ALTERNATIVES
TO PUBLIC INJECTING

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ALTERNATIVES

TO PUBLIC INJECTING

The current prescription opioid and heroin overdose epidemic has brought greater attention to injection drug use in public spaces. A recent New York Times article noted incidents of public injecting reported by local media in several states, stating:

"With heroin cheap and widely available on city streets throughout the country, users are making their buys and shooting up as soon as they can, often in public places. Police officers are routinely finding drug users — unconscious or dead — in cars, in the bathrooms of fast-food restaurants, on mass transit and in parks, hospitals and libraries."[1]

Public injecting poses a significant policy challenge for public health and safety. Injecting in public spaces has been associated with greater risk of overdose and HIV transmission. Many people who use drugs are unable to use them in safe and private environments but instead must turn to venues such as public bathrooms, empty warehouses, and parks. The reasons are complex. Drug use is both illegal and stigmatized; some people who use drugs are homeless, unstably housed or risk loss of housing if found using drugs. This lack of privacy and dignity, particularly when drugs are injected, compromises the health, wellbeing and safety of the people injecting the drugs and of the surrounding community.

Reducing public injection of drugs requires a multipronged approach ranging from accessible drug treatment to affordable supportive housing. This consultation on Alternatives to Public Injection was focused on one solution that has been implemented in a number of countries: supervised injection facilities (SIFs), also known as drug consumption rooms. Supervised injection facilities have received increased attention and consideration in recent months. Legislation to support the establishment of SIFs has been introduced in Maryland and California. SIF proposals are actively under discussion in Seattle, WA and Ithaca, NY. Outside of the United States, new SIFs are expected to open in France, Ireland and Canada.

Currently, there are nearly 100 SIFs in operation outside the United States, but as yet no U.S. jurisdiction has established a supervised injection facility. In light of growing policy interest in this strategy, Harm Reduction Coalition collaborated with Open Society Foundation and amFAR, The Foundation for AIDS Research to convene a consultation on Alternatives to Public Injection on September 30, 2015. Representatives from the NYS Department of Health AIDS Institute and the New York City Department of Health and Mental Hygiene participated in the consultation, along with stakeholders representing harm reduction, drug user health advocates, law enforcement and social service providers. Harm Reduction Coalition invited experts from several countries to share their various SIF models, planning and policy development process, implementation challenges, and evaluation results.

This report is a summary of the proceedings of the consultation. The report provides insights on the potential role of supervised injection facilities in the United States, and considerations for advancing policy, planning and implementation of SIFs based on experiences in other countries.

harm reduction COALITION

PRESENTERS
& ATTENDEES

Larry Campbell, Vancouver, Canada
Liz Evans, Vancouver, Canada
Peter Frerichs, Frankfurt, Germany
Marianne Jauncey MD, Sydney, Australia
Thomas Kerr PhD, Vancouver, Canada
Alex Kral PhD, San Francisco, USA
Werner Schneider, Frankfurt, Germany
Tony Trimingham, Sydney, Australia

Bruce Agins MD, Mary Ellen Cala, Alma Candelas, Holly Catania, Charles (Chilly) Clay, Allan Clear, Sandra Comer PhD, Matt Curtis, Sarah Evans, Taeko Frost, Mark Hammer, Terrell Jones, Hillary Kunins MD, Kali Lindsey, Demetrius McCord, Johanne Morne, Julie Netherland, Daniel O'Connell, Nkechi Oguagha, Maxine Phillips, Amu Ptah-Riojas, Daniel Raymond, Joyce Rivera, Mark Spawn, Sharon Stancliff MD, James Tesoriero PhD, Valerie White, Emily Winklestein

BACKGROUND,

AIMS & OBJECTIVES

The Harm Reduction Coalition has partnered for more than two decades with the New York State Department of Health and community-based harm reduction programs to protect the health of people who use drugs, many of whom experience profound marginalization through homelessness and housing instability, unemployment, involvement with the criminal justice system, and histories of trauma. Stigma and marginalization result in a substantial proportion of people who use drugs having little access to medical care and health services outside of hospital emergency rooms and prisons or jails. Harm Reduction Coalition and other community harm reduction programs seek to bridge the healthcare gap and address inequalities in access to basic health care, and have been successful in providing services to many underserved people who cannot, or will not, access traditional health care and social services.

These efforts have been instrumental in dramatically reducing HIV incidence among people who inject drugs (PWID). In 1992, the percentage of newly diagnosed HIV/AIDS cases attributed to injecting drug use was 52% in New York. By 2012, the proportion of newly diagnosed HIV cases attributed to injection drug use dropped to 3%.[2] These programs engage underserved communities through outreach and engagement, access to sterile syringes and other injection equipment, providing education, counseling and case management, and offering basic health and social services in a supportive and non-judgmental way.

New York, along with the rest of the country, is experiencing a public health crisis characterized by a dramatic increase in opioid overdose deaths. Despite scaling up strategies to reduce overdose risk and prevent overdose fatalities, this mortality trend shows little sign of abating. People who have experienced overdoses in the past, people with poor health, and those use drugs alone are among those most at risk for fatal overdose. Further, non-fatal overdose is estimated to be between 20 and 30 times more common than fatal overdose,[3, 4] and is associated with significant morbidity as well.[5] People who inject drugs in public places are especially vulnerable to overdose and other injection-related complications including contracting HIV, hepatitis and other blood-borne infections and soft tissue injuries. Public injection is often a rushed practice in attempt to avoid detection and arrest.

Internationally, close to 100 medically supervised injecting facilities (SIFs), also known as drug consumption rooms (DCRs), have been established in at least eight countries - with more being planned - as one of a number of public health strategies to reduce harms related to drug use, particularly among people who use drugs in public places.[6]

SIFs are sanctioned and supervised spaces for the hygienic consumption of pre-obtained drugs in a non-judgmental environment and under the observation of trained staff. SIFs represent a public health intervention operating as part of a wider network of services for people who use drugs, woven into local networks of coordinated strategies to address the individual risks and community impact of drug use. These programs aim to reach underserved and marginalized populations, address health inequities, and resolve public health and safety tensions related to public injecting.[7]

> *These programs aim to reach underserved and marginalized populations, address health inequities, and resolve public health and safety tensions related to public injecting."*

THE CONSULTATION

The first session of the meeting was focused on providing an overview of different models of supervised injection facilities, including their origins, operations, and oversight. Several commonalities emerged in core services:

- Medical supervision of injections, including emergency response to drug overdoses;
- Injection-related first aid (such as wound and abscess care);
- Assessment and referral to primary health care, drug treatment and social services;
- Harm reduction education and counseling;
- Access to syringes and other injecting equipment.

All of the established programs confronted initial opposition, which sometimes recurred periodically after they began operating. The SIFs presented at the consultation have decades of combined experience; Frankfurt, Germany's program was established in 1992, while Insite in Vancouver, Canada launched in 2003. All of the presenters emphasized the importance of buy-in from stakeholders, including local community, media and law enforcement. The challenges and results of their innovations and perseverance were shared and are summarized below.

THE PRESENTATIONS

FRANKFURT, GERMANY: DRUG CONSUMPTION ROOMS

Werner Schneider, former Drug Policy Coordinator for the City of Frankfurt in Germany, spoke about the success of their "Four Pillars" framework, which he helped pioneer. This Four Pillars approach sought to address public drug use and associated harms and to establish safer drug use as a legally-sanctioned integrated part of local policy. The four pillars approach is a jointly applied city-wide drug strategy addressing Prevention, Treatment, Enforcement, and Harm Reduction.[8]

In Frankfurt and a few other German cities, there were drop-in centers or "health rooms" operating in a legal grey area. These laid the groundwork for drug consumption rooms (DCRs), which would be operated as health-promoting services in drug and AIDS services organizations. To move into legally-approved health programs, it was critically important to gain the support of local public officials, which allowed Frankfurt to successfully overcome the initially strong opposition from the national government.

The first DCR in Germany was implemented in 1992, and three more were opened over the next few years. Today, DCRs comprise a major cornerstone of a comprehensive strategy that includes consumption rooms, three methadone treatment programs, 126 shelter beds, a large-scale syringe access program, street outreach, and a laundry room. The DCRs operate from 6:00 am to 11:00 pm six days per week. Utilization is tracked through a computerized identification system with unique personal identification codes. Every visit to the DCR is registered, and participants are surveyed annually about their health and drug consumption.

Preliminary debate about the establishment of a DCR revolved around concerns that it would attract more people who use drugs to the area, encourage young people to use drugs, and increase the overall rates of drug use. These concerns each proved to be unfounded, but are common across communities considering safer injection facilities, mirroring objections to syringe exchange programs and other harm reduction services. An abundance of evidence has consistently demonstrated that these objections are not borne out in experience.

> *"To move into legally-approved health programs, it was critically important to gain the support of local public officials."*

“Drug consumption rooms have been effective in saving lives.”

In Frankfurt, cooperation from the police was essential to the success of the DCR, according to Peter Frerichs. Frerichs served as the Vice-President of the Frankfurt Police Department in charge of law enforcement and coordination with harm reduction drug policy in the city at the time of the establishment of the DCRs. An initial problem they faced was that there was no latitude in the penal code to allow the police to exercise discretion on drug possession charges. To resolve this contradiction between law enforcement and public health, the Frankfurt mayor ordered all of the stakeholders to meet every week to coordinate efforts and develop solutions. These regular roundtable discussions led to the high court issuing a legal opinion that the DCR was a medical intervention, thus clarifying the role of law enforcement and providing the legal authority needed to move forward.

Since opening in 1992, the DCRs have documented 191,729 injections on site, and now average about 17,000 injections per month or 550 per day. Most of the uses are for heroin. In 2013, roughly half of the DCR participants were surveyed and consented to tests for HIV and hepatitis C. The survey found that more than 50% had a medical appointment in the prior month, 21% were homeless or living without stable housing, and 60% were unemployed. The seroprevalence rates were 3% for HIV and 41% for hepatitis C among those tested, which was down significantly from 8.6% for HIV and 61% for hepatitis C in 2004.

Between 2000 and 2013, DCR staff have provided on-site emergency first aid 3,180 times. No fatalities have occurred at the DCR, and the staff train participants in overdose prevention and the use of the opioid overdose reversal drug naloxone. Across the city, there has been an 80% reduction in overdose deaths.

The Frankfurt DCRs have two fundamental rules: no violence and no drug dealing (or sharing). DCR employees are also required to cooperate with the police when necessary.

Mr. Schneider summarized the following benefits of the DCRs:

1. DCRs have been very effective in saving lives;

2. Strong evidence suggests that DCRs help to reduce HIV and HCV infections;

3. DCRs can foster participant engagement in treatment and socialization;

4. DCRs reduced noise complaints and public safety concerns in the community without attracting young people or users from places outside of Frankfurt.

SYDNEY, AUSTRALIA: SUPERVISED INJECTING FACILITY

Marianne Jauncey, MD, the medical director of the Sydney Medically Supervised Injecting Centre (MSIC), reported that the Australian SIF was the first to open outside of Europe and the first in the English-speaking world. The Sydney SIF is a single-site service that opened in 2001 at a time of intense public and media scrutiny of overdose fatalities, drug-related crime, and police corruption. A very structured medical model was chosen as a way to gain legitimacy among the public and policymakers. Dr. Jauncey cited three key factors leading to the success of the SIF:

1. Changing state law to allow participants to self-administer drugs and possess controlled substances;

2. Securing the support of the local police;

3. Leadership by the faith community (the United Church is the licensed operator of the SIF).

The Sydney MSIC began as a pilot program in 2001. The MSIC operates as part of a comprehensive array of complementary syringe access services in over 400 pharmacies, 360 syringe access programs, and several syringe vending machines across Sydney. The Sydney MSIC utilizes a highly structured clinical model that provides services in a friendly, non-judgmental way to about 700-750 people a month. The service supervises roughly 170-200 injections per day on the site. For the majority of participants the drug of choice is heroin, but recently the SIF has observed an increase in people injecting prescription opioids.

A secondary benefit of the Sydney MSIC is the ability to provide "real-time" drug market monitoring data that can be utilized by public health professionals, academic researchers and law enforcement so they do not have to rely exclusively on traditional public health data surveillance, which has a two year lag in reporting. This real-time drug market surveillance can identify trends in overdose outbreaks, drug types, and purity to inform community education and rapidly adjust public health strategies.

The Sydney MSIC is funded by government asset forfeiture funds. The utilization of 'proceeds of crime' to fund the Sydney SIF has been beneficial in countering criticism from fiscal conservatives and critics of using government funds on public health and harm reduction for people who inject drugs. For the first nine years of operation, the Sydney MSIC operated as a pilot program. Legislation was enacted in 2010 which authorized the program on a permanent basis. Dr. Jauncey highlighted current discussions about whether to integrate the SIF into existing medical services or to remain as single-site program.

Dr. Jauncey stressed that the Sydney MSIC emerged as a local solution to a local problem. The success of the facility is due to the support of key champions, including strong allies in medicine and academia. The MSIC's continued survival as a pilot program at every election cycle was contingent upon the support of the local community and neighborhood businesses, support which has continued to increase over the years. In a large public opinion survey undertaken in 2014, 55% of the general public supported the SIF. Federal government acceptance of the SIF was initially slow, but acknowledgement has developed over time. The former Premier of the Australian state of New South Wales recently cited the Sydney MSIC as one of his proudest achievements.

> *"The success of the facility is due to the support of key champions, including strong allies in medicine and academia."*

Tony Trimingham became involved in drug policy reform in 2000 and was an instrumental advocate for the Sydney SIF. Trimingham is the founder of Family Drug Support (FDS), a non-profit organization that helps and assists the families of people who use drugs at problematic levels.

Mr. Trimingham lost his son Damien to a heroin overdose in 1997, two years after his son had started using heroin. Speaking as a parent, he suggested that harm reduction advocates partner with families who have been affected by fatal drug overdoses and other drug-related harms, including drug policy harms. This partnership, according to Mr Trimingham, can help win "hearts and minds" by articulating the burden of living with the stigma and shame surrounding drug use, and can assist with counteracting opposition to SIFs and other harm reduction services. Mr. Trimingham spoke of the pain he lives with now, 18 years later, which comes from imagining what we could have done to reduce the stigma and demonization of people who use drugs and the thousands of lives that could have been saved from overdose.

VANCOUVER, CANADA: SUPERVISED INJECTING FACILITY

Insite is a supervised injection facility operating in the Downtown Eastside of Vancouver; an area with a high concentration of socio-economic issues, including homelessness, income inequality and unemployment, and public drug use. The SIF opened at a time when many people were dying of HIV/AIDS and overdoses. The organizers of Insite were motivated to address these public health challenges through a campaign to combat discrimination and demonization of people who use drugs. Insite's director, Liz Evans, explained that the facility emphasized providing good medical care, establishing a safe and sterile environment, and fostering self-care and autonomy. The facility opened in 2003, providing an indoor space and sterile injecting equipment for people to use, along with counseling and linkage to housing and drug treatment. From the very beginning, academic researchers measured and evaluated all aspects of the services provided.

Insite's organizers consulted international experts, adopted Germany's Four Pillars framework, and extensively engaged local stakeholders, including those in the prevention and drug-free communities and law enforcement. The campaign organizers viewed law enforcement as potential allies, and gained their support by enlisting supportive police from other jurisdictions to engage Vancouver's Chief of Police. The success of those meetings resulted in the Police Chief writing a letter supporting harm reduction as a public health intervention.

Initially, there was strong opposition to the facility from providers of abstinence-based drug treatment, but engagement turned them into allies over time as they recognized Insite's role in referring participants to their treatment programs.

Alongside providing harm reduction and Housing First services, Insite also sought to address stigma and promote the human rights of people who had

been demonized by the media and labelled as a nuisance by the local community. Ms. Evans noted a shift in media narratives towards a more sympathetic portrayal of people who use drugs, which she credited in helping to broaden public support and ultimately securing political approval.

Canadian Senator Larry Campbell, former Mayor of Vancouver, added that Insite built upon the syringe access initiatives already in place across the city. Campbell also attributed the success of the SIF campaign to the adoption of Germany's Four Pillars model through ongoing community stakeholders meetings.

The Vancouver SIF engaged the scientific community from the very beginning in order to evaluate all aspects of the program. Thomas Kerr, PhD and colleagues at the British Columbia Centre for Excellence, oversaw the evaluations of Insite's implementation and the publication of over 40 peer-reviewed studies of Insite. The research of Dr. Kerr and colleagues addressed questions about the impact on participants' health, utilization of hospital and treatment services, public disorder, drug use in the community, and a cost-benefit analysis:[9]

1. Insite users were much more likely to engage in safe injecting and less likely to share injecting equipment;

2. There was a 35% reduction in fatal overdoses in the area around the program, compared to only a 9% reduction in the rest of Vancouver;

3. Frequent Insite users lived within three blocks of the program, and did not come from outside the community to use the facility;

4. A survey of more than 1,000 participants showed that Insite referred 18% to detox and other longer-term drug treatment programs;

5. Relations with police improved; 17% participants surveyed said the police helped them get to Insite;

6. Insite was estimated to save $14 million over 10 years in health care costs.

Even with local community support and a strong record of successful outcomes, Insite was vulnerable to political changes in the federal government and had to fight against closure in court for a number of years. In 2011, a unanimous Canadian Supreme Court ruling in favor of Insite ended the struggle and allowed them to remain open. Today, Insite's organizers are seeking to expand SIFs to other cities and integrate SIFs into medical clinics. Dr. Kerr and his team recently evaluated the integration of a SIF within an adult day treatment and residential program for people living with HIV.

> *"Initially, there was strong opposition to the facility from providers of abstinence-based drug treatment, but engagement turned them into allies over time as they recognized Insite's role in referring participants to their treatment programs."*

RESEARCH ON INTERIM INITIATIVES

Alex H. Kral, PhD reported on a proof of concept study he conducted at a community-based program in the United States that modified a bathroom to accommodate safer drug consumption and then shifted to opening a supervised injecting room (SIR). The aim was to evaluate the programs and compare the benefits and challenges in how each model operated.

The initial safer use bathroom was adapted from an existing single use bathroom with modifications made to allow for a private space suitable for injection. The bottom of the bathroom door was cut out, and a trained member of staff was present outside the bathroom in case of overdose, but supervision was otherwise limited. There was a waiting list for use of the room, which could be used for drug injection as well as drug inhalation.

The SIR was in a separate room at the agency with four stainless steel stations at which people could inject, along with a resting room. All stations were supervised by staff. Only injecting was permitted; inhalation/smoking was not allowed due to a lack of ventilation. Those utilizing the room had to be invited by the staff and were limited to about 50 people.

During its six months of operation, the safer use bathroom was used 1,246 times. Subsequently the SIR has been used 997 times in its first year of operations. Since implementation, there have been over 2,200 injections in total, with no overdoses, police visits, nor other adverse incidents. Most users were men, 75% of whom reported homelessness. The majority of participants reported using heroin, but some prescription opioid injection was also reported. Participants averaged 90 injections per month.

Staff participating in the study had been rigorously trained prior to commencement, and held weekly meetings throughout the duration of the trial. The participants were trained in self-care, overdose prevention, and safety awareness. Dr. Kral emphasized that study's success was due to the commitment of staff, despite significant challenges and constraints. The safer use bathroom model created more stress for staff, did not allow for full supervision of injections, and did not help reduce stigma associated with drug use. The illegal status of SIR prevented licensed personnel (physicians and nurses) from working there, while also limiting access to funding and opportunities to establish formal linkages to health care and social services.

LEGAL ISSUES
& REFORMS

The DCRs in Germany were able to rely on the health laws, criminal code and international drug conventions to obtain legal status from the high court. There were no similar legal provisions in Canadian or Australian laws.

In Canada, authority over drug laws falls under the federal government. Insite pursued an exemption from the drug control laws through a "Section 56" waiver under a research pilot. As they continued to operate, they relied on the local police to utilize discretion and not enforce the laws prohibiting drug possession. The SIF is now considered to be a healthcare facility.

Similarly in Australia, there were no provisions for legally possessing controlled substances in the SIF or in the area surrounding it. To prevent arrests the Sydney MSIC obtained temporary exemptions, which expired every two years and required bi-annual re-certifications. It took 9 years to secure a longer-term exemption.

In both Canada and Australia, establishing SIFs as research projects became a limiting factor, preventing their expansion beyond single, stand-alone facilities. However, participants acknowledged that utilizing a research exemption strategy was probably the only feasible path that initially allowed them to open. Efforts are underway to expand into different cities and integrate SIFs into clinical settings.

ENGAGING

LAW ENFORCEMENT & COMMUNITY SUPPORT

All of the speakers agreed that getting the support and cooperation of the police is critical. Dr. Jauncey from the Sydney MSIC talked about providing ongoing trainings with local police and securing the support of the local police commander. In Berlin and Vancouver, government leadership routinely brought stakeholders together to discuss and better understand drug problems, learn more about drugs and harm reduction, and respond to community issues and concerns. Senator Campbell, who worked in law enforcement prior to serving as Vancouver's mayor, stressed the importance of these regular community meetings in creating community support, or at least neutralizing opposition and making it possible for politicians to endorse the initiative. Speakers noted that police respond to data-driven presentations, and that scientific data should be emphasized.

Some discussion explored the opportunities for surveying local businesses and community groups to get a better sense of the issues they care about, where public drug use is occurring, and the impact of public injecting for various stakeholders. The speakers suggested opening up conversations with representatives from schools, business associations, faith leaders and religious organizations, the Mayor's office, and other local groups and opinion leaders. In such discussions, speakers endorsed highlighting that SIFs are evidence-based public health interventions. The role of SIFs should be framed in the context of the community concerns around prescription opioid and heroin use and overdose, along with homelessness and public safety. Media strategies benefit from appealing to public concerns and directly addressing potential criticisms. Support for SIFs should be cultivated within a broader framework of a continuum of evidence-based services and strategies responsive to local drug problems.

> ***"Getting the support and cooperation of the police is critical."***

CONCLUSIONS

> *"The key to their success has been in cooperation, coordinated efforts, local participation, and a commitment to creating a safer and healthier community for everyone."*

Although the SIFs and their histories varied in details and contexts, some major themes were common throughout all of them. The key to their success has been in cooperation, coordinated efforts, local participation, and a commitment to creating a safer and healthier community for everyone. Wherever they are located, programs that provide a supervised, safe place for people to come off the streets and use their drugs all showed benefits to the people who use them and to the community around them:

1. People who use SIFs take better care of themselves, reduce or eliminate their needle sharing, use their drugs more safely, and ultimately reduce their drug use;

2. SIF participants gain access to other medical and social services and entry into drug treatment;

3. There has not been a single overdose death in any of these programs over many years of operation and many thousands supervised of injections;

4. SIFs do not increase drug use in the area, nor do they encourage young people to initiate drug use;

5. Crime and public nuisance decrease in the areas around these programs.

> *"SIFs do not increase drug use in the area, nor do they encourage young people to initiate drug use."*

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APPENDIX 1

PRESENTER BIOS

Senator Larry Campbell was the Mayor of Vancouver when Insite opened, and was the architect of that program. He fought and won a landslide election on this issue and he can take credit for working out many of the practical and political details. He started out in his career, back in 1969, working for the Royal Canadian Mounted Police in Vancouver; by 1973, he was working with the Drug Squad. Starting in 1981 Campbell worked for the Vancouver District Coroner's office and in 1996 he was appointed British Columbia Chief Coroner, a post that he served in until 2000.

Liz Evans is the founder of the PHS Community Services Society, a housing and harm reduction organization which she ran for about twenty years. Liz is now an Open Society Foundations Fellow. The PHS spearheaded much of the SIF advocacy in Vancouver, and developed various program models, from the original mobile injection rooms to what is now Insite, a supervised injection facility co-located with a low-threshold detox center and transitional housing.

Dr. Thomas Kerr is co-director of the Urban Health Research Initiative at the British Columbia Centre for Excellence in HIV/AIDS, and a Professor in the Department of Medicine at the University of British Columbia. Dr. Kerr has extensive research experience in the areas of drug use, infectious diseases, and public health, especially in evaluating programs and treatments designed to address injection drug use and HIV/AIDS. Dr. Kerr was the principal investigator of the scientific evaluation of Insite-Vancouver's supervised injecting site.

Werner Schneider was the Drug Policy Coordinator of the City of Frankfurt and authored the original "Four Pillars Framework." It is hard to overstate the role of local officials like Schneider in promoting and implementing harm reduction policies in Germany, where harm reduction initiatives initially met with strong opposition from the central government. But as a result of his advocacy, the city governments of Amsterdam, Hamburg, Zurich and Frankfurt came together in a trans-governmental alliance to draft and sign a "Frankfurt Resolution" calling for a transition to harm reduction approaches.

Dr. Marianne Jauncey is a public health physician and the Medical Director of the Sydney Medically Supervised Injecting Centre (MSIC). This was the first supervised injecting service in the English-speaking world, and has been operating since 2001. Marianne began as the director at the MSIC in 2008, and is a passionate advocate for the service and for thinking differently about drugs and drug users. Working at the front-line Marianne sees first-hand the impact of the social determinants of health – that people's beginnings in life determine so much of where they end up. She believes that all people deserve to be treated with dignity and respect, and that the medical profession as a whole should be more active in advocating for social justice.

Dr. Alex Kral is Director of the Behavioral and Urban Health Program at RTI International, a non-profit research institute. He is an epidemiologist with two decades of experience conducting community-based research related to substance use, mental health, criminal justice, and infectious diseases.

Tony Trimingham is a psychotherapist who lost his son to a heroin overdose. This led Tony to found Family Drug Support, an organization that helps families of people who use drugs. Tony was instrumental in advocating for the opening of supervised injection facilities in Australia.

Peter Frerichs is the former Vice-President of the Police Department of the City of Frankfurt, in charge of law enforcement and coordination with harm reduction drug policy in the city.

APPENDIX 2

MEETING AGENDA

Program Presentations
Moderator: Sarah Evans, Open Society Foundations

- Werner Schneider (Germany)
- Liz Evans (Canada)
- Marianne Jauncey (Australia)
- Alexander Kral (USA)

Facilitated Questions
Facilitator: Allan Clear, Harm Reduction Coalition

- How did you decide on the type of model to use?
- Did you start with one model and move on to other models as time went on?
- Did you find one model easier to implement than others?
- What is the degree of integration of your program with other services?
- Can you comment on the benefits of stand-alone vs integrated models?
- How medicalized is your model? What clinicians are involved and what types of support do they receive?
- What type of staffing mix do you recommend?
- What is the cost of the model you chose, and what is its level of utilization?
- What is the oversight mechanism for your program?
- How have liability issues been addressed?

Policy and Research Presentations
Moderator: Sharon Stancliff, Harm Reduction Coalition

- Larry Campbell (Canada)
- Peter Frerichs (Germany)
- Tony Trimingham (Australia)
- Thomas Kerr (Canada)

Facilitated Questions
Facilitator: Daniel Raymond, Harm Reduction Coalition

Legal & Regulatory Context:

- What were the legal/regulatory barriers and how did you overcome them?
- What was the initial legal status of your model, and what is it now?

Stakeholder Support:

- How did you obtain cooperation from government?
- How did you gain public support / influence public opinion?
- How did you obtain cooperation from law enforcement – or ability to co-exist?

- What types of opposition did you encounter and how did you address it?
- How have you evaluated the impact of the program?
- What evaluation components have been most helpful in developing policy?

Lessons Learned:

- Can you talk about the pros/cons of a pilot program?
- Are there things you would do differently now than you did initially? If yes, what would that be and why?

harm reduction
COALITION

Harm Reduction Coalition is a national advocacy and capacity-building organization that promotes the health and dignity of individuals and communities impacted by drug use.

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