Is Now The Time For Supervised Consumption In New Haven? Assessing The Complexities Of Global Examples, National Efforts, And City Contexts To Support The Progress Of Local Harm Reduction

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Is Now the Time for Supervised Consumption in New Haven?

Assessing the Complexities of Global Examples, National Efforts, and City Contexts to Support the Progress of Local Harm Reduction

By

Mariah Frank

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Second Reader: Robert Heimer, Ph.D.
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Abstract

The overdose crisis has been an issue of public health and safety in the U.S. over the past 30 years, as a wave of increased addiction and overdoses beginning in 1990 brought it to public attention and political salience.¹ The impact of the current overdose crisis is felt deeply across the state of Connecticut and locally in the City of New Haven. Statewide data show that people in Connecticut are more likely to die from a drug overdose than they are from a car accident, firearm death or homicide, Alzheimer’s, influenza/pneumonia, diabetes, kidney disease, or septicemia (data not including deaths due to the COVID-19 virus).²³ Within the state, New Haven County accounted for 25% of all drug overdose deaths from 2015-2020 and the City of New Haven itself has the second most drug overdose deaths in the county, placing it among the top five cities in the state for drug overdose deaths.⁴

This thesis compiles information from global examples of successful implementation of supervised consumption facilities (SCFs), as well as national examples of current efforts for implementation, and explores the evidence regarding the ability of SCFs to alleviate some impacts of the overdose crisis. The information from this compilation is then paired with insights from a qualitative study of key informant interviews in New Haven, Connecticut. I conducted this qualitative analysis to focus on the facilitators and barriers to SCF implementation in New Haven, Connecticut; moreover, I use John Kingdon’s “Multiple Stream Theory”⁵ in order to distill evidence regarding the potential for changing the policies and/or practices needed to establish SCFs. After review of all evidence, it appears that New Haven is considering policy changes which would support SCF implementation. However, the work of SCF
implementation in New Haven will need to include more than just policy change. The process of SCF implementation will require relationship building and trust development among various communities in New Haven (e.g., residents of New Haven neighborhoods, business owners, religious communities, physicians, service providers, etc.) in order to work towards various forms of buy-in from these communities, ranging from active support to non-interference. Lastly, and crucially, this work needs to meaningfully include and center the voices of people who use drugs (PWUDs) in every step of the process. PWUDs need to be involved in all policy change and program implementation that concerns their health and well-being. Those in New Haven looking to implement SCFs need to listen to those with lived experience, incorporate their expertise, and continue the meaningful involvement of PWUD in this, and all, interventions.
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II. Introduction and Background on the Overdose Crisis: Nation, State, and City

This thesis seeks to provide an understanding of the barriers and facilitators to implementation of supervised consumption facilities (SCFs) in New Haven, as well as determine the current climate of opinions, understanding, and will for sanctioned implementation. In order to do so, I first provide background on the overdose crisis, it’s morbidity and mortality, and the trends that are currently seen across the country, the state of Connecticut, and locally in New Haven. From there, I highlight the evidence in support of supervised consumption as a harm reduction intervention, inclusive of personal, community, and economic impacts. While the evidence in support of supervised consumption is highly compelling, it alone is not enough to understand the complexities that come with the process of implementation. In order to understand this complexity, I explore how SCFs have been previously implemented using three global examples of supervised consumption operationalization, the factors that contributed to implementation, and key takeaways that provide lessons for SCF implementation in New Haven. In addition to these global contexts, I draw on the lessons from three different examples of efforts to implement supervised consumption in the U.S., as well as the barriers to implementation present in federal law, in order to provide more information on the national context in which New Haven is situated. Finally, this thesis explores the potential for SCF implementation at a local level in New Haven through a qualitative study of key informant interviews analyzed through the lens of context and interest convergence, taking into account key actors, policies, positionalities, and public opinion. The themes and analysis highlighted in this qualitative study make visible the
need and opportunity for supervised consumption in New Haven, as well as provide nuance to how one may go about SCF implementation.

The current public health emergency commonly referred to as the opioid crisis has become a particularly salient public health and safety topic in the U.S. in the past 30 years, since the current wave of increased addiction and overdoses began in 1990.1 Although the roots of more widespread opioid use, opioid use disorder, and oppressive involvement of the U.S. government in regulating opioids dates back centuries,6 the causes of the current crisis are multifaceted. The 1990s saw an increase in opioid prescribing for pain management, fueled by the real concern of undertreated pain, but blown out of proportion due to a confluence of deceptive marketing and abusive practices of drug companies (in which drug companies, such as Purdue Pharma, made false claims about abuse potential of their extended-release opioid formulations, provided incentives to promote sales, and obtained endorsements from leading physicians), a shift towards patient centered medical care (in order to reduce the suffering associated with surgery and/or trauma recovery, chronic pain, or terminal illness, which required self-reported pain assessment without objective reference points), and a decrease in the amount of time physicians spent with their patients (due to enforced time constraints on physician-patient interactions, making the prescription of opioids quicker and easier than working through behavioral approaches to pain management).6 The recognition of this untoward increase in opioid prescriptions led policymakers to enforce a short-sighted, reactionary shift in supply-side practices, restricting the amount of prescription opioids available without addressing the demand.6 This now unmet need for pain management, in turn, is linked to the
emergence of a market for diverted pharmaceuticals and ultimately, an increased market for narco-trafficking of heroin and fentanyl.\textsuperscript{3,6} The increased availability of heroin and fentanyl meant that opioid use transitioned toward an increase in the use of injection heroin and fentanyl, which correlates with an increase in infections, addiction and overdoses. Now we find ourselves in the midst of the overdose crisis, with deaths from synthetic opioid overdoses on the rise since 2013.\textsuperscript{8,9} Now, in 2021, the United States is still struggling to effectively curb the morbidity and mortality associated with addiction and overdoses. In 2018, nearly 70\% of drug overdose deaths involved an opioid, and the number of deaths due to overdose was four times higher than in 1999.\textsuperscript{10} Although the morbidity and mortality, associated with opioid use in the U.S. is staggering, it is important to understand that it is only one piece of the broader overdose crisis, collectively creating additional morbidities and impacts, including but not limited to increases in infectious disease,\textsuperscript{11} mass incarceration as a result of the War on Drugs leading to familial disruption (particularly in communities of color),\textsuperscript{12,13} loss of voting rights related to drug felonies,\textsuperscript{14,15} and male depopulation of policed communities (particularly communities of color).\textsuperscript{12,13,16} Additionally, the overdose crisis has claimed over half a million lives since 2000.\textsuperscript{17} Recent decades have also seen an increase in overdose morbidity and mortality related to the use of stimulant drugs, namely methamphetamine and cocaine. Overdose mortality involving cocaine and methamphetamine has risen steeply starting in 2009, with a ten-fold increase by 2019, and marked by 16,196 and over 16,500 overdose deaths respectively.\textsuperscript{18}

\textsuperscript{a} Pharmaceutical fentanyl is a synthetic opioid that has been approved for the treatment of severe pain. It is 50 to 100 time more potent than morphine. However, much of the fentanyl that is resulting in increased overdose deaths and drug-related harm among PWUDs in the U.S. is illegally manufactured and is often mixed with and sold in other drugs, such as heroin or cocaine, with our without the purchaser’s knowledge.\textsuperscript{7}
However, while stimulant-related overdose has steeply increased, stimulant use has not experienced the same trend, with reported stimulant use fluctuating from year to year.\textsuperscript{18} This indicates that the increase in stimulant-related overdoses is likely due to individuals intentionally using stimulants in combination with opioids, like heroin or fentanyl, or using stimulants that have been cut with opioids without their knowledge due to a tainting of the drug supply.\textsuperscript{18} Additionally, the COVID-19 pandemic has only exacerbated the overdose crisis nationwide. According to the CDC, a record number of drug overdose deaths, 81,000, occurred from June 2019 to May 2020: deaths related to synthetic opioid use were up 38%, deaths related to cocaine use were up 27%, and methamphetamine overdoses increased by 35%.\textsuperscript{19} Officials suggest that this is likely due to the impact of COVID-19,\textsuperscript{19} in which many people were most likely using drugs alone, with no one there to assist them in the case of an overdose. This evidence points to the clear conclusion that the overdose crisis is only getting worst, despite any efforts to alleviate its impact, and more needs to be done.

The national trends in the use of and overdoses related to opioids and other drugs hold true for Connecticut as well. The state is no stranger to the deleterious impacts of the overdose crisis. In relation to other states, data from 2018 put the opioid related deaths in Connecticut at 27.5 per 100,000, placing the state as the 6th highest in the country for opioid related overdose deaths.\textsuperscript{20} Additional 2018 data show that the age-adjusted drug overdose rate in Connecticut was 30.7 per 100,000 population, placing it as the 11th highest state in the nation for drug overdose deaths.\textsuperscript{10} Recent national data show that opioid related overdose deaths declined in 2018 but began increasing again in 2019 and rose to record levels in 2020.\textsuperscript{21–23} The decline of opioid related overdose deaths in 2018 was, “largely explained by reductions in deaths from prescription opioid
medications” and those declines have been reversed by the increasing overdose related deaths due to illicit drug use.\textsuperscript{21} According to the Connecticut Department of Public Health (DPH), residents of the state are more likely to die from an unintentional drug overdose than from a car accident.\textsuperscript{2} Additionally, according to CDC data, the overdose death rate in Connecticut greatly surpassed other causes of death, such as firearm death and homicide, at 4.9 and 2.8 per 100,000 respectively.\textsuperscript{3} These age-adjusted rates place drug overdose among the top 10 leading causes of death in Connecticut above Alzheimer’s, influenza/pneumonia, diabetes, kidney disease, and septicemia.\textsuperscript{3} Although there have been nearly 8,000 deaths in Connecticut due to COVID-19,\textsuperscript{24} data on the leading causes of death in the state do not currently reflect the death rates of COVID-19 compared to overdoses. Additionally, as with national trends, it would be ill-advised to ignore the role that COVID-19 played in the record number of overdoses in Connecticut in 2020. Through October 2020, Connecticut saw a 13% increase in drug overdoses compared to the previous year,\textsuperscript{25} again potentially associated with the impact that COVID-19 had on people using drugs alone and without anyone to assist them in the case of an overdose.

In Connecticut, the decline in opioid related drug overdoses in 2018, with overdose deaths associated with heroin decreasing in 2018 while overdose deaths related to fentanyl increased, is a reflection of the shifting illicit opioid market: fentanyl has replaced heroin in the state.\textsuperscript{4} Statewide data from the Connecticut DPH shows that 2020 had the highest number of drug overdose deaths since 2015, with fentanyl and heroin overdoses contributing the most to mortality, followed closely by cocaine.\textsuperscript{26} The data available from the Office of the Chief Medical Examiner also break down the drug overdose data by city and county. Since 2015, there have been 1,555 drug overdose
deaths in New Haven County, accounting for approximately 25% of all drug overdose
deaths in the state of Connecticut from 2015-2020.4 Additionally, there have been 273
drug overdose deaths in the city of New Haven since 2015, making it second only to
Waterbury for most overdose deaths in the county and among the top five cities in the
state for drug overdose deaths.4 Additionally, the substances associated with overdose
deaths in both New Haven County and the City of New Haven match statewide trends,
with fentanyl, heroin, and cocaine contributing the most to mortality.4

III. The Evidence Supporting Supervised Consumption Facilities: a brief summary

The statistics on drugs overdoses indicate that the public health threats
associated with overdose are present and pressing in the state of Connecticut. While
certain harm reduction methods and treatments, such as syringe exchanges, outreach
services that provide harm reduction materials, and medication assisted therapy have
been implemented for people who use drugs (PWUDs) and people with substance use
disorders, these methods were designed for ameliorating certain side-effects of injection
drug use, or drug use itself, but are not designed to protect against drug overdoses and
their consequences, including death. As noted by Beletsky et al, “These interventions do
not address the lack of a safe and hygienic setting for injection, nor are they sufficient to
overcome the behavioral influence of relationships and other factors present in informal
injecting milieus,”27 that can lead to overdose. As one of the top five cities in the state in
overdose deaths, New Haven is not currently meeting the needs of PWUDs in order to
reduce drug related overdose death. It stands to reason that if current interventions are
not and cannot be successful in this mission, it may be time to explore other options that have proven efficacious elsewhere.

Supervised consumption facilities (SCFs), also known as overdose prevention or risk management sites, show promise in ameliorating some of the health and human costs of the overdose crises. At time of writing, they have yet to be officially or formally implemented in Connecticut or in the United States. As defined by the Drug Policy Alliance, SCFs, “allow people to consume pre-obtained drugs under the supervision of trained staff and are designed to reduce the health and public order problems often associated with public drug consumption.” Additionally, SCFs can serve to reduce the some of the dangers of private drug consumption, such as using alone, without someone there to witness and respond to an overdose event. With regard to reducing the morbidity and mortality associated with drug use and drug overdoses, a review of evidence on SCFs operating outside the U.S. shows that they have been associated with a reduction in deaths from overdose, an increase in injection cessation, and a reduction in infections including HIV, hepatitis C virus, and soft tissue infections. Additionally, SCFs can serve to reduce the some of the dangers of private drug consumption, such as using alone, without someone there to witness and respond to an overdose event. With regard to reducing the morbidity and mortality associated with drug use and drug overdoses, a review of evidence on SCFs operating outside the U.S. shows that they have been associated with a reduction in deaths from overdose, an increase in injection cessation, and a reduction in infections including HIV, hepatitis C virus, and soft tissue infections. Additional evidence supports that SCFs are particularly efficacious in preventing fatal overdoses, with zero fatal overdoses being reported within supervised facilities.

In addition to the evidence supporting supervised consumption for the impact this intervention has on individual outcomes for PWUDs, SCFs also have a marked impact on the community around the facility. Supervised facilities have been linked to a decrease in overdose related deaths in the area around a site, not just among those who access the site. Additionally, SCFs lead to a decrease in what are commonly referred to as “public nuisance occurrences,” including public injection or drug use, public discarding of materials used for drug use, and public intoxication while also being
shown to increase access to health and other social services.\textsuperscript{36,37} SCFs have been shown to decrease drug related crime and violence in the neighborhoods around the site as well as decrease the demand for ambulance services for opioid-related overdoses.\textsuperscript{38,39} While the evidence strongly supports the efficacy of SCFs as harm reduction spaces for PWUDs, there is also promising evidence regarding support for these sites from the general public. It has been shown that once implemented, the support for a SCF increases over time.\textsuperscript{17,40–42} A final consideration that often comes up when discussing SCFs is the evidence around the associated financial savings. It has been estimated that the implementation of a SCF in a U.S. city would save approximately $3.5 million a year, when considering savings in avoided HIV and HCV infections, reduced skin and soft tissue infection, avoided deaths, and an increased uptake in medication assisted treatment.\textsuperscript{43} When taking into account cost savings for the healthcare system, including a decrease in ambulance rides, emergency department visits, and hospital stays associated with drug use and overdose, the savings range from $3.6 - $4.2 million in American cities.\textsuperscript{44}

**IV. Contextualized Snapshots of Supervised Consumption Facilities**

While the practice of informally supervising others during their drug use as a harm reduction strategy distinctly predates the implementation of any legislatively sanctioned or governmentally condoned SCFs, the analyses presented here will review notable achievements among sanctioned SCFs or unsanctioned SCFs that subsequently became sanctioned. Although not all are analyzed here, currently, there are about 120 sanctioned SCFs operating in ten different countries—all outside the U.S.\textsuperscript{28} – indicating
that this intervention is tested, proven to work, and is a widely accepted way to move forward on harm reduction. Sanctioned supervised consumption services are currently available to PWUDs in Australia, Canada, Denmark, Luxembourg, The Netherlands, Norway, Spain, France, Germany, and Switzerland. Although SCFs are generally thought of as sites that are exclusively used by people who inject drugs, often referred to as supervised injection facilities (SIFs) – a specific type of SCF -- many do allow for other methods of drug consumption, and therefore it is important to use the phrase “people who use drugs,” or PWUDs, rather than the more restrictive, “people who inject drugs,” or PWIDs. However, if specific context of a particular location’s history indicated that SCF implementation was born out of addressing the needs of PWIDs, this acronym, as was as the SIF acronym, will be used for accuracy to the history/site analysis. Everywhere else, PWUD will be used.

This section provides examples of SCF implementation around the world that inform the potential avenues of and considerations for SCF implementation in the U.S. and, more specific to this work, in New Haven, CT. These global examples provide insight into how SCFs/SIFs were able to open in other countries and the factors that were vital to their success. Reviewing this history serves to determine what factors and how these factors can be applied or incorporated into the efforts to implement SCFs in New Haven, CT.

A. The Netherlands

Most histories of supervised consumption begin with the first unsanctioned supervised consumption facility being opened in the Netherlands in the 1970s. In the time preceding its opening, there was a cultural shift in how the Dutch people
viewed drug use, particularly among youth. 45 “‘Deviant behavior,’ including drug use, was no longer seen as a maladjustment, but as a part of testing the limits while defining a personal way of life.”45 The movement for SCFs in the Netherlands derived from the organizing of young people who did not want to stop their drug use or could not stop their drug use because the traditional forms of drug services did little for them.45 Youth mobilization was supported by the church and an unsanctioned supervised consumption facility was opened near Rotterdam Central Station by a reverend of St. Paul’s Church to provide an alternative to street-based drug use.45 This site also experienced unofficial support from some law enforcement and local government.45 A second site opened within St. Paul’s Church itself and expanded after the closing of the first site.45 Each of these sites included multiple facets of harm reduction including basic medical care, counseling, food, laundry, showers, and drug consumption facilities.45

It took nearly two decades for there to be any movement from the government regarding supervised consumption in the Netherlands. In 1996, the City of Rotterdam officially supported the St. Paul’s Church SCF.45 The 1990s also brought about a shift in thinking about policing, noting that “constraint and pressure alone” were not a sufficient response to drug use.45 In October of 1996, in a key turning point for SCF implementation, the establishment of official SCFs became feasible after the College van Procureurs-general, the Board within The Hague that determines investigation and prosecution policy for The Netherlands,47 issued legal guidelines clarifying that possession of drugs in these consumption rooms was to be tolerated as long as the facilities fit into the local drug policy framework.46 Supervised consumption facilities were then elevated and supported by city councils, the police, the Public Prosecutor, and the national government.45
At present, Dutch SCFs are operated by municipalities and offer services including basic harm reduction and recreational use activities, health education, nursing services, infectious disease testing and referral to treatment, additional treatment referrals, and daytime activities. Many SCFs in The Netherlands now provide supervised smoking and supervised snorting rooms along with supervised injecting rooms. While some of these services may seem radical when thinking about the discussions of harm reduction currently taking place in the United States, they lend themselves to the idea that there is more that can be done to provide safer services, supply, and spaces for PWUDs.

The example from The Netherlands shows a distinct progression from an unsanctioned SCF opened out of need to sanctioned SCF supported by the government, law enforcement, and citizens. It is notable that unsanctioned SCFs in The Netherlands were able to operate as the result of non-interference and unofficial support from local governments and law enforcement before progressing to legal operation after policy change. This represents one viable pathway to SCF implementation.

**B. Switzerland**

The first SCF in Switzerland was opened in 1986. In the 1980s, health workers began to notice that PWID were injecting publicly after being kicked out of cafes and restaurants. These health workers then set up separate cafes specifically for use by PWID who began injecting on-site while the health workers could monitor them and help to modify riskier behaviors. In July 1998, a working group comprised of judges and the General Prosecutor completed a legal assessment regarding SCFs, a key move in the effort for SCF implementation. This assessment, commissioned by the Swiss
Federal Office for Public Health, concluded that, “the establishment of state-controlled consumption rooms does not violate Swiss national drugs legislation as long as the rooms improve the hygienic conditions under which consumption takes place and provide medical supervision and no drug dealing takes place.” As a result of this assessment, Swiss SCFs were deemed to be medical institutions and were therefore exempt from any police intervention.

The Swiss model of consumption rooms tends towards a small, discrete room within a cafe that includes several stainless steel tabletops where clients can sit to prepare their drugs for injection. In these rooms, PWID are provided with the full range harm reduction materials needed by people who inject drugs including needles, syringes, candles, sterile water, spoons, paper towels, cotton pads, bandages, and garbage bins. Although staff are not allowed to assist in injection, patrons of the cafe are permitted to assist one another. Cafes additionally include counselling rooms, medical clinics for primary care, referral to drug treatment for those who request it, free soup, tea and coffee, and cheap fruit and vegetables. The sterility of the supervised consumption rooms in the Swiss models is reflected to this day in the sterile, medicalized formats that are very common among SCFs.

The history of SIFs in Switzerland is marked by a different progression than that of The Netherlands. Although SCF implementation in Switzerland also began with unsanctioned sites opened out of need, SCFs were able to move into legality through a new interpretation of a law that was already in place. This interpretation allowed for SIFs to be considered medical facilities, which was key to their legal operation. Given the current status of federal drug law in the United States, the pathway to SCF implementation through a new interpretation may also be a viable option.
C. Canada

When discussing SCFs, especially in the context of the potential for their deployment in the United States, one example that frequently comes up is Insite, the first SCF in North America, which opened in the fall of 2003 in Vancouver, following approval from Health Canada in June of that year. Insite was a triumph for the PWID community after a long and hard-fought political advocacy campaign.

Prior to the opening of Insite, the mid-late 1990s saw a peak in drug related harms in Vancouver. Annual HIV infection rates were sitting around 19% for PWIDs in Vancouver and there were over 300 overdose deaths in British Columbia, resulting in the declaration of a public health emergency by Vancouver’s health authority. In 1994, in a key origin moment for SCF implementation in Canada, a group organized under the Provincial Chief Coroner of British Columbia published the “Cain Report,” which included recommendations for Vancouver to explore the implementation of supervised injection facilities based upon the evidence from facilities in Europe. When there was very little governmental movement after the Cain Report was published, local activists and PWID took matters into their own hands, opening an unsanctioned SIF in 1995. Although this site was closed by police about one year after its opening, the push for a SCF in Vancouver never stopped. In 2000-2001, the City of Vancouver released its Four Pillar Drug Strategy, which explicitly called for the opening of two SIFs in the city. Although a lack of authority to implement health programs prevented immediate action (due to provinces controlling the responsibility for healthcare administration, not cities), the announcement of the Four Pillar Drug Strategy was followed by a sequence of events that catalyzed the movement for supervised injection, including visits from European officials with SIF experience, the drafting of a full proposal for a pilot SIF by
the Harm Reduction Action Society, the mayoral election of Larry Campbell in 2002 who promised to establish a SIF within a month of being elected, the opening of another unsanctioned SIF after a police crackdown in Vancouver’s Downtown Eastside, and the practice of supervising injections by nurses at the Dr. Peter Centre, a residence for people living with HIV.\textsuperscript{51} When it opened in September of 2003 as North America’s first legally sanctioned SIF, Insite operated as a three year long scientific pilot program and was therefore exempt under Section 56 of the Canadian Controlled Drugs and Substances Act, a key factor in its success.\textsuperscript{46,51} Since its opening, Insite has been rigorously studied and evaluated, with publications attesting to the site’s impact, including a reduction in overdose deaths in and around the facility,\textsuperscript{34-35} reduction in mortality associated with injection-related skin infections,\textsuperscript{54} injection cessation,\textsuperscript{55} an increase in rates of addiction treatment uptake, both detoxification and long term treatment,\textsuperscript{56,57} a reduction in syringe sharing,\textsuperscript{49} reduction in public drug use and public disposal of drug paraphernalia,\textsuperscript{37} no increase in crime, including drug trafficking, assaults, or robbery and a decrease in vehicle break-ins and theft,\textsuperscript{39} an increase in uptake of services from higher risk individuals, including people who are homeless, people who inject cocaine, people who need assistance injecting, and sex workers,\textsuperscript{58,59} and savings in cost and strain on the city, government, and health care system.\textsuperscript{60,61} Tables 1, 2, and 3 show the impact Insite made on personal outcomes, community outcomes, and savings, along with the duration of the studies. Impacts are noted here in the way they are reported in their respective studies.
<table>
<thead>
<tr>
<th><strong>Outcome</strong></th>
<th><strong>Impact</strong></th>
<th><strong>Study Duration</strong></th>
<th><strong>Citation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overdose death averted within Insite</strong></td>
<td>1.9-11.7 deaths/year</td>
<td>03/01/04 – 07/01/08</td>
<td>34</td>
</tr>
<tr>
<td><strong>Overdose death around Insite</strong></td>
<td>35% decrease in fatal overdose within 500 meters of Insite (compared to 9.3% elsewhere in Vancouver)</td>
<td>01/01/01 - 09/20/03 compared to 09/21/03 - 12/31/05</td>
<td>35</td>
</tr>
<tr>
<td><strong>Cutaneous Injection-Related Infections (CIRI)</strong></td>
<td>Remained under 10%</td>
<td>01/04/04 – 12/31/05</td>
<td>54</td>
</tr>
<tr>
<td><strong>Injection cessation</strong></td>
<td>Cumulative incidence of 23.06%</td>
<td>12/01/03 – 06/01/06</td>
<td>55</td>
</tr>
<tr>
<td><strong>Addiction treatment uptake (detoxification)</strong></td>
<td>Increase in use of detoxification (Odds ratio 1.32)</td>
<td>12/01/03 – 03/01/05</td>
<td>56</td>
</tr>
<tr>
<td><strong>Addiction treatment uptake (detoxification)</strong></td>
<td>Increase in rapid entry into detoxification (Odds ratio 1.72)</td>
<td>12/01/03 – 03/01/05</td>
<td>57</td>
</tr>
<tr>
<td><strong>Long term addiction treatment uptake (after detoxification)</strong></td>
<td>Elevated rates of methadone initiation (Relative hazard 1.56) and other addiction treatment (Relative hazard 3.73)</td>
<td>12/01/03 – 03/01/05</td>
<td>56</td>
</tr>
<tr>
<td><strong>Service uptake of Insite</strong></td>
<td>43.2% reported using the SIF daily</td>
<td>12/01/03 – 07/30/04</td>
<td>59</td>
</tr>
<tr>
<td><strong>Syringe sharing</strong></td>
<td>Reduced syringe sharing (adjusted odd ratio 0.30)</td>
<td>12/01/03 – 06/01/04</td>
<td>49</td>
</tr>
<tr>
<td><strong>Increase in Safer Injection Education</strong></td>
<td>Among those who need help injecting (Odds ratio 2.20); Among sex-workers (Odds ratio 1.54)</td>
<td>05/31/03 – 10/22/04</td>
<td>58</td>
</tr>
</tbody>
</table>
### Table 2. Impact of Insite Across Community Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Impact</th>
<th>Study Duration</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syringe sharing</td>
<td>Reduced syringe sharing (adjusted odd ratio 0.30)</td>
<td>12/01/03 – 06/01/04</td>
<td>49</td>
</tr>
<tr>
<td>Public drug use</td>
<td>Predicted daily mean reduction from 4.3 to 2.4 people injecting in public</td>
<td>08/11/03 – 09/21/03 compared to 09/22/03 – 12/15/03</td>
<td>37</td>
</tr>
<tr>
<td>Publicly discarded syringes</td>
<td>Predicted daily mean reduction from 11.5 to 5.4 publicly discarded syringes</td>
<td>08/11/03 – 09/21/03 compared to 09/22/03 – 12/15/03</td>
<td>37</td>
</tr>
<tr>
<td>Drug trafficking</td>
<td>No change in crude totals (124 vs. 116)</td>
<td>10/01/03 – 09/30/04 compared to 10/01/04 – 09/30/05</td>
<td>39</td>
</tr>
<tr>
<td>Assaults/Robbery</td>
<td>No change in crude totals (174 vs. 180)</td>
<td>10/01/03 – 09/30/04 compared to 10/01/04 – 09/30/05</td>
<td>39</td>
</tr>
<tr>
<td>Vehicle break-in/theft</td>
<td>Decrease (302 vs. 227)</td>
<td>10/01/03 – 09/30/04 compared to 10/01/04 – 09/30/05</td>
<td>39</td>
</tr>
</tbody>
</table>

### Table 3. Impact of Insite On Cost Savings

<table>
<thead>
<tr>
<th>Factors Considered</th>
<th>Impact</th>
<th>Study Duration</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounting for prevention of death and new cases of HIV</td>
<td>$6 million/year</td>
<td>Data from various years of Insite’s operation and sources of cost estimations</td>
<td>61</td>
</tr>
<tr>
<td>Accounting for decreased syringe sharing</td>
<td>$14 million saved and 920 life-years gained over 10 years</td>
<td>10-year time horizon from study conducted in 2008</td>
<td>60</td>
</tr>
<tr>
<td>Accounting for decreased syringe sharing and increased safe injection practices</td>
<td>$20 million saved and 1,070 life-years gained over 10 years</td>
<td>10-year time horizon from study conducted in 2008</td>
<td>60</td>
</tr>
<tr>
<td>Accounting for decreased syringe sharing, increased safe injection practices, and referrals to methadone maintenance treatment</td>
<td>$18 million saved and 1,175 life-years gained over 10 years</td>
<td>10-year time horizon from study conducted in 2008</td>
<td>60</td>
</tr>
</tbody>
</table>
In 2006, the last year of the pilot program, Canada’s national election resulted in seating a Conservative government that was publicly opposed to harm reduction. The years following the election were fraught with legal battles that pitted the federal government against British Columbia and Insite over whether or not the facility would remain open.\textsuperscript{51} Three rulings, first by the Supreme Court of Canada, then an appellate court, and finally a second hearing by the Supreme court of Canada, resulted in judgements in favor of Insite. This is a highly impactful decision, with a court judgement ruling in favor of an evidence-based practice. In 2011, the rulings required that the federal government revise its policies to allow for the legal operation of SIFs in Canada.\textsuperscript{51,62} The federal government responded to this with Bill C-2, a highly prescriptive and restrictive list of twenty-six conditions that needed to be met before a supervised consumption facility could be opened.\textsuperscript{51} The political landscape in Canada shifted once again in 2015 with the election of a Liberal government under Justin Trudeau as Prime Minister, whose government came out openly in support of supervised consumption.\textsuperscript{51} As overdoses once again began to rise across Canada, the new Liberal government replaced Bill C-2 with Bill C-37, reducing the twenty-six conditions to open a supervised site down to five.\textsuperscript{51}

The 2011 Supreme Court of Canada decision and the replacement of Bill C-2 with Bill C-37 very clearly had ramifications for harm reduction and SCF implementation across Canada. The reduced number of conditions in combination with the Canadian government’s commitment to facilitating a timely review and implementation of proposals for supervised facilities meant that Health Canada was able to announce the approval of several new facilities across the country, including Toronto, Montreal, Edmonton, Vancouver, Surrey, and Victoria,\textsuperscript{63} with sites also considered in Ottawa.\textsuperscript{51} In
order to expand to meet the needs of PWUDs across Canada, it was crucial that each of these cities conduct their own analyses with regard to what model of supervised consumption would work in their municipality and for their populations. It would have been ill-advised to simply copy and paste Insite’s model into another city without considering the needs, circumstances, and conditions of PWUDs in the local context. Cost-effectiveness studies in both Toronto and Montreal indicated that although a single site was able to reach a large population of PWUDs in Vancouver, multiple smaller sites throughout these cities would be more efficacious.\textsuperscript{64–66} Similarly, in addition to their fixed sites, Montreal implemented a mobile site in order to better reach populations of PWUDs who are more dispersed throughout the city.\textsuperscript{67,68}

The process of SCF implementation in Canada was notably fraught. The move towards supervised consumption was set in motion by the Cain Report, initiated within the government. Despite the findings of this report, indicating the recommendation that SCFs be explored in Vancouver, it was a lack of action that ultimately spurred the opening of unsanctioned sites. The role of the government and the courts was highly influential in the case of SCFs in Canada, with differing court rulings and shifts in which political ideologies were in power greatly contributing to how supervised consumption was able to progress. The influence of the government and the courts could prove to be highly influential in the case of SCF implementation in New Haven as well, making the Canadian history of supervised consumption an important example. Additionally, the expansion of supervised consumption across Canada contains important lessons for application in New Haven. An assessment of what model, or combination of models, would be most effective and acceptable to the population of PWUDs in New Haven will be an important feature of potential SCF implementation.
V. Initial Effort to Open SCFs in the U.S.

The implementation of supervised consumption facilities globally has demonstrably influenced the discussion around implementation in the United States. While U.S.-based, harm reduction oriented PWUDs, service providers, and physicians have been pushing for SCFs as a life-saving and evidence-based intervention for decades, the country has yet to see the opening of any sanctioned SCFs. As before, it is highly important to note that these efforts happen regardless of sanction. There are unsanctioned SCFs operated by service providers and peers across the country. Their lack of legal or administrative sanction does not take away from the lives they’re saving, the improvements in health and well-being they are facilitating, and the groundwork they are laying. In addition to this work, several cities in the U.S. are working towards the implementation of sanctioned SCFs. As with the global examples of SCF implementation, there are many cities and organizations across the U.S. that have been working towards the implementation of a supervised site. This section outlines the efforts in three cities – San Francisco, Ithaca, and Philadelphia – as examples, but these are by no means an exhaustive account of implementation efforts in the country. Through these examples, this section touches on key themes relevant to potential SCF implementation in the U.S., such as the efforts to pass new drug policies and the role of the federal court system, along with addressing the overarching barrier that the federal law poses to SCF implementation.
A. San Francisco, California

San Francisco, like countless other cities across the United States, has dealt with the debilitating impacts of the overdose crisis for decades. In 2007, the Drug Policy Alliance (DPA), in conjunction with the Alliance for Saving Lives, began working towards the implementation of supervised consumption services in San Francisco. While much of this work was done through advocacy and behind the scenes work, this came to a head nine years later, when in 2016, the DPA drafted Assembly Bill 186 (AB-186) for Assembly member Susan Talamantes Eggman, and co-sponsored by Tarzana Treatment Center and Project Inform, that would be brought to the California Assembly during the 2017-2018 session. Passage of AB-186 would remove and add a section to the Health and Safety code that would allow for the opening of “overdose prevention programs” meeting specific requirements including, “a hygienic space supervised by health care professionals, as defined, where people who use drugs can consume pre-obtained drugs, sterile consumption supplies, and access to referrals to substance use disorder treatment.” While legislative passage of this bill was a large step forward for San Francisco harm reduction, AB-186 was vetoed by Governor Jerry Brown who stated in his veto that he did not believe, “enabling illegal drug use in government sponsored injection centers-with no corresponding requirement that the user undergo treatment-will not reduce drug addiction.” He then reiterated this opinion later in his veto note stating, “I repeat, enabling illegal and destructive drug use will never work. The community must have the authority and the laws to require compassionate but effective and mandatory treatment. AB-186 is all carrot and no stick.” Governor Brown’s sentiments are incorrect in assuming that drug policies always need a “stick.” His beliefs that SCFs enable drug use without offering any means by which to reduce
drug addiction, refer PWUD to treatment (if they want it), or ameliorate the morbidities and mortalities of drug use and overdose are fundamentally disproven by the evidence found through SCF evaluation. This body of evidence helped ensure that efforts towards SCF implementation in San Francisco did not die with this veto.

The veto of AB-186 halted official legislative movement on supervised consumption for a time, but the evidence in support of SCFs enabled the advocacy and administrative efforts at the city level to continue. San Francisco Mayor London Breed has been an open advocate for supervised injection prior to and throughout her mayorship.\textsuperscript{73,74} The Board of Supervisors for the city has also come out in favor of the implementation of supervised injection sites and unanimously approved an ordinance creating an overdose prevention program for the city.\textsuperscript{74} After several years of additional public administrative support, Senator Scott Weiner re-introduced legislation in 2020, as Senate Bill 57, which would allow San Francisco, Oakland, and Los Angeles to pilot supervised consumption facilities, with the pilots ending January 1, 2027.\textsuperscript{75} As reported, these sites are to be supervised injection sites, rather than broader supervised consumption sites. SB-57 will remove the current state prohibition and allow local authorities to decide whether to open safe injection facilities.\textsuperscript{71} Most recently, SB-57, was last amended on March 25, 2021 and was sent to the Senate Committee on Public Safety where it passed 4-1 on April 6, 2021.\textsuperscript{76} This version of the SB-57 has received verified support from numerous harm reduction, health justice, legal, and medical organizations as well as cities and counties in California with opposition from only a short list of entities including some organizations focused on law enforcement, traditional religious and family values, and college and university policing.\textsuperscript{77} The bill has been ordered to third reading set to take place on April 20, 2021.\textsuperscript{76}
B. New York State and Ithaca, NY

Like San Francisco, New York has seen movement toward and discussions around supervised consumption for years now. While New York City often receives much of the coverage coming out of the state, there is also movement in other parts of New York, namely upstate in Ithaca. While the push for supervised consumption in San Francisco was initially championed by non-profits and community organizations, Ithaca Mayor Svante Myrick has been leading the local push for progressive harm reduction for the better part of a decade. After speaking at a drug policy conference in 2013, Myrick began working with public health and drug policy experts to reform Ithaca’s response to drug use and illicit drug market. In April 2014, Mayor Myrick convened a meeting of key stakeholders to discuss a new strategy with regard to drug use and drug policy, including representation from the District Attorney’s Office, police department, fire department, the City of Ithaca, the city school district, and service and drug policy oriented non-profits and community organizations. The process of planning and gaining community buy-in continued and throughout 2015, the Mayor held public events and focus groups to discuss the new strategy towards drug use and policy in the city with community members. These focus groups consisted of law enforcement personnel, physicians, nurses, pharmacists, people who use drugs, young people, people of color, parents, business owners, and people in recovery. The culmination of years of work came in 2016 with the publishing of The Ithaca Plan, outlining the city’s new approach to drug use and the drug market. Among the recommendations within the report was to, “Explore the operation of a supervised injection site staffed with medical personnel as a means to: prevent fatal and non-fatal overdose, infectious disease, and bacterial infections; reduce public drug use and discarded needles; and provide primary
care and referrals to basic services, housing, and substance use services and treatment, including the integration of a primary health care provider at harm reduction sites.” In the Spring of 2017, the Drug Policy Alliance’s project EndOverdoseNY, in conjunction with VOCAL New York, The Katal Center for Health Equity and Justice, and the Student for Sensible Drug Policy rolled out the “Safe Shape Tour.” This 10-day tour traveled around the state of New York and featured a model safe consumption site to give citizens an idea of what one might look like. Among the stops on the tour was Ithaca.

The push for supervised consumption in Ithaca seemed to be consistent with efforts at the state level. In June 2017, New York Assembly Member Rosenthal, with members Peoples-Stokes, Gottfried, Skarlatos, Carroll, Lentol and Lupardo as co-sponsors, introduced Assembly Bill A8534, relating to the enactment of the Safer Consumption Services Act. In January 2018, A8534 was referred to the Assembly Health Committee, the last action taken on this bill. Following this, in May 2018, New York City Mayor Bill de Blasio called for the implementation of four pilot supervised injection facilities in the state and Mayor Myrick immediately asked Governor Cuomo for Ithaca to be considered as the location for a fifth site. Despite this action, attempts to move supervised consumption legislatively in New York has borne no fruit, with the Supervised Consumption Service Act being reintroduced as A60 and S498 in the 2019-2020 session, where it was referred to the Health Committee with no further action indicated, and then again as A224 and S603 in the 2020-2021 session, referred to the Health Committee on January 6, 2021 with no further action indicated as of yet. What will come from the introduction of A224 and S603 to the 2020-2021 session is still to be seen.
C. Philadelphia, Pennsylvania

Among cities in the U.S. actively pursuing implementation of supervised consumption sites, Philadelphia has certainly garnered a large amount of publicity for their efforts. Around 2015, a group in Philadelphia called the Sol Collective began the hard work of talking with people in a neighborhood of Philadelphia where it was hypothesized a supervised consumption site might be located. They wanted to start the process of community building and gaining buy-in from PWUDs, but also other communities members and Philadelphians who would be neighbors to the site. This work took several years and in January 2018, city officials in Philadelphia announced that they would allow -- but not fund -- a supervised injection facility in Philadelphia. Later that year, Safehouse, a non-profit focused on overdose prevention in Philadelphia, became incorporated with the goal of opening the city’s first supervised injection facility. Safehouse brought many Philadelphia stakeholders into the conversation, with their Board of Directors including Pennsylvania’s former governor and representation from Prevention Point (the city’s only syringe exchange) and the AIDS Law Project of Pennsylvania. Safehouse’s advisory board also has representation from Drexel’s Dornsife School of Public Health, Temple University’s health system, the Department of Behavioral Health and Intellectual Disability Services, and Project HOME (a housing, poverty, and homelessness services organization affiliated with the Catholic Church).

After incorporation, Safehouse, for reasons currently undocumented nor fully disclosed, moved the potential location of the SIF to a different part of the city, undoing much of the work that had been done by the Sol Collective in the years prior, disrupting relationships that had been made in one part of the city and upsetting
community members in a new area of the city that had not been informed or consulted.\textsuperscript{91} Pushback from community members was a formidable obstacle and soon, Safehouse faced another major barrier when in February 2019, the U.S. Attorney for the Eastern District of Pennsylvania filed a civil suit asking that a federal court declare supervised consumption sites illegal under the United States Controlled Substances Act.\textsuperscript{92} As the case proceeded through federal court, it garnered a significant amount of attention, potentially due to it being the first case of its kind in the U.S. This attention included 132 amicus briefs that were filed, including by 8 states and 6 cities who wrote in support of Safehouse, knowing that the implications of this ruling extended far beyond just Philadelphia.\textsuperscript{92} In October 2019, a U.S. District judge ruled that because Safehouse would operate with an ultimate goal of reducing drug use rather than facilitating it, their operation was not unlawful under the Controlled Substances Act.\textsuperscript{92} A few months later, in February 2020, a final declaratory judgement was issued stating that Safehouse could open lawfully, as could any supervised sites that opened after Safehouse within the Eastern District of Pennsylvania.\textsuperscript{92} Just two days after the final declaratory judgement was issued, the U.S. Department of Justice filed a Notice of Appeal and an Emergency Motion of Stay, asking that Safehouse be prevented from opening until after the Third Circuit Court issued their judgement.\textsuperscript{92} This stay was granted and the case was brought to the Third Circuit Court of Appeals\textsuperscript{92} to be ruled on by three judges. Once again, hundreds of amicus briefs were written, the vast majority in support of Safehouse, including 85 current and former prosecutors and law enforcement officials, 6 cities, and 10 states.\textsuperscript{92} In January 2021, the Third Circuit court ruled 2-1 against Safehouse, stating that it is unlawful to open under the Controlled Substance Act because, “Safehouse knows and intends that its visitors will come with a significant
purpose of doing drugs.” At this time, two district court judges have concluded that the opening of Safehouse would be lawful and two appellate court judges have ruled that it would be unlawful. As of March 2021, Safehouse has filed a petition for rehearing en banc, in order to have the case heard by the full appellate court panel rather than just three judges as it was before, with support again from numerous amicus briefs. Safehouse maintains that they will not open a site until it is ruled lawful to do so.

The efforts to implement SCFs in the U.S. have been met with various types of barriers and degrees of difficulty depending on the location. Experiences seem to be marked by a misunderstanding (or lack of belief) that SCFs are efficacious for the reduction of overdose and substance use morbidity and mortality and, in locations where bills are currently in the state legislature, that policy change is a long process, with bills often bumped from one legislative session to another or one committee to another. More broadly, every effort in the U.S. to implement supervised consumption is happening under the looming barrier of federal drug policy, an inescapable reality that all cities and states looking towards SCF implementation need to contend with.

VI. Federal Law: A Key Barriers to SCFs in the U.S.

The examples of SCF implementation globally as well as the attempts being made in the United States provide key insights with regard to how one may go about SCF implementation. In particular, a lesson learned from Canada was the need to change or obtain exemptions in federal policies for a facility like Insite to remain open. This remains the case for the U.S., where amendments to federal laws and/or support, or at least tacit permission, from government at all levels are necessary. Without one or
both of these, there is a high likelihood that implementation at the state or local level would be met with legal action from the federal government, as seen in the case of Safehouse, with the goal of deeming it unlawful and shutting down the facility.\textsuperscript{62} Fear of federal action amplifies state level resistance.

Any action taken against SCF implementation would be due in particular to two federal U.S. statutes; Sections 844 and 856 of the Controlled Substances Act. The particularly relevant part of Section 844 reads, “\textit{It shall be unlawful for any person knowingly or intentionally to possess a controlled substance unless such substance was obtained directly, or pursuant to a valid prescription or order, from a practitioner, while acting in the course of his professional practice...}”\textsuperscript{94} This statute makes drug possession illegal and therefore any person who would try to access a SCF in possession of drugs would be breaking the law.\textsuperscript{27} Although Section 844 is relevant to the conversation around supervised consumption, the statute that has come up more frequently as a concern for the municipal and other local actors with regard to SCFs is Section 856, colloquially known as the “Crack house Statute,” which reads, “\textit{....it shall be unlawful to (1) knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or using any controlled substance; (2) manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.”}\textsuperscript{94} Although proponents of SCFs argue that this statute was never meant to be applied to legally authorized public health interventions and therefore should not be used to infringe upon a state’s rights to
implement public health initiatives, this has been the primary argument utilized by the plaintiff in the United States vs. Safehouse case. While the Biden administration’s justice department is untested in regard to this specific issue, it is expected that in the future, if federal laws or sentiments around supervised consumption do not change, any entity that tries to implement a supervised consumption facility could meet the same legal action as Safehouse.

VII. A Qualitative Study of the Potential for SCF Implementation in New Haven, CT

Keeping this background information in mind as context, this thesis seeks to provide an understanding about the barriers and facilitators to implementation of supervised consumption facilities in New Haven, as well as determine the current climate of opinions, understanding, and will for sanctioned implementation. Activism and actions outside of the law in the United States have led to operating unsanctioned SCFs across the country, including in the state of Connecticut, that are operating daily to provide PWUDs with safer environments in which to use substances. This thesis presents additional local viewpoints as part of promoting a productive public discussion of what it would take for sanctioned sites to open, especially given the advantages that legality provides, including the ability to serve more people, to staff a site with licensed clinicians, create coordination with other services providers, and obtain funding to expand services and operating hours, all made possible by removing the threat and reality of criminal penalties for implementing a SCF. This qualitative study lends itself to the inclusion of greater detail, that cannot be captured by quantitative data alone, pertaining to the climate around harm reduction in New Haven and provides space for
key informants to further explain the opportunities for SCF implementation specific to the current context of the city.

A. Conceptual framework

With the overlapping and interwoven possibilities and complications that can come along with the implementation of a SCF, it can be very important for enacting entities to be highly opportunistic. Given these potential challenges, those looking to implement SCFs need to account for current political climates, the policy options that come with them, and how the public conceptualizes the problem of drug overdose, in order to determine if an opportunity for supervised consumption presents itself or can be made. John Kingdon’s Multiple Stream Theory, outlined in his book, “Agendas, Alternatives and Public Policies,” provides a framework that informs when a moment in time and space may be particularly opportune for policy change. Although the theory more broadly applies to determining when politicians are most likely to enact policy change in general, it translates well when thinking about the space for, and the kinds of issue streams that could contribute to, the potential for SCF implementation. Kingdon argues that policy change is most likely to occur when there is an alignment of problems, policy options, and political circumstances. In order to determine if an opportunity for policy change regarding supervised consumption is present in New Haven, I draw from theorists who have argued that these three streams aid in understanding why some governments manage to legally sanction SCFs and others do not. When problems, solutions, and politics align, a “window” opens to allow for policy change to occur. Steven Hayle has applied Kingdon’s Multiple Stream Theory to assess how SCFs were able to be opened in Canada but failed to be implemented in England
and Wales. The analysis portion of this thesis puts this into practice for New Haven, CT and will explore, among other things, how responses from key informants reflect the current framings of the problem, policy options, and political circumstances in the city to help determine if now, or soon, may be a particularly opportunistic time to try to implement SCFs. The themes extracted from key informant interviews highlight the current political climate of the city, state, and country, the presentation of supervised consumption as a policy option, and the ways in which different groups view drug overdose morbidity and mortality as a problem. The data contained within these themes converge to implicate a window of opportunity for SCF implementation.

B. Methods: Qualitative study with local key informants

This thesis presents a qualitative study, carried out through semi-structured interviews with key informants (n = 9) who have knowledge of the service provision and harm reduction landscape and climate in New Haven and the state of Connecticut. This study was granted a Category 2 exemption by the Yale Institutional Review Board and is considered Not Human Subjects Research. Key informants were recruited for this study through email. A full script of the recruitment email can be found in Appendix A. Interviews were conducted via video call over Zoom, recorded, and then transcribed. The full qualitative interview guide can be found in Appendix B. Upon transcription, recordings were deleted, and transcriptions were anonymized and edited to remove all identifying information in order to protect the identities of key informants. Interview transcriptions were then qualitatively coded using Dedoose software and themes were identified, including but not limited to the facets of Kingdon’s Multiple Stream Theory, as well as facilitators and barriers to SCF implementation in New Haven. Upon
completion of the first round of coding, the qualitative codebook was refined and then all interview transcripts underwent a second round of coding to ensure the codebook was appropriately applied.

C. Findings and Analysis: Understanding Barriers and Acknowledging Opportunity

Qualitative coding identified seven thematic parent codes which make up the skeleton of this analysis; barriers, facilitators, next steps, policy options, problematization, political circumstances, and “keep in mind,” a code devoted to other important facets of implementing a SCF in New Haven that should be kept in mind but that did not neatly fit into other code buckets. Barriers, facilitators, and “keep in mind” all contain subcodes that identify more specific aspects of the theme that were brought up on numerous occasions by key informants. For a full description of the parent codes, subcodes, as well as inclusion and exclusion criteria for each, see the qualitative codebook in Appendix C. This section highlights the themes of barriers and facilitators, considered alongside each facet of Kingdon’s Multiple Stream Theory, to make visible the ‘streams’ which can be usefully identified to see the possible spaces for action towards SCF implementation in New Haven, CT.

C1. Barriers

Key informants were asked to specifically identify barriers to the implementation of SCFs in New Haven, CT. For coding, “barriers” were defined as, “Anything that may hinder the process of implementation of supervised consumption services in New Haven.” Within the broader parent code of “barriers,” subcodes were identified due to
the ways in which they were implicated by multiple key informants. The subcodes identified were labeled as *PWUD organizing, location, stigma, resources/money, and Yale.* The final part of this section highlights additional barriers that were mentioned less frequently by key informants but contribute to the multifaceted complexities of SCF implementation in New Haven. Naming these barriers provides additional understanding of influential factors that challenge SCF implementation.

**Barrier -- PWUD Organizing**

Key informants identified that a lack of social and political organizing or unionization of PWUDs in New Haven may be a barrier to the implementation of SCFs in the city. This likely stems from the knowledge that the organization and/or unionization of PWUDs can and has been instrumental in the implementation of SCFs in the past, such as in the case of the Vancouver Area Network of Drug Users (VANDU) and the opening of Insite.51

“And there’s that kind of community organizing piece that you know, as I mentioned, starting out is absent here and frankly I think it’s to the detriment of any effort to potentially move forward with not just a supervised consumption site but I think meaningful scale up of any type of intervention.”96

This informant went on to elaborate on why the lack of unionization or organizing can become particularly problematic.

“Space needs to be seated to community in a meaningful way, and that's not just here that's so many places, but, without drug user organizing happening there's really no accountability in that and it becomes really easy to go forward without that meaningful engagement or to find ways to frankly shoehorn it in, in really tokenistic ways.”96

Other key informants indicated this lack of organization or unionization of PWUDs in New Haven as a barrier by comparing the city to others in the U.S. where advocacy
organizations made by and for PWUDs have been created and have been influential in harm reduction discussions.

“In San Francisco they have like a drug users union for people with lived experience, and I think there was more of a progressive conversation on harm reduction there compared to New Haven, where a lot of the conversations in New Haven are driven by well-intentioned people like myself, but who aren’t people [with] lived experience or active drug users, using the services. There’s more conversations being driven by service providers and not by drug users, which is something I’ve always noticed in New Haven.”

The lack of PWUD organizing in New Haven contributes to a maintenance of the harm reduction status quo and is juxtaposed against the reality that PWUD unions have helped move the needle on harm reduction in other cities and countries. The influence of PWUD organizing on the success of SCF implementation in the past provides credence to the idea that a lack of PWUD organizing in New Haven is a current barrier to implementation. Although there is work being done to begin the organizing of PWUD in New Haven, no group has been fully developed or included meaningfully in harm reduction efforts in the city.

**Barrier – Location**

Many key informants brought up the issue of location as a potential barrier to implementation. In postulating about where a SCF would be located in the city, as well as the process that would ensue in selecting a location, many key informants indicated strong tensions developing across groups in New Haven.

“I think they're gonna be enough people [who] want to try it, but I think where it is sited is going to be the biggest fight. I mean that was true in Philadelphia as well, where I think a lot of the debate was between the neighborhood and where it was going to be located and then I think that is really going to be where the rubber hits the road.”
Importantly, one informant noted how the surfacing of these tensions could result in open organizing and advocating against a SCF in New Haven.

“Siting could be highly political. You could have organizing against it, because that happens places and then you just go forward anyway. I mean a lot of these are just the barriers that happen in any other community that implements a site right like, business owners organized against them, church groups, concerned citizens like, this has happened so many places that have appointed a site.”

In addition to tensions around siting a SCF in New Haven, several key informants also indicated that selecting a location may be a barrier by nature of that fact that choosing an appropriate location or locations may be more difficult in the city.

“And that there are sort of a variety of pockets and areas where you might site such a facility....In New Haven you have the lower density, it may be distributed across a variety of geographic locations and making a decision about where to site such a facility is a public health and sort of scientific challenge to improve the return on investment.”

“Geographically, what does this look like in New Haven, given the kind of dispersion of the local drug using population, how it’s racially kind of segregated in some ways, and what that means for what a site or service might look like? You know that’s a big thing to figure out, especially within the context of what type of site becomes possible.”

The difficulty and potential barrier of selecting the location of a site or multiple sites for SCFs in New Haven harkens back to the example of SCF expansion in Canada. The model of a single site in Vancouver did not necessarily make the most sense when applied to other cities and therefore, these individual cities needed to overcome the barrier of figuring out locations and models that worked for the needs of PWUDs in their locality. New Haven too will need to take this on if it is to implement a SCF.
**Barrier – stigma**

Another highly relevant barrier indicated by key informants was the role that stigma still plays when considering substance use and harm reduction for PWUDs. This stigma, especially “not in my backyard” (NIMBy) sentiments, can influence policies.

“I think there’s NIMByism. I think that there’s deep down, there’s just really significant cultural hostility and hatred of people who use drugs. Hostility, hatred, blame, shame of people who use drugs and that gets written into local and state ordinances.”  

Some key informants noted how stigma still has a direct link to the criminality of drug use. Given the fact that SCFs give space for people to use substances, the criminality that is deeply tied to stigma poses a barrier to implementation.

“Well, we haven’t shifted people's thinking about drug use in general, and I think that's the sort of the main barrier in terms of looking at that, because it is ‘drug use is bad’ and ‘everybody who uses drugs is a criminal,’ right, and ‘the goal is to have them stop.’ And ‘the goal is to arrest in order to make them stop.’”

If the focus is on criminalization and not the health and well-being of PWUDs, the argument for SCFs can be particularly difficult to make. Finally, key informants touched on the role that internalized and self-stigma plays in the lives of PWUDs. The role that self-stigma plays in certain substance use behaviors, and as a barrier to altering those behaviors, cannot be underestimated.

“There’s a lot of self-stigma. The role of self-stigma in some populations is really deep and it leads to people using alone more so or in really small, you know confined settings.”

Stigma towards and internalized by PWUDs is still highly salient and deeply rooted in the city of New Haven. If the city is to implement a SCF, there is much work to be done to overcome this barrier, among PWUDs and others in the community, including but not limited to residents, service providers, and physicians.
**Barrier – resources/money**

A lack of resources and money was identified by key informants as a barrier to the implementation of a SCF in New Haven. Without appropriate funding and resources, it would be incredibly difficult to implement a SCF. Informants indicated that these much-needed resources and funds may not currently be available.

“New Haven’s broke, right. Like it's going to cost money to fund and implement a site, particularly if people have in mind that it needs to kind of like...so this has always been the danger of Insite [REDACTED]...it reinforced for people that, ‘Oh, we need [a] nursing station, nursing resource room, booth set up in this way, we need this footprint, we need the staffing compliment.’ That costs money and New Haven has no money.”

Without appropriate and sustainable resources and funding, any entity in the city would face difficulty opening a SCF.

**Barrier – Yale**

The presence and influence of Yale in the New Haven space was indicated by key informants to have advantages and disadvantages contributing as facilitators and barriers to implementation of supervised consumption services. This theme specifically explores the impact of Yale as a potential barrier, with its role as a facilitator explored in the following section. Key informants indicated that there are attributes of Yale and its omnipresence in New Haven that would strongly contribute as a barrier to SCF implementation. There are ways in which Yale may stand politically and structurally opposed to supervised consumption.

“I think Yale is huge. I mean they are absolutely a little “c” conservative entity. They kinda got a good game going and they don’t want to mess it up. They’re looking for the long term, they don’t want to do any big changes. I mean, arguably, a big “C” conservative entity as well. I think they are absolutely. It's not going to be located on Broadway, not that that would be the right place, but you can think Yale's push. I mean, a place like Broadway is kinda like a mall. It's like they would rather have like empty storefronts on Broadway then have something
that's not a Lululemon. And putting a safe consumption site in New Haven is absolutely not in line with that type of vision for the city.”97

In thinking back on the issue of a lack of resources for the implementation of a SCF, key informants also indicated that Yale may serve as a financial barrier as well.

“Yale’s a leech in New Haven. It’s simultaneously destroying the municipal tax base, while not meaningfully step[ping up] to the plate to address rampant inequity. And you know, Yale could probably do a lot more to move these things forward by getting out of the way and, just like paying its fair share New Haven.”96

Lastly, the relationship between Yale and the New Haven community, a relationship that has been marked by tension and perceived elitism of Yale by the community, may serve as a barrier to the implementation of a SCF in the city.

“That’s where the town-gown dynamic comes in and the reason why I bring it up is that I think actually a lot of harm reduction initiatives would be generally popular in New Haven if people in the Yale community can do a better job bridging that town-gown divide....my impression was there was some unnecessary division, because there was an impression that we have Yale elites sticking their noses up at the people who are scared.... that dynamic creates missed opportunities for broader acceptance and interest in harm reduction beyond the Yale community in New Haven.”101

The role and influence of Yale in New Haven is undoubtable. If Yale were to position itself in opposition to something like a SCF in New Haven, the power that Yale wields would stand firmly as a barrier to implementation.

**Additional Barriers**

In addition to the thematically coded barriers above, there were other barriers mentioned less frequently by key informants, but that my review of the literatures and the contextualized global and national stories of SCFs suggest are still highly relevant as specific barriers to implementation of SCFs in New Haven. A barrier that came up infrequently but is highly relevant is the federal law and legal barriers in place that can
be employed in opposition of supervised consumption, namely the Controlled Substances Act. The federal regulations and legal barriers may have come up infrequently due to the fact that the interview questions asked specifically about barriers in New Haven. However, although the implications of the federal law are not exclusive to New Haven, they inevitably influence the implementation of a SCF, as one informant very bluntly noted, “There are federal regulatory barriers, including the Department of Justice, that are a barrier.” In thinking about how to navigate the barriers of federal law, there seemed to be a mentality that there either needs to be policy change or there needs to be the will to work without it.

“So, you know structural level, I mean we need federal policy change or we need political courage to ignore the need for federal policy change and for someone to just go ahead. And either of those could work.”

Although it was not mentioned as frequently as other barriers, federal policy and legal barriers are some of the most serious threats looming over supervised consumption and harm reduction more broadly. While political courage may be needed to “just go ahead” and move forward with opening a site, this does not overcome the overarching threat and presence of federal opposition by way of the Controlled Substances Act.

Another less frequently mentioned barrier that holds weight in New Haven is the role of policing. For decades, New Haven has seen policing trends which reflect a false idea that police are enforcers of publicly understood morality, rather than the law. In cases where new, more progressive, leadership is appointed, there is often a gap between what those leaders say and what is actually practiced by the rank and file officers throughout the city. This becomes highly relevant when thinking about how drug use, overdose, PWUDs are moralized and stigmatized in New Haven, effectively dictating how they are policed. In addition to trend policing and inconsistencies
between what leadership says and what is done, the presence of police in New Haven is incredibly strong, with the New Haven Police Department (NHPD), Yale Police Department (YPD), and Hamden Police Department (HPD) making up the “Triple Occupation” of New Haven. This “Triple Occupation” results in opacity with regarding to conduct of officers and the surveillance of people in New Haven. These police forces have an amplified presence in the city due to the number of officers per capita totaling around or above the national average (2.4 officers per 1000 residents), with HPD employing 1.7 officers per 1000 residents, NHPD employing 3.1 officers per 1000 residents, and YPD employing 6.7 officers per 1000 students. The number of officers across all three police departments totals 601 officers in the city. If members of these police forces are in opposition to the implementation of a SCF, they too would serve as a very tangible barrier in the city.

“I think the challenge is, among the police department, the police Union and some of these working class communities, that town-gown divide is still a danger because they think they're...it can get caught up in the larger cultural upheaval of the moment and people who might otherwise be open to more humane treatment of people with addiction, if it gets polarized, you know [in the] culture wars of the moment, it could could cause people who might be willing to consider change becoming resistant and kind of reactionary way.”

The policing of PWUDs in New Haven could certainly translate into a policing of any sort of SCF that would be implemented in the city. Police could very well serve as a barrier to implementation, as well as a barrier to access for PWUDs, if a facility were to be opened.

A final barrier indicated by a key informant that is highly relevant to the discussion around SCFs in New Haven is the language used to describe the intervention.

“The messaging cannot be ‘safer use site’... the appetite exists for ‘overdose prevention.’ That is the public health framing that has been suggested very
heavily. Because, then it is a preventative measure, it is proactive. And it focuses on solving the end problem, not providing the means that could lead to an overdose. It's like a little psychological and political framing switch, but I think it's telling of what those folks have an appetite for.”

Any potential for SCFs in New Haven could be halted before implementation was even able to begin if those working towards implementation were to use language that was not palatable to people within the city and at various levels of government. Thinking critically and strategically about language is highly important, and using what may be deemed by others as the “wrong language” stands as a firm barrier to implementation. The barriers elucidated by key informants provide critical insight into what is imperative to be thinking about in movement towards implementation of a SCF in New Haven. Any entity interested in progressing on supervised consumption in the city would want to consider how these barriers are addressable, in the current moment and through coordination with specific allies, in order to move forward.

C2. Facilitators

While it is critically important to identify obstacles, it is also crucial to note what resources are already established that are beneficial, here noted as facilitators. For coding, “facilitators” were defined as, “Anything that may serve to help the process of implementation of supervised consumption services in New Haven.” As was done with the barriers, subcodes within the broader “facilitators” code were identified due to the ways in which they were implicated by multiple key informants. The subcodes identified were labeled as need, New Haven taskforces, organizations, the Vital Strategies Grant, and Yale.
Facilitator – Need: recognition of the overdose deaths as ‘tip of the iceberg’—and preventability of death

Many key informants specifically named “need” as a facilitator which could support initiatives to provide supervised consumption services. This need, as recognized by key informants and other parties within the City of New Haven, serves as a backdrop to the potential for SCF implementation. This need is characterized not only by overdose deaths but by any and all other harms incurred when the health and well-being of PWUDs are not prioritized.

“I think the other thing that supports this is the relative ongoing challenge and ongoing rise in opioid overdose deaths. You know, those numbers are not changing in the right direction, and so that supports looking for additional strategies... I always think it’s important to recognize it's kind of the tip of the iceberg. That for every death, there's so many other individuals who are suffering or experiencing harms related to opioids and potentially not accessing treatment. They're impacted, their families are impacted.... the numbers continue to increase, and so it means that there needs to be consideration of other strategies that have evidence of effectiveness in other jurisdictions.”

This need is also characterized by the continued harm and death that is entirely avoidable.

“The safe consumption sites are absolutely necessary. I've lost so many clients.... These are completely preventable if there was a site. So, I mean, it's just unquestionably necessary and you see the numbers that come out of Quinnipiac Valley Health and every week it's just 30 or more now. It didn't used to be like that. So, to give people the opportunity to live and just be in a safe place. It's huge.”

It is evident that there is a pressing need for additional interventions for PWUDs in New Haven. However, if need were enough, movement on harm reduction in the city would have progressed far beyond where it is currently. Nevertheless, the understanding of this need serves as a facilitator for potential implementation in tandem with other facilitators.
Facilitator – New Haven Taskforces as making space for action

In recent years, the City of New Haven and Yale have convened several complementary taskforces to discuss harm reduction and the overdose crisis in the city. Many key informants saw these taskforces as facilitators to the potential implementation of SCFs in New Haven. Several key informants credited Gregg Gonsalves, a professor at the Yale School of Public Health, Yale Law School, and devoted harm reductionist, to bringing these taskforces together in a beneficial way.

“I will say Gregg has done a great job of sort of getting people in the same room and starting to have sort of conversations together, because I think they’ve been an opportunity where, for example, we knew SWAN existed....but I never like sat in a room with them. But now I can say, ‘Oh I’ve been on phone calls with them, I’ve sat in a room.’ So, I think that effort that Gregg and company have done to start having people together and meeting and talking has been very helpful.... people are meeting and service providers are meeting with researchers, are meeting with potentially some people in the city to try to move these conversations forward.”

Importantly, many people on the taskforces work to ensure that when talking about health and health services in the city, PWUDs are being considered.

“Well, I mean things are already happening right, where Gregg Gonsalves is leading the harm reduction group and holding meetings and getting the input of experts who then say, ‘Oh, we can't forget about people who use drugs,’ and want to have them included which I agree with, and is critically important.”

These taskforces do work to have the ear of people throughout different parts of Yale, in different service organizations, city departments, and city government. Their presence and emphasis on centering the needs and health of PWUDs is a crucial facilitator in the New Haven landscape.

Facilitator – Organizations

Adjacent to the New Haven taskforces serving as facilitators, key informants also indicated that organizations in New Haven serve to facilitate potentially successful
initiatives of SCF implementation in the city. The culture of harm reductionist organizations in New Haven helps bolster the culture around harm reduction frameworks and serves as a facilitator for new interventions.

“I’ve worked at the APT foundation in the past, and I think at it’s very core, it is very harm reductionist. You know being open access as a [n opioid treatment program] is harm reductionist. They have had that sort of influence in New Haven, in setting a really high bar for what we ought to expect out of OTP in having good access to treatment. I’ve worked with SWAN...I think that they work closely with Cornell Scott and Phil Costello who does their kind of medical care and I think they’ve been big proponents of just meeting women who have transactional sex where they are. I think that’s harm reduction.”

Other key informants reinforced the role that the APT Foundation plays in the city and how their presence and mission serve to facilitate the potential for SCFs.

“So APT Foundation has always been a leader in, frankly not just locally, but nationally sort of taking these types of strategies and incorporating them in the treatment that they provide to patients who use substances. It’s hard to underestimate the value of a local community based organization and treatment facility in supporting these types of efforts.”

As stated by key informants, having support from established community organizations will be beneficial to any movement on the implementation of SCFs in New Haven. With a wide variety and amount of service organizations in the city, the impact that buy-in from community organizations could have would be a strong facilitator.

**Facilitator – Vital Strategies Grant**

In 2020, the City of New Haven received a grant from Vital Strategies, Inc., a global Bloomberg affiliated non-profit, that, “helps communities address substance-abuse crises through ‘harm reduction’ strategies.” This grant placed Christine Rodriguez in New Haven to work full-time for the city coordinating the work of harm reduction focused groups as well as, “city government-run efforts through a new Harm Reduction Task Force, operated under the aegis of the city’s Community Services...
Many key informants saw this grant and this new role as a facilitator to moving the needle on harm reduction and on supervised consumption in New Haven.

“I think, with Vital Strategies, placing somebody in tandem with the city, somebody like Christine Rodriguez who is well versed, I think that's a huge step and so that's incredibly hopeful. And really just hope that as she integrates herself into the political machine, it becomes more accepted to for us to push those envelopes. I know the conversations are happening.”

The work, efforts and mission of the grant and the coordinator position seem to resonate with city administration, including the Community Services Administrator, Dr. Mehul Dalal, which additionally serves as a facilitator.

“Well I've found the city scene to be very interested and I've spoken with Dr. Dalal and Vital Strategies had previously picked, and has hired, Christine Rodriguez to help the city roll out some harm reduction strategies, which is incredible.”

By accounts of key informants, this grant and the coordinator position serve to facilitate opening doors and pathways to potentially new harm reduction services in New Haven, inclusive of SCFs.

**Facilitator – Yale**

As previously noted, Yale was indicated as a facilitator to the potential implementation of a SCF in New Haven in addition to its role as a barrier. The advantages that Yale provides to the effort around SCF implementation reflect ways in which Yale can use its influence and power in New Haven in a way that is, hopefully, less exploitative and more helpful. Many of these facilitators indicated by key informants centered around Yale’s research capabilities and the “forward thinking” people currently at Yale who are committed to harm reduction work.

“So, the group of people at Yale, there’s a very interesting and wonderful group of people at Yale that are dedicated to researching harm reduction and care about
the principles and practice of it on kind of a city and a state level. So that’s really exciting.”91

While research can quickly become exploitative and problematic, the fact that there are researchers at Yale devoted to practicing research in way that is inclusive of and born from harm reduction principles stood out as a facilitator. Additionally, some informants spoke more broadly of the resources that Yale brings to the city.

“New Haven, it’s like many other American cities, but the unique thing, of course, is that Yale University is here. Which is very big....It provides opportunities for New Haven because it brings resources here in New Haven that wouldn’t otherwise be here because Yale’s here.”101

The draw that Yale has for people and resources has the potential to be highly beneficial as a facilitator for the implementation of SCFs in New Haven, as long as it continues to draw in people and resources with harm reduction principles centered in their practice.

C3. Next Steps

During the semi-structured interviews, key informants were asked to share what they believed were crucial next steps to moving forward with the implementation of a SCF in New Haven. For coding, “next steps” was defined as, “Important next steps to take towards the implementation of supervised consumption in New Haven.” Given the current landscape of facilitators and barriers present in the city, key informant interviews provided insight into what needs to start happening as soon as possible in order for the needle to begin to shift towards SCF implementation. One crucial next step identified by key informants was relationship building and getting buy-in from various different communities within New Haven.

“So, I think literally the step would be a public conversation. I don’t know if this conversation has ever taken place, but even the term harm reduction feels like not everyone knows what that means or could identify with that, and so I think a
public conversation on what it is, the different faces it could take, different things that are done around the country and then really getting buy-in.”

In addition to having conversations with the general public, communities of New Haven, and people who may be directly impacted by the implementation of a SCF, key informants also identified the need to get more groups of people involved.

“You’ll need buy-in from community leaders, buy-in from government leaders, buy-in from treatment providers, probably buy-in from sort of the standard routine health care providers, including the emergency medicine or the emergency medical services, as well as the hospital to at least be permissive. So there needs to be a shared perception that this is worth pursuing and of potential benefit.”

While some key informants keyed in on the need for relationship building and public conversations as next steps, others felt that the most crucial way forward was to just do it.

“Figure out what the model is and just do it. Is it a standalone site? Is it a van? I mean honestly it probably should be a van, like a repurposed RV? Because that would probably make the most sense, or is it two of them? Get someone to give you the money and just...Fuck it just do it. Don't spend the next two years, doing feasibility studies and community engagement or anything else, people are dying just go ahead. I don't see the point of waiting around stuff like this anymore. Right like it's...wait and hope it becomes popular enough to actually do? No, just do it. Demonstrate that it works.”

Although the “just do it” mentality may be in stark contrast to the framework of relationship building, it speaks to the perception that there is a drastic need for a change in a very immediate sense. Whatever the next steps are to be taken, it is clear from the key informant interviews that this process needs to start as soon as possible.

C4. The Sine Qua Non of Meaningful Policy Change: Policy option, Political circumstances, and Problematization

The facilitators and barriers highlighted by key informants provide contextualization to how certain institutions, individuals, and frameworks are situated
and interact in New Haven. The following three sections discuss how the landscape in New Haven can be analyzed through Kingdon’s Multiple Stream Theory based on responses from key informants.

C.4.1 Policy Option

The concept of a “policy option” represents one of the three key facets of Kingdon’s Multiple Stream Theory that this study examined in relation to the New Haven context. It would be impossible for supervised consumption to be implemented in the city if it were not seen as a meaningful policy option. However, responses from key informants appeared to indicate that supervised consumption is very much on the table as a policy option in the city, as even proposed by current Mayor Justin Elicker.

“The city’s relatively receptive around harm reduction right now, and I think that creates a unique space that could allow for scale up of more comprehensive harm reduction approaches that exist elsewhere. Certainly the mayor ran on a platform that included potentially supervised consumption sites and that’s a rare thing in any community… I mean you definitely say that about the U.S.”

“As far as like municipal entities, there's been some really great movement among kind of senior officials in this administration.... So hopefully we'll be seeing some movement around that. Just the fact that they’re willing to say the words safe use site is important.”

Additionally, the importance of movement towards supervised consumption as a policy option in other cities across the country cannot be understated. Key informants indicated that the discussions of supervised consumption as a policy option elsewhere enabled it to be a policy option in New Haven as well.

“There’s a momentum thing that happens around supervised consumption as a policy response that creates a reality in which it can even be discussed as a potential meaningful solution to an overdose crisis. So it's being discussed in Seattle, San Francisco, New York, Boston, all of these other cities, I think, creates a space where New Haven can talk about it and I would say, even more so within kind of the network of progressive ideas around intervening around substance
use like, it's kind of positioned in that way and understanding how supervised consumption can be located within these kind of international idea networks in the substance use space is worth considering."96

Situating supervised consumption as a policy option is crucial to the potential of SCF implementation. Based on responses from key informants, it appears that supervised consumption is highlighted as a policy option in New Haven and, if aligned with the other two streams, it serves to set the city up for policy change, according to Kingdon’s theory.

**C.4.2 Political Circumstances**

Along with the need for supervised consumption to be considered a policy option, Kingdon also indicates that in order to see policy change, there must be conducive or aligned political circumstances.5 With regard to New Haven specifically, key informants indicated, as in the case of policy options, that there seems to be a conducive political climate for talking about SCF implementation.

“The harm reduction practices all of a sudden became mainstream public health practices, endorsed by a wide variety of stakeholders and that has provided legitimacy to a variety of harm reduction practices. So I guess, I would say that of late, there seems to be a greater endorsement and support for harm reduction activities.”98

While some key informants reported political circumstances that seemed aligned with the potential for SCF implementation, others were more skeptical.

“So, I think the conversations that are being had are really good and everybody means really well but, at the end of the day, it seems like the political climate is what dictates and being in Connecticut, as much as people like to think it's blue, it’s purple. So we are where we are....But, there's the entrenched morality that hinders politicians, specifically from making good policy decisions and putting forth good policies to kind of expand the services that are globally known to have incredibly positive outcomes for a significant amount of people.”107
Finally, many key informants also noted, importantly, that New Haven is situated within a broader political and cultural context that underwent distinct changes in the past year.

“In this country, cultural change is afoot and fingers crossed hopefully for the better. The broad social awakening about racism and structural racism nationally and also in New Haven, overall helps the cause of promoting harm reduction, because of the way that addiction, especially in cities, historic cities where black populations migrated generations ago...there’s a convergence of interest. I do think that the awakening that’s happening right now around racial justice does present opportunities....the reason why presents opportunities, it's putting more pressure on politicians and institutions.”

The current political circumstances in New Haven may lend themselves to alignment with the two other key features identified as key within the Multiple Stream Theory, especially with the positioning of supervised consumption as a policy option. Lingering skepticism regarding favorable political circumstances is telling and the future of SCF implementation in New Haven may rely on ensuring that these circumstances appropriately align.

C.4.3 Problematization

The third and final facet of Kingdon’s Multiple Stream Theory rests on the idea of “problematization,” or the terms under which an issue is framed as a specific kind of problem (e.g., a problem of health, of morals, of good will, of law, etc.). While having the appropriate policy options and political circumstances are imperative for potential policy change, they are somewhat moot without the issue being problematized in a way that allows for connection to the changed political circumstances and policy options. In the case of supervised consumption, overdose and the morbidity and mortality of the overdose crisis needs to be problematized in such a way that lends itself to identifying supervised consumption as a helpful tool, as drug use and overdose as a problem of
health rather than morality, and is in alignment with the other two steams, policy
options and political circumstances. Key informants characterized exactly how the
morbidity and mortality of the overdose crisis are problematized, including how they
problematize these issues and how others see them. One key informant problematized
the issue by expressing their shock at the data:

“I mean a lot of people are dying in Connecticut, right? Like it's a crisis and I
don't think we can separate out things that might set conditions for this by not
first recognizing...I think I saw the data today and I was struck by how many
people have died. It's a super high overdose rate and it's completely addressable.
Fentanyl obviously is a game changer because it terrifies people.”

Although key informants, who have experience and expertise in substance use and harm
reduction, may problematize these issues a certain way (i.e., as public health problems),
they also provided insight into how other members of the public may view these issues.

“I think for the sort of the average person they just don't know that information
and all the messages they've received are, ‘drugs are bad,’ and the other thing is
this hierarchy of drugs right like...that those of us who go and buy alcohol on a
Friday and have some cocktails and all that sort of culture around drinking...like
they see that so differently than they would see somebody sniffing or shooting
heroin or fentanyl.”

By comparing the widely accepted use of alcohol to the far less widely accepted use of
other drugs, like heroin and fentanyl, we can see how the general public may
problematize issues around substance use a product of the use of certain “bad” drugs.
This type of problematization may set back efforts towards SCF implementation as it
leans on morality and crime as the key features of the problem. Finally, other key
informants indicated how the problematization of substance use and addiction has
historically not mirrored the way medicine has problematized other conditions.

“Historically there's an expectation that there's only one appropriate outcome for
people who use substances and that's abstinence and anything short of that is
permissive of ongoing substance use. That reflects a mindset that's completely
inconsistent with the way we view depression, depressive symptoms, even
The way in which the overdose crisis is problematized greatly contributes to the feasibility for SCF implementation in New Haven. While key informants and certain city actors may have problematized the crisis in a way that is usefully aligned with the current political circumstances and supervised consumption as a (health) policy option, key informant responses also indicate that there is work still to be done, on both a small and large scale, to create synergy of problematization across multiple groups of people.

A widespread shift in the public perception of drug use and overdose to one that reflects them as treatable health issues, rather than moral failings, allows for SCFs to be discussed and implemented as health interventions to promote better health outcomes. Greater alignment with this way of problematizing drug use and overdose may result in an easier progression toward SCF implementation and less opposition upon the opening of a site.

C5. Keep in Mind: Contextualizing Kingdon’s Theory in New Haven’s Reality

The final parent code utilized in this study was the code, “keep in mind,” reserved for topics and issues brought up by key informants that should be kept in mind when thinking about the implementation of supervised consumption in New Haven, but may not have seamlessly fit into other thematic codes. These codes serve to provide additional information about current factors at play in New Haven that provide nuance to how those looking to implement a SCF in New Haven should proceed through the potential policy window opening in the city. As with “facilitators” and “barriers,” “keep
in mind” was broken down into subcodes for greater clarity. These subcodes are labeled as center voices of PWLE/PWUDs, differing substance use, racial equity, and “what else,” understood as what else can be offered by a SCF in New Haven on top of supervised consumption services. In thinking about SCF implementation in New Haven, the response from key informants contained within these codes are important to remember, especially given that they are often left out of work that claims to be harm reduction, but fails to center harm reduction principles and the needs of PWUDs.109

**Center Voices of PWLE/PWUD**

Key informants indicated that it is absolutely vital for any action or discussions around the implementation of SCFs to center the voices of people with lived experience (PWLE) and PWUDs. This goes hand in hand with the need for organizing or unionization of PWUDs in New Haven, but is distinct in that it requires action on the part of those with power, who are not PWUDs, to relinquish control and provide space for PWLE/PWUDs to lead in these discussions.

“So, to go back to the community piece, just resurface when these discussions are happening, it's predominantly white people from Yale. And that needs to be figured out here, because I don't know how you intervene in New Haven without the community engaged and that can't happen if that's what the folks involved in this look like and, frankly, how their positioned...and you know that seems to be this community overall for how things get done and how intervention happens, but it really can't be. And people need to commit to and actually pony up the resources to create a space to center other leadership. And figure out what that can be and that's not going to be an overnight thing, but that has to happen overall in intervention around anything in social justice and health equity here and I would love to see that happen.”96

Providing space for leadership by PWLE/PWUD may not happen overnight, but many key informants see the need for it as soon as possible.

“There needs to be some cultural humility throughout the system, and I think that needs to happen immediately, and I think that it should lead to folks having
a seat at the table, and at the head of the table, but also because that will lead to better care for everybody.”

Centering the voices of PWLE/PWUD and allowing them to lead is not passive. It is something that takes deliberate action on the part of people with power and may be pivotal for New Haven’s ability to implement new harm reduction strategies, such as SCFs.

**Differing Substance Use**

Another critical aspect of supervised consumption that key informants noted was the need for planning and implementation to be inclusive of differing substance use. This is seen in the deliberate reference to these facilities by a name that is inclusive, like “supervised consumption facilities” or “overdose prevention programs” rather than something more exclusive, like “supervised injection site.” Key informants noted the need for programming to include PWUDs who use substances other than and in addition to opioids and methods of consumption other than or in addition to injection.

“But that that is to say that functionally not all people shoot and so therefore like if you're going to have a space for folks to hang out who snort or take pills or smoke, you need to you need to consider everybody, but also that a diversity of tactics really is what needs to be employed.”

The need for a diverse approach to a SCF that accommodates a variety of consumption methods and drug types is crucial, given the prevalence of intentional polysubstance use and the tainting of the drug supply, as noted,

“So, this comes up, and I think this is everywhere, but not just opioids. Stimulant involved deaths are spiking. Everyone uses many things. And we don't know what's in any of those things, so any interventional approach needs to accommodate multiple types of drugs, multiple routes of administration from injecting to smoking to snorting to anything else.”

The inclusion of differences in substances used and their routes of administration in the planning and implementation of a SCF in New Haven would be critically important to
its ability to alleviate some of the burden that the overdose crisis puts on PWUDs. Finally, operating a SCF that is accepting and inclusive of differing substance use adheres to the core principles of harm reduction.109

**Racial Equity**

Another highly important component of SCF implementation and harm reduction in New Haven voiced by key informants was the need to proceed in a way that prioritizes racial equity. Drug use and harm reduction are, “deeply racialized”100 and in order to implement truly harm reductionist interventions, any progress made towards SCFs in New Haven will need to reckon with the racism of the War on Drugs and of the city itself.

“I think unpacking NIMByism, unpacking racial politics. I think people need to reckon with crack/cocaine and the legacy of crack/cocaine and the destructiveness that in had in black communities and the way black communities have been harmed by policing, systemic poverty, disenfranchisement, loss of jobs, mass incarceration, and haven’t really felt safe.”91

“Of course, this is all embedded in oppression and racism. And that's, the main thing, so I also think if we're if we're looking at our the racism that is institutionalized in our nonprofits, in our state government, and the United States...if we start dismantling those structures, we open up the possibility to be able to look at drug use in a different way.”99

This racism is deeply rooted in all parts and parties that may be involved in implementation of a SCF in New Haven. It is vitally important that this work focus on breaking that down to center racial equity.
**What else?**

Finally, key informants noted that a SCF in New Haven, while it could be something as simple as a place where people are supervised during and after their drug use, could and should provide much more than that.

“All supervised consumption does is give space to the primary overdose prevention recommendation that we give to folks who use drugs, which is don't use alone and have Naloxone with you. We really need to demystify this in the sense that it really actually could be that simple. It doesn't need to though. It could have a lot of other services mapped onto it because, frankly, people need a lot of supports. Often, probably not the ones you're thinking of you know, access to housing, assistance addressing entanglements with the with carceral systems, different things like that.”

We know that contact with additional services within a SCF lends itself to the improvement of health, well-being, and social functioning of people who access the sites. The inclusion of other services beyond supervised consumption within a SCF should be kept in mind when thinking about implementation of a facility in New Haven.

**D. Discussion and Strategic Planning**

Close reading of the statements of the key informants provided essential insights into the current landscape of facilitators, barriers, and other key factors at play when thinking about the implementation of a SCF in New Haven, CT. These insights provide an understanding of how New Haven is currently positioned with regard to the expansion of harm reduction services in the city and potential paths forward. Most importantly, they suggest that New Haven is headed towards a potential policy window in which the successful implementation of a SCF in the city may be feasible.
D1. Applying Kingdon’s Theory of ‘Alignment’ to New Haven

As previously introduced, John Kingdon’s Multiple Stream Theory indicates that a window for policy change opens upon the alignment of policy options, political circumstances, and problematization of a specific issue.\textsuperscript{5} The key informant interviews gave clear indication of how New Haven is currently situated within this framework. Responses from key informants indicated that supervised consumption is on the table as a policy option in New Haven. At various levels within the city of New Haven – the task forces, Community Services Administration, and the mayor – there are people in positions of power who have set forth supervised consumption as an option. This will need to be sustained in order to make the possibility of a SCF in New Haven become a reality.

Key informants also elucidated that current political circumstances within the city may be aligned with this policy option and conducive to policy change around supervised consumption. Again, with a mayor and Community Services Administrator on board with SCF implementation, as well as reinforcement from the broader political circumstances currently shifting the United States, the political climate in New Haven seems very much open to supervised consumption. Hayle notes that the move towards supervised consumption in Canada was made partially possible by the election of less conservative politicians,\textsuperscript{95} a recent shift we have seen in New Haven, with the election of Justin Elicker as Mayor, in Connecticut with an empowered progressive wing in the state legislature, and nationally, with the election of Joe Biden as President. Although there is lingering concern with regard to Connecticut being more purple than it is blue,\textsuperscript{107} the Connecticut State Legislature has started to show this shift toward more progressive policies, including efforts to legalize cannabis with provisions to increase
equity and account for past racial injustice in drug law enforcement, efforts to define harm reduction outreach staff as essential community health workers, and the need to spend the recent influx in opioid settlement and American Rescue Plan moneys on evidence-based practices. While the Biden administration has been relatively quiet regarding moves on supervised consumption specifically, the American Rescue Plan does designate $30 million to be used to, “support community-based overdose prevention programs, syringe service programs, and other harm reduction services.”

The language of “overdose prevention programs” may be of particularly use to those looking to implement SCFs in New Haven and is of critical note when held in conjunction with responses from key informants indicating that “overdose prevention” is the advised terminology when talking about SCF implementation. Additionally, coming to an understanding of what position the Biden administration will take vis a vis § 844 and § 856 will be critical in taking steps to move forward on supervised consumption.

It is in the final of Kingdon’s three streams, problematization, where my analysis of key informant responses indicates that New Haven is falling short. Although New Haven declared overdose a public health emergency in 2016, many in New Haven still view overdose, and substance use in general, through a lens shrouded by stigma, moralization, and criminalization that is misaligned with harm reduction’s understanding of substance use. Again, although there are people in positions of power in New Haven who are aligned with SCF implementation, alignment within the community will also be crucial to successful and sustainable policy change and implementation of a SCF in the city. Hayle notes, in comparing SCF implementation in Canada to the failure for implementation in England and Wales, that Canada was able to
implement SCFs because the potential to improve the health of PWUDs overshadowed the concerns about crime. If New Haven is going to fully open the policy window for supervised consumption services, there is work to be done to shift the point of concern and center the health and well-being of PWUDs.

D2. Working Towards Aligned Problematization

Given the current alignment of supervised consumption as a policy option and the political circumstances in New Haven, there may be a need to act quickly with regard to SCF implementation in the city. However, this may also be the opportunity to employ the crucial relationship and trust building noted by the key informants. If those in New Haven who are working towards supervised consumption want to give it the best chance at passage and sustainability, open discussions, listening sessions, and relationship building with members of the community will be important. While this relationship building is crucial in and of itself, this process should work also towards creating aligned problematization of the overdose crisis and support, or at least permissiveness, of supervised consumption. These discussions would need to take place with people across the many communities of New Haven, across neighborhoods, demographics, among and between PWUDs and people who don’t, and should be led by people who are of the community, rather than someone who may be interpreted as an outsider. Work like this takes time, but in order to ensure the implementation of progressive action, it is critically important and must begin as soon as possible. It would be remarkably difficult to implement an overdose prevention and harm reduction intervention in the community if they do not problematize the morbidity and mortality of the overdose crisis as what they are – avoidable public health emergencies.
D3. Additional Strategic Planning

In addition to aligning problematization of substance use and the overdose crisis with the current policy options and political circumstances in New Haven, there are additional strategic steps that are likely to create movement towards the implementation of a SCF in the city. Beletsky et al. outline the critical steps that should be considered when attempting the implementation of a SCF, with two steps that are attainable for New Haven in an immediate sense; a decisive choice to pursue supervised consumption and planning for implementation.\(^{27}\) If applied to a New Haven context, these could work in support of the SCF implementation in the city.

1. **There needs to be a decision by a local or state authority to pursue SCFs as an intervention.**

   Although it appears that no official decisions of this type have been made for the City of New Haven or the State of Connecticut, the work of the mayor, Community Services Administration, and New Haven Taskforces appears to be working towards a way to decisively start this work. Once a choice like this is made public, it will be crucial that those involved have done their homework to prepare for not only implementation, but backlash as well.

2. **The Planning Phase**

   The multiple aspects of the planning phase in New Haven can and should be done simultaneously. The first part of planning, as articulated by Beletsky et al.,\(^{27}\) is the collection of evidence, which when applied to New Haven, would be a collection of evidence in support of supervised consumption facilities as well as evidence of the need...
for such services in the city. As emphasized by key informants, the evidence of need cannot and should not be seen only through the lens of those within the academy of Yale or the city municipal buildings. This process must center the voices, experiences, and expertise of PWUDs in New Haven at every step. Here is where the New Haven Taskforces, made up of service providers, Yale academics, and city representatives can act as a facilitator and begin to give PWUDs a seat at the head of the table. Let their experiences of using substances, accessing harm reduction, and existing in New Haven serve as evidence and credible knowledge in addition to the countless studies that have already proved the efficacy of SCFs as an intervention. This process would also serve to re-structure the narratives of problematization by having PWUDs work in tandem with others to define the problem. Tangibly, this operationalizes as inviting PWUDs to be meaningfully involved in the planning of a SCF in New Haven, every step of the way, from discussions with City government, to decisions regarding who will operate the facility, to what exactly they want offered and so much more.

The planning phase is also the time for garnering stakeholder support for supervised consumption in New Haven. This process should happen alongside the work to align the problematization of the overdose crisis. If not done carefully and deliberately, poorly managed relationship building could drive the process of alignment off the rails. Conversations, trust, and relationship building with stakeholders will need to include people from across the New Haven landscape, as articulated by one key informant, inclusive of community leaders, government leaders, treatment providers, EMS, and Yale New Haven Hospital. Building these relationships can hopefully garner buy-in from these groups, either as active support, silence, or non-interference. Implementation could also be facilitated if those of particular influence in the city, such
as government leaders, service organizations, and Yale New Haven Hospital, were to show buy-in through funding and active de-stigmatization efforts. In addition to all of these players, stakeholder buy-in (again through active support, silence, or non-interference) from PWUDs, business owners, other members of the Yale community, residents of New Haven who do not use drugs, and religious leaders will be essential. Hayle cites the buy-in from religious leaders as a contributing factor to the implementation of SCFs in Canada.\textsuperscript{114} The role and influence of religious leaders in New Haven is sizable\textsuperscript{97} and securing buy-in from religious leaders in the city could be strategically advantageous for those looking to implement SCFs.

Finally, during the planning stage, Beletsky et al. recommend preparing for the legal ramifications at either the state or federal level, as well as analyzing the criminal codes and regulations governing the conduct of medical professionals.\textsuperscript{27} In at least one conversation (outside the key informant interviews) with a well informed and engaged legal and public health actor, I got the inference that the political climate at the local and state level suggests that neither state nor local officials would seek to take legal action against a SCF in New Haven.\textsuperscript{115} It will also be crucial to look into the regulations governing medical professionals in Connecticut, given their primary role in overdose prevention protocols at medicalized SCFs. If New Haven were to pursue a non-medicalized peer model, allowing for employment of PWUDs at the SCF to do the job that physicians and nurses do in medicalized models, this may be less of concern and would also allow for continued meaningful involvement of PWUDs in not only accessing services, but doing the work they are already doing for each other in a way that compensates them for their skills. However, medicalized models are more widely accepted by the general population\textsuperscript{88} and therefore may be easier to implement in New
Haven. This would be an important opportunity for the input of PWUDs, in order to determine how they would want a facility to operate, listening to their input, and operationalizing it when implementing a site.

An additional consideration, when preparing for the legal ramifications associated with the opening of a SCF in New Haven, would be the current Good Samaritan Law in Connecticut. Presently, this law provides immunity from civil or criminal liability for health care professionals who prescribe, dispense, and/or administer opioid antagonists (e.g. Naloxone), as well as anyone else who administers an opioid antagonist, “if acting with reasonable care” when they believe that someone is experiencing an opioid overdose.\textsuperscript{116} While the Good Samaritan Law currently reads as fairly comprehensive to protect those acting in good faith to reverse an overdose from these liabilities,\textsuperscript{116} this law should be amended to ensure that individuals who operate, oversee, and provide care at SCFs, including physicians, nurses, and additional staff, are protected. The process of amending this law should take into account input from those working towards and in favor of SCF implementation, particularly PWUDS, healthcare professionals, and harm reduction organizations, in order to ensure that the law appropriately covers those supervising all sanctioned SCF activities. While working within or reforming federal law is often the first thought when preparing for the legal ramifications of SCF implementation, state level policies that influence the care of PWUDs, like the Good Samaritan Law, need to be considered as well.

Beyond the scope of Beletsky et al.’s scaffolding is the need to settle the issue of location that was identified by key informants. The process of choosing a location, or locations, for one or multiple SCFs in New Haven may very well be an arduous and
contentious process. While the talks around location(s) could and should certainly be brought up during the process of relationship building with stakeholders, it will also require more in-depth discussions and negotiations with the city, the Alders, business owners, and the residents of the neighborhoods in which a SCF could feasibly be located. While a brick and mortar building is often conceptualized as what a SCF might look like, it may also be beneficial for those looking to implement SCFs to look into mobile options, such as the overdose prevention van operated in Scotland. A mobile site or multiple mobile sites may allow for services to be accessible to more PWUDs in New Haven, given the way in which they are dispersed across the city, as noted by key informants. Additionally, something like a mobile site may actually be better protected from legal action by the federal government under the Controlled Substances Act as articulated by Judge Roth in the dissenting opinion in the United States vs. Safehouse 3rd circuit decision. Judge Roth states:

“At oral argument, the government conceded that Safehouse could provide the exact same services it plans to provide in the Consumption Room if it did not do so indoors— if, for instance, it provided a Consumption Room inside a mobile van. Yet, according to the Majority’s interpretation of section 856(a)(2), Safehouse would be committing a federal crime, punishable by twenty years’ imprisonment, if the Consumption Room services were provided inside a building, rather than in a mobile van, parked in front.”

While the 3rd Circuit decision only sets precedent for the geographic areas within the 3rd Circuit (Pennsylvania, New Jersey, Delaware, and the Virgin Islands) and does not mean that SCFs have been ruled unlawful in the 2nd Circuit, which contains Connecticut, the ramifications are still highly salient. If mobile supervised consumption is a potential loophole against legal action, it may be wise for harm reductionists in New Haven looking towards SCF implementation to consider this option. Most importantly,
the model and location of a site will need to be informed by PWUDs and ultimately located or implemented in such a way that it is most accessible to them.\textsuperscript{118}

In addition to location, there are outstanding variables related to the implementation of SCFs in New Haven that will need to be accounted for, including the awaited action on the part of the state to allocate funds from the American Rescue Plan and the matter of who exactly would be charged with opening and operating a SCF in the city. To the first point, at time of writing, the funds from the American Rescue Plan (ARP) dedicated to community-based overdose prevention services, syringe access services, and other harm reduction services have yet to be rolled out in Connecticut. Along with the $30 billion for these services, the ARP allocates $1.5 billion dollars in state block grants for substance use disorder (SUD) programs, of which Connecticut is set to receive $18.2 million.\textsuperscript{112} In March 2021, a task force of Connecticut harm reduction organizations, service providers, physicians, advocates, and Yale faculty published a letter to Governor Lamont urging that the process of fund allocation include community-based organizations in every part of the process, as well as sustain and expand the state’s harm reduction services, invest in a harm reduction-centered workforce to address the opioid crisis and educate health professionals on how to identify, prevent and treat SUDs, invest in innovative ways to care for PWUDs, ensure that funds are not allocated to any measures or programs that perpetuate stigma and discrimination against PWUDs, and develop a transparent and public mechanism of accountability to ensure that funds are distributed across the state equitably and effectively.\textsuperscript{119} How these funds are allocated, both in process and to what entities, will highlight key factors influential for how SCF implementation in New Haven may proceed, including the Governor’s willingness to work with community-based
organizations, the prioritization of harm reduction, the dedication to evidence-based practices, and the support, or lack of interference, from the state regarding SCFs. Whether or not Governor Lamont will implement these recommendations in the process of distributing ARP funds is an unknown variable that should be accounted for and tracked by those looking to implement SCFs in New Haven.

Tied to the issues of location and fund distribution is the unknown of what entity would be tasked with opening and operating a SCF in New Haven. This factor has remained unaddressed as the process for SCF implementation in the city has yet to formally progress. I do not aim to recommend a specific entity for the purpose of operating a SCF in the city, but urge that the process of selecting who will operate the SCF be a collaborative one, with input from services providers, city officials, physicians, Yale, and PWUDs in New Haven taken into account. The success of SCFs opening as research pilots indicates one potential way forward, but, again, does not directly implicate a specific entity for leading this pilot. The choice of who will operate the site should also be informed by the facilitators and barriers noted by key informants, namely the specific organizations in New Haven that work to facilitate SCF implementation, the taskforces convened in the city, and the role that Yale plays, both as a facilitator and a barrier. The question of who will operate a SCF in New Haven is currently left unanswered, but will need to be determined, and informed by community members from all across the city, if SCF implementation is to be viable.

The strategies and variables outlined here serve as important touchpoints towards the goal of supervised consumption implementation in New Haven, CT. While there are far more facets that contribute to the sustained operation and the acceptability, accessibility, availability, and quality of services provided by a SCF, they
are beyond the scope of this work. While the wheels are only first starting to turn on SCF implementation in New Haven, these strategies, as reinforced by key informants, global examples, and legal precedent will hopefully serve to support work towards supervised consumption in the city.

E. Limitations of this Study

While this study provided insight into the current landscape of barriers, facilitators, and current climate of opinions, understanding, and will for sanctioned SCF implementation in New Haven, there were certainly ways in which it was limited. This work serves as a starting point, not a finish line. Given the small sample size of key informant interviews and the type of key informants that contributed to this work, the finding and analysis are limited to the New Haven context and the perceptions and understandings of service providers, physicians, and Yale faculty. Future work would need to include input and analysis of interviews with local and state government officials, law enforcement, and first responders. Additionally, it will be important for future work towards either exploring SCFs in the city or actual implementation to consult with all of those parties, as well as residents of various New Haven communities, neighborhoods, and, crucially, people who use drugs. A final limitation of this study is that the qualitative analysis was conducted by a single coder, who was also the interviewer. While the interviews were coded multiple times, the use of a single person as interviewer and coder can introduce bias and does not allow for inter-rater reliability. Future work will want to consider the use of multiple codes in order to enhance inter-rater reliability and provide increased input into the appropriate application of the codebook.
VIII. Conclusion

The overdose crisis still presents a formidable public health emergency across the country. The ways in which the crisis has greatly impacted the City of New Haven, CT and the lives of PWUDs here are substantially injurious. Although many New Haven service providers, doctors, and harm reduction organizations have done tireless work to uplift and maintain the health and well-being the PWUDs in the city, the morbidities and mortalities associated with the overdose crisis continue to rise. It is time now, long overdue, to look towards other harm reductionist and evidence-based interventions. Supervised consumption facilities, whether they are housed in buildings, vans, tents, or any other model, present a highly efficacious and harm reductionist response to the ever-increasing overdose crisis in New Haven. The key informants interviewed for this work showed that New Haven may, at this moment or in the very near future, be in alignment with Kingdon’s Multiple Stream Theory, which posits that if problematization, policy options and political circumstances align, there is room for a significant change in innovation, here in initiating SCFs. By acknowledging the facilitators and barriers present in the city, identifying additional contributing factors to contextualize this effort in New Haven, and reinforcing the need for community focused relationship building, key informants indicated the potential ways forward for those looking to implement one or multiple SCFs in New Haven. The lessons imparted by the global and national examples, along with the responses from key informants, provide ways in which efforts for SCF implementation can work to shift and/or overcome the barriers currently at play and move the needle on harm reduction in New Haven.

It appears the city may be entering a key moment with an opportunity to create policy change. This is not only opportunistic, it is necessary. However, it is not
inevitable, as basic education and consensus building outside the specific knowledge circles of my key informants still needs to be done. Additionally, there needs to be deliberate actions on the part of those in power in New Haven to cede some of that power as well as space and time to PWUDs and to center their experience, needs, and critical expertise as harm reduction progresses in the city. This work serves to support current and future efforts of SCF implementation and looks to a more compassionate, harm reductionist, and destigmatizing practice for the health and well-being of people who use drugs.
IX. Citations


25. Fawcett, E. Connecticut projected to exceed last year’s number of fatal overdoses, as COVID-19 results in isolation and fentanyl drives deaths; over 1,300 fatalities expected in 2020. *courant.com* (2020).


73. Court Ruling Could Pave Way For Safe Injection Sites In San Francisco. *Crosscurrents*. 
77. SB-57 Senate Floor Analysis.
100. Key Informant #2. Key Informant Interview #2. (2021).
110. *An Act Concerning Labor Peace Agreements and a Modern and Equitable Cannabis Workforce.*
X. Appendices

A. Appendix A: Recruitment Email

Dear XXXX,

I hope you are doing well.

My name is Mariah Frank and I am a second year MPH student at the Yale School of Public Health (YSPH). As a second-year student, I am in the process of conducting my thesis research. The goal of my thesis is to explore the history of supervised consumption for drug use in the US and globally, the lessons learned from the legislative, administrative, and implementation processes of supervised consumption services (SCS), and use the thesis to develop and analyze the elements of potential strategic plans for implementation of supervised consumption services in New Haven, Connecticut. As part of my thesis, I am conducting qualitative, semi-structured interviews with key informants to learn about the climate in New Haven regarding harm reduction, sentiments towards supervised consumption, and the current barriers and facilitators to implementation of SCS in the city.

This thesis is being conducted under the supervision of YSPH faculty. After undergoing an IRB review, this work was granted Not Human Subjects Research status. If you choose to participate, I will ask if you are willing to have our interview recorded so that I may transcribe your responses for qualitative analysis. If granted permission to record, the transcription will be de-identified through a removal of all identifying information and be given a number for organization. Additionally, the recordings will be destroyed upon transcription. If not granted permission to record, I will take notes during our interview that will also be de-identified and given a number for organization. While there are no formal plans to publish this thesis, parts of this paper may be repurposed as needed for public use in the hopes that it will inform future supervised consumption work. I will not include any statements attributable to you without specific permission for use.

Based upon your previous work, I believe your insight would be crucially helpful to developing an understanding of what the future of SCS might look like in New Haven. As someone who is passionate about harm reduction and eager to learn about the possibilities for future harm reduction services in New Haven, I would very much appreciate if you would be willing to participate in an interview.

If you are willing to participate, please respond as soon as convenient, and I will work to schedule your interview at times convenient to you. All participation is of course voluntary and you can decide to withdraw at any time.

Thank you for your time and consideration.

Regards,

Mariah
B. Appendix B: Qualitative Interview Guide

1. How did you come to be involved with harm reduction?
   a. What specific perspectives and experiences do you bring to this work?

2. What seems to be the current climate around harm reduction in New Haven? In CT?
   a. Among service providers?
   b. Among clients/people who use drugs?
   c. Among New Haven residents?
   d. Among officials, including the Mayor’s office, police, health and fire departments?

3. Given the fact that the Federal government and its laws control access to ‘controlled substances’ who in CT or NHVN connects to, or advocates with the federal drug control implementers?

4. How have different communities’ and others’ feelings around harm reduction played out in conversations around harm reduction services like syringe exchange, drop-in centers, and MAT in New Haven? How are these views and feelings made public?

5. What are current facilitators for supervised consumption in New Haven/Connecticut?

6. What are current structural, political, or institutional barriers to supervised consumption in New Haven?

7. What might be next steps towards supervised consumption in New Haven/Connecticut?
   a. What role does the state play?
   b. Who are allies? Who are potential opposition voices?
   c. What are the oppositional voices saying?

8. Is there anything else that needs to be considered when developing a strategic plan for a supervised consumption facility in New Haven?

9. Would you be willing to share information about my thesis with other people in your network?
   a. If yes: I will email you and follow up after this interview to provide a short paragraph about the goals of this thesis so that you may forward it onto others who might be willing to speak with me. If they want to reach out, they can email me at mariah.frank@yale.edu.
   b. If no: Thank them for their time
### Appendix C: Qualitative Codebook

**Note: Bolded codes are Parent Codes. Codes indented and not-bolded are sub-codes hosted within the broader parent code.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barriers</strong></td>
<td>Anything that may hinder the process of implementation of supervised consumption services in New Haven but does not qualify for any of the more specific barrier codes.</td>
<td>This code includes any details provided by key informants that discuss structural, institutional, cultural, and/or conceptual barriers to the implementation of supervised consumption facilities.</td>
<td>Anything that is not indicated as a barrier by key informants is not included under this parent code.</td>
</tr>
<tr>
<td><strong>Barrier -- PWUD organizing</strong></td>
<td>How the current lack of PWUD organizing in New Haven may serve as a hindrance to the implementation of supervised consumption.</td>
<td>Comments around how PWUDs are not currently organized in New Haven, how the process and discussions of implementation would be different if there was a PWUD organization/union, or other comments about a lack of PWUD organizing.</td>
<td>Any comments unrelated to a lack of PWUD organizing as a barrier</td>
</tr>
<tr>
<td><strong>Barrier -- location</strong></td>
<td>How the potential location selection process for a supervised consumption site may serve as a hindrance to the implementation of</td>
<td>Comments about how certain neighborhood communities, “NIMBYS,” alderman, etc. would make the process of siting a supervised</td>
<td>Any comments unrelated to a choosing a location within New Haven or New Haven as a location itself as a barrier</td>
</tr>
</tbody>
</table>

83
<table>
<thead>
<tr>
<th>Barrier -- resources/money</th>
<th>How a lack of funding/money stands in the way of furthering harm reduction, in particular the opening of a supervised consumption facility.</th>
<th>Comments around New Haven being poor, Yale not paying its “fair share” to New Haven, questions around funding for a site and who would fund it all as barriers to implementation</th>
<th>Any comments unrelated to a lack of resources and/or funding as a barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barrier -- stigma</td>
<td>How the continued presence of stigma around substance use and PWUDs may serve as a hindrance to the implementation of supervised consumption.</td>
<td>Comments on stigma from community members specifically in New Haven or the greater stigma around substance use and addiction in the U.S. Comments about “NIMBYism” may also be included here.</td>
<td>Any comments unrelated to how stigma serves as a barrier to implementation of a supervised consumption site</td>
</tr>
<tr>
<td>Barrier -- Yale</td>
<td>How Yale and Yale affiliated people and places may serve as a hindrance to the implementation of supervised consumption.</td>
<td>Only comments about Yale that specifically reference how it may serve as a barrier to implementation. Comments about perceptions of Yale, Yale constantly doing research, Yale needing to give space for PWUDs to speak included here.</td>
<td>Any comments unrelated to how Yale specifically serves as a barrier to implementation. Other comments about Yale may be housed under other codes.</td>
</tr>
<tr>
<td>Facilitators</td>
<td>Anything that may serve to help the process of implementation of supervised consumption services in New Haven, but does not qualify for any of the more specific facilitator codes.</td>
<td>This code includes any details provided by key informants that discuss structural, institutional, cultural, and/or conceptual facilitators to the implementation of supervised consumption facilities.</td>
<td>Anything that is not indicated as a facilitator by key informants is not included under this parent code.</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Facilitator -- need</td>
<td>The need for supervised consumption/more harm reduction as a facilitator</td>
<td>Comments around how a need for supervised consumption based on immediacy of the overdose crisis, increasing number of overdose deaths and morbidities, etc. serve as a facilitator for implementation.</td>
<td>Any comments unrelated to how the need for supervised consumption as a harm reduction service is a facilitator</td>
</tr>
<tr>
<td>Facilitator – New Haven Taskforces</td>
<td>How the current task forces and working groups in New Haven around substance use and harm reduction may serve to help the implementation of supervised consumption.</td>
<td>Comments around the discussions had in task force meetings allow for thinking about supervised consumption and more progressive harm reduction strategies and how this facilitates potential implementation.</td>
<td>Any comments unrelated to how the establishment and regular meetings of the New Haven based overdose prevention and harm reduction task forces serve as a facilitator</td>
</tr>
<tr>
<td>Facilitator -- organizations</td>
<td>How different organizations in New Haven focused on substance use and harm reduction may serve to help</td>
<td>Comments about how organizations in New Haven who are already harm reduction minded and thinking about</td>
<td>Any comments unrelated to how currently establishment organizations in New Haven serve</td>
</tr>
<tr>
<td>Facilitator -- Vital Strategies Grant</td>
<td>How the current grant from Vital Strategies and the new position created by the grant in New Haven may serve to help the implementation of supervised consumption.</td>
<td>Comments about how the Vital Strategies Grant, the coordinator position, or related topics facilitate the potential implementation of a supervised consumption facility.</td>
<td>Any comments unrelated to how the grant awarded to the city by Vital Strategies or the associated position serves as facilitators to implementation.</td>
</tr>
<tr>
<td>Facilitator -- Yale</td>
<td>How Yale serves as a facilitator for progress on harm reduction in New Haven</td>
<td>Only comments about Yale that specifically reference how it may serve as a facilitator to implementation. Comments about research capabilities, idea generation, the power of Yale's name in favor of supervised consumption, etc. included here.</td>
<td>Any comments unrelated to how Yale specifically serves as a facilitator to implementation. Other comments about Yale may be housed under other codes.</td>
</tr>
<tr>
<td>Next Steps</td>
<td>Important next steps to take towards the implementation of supervised consumption in New Haven.</td>
<td>Comments about what needs to start now in order to move forward. What very tangibly needs to start happening in order to for supervised consumption to potential become a reality in New Haven.</td>
<td>Any comments unrelated to the next steps that need to be taken in order to move forward with supervised consumption implementation.</td>
</tr>
<tr>
<td>Policy options</td>
<td>Indicates options that are on the table for current policy change to address drug overdoses or how supervised consumption is given space as a policy option</td>
<td>Comments around how supervised consumption is being discussed as an option in New Haven or how the current discussions in other state provide space to supervised consumption to be considered an option in New Haven.</td>
<td>Any comments unrelated to how supervised consumption is thought of as a policy option.</td>
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<tr>
<td>--------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Political circumstances</td>
<td>Current or changing political circumstances that influence supervised consumption implementation</td>
<td>Comments about the current political circumstances in New Haven and in the country and how they influence the conversation around supervised consumption. Who is onside? Who is not? What does that mean for supervised consumption efforts?</td>
<td>Any comments unrelated to political circumstances influencing the conversations around supervised consumption.</td>
</tr>
<tr>
<td>Problematization</td>
<td>How overdose and drug use has been problematized.</td>
<td>Comments about how people currently think about the overdose crisis, how people conceptualize the problems associated with it</td>
<td>Any comments unrelated to how people problematize the overdose crisis and the comorbidities of substance use</td>
</tr>
<tr>
<td>Keep in Mind</td>
<td>Other important notes that should be kept in mind when thinking about the implementation of</td>
<td>This code includes any details provided by key informants that researcher deemed to be highly important to be “kept in mind.”</td>
<td>Any comments not perceived or determined by the researcher as important to be “kept in mind.”</td>
</tr>
</tbody>
</table>


supervised consumption in New Haven. Flagged as important to keep in mind since many of these aspects are often problematically forgotten in harm reduction planning and implementation.

<table>
<thead>
<tr>
<th>Center Voices of PWLE/PWUD</th>
<th>The need to and way in which people with lived experience and people who use drugs should be included in these conversations.</th>
<th>Comments regarding how people with lived experience and people who use drugs needs to be brought to the table when planning and implementing supervised consumption services.</th>
<th>Any comments unrelated to how PWLE and/or PWUDs need to be included in conversations around harm reduction and supervised consumption.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differing Substance Use</td>
<td>The importance of centering and including different types of substance use and different substances used in the discussion around supervised consumption.</td>
<td>Comments on how supervised sites cannot just focus on injection or on opioids. Attention needs to be paid to other modes of consumption and other types of drugs.</td>
<td>Any comments unrelated to planning and implementation of supervised consumption needs to include differing substance use.</td>
</tr>
<tr>
<td>Legacy of Yale</td>
<td>How Yale’s previous role in harm reduction in New Haven plays out currently and how it influences the implementation of supervised consumption.</td>
<td>Comments about the role Yale has played historically in New Haven, on harm reduction action and research, etc.</td>
<td>Descriptions of Yale and Yale’s influence unrelated to its role as a facilitator or barrier. Those would be included under their</td>
</tr>
</tbody>
</table>

While this is a subjective code, most other content from key informant interviews were either coded elsewhere or not relevant to the study purpose.
<table>
<thead>
<tr>
<th>Racial Equity</th>
<th>How racial equity needs to be considered in the process of implementing a supervised consumption facility.</th>
<th>Comments around how people of color are not being considered or brought to the table but need to be in discussions around supervised consumption and harm reduction. Comments regarding the segregation of New Haven and racial equity in siting an facility also included.</th>
<th>Any comments unrelated to how PWLE and/or PWUDs need to be included in conversations around harm reduction and supervised consumption.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What else?</td>
<td>Identify the need for supervised consumption but also note that there is so much else that is needed.</td>
<td>Comments regarding the need for supervised consumption that is couched within other services and connects those who access the site to other services they need in the city.</td>
<td>Any comments unrelated to a supervised consumption facility would need to be housed within or encompass other services to meet the needs of PWUDs in New Haven.</td>
</tr>
</tbody>
</table>