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

Response to Public Comments on Draft Evidence Report

November 13, 2020

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PWUD Groups and Networks		
National Harm Reduction Coalition		
1.	National Harm Reduction Coalition commends the thoughtful review and analysis by ICER staff of available evidence on the health and economic outcomes of a supervised injection facility (SIF), were such facilities to be established and implemented in the United States. This question has significant bearing on important policy issues related to strategies to address the current overdose epidemic and associated drug-related harms and consequences, including increased viral and bacterial infections among people who inject drugs (PWID). National Harm Reduction Coalition appreciated the opportunity to provide initial input during the drafting process, and in the following comments will highlight some additional considerations on the draft evidence report.	We appreciate the recognition by NHRC regarding the importance of a review and analysis of SIFs to inform policy and harm reduction interventions in the United States.
2.	First, we wish to note some distinct characteristics of the current landscape of coverage of syringe services programs (SSPs) and medication for opioid use disorder (MOUD) in the United States relevant to comparisons that draw upon international data on the incremental benefits of SIFs. An analysis of country-level coverage of SSPs and MOUD found that baseline coverage in the United States for these interventions falls significantly short of coverage in Australia, Canada, and most of Western Europe, specifically the countries with SIF data included in the draft evidence report.	The assessment of evidence and economic analysis assumes SSPs are available at levels in the study populations (e.g., Canada, Australia). Lower baseline levels of SSP availability in the United States could alter the expected outcomes in the economic model. We believe our approach to the analysis is conservative and may understate the actual benefit if SIFs also expand access to services provided by SSPs. No changes to the report narrative have been made in response to this comment.
3.	This observation suggests that the incremental benefits of SIFs vs. SSPs alone may actually be greater in the United States than in countries with higher baseline coverage of SSPs and MOUD, to the degree that more limited implementation of SSPs and MOUD in the U.S. has constrained their ability to reduce infectious disease transmission, overdose rates, and other relevant outcomes.	Yes, this is possible. There is no evidence to estimate the larger incremental benefit attributable to SIF services. Therefore, no changes to the report narrative have been made in response to this comment.
4.	Therefore an extrapolation of expected health benefits of SIF implementation in the United States which assumes that outcomes would be relatively equivalent to those seen in countries with higher baseline implementation of SSPs and MOUD would likely be overly conservative. Indeed, the CDC has recently reported on HIV outbreaks among PWID in several parts of the United States attributable in part to incomplete or inadequate SSP coverage, including in Seattle and Philadelphia – cities used in the draft evidence report's cost-effectiveness modeling.	We appreciate the perspective offered and agree that we attempted to make conservative assumptions.
5.	Collectively, these observations indicate that alongside a pressing and ongoing need to facilitate and ensure the scale-up of SSP and MOUD coverage across the United States, the potential health benefits of current SIF+SSP implementation in this country may actually exceed those documented in	See above.

	countries with greater baseline coverage to a degree that should be considered in modeling and conclusions.	
6.	Second, we call attention to a recent modeling study projecting 10-year mortality rates from infective endocarditis among opioid-using PWID in the United States relative to other causes of mortality. Second, we call attention to a recent modeling study projecting 10-year mortality rates from infective endocarditis among opioid-using PWID in the United States relative to other causes of mortality (Barocas JA, Eftekhari Yazdi G, Savinkina A, et al. Long-term infective endocarditis mortality associated with injection opioid use in the United States: a modeling study [published online ahead of print, 2020 Sep 9]. Clin Infect Dis. 2020;ciaa1346. doi:10.1093/cid/ciaa1346). Several reports have documented significant increases in injection drug use-associated infective endocarditis in the United States (see, e.g., Wurcel AG, Anderson JE, Chui KK, et al. Increasing Infectious Endocarditis Admissions Among Young People Who Inject Drugs. Open Forum Infect Dis. 2016;3(3):ofw157. Published 2016 Jul 26. doi:10.1093/ofid/ofw157).	The literature review of the evidence section of the report does exclude mathematical models or microsimulations, like Barocas et al. (2020), https://doi.org/10.1093/cid/ciaa1346. As an aside, we appreciate you calling attention to this recent study and we read it with great interest. The study by Wurcel et al. (2016) does not describe the benefits of a SIF or SSP intervention to prevent endocarditis or reduce associated morbidity/mortality, but does describe the scope of infective endocarditis and its burden to the healthcare system. We added a comment about the scope of IDU-EC and its burden to the healthcare system (via increasing hospitalizations). Refer to the subsection "Health Care Utilization for Infections" where we added this information and a reference to Wurcel et al. (2016).
7.	While overshadowed by overdose risk, endocarditis is a significant and growing cause of mortality among PWID, associated with substantial health care costs. National Harm Reduction Coalition therefore suggests that infective endocarditis may warrant deeper consideration in understanding the potential benefits of SIFs, despite current gaps in evidence directly assessing this question in countries with operational SIFs.	We were unable to find evidence about the degree to which a SIF contributes to risk reduction of endocarditis. We recognize that SSP services and lower levels of infectious disease transmission attributable to SIFs can be extrapolated to endocarditis over a period of time. The report acknowledges the link between bacterial infection and endocarditis on page 28: "Stakeholders noted that SIFs can be effective in preventing bacterial infections such as endocarditis..."
8.	In their modeling study, Barocas et al. estimated that infective endocarditis would contribute to 20% of all-cause mortality among opioid-using PWID over the next decade, resulting in a projected 257,800 deaths. Notably, the probability of death from infective endocarditis was driven by modifiable injection-related behaviors such as sterile injection technique and sharing of injection equipment, factors that are eminently conducive to intervention through SIFs. Indeed, according to this model, a 20-year-old female opioid-using PWID with high risk of endocarditis mortality due to injection risk behavior could lower her risk by 93% by adopting safer injection practices. Given the looming severity of infective endocarditis as a driver of both mortality among PWID and health care expenditures, policy makers and communities would benefit from greater understanding of the potential health and economic outcomes of SIFs on this infection.	While the economic model doesn't estimate cause-specific hospitalization, it does estimate the impact of a SIF on hospitalization, in part related to better infection control (and prevention of endocarditis). We agree that policy makers and communities would benefit from discussion about the potential health and economic outcomes of SIFs related to infection prevention.

9.	Third, while not outlined in the scope of this assessment, we strongly encourage ICER to give consideration to the outcomes of SIFs on racial and ethnic health disparities in the United States. As noted in the background section of the draft evidence report, overdose mortality rates have increased rapidly in the United States among African Americans and Latinos. Among PWID in the United States, HIV rates have long been significantly higher among African American injectors compared to white injectors, mediated by structural determinants which include greater exposure to incarceration and homelessness (see, e.g., Momplaisir F, Hussein M, Tobin-Fiore D, et al. Racial Inequities in HIV Prevalence and Composition of Risk Networks Among People Who Inject Drugs in HIV Prevention Trial Network 037. J Acquir Immune Defic Syndr. 2017;76(4):394-401. doi:10.1097/QAI.0000000000001521).	We added a paragraph in Chapter 6 under the header "Addressing Health Disparities". We highlight the contribution of SIFs in addressing health disparities related to income as well as race-ethnicity. We chose to cite an MMWR report about income group differences; and we added a comment on the confounding between income and race-ethnicity in rates of SUD.
10.	Health equity is an important theme in policymaking and advocacy, and merits attention in considerations of health and economic outcomes. While research gaps and demographic heterogeneity may limit the ability to extrapolate from the current evidence base in other countries, National Harm Reduction Coalition believes that substantive analysis of the potential benefits of SIFs must incorporate an equity lens to ensure appropriate allocation of benefits in planning and implementation. The well-documented contributions of structural drivers such as differential exposure to law enforcement, arrest, and incarceration as racialized mediators of risk and vulnerability to various health outcomes among PWID suggest that interventions such as SIFs that address the risk environment of injecting itself – above and beyond the impact of SSPs alone – may be uniquely positioned to reduce racial and ethnic disparities in health outcomes for PWID.	Thank you for this comment and bringing forward the lens of health equity. Refer to comment above (and edits to Chapter 6) to see how we addressed the possible benefits of a SIF in improving health equity. In Chapter 6, we added 3 sentences, including this one: "A SIF that is able to engage clients and successfully refer them to treatment can contribute to improving health equity for recovery as well as overdose-related deaths."
11.	In conclusion, National Harm Reduction Coalition supports the framework for analysis developed by ICER, and highlights three areas for consideration which may indicate greater health and economic impacts for SIFs, and potential benefits to health equity. National Harm Reduction Coalition particularly commends ICER in incorporating the perspectives and expertise of people who inject drugs and the collaboration with CAPUD. Far too often, PWID are left out of evidence review and policy discussions, and harm reduction principles demand meaningful involvement of people who use drugs in all relevant policies, planning, and programs. We therefore endorse ICER's upholding of this principle in the draft evidence report.	Thank you for recognizing our effort to include the voice and viewpoint of PWID. We are grateful to all of the stakeholders that we interviewed, especially the 11 PWUDs.
Drug Policy Alliance		
1.	The stakeholder interview summary section does not clearly show that stakeholders were asked to compare and contrast the differential health benefits of SSPs vs. SIFs/SCSs. The research question that drove the report was: What is the net health benefit of implementing a SIF (which includes an SSP)	We explored a number of topics during stakeholder interviews, including the comparison of SSPs vs SIFs/SCSs. Nearly all stakeholder interviews described the clear

	versus an SSP alone? The responses summarized, however, only highlighted the benefits of SIFs. We believe that had stakeholders been asked to answer this question specifically, it would have provided evidence that although the interventions share some characteristics, SIFs/SCSs clearly provide greater net health benefits, including, most clearly, the supervision of drug use and ability to immediately respond to any negative health consequence stemming from that use.	benefit of mortality reduction attributable to supervision and immediate response.
2.	**The report should acknowledge the role that SIFs/SCSs can play in addressing the growing number of stimulant-involved overdose deaths that could not be reduced by SSPs alone.** We appreciate that the introduction noted stimulant-involved overdose deaths are increasing, as this is an area of concern for the Drug Policy Alliance. Since many stimulant-involved overdoses do involve opioids[i], fentanyl test strips and naloxone access through an SSP would be helpful. Unfortunately, a significant portion of stimulant-involved overdoses do not involve an opioid and since there is no stimulant overdose antidote, naloxone access will not reduce these deaths and SIFs/SCSs may be most helpful in these cases. In addition, not all people who use stimulants inject them and SSP utilization is low among people who predominantly use stimulants unless the SSP also provides safer snorting or smoking equipment, yet the provision of safer snorting or smoking equipment is still illegal in many US states. On the other hand, SCSs where smoking and snorting are allowed can support people who use stimulants or co-use stimulants with other drugs in safer using strategies and provide immediate medical support and intervention when needed.	The opening paragraphs of the narrative note that non-opioids contribute to overdose-related mortality. We edited the introduction to draw attention to this calling out that 69.5% involved an opioid and the balance from cocaine or psychostimulants per data from Hedegaard H (2020) -- Drug overdose deaths in the United States, 1999–2018. NCHS Data Brief, no 356, a reference we have already cited in the report. We also call out the emerging problem with sources of drug overdose deaths other than opioids by saying "from 2012 to 2018, the age-adjusted death rate involving cocaine more than tripled, and overdose deaths involving psychostimulants increased nearly 5-fold over the same period." In Chapter 2, we note that there may be changes in drug injection preference for inhaled products. We have added language here to clarify that inhaled products do not necessarily mean opioids, in case the reader may have assumed otherwise.
3.	**The role of criminalization and law enforcement in the community must be further detailed as a key factor that limits the effectiveness and health benefits of both SSPs and SIFs/SCSs, yet this is understudied in outcomes research.** Although people who use SSPs acquire sterile equipment and naloxone to reduce risk of disease transmission, skin and soft tissue infection, and overdose, these impacts are severely limited due to policing practices that continue to target people who use drugs in the community. These dynamics are not always clearly measured or documented in outcomes research. Some key examples of how criminalization can limit the benefits of SSPs alone include: • The protections of Good Samaritan Laws when calling 911 in cases of community-based overdoses vary greatly from state to state where police are dispatched as first responders, and research suggests that people who use drugs often do not understand the protections or do not trust that law enforcement will abide by the law.	We have drawn attention to the important role of law enforcement on the effectiveness of SIFs in the subsection called "Uncertainties and Controversies". In one paragraph we say "Experts described the importance of local community support, including law enforcement, to open and maintain a SIF, noting that support for a SIF can erode when proposals and implementation plans with specific locations are presented to community stakeholders." Later we acknowledge, as does the Drug Policy Alliance, that "the contribution of law enforcement to a SIF's effectiveness is unknown" while acknowledging that SIF use depended on the client's ability to enter and exit freely without being intimidated or arrested by police officers. We have added new references recommended by the Drug Policy Alliance, in this same section to cite evidence, such as how heavier policing

	• The proliferation of drug-induced homicide prosecutions by law enforcement who respond to overdoses suggest that calling 911 while using drugs in the community can still be a criminalized act. • Recent reports of police using naloxone administration as grounds for drug charges may actually serve to deter people from carrying naloxone or calling 911 after it has been administered in community settings. • Ongoing police harassment and confiscation of equipment acquired at SSPs can mean that the community-wide benefits can be severely limited. • Similarly, recent research from Vancouver suggests that policing practices can also be disruptive to SIFs/SCSs benefits because they deter utilization.	affected the utilization of overdose prevention sites.
4.	**Drug checking equipment and materials remain inaccessible to most people who use drugs because they are expensive, time-consuming, and/or criminalized. The draft report did not adequately describe how only some SSPs can even distribute fentanyl test strips and SIFs/SCSs may be better sites for their provision and utilization.** We appreciated the inclusion of drug checking in the introduction, but it did not note the fact this technology is largely inaccessible and is still only a strategy to mitigate the harms of an unregulated and poisoned drug supply. While fentanyl test strips are cheaper, they do not provide quantitative data and are still criminalized in many states so they cannot be legally distributed for free and must be purchased directly by users. In drug markets where fentanyl has entirely replaced the heroin supply, fentanyl test strips also have less utility. “Safe supply” programs, heroin-assisted treatment, and other injectable opioid agonist treatments have proven efficacy and are far more cost-effective by addressing the root cause of many overdoses—an unpredictable supply.	We have introduced drug checking services as an example of harm reduction to address overdose mortality risk. The report is not intended to explore this topic in detail. Rather, we sought to place SIFs in the broader context of available (even if limited in reach) of other major harm reduction strategies -- SSPs, naloxone access, and drug checking services.
5.	**Fentanyl-involved overdoses have a much more rapid onset than those involving other opioids, requiring an equally rapid response to reverse overdose or provide assistance which can happen most effectively at an SCS.** While the report acknowledges the changes in the current drug supply, it should closely link these changes to increased overdose risk. The report could benefit from additional clarification that while SSPs can provide risk reduction education and naloxone, only an SCS can provide assistance while an individual is consuming a drug and staff can rapidly respond in case of an overdose event itself.	PWUDs and stakeholders described to us how a SIF could counteract risks of fentanyl or other toxic additives to the drug supply. In Chapter 2, we summarized this input this way: "... there may be unmeasured value of a SIF related to particularly volatile periods of changes in the toxicity and potency of the drug supply chain." Our intent was to describe changes in drug supply as increasing the risk of overdose. In the subsection "Changes in the Drug Supply and Injected Drug Class" where we review evidence on this topic, we added a phrase to clarify the purpose of drug checking.
6.	Moreover, a full dose of naloxone (which is what is typically administered by first responders and sometimes punitively) precipitates withdrawal for someone experiencing an opioid overdose, while SCSs often go to measures to avoid inducing	We have noted this practice in Chapter 2.3 as an example of how SIFs have respected the expertise of PWUD and include them in setting policies and operating the facility.

	withdrawal by titrating the dosage of naloxone administered and also by administering O2 (oxygen) to people experiencing overdose. This reduces the likelihood that someone who has recently overdosed will go into withdrawal and be forced to seek opioids again to alleviate symptoms, potentially increasing the risk of another subsequent overdose.	
7.	**It may be useful to use a table format to clearly summarize outcomes associated with SSPs vs. SIFs/SCS and effect sizes.** Currently, sections inconsistently summarize outcomes and whether both interventions had been studied on those outcomes. For example, the section on "injection risk behaviors" shows research on how SIFs and SSPs have an effect on this outcome, but the report does not include any studies that have looked at the effect of SSPs on safe disposal. As a result, the report is not truly comparing SIFs and SSPs on all of the same outcomes or metrics.	In the methods section (page 20, paragraph 3), we describe the rationale for inclusion of limited outcomes as "The included systematic reviews evaluated the effect of SSPs on injection risk behaviors (IRBs), HIV, or HCV. We did not find evidence from systematic reviews on the effects of SSPs for other outcomes included in our scope (e.g., access to MAT, overdose mortality); therefore, we have limited our review of the evidence of SSPs to infection prevention." We recognize that there are no head-to-head comparisons of SIFs vs. SSPs...and the project is actually trying to describe the incremental benefit of an SSP, which is best described as SIF+SSP vs SSP alone.
8.	You cite the Doleac and Mukherjee working paper on the moral hazard of naloxone. This manuscript has not undergone peer-review nor been published in a reputable journal. In addition, established drug policy researchers have identified serious methodological issues with the study they undertook, as well as the limitations of their causal claims. We would recommend removing this reference from the final report due to the potential harms of these unsubstantiated claims being used to further stigmatize people who use drugs.	We have characterized the paper by Doleac and Mukherjee as raising concerns. It seems fair to say these authors have raised concerns about the adverse effects of naloxone access.

#	Comment	Response/Integration
Clinicians and Experts		
Adams et al.		
1.	We are addiction medicine physicians in clinical practice who are actively engaged with addiction policy both nationally and regionally in the United States. We feel strongly that the final report of the Institute for Clinical and Economic Review (ICER) on safe injection facilities (SIFs) can advance the use of this life-saving intervention. The lack of access and opposition to SIFs is inconsistent with their benefits which have been well known for years based on the experience of over 150 programs in over 60 cities in 12 countries. In our view, this opposition is based on misunderstanding of harm reduction and overreliance on coercive measures to address substance use. There is a belief that harm reduction approaches would normalize and increase harmful drug use, although this is not the case. On the contrary, SIFs tend to reduce harmful drug use. Harm reduction approaches promote human rights and dignity. The positive impact of safe non-stigmatizing environments provided in SIFs is hard to measure but important. Harm reduction strategies and the disease model of addiction are not antithetical to each other but can, and should, co-exist along a continuum. Ambivalence toward change is a feature of substance use disorder which (along with inadequate and inaccessible services) causes many people to feel they are not ready to engage in treatment. For this reason, SIFs may be the only way to reach this important group of people, some of whom become willing to start treatment as the result of respectful non-stigmatizing contact with health personnel. Offering a safe, nonjudgmental space for people to use drugs can be the first step in building the trust necessary for a therapeutic alliance. SIFs represent a critical opportunity to pragmatically help people in whatever ways that they are ready to receive help when they are ready to receive it. Reducing harms, and making treatment more likely, are each reason enough to promote SIFs, especially because one of the harms being reduced is mortality, and because making treatment more likely occurs in people who would otherwise not receive it. An additional important benefit is challenging stigma in society. When people in SIFs receive assistance instead of punishment, while committing the 'crime' of drug	Chapter 2.2 (subsection "Access to Treatment") covers most of the key points made by this commenter. The ICER report does not attempt to explain why SIFs or harm reduction interventions may struggle to gain acceptance. This issue is likely to be discussed during the public meeting policy roundtable.

	use, the positive impact on stigma is profound. SIFs should make treatment available and encourage treatment in a way that remains welcoming to all. Substance use disorder is a treatable chronic medical disease. The expansion of SIFs will serve as a model of more effective ways of reducing harms, and fostering recovery where possible, as an alternative to coercive criminal justice approaches, or traditional treatment which may be perceived as stigmatizing, inflexible, or inconvenient, especially by those who are still ambivalent about change. This may be the greatest benefit of SIFs since stigma is likely to be the principal impediment to an effective approach to substance use in society. Perhaps the ICER final report can include some of these concepts.	

#	Comment	Response/Integration
Other		
Patients Rising		
1.	Patients Rising Now welcomes the opportunity to comment on ICER's September 24th draft evidence report about supervised injection facilities (SIFs), syringe services programs (SSPs), and other supervised consumption sites for people with substance use disorders (SUDs) who are not in treatment. As you know, we advocate on behalf of people with serious medical conditions and chronic diseases for them to have access to vital therapies and services. Access to such treatments can result not only in survival, but in significant improvement in quality of life and productivity. As such, improvements in access to care and services for people with SUDs is critically important, and encompasses a wide range of direct medical and community-based services and supports. In addition, the draft report is timely because October is National Substance Abuse Prevention Month. We were pleased to see ICER conduct a review that is outside its normal scope in both topic and content. By examining a community-based intervention that attempts to directly support the lives of people with a serious medical condition who have traditionally been underserved, the draft report may help promote awareness of options for legislators and other decision-makers. Similarly, the content of the draft report is very different from most of ICER's work, in that ICER conducted primary data collection by interviewing a wide variety and number of stakeholders; for example, for the draft report, ICER "participated in conversations with 37 key informants and/or organizations (4 advocacy organizations, 6 SIF/SSP staff members, 23 researchers, 5 clinical experts, 1 law enforcement officer, 8 legislative/policy experts)," as well as 11 clients and staff from facilities in Canada. That level of stakeholder engagement by ICER is substantially more robust than what we have seen in other ICER reviews. We also note that ICER arrived at its "base-case scenario" in the draft report by approaching the issue from the societal perspective rather than limited to the health care system's perspective. This is a wonderful approach that we have repeatedly recommended ICER use because it is fundamentally more patient/person-centered, and is a better approach for understanding and projecting real-world situations. Now that ICER has had an opportunity to experience directly the benefits of this methodology and analytical approach, we certainly hope that ICER will proceed in this manner with all future reviews and assessments. While we believe ICER has provided a useful overview in the	We appreciate your recognition of our effort to advance our analytic methods and project processes to be person-centered.

	draft report, there are several areas where we believe the report could be improved – primarily with additional descriptions, definitions, and use of language to help promote the adoption of better community-based care and service options. Therefore, our comments are organized into sections below about Substance Use Disorders, Treatment, and Social Determinants of Health; Stigma; Definitions; and Additional Points.	
2.	While the draft report does a good job discussing the effects that drug use has on both the person using the drug and the person's family, as well as the ability of SIFs and related facilities to improve people's lives, what is missing is a more in-depth discussion the actual disorder from which these people are suffering. Specifically, the draft report does not describe the biological basis of substance use disorders (SUDs), which may give some readers the antiquated and inaccurate impression that people who use drugs (PWUD) are recreational users, rather than individuals suffering from a significant medical condition with a biological basis. Thus, we urge ICER to include a much more expansive description of the physiological nature of SUDs, both in the final report and in the New England CEPAC's discussion. Including that information will help advance the public health and societal goal of reducing stigma for OUD and all SUDs, which we discuss further below. While the draft report does discuss how SIFs and SSPs can help PWUD get into treatment programs, we want to emphasize that point because it is crucial to understand that for people with SUDs – and particularly OUD – treatment may be lifelong, and those individuals who continue on MAT can enjoy successful and productive lives for many, many years. We also want to restate that even if SIFs or SSPs do an excellent job of helping individuals seek treatment for their SUDs, if there are no available treatment programs, or no space in those programs, then that is a systemic and societal failure to provide adequate access to health care services. We would encourage ICER to explore that facet of SIFs further, either in this report or in future activities. Another area where the draft report could be expanded is by discussing social determinants of health (SDOH), which are crucial factors for improving the health of individuals. The draft report discusses lack of stable housing, but other important SDOH challenges for PWUD may include lack of access to sufficient food and transportation. For PWUD, those SDOH challenges can be barriers to utilizing SIFs or SSPs, getting into treatment, staying in treatment, and maintaining their recovery – which is the ultimate goal for individuals with SUDs, the health care system, and society. Therefore, we encourage ICER to include more discussion of SDOHs and how	(1) Refer to response below re: biological basis of SUDs. (2) SIFs have the potential to address SDOH, and quite clearly, SIFs serve people with significant SDOH risks, including social isolation, housing, employment, and more. We edited a couple sections to reflect that these items are SDOHs. In our definition of the SIF model, social service support is not a core function/service of a SIF. We designated "referral coordination for social support (e.g., housing), health care and mental health services" as services that augment the three core features: sterile equipment, trained personnel for supervision, and naloxone administration (along with other first-responder medical care). (3) We concur that referral to MAT is only as good as the capacity for the healthcare system to receive them.

	they affect PWUD in the final report and the New England CEPAC's discussion, since without addressing SDOH for individuals even the best community-based and formal care services may not result in good clinical, personal, or societal outcomes.	
3.	Specifically, the draft report does not describe the biological basis of substance use disorders (SUDs), which may give some readers the antiquated and inaccurate impression that people who use drugs (PWUD) are recreational users, rather than individuals suffering from a significant medical condition with a biological basis.	The report does not address the biological basis or root causes of SUDs. We elected to begin the review and the narrative with the compelling need to address prevalence and risks associated with SUD, with a specific focus on opioids, as the SIF review is part of an ICER initiative to address the opioid epidemic in the United States. We do not feel we can do service in this report to the deep discussion that is warranted around the biologic basis of SUD. We have been and will continue to be careful in any presentation of this report to describe the population served by SIFs as vulnerable and marginalized (to avoid any confusion that SIFs are designed to support a recreational drug user).
4.	We feel strongly that one of the societal routes for improving care and lives of PWUD is to reduce or remove stigma associated with SUDs. As discussed above, SUDs are recognized as medical conditions with a biological basis. Reducing stigma will not only facilitate the creation of better treatment options, such as more clinical settings offering medication assisted treatments, but better community options for those not in recovery, such as SIFs. To help reduce the stigma associated with people with SUDs, and particularly PWUD, as we have written in the past, we encourage ICER to pay particular attention to word choices, and specifically the use of the words "addiction," "addicted" and "addict," since they have negative connotations that reinforce stigma and impair positive steps toward supportive care and treatment. For example, in the draft report there is the sentence, "Another client noted that electronic health records assured PWUD are labeled 'junkie' across the health care system, even before meeting a health care provider." This would be a perfect place in ICER's report to discuss the problems with the term "junkie" (as well as the various forms of "addict"), and how such terms can lead to stigmatization and reinforcement of societal and structural barriers to care and services. It is very clear that the word choices used by policy makers and service providers convey important levels of respect for PWUD. And such respect (or disrespect) then influences the individual's own self-respect and motivation for self-care, as well as broader societal attitudes. Specifically, positive word	We believe it is important to use language that de-stigmatizes SUD; and we sought to do so throughout the first draft. We will look for opportunities throughout the narrative to improve word choice. In some cases, the words come from the source (individual interview or research report) and we want to honor/respect it. For example, the word "junkie" is a direct quotation from a PWUD whom we interviewed; and the term conveys authentic feelings and perspective that we want to share in the section in which it appears (Chapter 2: Perspective of People Who Use Drugs).

	choices can lead to caring for individuals as part of society, while other word choices (e.g., "addict") are stigmatizing and can lead to bias against PWUD, which could result in reduced services and less funding for support and treatment programs. Examples of a positive change that could be made in the draft report would be replacing "addiction treatment" with "treatment for OUD (or SUDs)," e.g., "Insite users were found to be 30% more likely to engage in addiction treatment" and "Uniting MSIC does not have an integrated detoxification program but rather refers clients for addiction treatment." We know that ICER is capable of describing the situation and the benefits of interventions with positive language, since later in the draft report there is this sentence: "The opening of a SIF represents a community's commitment to treat substance use disorders as a health issue, rather than a criminal issue" (emphasis added). We encourage ICER to continue that language in the rest of the report, in the New England CEPAC's discussion, and in all its work going forward as a way to help advance such clinically and societally supportive attitudes and actions.	
5.	To help with the readability of the report, we suggest several additions and corrections in the Acronyms section on page vi: • DCR – Drug Consumption Room, which is defined on page 13. We recognize that there are many different terms used in the literature and commonly for these types of locations, so it would be helpful to ensure that all the acronyms are listed in the report. • NIMBY – Not in My Backyard is included in the list of acronyms, but does not appear elsewhere in the draft report. NIMBY is a by-product of stigma, which impairs communities' ability to provide better options and care for people with SUDs. Therefore, we believe it should be left in the report, and its meaning explored as part of the discussion of stigma as recommended above. • SCF – Supervised drug Consumption Facility (this acronym is defined on page 85, but first used on page 34 of the draft report). • SCS – is Safe Consumption Site (not "Spinal Cord Stimulator") • SDOH – Social Determinants of Health. This term is used in the report, but not included in the list of acronyms. • SUD – Substance Use Disorder. This term is used in the report, but not included in the list of acronyms. Since OUD is included in the list, we believe SUD should be included too.	All the relevant terminologies for SIFs have been included. In the report we have included "They are also called overdose prevention centers (OPS), safe or supervised consumption services (SCS), and drug consumption rooms (DCR)" NIMBY has been removed from the acronym list as it is not used in the report. SCS acronym has been corrected as Supervised Consumption Sites.
6.	While the report seems to apologize for the assessment being mostly qualitative rather than quantitative (e.g. "we were unable to conduct a quantitative assessment. Hence, our review provides a narrative description of the outcomes of interest"), we believe that type of assessment is very appropriate for this topic since people's lives are narratives not quantitative assessments.	We are not apologizing for the methods used by researchers who have studied SIFs. It is merely true that a pooled analysis of quantitative data, which is a feature in many ICER projects, is not possible for this review. ICER always looks for best available evidence.

7.	ICER may want to consider for the final report and the CEPAC's discussion how SIFs and SSPs can be integrated into community care teams in their geographic locations, since integration and teamwork across levels of care providers are clearly a positive trend in the US health care system, but that integration has been limited by barriers such as reimbursement and poor interoperability of electronic health records.	These topics may be considered during the policy roundtable.
8.	In considering the ability of SIFs to encourage and enable PWUD to enter treatment programs, not only is availability of such treatment programs a factor, but we believe the report should also mention – if not discuss in some detail – the differences between the health care systems in the countries that already have SIFs, such as Canada and Australia, and the US. Specifically, as ICER knows, insurance coverage and patient costs in the US may complicate referrals and access for PWUDs as they seek to enter and continue with treatment programs.	Referral to any diagnostic or treatment service in the US is influenced by the patient's insurance coverage and benefits. It is possible that treatment referrals from SIF could be different in the US vs. other countries and this could limit the value of a SIF in guiding patients into treatment. Employing the societal perspective, the ICER economic models assume that 5.78% of PWID access MAT due to a referral from the SIF and/or SSP. A scenario analysis illustrates the impact of altering this number, which could be used to estimate the possible impact of lower treatment access in the US (Table 5.5) and incremental difference between SIF and SSP (Table 5.14).
9.	COVID-19 has certainly changed the dynamic, need, and operations of SIFs and SSPs, as well as treatment programs. While we all hope that the pandemic's negative effects on health care and community services will not last for too much longer, we cannot know what changes to health care delivery and reimbursement will remain. Therefore, mentioning how the COVID-19 pandemic has altered the calculus and narrative for the utility of SIFs and SSPs should be included in the report.	We have chosen to not try to predict how the pandemic will change the usefulness or effectiveness of a SIF. The COVID-19 pandemic has changed all aspects of human life, including substance use behaviors. Some interviewees described how SIF (and SSP) operations have been altered by COVID-19, but it was not a consistent or dominant theme to highlight in the report.
10.	The draft report touches upon how physical or psychological pain can lead to people developing and living with OUD. As you know, the treatment of acute and chronic pain is a very complicated situation and in great need of improvement. We appreciate ICER including that facet of the situation in the draft report.	Thank you for your comment.
11.	The draft report's analysis of how SIFs may affect crime rates is problematic, since crime rates are influenced by many factors, and at the local level crime rates are affected by multiple SDOHs rather than just the availability of SIFs or SSPs.	The available data on crime associated with SIFs are limited. We have tried to present the limited data fairly, in a way that recognizes the limitations of research design of observations studies of crime in high-risk neighborhoods.
12.	We are somewhat confused about how to interpret the information in Tables 5.14, or what it means. We recognize that this same or similar information is also presented in Table E2. We suggest ICER clarify the information – and its significance – in the report's text and the column/row descriptions in the tables.	Changes to these tables are being made to improve readability. Thank you for calling out the difficulty you faced in interpreting them.

13.	We believe there are extra words in the first line on page 9 that confuse the meaning, and perhaps what is meant is, “laws that authorize” rather than “laws that remove that authorize.”	Thank you; we have reworked the sentence.
14.	On page 22, we believe the word “with” is missing from the final sentence: “We also supplemented our review with information submitted by stakeholders…”	The missing word has been added in the report.