
Safe Drug Consumption Spaces: A Strategy for Baltimore City

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Introduction

In the United States, the opioid epidemic is one of the most pressing public health crises of our time. In 2015, overdose fatalities surpassed those of gun homicides for the first time: Drug overdoses accounted for 52,404 deaths, 63 percent of which involved an opioid.¹ The overdose death rate involving opioids has more than quadrupled since 1999, largely attributable to the rise of prescribed and synthetic opioids, and subsequent nonmedical use.² At the same time, the explosion of cheap and increasingly available synthetic opioids such as fentanyl has increased the magnitude of overdose risk. Fentanyl, which is increasingly prevalent in the U.S., is 50 to 100 times more potent than heroin or morphine.

Baltimore City is reflective of these broad national trends. There are an estimated 19,000 people who inject drugs in Baltimore City.³ During the first half of 2016, there were 290 fatal overdose deaths, of which 51 percent involved fentanyl. This represented a 56 percent increase over overdose deaths during the same period in the previous year, and a 61 percent increase in fentanyl-related deaths.⁴

For every overdose death, thousands more experience nonfatal overdose, problematic addiction, and morbidities such as endocarditis and abscesses, and are at risk for infectious

diseases such as HIV and hepatitis C virus (HCV). These negative health outcomes often occur in the context of unsterilized injection environments. These problems are exacerbated because people who inject drugs (PWID) are less likely to access medical, mental health, and social services.⁵ Further, illicit drug use, particularly via injection in unsafe drug spaces (e.g., public bathrooms, parks, abandoned housings – “abandominiums”), exacerbates the potential for fatal overdose as well as HIV and HCV transmission.⁶

The failed war on drugs has also had a deleterious effect on public health. In addition to fueling some of the highest rates of incarceration worldwide, drug war supply-side strategies such as drug raids and crackdowns have had minimal, short-lasting impact and may lead to the displacement of drug activity zones.⁷ Furthermore, research has found that the war on drugs’ policing strategies are associated with increases in HIV transmission risk.⁸

In response to these unprecedented rates of overdose deaths, enduring morbidities associated with drug use, and the failed war on drugs, there has been increased interest in the U.S. in creative and effective interventions aimed to reduce harm to drug users and the broader community. This has led to discussions

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about the establishment of safe consumption spaces (SCSs) in cities across the U.S.

What are Safe Consumption Spaces (SCSs)?

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

Currently, 97 SCSs exist in 66 cities in 11 countries. Only two of these are situated in North America: Insite and the Dr. Peter Centre—both are located in Vancouver, British Columbia, and both allow for injection only. Owing to the precipitous rise in opioid overdose deaths in Canada, plans are underway to open additional SCSs in Ontario, including Toronto, as well as at five additional sites in Vancouver.⁹

SCSs are primarily staffed by medical or case management staff as well as current

or former people who use drugs (PWUD); these individuals do not assist in drug administration.¹⁰ SCS staff provide support by answering questions about safe consumption practices, providing sterile equipment (e.g., syringes, cookers) and condoms, and assisting in the event of an overdose through the administration of naloxone. A large body of evidence-based, peer-reviewed studies has demonstrated the public health impacts and cost-effectiveness of SCSs, owing to significant reductions in the transmission of HIV and HCV, a reduction in other morbidities such as abscesses, and a reduction of fatal overdose deaths.¹¹ Further, SCSs are uniquely effective at sustaining contact with the most marginalized PWUD who consume drugs in public places, and positively impacting the communities in which they are situated by reducing public drug use.¹²

Historical Overview of SCSs

Informal injection venues emerged across Europe as early as the 1960s and lasted into the 1980s, when they declined because of the rise of HIV. These spaces are distinct from modern-day SCSs because they lacked supervision and did not have explicit public health objectives. Many were better characterized as informal “shooting galleries.”¹³

The first official supervised facility opened in Berne, Switzerland in 1986. In 1988, the

Swiss General Prosecutor concluded that such facilities improved the hygienic conditions of drug injection and could lawfully operate under Swiss law, barring the sale of drugs on the premises.¹⁴ In the following decade, SCSs were established across Switzerland, Germany, the Netherlands, and Spain, with largely decentralized legislative processes ruling on their legality.

The establishment of SCSs outside of the European context began in the early 2000s and followed a different legal process. Facilities in both Australia and Canada were permitted to operate under legal exemptions granted to scientific trials and pilot projects.¹⁵ In 2001, the Medically Supervised Injecting Centre (MSIC) was established in Sydney, Australia in the Kings Cross area, home to large illicit drug markets that had been in operation since the 1960s.¹⁶ Kings Cross was marked by higher rates of fatal opioid overdose and ambulatory attendance than surrounding communities, prompting the New South Wales Royal Commission and Police Services to recommend harm-reduction programs in the region. An 18-month trial began in 2001 and was extended for a year before multiple rounds of evaluations of public health, economic, and crime statistics resulted in legalization of the MSIC by Parliament in 2010.

Shortly thereafter, the first legal SIF in North America was established in Vancouver, Canada. In 1997, the chief medical officer of Vancouver declared a public health emergency in response to a sharp spike in overdose deaths in British Columbia, particularly in the downtown eastside neighborhood of Vancouver. The HIV epidemic had also caused a spike in the death toll and greater demand for health services.¹⁷ In 2000, these crises led the mayor of Vancouver to endorse a four-pillar strategy focused on prevention, treatment, law enforcement, and harm reduction. This prompted enquiries into the legality and feasibility of establishing an SCS. In 2002, nurses at the Dr. Peter Centre implemented an SIF for their residents who were living with HIV. Although initially not legally sanctioned, British Columbia's College of Registered

Nurses confirmed the SIF was within the scope of nursing by preventing illness and promoting health. The Centre was limited to residents and not the general public. In 2003, however, a larger SIF was established—called Insite—as part of a three-year pilot project under scientific evaluation.¹⁸ After multiple extensions and an attempted closure, the Supreme Court of Canada, in 2011, voted unanimously in favor of keeping Insite open.¹⁹

SCS Models

SCSs vary in size, level of organization, number of services provided, and staffing patterns. There are three basic models of SCSs: 1) integrated; 2) specialized; and 3) mobile. These variations are deeply driven by the context in which the SCS exists, underscoring the importance of the social, economic, and political environments in which an SCS is developed and operated. There are several organizational and geographic commonalities across all three models. At a minimum, all spaces have designated hygienic booths—or divided spaces—where individuals can inject, smoke, or ingest drugs. SCSs are also primarily located in high drug-use neighborhoods or near open-air drug markets. Most SCSs have a registration system whereby people register upon first use and check in subsequently.

Integrated: The integration of SCSs into other services is the most common model. Most SCSs are community-based organizations that are part of a comprehensive package offering services that include drug treatment, medication assisted treatment (MAT), and syringe services programs (SSPs), as well as medical services that include primary care, testing for blood-borne viral infections, and wound care.²⁰ Additional services may include a drop-in center with showers, laundry facilities, employment programs, and case management.

Specialized: Specialized models solely provide a space for the hygienic consumption of drugs, with referrals made for other services.²¹ These

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models are often located in close proximity to other services that are utilized by people who use drugs.

Mobile: There are only a handful of mobile consumption rooms, including those in Berlin, Barcelona, and Copenhagen. These units are retrofitted vans or RVs with one to three booths dedicated to the safe consumption of drugs. They are staffed with individuals who sometimes provide a limited range of additional services such as syringe exchange, blood-borne virus testing, and referrals.²²

Scientific Evidence

Experimental research design, specifically the randomized control trial, is considered the gold standard for proving the effectiveness of an intervention on given health outcomes. But it is often not feasible given the ethical problems with “randomizing” people to an intervention and a control (absence of the intervention) condition when the intervention has been proven effective. This is true in other debated areas of public health such as gun research, where it is impossible to randomly provide guns to some and not to others to evaluate their effects in a given community. Therefore, in this case, a series of observational studies need to be conducted in a range of settings to build the scientific body of evidence to support SCSs.²³ In Europe, SCSs were established as part of existing or new services and, as a result, evaluations were often an afterthought given the focus was on service delivery. SCSs in Sydney and Vancouver were established as scientific pilot studies and

therefore have been evaluated in rigorous study designs (e.g., prospective cohort study) and provide much of the evidence on the benefits and lack of determinants of SCSs.

Table 1 (page 6) reflects a large body of research that documents the characteristics of SCS utilizers as well as evaluation studies examining the impact on risk behaviors (e.g., syringe-sharing, condom use), overdoses, drug-use patterns (e.g., treatment, cessation), mental health, and public impact (e.g., crime, perceptions).

Cost Effectiveness

The increased vulnerability and significant health needs of the PWID population results in higher costs to care for them. People who inject drugs are estimated to comprise 56 percent and 11 percent of all new HCV and HIV infections in the United States, respectively.²⁴ Sustained drug therapy and clinical management of these conditions, combined with frequent emergency room visits and inpatient hospital stays associated with skin and soft tissue infections (SSTI), have driven medical costs to an estimated USD \$6.6 billion annually in this population.²⁵

SCSs have been posited to reduce costs associated with this public health crisis by reducing needle re-use and sharing and, therefore, incidences of HIV/HCV and SSTI; reducing the costs to society of addictions and overdose deaths; and increasing the uptake into addiction counseling services.²⁶

The majority of estimates regarding cost-savings and cost-effectiveness of SCSs have been generated in Canada based on the experience of Insite in Vancouver. Studies in this setting have estimated that the program incurs negative net costs, reflecting both savings in cost and expected increases in life expectancy, and that annual societal benefit exceeds CAD \$6 million annually.²⁷ Specifically, Andresen and colleagues estimated savings of CAD \$500,000 per HIV death and USD \$660,000 per overdose death prevented at Insite.²⁸

A recent study modeled the expected costs and benefits of an SCS in San Francisco, California, the first such study in the U.S. The authors applied costs of operating a facility modeled after Insite in San Francisco, and found that a single SIF of the same size and capacity—13 injection booths—would cost \$2 million per year. The study estimated that this would result in net savings of USD \$3.5 million annually, ranging from \$2.2 million to \$4.8 million depending on the prevalence of—and the SIF impact on—HIV and HCV cases, overdose deaths prevented, MAT uptake, and decreased medical costs of treating SSTIs.²⁹ Overall, the authors conclude that an SIF in San Francisco would be an extremely cost-effective intervention, saving approximately \$2.33 for each dollar spent.

The available evidence highlights the range of parameters that must be considered when modeling costs and benefits of an SIF in a new location. These include geographic concentration or dispersion of PWID, prevalence of HIV and HCV, rates of SSTI care-seeking, overdose deaths, and needle-sharing. For example, the wider dispersion of PWID combined with the low HIV-incidence rate in Toronto translated to a lower cost-benefit ratio for the introduction of a single SIF than in settings like Ottawa or Vancouver.

Given the parameters described, it is expected that SIFs in Baltimore City would translate to considerable medical and social cost-savings. The scale of the opioid crisis in Baltimore City is considerably higher than some of the contexts in which modeling has been conducted.

Approximately 24 percent and 84 percent of people who inject drugs in Baltimore City are HIV- and HCV-positive, respectively, and overdose deaths are frequent. The concentrated regions of drug use and PWID populations within the city suggest that the initial introduction of a single SIF would translate to considerable savings via averted infections, SSTI care, and overdose deaths.

U.S. Context for the Introduction of SCSs

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

We describe four cities that are actively engaged in various planning stages of SCS development.

New York City: New York City houses the largest population of people who inject drugs worldwide. Since 2014, the SCS NYC campaign developed out of a broad-range multi-sectorial coalition of the New York drug users' union housed within Voices of Community Activists & Leaders (VOCAL-NY), harm-reductions service providers, legal organizations, drug policy organizations, churches, research institutes, housing organizations, and others. The coalition grew in response to the extent of public injecting and escalating rates of overdose deaths, similar to many other U.S. cities.³⁰ SCS NYC efforts helped create the New York Healthcare Professionals for SCSs, which began with a group of doctors at Montefiore Medical Center and now has well over 100 members. In September 2016, the New York State Department of Health released updated guidance that serves to regulate syringe

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

A number of studies have found that SCSs have been associated with reductions in infectious diseases over time.

HIV

- 30% of SCS clients in Vancouver and 17% in Sydney are HIV positive.³¹
- Estimates indicate that Vancouver's SCS has prevented 1,191 new HIV infections over 10 years.³²
- A recent study conducted to assess the cost-effectiveness of a SCS facility in San Francisco found it would generate \$3.5 million in annual savings based on hospital visits and medical-cost savings from averted HIV infections.

Hepatitis C (HCV)

- Rates of HCV are very high among PWID: 88% of users in Sydney are HCV positive.³³
- In an early study of Insite participants (N=691), the HCV positive rate was 87.6%.³⁴

High-risk behaviors

SCS use is associated with reductions in high-risk behaviors that have serious impacts on individuals and public health.

Syringe-sharing

- Sharing needles is one of the main modes of transmission for blood-borne viral infections among PWID; SCSs provide a supervised, sterile space to inject.
- Frequent use of an SCS is associated with a 69% decrease in syringe-sharing.³⁵
- Many SCS clients report a decrease in public-space injection and an increased use of sterile injection equipment.³⁶

Condom use

- Regular SCS attendance is associated with an 8% increase in condom use over two years.³⁷

Overdose

- In 2015, there were 768 overdose incidents and 0 deaths at Insite.³⁸
- In Frankfurt, SCSs prevented 10 overdose deaths per year in addition to countless nonfatal overdoses.³⁹
- The impact is also felt in surrounding neighborhoods: In Vancouver, there was a 35% reduction in overdose events around the Insite facility compared with the city as a whole; in Sydney, there was a 68% reduction in ambulance calls in the vicinity of its SCS.⁴⁰
- The B.C. Coroner's office reports that 60% of drug overdose deaths involved fentanyl in 2016, compared with 4% in 2012; the province has approved six new SCS sites to deal with this emergency.

Table 1 Continued: Observational and Impact Studies on SCSs

| Drug-use Patterns SCSs reduce drug use and connect users to addiction services. | |
|--|---|
| Treatment | <ul style="list-style-type: none"> • SCSs provide access to health and social services to a population that is otherwise difficult to engage.⁴¹ • In Vancouver, 57% of PWID attending Insite started addiction treatment, and 23% stopped injecting drugs altogether.⁴² |
| Cessation | <ul style="list-style-type: none"> • In 2015, Insite admitted 464 users into its onsite detox program; 252 completed the program (54%).⁴³ • In a separate Vancouver study, 23% of a cohort of Insite users ceased injecting entirely.⁴⁴ • In Sydney, 20% of SCS users were interested in starting a care program of some kind, and 25% of those people ended up entering care.⁴⁵ |
| Mental health | <ul style="list-style-type: none"> • PWID experience very high rates of serious mental health issues and have reduced access to medical and mental health services.⁴⁶ • In a 2016 study in Sydney, 82% of respondents reported having a mental health disorder, while only 23% were in treatment.⁴⁷ • 96% of the sample population in Sydney had experienced trauma, including a mean of three traumatic experiences before the age of 16.⁴⁸ • Facilities like Insite, which have onsite mental health counselors, social workers, and addiction treatment options, are a crucial link in the continuum of care. |
| Public impact SCSs do not increase crime, nuisance, or drug use in their communities. | |
| Nuisance | <ul style="list-style-type: none"> • SCSs reduce public injection, discarded syringes, and disorder in the area around them in both Vancouver and Sydney.⁴⁹ • Data collected over a 10-year period in Sydney also revealed no increase in offenses related to the trafficking or public drug consumption in the areas that surrounded the SIS.⁵⁰ • Insite is associated with decreased public injection in Vancouver.⁵¹ • A small study in Copenhagen found that use of the facility was associated with 56% fewer outdoor injections.⁵² |
| Public perceptions | <ul style="list-style-type: none"> • In Sydney, two random sample studies found that more than 70% of the local residents and 58% of the companies located around the SIS were in favor of the SIS.⁵³ • In Vancouver, there is evidence that police are accepting of Insite and even refer PWID to it. Among a cohort study of Insite users, 16.7% (n=1,090) were referred to Insite by police, and 2% learned about Insite from police.⁵⁴ |
| Perceptions among PWID | <ul style="list-style-type: none"> • Approximately 75% of the PWID in Vancouver reported that using Insite induced positive changes in their behaviors, notably in terms of public nuisance and safe injection practices.⁵⁵ • PWID reported their main motivations to use SCSs were a desire to inject safely and quietly, avoid public spaces, and prevent overdose. |

In January 2017, the King County Board of Health endorsed two SCS sites, one in Seattle and one located in the surrounding county.

services programs (SSPs) in New York, and includes language that encourages SSPs to facilitate safer injection practices at their program sites. Further, in November 2016, the New York City Council announced it would spend \$100,000 to study the pros and cons of supervised injection facilities. The Council is actively looking for the best location for SCSs, and it is planning on using its insurance policy to insure the SCSs regardless of their co-location with an organization that has existing insurance.

Ithaca: In 2014, Mayor Svante Myrick convened a panel of health officials, law enforcement, academics, and others to develop a report to guide the city on responding to epidemic rates of heroin overdoses in Ithaca. The report, “The Ithaca Plan: A public health and safety approach to drugs and drug policy,” recommends that the city “explore the operation of a supervised injection site staffed with medical personnel as a means to: prevent fatal and nonfatal overdose, infectious disease, and bacterial infections; reduce public drug use and discarded needles; and provide primary care and referrals to basic services, housing and substance abuse treatment.”⁵⁶ In response, in February 2016, Mayor Myrick became the first U.S. mayor to call for the opening of a “supervised injection facility.” Although this has met with great resistance from some republican state legislatures, it has extensive support from those who work with drug users as well as some law enforcement officials.

Seattle: In January 2017, the King County Board of Health endorsed two SCS sites, one in Seattle and one located in the

surrounding county. The King County Sheriff has expressed public support and the Justice Department has yet to comment about the legality of the impending plans.⁵⁷ In September 2016, the Seattle/King County Heroin and Prescription Opiate Task Force issued a set of recommendations to address the ongoing heroin epidemic. The Task Force was convened by Mayor Ed Murray and the King County Executive Dow Constantine, and was comprised of 43 people, representing a range of constituents including law enforcement, government and public health officials, epidemiologists, drug treatment specialists, and advocates. The Task Force met over several months and produced nine recommendations that address prevention, drug-user health, and treatment. These recommendations include the establishment of at least two supervised consumption spaces, referred to as “Community Health Engagement Locations.”

San Francisco: A range of conversations about SIFs have been occurring in San Francisco for close to a decade. A successful community forum was held on SIFs in 2007, but the idea faced serious backlash at the federal level. In 2010, the San Francisco Hepatitis C Task Force recommended that San Francisco “support and fund the creation of a legal supervised injection facility.”⁵⁸ But that idea stalled, too. In 2014, the San Francisco Human Rights Commission recommended that supervised injection facilities become part of a broader harm-reduction approach to drug use in the city.⁵⁹ In 2016, city legislation to create “navigation centers” for people experiencing homelessness included both wet housing (a residential facility where drinking is permitted)

and safe injection sites, but the SCSs were deleted before the legislation passed the city board of supervisors. Mayor Ed Lee expressed his support in January 2017 after having been an outspoken opponent. He joins other supportive city officials including Jeff Kositsky, director of the Department of Homelessness and Supportive Housing; and Barbara Garcia, director of the Department of Public Health.⁶⁰

Baltimore City

Baltimore City has seen increasing overdose deaths, especially those attributed to fentanyl, in the past few years. In response to this crisis, on October 1, 2015, the Baltimore City Health Commissioner, Dr. Leana Wen, issued a jurisdiction-wide standing order for naloxone, which resulted in a state law. The standing order is part of the Baltimore City Health Department's innovative citywide overdose prevention campaign, which also includes targeting overdose "hot spots" in real time and conducting a fentanyl education campaign.

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

Given the national conversation on SCSs and this context in Baltimore and Maryland, a group of advocates, academics, and clinicians began meeting during the summer of 2016 to explore the possibility of an SCS in Baltimore. They considered the feasibility of an SCS in Baltimore

through a racial justice lens, given the far-reaching impact of the failed war on drugs on Baltimore's citizens and neighborhoods. Throughout the summer, they held discussions with local foundations, the Baltimore City Health Department, religious leaders, PWUD, drug treatment advocates, and others to explore a possible SCS in Baltimore City. They invited a broader coalition of stakeholders who held two meetings at the end of 2016 to discuss the idea and develop an action plan. This group included representatives from the drug treatment community, community organizers, a peer outreach organization, funders, researchers, clinicians, the local behavioral health authority, and the Baltimore City Health Department. To further organize efforts, they secured funding from two foundations to support a community organizer who would lead the effort as well as broaden and strengthen the coalition and community education around SCSs.

Legal Analysis by the Drug Policy Alliance.⁶¹

A host of federal, state, and local laws currently present obstacles to the implementation and operation of a SCS. Both federal law and the Maryland criminal code currently make it illegal to possess any controlled substance.⁶² Every client who uses an SCS to consume illicit substances would accordingly violate the law. Moreover, SCS clients, staff, and operators would all be subject to potential criminal charges under federal and state laws that make it illegal to open, use, maintain, manage, or control any place for the purpose of using a controlled substance.⁶³ The owner of the property used as a SCS could also be subject to a potential civil forfeiture action under both state and federal law.⁶⁴

There is no question that the Maryland State Legislature has the power to modify state law to remove any state legal impediments to SCS operation.⁶⁵ It may also be possible for Maryland to authorize a SCS through

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administrative action by the executive branch. Health agencies in all states have rule-making authority to protect public health. In Maryland, the state Department of Health and Mental Hygiene has the authority to promulgate rules and regulations that it deems necessary to prevent diseases that endanger public health in the state.⁶⁶ It may also be possible for the Governor to issue a state-of-emergency Executive Order authorizing a SCS to address the opioid overdose crisis.⁶⁷

A SCS could also be locally authorized by a mayor, county agency, or city council. The power to enact local laws is granted by the Maryland State Constitution and the scope of this “home rule” power is very broad.⁶⁸ The Baltimore City Charter provides the Mayor and City Council of Baltimore full power and authority to “provide for the preservation of the health of all persons within the City” and to pass all ordinances not inconsistent with the Charter.⁶⁹ The Charter also provides that the Baltimore City Department of Health shall “establish and implement policy for the treatment and prevention of physical and mental illnesses” within the City.⁷⁰ In addition, under the Health Code of Baltimore City, the Health Commissioner has the duty to report and recommend to the Mayor “any extraordinary action needed” to “correct a health hazard” and any other matters “relating to the preservation of the health of the people”⁷¹ and may “adopt and enforce rules and regulations” to carry out their general duties.⁷² Finally, it may also be possible for the Baltimore City Health Department via the Health Commissioner,

as the “principal executive officer of a political subdivision,” to declare a local state of emergency under the Maryland Emergency Management Agency Act.⁷³

Explicit state authorization of SCSs is the optimal legal course because it not only eliminates uncertainty about the legality of a SCS, but legitimizes the operation in the eyes of subordinate governmental agencies.⁷⁴ A locally-authorized SCS would be open to claims that it conflicted with, or was preempted by, state law.⁷⁵ Indeed, a locally authorized SCS would authorize what state law prohibits—the possession and consumption of controlled substances, albeit in limited circumstances. As such, the effectiveness of local authorization would depend on an explicit or implicit agreement among stakeholders, such as local law enforcement and prosecutors, to avoid arrests based on state law and other legal challenges.⁷⁶ “Lowest level law enforcement priority” policies or memorandums of understanding among the relevant parties may help ameliorate risk of interference for a locally authorized SCS. Locally authorized programs, such as syringe exchange or Law Enforcement Assisted Division,⁷⁷ prove that local authorization can be both effective and successful.

While a state or municipality can certainly authorize a SCS, such authorization does not protect a SCS against a preemption challenge or federal enforcement action. In order to best insulate from a potential preemption challenge, community-based organizations or other independent entities should be permitted to operate the SCS as opposed

to any government entity (such as a local Department of Health) to avoid claims that state or local government officials or employees are violating federal law. With respect to potential enforcement action, the federal government could choose to enforce its controlled substances laws, including possession,⁷⁸ nuisance,⁷⁹ and forfeiture,⁸⁰ in an effort to shutter local- or state-authorized SCSs. Federal officials have a large degree of discretion with respect to federal enforcement action and how they might choose to use that discretion with respect to a SCS depends on the administration then in power and a host of other factors.⁸¹ Despite potential federal interference, there is a history of states and localities leading the charge with respect to reforming drug laws, whether it be syringe exchange or medical or recreational marijuana, in an effort to better protect the health and welfare of their citizens.

Conclusions

SCSs are a cost-effective, necessary part of a comprehensive package of services to reduce the burden of mortality and morbidity among PWUD, and to reduce the painful effects of this crisis on the wider community. In the simplest form of delivery, they are a low-threshold service aimed to reach some of the most marginalized PWUD with staff on hand to provide information and equipment, and to help prevent overdoses. SCSs have existed for more than three decades in Europe, and numerous peer-reviewed studies from Vancouver and Sydney support the extent of their effectiveness and benefits to PWUD who access them and the broader surrounding community, as well as the absence of significant harms. Among tens of millions of supervised injections, only one fatality has been reported in any SCS—in Germany in 2002, attributed to anaphylactic shock.⁸² Although some SCSs have been met with strong opposition at their onset, community attitudes improve over time as community benefits are felt.⁸³ Given the lack of credible science demonstrating any negative impact of SCSs, the predominance of opposition stems from moral and criminal arguments. These

are reflective of an anachronistic abstinence-based ideology and promotion of a drug war, which has dehumanized and criminalized PWUD, and failed to avert the harms of drug use to individuals and communities alike.

Research has shown that people who utilize SCSs take better care of themselves; use their drugs more safely; and have better access to medical, social, and drug treatment services compared to PWUD who do not access SCSs. In fact, SCSs play a key role in providing access to these necessary services. In terms of impact on the broader community in which SCSs are located, there is no evidence that SCSs negatively impact crime in the surrounding areas. And studies throughout Europe, Sydney, and Vancouver have demonstrated significantly lower levels of public drug use among SCS utilizers.⁸⁴

What follows are recommendations that target the process of developing and implementing an SCS. They outline the necessary sectors to include in these processes; the importance of a criminal justice framework, community education, and meaningful inclusion of PWUD; the nature of the SCS; and the role of research.

Recommendations

Establish two SCSs in Baltimore City, one on the east side and one on the west side.

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

SCSs, therefore, represent a safe alternative to criminal responses to drug use, and have been shown to measurably improve public health and criminal outcomes. For many, SCSs could literally function as an alternative to incarceration by reducing exposure to police.

Incorporate an integrated model. SCSs tend to serve some of the most marginalized PWUD in terms of socioeconomic indicators. Socioeconomic instability, such as unstable housing, often directly limits access to safe spaces in which to inject. An integrated model would best meet the needs of this population by providing low threshold medical services (wound care), referrals to housing, legal, and mental health; referrals to partner agencies; and tailored support to special populations. Therefore, placing a SCS in an existing community based organization will reduce the uptake time and expenses as well as embed it in an existing delivery system, which would have the potential of maximizing service utilization.

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

Allow other routes of drug administration. Ideally, an SCS will not be limited to providing just safe injection drug use, given the extent to which drugs are smoked and snorted. Although indoor smoking ordinances might preclude or challenge the inclusion of

smoking, a facility that allows for the range of routes of drug administration will have a broader impact.

Include current and former PWUD in a meaningful way. Central to the success of any SCS, PWUD should be included throughout the planning and implementation process, and in leadership positions. Such individuals possess relevant knowledge that cannot be otherwise gained, and will only enhance the relevance of services and experiences of those who utilize the SCS and its surrounding community.

Reach out to diverse sectors. Success of an SCS greatly depends on the diversity of sectors that are involved throughout its advocacy, development, and implementation process. Engage partners across multiple sectors—including civic and public health authorities, law enforcement, business owners, and community leaders—in open dialogue on SCS and harm-reduction strategies. This is a long-term process that needs to begin well in advance of an SCS opening its doors.

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

- **Engage the criminal justice system.** All elements of the criminal justice system should be involved in the development and implementation of the SCS. The police have a particularly important role to play. Although public health and public safety officials have distinct approaches, they have many similar goals, including the reduction of harms associated with drug use, to drug users and communities at large. Understanding the similarities between public health and public safety provides a foundation for an often times challenging discussion about their differences.
- **Involve business owners and residents.** Business owners and residents of high drug-use neighborhoods are at the forefront of understanding the impact of unsafe drug use. Many public bathrooms in high drug-use neighborhoods are often unofficially unsafe injection sites. As a result, business owners can be unexpected champions of safe consumption facilities because they understand the economic costs of unsafe consumption facilities.

Focus on community education. Educational efforts targeting the broader community, led by current and former people who use drugs, are necessary to dispel myths about the negative effects of SCS on neighborhoods. Share the body of scientific evidence in a user-friendly manner. This will not only result in minimizing opposition, but it could also lead to unanticipated allies.

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

Undertake rigorous research. There continues to be a need for the rigorous evaluation of SCSs, both to inform service delivery of a specific SCS and to continue growing a base of evidence. It is important to understand not only *who* uses SCSs but also *how* those facilities are used, as well as their impact on PWUD and the broader community.

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- 63 21 U.S.C.A. § 856; Md. Code Ann., Crim. Law § 5-605 ("(a) 'Common nuisance' means a dwelling, building, vehicle, vessel, aircraft, or other place: (1) resorted to by individuals for the purpose of administering illegally controlled dangerous substances; or (2) where controlled dangerous substances or controlled paraphernalia are manufactured, distributed, dispensed, stored, or concealed illegally. In general (b) A person may not keep a common nuisance."); Md. Code Ann., Crim. Law § 10-202 ("A person who keeps a disorderly house is guilty of a misdemeanor and on conviction is subject to imprisonment not less than 10 days and not exceeding 6 months or a fine not less than \$50 and not exceeding \$300 or both."); *Olson v. State*, 208 Md. App. 309, 367 (2013) ("A disorderly house includes ... a place where people assemble to engage in drug use.") (emphasis added).
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- 67 The Maryland Emergency Management Agency Act ("MEMA Act") grants the Governor the authority to declare a state of emergency in response to "any [] disaster in any part of the State that requires State assistance to supplement local efforts in order to save lives and protect public health and safety".⁶ The Governor declares this emergency via executive order or proclamation and has the authority to suspend any statute, rule, or regulation of a State agency or political subdivision for the duration of the emergency.
- 68 See, e.g., MD Const., Art. 11-E, § 3 ("Any such municipal corporation, now existing or hereafter created, shall have the power and authority, (a) to amend or repeal an existing charter or local laws relating to the incorporation, organization, government, or affairs of said municipal corporation heretofore enacted by the General Assembly of Maryland . . ."); MD Const., Art. 11-F, § 3 ("Except as otherwise provided in this Article, a code county may enact, amend, or repeal a public local law of that county, following the procedure in this Article.").
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Safe Drug Consumption Spaces:
A Strategy for Baltimore City

**by Dr. Susan Sherman, Kyle Hunter,
and Saba Rouhani**

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