

Statement in support of safe consumption spaces

In the midst of a national fatal overdose epidemic that is claiming 180 American lives every day, the Legal Action Center (LAC) calls on the federal government, as well as state and local jurisdictions, to support and fund demonstration projects for safe consumption spaces (SCS). Saving lives must be paramount to addressing this crisis. Promising public health strategies to prevent overdose deaths must be supported.

Substance use disorder (SUD) is a chronic brain disease that can be prevented, treated, and successfully managed.¹ Research has found that relapse rates for SUD are comparable to those for other chronic diseases such as diabetes and hypertension.² SUD treatment has also been shown to cut drug use in half, reduce crime by 80 percent, and reduce arrests by up to 64 percent.³ We must do everything we can to ensure that SUD treatment services and medications are available to all those who need and want them. Yet, currently only 1 in 10 Americans with SUDs get the treatment that they need, underscoring the need to improve access to life-saving care by investing more resources into SUD services and medications.⁴

At the same time, not every individual who uses drugs has a diagnosed or diagnosable SUD and not all those who have an SUD are ready or willing to seek SUD care. Lack of readiness does not make these individuals any less deserving of critically needed health care and supports. For this population, evidence-based harm reduction services like syringe exchange can both mitigate harm and link individuals to SUD *treatment* when they are ready and willing to participate.⁵ Indeed, because safe consumption spaces are staffed by health professionals and counselors, and are hygienic, safe, and welcoming places which attend to the multiple needs (including SUD treatment) of individuals whose lives have been nearly destroyed by this disorder, SCSs offer an invaluable opportunity for society to help fellow Americans take the first step into recovery.

We recognize that SCSs are a relatively new and somewhat controversial concept in the United States and that they do not yet have broad support. However, SCSs are in line with and the next logical step to the decades-old evidence-based practice of syringe exchange programs (SEPs). Furthermore, several organized bodies of public health experts, including the [American Medical Association](#), [AIDS United](#), and [the Infectious Diseases Society of America, the HIV Medical Association and the Society of Infectious](#)

¹ Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine*, 374(4), 363-371.

² McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *Jama*, 284(13), 1689-1695.

³ The National Council for Community Behavioral Health, Preventing and Treating Substance Use Disorders: A Comprehensive Approach, <https://www.thenationalcouncil.org/wp-content/uploads/2013/05/Substance-Use-Disorders.pdf> (last visited Jan. 7, 2016).

⁴ U.S. Substance Abuse and Mental Health Services Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (2017) <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf>

⁵ Centers for Disease Control and Prevention factsheet (2017). Reducing Harms from Injection Drug Use & Opioid Use Disorder with Syringe Services Programs <https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf>

[Diseases Pharmacists](#) have expressed their support for SCSs as a recommended strategy to save lives and reduce harms to the individual and public health.

In addition to key organizations in the public health community embracing them, U.S. Surgeon General Jerome Adams has also expressed openness to the concept of SCSs. While expressing his belief that more data is needed, the Surgeon General described the facilities as “one of many tools to consider.”⁶ He further voiced his willingness to carefully review the data on SCSs and to lead the discussion regarding this approach. We applaud his leadership and agree with the position that demonstration projects must be initiated in order to rapidly begin collecting the data needed to understand whether and/or how best to implement this approach nationally.

Worldwide, there are roughly 100 SCSs in no less than 66 cities in eight European countries and Canada. Because trained clinical staff are present as emergency first responders, not one fatal overdose has been reported in any of these SCSs.

When public health experts initially proposed syringe exchange programs (SEPs) in the late 1980s and early 1990s, most political leaders were reluctant to give their support, although ultimately many did. At the time, many expressed concerns that SEPs would have the unintended result of increasing intravenous drug use. This concern turned out to be unfounded and, in fact, research has demonstrated the effectiveness of SEPs in saving lives and reducing the spread of HIV. In New York, for example, the HIV prevalence among NYC injection drug users decreased from 54% in 1990 to under 3% in 2015. The Legal Action Center was an early proponent of SEPs for the same core reason that we support SCSs: we believe that saving lives, and improving lives through linkages to treatment and health care, must be paramount.

⁶ Video from Surgeon General Jerome Adams’s Confirmation Hearing: <http://www.sideeffectspublicmedia.org/post/surgeon-general-nominee-jerome-adams-tells-confirmation-panel-science-important-not-enough> (starting at 2:22)

Although the data is not yet conclusive (as it is with syringe exchange programs), every study that has examined SCSs,⁷ including a recent examination of an unsanctioned SCS in the US,⁸ has reported positive outcomes (including on the metrics listed above). Further, no SCS has been linked to an increase in substance use or crime. Years of [study](#) show that SCSs are associated with reductions in fatal overdoses, of which Americans suffered [nearly half a million between 2000 and 2014](#), and 64,000 in 2016 alone. Further, like needle exchanges, SCSs are a proven means by which to check the spread of blood-borne infections such as HIV and Hepatitis C (HCV), both of which are conditions against which the U.S. has made impressive strides which could be undone by the current overdose crisis.

When SEPs were first introduced in New York, they were piloted on a small scale and expanded as they began demonstrating success. SCSs should also begin as pilots. They should be evaluated for effectiveness in saving lives, as well as their impact on other metrics including: reductions in the spread of blood-borne diseases, increases in linkage to SUD treatment and changes in the numbers of arrests and other criminal justice interactions. Beginning with pilots will also help to identify which models are most effective in meeting this and other goals. If they prove successful, they must be expanded quickly. With tens of thousands of people dying every year, our government must use all resources at its disposal to maximize the availability of all lifesaving interventions.

As the overdose epidemic continues to escalate, we must act decisively, rationally, and with urgency to address this crisis. While the data is not conclusive about the effectiveness of SCSs, there is sufficient evidence to suggest that they have the potential to save lives and mitigate other harms. To confront the scale of this epidemic and begin reducing the immense death toll, we must try all possible responses, including some such as SCSs that have not yet been fully tested. We urge local, state and federal authorities to fund and support demonstration projects that would allow for more robust evaluation of this intervention, while simultaneously saving lives.

⁷ Fatal overdoses decreased 35% around Insite facility in Vancouver compared to a 9.3 percent reduction in the rest of Vancouver. Brandon DL Marshall et al. (April 2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *The Lancet*. Volume 377, No. 9775, Pages 1429–1437; a meta-analysis of peer reviewed research found a 69% reduction in the likelihood of syringe sharing among SIF users, Milloy, M.-J. and Wood, E. (March 2009) Emerging role of supervised injecting facilities in human immunodeficiency virus prevention. *Addiction*. Volume 104, Issue 4; Another study of Insite found a 30 percent increase in patients accessing treatment after the establishment of a SIF. DeBeck K et al. (January 2011). Injection drug use cessation and use of North America's first medically supervised safer injecting facility. *Drug and Alcohol Dependence*. Volume 113, Issues 2–3, Pages 172-176; Another study found that Insite was associated with an incremental net savings of almost \$14 million and 920 life-years gained over 10 years. Bayoumi AM and Zaric GS (November 2008). The cost-effectiveness of Vancouver's supervised injection facility. *CMAJ*. Volume 179, Issue 11, Pages 1143-1151; Another meta-analysis found that SCSs did not increase drug injecting, drug trafficking or crime in the surrounding environments. They were also found to be associated with reduced levels of public drug injections and dropped syringes. Potier C et al. (December 2014). Supervised injection services: what has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence*. Volume 145, Pages 48-68

⁸ Kral, A. H. and Davidson P. J. (2017). Addressing the Nation's Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the U.S. *American Journal of Preventive Medicine*. Volume 53, Issue 6, Pages 919–922