

**NATIONAL**  
**HARM REDUCTION**  
**COALITION**

October 22, 2020

Comments on: Supervised Injection Facilities and Other Supervised Consumption Sites: Effectiveness and Value; Draft Evidence Report. Institute for Clinical and Economic Review, September 24, 2020.

Submitted on behalf of National Harm Reduction Coalition

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.

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 (Larney S, Peacock A, Leung J, et al. Global, regional, and country-level coverage of interventions to prevent and manage HIV and hepatitis C among people who inject drugs: a systematic review. *Lancet Glob Health*. 2017;5(12):e1208-e1220. doi:10.1016/S2214-109X(17)30373-X).

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. 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 (Lyss SB, Buchacz K, McClung RP, Asher A, Oster AM. Responding to Outbreaks of Human Immunodeficiency Virus Among Persons Who Inject Drugs-United States, 2016-2019: Perspectives on Recent Experience and Lessons Learned. *J Infect Dis.* 2020;222(Supplement\_5):S239-S249. doi:10.1093/infdis/jiaa112). 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 countries with greater baseline coverage to a degree that should be considered in modeling and conclusions.

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). 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.

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

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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.

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).

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.

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.

Please do not hesitate to contact us if we can be of any assistance.

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On behalf of National Harm Reduction Coalition,

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**RE: Draft Evidence Report – Supervised Injection Facilities and Other Supervised Consumption Sites: Effectiveness and Value**

The Drug Policy Alliance is the nation’s leading nonprofit fighting for drug policies grounded in science, compassion, health and human rights. We appreciated the opportunity to provide input on your initial draft scoping document and were happy to see that our comments were integrated into the methods. We are writing again today to provide input on additional considerations for the current draft evidence report on Supervised Injection Facilities (SIFs) and other Supervised Consumption Sites (SCSs) to clarify the differential health benefits of SIF/SCSs compared to syringe services programs (SSPs) alone:

- **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) 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.
- **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<sup>i</sup>, 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 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<sup>ii</sup> that people who use drugs often do not understand the protections or do not trust that law enforcement will abide by the law.
  - The proliferation of drug-induced homicide prosecutions<sup>iii</sup> 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<sup>iv</sup> 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<sup>v</sup> and confiscation of equipment acquired at SSPs can mean that the community-wide benefits can be severely limited.
  - Similarly, recent research<sup>vi</sup> from Vancouver suggests that policing practices can also be disruptive to SIFs/SCSs benefits because they deter utilization.
- **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. Advanced drug checking equipment is costly to acquire, maintain, and utilize, often requiring specially trained staff to use and repair them. In addition, the utility is limited if people who use drugs must travel to access the technology but cannot use drugs at the same location. 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.
- **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. Moreover, a full dose of naloxone (which is what is typically

administered by first responders and sometimes punitively<sup>vii</sup>) precipitates withdrawal for someone experiencing an opioid overdose, while SCSs often go to measures to avoid inducing 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.

- **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.

One additional note:

- You cite the Doleac and Mukherjee working paper<sup>viii</sup> 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<sup>ix</sup> 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.

The Drug Policy Alliance supports ICER’s efforts to document the clinical effectiveness and value of SIFs/SCSs and we agree with your ultimate assessment that they have a positive net benefit beyond those provided by SSPs alone. Should you have any questions or concerns, please do not hesitate to contact me at [svakharia@drugpolicy.org](mailto:svakharia@drugpolicy.org) or (607) 222-8961.

Thank you,

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10-21-2020

PUBIC COMMENT TO THE SUPERVISED INJECTION FACILITIES DRAFT EVIDENCE REPORT OF THE INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW

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 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.

Sincerely,

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- <sup>i</sup> Hedegaard, Holly, Merianne Rose Spencer, and Matthew F. Garnett. 2020. "Increase in Drug Overdose Deaths Involving Cocaine: United States, 2009–2018," no. 384: 8.
- <sup>ii</sup> Latimore, Amanda D., and Rachel S. Bergstein. 2017. "'Caught with a Body' yet Protected by Law? Calling 911 for Opioid Overdose in the Context of the Good Samaritan Law." *International Journal of Drug Policy* 50 (December): 82–89. <https://doi.org/10.1016/j.drugpo.2017.09.010>; Moallem, Soroush, and Kanna Hayashi. 2020. "The Effectiveness of Drug-Related Good Samaritan Laws: A Review of the Literature." *International Journal of Drug Policy*, May, 102773. <https://doi.org/10.1016/j.drugpo.2020.102773>.
- <sup>iii</sup> Peterson, Meghan, Josiah Rich, Alexandria Macmadu, Ashley Q. Truong, Traci C. Green, Leo Beletsky, Kimberly Pognon, and Lauren Brinkley-Rubinstein. 2019. "'One Guy Goes to Jail, Two People Are Ready to Take His Spot': Perspectives on Drug-Induced Homicide Laws among Incarcerated Individuals." *International Journal of Drug Policy* 70 (August): 47–53. <https://doi.org/10.1016/j.drugpo.2019.05.001>.
- <sup>iv</sup> Kuwabara Blanchard, Sessi. 2020. "Naloxone Now Used as Evidence to Prosecute Indiana OD Victims." *Filter*. February 19, 2020. <https://filtermag.org/overdose-prosecution-indiana-naloxone-hancock/>.
- <sup>v</sup> Beletsky, Leo, Jess Cochrane, Anne L. Sawyer, Chris Serio-Chapman, Marina Smelyanskaya, Jennifer Han, Natanya Robinowitz, and Susan G. Sherman. 2015. "Police Encounters Among Needle Exchange Clients in Baltimore: Drug Law Enforcement as a Structural Determinant of Health." *American Journal of Public Health* 105 (9): 1872–79. <https://doi.org/10.2105/AJPH.2015.302681>.
- <sup>vi</sup> Collins, Alexandra B., Jade Boyd, Samara Mayer, Al Fowler, Mary Clare Kennedy, Ricky N. Bluthenthal, Thomas Kerr, and Ryan McNeil. 2019. "Policing Space in the Overdose Crisis: A Rapid Ethnographic Study of the Impact of Law Enforcement Practices on the Effectiveness of Overdose Prevention Sites." *International Journal of Drug Policy*, September. <https://doi.org/10.1016/j.drugpo.2019.08.002>.
- <sup>vii</sup> Bledsoe, Bryan. 2018. "The Weaponization of Narcan." *JEMS*. December 21, 2018. <https://www.jems.com/2018/12/21/the-weaponization-of-narcan/>.
- <sup>viii</sup> Doleac, Jennifer L., and Anita Mukherjee. 2019. "The Moral Hazard of Lifesaving Innovations: Naloxone Access, Opioid Abuse, and Crime." SSRN Scholarly Paper ID 3135264. Rochester, NY: Social Science Research Network. <https://papers.ssrn.com/abstract=3135264>.
- <sup>ix</sup> Stevens, Alex. 2020. "Critical Realism and the 'Ontological Politics of Drug Policy.'" *International Journal of Drug Policy*, May, 102723. <https://doi.org/10.1016/j.drugpo.2020.102723>.



October 22, 2020

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RE: Draft Evidence Report “Supervised Injection Facilities and Other Supervised Consumption Sites”

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Dear Dr. Pearson:

Patients Rising Now welcomes the opportunity to comment on ICER’s September 24<sup>th</sup> 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.<sup>i</sup>

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),”<sup>ii</sup> 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 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.

### Substance Use Disorders, Treatments, and Social Determinants of Health

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,<sup>iii</sup> 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 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.

### Stigma

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,<sup>iv</sup> 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.”<sup>v</sup> 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 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”<sup>vi</sup> and “Uniting MSIC does not have an integrated detoxification program but rather refers clients for addiction treatment.”<sup>vii</sup>

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).<sup>viii</sup> 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.

### Definitions and Acronyms

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.

### Additional Points

- 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”<sup>ix</sup>), we believe that type of assessment is very appropriate for this topic since people’s lives are narratives not quantitative assessments.
- 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.
- 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.
- 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.
- The draft report touches upon how physical or psychological pain can lead to people developing and living with OUD.<sup>x</sup> 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.
- The draft report’s analysis of how SIFs may affect crime rates<sup>xi</sup> 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.
- 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.
- 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.”
- On page 22, we believe the word “with” is missing from the final sentence: “We also supplemented our review with information submitted by stakeholders...”

### Conclusions & Recommendations

We are encouraged that ICER found that, “On balance, we believe we have high certainty that, compared with SSPs, SIFs prevent overdose deaths,”<sup>xii</sup> and that, “there is high certainty that SIFs, compared with SSPs provide a small, or substantial net health benefit.”<sup>xiii</sup>

While the draft report contains many important facets of how SIFs could improve the lives of people with untreated SUD (or are otherwise not in recovery), and society overall, we believe including more expansive consideration of the biological basis for SUDs as a family of medical conditions, and how stigma is a barrier that should be reduced to enable effective and efficient individual care and provision of community services, the report’s discussion and ICER’s coverage of this topic would be significantly more robust and useful.

Sincerely,



Terry Wilcox  
Co-Founder & Executive Director, Patients Rising Now

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<sup>i</sup> <https://www.cdc.gov/drugoverdose/index.html> (accessed October 13, 2020)

<sup>ii</sup> Draft report, p. 14.

<sup>iii</sup> Draft report, p. 19 and pp. 38-39.

<sup>iv</sup> <http://icerwatch.org/wp-content/uploads/2018/10/100418-Patients-Rising-Now-Comments-to-ICER-RE-Treatments-for-OUD-draft-v6.pdf>

<sup>v</sup> Draft report, p. 15.

<sup>vi</sup> Draft report, p. 20.

<sup>vii</sup> Draft report, p. 21.

<sup>viii</sup> Draft report, p. 64

<sup>ix</sup> Draft report, p. 24.

<sup>x</sup> Draft report, p. 16.

<sup>xi</sup> Draft report, p. 36.

<sup>xii</sup> Draft report., p. 42.

<sup>xiii</sup> Draft report., p. 42.