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VIEWPOINT

Supervised Injection Facilities

Legal and Policy Reforms

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Supplemental content

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The US Centers for Disease Control and Prevention reported that more than 70 000 deaths from drug overdoses occurred in 2017, including prescription and illicit opioids, representing a 6-fold increase since 1999.¹ Innovative harm-reduction solutions are imperative. Supervised injection facilities (SIFs) create safe places for drug injection, including overdose prevention, counseling, and treatment referral services. Supervised injection facilities neither provide illicit drugs nor do their personnel inject users. Supervised injection facilities are effective in reducing drug-related mortality, morbidity, and needle-borne infections. Yet their lawfulness remains uncertain. The Department of Justice (DOJ) recently threatened criminal prosecution for SIF operators, medical personnel, and patrons.

Public Health Foundations

One year after President Trump declared the opioid crisis a public health emergency in October 2017, the administration allocated \$320 million for treatment and enforcement. However, no direct funds were

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devoted to harm reduction,² characterized by the Surgeon General as “public health-oriented and cost-effective.”³ The American Medical Association, among many health organizations, supports the creation of and funding for SIFs.⁴ Licensed personnel at SIFs supervise clients’ drug injections and administer naloxone or other lifesaving procedures when needed. These interventions are similar to services drug users receive from emergency medical personnel, but which often come too late after overdoses involving high-potency heroin and fentanyl.

After the first SIF opened in Bern, Switzerland, in 1986, sites in multiple countries followed. As of April 2018, 78 official SIFs operated in Europe (Denmark, France, Germany, Luxembourg, Norway, Spain, and the Netherlands), as well as in Australia and Canada. Ireland and Portugal recently authorized SIFs.

Clandestine SIFs have operated in the United States since 2014. Similar practices are undertaken in other settings; for example, a New York, New York, needle exchange program allows patrons to inject in its bath-

rooms, providing emergency services if necessary. Although no state or locality openly operates SIFs, several have proposed their creation (an eFigure map appears in the [Supplement](#)).

Public Health Benefits

Although the data are limited, SIFs provide public health benefits and are associated with substantial decreases in overdose fatalities among patrons and in surrounding communities. A SIF in Sydney, Australia, reported no deaths among 5925 overdoses from 965 000 supervised injections from 2001-2015.⁵ A SIF in Barcelona, Spain, reported a 50% reduction in overdose mortality in the vicinity from 1991 (1833 deaths) to 2008 (773 deaths).⁶ Declines in publicly discarded syringes have also been observed. Monthly averages of unsafely disposed syringes collected near the Barcelona SIF decreased from 13 000 in 2004 to 3000 in 2012. Importantly, SIFs do not increase overall drug or other related crime rates in surrounding areas. To the contrary, the US-based clandestine SIF is credited with averting an estimated 2300 public injections in proximity to its location from 2014-2016.⁷

The Insite SIF in Vancouver, British Columbia, Canada, is illustrative. No fatal overdoses were reported between March 2004 and February 2008. Among a select group of 621 drug users at the facility, 42% (261 persons) entered addiction treatment during the 2 years since its opening in 2003.

Researchers also attribute Insite with preventing 80 HIV infections annually. Within 3 months of opening, public injections in the surrounding 10 blocks decreased by nearly half (from 4.3 to 2.4 per day).⁶ Community overdose deaths decreased 35% (from 254 to 165 deaths per 100 000 persons) over 4 years starting in 2001. Neighborhood rates of drug trafficking, assault, and robbery did not increase after Insite opened. Whether these same beneficial results would occur in the United States needs to be tested.

Legal Controversy

Despite public health benefits, state and local efforts to authorize SIFs have generated a legal and political firestorm. Critics charge that the government should not subsidize or incentivize harmful and unlawful behaviors. Some states have preempted the opening of SIFs. In 2017, the municipalities of Kent and Snohomish in Washington State restricted zoning to prohibit them. The state’s supreme court is considering whether a SIF ban should be put to a public vote. Additional concerns in-

clude legal liability for health professionals overseeing or staffing SIFs and limitations on malpractice insurance coverage for engaging in unlawful activities.

In late August 2018, Deputy Attorney General Rod Rosenstein characterized SIFs as “taxpayer-sponsored havens to shoot up.” “Because federal law clearly prohibits injection sites,” he argued, “[jurisdictions] should expect [DOJ] to meet the opening of any [SIF] with swift and aggressive action.”⁸ Later, the DOJ labeled New York City’s planned SIF as incompatible with appropriate opioid response efforts.

The DOJ claim that SIFs violate federal drug laws resulted in state and local reluctance to open these facilities. The governor of California vetoed legislation authorizing SIFs in San Francisco. The governor of Pennsylvania said he could not support SIFs without a change in federal law. Undeterred, San Francisco, California; Philadelphia, Pennsylvania; Denver, Colorado; Seattle, Washington, and other localities continue to explore the formation of SIFs.

Misapplication of Federal Criminal Laws

Courts have yet to review the DOJ interpretation of the Controlled Substances Act (CSA), which prohibits any person from possessing illicit drugs or operating places that knowingly allow use of illicit drugs on the premises.

The CSA explicitly immunizes state, tribal, or local officers “lawfully engaged in the enforcement of any law or municipal ordinance relating to controlled substances.”⁹ Although this immunity applies mainly to conducting drug investigations or raids, it could offer a creative defense if states or localities authorize SIFs. The DOJ, moreover, could decline to enforce federal drug laws that are incompatible with state legalization of SIFs. Despite its threats, for example, the DOJ has not aggressively enforced federal laws in states that have legalized marijuana.

The CSA prohibition on premises allowing illicit drug use presents the most difficult legal challenge to SIFs. However, this provision is targeted historically against crack houses or other drug enclaves, not public health enterprises. Supervised injection facilities are not drug havens, but rather places to help safeguard the health

of the public. In April 2017, a Massachusetts task force characterized SIFs as medical treatment for at-risk patrons.

The Criminalization of Public Health

The criminalization of public health initiatives has a long, sordid history, including resistance to needle exchanges and expedited partner therapies. In each case, legislators and judges have come to view criminal strategies as unjustified. Armed with evidence of effectiveness, health officials have persuaded policy makers to value harm reduction. Greater respect for states’ public health powers could considerably narrow the DOJ’s ability to prosecute SIF patrons and staff.

Use of SIFs for Research

If the DOJ persists in threatening prosecution of SIFs, states could seek a research exemption under CSA §823(f), which permits government-funded public health studies. Registered health professionals may allow research participants to use heroin or other schedule I drugs in the public’s interest. Establishing SIFs for express research purposes would help to build an evidence base that could influence policy makers over the long-term.

Public Health Prevention and Response

Punitive drug laws have failed to curtail the opioid epidemic. Whether SIFs will succeed in the United States is undetermined, but harm-reduction strategies abroad have prevented overdose deaths and promoted drug dependency treatment for decades. Wise implementation of drug laws can be compatible with harm reduction. In community settings, police could enforce the CSA, bringing offenders before drug courts. These specialized courts screen and assess health risks and needs using graduated sanctions and incentives to usher offenders into treatment and rehabilitation. However, criminal law has no value in public health initiatives like SIFs designed to prevent harms and counsel clients. The opioid crisis remains a national public health emergency that demands therapeutic strategies guided by scientific evidence, and not inappropriate applications of punitive criminal laws.

ARTICLE INFORMATION

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