportation and safety concerns. Individuals would either travel to the location of the observation facility or would inject elsewhere and possibly drive to the facility.

---

<sup>21</sup> The population of greater metropolitan Vancouver was 2,571,262 in 2017. Vancouver City’s population was 631,486 in 2016. Greater metro Montreal population was 3,824,221 2011. Montreal City’s population was 1,649,519 in the 2011 census. Greater metro Toronto was 5,928,040 in 2016. Toronto City’s population was 2731,571 in 2016. Sydney’s population was 5,005,400 in 2016, and was 4,627,345 in 2011.

<sup>22</sup> European Monitoring Centre for Drugs and Drug Addiction. Updated 7/6/2018. *Perspectives on Drugs: Drug Consumption Rooms: an overview of provision and evidence.*

## Conclusion

The Governor's Opioid Coordination Council thanks the Senate Judiciary Committee for the opportunity to provide input on this timely and important topic. Saving the lives of Vermonters suffering from opioid addiction is a goal passionately shared by everyone engaged in this issue – both supporters and opponents of SIFs. The OCC has worked diligently over several months to thoroughly respond to the questions presented and information sought by the Senate Judiciary Committee. Based on this review of the information, research and studies on SIFs, the OCC has unanimously reached the following conclusions.

- 1. Safe Injection facilities are presently not a viable option for Vermont. They are illegal under federal law and highly controversial. Cost-effectiveness and neighborhood impacts are unknown. Most importantly, they have an unproven track record of harm reduction and for providing a pathway to treatment.** They are expensive to operate and have never been utilized in a rural state like Vermont, which would pose unique challenges not present in the urban settings in which SIFs currently operate. When compared with other harm reduction and treatment models with proven efficacy, including syringe services programs and Hub and Spoke treatment programs, it is clear that Vermont should continue to invest its limited resources in these areas rather than in experimental models like SIFs.
- 2. Support for and increased investment in syringe service programs will provide Vermont many of the desired outcomes sought through the SIF model to address the core societal harms resulting from injection drug use:**
  - HIV and HCV infection, and other infections and conditions that are life threatening and require sometimes extensive treatment;
  - Overdoses and overdose mortality; and
  - Lack of avenues to connect and transition people with SUDs to treatment.

These harms are being addressed by SSPs, which are currently in operation in Vermont. SSPs are legal, have greater public support, are collecting data, and are significantly more cost-effective than SIFs. Their services increasingly include providing fentanyl testing strips, which is already altering behavior toward more cautious injection practices; naloxone, to reverse overdose when needed; and at Howard Center's SafeRecovery, low-barrier access to medication-assisted treatment (MAT). To ensure these services are available where needed across Vermont, and to support SSPs' role in transitioning participants to treatment, additional resources will be needed. A proposal to utilize \$1 million in tobacco settlement funds to expand the SSPs will be presented by AHS as part of the budget adjustment in January 2019.
- 3. Placement of trained recovery coaches and other intervention professionals in SSPs, emergency departments, and in partnerships with law enforcement and first responders, also expands the reach of intervention.** Recovery coaches include trained peers and other service providers who engage directly with individuals in need of treatment and recovery services. The OCC has recommended the statewide expansion of recovery coaching in a variety of settings, and ongoing support of recovery coach training through Vermont's Recovery Coach Academy. Federal funding has been secured to invest in these efforts.

**Note:** *Appendix IV* provides the OCC Interim Strategy Recommendations on Syringe Services Programs and Naloxone. *Appendices VI and VII* contains additional information regarding SSP outcomes.

## Appendices

- Appendix I: Members and Staff of the Opioid Coordination Council
- Appendix II: Glossary
- Appendix III: Letter from the Senate Judiciary Committee
- Appendix IV: Opioid Coordination Council Interim Strategies on Syringe Services Programs and Naloxone
- Appendix V: Literature Review by Vermont Department of Health
- Appendix VI: Syringe Services Program Info Sheet
- Appendix VII: Additional information regarding infection rates and syringe service program information

## **Appendix I: Members and Staff of the Opioid Coordination Council**

### **Members**

Al Gobeille, Co-chair, Secretary, Agency of Human Services

Tom Anderson, Co-chair, Commissioner, Department of Public Safety

Jim Leddy, Co-chair, Community Leader

Mark Levine, M.D., Commissioner, Department of Health

David Allaire, Mayor, City of Rutland

Lori Augustyniak, Director, PreventionWorks!

Bob Bick, Executive Director, Howard Center

Kevin Black, U.S. Drug Enforcement Agency

Jill Berry Bowen, Chief Executive Officer, Northwestern Medical Center

Michael Bucossi, Chief, Brattleboro Fire Department

Adam Bunting, Principal, Champlain Valley Union High School

Sara Byers, President, Leonardo's Pizza

Seth DiSanto, Chief, Newport Police Department

T.J. Donovan, Vermont Attorney General

Liz Genge, Property and Asset Management Director, Downstreet Housing & Community Development

Hon. Brian Grearson, Chief Judge, Superior Court

Peter Mallery, Vice-President of Gov. Relations & Community Outreach, VT Association for Mental Health & Addiction Recovery

Roger Marcoux, Jr., Sheriff, Lamoille County

Christina Nolan, U.S. Attorney

Debra Ricker, President, Worksafe Traffic Control Industries

Ken Sigsbury, Director, Turning Point Center, Bennington

Stephanie Thompson, Springfield Town Select Board; NEHIDTA

### **Staff**

Jolinda LaClair, Director, Drug Prevention Policy

Rose Gowdey, Community Engagement Liaison

Eleanor Springer, VISTA volunteer

## Appendix II: Glossary of Terms

### Drug Consumption Rooms

Term commonly used in the European union for “Safe Injection Facility (SIF)” (see below)

### Fentanyl

A synthetic opioid, part of a category of novel psychoactive substances that are either known to be opioids or have opioid-like effects. Fentanyl is one of the most well-known synthetic opioids, since it has been exhaustively researched. Discovered in the 1960’s, fentanyl was originally only used for surgery, but its clinical use expanded in the 1990’s. Currently, synthetic opioids are being produced in clandestine labs and are often used as cutting agents with heroin and other drugs. Potency and effects can vary widely among these substances, and short and long-term health risks are not always clearly known.<sup>1</sup>

People at highest risk of fatal overdose are those who unknowingly take fentanyl. Because of the higher potency of fentanyl and other synthetic opioids compared to heroin, those who use heroin that has fentanyl in it may take an amount based on their experience of heroin potency, and overdose because of the presence of the more potent opioid.<sup>2</sup>

### Fentanyl Test Strips

Allow people who inject drugs to test their drugs for fentanyl. This enables them to adjust their behavior by deciding not to use this batch, to use less, to ensure they have naloxone on hand, and/or to ensure they use in the presence of someone else. A pilot project by the Vermont Department of Health has demonstrated such behavior changes. To test for fentanyl, one mixes a small amount of the drug supply with water and dips the strip in. Lines appear on the strip if fentanyl is present. The Howard Center in Burlington has started providing fentanyl test strips in addition to free doses of naloxone and sterile injection supplies.<sup>3</sup>

### Harm Reduction

According to the Drug Policy Alliance, harm reduction is a public health philosophy and intervention that seeks to reduce the harms associated with drug use and ineffective drug policies.<sup>4</sup> This approach involves using evidence-based drug education, drug-related illness and injury prevention, and effective drug treatment.

### Safe Consumption Facility/Safe Consumption Site

See “Safe Injection Facility (SIF)”

### Safe Injection Facility (SIF)

The Drug Policy Alliance defines SIFs as legally sanctioned facilities where people who use non-prescription injection drugs to inject previously-obtained drugs under the supervision of medical professionals or trained staff. SIFs are intended to reduce the health and societal problems associated with injection drug use.<sup>5</sup> Also known by:

<sup>1</sup> <http://www.drugpolicy.org/what-are-synthetic-opioids-fentanyl>

<sup>2</sup> <http://www.drugpolicy.org/how-many-people-are-fatally-overdosing-due-fentanyl-why>

<sup>3</sup> <https://www.mynbc5.com/article/howard-center-distributing-free-fentanyl-test-strips/22523316>

<sup>4</sup> <http://www.drugpolicy.org/issues/harm-reduction>

<sup>5</sup> <http://www.drugpolicy.org/issues/supervised-injection-facilities>

- Safe Consumption Facility
- Safe Consumption Site
- Safer Injection Facility
- Supervised Injection Rooms
- Drug Consumption Rooms (EU)
- Overdose Prevention Site

#### Supervised Injection Rooms

See “Safe Injection Facility (SIF)”

#### Syringe Exchange Program (SEP)

See “Syringe Service Program (SSP)”

#### Syringe Exchange Service (SES)

See “Syringe Service Program (SSP)”

#### Syringe Services Program (SSP)

Community-based programs that provide access to sterile needles and syringes free of cost and facilitate safe disposal of used needles and syringes. Most SSPs offer other prevention-oriented materials and services, such as education on safer injection practices and wound care; overdose prevention and reversal; referral to treatment programs including medication-assisted treatment; and testing and counseling for HIV and Hepatitis C.<sup>6</sup> Also known by Syringe Exchange Program (SEP), and Syringe Exchange Service (SES).

#### Naloxone (brand name Narcan)

An opioid antagonist that temporarily reverses the effects of an opioid overdose, namely slowed or stopped breathing. Expanding awareness and availability of this medication is a key part of the public health response to the opioid epidemic. Research has shown that when naloxone and overdose education are made available to community members, overdose deaths decrease in those communities.<sup>7</sup>

<sup>6</sup> <https://www.cdc.gov/hiv/risk/ssps.html>

<sup>7</sup> Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ (Clinical research ed.)*. 2013;346:f174. <https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html>

Appendix III: Letter from the Senate Judiciary Committee

115 STATE STREET  
MONTPELIER, VT 05633  
TEL: (802) 828-2228  
FAX: (802) 828-2424



SEN. DICK SEARS, CHAIR  
SEN. JOE BENNING, VICE CHAIR  
SEN. ALICE W. NITKA, CLERK  
SEN. TIM ASHE  
SEN. JEANETTE K. WHITE

STATE OF VERMONT  
GENERAL ASSEMBLY  
SENATE COMMITTEE ON JUDICIARY

January 30, 2018

Vermont Opioid Coordination Council  
Vermont Department of Health  
108 Cherry Street  
Burlington, VT 05402

Dear Council members,

We are in receipt of a letter from Jolinda LaClair dated January 23, 2018 inviting input from the Senate Committee on Judiciary on safe consumption facilities. We appreciate the opportunity to share our experience examining the issue to-date and we offer the following observations.

The Senate Committee on Judiciary recently took testimony on S.107, An act relating to limiting drug-related criminal liability and civil forfeiture actions against persons associated with an approved safer drug consumption program. The legislation proposes removing specific criminal and civil penalties for clients and staff of an approved safe consumption facility, but does not establish or fund such facilities. (See attached S.107) After considering the legislation, we are looking to the Council for a more in-depth review of the research and data to aid us in determining whether such legislation would be a useful tool in reducing the multiple harms associated with drug use and in increasing the opportunity for more people to access treatment.

The Committee heard from several witnesses, including Chittenden State’s Attorney Sarah George, Commissioner of Public Safety Thomas Anderson, Sarah Evans of the Open Society Foundation, Grace Keller of the Howard Center’s Safe Recovery Support and Education Program, UVM physician Patricia Fisher, and Theresa Vezina of Vermont Cares.

In November 2017, a commission created by Ms. George and composed of public health professionals, medical professionals, and law enforcement for the purpose of examining the various issues associated with safe consumption facilities released a report recommending the implementation of safe consumption sites in Chittenden County and around the State. (See attached “A Public Health & Safety Analysis in Support of Supervised Injection Facilities.”)

The report stated that research data show that such facilities prevent overdose deaths, reduce transmission of infectious diseases and other health problems associated with intravenous drug use, provide an opportunity for treatment for long-term drug users, improve public safety by

Vermont Opioid Coordination Council

January 26, 2018

Page 2 of 3

reducing public injecting of drugs and reducing discarded syringes in public locations, do not encourage increased drug use or an increase in crime in the areas in which such facilities are located, and decrease costs to the health care system.

While most witnesses who appeared before the Committee supported the concept of S.107, many in the law enforcement community remain opposed to such programs. Commissioner Anderson raised concerns such as whether the removal of penalties for such sites could be perceived as a State sanctioning of illegal drug use and send the wrong message to youths about the dangers of drugs, whether the bill could create a market for drug dealers because clients of such facilities would need to purchase their drugs on the streets, and whether such sites actually aid in reducing the number of people addicted to opioids. Commissioner Anderson also raised the issue that while Vermont could provide immunity under State law for such facilities, the people associated with them would be subject to possible enforcement action under the federal Controlled Substances Act. (See attached "Written Statement of Thomas D. Anderson to the Vermont Senate Judiciary Committee, S.107.")

The Committee respectfully requests that the Council consider the various points of view that have been expressed in response to this legislation and delve into additional issues that may help inform us as we consider the best path forward. Issues and questions from the Committee include:

- An examination of the experiences of places such as Seattle, WA; Philadelphia, PA; Ithica, NY; New York City, NY; Montreal, Canada; and Vancouver, Canada where such facilities are either currently operating or in the authorization process.
- The efficacy and outcomes of safe consumption facilities operating in other jurisdictions around the world.
- The costs to local or State government if such a facility were operated in Vermont by an independent organization and whether such a facility can result in net savings with respect to a reduced need for health care, emergency services, and law enforcement.
- The appropriate methods and measures for determining the health-related and public safety outcomes for such a facility.
- Whether there are legal risks or liabilities to the State in approving, but not operating, such a facility.
- The federal criminal and civil legal risks facing clients, staff, volunteers, and organizations associated with such a facility.
- The potential public safety issues associated with such a facility as evidenced by experience in other jurisdictions and whether there is any evidence that safe consumption facilities in other jurisdictions have increased crime in those neighborhoods or created a new market for drugs.
- Whether local governments should have the ability to prohibit such a facility from locating in that community or whether restrictions should be limited to time, place, and manner.

Vermont Opioid Coordination Council

January 26, 2018  
Page 3 of 3

The Senate Committee on Judiciary shares the Council's objective in developing and supporting prevention, treatment, recovery, and law enforcement strategies to address our State's opioid epidemic. However, we also want to continue our efforts at harm reduction, recognizing that there are over 20,000 Vermonters addicted to opioids and only about 7,000 of those people are currently in treatment. We must do everything we can to give those Vermonters a chance at recovery. Increased availability of Narcan, immunity from liability for reporting drug overdoses, needle exchange programs, and medicated-assisted treatment are all important aspects of a harm-reduction model that works hand-in-hand with prevention, treatment, recovery, and law enforcement strategies. We look forward to hearing from you regarding whether safe consumption facilities can be a part of saving lives here in Vermont.



\_\_\_\_\_  
Senator Richard Sears on behalf of the Senate Committee on Judiciary

## **Appendix IV: Opioid Coordination Council Strategies on Syringe Services Programs and Naloxone**

**EXPAND VERMONT'S SYRINGE EXCHANGE PROGRAMS AND SERVICES TO INCREASE GEOGRAPHIC REACH AND HOURS OF OPERATION. SUPPORT ACCESS TO INCREASED CASE MANAGEMENT SERVICES FOR ALL PARTICIPANTS.**

Action: Vermont Department of Health will lead a working group to develop an implementation plan by June 2018. *(Update: Syringe Services Working Group through Vermont Department of Health convened and completed an interim report with strategies, Summer 2018.)*

Narrative: When best practices are engaged, syringe services programs (SSPs) have proven to be effective for intervention and referral to treatment for people who inject drugs. Important among these programs are high accessibility in hours and locations, and the ability to engage regularly, without expectation, with program staff so that referral to treatment is possible when the individual is ready. The Department of Health currently funds four organizations that operate syringe services programs in eight Vermont locations. Outside of Chittenden County, the highest hours of operation are eight per week, and lowest is less than two hours per week. The average is 3.4 hours per week (these hours do not include a mobile service which can be called to determine its availability). In Burlington, Safe Recovery is open 35 hours per week.

**SUPPLY WITH NALOXONE, AND PROVIDE EFFECTIVE TRAINING TO ALL VERMONT LAW ENFORCEMENT, EMS, AND PEOPLE LIKELY TO BE NEAR A PERSON WHO MAY OVERDOSE.**

Action: The Vermont Department of Health will conduct continuous outreach and education in an effort to reach 100% utilization of naloxone for any emergency as needed.

Narrative: Every life saved has infinite impact: on family, on community, on Vermont. People suffering with SUD are our friends, neighbors, sisters, brothers, daughters, sons, mothers and fathers. They are worthy and valued, especially to those who love them. Last year, 106 Vermonters lost their lives to an overdose. If this trend continues, we will lose an equal or greater number of Vermonters next year. Naloxone has the power to save lives -- the life of the individual with SUD, and the lives in families and communities otherwise devastated by heart-breaking cycles of addiction. With Naloxone, treatment, and recovery can be possible.

In addition, law enforcement and first responder personnel face risks from fentanyl, its analogs such as carfentanil, and other opioids when called to emergency and overdose situations. While current data suggests that normal procedures are protective against these threats, we support the President's Commission Recommendations' call for supplying and training first responders, and for research on law enforcement and first responder exposure rates.<sup>29</sup> Naloxone supply and training in every appropriate organization across the state is an investment in the rescue and protection teams of our state.

Approximately 9,000 naloxone kits were distributed in 2016 to naloxone distribution sites, Vermont EMS, and law enforcement agencies. As of November 13, 2017, naloxone is available for public distribution at 30 sites across Vermont,<sup>30</sup> carried by all Vermont EMS agencies, and 74 of 78 Vermont Law Enforcement agencies. Budget impact will be minimal, as coverage is high now and funds are currently available.

**Appendix V: Literature Review by Vermont Department of Health**Opioid Coordination Council  
Safe Injection Facility Project

Literature Review by John Searles, Ph.D., Vermont Department of Health, as of 08-31-18

- 1. An examination of the experiences of places such as Seattle, WA; Philadelphia, PA; Ithaca, NY; New York City, NY; Montreal, Canada; and Vancouver, Canada where such facilities are either currently operating or in the authorization process.**
- 2. The efficacy and outcomes of [SIFs] operating in other jurisdictions around the world.**
- 7. The potential public safety issues associated with such a facility as evidenced by experience in other jurisdictions and whether there is any evidence that [SIFs] in other jurisdictions have increased crime in those neighborhoods or created a new market for drugs.**

Safe injection Facilities (SIFs) also called drug consumption rooms (DCR) were first introduced in Europe in the 1980s to address a predicted epidemic of HIV among people who injection drugs<sup>8</sup>. These sites operated under the assumption that offering an aseptic environment with sterile needles, alcohol swabs, and medical personnel to address any adverse reactions was a better alternative to “back alley” drug using or “shooting galleries.” In a crisis mode (such as an impending HIV epidemic among IDU and their sexual partners) health officials sought to limit the impact of a potentially devastating disease within this population even though heroin and other injectable drugs (e.g., cocaine) are illegal. SIF’s were preceded by syringe exchange programs and opioid substitution therapies that also strove to limit adverse consequences of IDU. All these programs fall under the general rubric of “harm reduction” which is essentially an acknowledgement that abstinence treatment methods do not always obtain optimum results and it is important as a public health matter to offer alternative strategies to those unable or unwilling to discontinue use. All also have the opportunity for an educational component (e.g., increased risk of serious disease with needle sharing), access to additional medical services, and an open invitation to other treatment options. All three are critical factors that play important roles in decreasing adverse consequences of injection drug use.

Until recently there has been very little published research of the effectiveness of SIFs on overdoses, overdose deaths, morbidity of blood-borne infectious disease (e.g., HIV, Hepatitis B & C), blood-borne infectious disease spread, other physical, mental, and social health issues, and crime. This is likely due to two main reasons: 1) lack of an adequate control group, and 2) an emphasis on the immediate clinical aspects rather than an evaluation approach considering the impact of potential health epidemics such as HIV. However, when Health Canada approved a SIF (named InSite) for Vancouver, BC in 2003, it mandated an ongoing evaluation by an external organization. While still lacking an adequate control group, the evaluators reported variables of interest with a high degree of specificity (but with some controversy – see footnote 4). Potier et al. (2014)<sup>9</sup> provided a review of the existing literature from 75 relevant articles. Not surprisingly, most of the results they present were from the Vancouver evaluations. Below is a summary of their report.

- Demographics of People Who Inject Drugs
  - Mostly Male

<sup>8</sup>Rhodes & Hedrich (Eds.) (2010). Harm Reduction: Evidence, Impacts, and Challenges. Luxembourg: European Monitoring Centre for Drugs and Drug Addiction.

<sup>9</sup>Potier et al. (2014). Supervised Injection Services: What Has Been demonstrated? A Systematic Literature Review. *Drug and Alcohol Dependence*, 145, 48-68.

- Age 30-35
- Frequent housing insecurity
- Frequent unemployment
- Medical Problems
  - 88% seropositive for HCV
  - 2% (Sydney) to 30% (Vancouver) positive for HIV
- Overdoses and Overdose Fatalities
  - Number of overdose fatalities at any SIF since inception: 0
  - Number of overdoses fatalities in the area of InSite (Vancouver Downtown East Side - DTES<sup>10</sup>) were reduced 35%, suggesting that between 2 to 12 fatal overdoses were avoided<sup>11</sup>
- Injection Behavior
  - Significantly reduced syringe sharing, reuse, and public space injecting
- Drug Related Harms (but see comments below)
  - No evidence that SIFs reduced viral transmission of disease
  - Significant increase in condom use
  - 25% of InSite participants received care for injection related harms (e.g., lesions at injection sites)
  - Estimates of the number of HIV infections prevented range from 4-8<sup>12</sup> to 19-57<sup>13</sup>
- Access to Treatment Programs
  - Among SIF participants there was an increase in access to addiction treatment services such as detoxification programs, initiation of methadone therapy, and referral to a treatment center
- Impact on drug use in public spaces
  - Reduction in the number of people injecting in public
  - Reduction in the number of syringes dropped
  - Reduction in the amount of injection related litter
- Impact on crime (but see comments below)
  - For both Vancouver and Sydney Australia, studies demonstrated no increase in crime, violence, or drug trafficking compared to pre-SIF times as well as non-SIF cities

Here are data from 2017 from InSite:

<sup>10</sup> DTES has a population of 18,477 people; total population of Vancouver = 604,000; British Columbia = 4.6 million

<sup>11</sup> This has been disputed by Pike et al. (2011). Analysis of the 2010 *Lancet* Study on Drug deaths from Overdose in the Vicinity of Vancouver's InSite Supervised Injection Facility. *The Journal of Global Drug Policy and Practice*, 5, 1-14. Pike et al. (2011) contend that the decrease is an artifact of an oversupply of heroin in 2001 and a sudden subsequent decrease in overdose deaths in 2002 as a function of heroin supply reductions; and that since InSite's opening in 2003 there has actually been an increase in drug overdose deaths. In addition, a Health Canada evaluation of InSite from an expert advisory committee stated that "*Mathematical modelling (see caution about validity below) suggests that INSITE saves about one life a year as a result of intervening in overdose events.*" [http://www.hc-sc.gc.ca/ahc-asc/pubs/\\_sites-lieux/InSite/index-eng.php#imp](http://www.hc-sc.gc.ca/ahc-asc/pubs/_sites-lieux/InSite/index-eng.php#imp) (but see material in the following pages)

<sup>12</sup> Pinkerton (2011). How Many HIV Infections Are Prevented by Vancouver Canada's Supervised Injection Facility? *International Journal of Drug Policy*, 22, 179-183. Andresen & Boyd (2010). A cost-benefit and Cost-effectiveness analysis of Vancouver's supervised Injection Facility. *International Journal of Drug Policy*, 21, 70-76.

<sup>13</sup> Andresen & Boyd (2010). A cost-benefit and Cost-effectiveness analysis of Vancouver's supervised Injection Facility. *International Journal of Drug Policy*, 21, 70-76.

- 175,464<sup>14</sup> visits to the site by 7,301 unique individuals [there are an estimated 15,000 people who inject drugs in Vancouver]
- An average of 537 visits per day to needle exchange service
- An average of 415 injection room visits per day
- 2,151 overdose incidents
- 3,708 clinical treatment interventions
- Principle substances reported were heroin (64% of instances) methamphetamine (25% of instances) and cocaine (6% of instances).
- 28% of participants were women
- 18% of participants were aboriginal
- 5,368 referrals to other social and health services (2015 data)
- 464 referrals to onsite detox in 2015 and 517 in 2016<sup>15</sup>
- In August 2016 88% of the heroin tested positive for fentanyl

In the United States, King County (Seattle) has progressed the furthest in planning to open a SIF (which they call Community Health Engagement Locations – CHELs). However, after finding a location for the first one the landlord backed out when told of the purpose of the space. This was due to federal civil and criminal forfeiture laws which allows the government to seize property involved in illicit drug activities. They are now considering two other options: a mobile SIF (which does not get around the forfeiture problem) and/or setting up a SIF within a faith-based property (e.g., church). Whether the federal government would simply apply the forfeiture rules to such property is unknown. We have reached out to key stakeholders in San Francisco, Philadelphia, New York City, and Boston to discuss current SIF implementation plans. As of this date, we have not had a response.

InSite in Vancouver, BC has been operating since 2003 initially under a waiver from Health Canada to avoid any federal, state, and local interference. One of the conditions of the operational waiver InSite received from Health Canada was to establish a continuing 3-year “independent” evaluation group. The group is affiliated jointly with the British Columbia Centre for Excellence in HIV/AIDS and the Department of Medicine, University of British Columbia. Please note that the two principal authors of all the research reports were the ones who were the chief promoters of InSite to the government<sup>16</sup> and had published research previously that promoted a SIF in Vancouver<sup>17</sup> so this is not truly an “independent” evaluation. All the peer reviewed research published by this group is positive (e.g., reduced overdose deaths, increased access to treatment, reduced public drug injection use, reduced crime, etc.) which in and of itself does not show bias. However, the results are often misinterpreted or overly optimistic. For example, Marshall et al. (2011) reported a 35% decrease in overdose mortality rates for the period 15 months after InSite opened (September 21, 2003) compared to the 33 months prior to the opening of the SIF while a nonsignificant decrease was observed in the rest of the city<sup>18</sup>.

<sup>14</sup> This represents 5.2% of all injections in the InSite service area (Andresen & Boyd, 2010).

<sup>15</sup> In 2017 InSite reports that 18443 clients accessed their detox program (called Onsite). That is a 3785% increase since 2015 which seems on the surface to be unlikely. “Referrals” and “access” may not be the same thing, but nonetheless it is unnecessarily confusing.

<sup>16</sup> In 2000 Kerr authored a document titled “Safe Injection facilities proposal for Vancouver Canada” for the Harm Reduction Action Society.

<sup>17</sup> Wood et al. (2001). Unsafe Injection Practices in a Cohort of Injection Drug Users in Vancouver: Could Safer Injecting Rooms Help? CMAJ, 165, 405-410.

<sup>18</sup> Within a range of 500 meters of the SIF in the DTES there was a reported decrease from 253.8 to 165.1 deaths per 100,000 person-years. The rest of Vancouver rate went from 7.6 to 6.9 deaths per 100,000 person-years. It

What is missing is the fact that the Vancouver Police Department implemented a significant “crackdown” in this area in the 6 months prior to InSite opening.<sup>19, 20, 21</sup> The documented increased police presence was dramatic and operating 24 hours per day, seven days per week. One of the results of this increased police presence was a displacement of both the drug market and drug use from this area to an adjacent area. Thus, a 35% reduction in OD death rate in the area immediately surrounding the SIF is not entirely due to the opening of the SIF. In addition, the increased police presence likely had an influence on the observed reduction in crime in the vicinity. Despite this documented increased in police activities in the vicinity of InSite, the evaluators remark that “...we know of no changing of policing policy that could have confounded our results.”<sup>22</sup> The report indicating a 35% reduction in overdose death rate around the InSite location only references data from 2003 to 2005. There has not been an update since the article was published in 2011. Also, in the period 2001 – 2003 there was a significant reduction in overdose deaths (-35.4%), naloxone use (-45.1%), amount of heroin seized (-63.8%) and heroin use (-45%) in Western Canada compared to 1998-2000<sup>23</sup>. There is speculation that this may have been at least partially a function of a dramatic increased law enforcement effort in Australia to disrupt local heroin markets suggesting that British Columbia illicit drug supply was from the same source as Australia<sup>24</sup>. Finally, on this point, the majority of the overdose deaths in this study were attributed to cocaine, not opioids. It is also noteworthy and somewhat contradictory there was no change in the rate of individuals stopping injection drug use after the SIF opened<sup>25</sup>. This suggests the SIF is failing to attract people who inject drugs to treatment. Other issues with the researchers from InSite include:

- Refusal of requests to access to data from independent external investigators<sup>26</sup>
- No prospective, longitudinal studies demonstrating effects over time have been published
- Aggressively accusing researchers who question conclusions of “being biased and blinded by ideology”<sup>27</sup>
- A lack of published data on the effect that InSite has had on “reducing HIV, hep-c, or the rate of serious illness that results from drug use.”<sup>18</sup>
- The actual use of InSite is quite low with one study showing 5.2% of all injections occurring at the SIF. (See footnote 7)

---

appears that their calculation of “person-years” was based on the entire population of the areas under study, rather than those who would actually be exposed to risk during the study period (i.e., people who inject drugs).

<sup>19</sup> Dandurand et al. (2004). Confident Policing in a Troubled Community: Evaluation of the Vancouver’s Police Department City-Wide Enforcement Team Initiative. <http://www.vancouveragreement.ca/wp-content/uploads/ConfidentPolicing2004sm.pdf>

<sup>20</sup> McKay, J (2012). Statement to Lancet.

<https://www.toronto.ca/legdocs/mmis/2016/hl/comm/communicationfile-59447.pdf>

<sup>21</sup> Christian et al. (2012). Overdose Deaths and Vancouver’s Supervised Injection Facility. *The Lancet*, 379, 117.

<sup>22</sup> Marshall et al. (2011). Reduction in Overdose Mortality After the Opening of North America’s First Medically Supervised Safer Injecting Facility: A Retrospective Population-Based Study. *The Lancet*, 377,1429-1437. For a discussion of the politicization of these reports see Elliot (2014). Debating Safe Injection Sites in Vancouver’s Inner City: Advocacy, Conservatism, and Neoliberalism. *Contemporary Drug Problems*, 41, 5-40.

<sup>23</sup> Wood et al. (2006). Changes in Canadian Heroin Supply Coinciding with the Australian Heroin Shortage. *Addiction*, 101, 689-695.

<sup>24</sup> Degenhardt et al. (2005). Evaluating Explanations of the Australian ‘Heroin Shortage’. *Addiction*, 100, 459-469.

<sup>25</sup> Kerr et al. (2006). Impact of a Medically Supervised Safer Injection Facility on Community Drug Use Patterns: A Before and After Study. *BMJ*, 332, 220-222.

<sup>26</sup> <https://www.theglobeandmail.com/news/national/we-still-await-the-scientific-proof-of-harm-reductions-success/article714998/>

<sup>27</sup> [https://www.huffingtonpost.ca/mark-hasiuk/InSite-vancouver\\_b\\_3949237.html](https://www.huffingtonpost.ca/mark-hasiuk/InSite-vancouver_b_3949237.html)

- While InSite has been operational for 15 years, a cost-benefit analysis of the SIF used only simulated/hypothetical data<sup>28</sup>. This may be a function of the difficulty in specifying operational model parameters and collecting appropriate data.

Figure 1 shows the overdose death in raw numbers and rate per 100,000 from 1992 to May 31, 2018 for all British Columbia. Note the considerable increase in both actual number of deaths and the rate of overdose deaths per 100,000 starting 2014. This likely is due to the introduction of non-pharmaceutical fentanyl into the marketplace around this time.

Figure 2 shows overdose death rate by Health Authority in British Columbia. InSite is overseen by the Vancouver Coastal Health Authority. These newer data show a rapidly increasing overdose death rate among all Health Authorities in British Columbia and the highest rate is in the area where InSite is located.

Figure 3 shows the standardized mortality ratio (SMR) for the area of Vancouver where InSite is located (DTES), the SMR for the rest of the city, and the ratio of the two<sup>29</sup>. These data suggest an increase in the DTES SMR following the opening of InSite continuing to 2007 when SMR drops for both the DTES and the rest of Vancouver. However, the ratio of the DTES SMR and the rest of Vancouver remains steady from 2009 to 2015. Note that every DTES SMR is considerably above 1, while every SMR for the rest of Vancouver hovers around 1 or below which means drug death mortality rates were not elevated unlike the DTES.

Figure 4 presents the overdose death rate for specific areas of Vancouver over time. The DTES is located within the red oval. As can be seen, the DTES consistently has the highest rate in Vancouver each year.

InSite and other facilities in other countries are typically located in neighborhoods with an identifiable high density of people who inject drugs and dealers (it is not uncommon for individuals to purchase drugs near the facility and then enter InSite to inject). In Vancouver, InSite is located in an urban area with an estimated 5,000 people who inject drugs within a 10-block radius<sup>30</sup>. There is no comparable area in Vermont in general or Burlington specifically; siting a SIF in Vermont would be problematic no matter where it would be located. Long drives on ice/snow covered roads could potentially depress attendance or elevate traffic accident risk (especially post injection drives). While there have been reports of increased access to treatment and detox programs<sup>31</sup> at InSite there are very little data demonstrating successful long-term treatment (abstinence oriented or MAT) among this population. Access to treatment is not equivalent to enrolling and remaining in a treatment program.

<sup>28</sup> Bayoumi & Zaric (2008). The Cost-effectiveness of Vancouver's Supervised Injection Facility. *CMAJ*, 179, 1143-1151.

<sup>29</sup> SMR compares age and gender adjusted mortality rates for the population and specific area. The SMR for the population, in this case all of British Columbia is 1.0. (A full size copy of this chart is attached to the end of this document)

<sup>30</sup> Wood & Kerr (2006). What Do You Do When You Hit Rock bottom? Responding to drugs in the city of Vancouver. *International Journal of Drug Policy*, 17, 55-60.

<sup>31</sup> Wood et al. (2006). Attendance at Supervised Injection Facilities and Use of Detoxification Services. *New England Journal of Medicine*, 354, 2514.

A recent journal article describes an unsanctioned (underground) SIF located in “in an urban area of the United States” established in 2014<sup>32, 33</sup>. The facility is open 4-6 hours/day, 5 days per week. Due to the potential for legal injunctions, use of the SIF is by invitation only. Potential participants are invited by staff on the basis of perceived need and regular attendance at the service agency (e.g., syringe exchange services) and are asked not to publicize the existence of the SIF. Eighty percent of the participants reported heroin as their drug of choice, injecting a mean of 113 times per month (not all at the SIF). Ninety-one percent are men, 81% are homeless, and 80% are white. For the first 2 years of operation, 100 participants injected 2754 times at the SIF – representing less than 1% of all potential injections over that time frame. Anecdotal evidence suggests that these unsanctioned SIFs are currently in operation in several US cities with substantial numbers of people who inject drugs<sup>34</sup>.

Another article describes an attempt by researchers and clinicians (called “activist researchers” in the paper) to establish a “pop-up” SIF in the South Bronx area of New York City (150<sup>th</sup> St. and St. Ann’s Avenue)<sup>35</sup>. This area had been identified as a place where people who inject drugs congregated due to a nearby abandon and partially underground rail line (called “The Hole” by the researchers). The SIFs were two high-end porta-potties that the researchers had modified for a safe injection space use. One of the two was also available to be used as originally intended. The result was that very few of the area residents used these SIFs and preferred to continue injecting with their colleagues inside The Hole. These researchers concluded that the failure to engage the SIFs in this context was due to it proscribing “the injector community’s ethos around sharing drugs” (p.13). Since all SIFs so far established do not allow for sharing or assisted injecting, this inference seems to contravene one of the primary principles of SIFs.

In summary, data on the effectiveness of SIFs are inconclusive. Research needs to be expanded to include other sites and investigators. Independent evaluators and data access to outside scientists would also enhance the overall appraisal of SIFs efficacy.

- 3. The costs to local or state government if such a facility were operated in Vermont by an independent organization and whether such a facility can result in net savings with respect to a reduced need for health care, emergency services, and law enforcement.**
- 4. The appropriate methods and measures for determining the health-related and public safety outcomes for such a facility.**

InSite is funded by Health Canada through the Vancouver Coastal Health Authority at \$3,000,000 per year. The King County (Seattle) initiative in Washington state is estimated to cost \$1.3 million per year to operate. Since there is no state income tax in Washington, securing a stable funding source is a priority for advocates of SIFs.

---

<sup>32</sup> Davidson et al. (2018). Using Drugs in Un/Safe Spaces: Impact of Perceived Illegality on an Underground Supervised Injecting Facility in the United States. *International Journal of Drug Policy*, 53, 37-44.

<sup>33</sup> Kral & Davidson (2017). Addressing the Nation’s Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site. *American Journal of Preventive Medicine*, 53,919-922.

<sup>34</sup> Brad Finegood (2018). Personal communication.

<sup>35</sup> Wolfson-Stofko et al. (2016). The Portapotty Experiment: Neoliberal Approaches to the Intertwined Epidemics of Opioid-Related Overdose and HIV/HCV and Why We Need Cultural Anthropologists in the South Bronx. *Dialectical Anthropology*, 40, 495-410.

The cost associated with InSite has been reported to be offset by reduction in blood-borne disease treatments such as hepatitis B, hepatitis C, and HIV (medicines, doctor, hospital and ER costs, lost productivity, etc.)<sup>36</sup> as well as potential lives saved<sup>37</sup>. However, this cost recovery model has been disputed<sup>38</sup>. There are a number of model assumptions that are employed to produce specific outcomes, and all are subject to selective interpretation<sup>39</sup>. For example, Bayoumi & Zaric (2008) build their model under the assumption “that 21% of the of people who inject drugs would use the facility regularly” (p.1146). However, “people who inject regularly” is defined as individuals who reported that “all, most, or some” of the injections occurred at the facility (p1146). This seems an overly broad definition of “regular use.” Furthermore, most of the cost savings reported appear to be a function of syringe exchange programs<sup>40</sup>. Other cost-benefit analyses are based on purely hypothetical data (e.g., San Francisco, Baltimore) since there are no SIFs open so no hard data are available for analysis. Cost-benefit projections without actual data are subject to a number of methodological problems. This includes applying model assumptions in one geographic location (e.g., Vancouver’s DTES) to another geographic location (e.g., Vermont) which may not share comparable demographic profiles. Another example comes from a recent report on the feasibility of SIFs that determined that 80% of potential SIF clients in New York City would not travel more than 2 miles to use the facility<sup>41</sup>. Given Vermont’s widely distributed population of people who inject drugs, this model would seem impractical. Also, given current budget constraints in Vermont, this may be an understudied but significant consideration in the discussion<sup>42</sup>. Therefore, it is likely that any proposed SIF in Vermont would likely be funded and implemented through an outside third party.

##### **5. Whether there are legal risks or liabilities to the State in approving, but not operating, such a facility.**

<sup>36</sup> Bayoumi & Zaric (2008). The Cost-effectiveness of Vancouver’s Supervised Injection Facility. *CMAJ*, 179, 1143-1151.

<sup>37</sup> Andresen & Boyd (2010). A Cost-Benefit and Cost Effectiveness Analysis of Vancouver’s Supervised Injection Facility. *International Journal of Drug Policy*, 21, 70-76.

<sup>38</sup> DesJarlais et al. (2008). Evaluating Vancouver’s Supervised Injection Facility: Data and Dollars, Symbols and Ethics. *CMAJ*, 179, 1105-1106.

<sup>39</sup> Cost-benefit analyses in health care often become contentious for several reasons. SIFs are primarily directed to serve individuals on the fringes of society. The argument quickly devolves to “how much is a human life worth?” The underlying assumption is that no amount of money is too much if a life can be saved. From a fiduciary perspective this is clearly a false dichotomy since governments have limited capital and needs to determine which programs have the maximum return on investment for both the individuals affected and society at large. The concept then is to approximate the societal costs (e.g., health care) associated with injection drug use (e.g., blood borne diseases, HIV, etc.) and compare to the costs of operating the facility. If the cost savings is higher than the operations expenditures, then there is a net cost benefit. However, it may be less cost effective than alternative programs (e.g., syringe exchange).

<sup>40</sup> Decreased needle sharing accounts for 79% of HIV and Hepatitis C infections projected to be averted (Bayoumi & Zaric, 2008).

<sup>41</sup> New York City Department of Health (2018). Overdose Prevention in New York City: Supervised Injection as a Strategy to Reduce Opioid Overdose and Public Injection. <https://www1.nyc.gov/assets/doh/downloads/pdf/public/supervised-injection-report.pdf>

<sup>42</sup> Vermont has made a significant investment in increasing access to medically assisted treatment for opioid use disorders (OUD) in establishing and expanding the “Hub and Spoke” system of care.

**6. The federal criminal and civil risks facing clients, staff, volunteers, and organizations associated with such a facility.**

Medical staff liability: The Massachusetts Medical Society (MMS) in 2017 published a report of the Task Force on opioid Therapy and Physician Communication entitled “Establishment of a Pilot Medically Supervised Injection Facility in Massachusetts<sup>43</sup>.”

- a. The report indicates that “the legal risk to physicians and health care providers is too great to pilot a SIF without the modification of laws in Massachusetts or without obtaining explicit exemptions from state and federal laws.” (p.17)
- b. With respect to professional liability factors the report states that “...SIFs are not a service that would currently be covered under existing professional liability policies and that development of such coverage would be extremely difficult, especially under current Massachusetts laws.” (p.18) Further, “physicians must have insurance coverage for all medical activities as a condition of medical licensure in Massachusetts, or they must post a personal approved bond. In the case of a SIF, the Board of Registration of Medicine might well not approve such a bond or the underlying activity.” (p.18)
- c. These caveats are likely applicable to health care workers in Vermont. Without significant changes in state and federal laws, it is difficult to see a path forward for SIFs in Vermont. We are aware that there are current plans to open two SIFs in Seattle, WA (as well as Philadelphia, New York City, and San Francisco) and we have been in contact with Brad Finegood of the King County Department of Community and Health Services. He had indicated previously that they will likely proceed to purchase/lease two sites in the area as Safe Consumption Sites<sup>44</sup> (called Community Health Engagement Locations - CHELs). However, in a recent telephone call, he related that they had selected a site for the initial SIF. When the landlord was told what the site was for, the lease offer was retracted due to the federal forfeiture laws applied to individuals and property they own that may be involved in illicit drug activity. The Task Force suggested its recommendations (chief among them, the establishment of two CHELs)<sup>45</sup> be prioritized based on the following factors:
  - i. Evidence base for effectiveness
  - ii. Population health/safety impact
  - iii. Community support
  - iv. Equity
  - v. Complexity/feasibility
  - vi. Legal considerations
  - vii. Cost
  - viii. Sustainability
- d. There is a section entitled “Summary of Legal Considerations” in the Task Force Recommendations written by an ACLU Policy Director who endorses the legal standing of the CHELs based on

<sup>43</sup> Fitzgerald et al. (2017). Establishment of a Pilot Medically Supervised Injection Facility in Massachusetts. Massachusetts Medical Society. <https://www.massmed.org/advocacy/state-advocacy/sif-report-2017/>

<sup>44</sup> As part of the Task force equity commitment they are called safe consumption sites in recognition of data that suggests Caucasians have high rates of injecting drugs and African Americans have a high rate of smoking them.

<sup>45</sup> <https://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/task-forces/heroin-opiates-task-force.aspx>

- i. Federal response to medical and recreational marijuana
- ii. State and federal response to syringe exchange programs
- iii. Previous actions of prosecutorial discretion

However, it seems likely that marijuana and injected/smoked opioids and/or other illicit drugs (e.g., cocaine, methamphetamine, etc.) would provoke a different legal response especially from the federal government. Marijuana is rarely fatal (despite the potential of serious physical, mental, and social harms of early and persistent marijuana use<sup>46, 47, 48</sup>) but opioids carry a significant risk of mortality especially in the current fentanyl-laced heroin context. It would be surprising if there was not a federal response; in Vermont the US Attorney's office issued a robust negative response<sup>49</sup> to a recommendation by the States Attorney for Chittenden County to support SIFs<sup>50</sup>. Both the Vermont Commissioner of Public Safety and the Vermont Association of Chiefs of Police are on record being opposed to SIFs.

"But many safe injection site proposals seem to be waylaid in community debate and legal uncertainty. Scott Burris, director of Temple University's Center for Public Health Law Research, says municipalities are worried about a showdown with Jeff Sessions' Department of Justice.

"You can talk about cities racing to be first," Burris says. "But my guess is that you have a lot of cities who are actually racing to be second. When officials with the Justice Department are asked where Sessions stands on the issue, they offer a [statement issued late last year](#) by a U.S. attorney in Vermont saying health workers at a supervised injection site would be vulnerable to criminal charges and the property could be at risk of being seized by federal law enforcement."<sup>51</sup>

---

<sup>46</sup>

[http://marijuanacommission.vermont.gov/sites/mc/files/doc\\_library/Health%20and%20Safety%20Endpoints%20Revised%2011\\_14\\_17%20%28%29.pdf](http://marijuanacommission.vermont.gov/sites/mc/files/doc_library/Health%20and%20Safety%20Endpoints%20Revised%2011_14_17%20%28%29.pdf)

<sup>47</sup>

[http://www.healthvermont.gov/sites/default/files/documents/2016/12/ADAP\\_HIA\\_Marijuana\\_Regulation\\_in\\_Vermont.pdf](http://www.healthvermont.gov/sites/default/files/documents/2016/12/ADAP_HIA_Marijuana_Regulation_in_Vermont.pdf)

<sup>48</sup> [http://www.healthvermont.gov/sites/default/files/documents/2017/02/ADAP\\_HIA%20Update.pdf](http://www.healthvermont.gov/sites/default/files/documents/2017/02/ADAP_HIA%20Update.pdf)

<sup>49</sup> <https://www.justice.gov/usao-vt/pr/statement-us-attorney-s-office-concerning-proposed-injection-sites>

<sup>50</sup> <https://www.burlingtonfreepress.com/story/news/local/2017/11/29/safe-injection-sites-needed-vermont-says-study-group/902666001/>

<sup>51</sup> Allyn, B. (2018). "Cities Planning Safe Injection Cites Fear Justice Department Reaction." National Public Radio, July 12. <https://www.npr.org/sections/health-shots/2018/07/12/628136694/harm-reduction-movement-hits-obstacles>

Figure 1  
Number of Overdose Deaths and Rate per 100,000 in British Columbia<sup>52</sup>

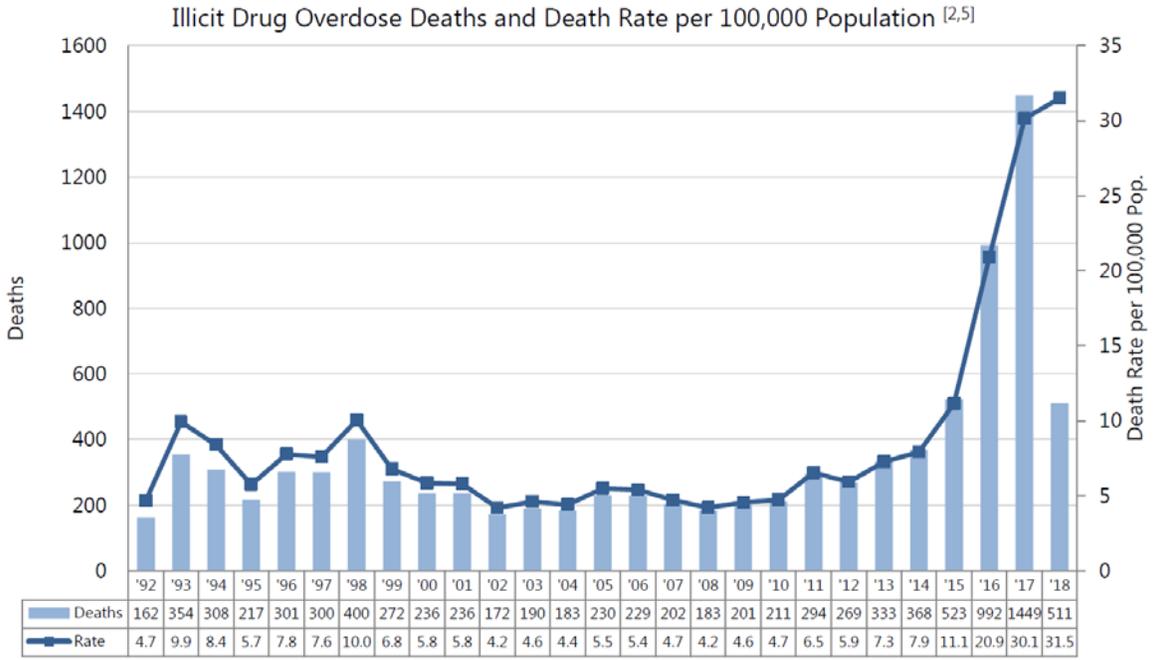
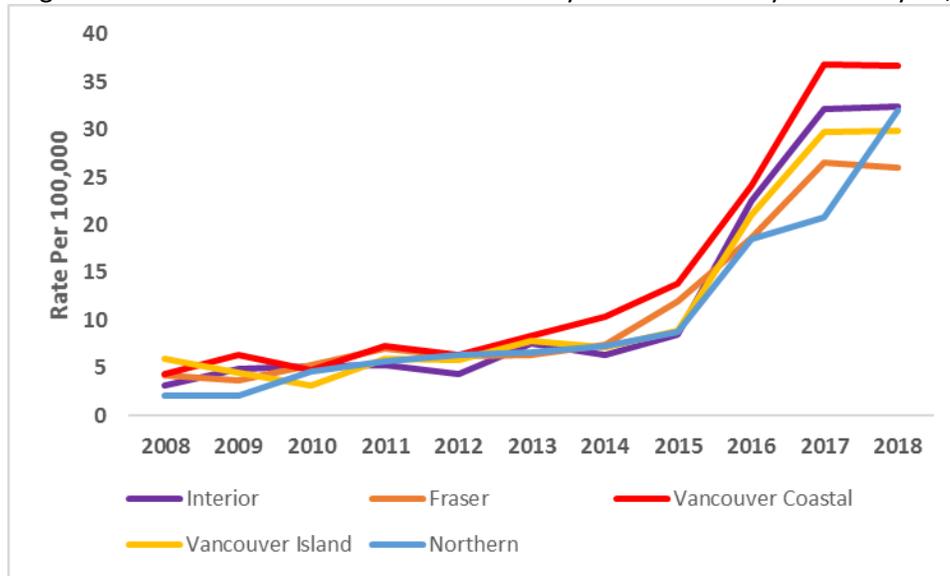


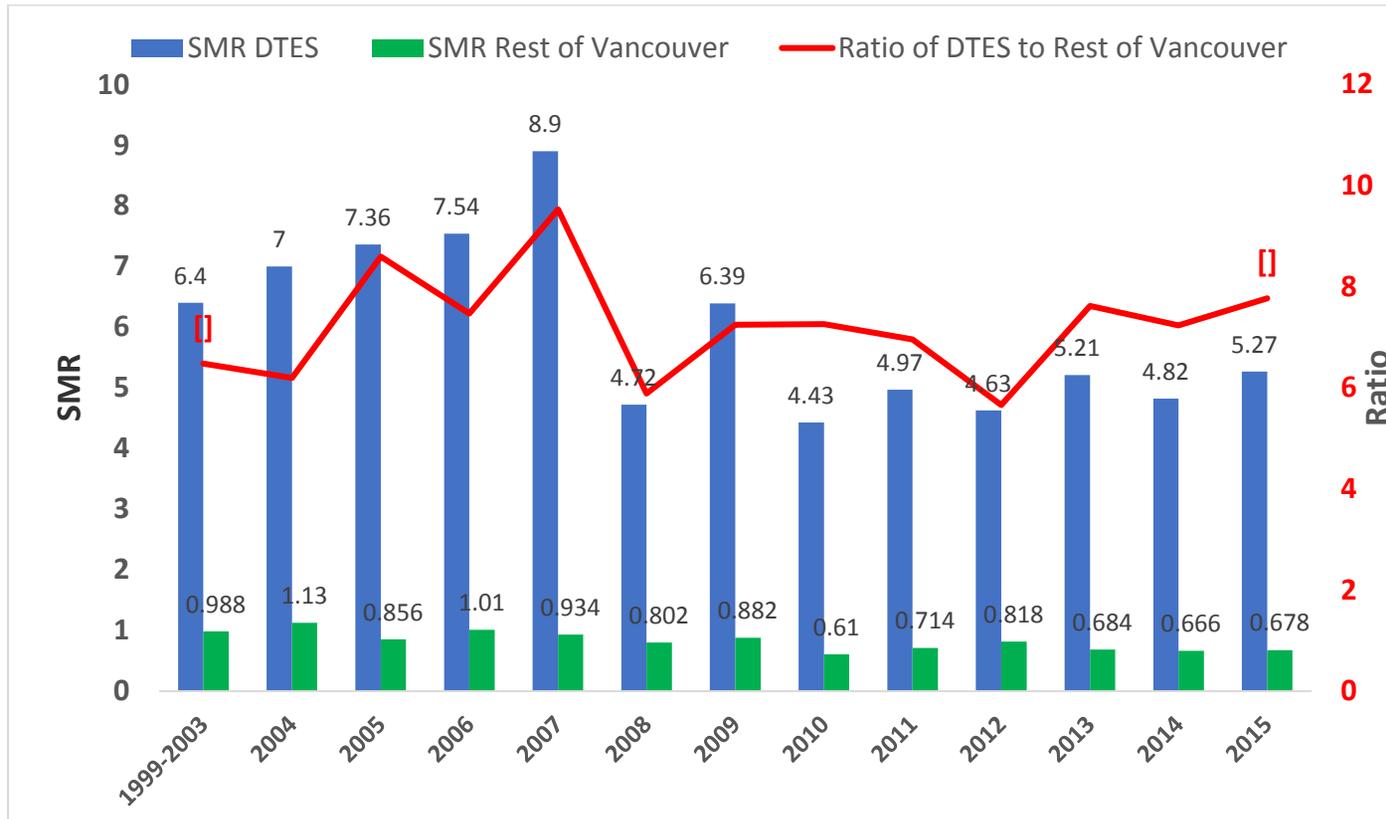
Figure 2  
Illicit Drug Overdose Death Rate in British Columbia by Health Authority 2008-May 31, 2018<sup>53</sup>



<sup>52</sup> <https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf>

<sup>53</sup> <https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf>

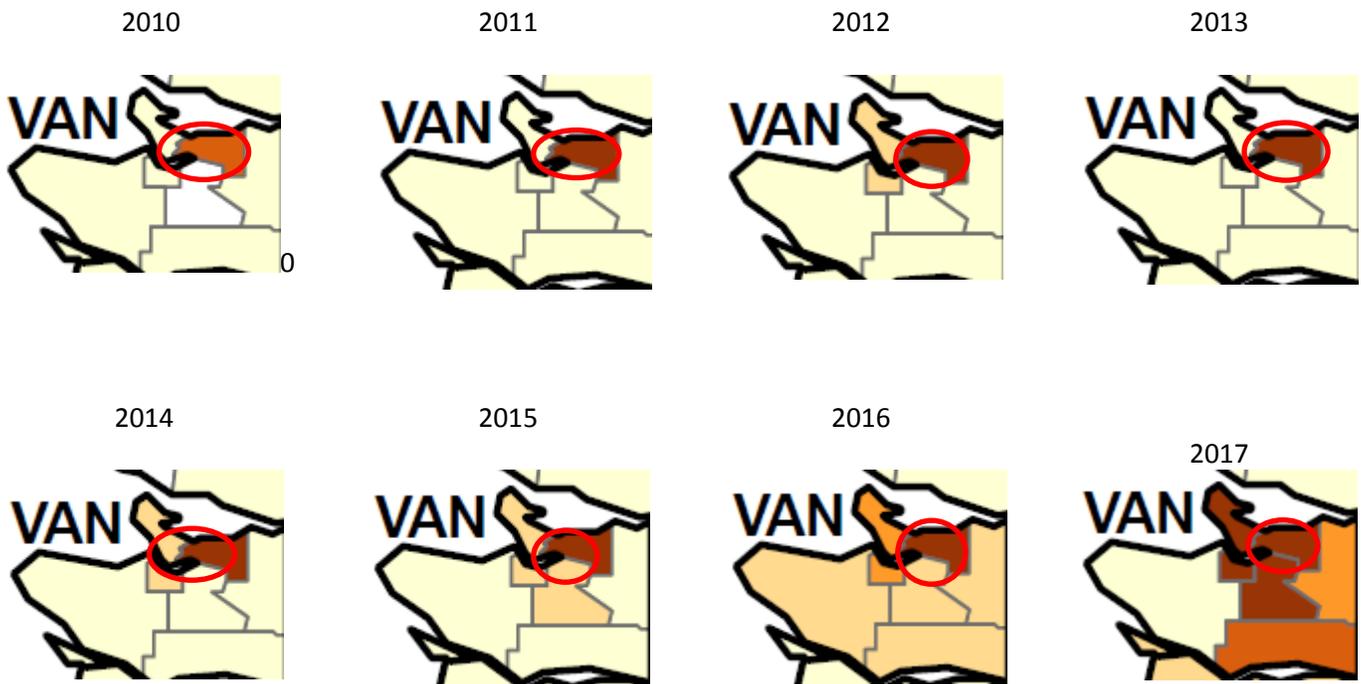
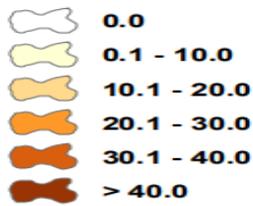
Figure 3  
 Drug-Death Standardized Mortality Rates for DTES\* Compared to the Rest of Vancouver 1999-2015<sup>1</sup>



\*Where the DTES (InSite) is located.

<sup>1</sup> Source: British Columbia Vital Statistics <https://www2.gov.bc.ca/gov/content/life-events/statistics-reports>

Figure 4  
City of Vancouver Overdose Death Rate per 100,000  
2010-2017<sup>1</sup>



<sup>1</sup> <http://www.bccdc.ca/resource-gallery/Documents/Statistics%20and%20Research/Statistics%20and%20Reports/Epid/Other/Illicit%20Drug%20Overdose%20Deaths%20by%20LHA%20-%20No%20Counts.pdf>

**Appendix VI: Syringe Services Program Info Sheet**

(information received from SafeRecovery program of Howard Center, Chittenden County, 2016 and 2017 data, and from Vermont Department of Health Program Chief Daniel J. Daltry, MSW)

<b>Safe Recovery</b>	CY 2016	CY 2017
# of visits	10,406	7,565
# of individual clients	1,681	1,338
# of secondary exchange clients	9,410	6,414
# of new clients	632	306
# referred to treatment	854	828
# successfully linked to treatment through Hub and Spoke	na	228
% of clients report having experienced an abscess or injection site infection	68%	68%
Avg # of visits per client	6.19	5.65

**Factors in Reduction in numbers:**

- Corresponds with timely access to treatment -- Positive impact of additional Hub services in northwestern Vermont, adding 200 slots to the area and eliminating the wait list. Also, addition of Spokes.
- Availability of treatment also reduces the number of people who go from pills to injection.

**2017 first year tracking successful linkage to treatment through Hub and Spoke**

- SafeRecovery is the only SSP that can track this measure, as it is directly linked to a Hub. Other SSPs are unable to gain this information due to confidentiality restrictions.

**Appendix VII: Additional Vermont Information on the Cost of Endocarditis Associated with Injection Drug Use**

**Additional Vermont information on the cost of endocarditis associated with injection drug use**

Dr. Levine has obtained figures from the University of Vermont Medical Center<sup>1</sup> for incidence of “endocarditis and drug abuse diagnosis code in same visit” by fiscal year. This rate has risen from ten visits (nine unique individuals) in 2012-2013, to 80 visits (59 unique individuals) in 2016-2017. They report 27 patients over the same five-year period with repeat visits.

**Endocarditis and Drug Abuse Diagnosis Code in Same Visit by Fiscal Year**

<b>Fiscal Year (Oct - Sept)</b>	<b># Visits</b>	<b># Unique MRNs*</b>
2012-2013	10	9
2013-2014	11	10
2014-2015	23	18
2015-2016	59	50
2016-2017	80	59
<b>Total</b>	<b>183</b>	<b>146</b>

\*The first year within the 5 years analyzed that the patient had an IP visit where they were coded with endocarditis and drug abuse. If a patient appeared in more than 1 fiscal year they were assigned to the first year.

- \*\*27 Patients had more than 1 IP visit during the past 5 years
  - 1 patient had 5 IP visits
  - 2 patients had 4 IP visits
  - 3 patients had 3 IP visits
  - 21 patients had 2 IP visits

\*\*\*ICD diagnosis coding does not have the specificity of IV vs PO drug abuse. Therefore, the numbers above include all drug abuse codes, not just IV.

**Cost**

Estimates from UVMHC and in the North Carolina study suggest the costs related to treating endocarditis range from \$50,000 for shorter term treatment, to \$100,000 for six weeks of inpatient care and intravenous antibiotics to \$500,00 or more for a valve replacement and lifelong anticoagulation.

---

<sup>1</sup> Information obtained by Commissioner Mark Levine, M.D., Vermont Department of Health, through personal communication from Dr. Steve Leffler, University of Vermont Medical Center.