Supervised Injection Facilities and Other Consumption Sites: Final Policy Recommendations

January 8, 2021

Policy Recommendations

Introduction

The following policy recommendations reflect the main themes and points made during the Policy Roundtable discussion at the December 3, 2020 New England CEPAC public meeting on supervised injection facilities and other consumption sites. At the meeting, ICER presented the findings of its revised report on these treatments and the New England voting council deliberated on key questions related to their comparative clinical effectiveness, potential other benefits and contextual considerations, and cost impact of this intervention. Following the votes, ICER convened a Policy Roundtable of two community experts who themselves were or had been PWUD, one elected state representative, one academic researcher, one Canadian law enforcement officer, one physician specialized in addiction medicine, and one harm reduction professional to discuss how best to apply the evidence and votes to real-world practice and policy. The discussion reflected multiple perspectives and opinions, and therefore, none of the statements below should be taken as a consensus view held by all participants.

A recording of the conversation can be accessed here, and a recording of the voting portion of the meeting can be accessed here. More information on Policy Roundtable participants, including conflict of interest disclosures, can be found in the appendix of this document. ICER's report on this intervention, which includes the same policy recommendations, can be found here.

The roundtable discussion was facilitated by Dr. Steven Pearson, MD, MSc, President of ICER. The main themes and recommendations from the discussion are organized by audience and summarized below.

The following recommendations have been informed by the policy roundtable discussion, stakeholder interviews, and evidence described elsewhere in this report. The recommendations are built upon the basic idea that opioid use disorder is a health issue and warrants compassionate and effective interventions that can reduce the harms experienced by people who use drugs. These people include some of society's most marginalized people who are living with mental illness, unstable housing, and other barriers to good health and social integration. Our society has a responsibility to use resources in a responsible manner to address the needs of PWUD and to treat them as neighbors in need, not criminals.

Communities & Policy Makers

The evidence is adequate to demonstrate that SIFs save lives and save money. Community, state, and federal policy leaders should move forward to take the steps needed to launch pilot SIF programs in areas of established need and with strong local involvement of many sectors of the community, including, most importantly, people who use drugs themselves.

Although future research should continue to explore the relative impact of different approaches to providing SIFs, and to document further the impact of SIFs on outcomes of interest to the broader community, such as property values, cleanliness, and crime, current evidence that SIFs prevent overdose deaths and reduce overall costs is adequate now to support action to develop and launch these types of facilities in locales in which there is an established need. The set of actions that should be taken to accomplish this goal will be described in the recommendations below.

The design of SIFs in different locations should be customized to meet local needs and opportunities, guided by needs assessment and community dialogue.

States or metropolitan regions should facilitate community dialogue by conducting needs assessments to identify neighborhoods where there is high overdose risk and community support for harm reduction. This early phase of the process should incorporate methods to cultivate community dialogue about SIF benefits, limitations, and implementation concerns. The process should be open and inclusive, providing opportunities for individuals and organizations who may oppose SIFs to learn more and draw informed conclusions about the net health benefit.

Local community leaders should engage people who use drugs (PWUD) to customize the design of each SIF. PWUD can help inform the types of substances being used in the area, leading to prioritization of the kinds of training and infrastructure needed for each SIF. For example, in some areas the smoking of opioids, rather than injection, has become predominant, leading to the need for different facilities within SIFs. Ultimately, this process should be driven "from the streets up." PWUD should serve as the primary experts in how to build a safe environment that fosters positive relationships and outcomes. Public health, medical, and law enforcement professionals can serve critically important but supportive roles in SIF design -- always listening and assuring that core features (e.g., supervision, clean supplies, and first responder care) are available.

SIFs should be seen as one part of a broader network of services that can reduce harm, in part by linkages to access medication-assisted treatment (MAT) programs.

In addition to reducing near-term mortality risk, a SIF helps clients become aware of and access medical, mental health, and social support services, including the use of addiction treatment services. A SIF by itself does not expand a community capacity for needed services. Government agencies, such as CMS, state Medicaid programs, and state departments of mental health, should

therefore include SIFs as part of broader efforts to expand access to effective medication-assisted treatment. Other complementary measures that should be considered include eliminating patient panel size restrictions or raising the limits for prescribers of buprenorphine, permitting primary care providers to prescribe methadone for medication-assisted treatment (MAT), and increasing reimbursement levels for MAT programs.

Federal Regulators

The White House and the Attorney General should clarify that SIFs will not be considered illegal and that healthcare workers and others involved in providing services will not suffer adverse legal or professional consequences.

The United States government should clarify that the federal crack house statute (21 USC § 856) will not be used to prosecute individuals, organizations, or government agencies that permit, fund operations of, or work at SIFs. Without this clarification, many communities that want to explore SIFs to reduce overdose mortality will be stymied by legal uncertainty and related costs -- financial and political. The immunity clause of the Controlled Substances Act may be a shield against federal interference for government-sponsored SIFs. The US Attorney General, Drug Enforcement Agency, or White House should review this law as well as others that may offer legal protections for SIFs. Also, state boards that credential healthcare workers must clarify that physicians, nurses, social workers, emergency medical technicians, and others are working within their scope of license while at a SIF. Healthcare providers must be held harmless from professional liabilities (e.g., malpractice) associated with responding to an overdose occurring at a SIF.

The White House should consider (re)creating a Cabinet-level national leadership position to guide policy development for substance use disorders and the opioid epidemic.

The White House should consider re-establishing a Cabinet position dedicated to addressing substance use disorder and the overdose epidemic that is haunting communities across the United States. This leadership role would help coordinate national resources and policies in public health, law enforcement, and medical care to advance the implementation and research of harm reduction strategies, including SIFs. This cabinet office should explore all options to reduce the rising overdose mortality risk of illicit drugs. For example, safer supply programs, which are available in some European countries, and under consideration elsewhere, merits federal review.

Researchers & Funders

Research on SIFs should continue in order to generate both generalizable findings and evidence on the broader impact of specific SIFs in their own communities.

While the New England CEPAC voted 15-0 in favor of the evidence supporting the net health benefit of a SIF, uncertainty remains on implementing this public health intervention in different types of communities. Non-profit foundations and government agencies should include research funding when investing in projects that support the development of local variations on opening and operating a SIF. With proper evaluation methods, the projects -- small and large -- can estimate the incremental benefit of a SIF in combination with other harm reduction strategies (e.g., naloxone access, safe supply), social supports (e.g., housing security), and treatment/recovery services. Research should be balanced and include evaluation for potential harms from SIFs, including the potential to draw a large number of opioid users to a small area (the "honeypot effect"), increased litter/trash, crime, drug use in public, and property value decline. It is recommended that multi-stakeholder teams coordinate evaluation projects with methodological and analytic support from independent, university-affiliated researchers.

New mechanisms should be developed to ensure the long-term financial sustainability of SIFs following early pilot funding.

The ICER economic model demonstrated substantial cost savings to the healthcare system via reduced ambulance rides and hospitalizations. Given the age, poverty, and homelessness status of most SIF clients, it is believed state Medicaid agencies would realize the majority of cost-savings attributable to a SIF. There are multiple options for building a sustainable funding source for SIFs, including Medicaid program waivers and federal public health agencies that support harm reduction interventions. Private foundations and philanthropic organizations should continue to support the development and initial operations of SIFs until sustainable public funding sources are secured. Research evaluation of initial SIFs in the United States will be instrumental in confirming the cost savings anticipated, thereby supporting the benefits of long-term funding.

Appendix A

Appendix Tables 1 through 3 contain conflict of interest (COI) disclosures for all participants at the New England CEPAC public meeting on December 3, 2020.

Table A1. ICER Staff and Consultants and COI Disclosures

ICER Staff and Consultants	
Rajshree Pandey, MPH, PhD,* Research Lead, ICER	**Catherine Koola, MPH,*** Program Director, ICER
David Rind, MD, MSc,* Chief Medical Officer, ICER	**Azanta Thakur, BS,*** Program and Event Coordinator, ICER
Eric Armbrecht, PhD,* Professor of Health Outcomes, Saint Louis University	**Katherine Fazioli, BS,*** Research Lead, ICER
Greg Guzauskas, MSPH, PhD,* Senior Research Scientist, University of Washington	**Rick Chapman, PhD, MS,*** Director of Health Economics, ICER
Ryan Hansen, PharmD, PhD,* Professor, University of Washington	**Steven D. Pearson, MD, MSc,*** President, ICER

*No conflicts of interest to disclose, defined as individual health care stock ownership (including anyone in the member's household) in any company with a product under study, including comparators, at the meeting in excess of $10,000 during the previous year, or any health care consultancy income from the manufacturer of the product or comparators being evaluated.

Table A2. Policy Roundtable Participants and COI Disclosures

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

Table A3. New England CEPAC Panel Member Participants and COI Disclosures

Participating Members of New England CEPAC	
Albert Whitaker, MA,* Interim Pastor, St. Mark Congregational Church and Consultant	**Robert Aseltine, Jr., PhD (Chair),*** Professor and Chair, Division of Behavioral Sciences and Community Health Directors, Center for Population Heatlh
Kelly Buckland, MS,* Executive Director, National Council on Independent Living	**Marthe Gold, MD, MPH,*** Senior Scholar, New York Academy of Medicine
Jason Wasfy, MD, MPhil,* Director, Quality and Outcomes Research, Massachusetts General Hospital Health Center	**Megan Golden, JD,*** Co-Director, Mission: Cure
Jason Schwartz, PhD,* Assistant Professor, Department of Health Policy and Management, Yale School of Public Health	**Brian P. O'Sullivan, MD,*** Professor of Pediatrics, Geisel School of Medicine at Dartmouth College
Claudia Gruss, MD, FACP, FACG,* Gastroenterologist and Internist, Western Connecticut Medical Group	**Stephen Kogut, PhD, MBA, RPh,*** Professor of Pharmacy Practice, University of Rhode Island College of Pharmacy
Tara Lavelle, PhD,* Assistant Professor, Center for the Evaluation of Value and Risk in Health at Tufts Medical Center	**Eleftherios Mylonakis, MD, PhD, FIDSA,*** Chief of Infectious Diseases Division and Dean's Professor of Medicine, Warren Alpert Medical School of Brown University
Greg Low, RPh, PhD,* Program Director, MGPO, Pharmacy Quality and Utilization Program	**Kimberly Lenz, PharmD,*** Clinical Pharmacy Manager, MassHealth
Rena Conti, PhD,* Associate Research Director of Biopharma and Public Policy, Associate Professor, Boston University	**Edward Westrick, MD, PhD,*** Primary Care Physician, Assistant Medical Director, Comprehensive Community Action Program

*No conflicts of interest to disclose, defined as individual health care stock ownership (including anyone in the member's household) in any company with a product under study, including comparators, at the meeting in excess of $10,000 during the previous year, or any health care consultancy income from the manufacturer of the product or comparators being evaluated.