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Safe Injection Facilities in the Tenderloin:

Starting with Operational Plans

by

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A Capstone Project submitted in partial fulfillment of the requirement
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Abstract

There are over 90 safe injection facilities (SIFs) in at least 11 countries around the world, except in the United States. SIFs are spaces where people who inject drugs (PWID) can bring their pre-obtained drugs in a hygienic space and use them under supervision. The goal of these sites is to reduce the harmful effects of injection drug use and refer PWID to other medical, social, and treatment services. The Safer Inside Coalition, a community-driven health initiative, in the Tenderloin district of San Francisco recommended opening a SIF in the Tenderloin to improve the health of the community and individual drug users. The purpose of this project was to develop an operational plan for a SIF. Based on a literature review and coalition meetings, two operational plan models were developed – a centralized model and an integrated model. These were compiled in a report for community organizations to review to assess feasibility of implementing these services in the Tenderloin district. Further development needs to be done to work out more specific details based on the model that is chosen and the needs of the community.

Keywords: harm reduction, injection drug use, Tenderloin, San Francisco, drug treatment, recovery

Executive Summary

There are approximately 7,000 people who inject drugs in the Tenderloin district of San Francisco. Many of these people are homeless and are injecting in public places and disposing their syringes in the street, endangering their lives and the community. The Safer Inside coalition is a community-driven health initiative that includes members of different organizations in the Tenderloin working towards improving the health and safety of the Tenderloin and drug users within the community. One of the priority recommendations for the group was to establish operational plans for a safe injection facility in the Tenderloin.

Safe injection facilities are legal spaces where people can bring pre-obtained drugs and use them under supervision in a hygienic environment. The goals of these facilities are to reduce morbidity and mortality, public drug use, discarded needles and HIV and Hepatitis C risks. They also serve as a linkage to drug treatment, health services, and social services. While there are no current safe injection services in the United States, this approach is being used in at least 10 other countries with over 90 sites worldwide. The two main models are centralized and de-centralized. A de-centralized model or integrated model is where safe injection services are added to an existing harm reduction program. A centralized or specialized site is one that is independent from other programs and whose purpose is just to provide supervised injection and education with referrals to other services.

Based on the research from other models around the world and conversations with members of the Safer Inside coalition, two operational plans were developed – a specialized model and integrated model. These were presented in a report for executive directors of community organizations to view and discuss to determine which model would be the best fit for the community.

The report contains:

- Background information about Safer Inside
- Major assumptions that the plans were based on, including information from a law currently being debated in the California legislature on this topic
- An overview of service for both models
- A side-by-side outline of components for the two models
- Justifications for the different program features, explaining what the recommendations were based on
- Evaluation measures from an operational standpoint
- Other considerations that need to be discussed
- A preliminary budget for a specialized site was also added but the costs for some components still need to be added by organizations with more accurate numbers. The budget serves as a template for the coalition members and executive directors to start thinking about the different components that will be needed and can be adjusted based on the model that is chosen.

This document is a preliminary document that can still be added to based on input from other stakeholders and other experts. These operational plans are designed to be used as a two-year demonstration project and the impacts of the site are to be evaluated. There are advantages to each model and ultimately the goal is to clean up the streets of the Tenderloin and promote the health of people who inject drugs.

There are an estimated 22,500 people who inject drugs (PWID) in San Francisco (Chen, McFarland, & Raymond, 2016). The majority of them are homeless (68.6%) and almost half of them use heroin (San Francisco Department of Public Health [SFDPH], 2017). Furthermore, in San Francisco, PWID account for 21% of people with HIV and approximately 70% of active Hepatitis C infections (SFDPH, 2017). Death due to heroin, fentanyl, and methamphetamine in San Francisco has also been increasing in recent years. The city's Tenderloin district has the largest percentage of unintentional opioid or stimulant deaths (33%) and the largest percentage of PWID (31%) (SFDPH, 2017).

San Francisco has used a variety of harm reduction methods to treat the substance abuse disorders in the city such as providing syringe exchange programs and making it easier to obtain sterile syringes from pharmacies. The city also increased the availability of publicly-funded substance use treatment and medication-assisted treatment for opioid addiction. San Francisco was the first city in the United States to use public funds to increase the availability of naloxone to reduce the number of opioid overdoses (SFDPH, 2017).

Despite these efforts, there is still a problem with public injecting, especially in the Tenderloin. Safe injection facilities (SIF) provide a safe space where PWID can inject drugs using clean supplies under supervision and which connects them to other social and health services. *Safer Inside: A community-driven initiative for a healthier Tenderloin* is a coalition comprised of members of different organizations in the Tenderloin working towards improving the health and safety of the Tenderloin and drug users within the community. One of the priority recommendations of the coalition was to develop operational plans for a SIF in the Tenderloin.

Review of Literature

Harm Reduction Philosophy

Harm reduction is a social policy that started gaining attention in the 1980s relating to drug use. It was introduced as an alternative to abstinence-only treatment for substance abuse. The priority in harm reduction is to decrease the harmful consequences of drug use, whereas, the priority of abstentionism is to reduce the prevalence of drug use (Pates & Riley, 2012). The main principles of harm reduction are: pragmatism, humanistic values, focus on harms, and hierarchy of goals. Pragmatism involves accepting that some use of drugs is normal or inevitable in society. Humanistic values focuses on respecting the dignity and rights of drug users without judgment on their use. Focus on harms is recognizing that the potential harm from use is more important than the extent of drug use. Finally, hierarchy of goals is where harm reduction programs focus on the most urgent needs (Pates & Riley, 2012).

There are many different types of programs that fit into the category of harm reduction. These include needle/syringe exchange programs, opiate substitution therapies, and supervised injection facilities. There is strong evidence that opiate substitution therapies are effective in decreasing adverse effects of injecting drugs (Korsmeyer & Kranzler, 2009; MacArthur et al., 2014). Another popular harm reduction method is syringe or needle exchange programs. These have been shown to reduce the incidence of HIV while also helping drug users connect with other services (Korsmeyer & Kranzler, 2009). Safe injection facilities are another form of harm reduction because they can be used to treat overdoses early and save lives.

History of Safe Injection Services

Safe injection facilities (SIF) or drug-consumption rooms (DCR) are defined as legally sanctioned facilities that allow for the hygienic consumption of pre-obtained drugs under

supervision (Kimber, Dolan, Van Beek, Hedrich, & Zurhold, 2003). The primary goals of these services are to reduce public drug use, morbidity and mortality, inappropriately discarded needles, HIV and Hepatitis C (HCV) risks, and to serve as a gateway to drug treatment, health services, and social services (Kimber et al., 2003). These spaces evolved from health and public issues related to large urban drug scenes that were not being addressed by existing programs. The establishment of a SIF was usually the result of a local effort to change policies to allow these services to be introduced (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2016)

The first DCR was opened in Berne, Switzerland in 1986. Since then SIFs and DCRs have been established in Germany, Netherlands, Spain, Norway, Luxembourg, Denmark, Greece, France, and Switzerland with a total of 90 DCRs in Europe. Other European nations that are considering opening SIFs are Slovenia, Scotland, Ireland, and Belgium (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2017). There is one medically supervised injection site in Sydney, Australia and no official sites in Asia or South America (EMCDDA, 2017).

In 2003, Canada opened Insite in Vancouver, the first legally approved SIF in North America. It was allowed to operate as a research pilot program as an exception under the Canadian Controlled Drugs and Substances Act (Hedrich, 2004). In 2006, the Canadian federal government threatened to revoke the exemption which led to supporters taking the case to the Supreme Court. In September 2011, the Canadian Supreme Court made a unanimous ruling in favor of Insite staying open (Hyshka, Bubela, & Wild, 2013). Dr. Peter Centre in Vancouver is a clinic for people living with HIV/AIDs that also provides supervised injection services for members. It was approved for the same exemption as Insite (Lupnick, 2016). As of June 2017,

there were two more sites that opened in Surrey, B.C. These sites are the first that have been approved for allowing substances taken orally and nasally, in addition to injecting (Bains, 2017). Three sites in Montreal have also opened in June 2017, including the first mobile unit in North America (Laframboise, 2017). One more site has been approved for Montreal and three sites are set to be opened in Toronto (Lejtenyi & Gillies, 2017). There are no sites in the United States to this date but there are many cities in the country that are working towards opening a SIF (Project Inform, 2016).

Supervised Consumption Models

There are many different types of models for supervised consumption sites. The two basic models are integrated and specialized. The integrated model is where a consumption area is added to or integrated into an existing facility that provides services to drug users and the homeless population (Hedrich, 2004). The consumption area is a separate area where clients can safely use their drugs under supervision and is just one of many other services that are provided by the facility. There is typically a separate registration or check-in area for staff to control admission to the consumption area. The integrated model is the most common but there is substantial variation in how the centers operate and in the services they provide as these are dependent on the limitations of the facility where the SIF is co-located (Hedrich, 2004).

Specialized facilities are stand-alone sites that are exclusively for people who use drugs. These are usually set up in places where open drug scenes are major factors in a city. Many of these facilities offer other services above supervision of drug consumption, such as needle exchange and drug-related medical care. They also serve as a connection to other services that their clients may need such as drug treatment programs, healthcare, and shelters for the homeless (Hedrich, 2004).

Other models for SIFs include mobile units and informal sites. Mobile units are usually large buses or vans that contain several injecting stations and have a staff member to supervise injection. These usually drive around the city to hit high drug volume areas. Informal sites are generally run by former and current drug users and are tolerated by law enforcement (Hedrich, 2004).

Basic services that are offered in specialized and integrated models are needle exchange programs, basic medical care (i.e. to treat overdoses), education on safe using practices, and referral. Staffing varies considerably depending on the site; however, all have staff available for registration and supervision of consumption. In Europe, 60-70% of facilities offer access to a nurse or physician (EMCDDA, 2017).

Impacts of Safe Injection Services

In 2014, a systematic review was written on the evidence of the positive and negative consequences of safe injection services (Potier, Laprévote, Dubois-Arber, Cottencin, & Rolland, 2014). There were seventy-five relevant articles included and the authors found that SIFs were effective in promoting safe injection practices, attracting marginalized injection drug users, reducing frequency of overdoses, and enhancing access to health care. There were no cases of overdose deaths within any of the facilities in which this was evaluated. In Vancouver, there was a 35% decrease in the number of lethal overdoses around the facility (Potier et al., 2014). Furthermore, SIFs were associated with reduced numbers of dropped syringes and public drug injections. They did not find any increase in drug use, drug trafficking, or crime in areas surrounding SIFs (Potier et al., 2014).

While the studies indicated that there was not an increase in local people who use drugs around a SIF, there was not a decrease either (Potier et al., 2014). One of the limitations of the

studies included in this review is that most of the samples for these are convenience samples so it is difficult to determine how representative the results are for all people who use drugs.

Furthermore, many of the places that are studied have eligibility requirements which means that there would be a subset of people who would not be able to utilize these services (Potier et al., 2014).

Barriers and Facilitators for Safe Injection Services in San Francisco

United States. There are no legally sanctioned SIFs operating in the United States to this date. While there are no laws that allow or forbid SIFs, there is some controversy about how drug laws are interpreted creating some difficulty in establishing these services in the U.S. There are laws in 19 states that authorize syringe exchange programs and/or pharmacy syringe sales and these laws could be extended to include allowing injecting as well. However, there are issues involving the consumption and possession of illegal drugs on the premises (Beletsky, Davis, Anderson, & Burris, 2008).

These issues are further complicated by how police want to enforce certain laws and the political climate. If police are not supportive and involved, there would be a risk that clients might be arrested for drug possession when they are entering a facility. There would also be risks for the staff members that work there, especially if they are licensed professionals. The situation can get complicated if a state or local government authorizes a SIF but the federal law enforcement agencies view it as a challenge to the existing national drug laws (Beletsky et al., 2008). Furthermore, depending on the political party that has control of local, state, and federal government, enforcement and acceptability may change dramatically.

There is also a lot of stigma associated with drug use and opponents of SIFs fear that it will increase drug use, condone drug use, or have a negative impact on public order (Semaan et

al., 2011). There are some people who have issues with interventions for injection drug users due to their negative attitudes towards this population. Access to funding may also be limited based on constrained budgets and how important an issue it is for the U.S. health care system (Semaan et al., 2011).

San Francisco. There are many factors that might affect the success of a SIF in San Francisco. There has been some research into the feasibility and acceptability of establishing safe injection services in San Francisco. Recently, researchers estimated the economic costs and benefits of establishing a SIF in San Francisco, considering potential savings from averted HIV and HCV infections, reduced skin and soft tissue infection, averted overdose deaths, and increased medication-assisted treatment uptake. It was found that a \$2.33 savings would be generated from each dollar spent on a SIF and would generate an annual net savings of \$3.5 million for a SIF with 13 booths (Irwin, Jozaghi, Bluthenthal, & Kral, 2016).

Furthermore, there have been studies (Kral et al., 2010) done among injection drug users (IDUs) in San Francisco regarding their willingness to use a SIF. It was found that 85% of IDUs reported they would use a SIF, especially among those who have injected publicly (Kral et al., 2010). However, in a qualitative study of community stakeholders in the Tenderloin where there is a lot of public injecting, many expressed concerns that a SIF might increase illicit activities and attract more IDUs to the neighborhood and increase the stigma associated with the Tenderloin (Wenger, Arreola, & Kral, 2011).

In April 2017, the San Francisco Board of Supervisors passed a resolution for the Department of Public Health to form a Task Force to develop recommendations on safe injection services in San Francisco. They will submit a recommendation in three months from the first meeting to the Mayor and the Board of Supervisors (“Safe injection services task force,” 2017).

There is also a bill, AB 186, in the California Assembly to legalize injection drug use under the supervision of health care professionals (Eggman, Wiener, & Friedman, 2017). As of July 2017, this bill had already passed the California State Assembly and was in the California Senate. AB 186 would allow specified counties or cities to authorize the operation of supervised injection services programs for *adults* that includes a hygienic space supervised by health care professionals where PWID can consume pre-obtained drugs, sterile consumption supplies, and access to referrals to substance use disorder treatment. This bill would exempt a person from existing criminal sanctions solely for actions or conduct on the site of a safer drug consumption services program authorized by the city or county (Eggman et al., 2017).

Safer Inside: A Community-Driven Initiative for a Healthier Tenderloin

Background

The Safer Inside coalition was founded in the spring of 2015. It started as a group of people working in the Tenderloin district who came together to discuss public safety. They were particularly concerned with the number of used needles on the street and how often public injecting was visible. The solution that the group came to was supervised injection services and so they became the “needle group”. This multi-sector community-driven collaboration is comprised of leaders representing business, education, philanthropy, public health, law enforcement, and social service non-profit organizations with the goal of improving the health of the Tenderloin community and individual drug user health.

Coalition characteristics

The Safer Inside Coalition now consists of members from Dataway, DeMarillac Academy, Drug Policy Alliance, Episcopal Community Services, Glide, Gubbio Project, Hospitality House, St. Anthony Foundation, San Francisco AIDS Foundation, Urban Survivors

Union, Saint Francis Foundation, San Francisco DA's Office, SF Department of Public Health, Mayor's Office of Economic and Workforce Development, SF Tenderloin Police Department, and people who use injection drugs. Most of the group members are volunteers who participate in addition to their current jobs. The Tenderloin Health Improvement Partnership (TLHIP) with the support of Saint Francis Foundation hired an outside consultant to be the group organizer and provides incentives for people who use drugs to participate in the monthly meetings.

Objectives and Action Steps

The mission of the Safer Inside collaboration is to improve the health and safety for all persons who live, work or congregate in the Tenderloin, and to promote a humane response to persons who inject drugs (PWID) through a Four Pillars Approach to individual and community harm reduction. The Four Pillars framework is widely used in substance use harm reduction programs and focuses on prevention, harm reduction, treatment, and law enforcement. The Safer Inside group added "recovery" and "monitoring and evaluation" to the framework. Community members from each pillar were involved in the group. The objectives of the Safer Inside collaboration are to:

1. Reduce the detrimental effects of substance use and addiction among persons who use injection drugs
2. Reduce community exposure to improperly discarded needles and syringes
3. Reduce public injecting drug behavior
4. Increase the availability of syringe disposal options
5. Increase opportunities for safer injection
6. Help PWID to access services – medical, detox, and treatment

Seven priority recommendations were identified which were:

- Provide peer outreach to people who inject drugs in the Tenderloin
- Develop a public information campaign
- Develop an operational plan to establish a supervised injection site
- Develop an operational plan to establish a clinical detoxification facility,
- Develop an operational plan to establish a drug user resource center
- Enforce local practices for drug-related offenses
- Support a research plan of a two to three-year demonstration project.

Problem Analysis

It was decided, based on research from other harm reduction programs, that the best way to achieve the objectives of the Safer Inside coalition was to open a SIF in the Tenderloin district of San Francisco. Before organizations in the Tenderloin would feel comfortable with this, they needed to see operational plans on how it would work and how much it would cost. Furthermore, the coalition needed to decide whether an integrated or specialized model would be more appropriate or feasible in the Tenderloin.

The goal of this capstone project was to develop two potential operational plans for specialized and integrated safe injection services for the Tenderloin district in San Francisco. These would be presented to executive directors of harm reduction programs in the Tenderloin to determine which model they would be able to support and what additional resources they may require to implement a SIF in the community.

Methods

Since official safe injection sites have never been operated in the United States, a thorough literature review was done to search for information on how safe injection sites have been operated in other countries. The review included peer-reviewed journal articles, websites,

and news articles. Information regarding operations was compiled to create a better understanding about the mechanics of operations with a focus on staffing, space allocation, restrictions, eligibility requirements, and services offered.

Data were also collected from members of the Safer Inside coalition to assess what San Francisco-specific features they wanted to include. This information was gathered based on comments made during coalition meetings and during additional informal interviews and discussions with key members of the coalition. Most of the information gathered at this stage was general but notes were made from each conversation and were later analyzed to determine whether particular desired features emerged that differed from those in use in other sites.

After collecting this information, an outline was made addressing different aspects of how two different models of safe injection sites might be run. The draft outline was presented to the coalition for their specific feedback. This was to obtain more detailed information from them, as well as give them a clearer vision of how safe injection facilities might look in San Francisco. The outline was distributed via google doc to members of the coalition and asking for their specific notes and recommendations about the different components. This approach resulted in feedback from only one member. Several weeks later, a conference call was set up between members of the coalition from harm reduction organizations that are potential hosts of a SIF. During this conference call, the points from the outline were discussed to agree on assumptions for the basis of safe injection services in the Tenderloin. This meeting was recorded and notes were taken to extract more questions and themes.

Feedback from the stakeholders was synthesized with information from the literature review and then analyzed to put together a more detailed outline and a set of major assumptions for two different models (Figure 1).

Figure 1: Operational Plan Assumptions Outline Used in Coalition Meetings

Major Assumptions for Centralized Location

- Open 365 days/year
- Start at 16 hrs/day
- 15 booths (maximum)
- Physical space
 - Reception/waiting room
 - Injecting area with area for resuscitation and sinks for washing hands
 - Chill out room
 - Bathrooms
 - Locked closet/storage for supplies
 - Private spaces for counseling/private medical services etc
- Staffing
 - Licensed clinical personnel (2 present at all times) – according to Insite staffing
 - Peer health educators (7 present at all times) – according to Insite staffing
 - Medical/program director (only available 8 hrs/day)
 - Security officer (at all times)
 - Social worker (only available 8 hrs/day)
- Services offered
 - Provide safe injecting supplies
 - Primary health care
 - Safer injecting education
 - Overdose prevention education
 - Counseling
 - Refreshments in chill out area
 - Clothes
- ❖ Major Assumption for De-Centralized Location
 - Open during days/hours of site
 - 2 booths
 - Physical space
 - Use existing reception/check-in
 - Have injection booths in location where there is room for privacy but can be supervised by clinical personnel
 - Another space where client can hang out after injecting
 - Staffing
 - At least 1 licensed personnel
 - Peer health educators
 - Other staff support from existing organization
 - Additional service provided (on top of already existing services)
 - Provide safe injecting supplies
 - Primary health care (wound care, HIV and STI testing)
 - Safer injecting education

The outline was formed by utilizing the Supervised Injection Services Toolkit from Toronto for program components that needed to be considered (Toronto Drug Strategy Implementation Panel, 2013). Remaining, unanswered questions were noted (Appendix A). These drafts were presented at a monthly coalition meeting to elicit more feedback. Detailed notes were taken to extract more themes. Another meeting was scheduled with more key stakeholders, such as users and representatives from organizations to discuss and answer the remaining questions. Operations-related themes were taken from the Yes to SCS city-wide coalition meetings and the San Francisco Department of Public Health and Board of Supervisors Safe Injection Task Force meetings.

The data for the budget was collected by contacting suppliers for needle exchange programs in San Francisco to estimate the costs of supplies. Data from government websites were used to collect information on average wages for staff. This information was collected and inputted into Excel based on the assumptions that were agreed upon in the operational plan.

Findings

Based on the literature review and the discussions with the Safer Inside coalition members, the plan was based on a number of underlying assumptions:

- Safe injection services are necessary for the health and safety of the community and drug users
- The target population are PWID who are homeless and/or primarily use drugs in public areas in the Tenderloin
- A SIF would be beneficial in the Tenderloin
- A SIF would be able to get funding and support

- Success of the SIF would rely on utilizing good neighbor strategies by working with local law enforcement, businesses, and community members
- The SIF would start as a 2-year demonstration project that would lead to more SIFs by year 3
- Evaluations will be done to assess success by collecting data on who is using the service, how many referrals are being made, and health and neighborhood impacts (See Appendix B for more details)

Overview for centralized model

The centralized model is an example of a site that is an independent program (potentially supported by existing organizations) in the Tenderloin and would offer a safe, clean space for PWID to use under supervision.

Service model for clients:

1. Clients arrive at the reception area and check-in. On the first visit, demographic, risk behavior, injecting practices, and other healthcare and living situation measures (see Appendix B for types of questions) would be obtained for monitoring and evaluation purposes and the client would be given a unique identifier that they would use for entry at each future visit. Clients would also be asked about types of drugs being brought in at each visit and assessed for special needs/accommodations
2. Clients would wait in reception until an injection booth is available and then they would proceed to the injecting area.
3. At the injection area, clients would wash their hands and be given clean supplies and proceed to an injection booth where they would be given approximately 30 minutes to

inject (may take longer if necessary). Clients would be supervised by the staff and have the option of receiving education about safe injecting if needed.

4. After successful injection, they would proceed to the user lounge where they can relax, be monitored by staff to ensure safety (e.g. prevent overdose) and talk to their peers and staff. Here, other referrals can be made if the client is interested.
5. Clients can spend approximately an hour in the lounge and this can vary based on need and space requirements.

Overview for de-centralized model

The de-centralized (or integrated) model is an example of what would be added to an existing harm reduction program in the Tenderloin to provide a safe, clean space for PWID to use under supervision.

In this setting, the service will look different depending on the program that it is integrated with; however, this is the basic model of how it will work for clients in this type of setting:

1. Clients would check-in at a private area where demographic, risk behavior, injecting practices, and other healthcare and living situation measures (see Appendix B for types of questions) for monitoring and evaluation purposes would be collected and a unique identifier would be assigned. Clients would be asked about types of drugs being brought in each visit.
2. While clients are waiting to use the injection booths, they could use the waiting rooms or space that already exists in the facility.

3. Clients would then go into the injecting area, wash their hands, and collect clean injecting supplies and inject their drugs at a booth under supervision. Other safe injecting education will be provided if needed.
4. After successful injection, clients can spend time in the existing space of the facility for continued monitoring and clients can access the other services that the existing organization offers.

Justifications for Program Features

The two operational plan outlines were divided into sections outlining the features that each model would include (see Appendix C for more details of what is included).

Services offered. The proposed services are based on the literature of what other SIFs offer (EMCDDA, 2017; Hunt, 2006; Schaffer, Stover, & Weichert, 2014; Schatz & Nougier, 2012) and based on conversations with the members of Safer Inside as to the key services they wanted to offer to the community. The services are also within the minimum requirements for safe consumption services outlined in AB 186 (Eggman et al., 2017). Within the integrated model, more services may be offered depending on what the facility already has to offer. Furthermore, if the SIF were to be integrated into a syringe-exchange program, the clean injecting equipment will already be available.

Hours of operation. The hours suggested in the centralized site are a starting point; hours can be expanded or decreased as the budget allows. However, the starting point of two 8-hour shifts allows for increased availability of the service, as evidence suggests that users would prefer a space to be open 24 hours a day, according to the San Francisco Board of Supervisors Task Force Meeting on July 21, 2017. Furthermore, the hours of 6am-2pm and 4pm-midnight were suggested by members of the coalition to provide services for those who need to use early

in the day and later in the evening. This also will help to bring public injecting indoors during morning and evening commute times. The hours for the de-centralized model can also be adjusted as needed based on the characteristics of the specific site.

Physical design. The design for the centralized model is based on Insite in Vancouver and the medically supervised injection site in Sydney (the two models with the most research). The addition of curtains around a larger booth was suggested by members of the coalition to provide additional privacy for those who need to inject into more sensitive areas of the body and can be used for private medical care. The need for mirrors and sinks in the injecting areas are for better ability to monitor clients and promote clean practices. The user lounge is based on Insite as a comfortable area for clients to hang out after injection under supervision if needed. This would also be an area where they can talk to staff about referral to other services.

For the de-centralized model, the recommendation is to have a private area for check-in is to keep this service separate from the other services that are offered at the facility and for evaluation purposes. It is also to protect the privacy of the clients who are there to use this service. The model for this could vary depending on the space restrictions of the existing program. The proposal of the use of the existing waiting room for monitoring of clients after using is to continue to make sure that clients are safe before sending them back out on to the streets.

Staffing. The staffing was decided by coalition members based on presumed need. The reason that a licensed clinical staff is to be available at all times in both models is for demonstration purposes. It is the model that is used at many of the researched sites (EMCDDA, 2017; Schaffer et al., 2014) and is required by AB 186 (Eggman et al., 2017). This is by no means the only model, and sites can be opened that do not have licensed clinical staff but this is

the proposition to increase safety and for compliance under AB 186. Peer health educators are used at Insite, and are supported by the coalition as they can assist in talking to clients and getting them comfortable and providing education and supervision. Peer health educators could also assist in cleaning up after each injection. In de-centralized sites, potentially two or more peer educators may need to be in place to have at least two people able to respond to a medical emergency and still have staff that can continue to monitor the other clients. If the existing program already has staff that can help monitor, it may not be necessary to add more staff. Safety monitors are essential for security of the site and help to de-escalate situations and AB 186 mentions having adequate security in place.

Supplies. Recommendation on supplies were based on input from syringe exchange programs and members of the coalition and on supplies that are listed at other sites.

Service rules. Service rules were based originally on rules that are in place in other existing sites in other countries. However, due to some research on the consequences of having too many restrictions to access (Schaffer et al., 2014), the suggested rules were agreed upon by members of the coalition to make the site low-barrier. While there is a rule for clients to be over 18 per AB 186, IDs will not be checked. The rules that were suggested reflect the goals of the coalition to serve the majority of PWID in the Tenderloin.

Budget. The budget (see Appendix D) was set up with all the categories that need to be included for a specialized site based on the operational plan outline. It includes salaries for staff for a site that is open 16 hours per day with up to 15 booths. The numbers can be adjusted as needed depending on the model that is chosen and actual cost of services or items. There are still many gaps where the costs are unknown but can be determined by the organizations that are considering the development of a SIF.

Discussion and Implications

The operational plans were developed based on the literature review and feedback from community members. The two operational models presented gave an overview of how the program would work in each setting and what features would need to be included. The report presented to the group contains a basic introduction to the Safer Inside Coalition, the major assumptions the plan was based on, information about AB 186, an overview of service for both models, the outline of included features for both models, the justification of features, operational evaluation components, and other considerations that still have not been decided on. A preliminary budget was also added; however, it is not complete and there are pieces that still need to be determined. The plans are still an ongoing discussion as there are many factors that need to be considered and many different opinions on the model and features.

Supporting and Opposing Forces

There are several factors that positively impact a specialized model. There is a lot of support within the harm reduction community for these services to be offered. It could be run by a memorandum of understanding with existing harm reduction programs so several programs could contribute to the site (either through funding, personnel, supplies, etc). A specialized model would also be easier to evaluate as it will focus just on the safe injection services and could serve a larger number of clients. However, some of the negative aspects of a specialized model are that it might not be able to provide many additional services and clients would then need to go to a different location for other services. It would also be more expensive due to rental costs of a building and starting a program from scratch.

The integrated model is the most popular model around the world (Hunt, 2006; Schaffer et al., 2014; EMCDDA, 2017). There are several harm reduction programs in the Tenderloin that

have already expressed interest in adding this service on to their program. It would allow PWID access to other services without having to go to a different location. It may be less expensive as many of the programs could use existing space, staff, and supplies. However, it may be difficult for other clients who are on opioid substitution therapy or going through detox to know that drugs are being used in the same facility and may lead to relapse. It would also put more responsibility and liability on the existing program and it would be harder to see an impact if there are a limited number of people who can be using the service.

The performance measures in Appendix B are an important part to ensuring that the SIF is successful and will continue to be supported. The evaluation plan is another piece of operations that needs to be expanded upon in further discussion. There will be data collected on every aspect of the program. For example, there would be a record of demographic, risk behavior, injecting practices, and other healthcare and living situation measures for clients; how often clients utilize the service; how many supplies are given out; what types of and how often safe injecting education is given; what types of and how often medical treatments are given; how many overdoses/reversals; and what types and how often are referrals to other services.

Limitations of Methods

There were several challenges that arose from the type of data collection utilized for this project. First, most of the data was collected from secondary sources because it could not be collected from primary sources due to the lack of SIS services in the United States. This made it difficult to find specific information on how SIS are run as the data were limited to whatever information was published. It also proved difficult to get responses from people in other countries that currently have these services.

Furthermore, it was difficult to plan for scenarios without specifics on where the SIS might be located (if it is a specialized model) or what organizations would house it (if it is an integrated model). For example, some organizations have connections with licensed healthcare professionals while others do not, so individual agency characteristics could limit the type of services that could be offered in a specific location. This information was important for an accurate outline for the operational plans. However, at the time of the study, this information was still not decided.

Other challenges arose from working with a large group of people who were all very busy and had separate full-time jobs. It was difficult to get all these key people to weigh in and provide information that would be useful to the development of the project. This was further complicated by the fact that this coalition was also focusing on outreach to support this idea so there was a split in focus. Due to these challenges, the best way to get feedback from the members was to provide a hard copy of the drafts in a meeting that they had agreed to attend.

Finally, if this project were repeated with more resources and time, it would be helpful to visit at least one of the already existing SIFs and get an existing operational plan that could serve as a model. It would also be helpful to conduct some primary data collection from stakeholders and users about components that are important to them in a SIF. However, this data has already been collected via a study conducted in 2010 and another recent survey in the fall of 2016 and beginning of 2017. Unfortunately, the results from the recent studies are restricted since the studies have not been published.

Other Limitations

Due to time constraints and the difficulty in getting feedback from different key players, this operations outline is just the beginning. The proposal will undoubtedly be revised and added

to many times before a service model is agreed upon and implemented. There are many more stakeholders that should have a say in some of the program design and services that were not able to give their input due to the limited time in which this project was conducted. There are also the Yes to SCS coalition and the Department of Public Health's task force working on this topic, so their input may have an impact on the final operational plan that gets approved.

Furthermore, while the intent of the Safer Inside coalition is to open a SIF in the Tenderloin regardless of the bill that is in the California Legislature, if AB 186 does not pass it will raise more questions and concerns that would need to be addressed to protect the clients and staff of the facility. The federal government also does not have any exemptions to laws that would allow for SIFs and so there is always the added threat of the federal government interfering with operations.

Recommendations for Next Steps

Moving forward, these plans should be built upon, adding more input from community members and PWID. There should also be people with legal expertise working with programs that are interested in being involved to address liability and licensing issues. Input and cooperation with the police is necessary to ensure that everyone agrees in terms of what is acceptable and what is not. The important part of a SIF, regardless of model, is for it to be a safe place for PWID, so policies need to be put in place to ensure safety. It would be helpful if people from other existing SIFs around the world could come to San Francisco and help to inform what works and what does not to make sure that the program that is designed will function well and reach the largest number of people. Continuing to educate the public and officials about the scientific benefits of SIFs is crucial to making it successful.

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Appendix A: Questions Requiring Input from Coalition Members

- How long will clients need to be in the facility?
- What hours do we want for the centralized location?
 - 8 am – midnight
 - 6 am- 2pm, 4pm – midnight
 - Other?
- What level of clinical personnel is needed?
 - Do we need them to provide prescriptions? (NP)
 - Assessments and treatment (Nurses)
- Scope of practice for peer health educators
 - They can be trained in naloxone administration and CPR and assist with resuscitations or just focus on education
- Scope of practice for social worker/counselors?
- What other medical services are we offering besides emergency procedures, resuscitation, wound care, and HIV/STI testing)
- What type of counseling are we going to offer?
 - Referral to services?
 - Therapy?
- **Service rules (other assumptions we need to agree on):**
 - Restrictions on types of drugs allowed to inject
 - *If so, which ones? What treatments do we need?*
 - Restrictions on drug dealing on site
 - Restrictions on sharing drugs
 - Restrictions on body sites where people can inject
 - Assisted injection
 - Time limits for injecting or using chill out room
 - Verbal or physical violence
 - Limit of number of injections per visit
 - Expulsion for breaking rules (i.e. what would the length of expulsion be)
 - Dispute resolution process
- Are we going to offer to test drugs?

Appendix B: Performance Measures

- How much?
 - o # SIFs
 - o - Service utilization patterns
 - o # of people
 - o Frequency of use
 - o Number of new and existing clients of the broader health service
 - o Services accessed on site
 - o Reasons for using service
 - o # tests for HIV and other blood borne illnesses
 - o # overdose events treated successfully
 - o Service referral patterns (# and type of referrals)
- How well?
 - o % who are referred to recovery services
 - o % who recover
 - o % of total TL IDUs who use services
 - o % repeat clients
 - o % satisfied with service
 - o % awareness of SIS in TL
- Is anyone better off?
 - o Degree of successful referral
 - o % understand importance of referral
 - o % motivated to attend referral
 - o % attended one visit
 - o % attended repeat visits
 - o % reporting help-seeking behavior
 - o % exhibiting basic health and hygiene
 - o % of peers responding effectively to overdose offsite
 - Health impacts:
 - o o Incidence of HIV, ep C, hep B infections
 - o o Incidence of abscesses and other skin/vein related problems
 - o #% fewer overdose deaths or overdoses
 - o #/% of successful recoveries

*Important to note that impacts will be seen/measured in a several block radius of the site as that is the expected area to have the greatest impact

Appendix C: Program Details Outline for Both Models

Outline for Centralized Model	Outline for De-centralized Model
Services offered:	Services offered (in addition to services already provided):
<ul style="list-style-type: none"> • Provide safe injecting supplies – such as syringes, alcohol, cookers, sterile water, tourniquets, etc. and safe smoking supplies 	<ul style="list-style-type: none"> • Provide safe injecting supplies – such as syringes, alcohol, cookers, sterile water, tourniquets, etc.
<ul style="list-style-type: none"> • Referral to primary health care – connecting clients to health care providers so that they are in the health care system and are not relying on expensive emergency department visits 	<ul style="list-style-type: none"> • Treat immediate health concerns directly related to injecting – this includes treating overdoses, wound care for injection related wounds, administration of oxygen and other medications related to adverse reactions of drug use, and calling paramedics if further emergency medical attention is required
<ul style="list-style-type: none"> • Treat immediate health concerns directly related to injecting – this includes treating overdoses, wound care for injection related wounds, administration of oxygen and other medications related to adverse reactions of drug use, and calling paramedics if further emergency medical attention is required 	
<ul style="list-style-type: none"> • Harm reduction education <ul style="list-style-type: none"> ○ Safer injecting education, such as vein care, sterile practices, nutrition, dosing, appropriate disposal of equipment, HIV and HCV prevention education, etc. ○ Overdose prevention education ○ Support for long-term users 	<ul style="list-style-type: none"> • Harm reduction education <ul style="list-style-type: none"> ○ Safer injecting education, such as vein care, sterile practices, nutrition, dosing, appropriate disposal of equipment, HIV and HCV prevention education, etc. ○ Overdose prevention education ○ Support for long-term users
<ul style="list-style-type: none"> • Harm reduction counseling <ul style="list-style-type: none"> ○ This would include linkages to treatment, detox, other counseling services, opioid replacement therapies 	
<ul style="list-style-type: none"> • Testing for fentanyl on request with fentanyl testing strips 	<ul style="list-style-type: none"> • Testing for fentanyl on request with fentanyl testing strips
Hours of operation:	Hours of operation:
<ul style="list-style-type: none"> • Open 365 days/year • Start at 16 hours/day (two 8-hour shifts) 	<ul style="list-style-type: none"> • Open during days/hours of the existing program

<ul style="list-style-type: none"> Proposed hours: 6am-2pm, 4pm - midnight 	<ul style="list-style-type: none"> May expand hours or offer this service at different hours depending on the site
Physical design:	Physical design:
<p>Reception/waiting room</p> <ul style="list-style-type: none"> space where clients can check-in and wait for booth to become available. This room would contain seating and water filtration system and cups so clients have access to water while they wait. 	<p>Private area for check-in</p> <ul style="list-style-type: none"> There could be different models depending on the agency to promote privacy (For example, could be a small desk off to the side, an administrator collecting information with a laptop or tablet)
<p>Injecting area</p> <ul style="list-style-type: none"> contain up to 15 booths or injecting stations, each booth would consist of a table (that is easily sanitized), chair, and mirrors. There would be a nurses' station for supplies, at least one sink for washing hands, and a disposal area for used equipment. Mirrors placed on either end of the room to make it easier for monitoring clients. There could be a booth at the end or corner of the room with curtains that come around for more privacy (if needed). 	<p>Injecting area</p> <ul style="list-style-type: none"> contains minimum of 2 booths or injecting stations, each booth would consist of a table (that is easily sanitized), chair, and mirrors. There would be at least one sink for washing hands and a disposal area for used equipment. There would also be a supervision area or table containing supplies and emergency equipment and crash cart. Must be enough space for supervision of injections
<p>User lounge</p> <ul style="list-style-type: none"> safe space with seating for clients to utilize after injecting to continue to be monitored and talk with staff and peers 	<p>Clients could use existing waiting room for waiting before and after injection</p>
Bathrooms	
Private space that can be used to store supplies and provide private medical services or counseling	
Staffing:	Staffing:
Staff:	Staff:
<p>Licensed clinical personnel (minimum RN, 1 per shift)</p> <ul style="list-style-type: none"> their role would be for treatment such as medical emergency, wound care, and referral to other medical services 	<p>Licensed clinical personnel (minimum RN)</p> <ul style="list-style-type: none"> one nurse for supervision and for treatment such as medical emergencies and wound care.
Peer health educators (minimum 4 per shift)	Peer health educators (minimum 1 per shift)

<ul style="list-style-type: none"> • there would be one in reception, at least 2 in injecting area for observation and can assist with administering naloxone and other safer injecting education, and one in user lounge for supervision and referral to services 	<ul style="list-style-type: none"> • for monitoring clients after injection and can also provide some harm reduction education
<p>Administrator (1 per shift)</p> <ul style="list-style-type: none"> • work in reception and check-in all clients and collect data 	<p>Administrator (1 per shift)</p> <ul style="list-style-type: none"> • work in reception and check-in all clients and collect data
<p>Program manager (can work 40 hrs/wk, but be available on-call)</p> <ul style="list-style-type: none"> • this would be the manager of the facility 	<p>Depending on existing program staff, may need additional staff because two people must be available at all times to respond to medical emergencies</p>
<p>Medical director (sub-contracted)</p> <ul style="list-style-type: none"> • available for managing more complex medical issues 	
<p>Safety monitor (at least 1 per shift)</p> <ul style="list-style-type: none"> • helps provide a safe environment for staff, clients, volunteers, and other occupants of the SIF by means of crisis intervention and conflict de-escalation 	
<p>Navigator (1 per shift)</p> <ul style="list-style-type: none"> • Navigators work with clients who are not in care to identify factors contributing to a lack of engagement, such as a loss of health benefits, substance use, mental illness and homelessness. Navigators work to address these barriers by providing referrals to social services, and assist with re-linking clients to care 	
<p>Program associate (40 hrs/wk)</p> <ul style="list-style-type: none"> • in charge of scheduling, logistics, payroll 	
<p>Maintenance/cleaning (sub-contracted or potential peer-contract)</p>	
<p>Key qualifications</p> <ul style="list-style-type: none"> • Non-judgmental • Experience working with PWID 	<p>Key qualifications</p> <ul style="list-style-type: none"> • Non-judgmental • Experience working with PWID

<ul style="list-style-type: none"> • Understanding of harm reduction principles • Understanding of overdoses, HIV/HCV infections, substance use treatment modalities, homelessness, stigma, etc 	<ul style="list-style-type: none"> • Understanding of harm reduction principles • Understanding of overdoses, HIV/HCV infections, substance use treatment modalities, homelessness, stigma, etc
<p>Training:</p> <ul style="list-style-type: none"> • CPR • Universal precautions – prevent/respond to needle-stick injuries • Wound care/assessment • Stimulant overdose training • Naloxone training – DOPE • Safe handling of biohazards such as injecting supplies • De-escalation training • Crisis training • Cross-culture training 	<p>Training:</p> <ul style="list-style-type: none"> • CPR • Universal precautions – prevent/respond to needle-stick injuries • Wound care assessment • Stimulant overdose training • Naloxone training - DOPE • Safe handling of biohazards such as injecting supplies • De-escalation training • Crisis training • Cross-culture training
Supplies:	Supplies:
Wound care supplies – gauze, bandages, saline, tape, lidocaine, long q-tips, antibiotic ointment, towels	Wound care supplies – gauze, bandages, saline, tape, lidocaine, long q-tips, antibiotic ointment, towels
Naloxone	Naloxone
Oxygen tanks, masks, tubing	Oxygen tanks, masks, tubing
Sharps container	Sharps container
Safe injecting supplies – syringes, tourniquets, alcohol swabs, sterile water/saline, cookers, pill filters, lighters	Safe injecting supplies – syringes, tourniquets, alcohol swabs, sterile water/saline, cookers, pill filters, lighters
Clean smoking supplies – rubber stem tips, alcohol swabs, copper chore boy, sugar-free gum	
Universal precautions – gloves, masks, eye wear, soap for handwashing, hand sanitizer, paper towels	Universal precautions – gloves, masks, eye wear, soap for handwashing, hand sanitizer, paper towels
Cleaning agents	Cleaning agents
Fentanyl testing strips	Fentanyl testing strips
Service Rules:	Service Rules:
At least 18 years of age	At least 18 years of age
Only injectable drugs	Only injectable drugs
All drugs must be procured prior to entering the site	All drugs must be procured prior to entering the site

No sharing of drugs brought into site	No sharing of drugs brought into site
Staff will not assist injection	Staff will not assist injection
Estimate 30 min per injection, estimated hour in lounge based on need and space requirements	Estimate 30 min per injection, estimated hour in lounge based on need and space requirements
Protocols will be in place for the safety and well-being of all people (such as those from existing behavioral protocols from harm reduction agencies)	Protocols will be in place for the safety and well-being of all people (such as those from existing behavioral protocols from harm reduction agencies)
No limit on times clients can use the site, however, they need to get back in line after use	No limit on times clients can use the site, however, they need to get back in line after use

Appendix D: Preliminary Budget

Budget for Centralized Site						
Assumptions:						
30 min per injection: 2 injections per hour per booth						
60 min in user lounge						
Check in:						
15 min for first time						
5 min for return visit						
This budget is based on centralized site, open 16 hours/day, up to 15 booths - potentially 480 injections per day						
Salaries	FT E	Hourly	Salary	Benefits at 35%	total per FTE	total
RN	2	\$60	\$124,800	\$43,680	\$168,480	\$336,960
Peer Health Eds	8	\$17.50	\$36,400	\$12,740	\$49,140	\$393,120
Administrator	2	\$20	\$41,600	\$14,560	\$56,160	\$112,320
Program Manager	1	\$35	\$72,800	\$25,480	\$98,280	\$98,280
Safety Monitor	4	\$18	\$37,440	\$13,104	\$50,544	\$202,176
Navigator	2	\$24	\$49,920	\$17,472	\$67,392	\$134,784
Program Associate	1	\$22	\$45,760	\$16,016	\$61,776	\$61,776
Relief Staff	2	\$22	\$45,760	\$16,016	\$61,776	\$123,552
					Total:	\$1,462,968
Staff Development						
Total cost for all staff - to be done at start of program, may need to be repeated on annual, bi-annual basis depending on staff turn-around						
CPR plus First Aid		\$2,200				
Universal precautions		\$1,100				
Naloxone training		0				
De-escalation training		\$770				
Crisis training		\$500				
Cross-culture training		\$500				
Harm Reduction training		0				
Program Expenses/Start up						

Equipment and Supplies	Quantity	Total Cost for quantity listed			
Sterile tables	15	\$2,000			
Mirrors	15	\$400			
Chairs	60	\$3,000			
Reception desk	1	\$1,500			
Staff counter with storage	1	\$3,000			
Observation mirrors	2	\$200			
Dividers	15				
Curtains	2				
Slnk	1				
Water dispenser	3	\$300			
Lighting					
Metro shelving					
Crash cart for nursing station	1	\$500	for empty cart, not including supplies		
Staff desks	3				
Folding tables	3	\$250			
Walkie talkie/radios	4	\$800			
Lockers for staff	12	\$1,000			
Office Supplies					
Computers (1 for each room, for data collection, and 1 for program manager and 1 for program associate)	5	\$5,000			
Phones	5				
Internet connection	12	\$400			
Printer	2				
Office Expenses					
Paper					
Pens					
Printer cartridges					
Clipboards					
General					
Paper cups					
Custodial Supplies					
Mops					
Brooms					
Cleaning agents					
Biohazard kits					
Blood-cleanup kits					
Sanitizing wipes					

Soap						
Paper towels						
Operating supplies						
Medical:						
Wound care supplies						
Naloxone	\$0 via DOPE project					
Oxygen/oxygen tubing/masks						
Universal precautions						
Fentanyl testing strips						
Injectng supplies:						
Syringes	\$132/case of 500					
Cotton	\$17/case of 600					
Tourniquets	\$130/case of 800					
Alcohol swabs	\$33/case of 4,000					
Sterile water/saline	\$125/case of 1,000					
Cookers						
Pill filters	\$230/case of 1,000					
Lighters	\$16/case of 100					
Sharps containers	\$176/case of 100					
Program Expenses						
Software and supplies	tec k so up					
Recruitment						
Utilities						
Internet/Phone						
Rent						
Insurance						
Graphic design						
Branding						
T-shirts/scrubs						
Promotional materials						
Information and referral materials						
Professional Services (All these are sub-contracted, not regular staff):						
MD - not full-time staff, just available for complex medical issues and/or prescriptions						

Maintenance						
Biohazard pickup						
Custodial						
Legal						
Security (if contracted out)	\$2 5/h r					