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# Supervised Injection Facilities and Other Supervised Consumption Sites: Effectiveness and Value

Public Meeting — December 3, 2020

Meeting materials available at: <https://icer-review.org/topic/opioids-supervised-injection-facilities/>





## Why are we here today?

*Lots of people are dead because they overdosed in public alone with no help around them...I can think of 13 people who are still alive today because I was there to call 911 or seek help.*

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Client of a Supervised Consumption Site



## Why are we here today?

*People who use drugs don't have a lot of places they can go without being stigmatized, so it's so important to have a place you can go and be welcomed and use safely.*

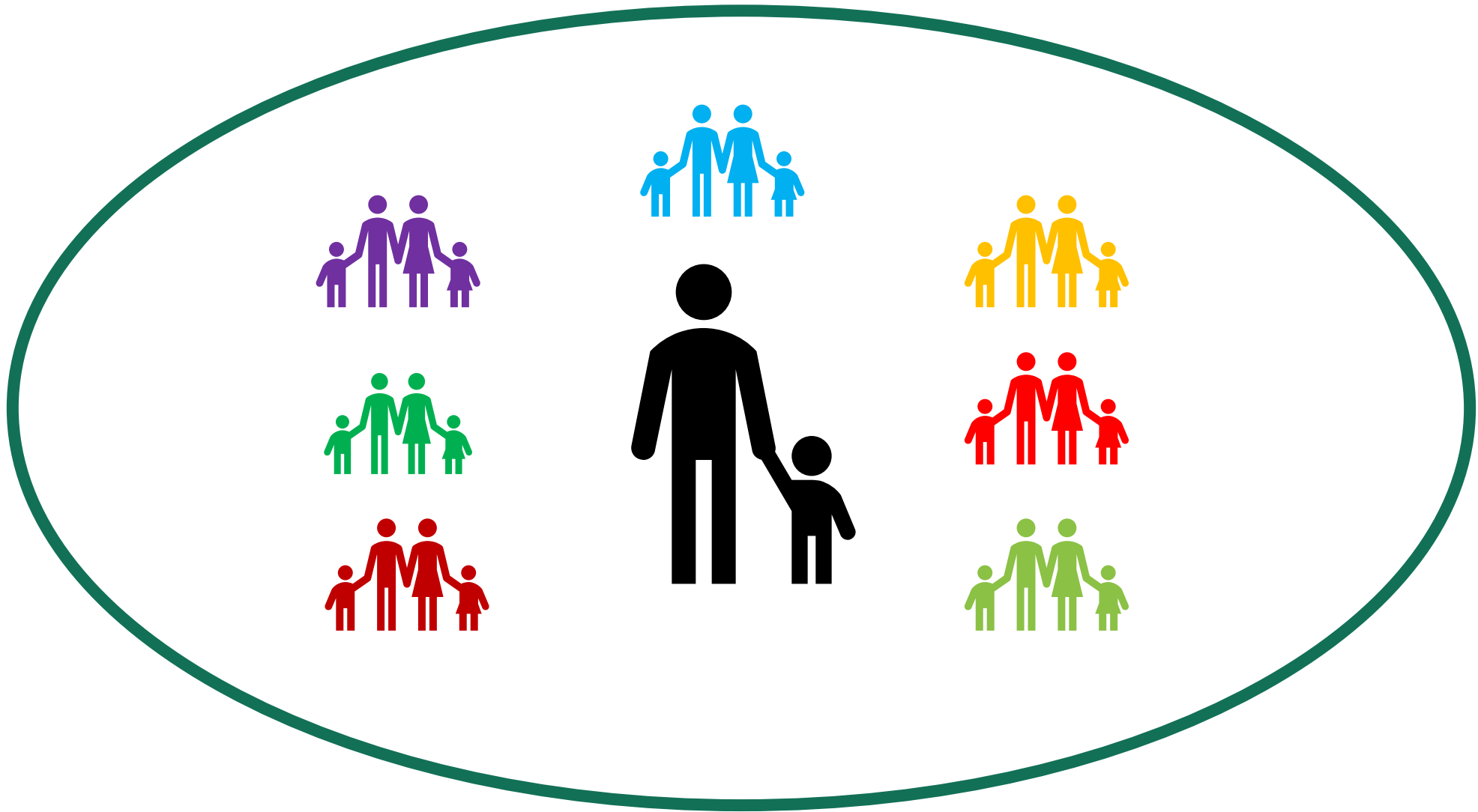
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Staff Member/Client at Overdose Prevention Site

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# Why Are We Here Today?

- The national opioid crisis continues
- How do we make the best use of our resources to help people?



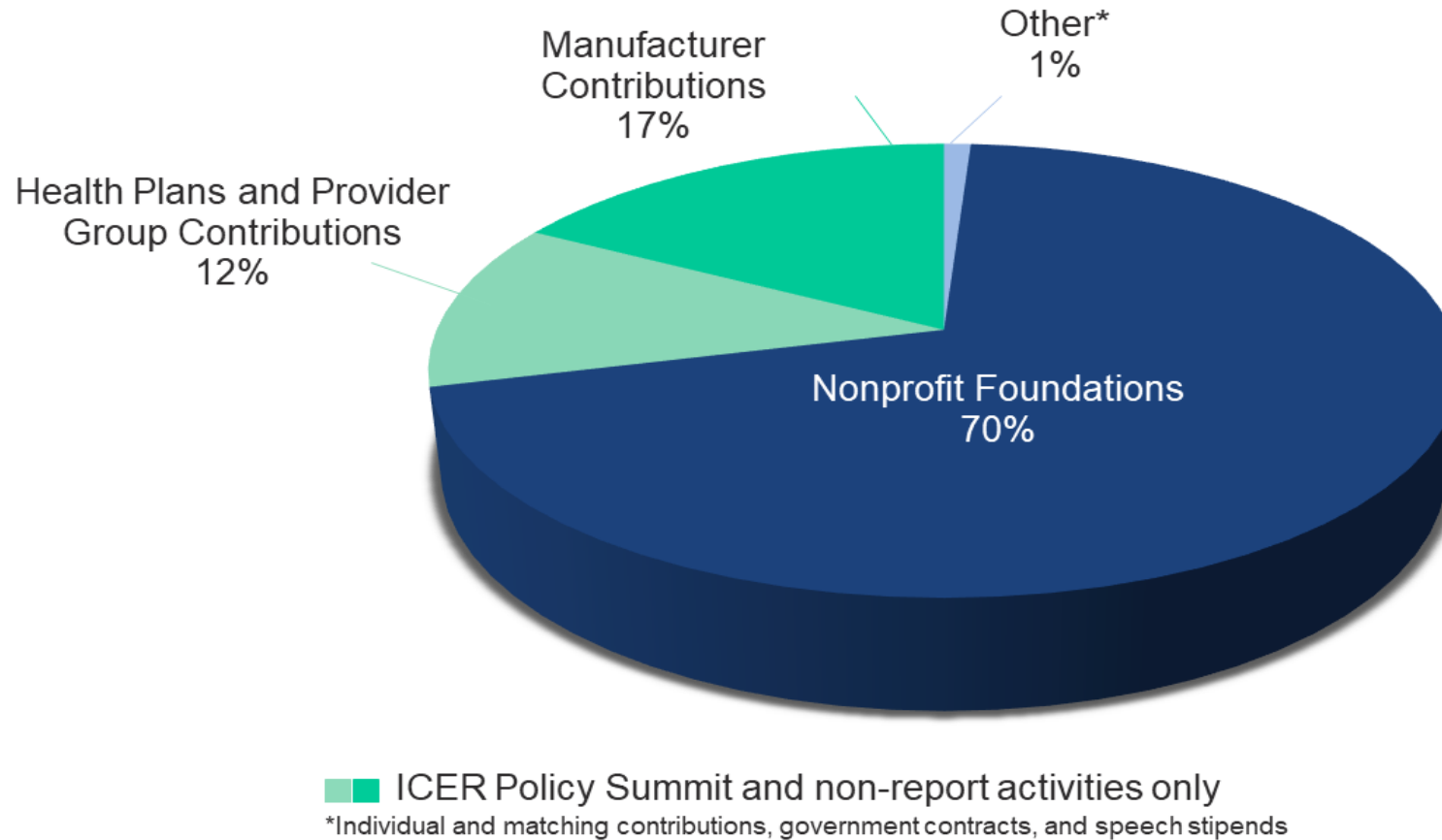
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# Organizational Overview

- The New England Comparative Effectiveness Public Advisory Council (CEPAC)
- The Institute for Clinical and Economic Review (ICER)

# Sources of Funding, 2020

<https://icer-review.org/about/support/>



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# How was the ICER report developed?

- Scoping with guidance from PWUD, harm reduction organizations, staff members of SIFs/SSPs, researchers, clinical experts, legislative experts, and law enforcement
- Internal ICER staff evidence analysis
- University of Washington cost-effectiveness modeling
- Public comment and revision
- Expert reviewers
  - Brandon Marshall, PhD, Associate Professor of Epidemiology, Brown University School of Public Health
  - Amos Irwin, Program Director, Law Enforcement Action Partnership (LEAP)
  - Matthew Bonn, Program Coordinator, Canadian Association of People who Use Drugs (CAPUD)
- How is the evidence report structured to support CEPAC voting and policy discussion?





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# Components of Long-Term Value for Money

**Special Social/Ethical Priorities**

**Benefits Beyond “Health”**

**Total Cost Overall**  
Including Cost Offsets

**Health Benefits:**  
Return of Function, Fewer Side Effects

**Health Benefits:**  
Longer Life

# Agenda

Time	Activity
12:30 pm—12:50 pm	<b>Meeting Convened and Opening Remarks</b> Steven D. Pearson, MD, MSc, ICER
12:50 pm—1:20 pm	<b>Presentation of the Clinical Evidence</b> Eric Ambrecht, PhD, Saint Louis University
1:20 pm – 1:50 pm	<b>Presentation of the Economic Model</b> Greg Guzauskas, MSPH, PhD, University of Washington
1:50 pm—2:00 pm	<b>Public Comments and Discussion</b>
2:00 pm – 2:10 pm	<b>Break</b>
2:10 pm – 2:50 pm	<b>New England CEPAC Deliberation and Vote</b>
2:50 pm – 3:00 pm	<b>Break</b>
3:00 pm – 4:40pm	<b>Policy Roundtable</b>
4:40 pm—5:00 pm	<b>Reflections from New England CEPAC and Closing Remarks</b>
5:00 pm	<b>Meeting Adjourned</b>

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# PWUD and Clinical Experts

**Matthew Bonn**, Program Coordinator, Canadian Association of People Who Use Drugs

- *No financial conflicts to disclose.*

**Peter Leslie**, Harm Reduction Community Health Worker Educator

- *No financial conflicts to disclose.*

**Alexis Roth, PhD**, Associate Professor, Drexel University

- *No financial conflicts to disclose.*

**Scott Handland, MD**, Assistant Professor of Pediatrics, Boston University School of Medicine

- *No financial conflicts to disclose.*

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# Presentation of the Clinical Evidence

**Eric S. Armbrecht, PhD, MS**

Professor

Saint Louis University School of Medicine  
Department of Health and Clinical Outcomes Research



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## Key Collaborators

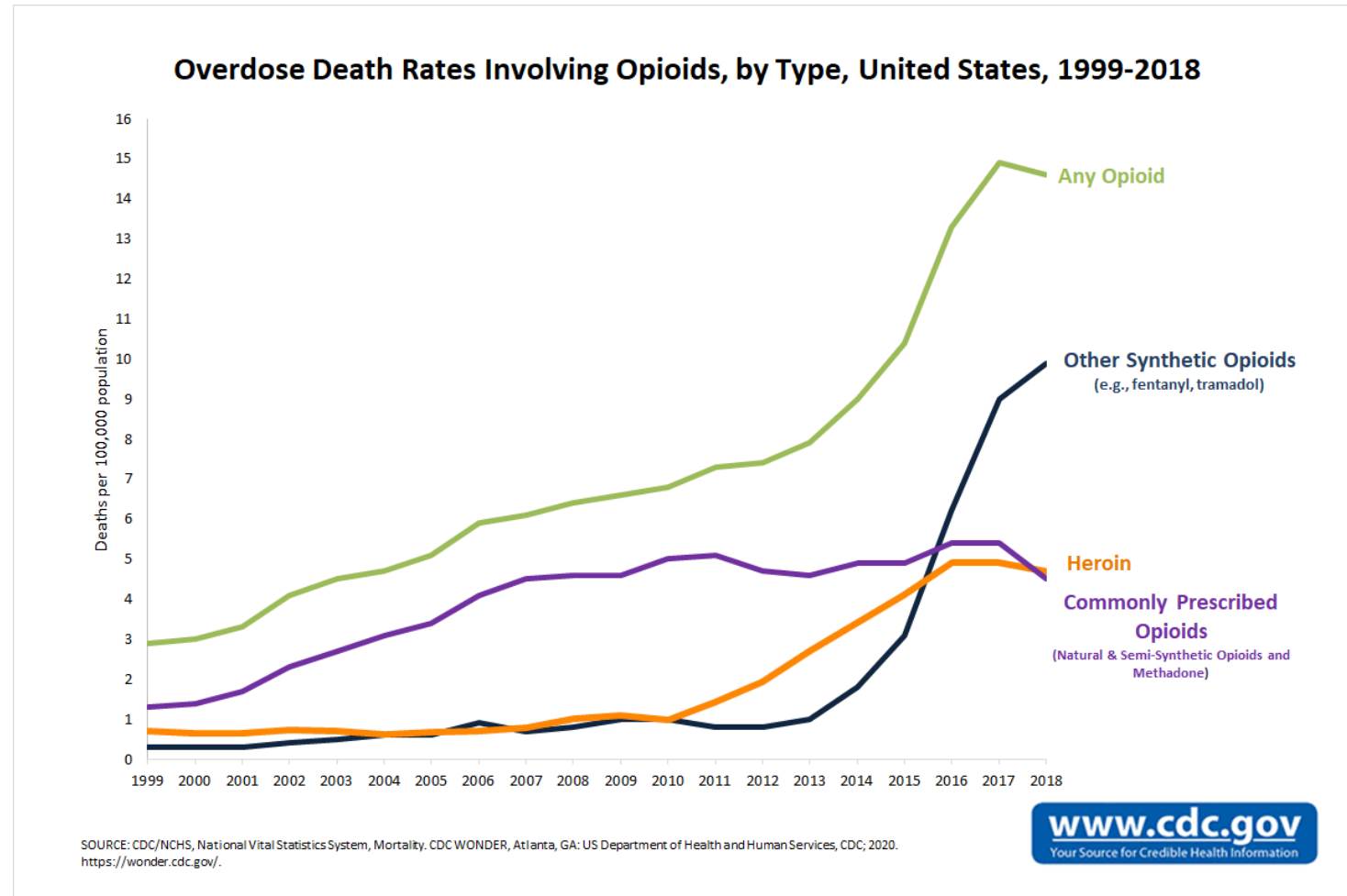
- Rajshree Pandey, PhD, MPH, Research Lead, ICER
- Katherine Fazioli, BS, Research Lead, ICER
- Serina Herron-Smith, BA, Research Assistant, ICER
- Eric Borrelli, PharmD, MBA, Evidence Synthesis Intern, ICER

### *Disclosures:*

We have no conflicts of interest relevant to this report

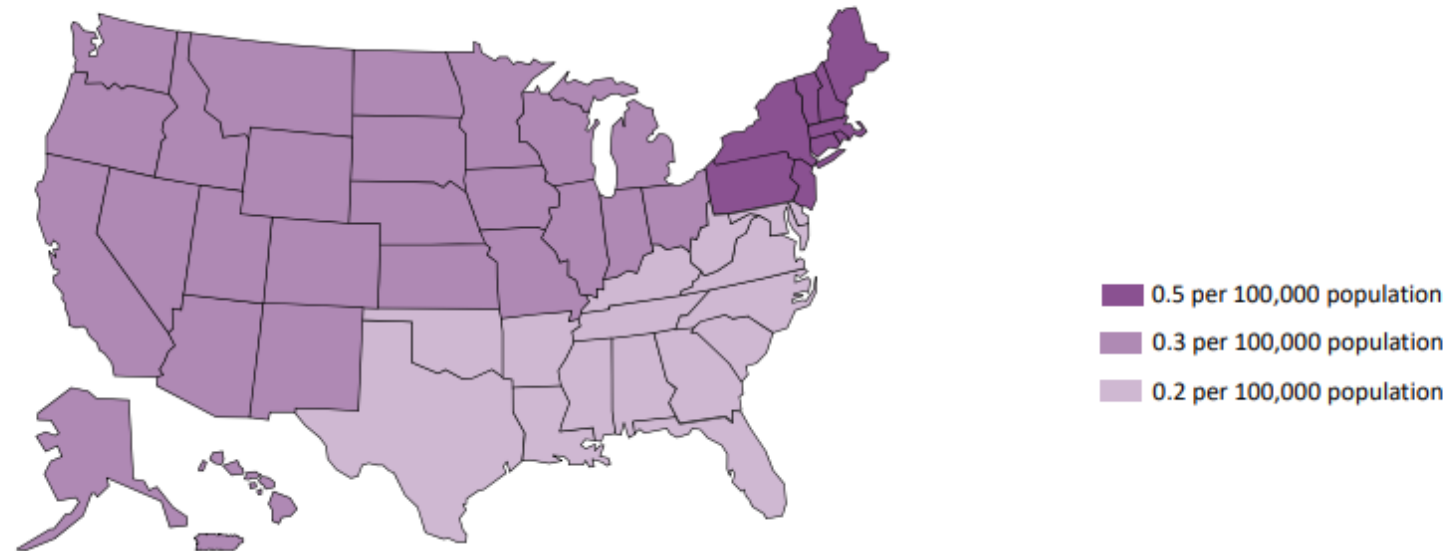
# Background

- Opioids are a class of drugs including both prescription pain medications and illicit drugs
  - Codeine, oxycodone, methadone, fentanyl, heroin, or cocaine
- Opioid Epidemic
  - Leading cause of injury-related death in the United States today
  - Of the 67,367 drug overdose deaths that occurred in 2018, ~70% (46,802) involved opioids



# Drug Use, Misuse, Substance Use Disorder, and Treatment

Self-reported prevalence of heroin use in the past year by region, persons 12+ years old — United States, 2018



Source: Center for Behavioral Health Statistics and Quality. 2018 National Survey on Drug Use and Health (NSDUH). Substance Abuse and Mental Health Services Administration (SAMSHA), Rockville, MD.



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# Examples of Harm Reduction for Opioid Use Disorder

- Medications – methadone and buprenorphine
- Syringe service programs (SSPs) – provide equipment for safer injections
- Naloxone access (antidote to opioid overdose)
- Drug checking services – screen for risky drugs (e.g., fentanyl)
- Supervised injection facilities (SIFs)

\* <https://www.cdc.gov/drugoverdose/data/analysis.html>

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# Supervised Injection Facility

## Core Features

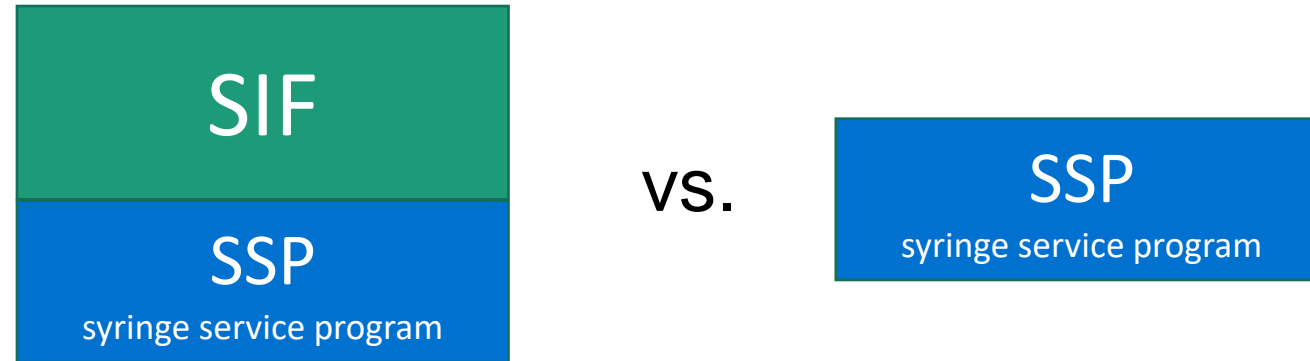
- sterile equipment
- trained personnel for supervision
- first-responder medical care (e.g., oxygen, naloxone)

## Add-on Services Examples

- health screening
- treatment for substance use disorders (SUDs)
- referral coordination for social support (e.g., housing)
- health care and mental health services

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# Scope of Review



Research  
question

What is the net health benefit for a community (with an established SSP) to implement a SIF?

# Available Services

Attribute	SIF+SSP	SSP Only
Supervision of injection	X	
Oxygen and first responder care	X	
Immediate naloxone administration	X	
Clean, sterile equipment	X	X
Take-home naloxone	X	X
Referrals (social, medical, and mental health services)	X	X
Injection risk behavior education	X	X

# Overview of the Literature

identified 1,188 potentially-relevant references for SIFs

	SIFs	SSPs
Number of Included Studies	48 studies [Canada (n=33); Australia (n=8); Germany (n=2), Denmark (n=3), and Spain (n=2)]	4 systematic reviews (one review of 13 reviews and three recent systematic reviews)
Outcomes Assessed	<ul style="list-style-type: none"><li>• overdose mortality (in and out of SIF)</li><li>• ambulance / emergency services</li><li>• infection prevention / injection behaviors</li><li>• community and environmental outcomes</li><li>• uptake of social, medical and mental health services (e.g., MAT)</li><li>• quality of life</li></ul>	<ul style="list-style-type: none"><li>• infection prevention and injection behaviors</li></ul>



# Clinical Evidence

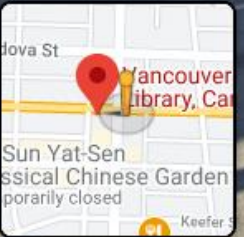
# Mortality

Outcome	Evidence/Findings	Confidence
Overdose mortality within SIF	<ul style="list-style-type: none"><li>No deaths at facility</li></ul>	HIGH
Overdose mortality within communities	<ul style="list-style-type: none"><li>35% reduction within 500 m of SIF vs. 9.3% reduction elsewhere in City of Vancouver (Marshall 2011)</li></ul>	MODERATE

**Summary:** SIFs reduce mortality risk

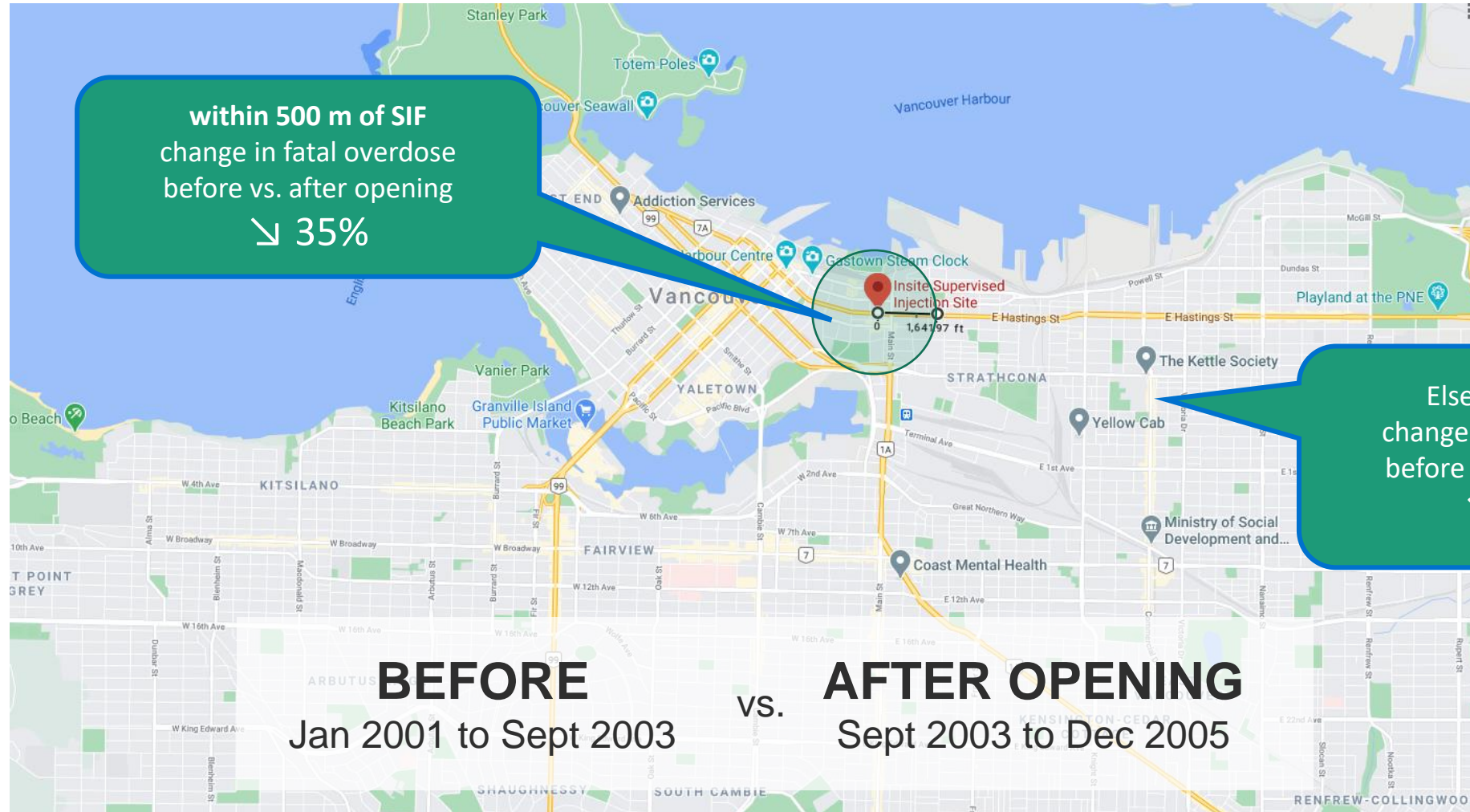


Insite Vancouver  
Downtown Eastside  
Neighborhood





# Mortality: Marshall BD, et al. Lancet. 2011;377(9775):1429-1437.



# Ambulance/Emergency Services

Outcome	Evidence/Findings	Confidence
Ambulance rides (for overdose)	<i>When is SIF open</i> <ul style="list-style-type: none"><li>SIF neighborhood: -80% vs. Elsewhere in City: -60% (p &lt; 0.05)</li></ul> <i>All times of day</i> <ul style="list-style-type: none"><li>SIF neighborhood: -68% vs. Elsewhere in City: -61% (p &lt; 0.05)</li></ul>	MODERATE

**Summary:** SIFs reduce healthcare utilization of emergency response services

# Infection Prevention/Injection Risk Behaviors

Outcome	SIF+SSP	SSP Only	Confidence
Syringe sharing	<ul style="list-style-type: none"> <li>69% reduction</li> </ul>	<ul style="list-style-type: none"> <li>48% reduction</li> </ul>	MODERATE
HIV prevalence or infection	<ul style="list-style-type: none"> <li>Not significant</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in HIV transmission risk (pooled effect size: 0.42; 95%CI 0.22 to 0.81)</li> </ul>	UNCERTAIN
Healthcare utilization for skin-related infection	<ul style="list-style-type: none"> <li>SIF clients 5 times more likely to get hospitalized</li> <li>Referrals from SIF had 8-day shorter length of stay</li> </ul>	<ul style="list-style-type: none"> <li>NR</li> </ul>	LOW

**Summary:** SIF improves injection risk behaviors (a proxy for HIV or hepatitis infection) better than SSP Only, but no direct comparison.

# Community and Environment

Outcome	Evidence/Findings	Confidence
Public drug use	<ul style="list-style-type: none"><li>~50% reduction measured by objective counting and stakeholder survey</li></ul>	MODERATE
Litter/trash	<ul style="list-style-type: none"><li>~40-50% reduction measured by objective counting and stakeholder survey</li></ul>	LOW
Crime	<ul style="list-style-type: none"><li>No material impact on crime.</li></ul>	LOW

**Summary:** SIF reduces injecting in public places and litter/trash; no apparent evidence of change in crime.

# Uptake of Social, Medical and Mental Health Services

Outcome	Evidence/Findings	Confidence
Enroll in MAT or detox program	<ul style="list-style-type: none"><li>• 8x more likely for high vs. low frequency SIF use</li></ul>	LOW
Access medical services	<ul style="list-style-type: none"><li>• 37% (frequent use) vs. 17% (rare use)</li></ul>	LOW
Access counseling services	<ul style="list-style-type: none"><li>• 46% (frequent use) vs. 25% (rare use)</li></ul>	LOW
Housing or social supports	<ul style="list-style-type: none"><li>• Anecdotal evidence only</li></ul>	UNCERTAIN

**Summary:** Clients who visit SIFs frequently access more medical, mental health, and support services, including MAT

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# Perspective of the Client

from interviews with 48 stakeholders

- Camaraderie and community
- Healthcare system bias
- Housing security
- Integrated services

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*“Needle exchange programs, yeah, it’s great, but it’s a momentary interaction; they’re not going to be there to save your life.” – SCS Client*

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*“Most interactions with pharmacists, doctors, lawyers...are all so stigmatizing. They make you feel kind of like a moral failure.” – OPS Staff Member and Client*

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*“A simple consumption room is better than nothing but having a little bit of social support on-site is fantastic” – SIF Manager*

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## Controversies and Uncertainties

impact estimates of effectiveness

- Research methods
  - Study design
  - Generalizability
- Changes in drug supply
- Frequency of SIF use
- Law enforcement and role of community
- Widespread naloxone access

## Implementation Concerns

potential disadvantages and challenges

- Honey-pot effect
  - Attract *more* drug-related activity to the SIF's neighborhood
- Employee safety

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# Potential Other Benefits and Contextual Considerations

the CEPAC will vote on 4 items today

- Differentially benefits a historically disadvantaged or underserved community
  - SIFs serve vulnerable, marginalized people with substance use disorder who have lower life expectancy, higher disability
  - Housing insecurity, mental illness, childhood trauma, unemployment



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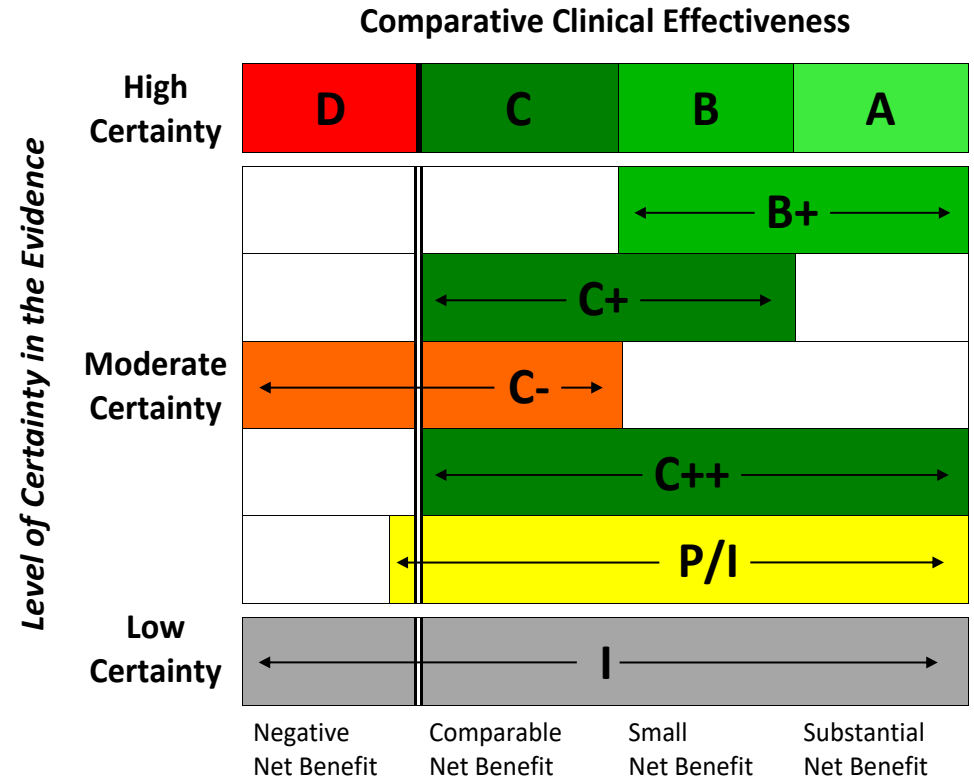
# Public Comments

a few of the many comments received

- Contribution of law enforcement on SIF effectiveness
- Inclusion of stimulant-involved overdose mortality
- Impact of Covid19 on overdose risk and need for SIFs

# ICER Evidence Rating

- B+
  - Moderate certainty of small or substantial net health benefit, with high certainty of at least a small net health benefit*
- Comparison: SIF+SSP vs. SSP alone



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# Summary

## A Supervised Injection Facility....

- Serves vulnerable and marginalized people, including those at highest risk for bloodborne disease
- Prevents overdose death
- Improves injection risk behaviors
- Reduces visibility of drug use (e.g., injecting in public places, syringe litter)
- Has no apparent impact on crime
- Assists clients with accessing medical, mental health, and social support services, including the use of addiction treatment services

**Questions?**

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# Cost-Effectiveness

**Greg Guzauskas, MSPH, PhD**

Research Scientist, Comparative Health Outcomes, Policy, and Economics (CHOICE)  
Institute

University of Washington



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# Key Economic Model Team Members

## **Ryan Hansen, PharmD, PhD**

Associate Professor, Comparative Health Outcomes, Policy, and Economics (CHOICE) Institute, University of Washington

## **Rick Chapman, PhD, MS**

Director of Health Economics, ICER

### *Disclosures:*

Financial support provided to the University of Washington from the Institute for Clinical and Economic Review (ICER).

University of Washington researchers have no conflicts to disclose defined as more than \$10,000 in healthcare company stock or more than \$5,000 in honoraria or consultancies relevant to this report during the previous year from health care manufacturers or insurers.

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# Objective

To evaluate the incremental costs and cost-effectiveness of a SIF+SSP compared to an SSP-only in various U.S. cities.



# Methods in Brief



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# Methods Overview

- **Setting:** United States
- **Perspective:** Modified Societal Perspective
- **Time Horizon:** 1 Year
  
- **Primary Outcomes:**
  - Cost per outcome
  - Overdose deaths prevented
  - Emergency service avoided (ED visits, ambulance rides, and hospitalization)

# Community Characteristics

City Characteristics	Boston	Philadelphia	San Francisco	Atlanta	Baltimore	Seattle
Population Density (people/square mile)	13,943	11,692	18,581	3,858	7,594	8,391
Commercial Property Value (cost per square foot)	\$550	\$207	\$300	\$244	\$202	\$414
Cost of Living Ratio vs. Vancouver, BC	1.24	1.05	1.47	0.93	0.95	1.18
Number of PWID within city limits	29,500	68,800	22,500	23,100	42,200	26,000
Number of Overdose Deaths per Year	250	1,150	330	482	692	227

# Key Model Assumptions

Assumption	Rationale
<b>SIFs in US cities are comparable to Insite (Vancouver, BC, Canada) in terms of effectiveness, services offered, and cost of living-adjusted operating costs.</b>	Insite is the first and most well-documented SIF in North America.
<b>The US cities modeled have a 0.25-mile radius area within the city that could have 2100 PWID clients for a SIF.</b>	The Insite client-service rate is the basis for the healthcare resource use effectiveness estimates for SIFs in all modeled cities.
<b>Rates of HIV/hepatitis C/other infections are equivalent between SIF+SSP and SSP only.</b>	Short model time horizon (1 year) and the complexity of estimating the timing of infections and attributing costs to these conditions.
<b>Rates of initiation and continuation of MAT are equivalent between SIF+SSP and SSP-only.</b>	Lack of comparative data between these two services.

# Overdose Mortality Inputs

Parameter	Estimate (sensitivity analysis range)
Fatal OD reduction within 0.25 mi <sup>2</sup> of SIF <sup>21</sup>	35.0% (±20%)
Fatal OD reduction beyond 0.25 mi <sup>2</sup> of SIF <sup>21</sup>	9.3% (±20%)
Proportion of total overdose deaths occurring within 0.25 mi <sup>2</sup> of SIF <sup>22</sup>	5% (±20%)

Absolute difference: 25.7%

$$\begin{array}{c}
 \boxed{25.7\%} \times \boxed{5\%} \times \boxed{\text{Overall OD deaths/city}} = \boxed{\text{SIF+SSP Reduction in OD Deaths/city}}
 \end{array}$$

22. Irwin A, et al. Harm Reduct J. 2017;14(1):29.

# Operating and Facility Cost Inputs

Parameter	Estimate (sensitivity analysis range)
Insite Annual Operating Cost	\$1.7 million ( $\pm 20\%$ )
Term of Commercial Loan (assumption)	15 years
SIF Square Footage	1000
Adjusted SSP Annual Operating Cost	\$1.5 million ( $\pm 20\%$ )

# Overdose and Emergency Services Outcome Inputs

Parameter	Estimate (sensitivity analysis range)
<u>Overdose (OD) Inputs</u>	
Total annual injections	180,000 ( $\pm 20\%$ )
Number of unique clients/month	2,100 ( $\pm 20\%$ )
Percent of injections resulting in OD	0.95% ( $\pm 20\%$ )
<u>Emergency Services Inputs</u>	
Proportion of ODs at SIF+SSP resulting in ambulance ride	0.79% ( $\pm 20\%$ )
Proportion of ODs at SIF+SSP resulting in ED visit	0.79% ( $\pm 20\%$ )
Proportion of SSP-only ODs resulting in ambulance ride	46% ( $\pm 20\%$ )
Proportion of SSP-only ODs resulting in ED visit	33% ( $\pm 20\%$ )
Proportion of ED visits resulting in hospitalization	48% ( $\pm 20\%$ )

# Emergency Services Cost Inputs

Location	Ambulance Ride Costs ( $\pm 20\%$ ) <sup>31</sup>	Overdose-Related Hospitalization Cost ( $\pm 20\%$ ) <sup>32</sup>
Boston	\$523	\$8,379
Philadelphia	\$487	\$7,502
San Francisco	\$566	\$8,683
Atlanta	\$462	\$5,890
Baltimore	\$493	\$7,502
Seattle	\$516	\$8,683

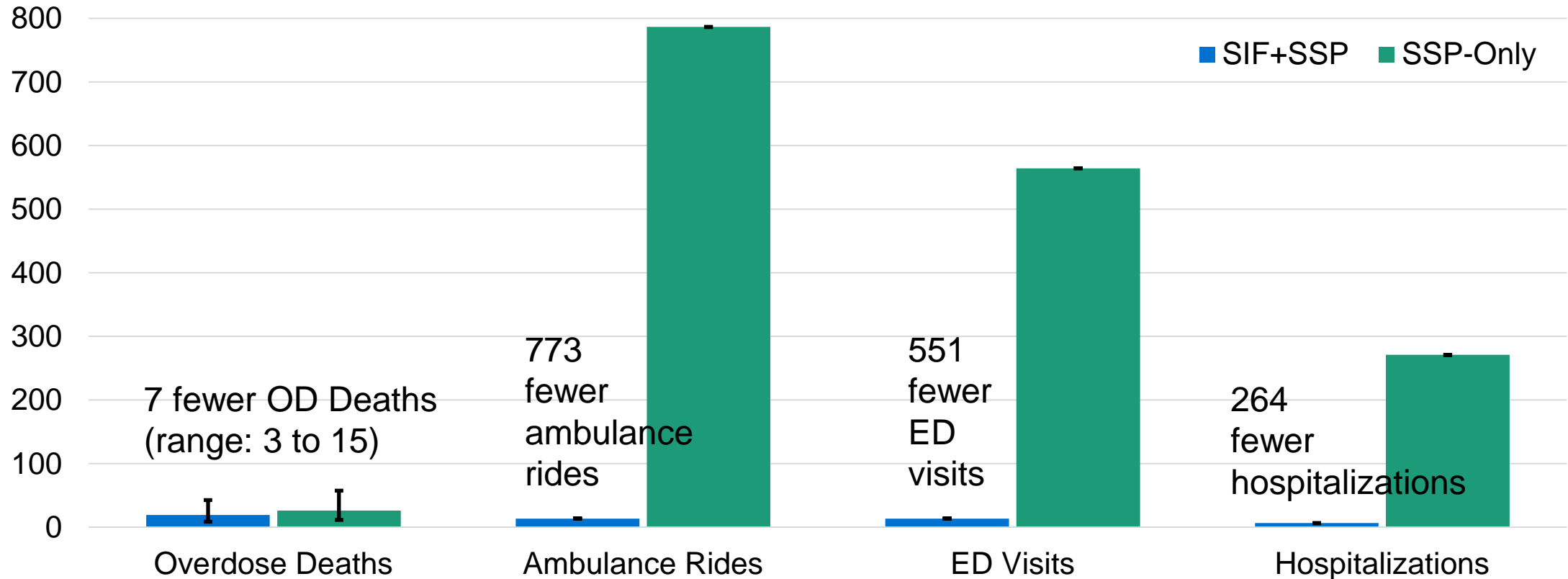
Overdose-related ED Visit Cost (all locations): \$3,451<sup>33</sup>



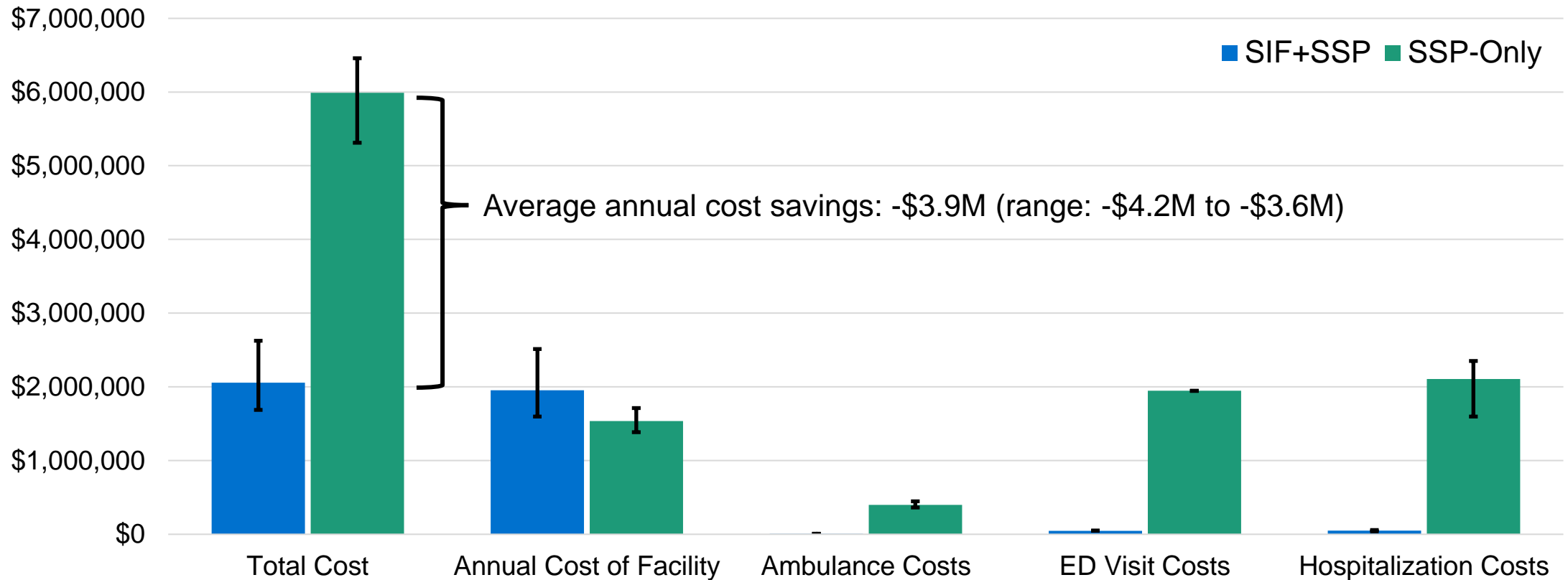
# Results



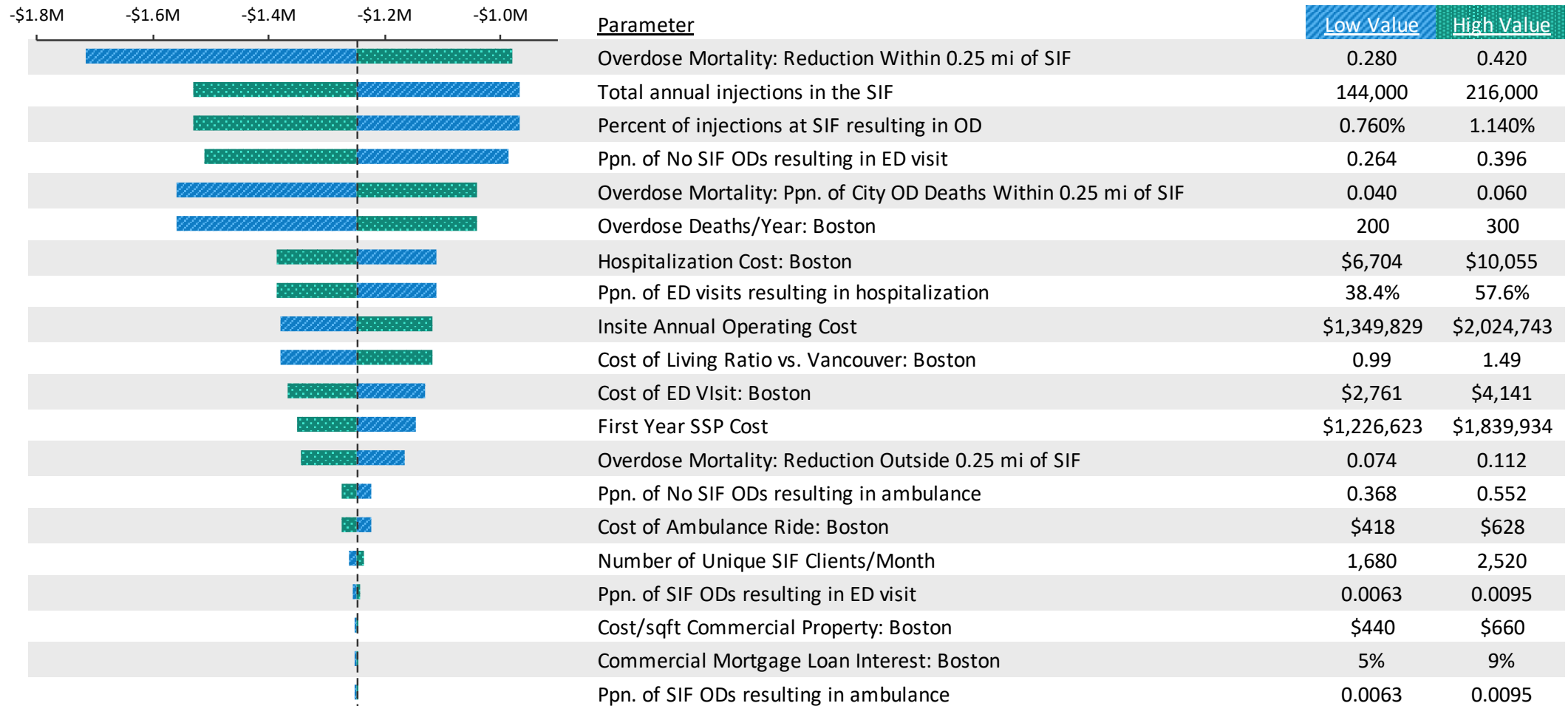
# Base-Case Results: Average Events Per City



# Base-Case Results: Average Costs Per City



# One Way Sensitivity Analyses: Boston



# Scenario Analysis of Overdose Rate Needed for Cost Parity

	Base Case OD Rate	Base Case Incremental Cost	Break Even Threshold OD Rate	Incremental Cost
<b>Boston</b>	0.95%	-\$4,009,000	0.11%	\$0
<b>Philadelphia</b>	0.95%	-\$3,899,000	0.08%	\$0
<b>San Francisco</b>	0.95%	-\$3,833,000	0.16%	\$0
<b>Atlanta</b>	0.95%	-\$3,623,000	0.05%	\$0
<b>Baltimore</b>	0.95%	-\$4,023,000	0.05%	\$0
<b>Seattle</b>	0.95%	-\$4,199,000	0.08%	\$0

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## Limitations

- The costs of operating a SIF in cities around the US are extrapolations from a single North American SIF in Vancouver, BC.
- The mortality risk reduction estimates we used also come from the estimated impact of that same single North American SIF at a single point in time.
- We cannot currently account for rapidly evolving pandemic-associated factors.

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## Comments Received

- MAT uptake should be higher in a SIF.
- Risk of chronic (HCV/HIV) and acute (e.g., skin) infections should be lower at a SIF.
- The baseline risk of overdose should be higher/lower depending on the local fentanyl supply.

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# Conclusions

- In all six cities, SIFs were estimated to reduce mortality by avoiding overdose deaths.
- The costs of operating a SIF were estimated to be higher than operating an SSP across all six cities. However, those costs were offset by cost savings attributed to SIFs through the avoidance of ED visits and subsequent hospitalizations.
- Overall, SIFs were found to be cost-saving in all six American cities, and these results were robust to variability in our model inputs.

**Questions?**



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# Public Comment and Discussion

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# Alex Kral, MS, PhD

## RTI International

### *Conflicts of Interest:*

- No conflicts of interest to disclose.

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## Comments on Boston Globe Article

One of my main concerns about safe injection sites is that they need to have a programming component to address the substance use disorder. Freyer states that those who avail themselves of these sites are more willing to go into treatment and that the crime rate in the area is not impacted. I think the article would have been more complete with some statistics on this instead of a casual mention. The closest thing that we have to an injection site in Boston is Mass and Cass. My sense from speaking to business owners and others who work in that area is that the crime rate has been impacted significantly. The idea is worth considering but we need more information this article missed an opportunity to provide it.

It could save money and lives but officials and politicians who approve these site are not opening them a few blocks down the street from where they, their families and children reside...

Source: <https://www.bostonglobe.com/2020/11/13/metro/influential-research-group-concludes-safe-injection-sites-save-lives-money>

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## Comments on Boston Globe Article

What does running a "supervised injection" site cost (there is no such thing as safe injection of street drugs), and what services could be purchased for that same price to support people trying to get clean, or stay clean. The site would need to be 24 hours, 365, would need round the clock medical staff, custodial staff, and security staff. Rent and insurance, including insurance for when someone dies or is damaged despite medical care. or one customer injures another customer, or a staff member.

How many rehab beds could be had for the same price? Because when someone hits their low and is willing to go for treatment, there usually is not a bed for them. Let's fund that first.

No! No! No! This is a horrible idea! People with drug dependency and abuse issues need help to get clean, not a safe, clean place to use! This doesn't promote treatment for these issues. It promotes a comfortable place to use. Why would anyone want to stop using if they were made to feel comfortable and safe while using. Ridiculous!

Source: <https://www.bostonglobe.com/2020/11/13/metro/influential-research-group-concludes-safe-injection-sites-save-lives-money>

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# Break

Meeting will resume at 2:00pm ET



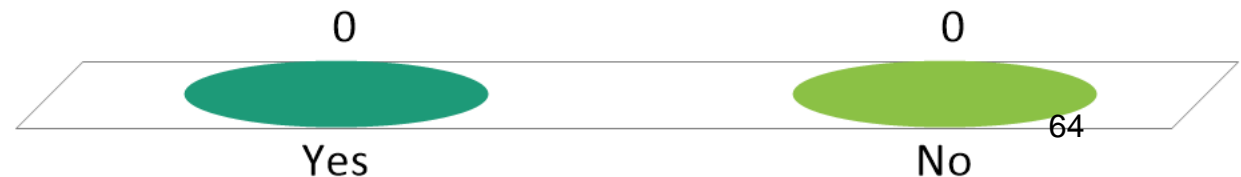


# Voting Questions

**1. Given the currently available evidence, is the evidence adequate to demonstrate that the net health benefit of SIFs is superior to that provided by SSPs alone?**

A. Yes

B. No





## 2. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to SIFs. Refer to table below.

Likert Scale of Potential Other Benefits and Contextual Considerations		
1 (Suggests Lower Value)	2 (Neutral)	3 (Suggests Higher Value)
This intervention will not differentially benefit a historically disadvantaged or underserved community.		This intervention will differentially benefit a historically disadvantaged or underserved community.
Uncertainty or overly favorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too optimistic.		Uncertainty or overly unfavorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too pessimistic.
Will not significantly reduce the negative impact of the condition on family and caregivers vs. the comparator.		Will significantly reduce the negative impact of the condition on family and caregivers vs. the comparator.
Will not have a significant impact on improving return to work and/or overall productivity vs. the comparator.		Will have a significant impact on improving return to work and/or overall productivity vs. the comparator.
Other		Other

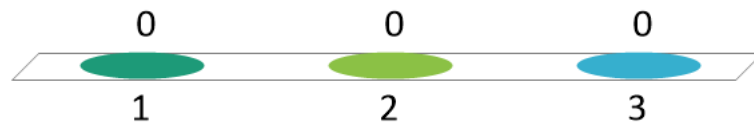
## 2a. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to SIFs. Refer to table below.

A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Neutral)	3 (Suggests Higher Value)
This intervention will not differentially benefit a historically disadvantaged or underserved community.		This intervention will differentially benefit a historically disadvantaged or underserved community.



## 2b. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to SIFs. Refer to table below.

A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Neutral)	3 (Suggests Higher Value)
Uncertainty or overly favorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too optimistic.		Uncertainty or overly unfavorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too pessimistic.



## 2c. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to SIFs. Refer to table below.

A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Neutral)	3 (Suggests Higher Value)
Will not significantly reduce the negative impact of the condition on family and caregivers vs. the comparator.		Will significantly reduce the negative impact of the condition on family and caregivers vs. the comparator.



## 2d. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to SIFs. Refer to table below.

A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Neutral)	3 (Suggests Higher Value)
Will not have a significant impact on improving return to work and/or overall productivity vs. the comparator.		Will have a significant impact on improving return to work and/or overall productivity vs. the comparator.



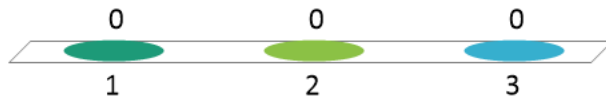
## 2e. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to SIFs. Refer to table below.

A. 1

B. 2

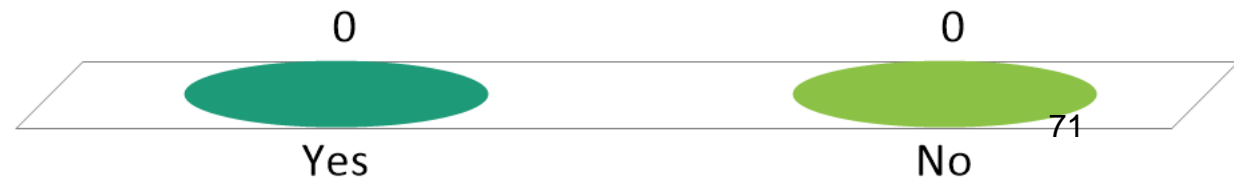
C. 3

1 (Suggests Lower Value)	2 (Neutral)	3 (Suggests Higher Value)
Other		Other



### 3. Given the currently available evidence, is the evidence adequate to demonstrate that compared with SSPs, SIFs are cost-saving?

- A. Yes
- B. No



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# Break

Meeting will resume at 2:50pm ET







# Policy Roundtable

# Policy Roundtable

Policy Roundtable Participant	Conflict of Interest
<b>Matthew Bonn</b> , Program Coordinator, Canadian Association of People Who Use Drugs	Matthew Bonn has no financial conflicts to disclose.
<b>Cindy Friedman</b> , Senator, Massachusetts Senate	Senator Friedman has no financial conflicts to disclose.
<b>Scott Hadland, MD, MS</b> , Assistant Professor of Pediatrics, Boston University School of Medicine	Dr. Hadland has no financial conflicts to disclose.
<b>Peter Leslie</b> , Harm Reduction Community Health Worker Educator	Peter Leslie has no financial conflicts to disclose.
<b>Bill Spearn</b> , Inspector, Vancouver Police Department	Inspector Spearn has no financial conflicts to disclose.
<b>Alexis Roth, PhD</b> , Associate Professor, Drexel University	Dr. Roth has no financial conflicts to disclose.
<b>Laura Thomas</b> , Director of Harm Reduction Policy, San Francisco AIDS Foundation	Laura Thomas has no financial conflicts to disclose.



# **NE CEPAC Council Reflections**

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## Next Steps

- Meeting recording posted to ICER website next week
- Final Report published on or around January 8, 2021
  - Includes description of NE CEPAC votes, deliberation, policy roundtable discussion
- Materials available at: <https://icer-review.org/topic/opioids-supervised-injection-facilities/>

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# Adjourn

