

## Safe Drug Consumption Spaces: Implications for Baltimore City

A Report for the Abell Foundation  
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### INTRODUCTION

In the United States, the opioid epidemic is one of the most pressing public health crises of our time. In 2015, overdose fatalities surpassed those of gun homicides for the first time; drug overdoses accounted for 52,404 deaths, 63% of which involved an opioid.<sup>1</sup> The overdose death rate involving opioids has more than quadrupled since 1999, largely attributable to the rise of prescribed and synthetic opioids and subsequent non-medical use.<sup>2</sup> With 259 million prescriptions annually, current opioid availability in the legal market is such that there is enough supply for every American adult have 75 pills.<sup>3</sup> Many Americans whose first exposure to opioids is through these prescriptions later move to illegal drugs to sustain their use. As persons develop tolerance to the effects of prescription opioids, they require greater amounts or stronger medications to avoid painful withdrawal symptoms. High costs of diverted prescription medications and drug tolerance may drive persons to inject illicit drugs, such as heroin.<sup>41</sup> Further, physicians are experienced increase pressure not to rescue or cut people off of opioids, many patients look to illicit means to obtain opioids or heroin. At the same time, the explosion of cheap and increasingly available synthetic opioids such as fentanyl has increased the magnitude of overdose risk. Fentanyl, increasingly prevalent in the U.S. setting, is 50-100 times more potent than heroin or morphine. Fentanyl is a profitable addition to the drug trade because it is cheaper to make and more potent than prescription opioids, heroin, and cocaine.<sup>4-</sup>

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For every overdose death, thousands more experience nonfatal overdose, problematic addiction, morbidities such as endocarditis and soft tissue infections (e.g., abscesses), and are at risk for infectious diseases such as HIV and hepatitis C virus (HCV). These negative health outcomes often occur in the context of unsterilized injection environments. These problems are exacerbated because people who inject drugs (PWID) are less likely to access medical, mental health and social services.<sup>7,8</sup> Further, illicit drug use, particularly via injection in unsafe drug spaces (e.g., public bathrooms, parks, abandoned housings –“abadominiums”) exacerbates the potential for fatal overdose as well as HIV and HCV transmission.<sup>9,10</sup>

Empirical evidence has demonstrated the short-comings of the U.S. war on drugs, underscoring the need for innovative approaches to address substance use disorders and related consequences. In addition to fueling some of the highest rates of incarceration worldwide, drug war supply-side strategies such as drug raids and crackdowns have had minimal, short-lasting impact and may lead to the displacement of drug activity zones.<sup>11-14</sup> Furthermore, research has found that war on drugs’ policing strategies are associated with increases in HIV transmission risk.<sup>15-19</sup> Given the unprecedented effects of the opioid epidemic, there has never been a more critical time to implement innovative and humane public health approaches to address problematic drug use.

In response to these unprecedented rates of overdose deaths, enduring morbidities associated with drug use, and the failed war on drugs, there has been increased interest in the U.S. in innovative and effective interventions aimed to reduce harm to people who use drugs and the broader community. This has led to many discussions about the establishment of safe consumption spaces (SCSs) throughout the U.S. Roughly 97 SCSs exist in 66 cities in 11

countries. Only two of these are situated in North America: Insite and the Dr. Peter Centre located in Vancouver, British Columbia, both of which allow for injection only. Owing to the precipitous rise in opioid overdose deaths in Canada, plans are underway to open SCSs in Ontario including Toronto five additional sites announced in Vancouver, and three were just approved in Montreal.<sup>20</sup> SCS discussions at various planning phases are underway in several U.S. cities.

There are numerous terms used to describe these safe drug consumption spaces, including: supervised or safer injection facilities (SIFs); safer injection sites (SISs); safe drug consumption spaces (SDCSs); safe consumption spaces (SCSs); and drug consumption rooms (DCRs). The latter three spaces refer to those in which drugs can be ingested by any route of administration (e.g., smoking, snorting, injecting) and not exclusively injection, as in SIFs. Given that the term “SCS” is inclusive of all types of routes of administration, we use that term throughout this report unless a space is specifically referred to by another term.

For over 30 years, SCSs have been established to support healthy behaviors among people who use drugs (PWUD) to provide them with a supervised, safe, and hygienic space to consume previously acquired drugs, improve their health and wellbeing, and reduce public disorder that is commonly associated with drug use.<sup>21</sup>

SCSs are primarily staffed by medical or case management staff as well as current or former PWUD who do not assist in drug administration.<sup>22</sup> SCS staff provide support by answering questions about safe consumption practices, providing sterile equipment (e.g., syringes, cookers) and condoms, and assisting in the event of an overdose through the administration of naloxone. A large body of evidence-based, peer-reviewed studies has demonstrated the public health impacts and cost-effectiveness of SCSs, owing to significant reductions in averting HIV, HCV, reduction in other morbidities such as abscesses, and averting fatal overdose deaths.<sup>23-28</sup> Further, SCSs are uniquely effective in sustaining contact with the most marginalized PWUD who consume drugs in public places, and positively impact for the communities in which they are situated by reducing public drug use.<sup>29</sup>

SCSs have been found to be associated with numerous benefits to PWUD who use them, including reductions in blood-borne disease transmission by providing clean needles and injection education. With millions of injections having occurred within SCSs, none have been fatal. The impact of SCSs on overdose extends beyond their walls; a significant reduction in overdose deaths has been found in the area surrounding Vancouver’s SCS compared to other areas in Vancouver.<sup>24</sup> They have served to connect marginalized PWUD with medical and social services (e.g., primary care, case management) that otherwise are not widely accessed. Although these venues have been criticized for many reasons, foremost in promoting and condoning drug use, there is no evidence to support these claims. SCS staff intervene in case of overdose, meaning that while tens of thousands of PWUD have overdosed in SCSs worldwide, none have been fatal.<sup>30</sup> SCS staff reduce bacterial infection by cleaning wounds and identifying serious infections early that need medical treatment.<sup>31</sup> Staff build trust with PWUD and often encourage hard-to-reach PWUD to enter addiction treatment, reducing both medical issues and crime costs associated with drug use.<sup>32</sup> SCSs generate a number of other concrete but less quantifiable benefits. They facilitate access to a hard-to-reach population who are not in drug treatment.<sup>33</sup>

Further, SCSs have contributed to increasing the wellbeing of the communities in which they are positioned, with qualitative and quantitative studies showing reductions in public injections,

discarded syringes, and the drug-related violence, as well as support from residents of surrounding neighborhoods.<sup>34-36 37,38 39</sup>

There are a number of efforts to establish SCSs at various stages of development throughout the U.S. including Seattle, New York, Ithaca, and San Francisco. Baltimore city is at a nascent stage of organizing various stakeholders to explore the feasibility and nature of a SCS.

This report aims to synthesize the breadth of scientific and gray literature about SCSs worldwide. Specifically, the report discusses:

- an overview of history of SCS internationally;
- a discussion of SCS models;
- a description of who uses SCSs and how to minimize barriers to access;
- an extensive discussion of the Vancouver SIF, Insite;
- the scientific evidence about the impact of SCS on infectious disease and drug use outcomes; receptivity of SCSs among people who use drugs and vested stakeholders (e.g., police, business owners);
- cost effectiveness data on SCSs;
- a description of current activities to develop SCSs in the U.S. and Baltimore;
- a legal analysis for the establishment of an SCS in Maryland;
- and conclusions including recommendations for establishing an SCS in Baltimore.

## **HISTORICAL OVERVIEW OF SCSs**

Informal injection venues organized by PWID emerged across Europe as early as the 1960s into the 1980s, owing to the rise of HIV. These spaces are distinct from modern day SCSs due to their lack of supervision and explicit public health objectives. Many were better characterized as informal “shooting galleries.”<sup>40-42</sup> These venues were operating in a policy context characterized by abstinence-oriented approaches largely reliant on traditional inpatient detoxification programs to address drug use in society. However, throughout the 1980s, the HIV epidemic highlighted those excluded by these approaches both as an extremely vulnerable population and a vital group to target to interrupt ongoing transmission.<sup>40</sup> This, alongside an increase in drug-related deaths from overdose and public concern about drug-related behaviors and societal impacts, incentivized a shift in policy approaches.<sup>41,43</sup> A new focus on reaching individuals who were missed by traditional approaches and reducing individual and societal harms associated with drug use emerged, paving the way for a number of harm reduction programs including targeted outreach, needle exchange, and ultimately sanctioned SCS.

The first official supervised facility opened in Berne, Switzerland in 1986. In 1988, the Swiss General Prosecutor led an assessment concluding that such facilities improving the hygienic conditions of injection and barring the sale of drugs on the premises could lawfully operate under Swiss law.<sup>40</sup> In the following decade, SCSs were established across Switzerland, Germany, the Netherlands, and Spain, with largely decentralized legislative processes ruling on their legality. Shortly after their emergence in Germany, the Chief Public Prosecutor of Frankfurt concluded that given a set of strict implementation regulations, consumption facilities complied with both German narcotics law and relevant United Nations Conventions. In 2000, the German Parliament and Council of Federal States officially adopted an amendment legalizing SCS, with autonomy remaining at the state level to issue licenses within their territory.

Since that time, facilities have since opened in Norway, Luxembourg, Denmark, France, Greece, and Slovenia in.<sup>21</sup>

The establishment of SCS outside of the European context began in the early 2000s and followed a different legal process. Facilities in both Australia and Canada were permitted to operate under legal exemptions granted to scientific trials and pilot projects.<sup>40</sup> In 2001, the Medically Supervised Injecting Centre (MSIC) was established in Sydney, Australia in the Kings Cross area, home to one of the largest illicit drug markets that had been in operation since the 1960s.<sup>32</sup> Kings Cross was marked by higher rates of fatal opioid overdose and ambulatory attendance than surrounding communities, prompting the New South Wales Royal Commission and Police Services to recommend harm reduction programs in the region. An 18-month trial began in 2001 and was extended for a year before multiple rounds of public health, economic and crime statistics evaluations resulted in legalization of the MSIC by Parliament in 2010.

Shortly after the establishment of Sydney's MSIC, Vancouver, Canada became host to the first such legal SIF (as it is called) in North America. A more complete history of Vancouver's experience and its implications for future advocacy in the North American context is discussed below. In brief, a sharp spike in overdose deaths in British Columbia and particularly in the downtown eastside neighborhood of Vancouver throughout the 1990s, accompanied by the death toll and health services challenges stemming from the HIV epidemic, led the chief medical officer to declare a public health emergency among PWID in 1997.<sup>44</sup> This crisis led to endorsement of a four-pillar strategy focused on prevention, treatment, law enforcement, and harm reduction by the Mayor of Vancouver in 2000, prompting enquiries into the legality and feasibility of establishing SCS. In 2002, nurses at the Dr. Peter Centre implemented an SIF for their residents who were living with HIV, which was initially not legally sanctioned it was confirmed within the scope of nursing by the British Columbia's College of Registered for the purposes of preventing illness and promoting health. The Centre was limited to residents and not the general public. In 2003, a larger SIF was established, Insite, as a part of a 3-year pilot project under scientific evaluation.<sup>45</sup> After multiple extensions and an attempted closure, the Supreme Court of Canada voted unanimously in favor of keeping Insite open in 2011.<sup>44</sup>

The emergence of SCSs and their path to legal legitimacy in different settings has exhibited some important shared characteristics. Key drivers of SCS adoption have included extensive public injection, increased injecting drug-related overdoses, HIV and other complications, as well as increasing documentation of the failures of traditional abstinence and drug enforcement-based approaches to prevent addiction. As SCSs were often introduced near open-air drug markets (areas where drugs are sold in the open), an important additional driver in their establishment was the public concern and fatigue with highly visible public drug consumption and often fostered favorable public opinion.<sup>36,40</sup> While support of different actors varied by setting, another commonality in these sites was the perception among some law enforcement, criminal justice, and medical sectors that SCSs could act as a service entry point to populations that were traditionally inaccessible by public programs.<sup>40</sup>

An additional similarity across these contexts is the adherence to strict guidelines in order to develop and sustain legal legitimacy and public health impacts. Some of the conditions that are upheld across sites include the sole practice of self-injections, the prohibited sale of drugs on premises, the ineligibility of those wanting to consume or inject for the first time, and PWUD accompanied by children. Minors under the age of 18 are also generally prohibited from entry, although some sites do permit those over 16 years on a case-by-case basis.<sup>43</sup> Similarly, most SCSs do not allow pregnant women entry, though some allow entry predicated on the receipt of specialized counseling.<sup>40</sup>

Research across a number of countries has shown that SCSs are reaching marginalized PWUD who have a high burden of HIV and HCV infection<sup>43</sup> and are at a high risk for HIV and fatal overdose, and who inject drugs publically.<sup>40,46,47</sup> Studies in Vancouver and throughout Europe have found that the majority of SCS users were male, in their early 30s, and were characterized by high rates of unstable housing and employment as well as high rates of incarceration.<sup>23,46,48-50</sup> The most frequently reported drugs used in MSIC and Insite were primarily heroin, cocaine, opioids, and amphetamines.<sup>49,50</sup> In Vancouver, Insite clients were more socioeconomically marginalized than other PWID who did not attend Insite. Before the opening of Insite, SIF clients reported higher rates of overdose, more frequent daily injection (cocaine or heroin), and higher rates of public injecting compared to PWID who did not use Insite.<sup>47</sup> The social and economic vulnerability that characterizes many SCS utilizers underscore how successful these venues are in attracting marginalized and vulnerable PWUD.

## SCS MODELS

SCSs vary in size, level of organization, number of services provided, and staffing patterns. There are three basic models of SCSs: 1) integrated; 2) stand alone; and 3) mobile. There are several organizational and geographic commonalities across all three models. SCSs are also primarily located in high drug use neighborhoods or near open-air drug markets. Most SCSs have a registration system whereby people register upon first use and check in subsequently. At a minimum, all spaces have designated hygienic booths or divided spaces where individuals can inject, smoke, or ingest drugs. Each of these subdivided spaces has a sharps container for needle disposal and often a mirror, so that PWUD can be viewed by someone behind them in case of an overdose. These variations are driven by the context in which the SCS exists, underscoring the importance of the social, economic, and political environment in which a SCS is developed and operated.

Integrated SCSs: The integration of SCSs into other services is the most common model. Most SCSs are community-based organizations that are a part of a comprehensive package of offered services including drug treatment, medication assisted treatment (MAT), and syringe services programs (SSPs), as well as medical services including primary care, testing for blood borne viral infections, and wound care.<sup>51</sup> Additional services may include a drop-in center with showers, laundry facilities, employment programs, and case management. The advantage of this model is that it is a “one stop shop” and demonstrates the importance of service integration. The disadvantages can be the challenges of having drug treatment or MAT co-existing in a space with active drug use, which can serve as a trigger and therefore limit its appeal to some in need.<sup>22</sup> To overcome this challenge, many SCSs physically separate the space in which drugs are consumed from other drug services including drug counseling, drug treatment, and MAT services. Even with this separation, individuals who are no longer using drugs or living in drug using neighborhoods might be challenged by coming to a high drug-using neighborhood that could serve as a trigger. A prominent example of this model is a large integrated SCS in Bonn, Germany, hosting a café, kitchen, showers and laundry, and has the capacity to house up to 6 clients for up to 3 weeks for detoxification. Integrated models are viewed as best practices because of the range of services that are tailored to and can be accessed by PWUD.

Stand alone: Standalone models solely provide a space for the hygienic consumption of drugs, with referrals made to other services.<sup>22</sup> These models are often located in close proximity to other services that are utilized by PWUD. This single focus creates less organizational

complexity and is therefore less expensive. But conversely, their greatest disadvantage is the lack of access to necessary range of services for those who utilize the space. They are most often staffed by trained health professionals, such as nurses, to “supervise” injections and to respond to any adverse events (e.g., overdose).

**Mobile:** SCSs are most typically fixed sites that are located in vicinity to established drug markets; however, mobile sites might best meet the needs of PWUD if drug markets are mobile or drug scenes are diffuse. There are only a handful of mobile consumption rooms, including those in Berlin, Barcelona, and Copenhagen. These units are retrofitted vans or recreational vehicles (RVs) with 1-3 booths dedicated for the safe consumption of drugs. They are staffed with individuals who sometimes provide a limited range of additional services such as syringe exchange, blood borne virus testing, and referrals. Given the fewer number of booths, their operational cost per client is higher than a fixed site. Mobile sites can be a step to establishing a fixed site, as was the case in Barcelona.<sup>51</sup>

## **INSITE, VANCOUVER, BRITISH COLUMBIA**

Insite, North America’s first legal SCS located in Vancouver’s Downtown Eastside neighborhood, opened its doors to clients in 2003. In addition to clean, medically supervised injection stations, the facility also houses Onsite, a 12-bed drug detox and temporary housing facility which opened in 2007 directly above Insite.

### **Key Insite Statistics:**

- 0** - fatalities from overdose events at Insite
- 905** - visits daily
- 587**- daily injections
- 722** - average number of visits per day in 2015
- 2,047** - estimated number of HIV cases averted
- 2,800** - intakes into the Onsite detox program
- 4,922** - number of overdose events overseen by medical staff
- 6,352** - unique individuals who visited Insite in 2015
- 263,713** - total client visits in 2015

Insite’s legally sanctioned status is the result of a social movement sustained by local organizations and groups of drug users. These groups mobilized in collaboration with Vancouver Health Services (VHS) to establish Insite, and have fought high-profile court battles at the provincial and federal level in Canada to keep Insite operating permanently. Below is a timeline of key moments in its history.

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### **Insite Timeline**

#### **Before Insite**

**1980s:** Injection drug use climbs in the Downtown Eastside neighborhood (DTES). Neighborhood is functionally an “open-air drug market.”

**1989:** Vancouver’s first needle-exchange starts in DTES begins in response to HIV, HCV and overdose.

**1995:** Back Alley, an unsanctioned SCS is founded by a group of PWID. The project receives unofficial support from the B.C. Centre for Disease Control and the Vancouver Police, but is shut down after a year due to lack of funds.

**1997:** A public health emergency is declared in Vancouver because of the epidemic of overdose deaths in an attempt to galvanize political action.

**1997-2001:** The Vancouver Area Network of Drug Users (VANDU) operates several peer-run SCSs for short periods of time, building limited support for their establishment.

#### Founding Insite

**2001:** *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver* is released by Vancouver Health services, outlining the principles of prevention, treatment, harm reduction, and enforcement that would guide government intervention in the crisis.

**2003:** After several feasibility studies, Insite opens its doors with a three-year exemption from the Controlled Drugs and Substances Act (CDSA). The PHS Community Services Society and the Vancouver Health Authority operate the facility.

#### The Fight to Stay Open

**2006:** The Federal Minister of Health grants a temporary, 15-month extension to the exemption from CDSA.

**August 2007:** Worried that the Federal Government was close to shutting Insite despite an extensive body of peer-reviewed research supporting its benefits, PHS filed suit in the B.C. Supreme Court with two PWUD.

**October 2007:** The Federal Minister of Health and then B.C. Supreme court gives an additional 6-month extension until 2009, giving the Canadian Parliament time to amend the CSDA.

**2010-11:** The federal government, having appealed the BC Supreme Court's ruling, brings the case to the Supreme Court of Canada.

**September 2011:** In a unanimous decision, the Supreme Court rules that attempts by the federal health minister to close Insite violated the constitutional rights of those who need it.

#### Current

**2015:** The federal government enacts Bill C-2 (called the "Respect for Communities Act"), which will allow exemptions to the CDSA only in exceptional circumstances and under potentially prohibitive regulations for new SCSs.

**2016:** Vancouver Coastal Health is in the process of applying for 5 more SCS sites in B.C. to combat the worsening opioid epidemic.

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## **SCIENTIFIC EVIDENCE OF THE IMPACT OF SCSs**

Experimental designs and in particular, the randomized control trial is considered the gold standard for proving the effectiveness of an intervention on a given health outcomes. But it is often not feasible given the ethical problems with "randomizing" people to an intervention and a

control (absence of the intervention) condition when the intervention has been proven effective. This is true in many debated areas of public health such as gun research, where it is impossible to randomly provide guns to some and not to others to evaluate their effects in a given community. Therefore, a series of observational studies often need to be conducted in a range of settings to build the scientific body of evidence to support SCSs, in this case.<sup>52</sup> In Europe, SCSs were established as a part of existing or new services and as a result, evaluations were often an afterthought given the focus was on service delivery. SCSs in Sydney and Vancouver were established as scientific pilot studies and therefore have been evaluated in rigorous observational study designs (e.g., prospective cohort study) and provide much of the evidence on the benefits and lack of determinants of SCSs. It is important to note that good policies do not necessarily have to be proven with data. Some things just make sense intuitively and some policies on the face of it, are appealing given a context – such as high rates of overdose, HIV, and HCV.

Table 1 reflects a large body of research that documents characteristics of SCS utilizers as well as evaluation studies examining the impact on risk behaviors (e.g., syringe sharing, condom use), overdoses, drug use patterns (e.g., treatment, cessation), mental health, and public impact (e.g., crime, perceptions).

**Table 1: Observational and Impact Studies on SCSs**

<b>Infectious diseases</b>
<p><b>HIV</b></p> <ul style="list-style-type: none"> <li>• 30% of SCS clients in Vancouver and 17% in Sydney are HIV positive.<sup>47,53</sup></li> <li>• In Vancouver, creation of an SCS has been estimated to prevent 1,191 new HIV infections over 10 years.<sup>22,54</sup></li> <li>• A recent study conducted to assess the cost-effectiveness of a SCS facility in San Francisco found it would generate \$3.5 million in savings annually based on hospital visits and medical cost savings from averted HIV infections.</li> </ul>
<p><b>Hepatitis C (HCV)</b></p> <ul style="list-style-type: none"> <li>• Rates of HCV are very high among PWID: 88% of users in Sydney are HCV positive.<sup>55</sup> In an early study of Insite participants (N=691), the HCV positive rate was 87.6%.<sup>55</sup></li> </ul>
<b>Risk Behaviors</b>
<ul style="list-style-type: none"> <li>• SCS use is associated with reductions in high-risk behaviors that have serious impacts on individuals and public health.</li> </ul>
<p><b>Syringe sharing:</b></p> <ul style="list-style-type: none"> <li>• One of the main modes of transmission for blood-borne viral infections among PWID; SCSs provide a supervised, sterile space to inject.</li> <li>• Frequent use of a SCS was associated with a 69% decrease in syringe-sharing.<sup>7,27</sup></li> <li>• Many SCS clients report a decrease in public-space injection and increased use of sterile injection equipment.<sup>28</sup></li> </ul>
<p><b>Condom use</b></p> <ul style="list-style-type: none"> <li>• Regular SCS attendance was associated with an 8% increase in condom use over two years.<sup>56</sup></li> </ul>

**Overdose**

- In 2015 there were 768 overdose incidents and 0 deaths at Insite.<sup>57</sup>
- In Frankfurt, SCSs have prevented 10 overdose deaths per year in addition to countless nonfatal overdoses.<sup>24</sup>
- The impact is also felt in surrounding neighborhoods: in Vancouver
- The B.C. Coroner's office reports that 60% of drug overdose deaths involved fentanyl in 2016, compared with 4% in 2012; the province has approved 6 new SCS sites to deal with this emergency.

**Drug Use Patterns:**

- SCSs reduce drug use and connect users to addiction services.

**Treatment**

- SCSs provide access to health and social services to a population that is otherwise difficult to engage.<sup>58-60</sup>
- In Vancouver, 57% of PWID attending Insite started addiction treatment, and 23% stopped injecting drugs altogether.<sup>33</sup>

**Cessation**

- In 2015, Insite admitted 464 users into their Onsite detox program and 252 completed the program (54%).<sup>57</sup>
- In a separate Vancouver study, 23% of a cohort of Insite users ceased injecting entirely.<sup>33</sup>
- In Sydney, 20% of SCS users were interested in starting a care program of some kind, and 25% of those people ended up entering care.<sup>59</sup>

**Mental Health**

- PWID experience very high rates of serious mental health issues and have reduced access to medical and mental health services.<sup>7,61</sup>
- In a 2016 study in Sydney, 82% of respondents reported having a mental health disorder, while on 23% were in treatment.<sup>61</sup>
- 96% of the sample population in Sydney had experienced trauma, including a mean of 3 traumatic experiences before the age of 16.<sup>61</sup>
- Facilities like Insite, which have on-site mental health counselors, social workers, and addiction treatment options are a crucial link in the continuum of care.

**Public Impact**

- SCSs do not increase crime, nuisance or drug use in their communities.

**Nuisance**

- SCSs reduce public injection, discarded syringes, and disorder in the area around them in both Vancouver and Sydney.<sup>34-36</sup>
- Data collected over a 10-year period in Sydney also revealed no increase in offenses related to the trafficking or public drug consumption in the areas that surrounded the SIS.<sup>37,38</sup>
- Insite was associated in decreased public injection in Vancouver.<sup>39</sup>
- SCSs have been associated with reductions in public injections. A small study in Copenhagen found that use of the facility was associated with 56% fewer outdoor injections.<sup>29</sup>

### **Public perceptions**

- In Sydney, two random sample studies found that more than 70% of the local residents and 58% of the companies located around the SIS were in favor of the SIS.<sup>36</sup>
- In Vancouver, there is evidence that police are accepting of Insite and even refer PWID to them. Among a cohort study of Insite users, 16.7% (n=1,090) were referred to Insite by police, and 2% learned about Insite from police.<sup>62</sup>

### **Perceptions among PWID**

- Approximately 75% of the PWID in Vancouver reported that using Insite induced positive changes in their behaviors, notably in terms of public nuisance and safe injection practices.<sup>35</sup>
- PWID reported their main motivations to use SCSs were a desire to inject safely and quietly, the desire to avoid public spaces, and prevent overdose.

## **COST EFFECTIVENESS**

Increased vulnerability and health needs of the PWID population incur significant costs. Medical utilization is particularly high in this group, which has been estimated to comprise 56% and 11% of all new HCV and HIV infections in the United States, respectively.<sup>63,64</sup> Sustained drug therapy and clinical management of these conditions, combined with frequent emergency room visits and inpatient hospital stays associated with skin and soft tissue infections (SSTI), have been estimated to drive medical costs to an estimated U.S. \$6.6 billion annually in this population.<sup>65</sup> SCSs have been posited to reduce costs associated with this public health crisis by reducing needle re-use and sharing and therefore incidence of HIV/HCV and SSTI, by reducing the costs to society of addictions and overdose deaths, and by increasing the uptake into addiction counseling services.<sup>66</sup>

The majority of estimates regarding cost-savings and cost-effectiveness of SCSs have been generated in Canada based on the experience of Insite in Vancouver. Studies in this setting have estimated that the program incurs negative net costs, reflecting both savings in cost and expected increases in life expectancy, and that annual societal benefit exceeds CAD \$6 million annually.<sup>67</sup> Specifically, Andresen and colleagues estimated savings of CAD \$500,000 per HIV death and USD \$660,000 per overdose death prevented at Insite.<sup>67</sup> Aside from preventing fatalities, SCS lead to cost-savings by averting infections that would otherwise need clinical management. A mathematical projection of the consequences of closing Insite estimated 83.5 additional incident HIV infections annually at a cost of CAD \$17.6 million in related life-time medical costs to the Canadian government, compared with the CAD \$3 million annual operating costs associated with keeping Insite open.<sup>68</sup> To inform decision-making and advocacy efforts in prospective cities, various studies have also modeled expected cost impacts of implementing a SIF in Ottawa, Saskatoon, Toronto, and Montreal. Projections in these contexts highlight important parameters that affect cost-effectiveness, but have all yielded encouraging results. In Montreal, it was estimated that SIF implementation would facilitate a net cost saving of CAD \$686,000 and CAD \$800,000 by averting 11 cases of HIV and 65 cases of HCV per year, respectively.<sup>69</sup> Similar work has shown that despite variation between cities, even conservative estimates yield clear cost-benefit and net savings associated with SIF implementation in Toronto, Ottawa and Saskatoon. In Toronto, where cost-savings were projected to be lower due to low HIV prevalence and high geographic dispersion of PWID, a net saving of CAD \$9.6 million was projected over a 20-year period after accounting for projected operating costs.<sup>70</sup>

A recent study modeled the expected costs and benefits of a SCS in San Francisco, California - the first such study in the U.S. Authors applied costs of operating a facility modeled after Insite in San Francisco, and found that a single SIF of the same size and capacity - 13 injection booths - would cost

\$2 million per year. The study estimated that this would result in net savings of USD \$3.5 million annually, ranging from \$2.2 to 4.8 million depending on the prevalence and SIF impact on the following: HIV and HCV cases averted; overdose deaths prevented; MAT uptake; and decreased medical costs of treating SSTIs.<sup>66</sup> When modeled independently, annual savings and financial benefits to society of each parameter were estimated as follows: \$1.3 million for reductions in HIV; \$1.3 million for reductions in HCV; \$1.7 million for decreased SSTI-related medical needs; \$284,000 for averted overdose deaths; \$1.5 million for increased uptake of methadone therapy. Due to co-occurrence of these conditions within the same population, these independent assessments do not add up to the overall savings; however, separate estimates are notable because they demonstrate that improvements in any two of HIV, HCV, MAT uptake and SSTI care would be enough to offset the annual costs of a facility alone. Overall, authors conclude that a SIF in San Francisco would be an extremely cost-effective intervention, saving approximately \$2.33 for each dollar spent.

The available evidence highlights the range of parameters that must be considered when modeling costs and benefits of SIF in a new location. These include geographic concentration or dispersion of PWID, prevalence of HIV, HCV, rates of SSTI care-seeking and overdose deaths, and of needle-sharing among others. For example, the dispersion of PWID combined with the low HIV incidence rate in Toronto translated to a lower cost-benefit ratio for the introduction of single SIF than in settings like Ottawa or Vancouver. Projections still suggest that SIF would be cost-effective in the Toronto context, with the caveat that greater returns would be expected as the number of facilities increased throughout the city to address the needs of the population. In contrast, cities with concentrated areas of poverty, public injection and PWID demonstrate higher initial cost-savings which may not be improved with marginal additions in facilities over time. Given the parameters described, it is expected that SIF in the context of Baltimore City would translate to considerable medical and social cost-savings. The scale of the opioid crisis in Baltimore City is considerably higher than some of the contexts in which modeling has been conducted. Approximately 24% and 84% of PWID are HIV- and HCV-positive, respectively, and overdose-deaths are frequent. Given the existence of concentrated regions of drug use and PWID populations throughout the city, there is good reason to believe that the initial introduction of a single SIF would translate to considerable savings via averted infections, SSTI care and overdose death. Another consideration is changes to the costs of operating a facility in different cities. Authors projecting costs of implementation inflated operating costs to adjust for cost-of-living in San Francisco; this would not be the case in Baltimore, where cost-of-living and factors like real-estate value are considerably lower than Vancouver or San Francisco.

Finally, cost analyses must be interpreted with full consideration of their limitations. First, the conservative assumptions adopted in most costing exercises provide underestimates of likely savings. The majority of projections have modeled cost-savings associated with averting HIV and HCV only; the recent study in San Francisco was the first to include infections, SSTI, overdose prevention and treatment uptake all together. While these are difficult to quantify, examining broader impacts of SIF in their ability to improve social determinants of health as well as cost-savings is important. For example, while difficult to cost, it is important to consider the benefits of SIF in complementing other programs, reducing of health disparities, promoting of social justice and equity and helping to reduce violence or residential instability in disadvantaged neighborhoods.

## **US CONTEXT**

Over the past few years, there have been a growing number of cities that have had SCSs recommended by either city drug (e.g., heroin, fentanyl) taskforces, city elected officials, or advocacy efforts. As previously mentioned, the increased attention to SCSs in a number of U.S. cities are directly related steep increases in overdose deaths and abuse of prescription opioids leading to expanded injection drug use epidemics, as well as the harms produced by the war on drugs. Pills have become a

new gateway to heroin injection for the new profile of drug users. This demographic change has accompanied a geographic shift for problematic opioid use, with policy makers in these locations being pressured to respond to the addiction and overdose epidemic as never before. This has resulted in potentially new advocates for innovative solutions. Although syringe exchange is distinct from SCSs, it shares similar roots in that it was an evidence-based, cost effective intervention that was implemented worldwide, and was challenged politically and morally in the U.S. for over two decades.

Although well over 200 SSPs were in existence in 2015 in the US, in January of that year the U.S. Congress lifted the ban on using federal monies to support SSP operations, with the exception of using dollars to purchase needles and syringes—a move seen by many as a response to the changing face and place of opioid abuse. Scott County, Indiana has come to signify this change.<sup>71,72</sup> In 2015, this rural county experienced a substantial increase in HCV infection followed by a linked outbreak of HIV cases attributed to injection of oxymorphone, a synthetic prescription opioid. 135 people were infected with HIV in the first half the 2015, compared to the typical number of 5 cases per year.<sup>73</sup> At the time of the outbreak, the non-medical use of syringes was a felony punishable by up to 3 years in prison. The Governor of Indiana, Mike Pence at that time, changed the state's policy to allow SSPs for a year on the basis of a public health emergency. Similar outbreaks of HCV have been reported in Kentucky and West Virginia, paving the way for new SSPs there as well as new advocates. The dialogue has shifted.

This new and continuously changing backdrop of drug use and drug-related deaths in the U.S. has paved the way for new discussions among community members, policy makers, and law enforcement around solutions to problematic drug use. In some places, this includes meaningful discussions of SCSs. We describe four cities that are actively engaged at various planning stages of SCS development.

*New York City:* New York City houses the largest population of people who inject drugs worldwide. Since 2014, the SCS NYC campaign which developed out of a broad range multi-sectorial coalition of the New York drug users' union housed within Voices of Community Activists & Leaders (VOCAL-NY), harm reductions service providers, legal organizations, drug policy organizations, churches, research institutes, housing organizations, and others. The coalition developed largely in response to the extent of public injecting<sup>10</sup> and escalating rates of overdose deaths, similar to many other U.S. cities. Two important recent studies conducted in New York helped to provide evidence for the importance of SCSs given the extent of public injection. A 2014 study of public injection in New York city SSP participants across the city found that among people who inject drugs (n=477), the third most frequent location for injecting was public bathrooms (14%), with nearly half of the sample having reported injecting in a bathroom and over one-third reported injecting in a street or park in the last month.<sup>9,73</sup> Another study found that 34% of managers of business establishments in high drug-using neighborhoods in New York reported having encountered syringes, with 24% having found drug paraphernalia contaminated with blood.<sup>10</sup> A product of SCS NYC efforts was the creation of the New York Healthcare Professionals for SCSs, which began by a group of doctors at Montefiore Medical Center and now has well over 100 members. Further, in November 2016, New York City Council recently announced it would spend \$100,000 to study the pros and cons of supervised injection facilities. In September 2016, the New York State Department of Health released updated guidance which serve as regulations for SSPs in New York, which included language that encourage SSPs to facilitate safer injection at their program sites in such instances that people use those spaces to inject. This is reflective of extensive and long-term advocacy efforts at the city and state levels. The Council is actively looking for the best location for SCSs and they are planning on using their insurance policy to insure the SCSs regardless of its co-location with an organization that has existing insurance. This signals willingness on the part of the county to incur the risks necessary to move forward with this model, an encouraging sign for advocates and PWUD alike.

*Ithaca:* In 2014 Mayor Svante Myrick convened a panel of health officials, law enforcement, academics, and others to develop a report to guide the city on responding to epidemic rates of heroin overdoses in Ithaca. The report was entitled “The Ithaca Plan: A public health and safety approach to drugs and drug policy” and recommended the city “explore the operation of a supervised injection site staffed with medical personnel as a means to: prevention fatal and non-fatal overdose, infectious disease, and bacterial infections; reduce public drug use and discarded needles; and provide primary care and referrals to basic services, housing and substance abuse treatment.”<sup>74</sup> In response, in February 2016, Mayor Myrick became the first U.S. mayor to call for the opening a “supervised injection facility.” Although this has met with great resistance from the Republican state legislatures, it has extensive support from those who work with drug users as well as some law enforcement officials. Ithaca provides a strong example of the possibility of promoting this model in a more politically conservative setting, and should be watched closely for key lessons and challenges that may be applicable elsewhere.

*Seattle:* In January 2017, the King County Board of Health endorsed two SCS sites, one in Seattle and one located in the surrounding county. The King County Sheriff has expressed public support and the Justice Department has yet to comment about the legality about the impending plans. In September 2016, the Seattle/King County Heroin and Prescription Opiate Task Force, which was established after a state of emergency given the rise in homelessness, issued a set of recommendations to address the ongoing heroin epidemic. The Task Force was convened by Mayor Ed Murray and the King County Executive Dow Constantine and was comprised of 43 people, representing a range of constituents including law enforcement, government officials, public health, epidemiologists, drug treatment, and advocates. The Task Force met over several months and produced nine recommendations that address prevention, drug user health, and treatment. The establishment of at least two supervised consumption spaces, referred to as “Community Health Engagement Locations” were included as a part of a comprehensive approach to address drug addiction. Seattle drew from New York’s experience and recently established an advocacy group of healthcare professionals called the Healthcare Professionals for Safer Consumption Spaces, comprised of over 60 physicians and nurses who are publically supporting SCSs. Such advocacy further destigmatizes SCS as a concept and brings it to the center as opposed to keeping it on the margins.

*San Francisco:* A range of conversations about SIFs have been occurring in San Francisco for close to a decade. A successful community forum was held on SIFs in 2007, but had serious backlash at the federal level with South Carolina Senator Jim DeMint attached an amendment to the Labor, Health and Human Services and Education appropriations bill prohibiting the use of Health and Human Services funds for any cities that create legal safe-injection drug sites. The amendment was removed in committee. Conversations continued in San Francisco among community organizations with city officials and the chief of police. In 2010 the San Francisco Hepatitis C Task Force recommended San Francisco “support and fund the creation of a legal supervised injection facility.”<sup>75</sup> During this time, a study examined community stakeholders’ (e.g., business representatives, residents, police, religious leaders, advocates) attitudes towards a SIF located in a high drug using area, the Tenderloin district. Stakeholders were concerned how a SIF would impact the community which was already struggling with safety and cleanliness, but were open to talking about SIFs and interested in how a SIF might support neighborhood goals.<sup>76</sup> Another study examined SIF acceptability among 600 PWID in San Francisco and found that 86 percent endorsed using a SIF.<sup>77</sup> Having injected in public and homelessness were significantly associated with willingness to use a SIF. In 2014, the San Francisco Human Rights Commission recommended supervised injection facilities as a part of a broader harm reduction approach to drug use in the city.<sup>78</sup> In 2016, city legislation to create “navigation centers” for homeless included both wet housing (residential facility where drinking is permitted) and safe injection sites, but the SCSs were deleted before it passed the city board of supervisors. As of early December

2016, support from city officials include Jeff Kositsky, director of the Department of Homelessness and Supportive Housing, and Barbara Garcia, director of the Department of Public Health.

## **BALTIMORE CITY**

Similar to the rest of the country, Baltimore City has seen steep increases in overdose deaths. Many attributed to fentanyl. There are an estimated 19,000 PWID in Baltimore City.<sup>75</sup> In the first half of 2016, there were 290 fatal overdose deaths, of which 51% involved fentanyl. This represented a 56% increase over overdose deaths during the same period in the previous year, and a 61% increase in fentanyl related deaths.<sup>76</sup> In response to this crisis, on October 1, 2015, Baltimore City Health Commissioner, Dr. Leana Wen issued a jurisdiction-wide standing order for naloxone, which resulted in a state law. The standing order is a part of the Baltimore City Health Department's innovative city-wide, overdose prevention campaign that also includes targeting overdose "hot spots" in real time and conducting a fentanyl education campaign. These efforts represent the type of wide-scale and creativity that are needed to abate the harmful effects of both the prescription opioid epidemic that has facilitated new people injecting drugs and the fentanyl-related overdose epidemics.

Given the national conversation on SCSs and this context of Baltimore, a group of advocates, academics, and clinicians began meeting to explore the possibility of a SCS in Baltimore during the summer of 2016. They aimed to explore the feasibility of an SCS in Baltimore through a racial justice framework lens, given the far-reaching impact of the failed war on drugs on Baltimore's citizens and neighborhoods. Throughout the summer, they held discussions with local foundations, the Baltimore City Health Department, religious leaders, PWUD, drug treatment advocates, and others to explore how organize for a SCS in Baltimore City. They invited a broader coalition of stakeholders who held two meetings at the end of 2016 to begin a broader discussion and develop an action plan. This group included representatives from the drug treatment community, a community organizing organization, a peer outreach organization, funders, researchers, clinicians, the local behavioral health authority, and the Baltimore City Health Department. To further organizing efforts, they have secured funding from two foundations to support a community organizer to lead the effort as well as broaden and strengthen the coalition and community education around SCSs.

In 2016, Maryland was one of the first states to have a bill introduced that allowed for the establishment of SCSs. Delegate Dan Morhaim, an emergency room physician who represents part of Baltimore County, introduced a comprehensive harm reduction legislative package including a bill to allow for the establishment of safe drug consumption programs in Maryland. This bill would have allowed local health departments to singularly establish such programs. Community-based organizations would have also been allowed to establish such programs after obtaining approval from the Department of Health and Mental Hygiene. The bill did not make it out of committee but it was widely written about, laying the groundwork for a similar bill that Delegate Morhaim is introducing this year.

## **LEGAL ANALYSIS**

The following is a summary of a legal analysis of liability and criminal issues related to operating a SCS in Baltimore was prepared by the Drug Policy Alliance.

**Legal Statues:** Under current federal and state law, SCS clients, staff/operators, and property owners would be exposed to certain legal risks. However, all states and some municipalities have the authority to sanction the operation of a SCS, including the use and possession of illegal drugs on the premises. States and municipalities have the duty to protect and preserve the welfare of their citizens. The legal

authority to fulfill this duty, called the “police power,” has been recognized as a basic attribute of the state since the founding of the nation.<sup>77</sup> Given the evidence from existing consumption sites, a state or municipality could view a SCS as a reasonable public health measure with the potential to address the host of problems associated with injection drug use. Authorizing a SCS would therefore be a logical and prudent exercise of the police power. Despite the power to authorize SCS under state or local law, however, federal authorities could still interfere with these facilities under the Controlled Substances Act.<sup>78</sup>

A host of federal, state, and local laws currently prohibit or complicate the implementation and operation of a safe consumption site. Both federal law and the Maryland criminal code currently make it illegal to possess any controlled substance.<sup>79</sup> Every SCS client in possession of drugs to consume at a SCS would be in violation of these laws. This could even extend to SCS staff with “constructive possession,” but this would need staff to have control over the drugs, which is not likely. State law also prohibits use and possession of drug paraphernalia except under limited circumstances.<sup>80</sup>

SCS clients, staff, and operators would all be subject to potential criminal charges under the so-called federal “crack house” statute.<sup>79</sup> Although originally enacted in response to the crack cocaine epidemic of the mid 1980s, they are broadly written to enable prosecution of persons who use, open, or maintain property where any controlled substance is consumed, manufactured, or distributed. The federal law makes an owner or leaser accountable for a number of drug consumption and selling activities including, knowingly lease, rent, use or maintain a place for the purposes “unlawfully manufacturing, storing, distributing, or using a controlled substance.”<sup>79</sup> Maryland does not have a state “crack house” statute equivalent per se. SCS clients, staff, and operators would all be subject to potential criminal charges under various state nuisance laws.<sup>81</sup> The owner of the property used as a SCS would be subject to a potential civil forfeiture action under both state and federal law.<sup>82</sup> The property owner would be able to rely on an “innocent owner” defense only if the owner were unaware of the illegal activity (i.e., the SCS).

Lastly, SCS staff may face a threat of civil lawsuits and attendant liability. If someone were to overdose and die while using drugs at a SCS, for instance, it is conceivable that the family could bring a wrongful death lawsuit. This risk, however, does not depart dramatically from the risks already inherent in operating a needle exchange program. Further, SCS staff and operators would likely have very good defenses to civil liability. Depending on the structure and program criteria, a host of other laws could potentially be implicated. For instance, if health care professionals staffed the SCS, there may be some concern with license revocation for unprofessional conduct for operation of a SCS (though unlikely).<sup>83</sup> Alternatively, the Dr. Peter Centre in Vancouver was authorized to provide safe injection services in large part because the nurses at the Centre argued that such services were within their scope of practice.

### **Authorization of a SCS in Maryland**

State Authorization: Explicit SCS authorization by the Maryland State legislature is the optimal legal course because it not only eliminates uncertainty about the legality of a SCS, but legitimizes the operation in the eyes of subordinate governmental agencies. This would decrease the chance that a local police department or prosecutor would take formal action against it and would also provide SCS operators and clients with protection against informal police pressure or interference. Finally, state legislative authorization puts the SCS on its strongest footing against a challenge from the federal government.<sup>77</sup> State authorization legislation will likely be the most difficult path to authorizing a SCS. Dr. Morhaim’s reintroduction of the legislation was not successful in 2017.

It may also be possible for Maryland to authorize a SCS through administrative action by the executive branch. Health agencies in all states have rule-making authority to protect public health. In Maryland,

for example, the state Department of Health and Mental Hygiene (DHMH) has the authority to promulgate rules and regulations that it deems necessary to prevent diseases.<sup>84,85</sup> It may also be possible for the Governor to issue a state-of-emergency Executive Order authorizing a safe injection facility to address the opioid overdose epidemic.<sup>86</sup> If unchallenged or upheld, the effect of an executive authorization on implementation would be similar to state legislative authorization.<sup>77</sup> Whether legislatively or administratively authorized, state-sanctioned SCS could still be impacted by federal drug laws, which is discussed more fully below.

Local Authorization: A SCS could also be locally authorized by a mayor, county agency, or city council. The power to enact local laws is granted by the Maryland State Constitution and the scope of this “home rule” power is very broad.<sup>87</sup> Depending on the location of the SCS, the city or county charters should be reviewed to determine the extent of their power to enact a local law authorizing a SCS, but, generally speaking, it should be within municipal or county authority, and, as with a state law, would need to address any local legal impediments to SCS operation (such as, for instance, any local laws against possession or nuisance). With respect to Baltimore, the Baltimore City Charter, Baltimore City Code, and local authority granted by the Annotated Code of Maryland all provide potential means of locally authorizing a SCS in the City.

The Baltimore City Charter provides the Mayor and City Council of Baltimore full power and authority to exercise all powers granted to them by the Constitution of Maryland or the Maryland General Assembly.<sup>88</sup> This includes the power “to provide for the preservation of the health of all persons within the City.”<sup>89</sup> This route of authorization is straightforward and would provide good legal protection. Executive departments within the Baltimore City government, acting through their directors, commissions, and boards, may adopt rules and regulations for the operation of their respective departments.<sup>90</sup> The Baltimore City Department of Health shall “cause all laws for the preservation of the health of the inhabitants of Baltimore City to be faithfully executed” and shall “establish and implement policy for the treatment and prevention of physical and mental illnesses” within the City.<sup>91</sup> A SCS could accordingly be authorized via ordinance or possibly even by the Department of Health under their authority to preserve health and prevent illness.

In addition to the Commissioner’s powers as outlined by the Charter, the Commissioner has general duties as outlined by the Health Code of Baltimore City. Related to the implementation of a SCS, the Commissioner has the duty to report and recommend to the Mayor “any extraordinary action needed” to “correct a health hazard” and any other matters “relating to the preservation of the health of the people.”<sup>92</sup> More specifically, the Commissioner may “adopt and enforce rules and regulations” to carry out their general duties.<sup>93</sup> The Commissioner also has the power to establish health clinics and centers within the City as long as guidelines and procedures are adopted for the administration and operation of these entities.<sup>94</sup> It would be possible under this authority for safe consumption services to be integrated as part of a larger health care clinic, the model followed by Dr. Peter Centre in Vancouver.

Finally, the “principal executive officer of a political subdivision may declare a local state of emergency” under the Maryland Emergency Management Agency Act (“MEMA Act”).<sup>95</sup> A “political subdivision” means a county or municipal corporation of the state, which could mean the Baltimore City Health Department via the Health Commissioner.<sup>96</sup> There is some precedent around the country for declaring states of emergency with respect to controlled substances, including, among others, the state of California allows for needle exchange and one by the Governor in Massachusetts to make naloxone available over the counter.

A locally-authorized SCS would, however, be one the weakest footing in relation to a federal challenge. Moreover, it would be open to claims that it conflicted with, or was preempted by, state law.<sup>77</sup> Indeed, a locally authorized SCS would authorize what state law prohibits—the possession and consumption of

controlled substances, albeit in limited circumstances. A syringe exchange program authorized by Atlantic City was successfully challenged in court by a local prosecutor, who argued it was prohibited by a state drug law. On the other hand, many other municipalities, including Philadelphia, Cleveland, Los Angeles, and San Francisco, authorized syringe exchange programs at the local level and were never challenged.

A locally authorized SCS would also need to address the possibility of police interference. Though municipal police departments would arguably comply with local law, they are also deputized to enforce state law and could choose to arrest and charge clients with violations of state drug possession laws. The durability of local authorization would thus depend on an explicit or implicit agreement among stakeholders, such as local law enforcement and prosecutors, to avoid arrests and other legal challenges.<sup>77</sup> One potential strategy could be to simultaneously enact a “lowest level law enforcement priority” ordinance with respect to SCS participants. This tool has been used by a number of municipalities with respect to marijuana arrests. It could also be possible, either in conjunction with an authorizing ordinance or even without, to enter into a Memorandum of Understanding among all relevant stakeholders to allow the SCS to operate under the terms of the Memorandum, which would rely heavily on police and prosecutors using their prosecutorial discretion to the benefit of the SCS. This strategy was executed in the context of Law Enforcement Assisted Diversion in Seattle and was a very effective model of local action.

Despite the potential challenges of a local authorization, there are a number of important reasons to pursue this avenue of authorizations for a SCS. City and county governments bear the brunt of the burden of service delivery and emergency response to drug use and are likely best able to judge the necessity and effectiveness of locally implemented interventions, such as a SCS.<sup>78</sup> Moreover, there is likely to be greater cultural and political homogeneity relative to SCS in a single city versus across the state, and so a local ordinance or administrative measure may be more politically feasible. Finally, the history of syringe exchange programs is instructive. When those programs were still in their infancy and did not have widespread political support, many city governments stepped up to the plate to provide a critical intervention which has yielded enormous health benefits for hundreds of thousands of individuals. As with the example of syringe access, the willingness of local municipalities to tolerate some potential challenges can result in the establishment and expansion of a critical public health intervention that will save lives.

#### Impact of Federal Drug Laws on State or Local SCS Authorization

State or local authorization cannot nullify federal drug laws, and so does not protect a SCS against a preemption challenge or federal enforcement action.<sup>77</sup>

With respect to federal preemption (and state preemption for that matter), it is best to authorize community-based organizations to operate the consumption site/services as opposed to any government entity such as a local Department of Health. Having a Department of Health operate a SCS would arguably require government employees to violate federal law (the “crack house” statute) and so could be directly preempted by federal law. Indeed, it is for this reason that laws permitting the recreational or medical use of marijuana purposefully do not involve state officers in the actual distribution or testing of marijuana, but, rather, only in the licensing.<sup>97</sup> On the other hand, merely authorizing, for instance, a state or local Department of Health to approve or permit the establishment of SCS by community-based organizations (akin to licensing of medical marijuana dispensaries) would likely not be preempted by federal law. Indeed, a state can decide that certain conduct does not violate state law even if it offends federal law.<sup>97</sup> It is then for the federal government to decide how, if at all, it wants to enforce the federal law.

With respect to potential federal enforcement action, there are at least two sections of the federal Controlled Substances Act that could be interpreted to bar a SCS. Section 844 prohibits drug possession and so is violated by every client who appears at the SCS with drugs. Although federal law enforcement officials rarely if ever target simple possession by individuals, the law would allow them to do so if they wished to interfere with the operation of a SCS. A SCS authorized at the state or local level could also be deemed to violate Section 856 (the federal “crack house” statute). If SCS staff, operators, or clients were prosecuted under the crack house statute, there are a number of potential defenses. Aside from technical arguments about the way the laws are written, defenders of a SCS could point to the legislative history of the statutes, which were never intended to cover public health interventions such as a SCS. Further, a state or municipality could argue that federal interference with a SCS oversteps the bounds of federal regulatory authority.<sup>77</sup>

As noted above, the owner of the property used as a SCS could also be subject to a potential civil forfeiture action under federal law.<sup>98</sup> Former United States District Attorney for the Northern District of California, Melinda Haag, has used the federal forfeiture statute as a mechanism by which to attempt to dismantle medical marijuana dispensaries in the Bay Area. It is certainly possible that other justice department officials like her would employ the same tactic against a SCS authorized at the state or local level. Of course, whether or not the federal government would choose to take any action depends on the administration in power and the degree to which state and local federal officials exercise their high degree of discretion. It is possible that the federal government could simply choose not to take any action with respect to a SCS. Indeed, given limited resources, legal uncertainty, and higher priorities, federal law enforcement personnel routinely decide not to pursue cases they deem less important. It is also possible that the federal enforcement agencies aggressively pursue a SCS as a direct challenge to national drug laws.<sup>77</sup>

## CONCLUSIONS

SCSs are a cost effective and necessary part of a comprehensive package of services to reduce the burden of mortality and morbidity among PWUD, and to reduce the painful effects of this crisis on the wider community. In the simplest form of delivery, they are a low threshold service aimed to reach some of the most marginalized PWUD with staff on hand to provide information, equipment, and help to prevent overdoses. SCSs have existed for over three decades in Europe and numerous peer-reviewed studies from Vancouver and Sydney support the extent of their effectiveness and benefits to PWUD who access them and the broader surrounding community, as well as the absence of significant harms. Among tens of millions of supervised injections, there has only been one reported fatality in any SCS in Germany in 2002, attributed to anaphylactic shock.<sup>40</sup> Although some SCSs have been met with strong opposition at their onset, community attitudes improve over time as community benefits are felt.<sup>36,40</sup> Given the lack of credible science demonstrating any negative impact of SCSs, the predominance of opposition stems from moral and criminal arguments. These are reflective of an anachronistic abstinence-based ideology and promotion of a drug war, which has dehumanized and criminalized PWUD and failed to avert the harms of drug use to individuals and communities alike.

Research has shown that people who utilize SCS take better care of themselves, use their drugs more safely, and have better access to medical, social and drug treatment services compared to PWUD who do not access SCSs. SCSs play a key role in providing access to necessary services. In terms of impact on the broader community in which SCSs are located, there is no evidence that SCSs negatively impact crime in the surrounding areas. And studies throughout Europe, Sydney and Vancouver have demonstrated significantly lower levels of public drug use among SCS utilizers.<sup>28,39</sup>

What follows is a series of recommendations for the process of developing and implementing an SCS, necessary sectors to include in these processes, the importance of a criminal justice framework, the importance of community education, the meaningful inclusion of PWUD in the various processes, the nature of the SCS, and the role of research.

## RECOMMENDATIONS

This report recommends the establishment of an SCS in Baltimore City. An SCS in Baltimore should be an integrated model that provides low threshold medical services (wound care), referrals to housing, legal, and mental health referrals to partner agencies and tailor support to special populations. It should be located in existing community based organizations, one on the east side of Baltimore and one on the west side. It should provide appropriate space to accommodate a variety of drug consumption methods separately (e.g., injecting room, smoking room). The following recommendations are evidence-based guiding principles for the planning and implementation of an SCS in Baltimore.

### **1. People who use drugs should be central to every aspect of the planning and implementation process.**

The meaningful inclusion of current and former PWUD is central to the success of any SCS. This means including them throughout the planning and implementation processes in decision making and in leadership positions. Such individuals possess relevant knowledge that cannot be otherwise gained, and will only enhance the relevance of services and experiences of those who utilize the SCS and its surrounding community. It is often a mistake of service delivery not to include PWUD in a meaningful or ongoing way, potentially reflecting judgements about active drug users or not valuing their unique perspective. SCSs can be a powerful important component of community capacity building within the drug user community that fosters a sense of empowerment and collective self-care.

### **2. Engage a diversity of sectors throughout the process.**

Success of a SCS greatly depends on the diversity of sectors that are involved throughout its advocacy, development, and implementation process. At the onset of the planning process, engage partners across multiple sectors -including people who use drugs, city officials, criminal justice, religious leaders, local businesses, and other social justice movements. It is vital that such stakeholders have a deep understanding of the evidence supporting and the benefits of SCSs. It is likely that attending to the diversity of stakeholders necessitates separate conversations initially, to ensure that they are supportive and not obstructive. Messaging around how SCSs fit into a comprehensive package of services aimed to reduce the deleterious effects of harmful drug use among PWUD and the community at large is vital to their initiation and sustainability. Developing the nuances of this messaging will occur during initial conversations with these and other stakeholders. Specific sectors include:

*Involve civic and public health authorities:* The involvement and support of city leaders, particularly that of the health commissioner is key to the success of an SCS. As noted in the legal analysis section, the city's possible liability issues indicate that a more sustainable model is an SCS that is part of another or its own nonprofit. But the health commissioner and the BCHD should be involved in all stages of the process so that the SCS will be maximally integrated into existing city harm reduction efforts.

*Engage the criminal justice system:* All elements of the criminal justice system should be involved in the development and implementation of the SCS. The police have a particularly important role to play. Although public health and public safety officials have distinct approaches, they have many similar goals, including the reduction of harms associated with drug use to drug users and communities at large. Understanding the similarities between public

health and public safety provides a foundation for an oftentimes challenging discussion about their differences. To that end, ongoing police training can help to ensure, as best possible, support from street-level police. Police have been engaged in SCS in several cities including Vancouver, where they were actively a part of developing the city's four-pillar strategy. By having their involvement begin at this early stage, they were a part of they supported the establishment of Insite as a part of comprehensive and multi-sectorial recommendations. Police participation in the planning process will provide unique insights given their extensive familiarity with street drug use patterns and PWUD. But it is important to ensure that PWUD have the opportunity to interact with police positively in the process, as the majority of interactions are in the context of negative interactions such as arrest. Further, these interactions could help alleviate concerns from the broader drug using community as to the nature of police involvement. A study during the first two years that Insite was open, 17% of surveyed Insite clients (N=1,090) were referred to Insite by police, demonstrating a true measure of foot patrol police support.<sup>62</sup>

*Business owners and residents:* Business owners and residents of high drug use neighborhoods are at the forefront of understanding the impact of unsafe drug use. Many public bathroom in high drug use neighborhoods are often unofficially unsafe injection sites and overdose. As a result, business owners can be unexpected champions of safe consumption facilities and understand the economic costs of unsafe consumption facilities.

### **3. Community education in harm reduction is central to a SCS' success.**

Changes in public opinion are best achieved when community education and engagement activities begin in advance of establishing a SCS. Educational efforts led by current and former people who use drugs targeting the broader community is necessary to dispel myths about the negative effects of SCS on neighborhoods through sharing the body of scientific evidence in a user-friendly manner. This will not only result in minimizing opposition but could also lead to unanticipated allies. Public education needs to occur in a number of formats including city council of city council briefings and town hall briefings.

### **4. An SCS should operate from racial and criminal justice frameworks.**

SCSs are a part of a larger conversation of criminal justice reform. The failed war on drugs waged in cities such as Baltimore has had enduring socioeconomic impact, particularly on African Americans. SCSs represent a safe alternative to criminal responses to drug use, and have been shown to have measurably improved public health and criminal outcomes. For many, SCSs could literally function as an alternative to incarceration by reducing exposure to police.

### **5. An Integrated SCS is the most effective model.**

SCSs tend to serve some of the most marginalized PWUD in terms of socioeconomic indicators. Socioeconomic instability, such as unstable housing often directly limits their access to safe spaces in which to inject. An integrated model would best meet the needs of this population. Designing SCSs with these PWUD in mind could inform the nature of ancillary services provided and the extent of case management provided. Ideally, an array of services will be located on site including wound care, syringe exchange, overdose prevention training and naloxone distribution, drug testing (e.g., fentanyl testing strips), primary care, and trauma informed care. Case managers could provide housing, legal, and mental health referrals to partnering organizations. Even if services are not on site, SCSs are best implemented when they function as a bridge to other necessary drug treatment, housing, and legal services. Providing low threshold services also is a way to meet this population, as having intensive intake programs or needing identification could serve as real barriers to accessing services. Including current or former PWUD in the SCS planning, implementation, and operating phases will enhance the facility's ability to meet the needs of marginalized drug users.

## **6. An SCS should attend to the various way that people administer drugs.**

Ideally, an SCS will not be limited to providing just safe injection drug use, given the extent to which drugs are smoked and snorted. Although indoor smoking ordinances might preclude or challenge the inclusion of smoking, a facility that allows for the range of routes of drug administration will have a broader impact. Given the that new initiates to drug use more often smoke or snort rather than inject drugs, an SCS that is not limited to injection drug use is more likely to be used by new initiates to drug use, who might not otherwise access ancillary services. A study of Insite clients (N=1,065) found that the facility was not associated with a rise in initiation of new initiates to drug use.<sup>99</sup> Further, an ethnographic study of an unsanctioned safer smoking room in Vancouver found that the space reduced utilizers' exposure to policing and violence associated with street drug sales.<sup>100</sup> As in this space and throughout Europe, rooms for injection should be separate from smoking and sniffing as not to create a sense of encouragement for injection drug use.

*Special Populations:* Services should be tailored to special populations who are often but not always excluded from SCSs such as pregnant women or minors. Distinct protocols will need to be implemented to meet the needs of these populations. For example, if pregnant women attend, all should have to meet with the SCS staff to discuss prenatal care and support, and be given a warm (e.g., person) referral to prenatal services if they are not already engaged in care.

## **7. Consider multiple locations.**

Drug use and fatal overdoses is not confined to one geographic location in Baltimore, but rather are dispersed throughout the city. Further, the invisible barrier of Martin Luther King Boulevard underscores the importance of initially having two SCSs, located on the east and west sides of town. Even though more than one location will initially increase the workload of finding organizations to house the SCSs, educating the public and gaining buy-in from key stakeholders, having two SCSs is fitting given the geographical divide and the extent of drug use in Baltimore.

## **8. Rigorous research is needed to offensively and defensively demonstrate the impact of an SCS.**

There continues to be a need for the rigorous evaluation of SCSs, both to inform service delivery of a specific SCS and to continue a growing evidence-based. It is important to understand who and how people using SCSs and their impact on PWUD and the broader community. Part of Vancouver's story is told through 50+ academic journal articles that have been used for advocacy within Vancouver and beyond. The solid research helped to keep the arguments about Insite real, in that the facts held people accountable to their words when they were critiquing Insite with unsubstantiated and often times incorrect statements. Research should be as low burden to SCS clients as possible, but building the evidence is a part of how such schemes can held weather the storm created by changing politics and frameworks around drug use.

## Literature Cited

1. Centers for Disease Control and Prevention. State Data: Opioid Overdose. 2016; <http://www.cdc.gov/drugoverdose/data/statedeaths.html>.
2. Rudd RA SP, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths - United States, 2010-2015. In: CDC US, ed2016.
3. Control CfD, Prevention. Opioid pain killer prescribing: Where you live makes a difference. *CDC Vital Signs*. 2014.
4. DEA. *Fentanyl Fact Sheet*. United States Drug Enforcement Administration;2015.
5. Amlani A, McKee G, Khamis N, Raghukumar G, Tsang E, Buxton JA. Why the FUSS (Fentanyl Urine Screen Study)? A cross-sectional survey to characterize an emerging threat to people who use drugs in British Columbia, Canada. *Harm reduction journal*. 2015;12:54.
6. Peterson AB, Gladden RM, Delcher C, et al. Increases in Fentanyl-Related Overdose Deaths - Florida and Ohio, 2013-2015. *MMWR Morb Mortal Wkly Rep*. 2016;65(33):844-849.
7. Kerr T, Tyndall M, Li K, Montaner J, Wood E. Safer injection facility use and syringe sharing in injection drug users. *Lancet*. 2005;366(9482):316-318.
8. DeBeck K, Small W, Wood E, Li K, Montaner J, Kerr T. Public injecting among a cohort of injecting drug users in Vancouver, Canada. *J Epidemiol Community Health*. 2009;63(1):81-86.
9. IDUHA. *Harm Reduction in New York City*. New York, NY: Injection Drug Users Health Alliance;2015.
10. Wolfson-Stofko B, Bennett AS, Elliott L, Curtis R. Drug use in business bathrooms: An exploratory study of manager encounters in New York City. *The International journal on drug policy*. 2016;39:69-77.
11. Werb D, Rowell G, Guyatt G, Kerr T, Montaner J, Wood E. Effect of drug law enforcement on drug market violence: a systematic review. *The International journal on drug policy*. 2011;22(2):87-94.
12. Sherman LW, Rogan DP, Edwards T, et al. Deterrent effects of police raids on crack houses: A randomized, controlled experiment. *Justice Quarterly*. 1995;12(4):755-781.
13. Benson BL, Rasmussen DW, Sollars DL. Police bureaucracies, their incentives, and the war on drugs. *Public Choice*. 1995;83(1-2):21-45.
14. Sherman LW. Police crackdowns: Initial and residual deterrence. *Crime and Justice*. 1990:1-48.
15. Cooper H, Moore L, Gruskin S, Krieger N. Characterizing perceived police violence: implications for public health. *Am J Public Health*. 2004;94(7):1109-1118.
16. Kerr T, Small W, Wood E. The Public Health and Social Impacts of Drug Market Enforcement: A Review of the Evidence. *International Journal of Drug Policy*. 2005;16:210-220.
17. Maher L, Dixon D. Policing and public health: Law enforcement and harm minimization in a street-level drug market. *British Journal of Criminology*. 1999;39(4):488-512.
18. Werb D, Kamarulzaman A, Meacham MC, et al. The effectiveness of compulsory drug treatment: A systematic review. *The International journal on drug policy*. 2016;28:1-9.
19. Kerr J, Jackson T. Stigma, sexual risks, and the war on drugs: Examining drug policy and HIV/AIDS inequities among African Americans using the Drug War HIV/AIDS Inequities Model. *International Journal of Drug Policy*.37:31-41.
20. *Illicit Drug Overdose Deaths in BC: January 1, 2007 - November 30, 2016*. Burnaby, BC: Ministry of Public Safety & Solicitor General;2016.
21. EMCDDA. *Drug Consumption Rooms: An Overview of Provision and Evidence*. European Monitoring Centre for Drugs and Drug Addiction;2016.

22. Otter D. *Safe Consumption Facilities: Evidence and Models*. Seattle, WA: King County Heroin and Opiate Addiction Task Force;2016.
23. Wood E, Tyndall MW, Montaner JS, Kerr T. Summary of findings from the evaluation of a pilot medically supervised safer injecting facility. *Cmaj*. 2006;175(11):1399-1404.
24. Marshall BD, Milloy MJ, Wood E, Montaner JS, Kerr T. Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *Lancet*. 2011;377(9775):1429-1437.
25. McKnight I, Maas B, Wood E, et al. Factors associated with public injecting among users of Vancouver's supervised injection facility. *Am J Drug Alcohol Abuse*. 2007;33(2):319-325.
26. Milloy MJ, Kerr T, Tyndall M, Montaner J, Wood E. Estimated drug overdose deaths averted by North America's first medically-supervised safer injection facility. *PLoS One*. 2008;3(10):e3351.
27. Milloy MJ, Wood E. Emerging role of supervised injecting facilities in human immunodeficiency virus prevention. *Addiction (Abingdon, England)*. 2009;104(4):620-621.
28. Stoltz JA, Wood E, Small W, et al. Changes in injecting practices associated with the use of a medically supervised safer injection facility. *J Public Health (Oxf)*. 2007;29(1):35-39.
29. Kinnard EN, Howe CJ, Kerr T, Skodt Hass V., B.D. M. Self-reported changes in drug use behaviors and syringe disposal methods following the opening of a supervised injecting facility in Copenhagen, Denmark. *Harm Reduction Journal*. 2014;11(1):29.
30. Semaan S, Fleming P, Worrell C, Stolp H, Baack B, Miller M. Potential role of safer injection facilities in reducing HIV and hepatitis C infections and overdose mortality in the United States. *Drug Alcohol Depend*. 2011;118(2-3):100-110.
31. Lloyd-Smith E, Wood E, Zhang R, et al. Determinants of hospitalization for a cutaneous injection-related infection among injection drug users: a cohort study. *BMC Public Health*. 2010;10:327.
32. Committee MMSICE. *Final Report of the Evaluation of the Sydney Medically Supervised Injection Centre*. Sydney, Australia: MSIC Evaluation Committee;2003.
33. DeBeck K, Kerr T, Bird L, et al. Injection drug use cessation and use of North America's first medically supervised safer injecting facility. *Drug Alcohol Depend*. 2011;113(2-3):172-176.
34. Wood E, Kerr T, Montaner JS, et al. Rationale for evaluating North America's first medically supervised safer-injecting facility. *Lancet Infect Dis*. 2004;4(5):301-306.
35. Petrar S, Kerr T, Tyndall MW, Zhang R, Montaner JS, Wood E. Injection drug users' perceptions regarding use of a medically supervised safer injecting facility. *Addict Behav*. 2007;32(5):1088-1093.
36. Salmon AM, Thein HH, Kimber J, Kaldor JM, Maher L. Five years on: what are the community perceptions of drug-related public amenity following the establishment of the Sydney Medically Supervised Injecting Centre? *The International journal on drug policy*. 2007;18(1):46-53.
37. Fitzgerald JL. Mapping the experience of drug dealing risk environments: an ethnographic case study. *The International journal on drug policy*. 2009;20(3):261-269.
38. Freeman K, Jones CG, Weatherburn DJ, Rutter S, Spooner CJ, Donnelly N. The impact of the Sydney Medically Supervised Injecting Centre (MSIC) on crime. *Drug Alcohol Rev*. 2005;24(2):173-184.
39. Wood E, Tyndall MW, Lai C, Montaner JS, Kerr T. Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. *Substance abuse treatment, prevention, and policy*. 2006;1:13.

40. Hedrich D. *European Report on Drug Consumption Rooms*. European Monitoring Centre for Drugs and Drug Addiction;2004.
41. Roberts M, Klein A, Trace M. *Drug consumption rooms*. 2004.
42. Dolan K, Kimber J, Fry C, Fitzgerald J, McDonald D, Trautmann F. Drug consumption facilities in Europe and the establishment of supervised injecting centres in Australia. *Drug and Alcohol Review*. 2000;19:337-346.
43. Potier C, Laprevote V, Dubois-Arber F, Cottencin O, Rolland B. Supervised injection services: what has been demonstrated? A systematic literature review. *Drug Alcohol Depend*. 2014;145:48-68.
44. Harati D.F. *Inside Insite: how a localized social movement led the way for North America's first legal supervised injection site*. Cambridge, Mass., Harvard Law School; 2015.
45. Kerr T, Kimber J, Debeck K, Wood E. The role of safer injection facilities in the response to HIV/AIDS among injection drug users. *Curr HIV/AIDS Rep*. 2007;4(4):158-164.
46. Dubois-Arber F, Benninghoff F, Jeannin A. Typology of injection profiles of clients of a supervised drug consumption facility in Geneva, Switzerland. *Eur Addict Res*. 2008;14(1):1-10.
47. Wood E, Tyndall MW, Li K, et al. Do supervised injecting facilities attract higher-risk injection drug users? *Am J Prev Med*. 2005;29(2):126-130.
48. Richardson L, Wood E, Zhang R, Montaner J, Tyndall M, Kerr T. Employment among users of a medically supervised safer injection facility. *Am J Drug Alcohol Abuse*. 2008;34(5):519-525.
49. Tyndall MW, Kerr T, Zhang R, King E, Montaner JG, Wood E. Attendance, drug use patterns, and referrals made from North America's first supervised injection facility. *Drug Alcohol Depend*. 2006;83(3):193-198.
50. Kimber J, Dolan K, van Beek I, Hedrich D, Zurhold H. Drug consumption facilities: an update since 2000. *Drug Alcohol Rev*. 2003;22(2):227-233.
51. Network EHR. *Drug Consumption Rooms in Europe: Models, Best Practice and Challenges*. European Harm Reduction Network;2014.
52. Maher L, Salmon A. Supervised injecting facilities: how much evidence is enough? *Drug Alcohol Rev*. 2007;26(4):351-353.
53. Wood E, Tyndall MW, Zhang R, et al. Attendance at supervised injecting facilities and use of detoxification services. *N Engl J Med*. 2006;354(23):2512-2514.
54. Bayoumi AM, Zaric GS. The cost-effectiveness of Vancouver's supervised injection facility. *Cmaj*. 2008;179(11):1143-1151.
55. Wood E, Kerr T, Stoltz J, et al. Prevalence and correlates of hepatitis C infection among users of North America's first medically supervised safer injection facility. *Public Health*. 2005;119(12):1111-1115.
56. Marshall BD, Wood E, Zhang R, Tyndall MW, Montaner JS, Kerr T. Condom use among injection drug users accessing a supervised injecting facility. *Sex Transm Infect*. 2009;85(2):121-126.
57. Insite. *The Demilitarized Zone in North America's Drug War*. In: Insite, ed. Vancouver, B.C.: Insite.
58. Wood E, Tyndall MW, Zhang R, Montaner JS, Kerr T. Rate of detoxification service use and its impact among a cohort of supervised injecting facility users. *Addiction (Abingdon, England)*. 2007;102(6):916-919.
59. Kimber J, Hickman M, Degenhardt L, Coulson T, van Beek I. Estimating the size and dynamics of an injecting drug user population and implications for health service coverage: comparison of indirect prevalence estimation methods. *Addiction (Abingdon, England)*. 2008;103(10):1604-1613.

60. Milloy MJ, Wood E, Reading C, Kane D, Montaner J, Kerr T. Elevated overdose mortality rates among First Nations individuals in a Canadian setting: a population-based analysis. *Addiction (Abingdon, England)*. 2010;105(11):1962-1970.
61. Goodhew M, Salmon AM, Marel C, Mills KL, Jauncey M. Mental health among clients of the Sydney Medically Supervised Injecting Centre (MSIC). *Harm Reduction Journal*. 2016;13(1):29.
62. DeBeck K, Wood E, Zhang R, Tyndall M, Montaner J, Kerr T. Police and public health partnerships: evidence from the evaluation of Vancouver's supervised injection facility. *Substance abuse treatment, prevention, and policy*. 2008;3:11.
63. Prevention. CfDCA. HIV Surveillance Report. 2014.
64. Klevens RM, Hu DJ, Jiles R, Holmberg SD. Evolving epidemiology of hepatitis C virus in the United States. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America*. 2012;55 Suppl 1:S3-9.
65. Sterling EE. *A businessperson's guide to the war on drugs*. Business Council for Prosperity and Safety. . 2015.
66. Irwin A, Jozaghi E, Bluthenthal RN, Kral AH. A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA. *Journal of Drug Issues*.0(0):1-21.
67. Andresen MA, Boyd N. A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility. *The International journal on drug policy*. 2010;21(1):70-76.
68. Pinkerton SD. How many HIV infections are prevented by Vancouver Canada's supervised injection facility? *The International journal on drug policy*. 2011;22(3):179-183.
69. Jozaghi E, Reid AA, Andresen MA. A cost-benefit/cost-effectiveness analysis of proposed supervised injection facilities in Montreal, Canada. *Substance abuse treatment, prevention, and policy*. 2013;8:25.
70. Enns EA, Zaric GS, Strike CJ, Jairam JA, Kolla G, Bayoumi AM. Potential cost-effectiveness of supervised injection facilities in Toronto and Ottawa, Canada. *Addiction (Abingdon, England)*. 2016;111(3):475-489.
71. Adams J. HIV Outbreak in Indiana. *N Engl J Med*. 2015;373(14):1379-1380.
72. Strathdee SA, Beyrer C. HIV Outbreak in Indiana. *N Engl J Med*. 2015;373(14):1380-1381.
73. Conrad C, Bradley HM, Broz D, et al. Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxymorphone--Indiana, 2015. *MMWR Morb Mortal Wkly Rep*. 2015;64(16):443-444.
74. Wilkinson G, Fan L. *The Ithaca Plan: A public health and safety approach to drugs and drug policy*. Ithaca, New York2016.
75. *Baltimore Mayor's Heroin Treatment & Prevention Task Force*. Baltimore, Maryland2015.
76. *Drug- and Alcohol-Related :Intoxification Deaths in Maryland*. 2015.
77. Beletsky L, Davis CS, Anderson E, Burris S. The law (and politics) of safe injection facilities in the United States. *Am J Public Health*. 2008;98(2):231-237.
78. Burris S, Anderson ED, Beletsky L, Davis CS. Federalism, policy learning, and local innovation in public health: the case of the supervised injection facility. *St Louis University Law Journal*. 2009;53.
79. 21 USC. Sec. 856.
80. MD. Code Ann., Crim. Law. Sec. 5-619; Md. Code Ann., Health-Gen. 24-802 (Authorizing Syringe Exchange in Baltimore).
81. MD. Code Ann., Crim. Law 5-605; MD. Code Ann., Crim. Law 10-202; Olson v. State, 208 MD. App. 309, 367 (2013).
82. MD. Code Ann., Crim. Proc. 12-102; 21 USC Sec. 881(a)(7).
83. MD. Code Ann., Health Occ. 14-404.

84. MD. Code Ann., Health – General 18-102; Md Code Ann., Health – General 2-104(b)
85. 13 MD. Code Ann., Health – General 18-102; Md Code Ann., Health – General 2-104(b)
86. MD. Code Ann., Public Safety. 14-1-14. (The Maryland Emergency Management Agency Act)
87. MD Const., Art. 11-E. Sec. 3; MD Const., Art. 11-F, Sec. 3.
88. Charter of Baltimore City article. II. .
89. Charter of Baltimore City article. II. Sec. 11.
90. MD Const., Art. 11-E. Sec. 1.
91. Charter of Baltimore City art. VII. Sec. 56.
92. Baltimore City Code, Health Article 2-105.
93. Baltimore City Code, Health Article 2-106.
94. Baltimore City Code, Health Article 3-302.
95. Md. Code Ann., Pub. Safety. 14-111.
96. Md. Code Ann., Pub. Safety. 14-101(g).
97. Chemerinsky E, Forman J, Hopper A, Kamin S. Cooperative federalism and marijuana regulation. *UCLA Law Review*. 2015;62(1):2014-2025.
98. 21 USC. Sec. 881(a)(7).
99. Kerr T, Tyndall MW, Zhang R, Lai C, Montaner JS, Wood E. Circumstances of first injection among illicit drug users accessing a medically supervised safer injection facility. *Am J Public Health*. 2007;97(7):1228-1230.
100. McNeil R, Kerr T, Lampkin H, Small W. "We need somewhere to smoke crack": An ethnographic study of an unsanctioned safer smoking room in Vancouver, Canada. *The International journal on drug policy*. 2015;26(7):645-652.