Somerville Supervised Consumption Site

Needs Assessment and Feasibility Report - DRAFT

Revised June 1st 2021

Alexandra B. Collins, Juliet Flam-Ross, Sarah Casey, Tj Thompson, Stephen Kelley, Cassie Hurd, Dhruv Gaur, Abdullah Shihipar, and Brandon Marshall

Study Team

Alexandra B. Collins, PhD
Investigator
Brown University School of Public Health

Juliet Flam-Ross, BA
Research Data Associate
Boston Medical Center

Sarah Casey, BA
Harm Reduction Specialist
ONESTOP Harm Reduction Center

Tj Thompson
Peer Research Associate
Material Aid and Advocacy Program

Stephen Kelley
Peer Research Associate
Material Aid and Advocacy Program

Cassie Hurd, BA
Executive Director
Material Aid and Advocacy Program

Dhruv Gaur, BA
Research Assistant
Brown University School of Public Health

Abdullah Shihipar, MPH
Research Associate, Narrative Projects & Policy Impact Initiatives
Brown University School of Public Health

Brandon D.L. Marshall, PhD
Associate Professor
Brown University School of Public Health

This report was produced by the People, Place & Health Collective (@pph_collective), a research collaborative at the Brown University School of Public Health that studies drug use and infectious disease epidemics.

PPHC at Brown University | people place & health collective

Acknowledgements

We would like to thank all of the community members, participants, and organizations who participated in this study and provided guidance and feedback that informed this report. We are especially grateful for the individuals who were willing to share their experiences and opinions to inform this work and next steps. Additionally, we would like to acknowledge the invaluable and continued contributions of the Somerville SCS Task Force whose members have supported this assessment and provided significant overall guidance.

The study team would like to extend particular thanks to Miriam Harris, MD, for her ongoing consultations and guidance throughout this process. We would also like to acknowledge the tireless efforts of Aubri Esters in centering the needs and perspectives of people who use drugs. In addition to ongoing advocacy efforts, Aubri also led the focus groups interviews with people who use drugs included in this report.

We would also like to thank William Goedel, PhD, for his support conducting spatial analyses for this project. Additionally, we would like to express our gratitude to Corey Davis, JD, for his feedback and guidance over the course of this project.

External Reviewers

We would also like to thank the following external reviewers who provided critical insights and feedback on this report.

Thomas D. Brothers, MD
Resident Physician/Fellow
Department of Medicine, Dalhousie University
Halifax, Nova Scotia, Canada

Elaine Hyshka, PhD
Assistant Professor
School of Public Health, University of Alberta
Edmonton, Alberta, Canada

Funding

This evaluation was funded by the City of Somerville, Department of Health and Human Services.

Disclaimer

This needs assessment and feasibility report was prepared for the City of Somerville by Drs. Alexandra Collins and Brandon Marshall, with the support of Juliet Flam-Ross, Sarah Casey, Tj Thompson, Stephen Kelley, Cassie Hurd, Dhruv Gaur, and Abdullah Shihipar, and in partnership with the Somerville SCS Task Force. The views expressed in this report are those of the authors only and do not represent the official positions or policy of the City of Somerville nor the authors' institutions.

Table of Contents

Table of Contents

Executive Summary

This section will be completed following the Town Hall on June 10th 2021.

Summary of recommendations

Disclaimer: Please note that these recommendations may change following the Town Hall, June 10th 2021.

The city of Somerville would benefit from an integrated supervised consumption site (SCS).

In an integrated SCS, consumption services are one part of a broad range of harm reduction, health, and social services services offered in the facility. Primary and secondary data analyses underscore the need for an integrated SCS in Somerville to address morbidity, mortality, and social impacts of the overdose crisis, as well as increase access to health and ancillary services for people who use drugs in Somerville. Participants—including those who do and do not use drugs—were largely supportive of a SCS in the city to reduce fatal overdose risk. In addition to harm reduction services, wraparound health and social services need to be included in the SCS. We recommend that the lead organization of the site be an organization that already provides harm reduction services and/or supports people who use drugs to improve uptake, and be determined by a Community Advisory Committee that is inclusive of representatives from the Somerville SCS Task Force. We recommend the consumption room be open 24 hours a day if feasible, with the drop-in center open from 8am - 6pm.

The city of Somerville should consider Davis Square or East Somerville for an integrated SCS.

Data from the Somerville community survey, city overdose surveillance data, and focus group data point to Davis Square and/or East Somerville as being suitable locations for an integrated SCS. Over half of participants reported that East Somerville would be best suited for an SCS, followed by Davis Square. We recommend at least one SCS be established in either Davis Square or East Somerville, but ideally both locations would have an integrated SCS. Importantly, these neighborhoods are also easily accessible by transit, which was noted as important among people who use drugs.

People who use drugs should be meaningfully included throughout the planning, design, and implementation processes.

Data from people who use drugs and the Somerville SCS Task Force underscored the importance of including people who use drugs in the planning, design, and operation of an SCS, as well as selecting the organization that will operate the SCS. To improve suitability and uptake, we recommend that a Community Advisory Committee be convened that includes a range of stakeholders (inclusive of people who use drugs) to guide these processes.

The City should undertake a transparent and community-engaged process with a range of stakeholders (e.g. people who use drugs, business owners, residents, health and social service providers, police) in the planning and implementation phases of a SCS.

We recommend that the City organize a series of public forums that feature diverse perspectives and stakeholders, including local community members affected by the overdose crisis. The goals of such meetings might include addressing concerns, increasing public understanding and acceptance of needs for a SCS, and ensuring better integration into the community.

Mechanisms should be established for ongoing monitoring and evaluation of an SCS.

Evaluation processes should be undertaken to document the impact of the site on morbidity and mortality of clients, fatal overdose rates, and community impact.

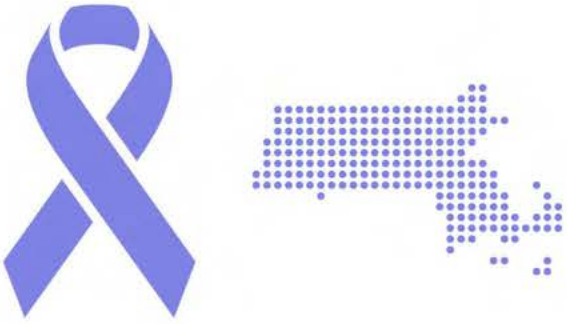
List of Figures

List of Tables

Survey of people who use drugs

Introduction

The overdose crisis in Somerville



The New England region of the United States has been particularly hard hit by the nation's overdose crisis. In 2019 the rate of overdose death reached 32.1 per 100,000 in the Commonwealth of Massachusetts, far exceeding the national average of 21.6 per 100,000 [1]. The state now has the eighth highest rate of overdose mortality in the country and the second highest in New England [2]. Although 2020 statistics are incomplete, provisional data indicate that the COVID-19 pandemic has greatly worsened the overdose crisis [3], with Massachusetts residents experiencing job loss, housing instability and homelessness, isolation, depression, anxiety, and other stressors that increase overdose risk. While fentanyl continues to be involved in more than 90% of deaths, fatal overdoses involving cocaine and amphetamines have increased sharply during the COVID-19 pandemic [4]. Increasing overdose mortality rates among Black residents underscore the racial health inequities that have been exacerbated by the pandemic [4].

The City of Somerville has experienced firsthand the devastation wrought by overdose deaths, and the incalculable toll of preventable death on persons who use drugs, their friends, families, and loved ones. Between 2012 and 2018 the number of opioid-involved overdose deaths among Somerville residents increased more than fivefold. While some progress was noted in 2019 and 2020, these data are provisional and subject to change [5][6].

Fatal overdoses only represent the 'tip of the iceberg' in terms of the true burden of accidental overdose experienced by Somerville residents. According to SomerStat: The Mayor's Office of Innovation and Analytics, the Somerville police and fire departments have responded to more than 100 opioid-related overdoses each year since 2015 [7]. Since the majority of persons who experience a non-fatal overdose do not seek emergency services, this figure is likely an under-estimate. Most studies suggest that the non-fatal to fatal overdose ratio is anywhere between 20:1 to 40:1 [8,9], which suggests that Somerville residents experience between 340 and 680 non-fatal overdoses each year.

The Commonwealth of Massachusetts is also experiencing a rapid increase in HIV cases among people who use and inject drugs. Large outbreaks have occurred in the cities of Lawrence and Lowell. In addition, over 100 new HIV cases have been identified among people who inject drugs in the City of Boston since 2019, particularly among persons who are experiencing homelessness [10].

Introduction

The public health response

A comprehensive public health approach to addressing the health and social needs of people who use drugs amid an overdose crisis and HIV epidemic involves the implementation, scale-up, and sustainment of coordinated measures focused on prevention, treatment, harm reduction, and recovery. A recent mathematical modeling study using data from Massachusetts found that no single intervention is expected to reduce overdose mortality by 40%, highlighting the need for a comprehensive set of interventions [11]. A summary of evidence-based approaches to reduce overdose death is beyond the scope of this report, and has been reviewed elsewhere [12], but includes increased access to medications for the treatment of opioid use disorder, enhanced distribution of naloxone, and community-based recovery support.

What is harm reduction?

Harm reduction is a philosophy of care and set of principles and approaches that aim to reduce the harms associated with drug use, as well as the harms resulting from racialized and punitive drug policies. Importantly, harm reduction is grounded in social justice and prioritizes dignity, agency, and respect for people who use drugs. A range of evidence-based harm reduction interventions have been implemented across the US to address overdose risk and drug-related harms (e.g., transmission of HIV or hepatitis C), including expanded access to naloxone, drug checking services, scale-up of medications for opioid use disorder, and syringe service programs. Critically, most harm reduction interventions have been developed by and for people who use(d) drugs. Supervised consumption sites (SCS) are an additional public health intervention to mitigate fatal overdose and reduce harms associated with drug use. However, no sanctioned SCSs currently exist in the US, despite ongoing efforts across a number of states.

Supervised consumption sites

SCSs—also referred to as supervised injection facilities, drug consumption rooms, or overdose prevention sites—are hygienic environments where individuals can bring pre-obtained drugs to use under the supervision of health care professionals or trained staff who can respond with oxygen and naloxone in the event of an overdose. These services aim to reduce harms associated with drug use by providing access to sterile drug use supplies, rapid emergency overdose response, and often wraparound health and ancillary supports. SCSs are also important for providing a space for people who otherwise use drugs alone, which significantly increases fatal overdose risk [13]. There is no evidence that establishing an SCS leads to an influx of clients from other communities. In fact, the majority of SCS clients and users of other harm reduction services reside within one mile of these programs [14].

For additional information on SCS service environments, including tours of existing SCSs, please refer to the videos in the supplemental resource compendium.

Consumption room at the Dr. Peter Center. Source: https://www.catie.ca/sites/default/files/catie-drpeter-ops-scs-11062019.pdf

The first sanctioned SCS was established in Switzerland in 1986 and there are now over 120 sites located in 11 countries [15]. While SCSs operate under a range of models, they are part of a larger continuum of care for people who use drugs and seek to connect with individuals who may not be readily engaged in existing healthcare settings.

Introduction

A review of the evidence

A considerable amount of research has examined the health and public safety impacts of SCSs, which has been summarized elsewhere [16,17]. This body of work has consistently documented the public health benefits of these interventions, including: reductions in harms associated with illicit drug use; connecting people who use drugs to health and treatment services; and improving neighborhood conditions and public order. A brief review of this evidence is included below.

Impacts on mortality

SCSs are an effective intervention that reduces overdose deaths. No fatal overdoses have ever been reported in sanctioned SCSs worldwide [17]. In Vancouver, Canada, Insite—North America's first sanctioned SCS—is estimated to avert two to 12 overdose deaths per year among clients [9]. However, due to the proliferation of illicitly-manufactured fentanyl in the drug supply, Insite and other surrounding SCSs are likely to avert significantly more fatal overdoses in coming years. In Sydney, Australia, the opening of an SCS resulted in a 68% decrease in neighborhood ambulance calls for drug overdoses during the SCS operating hours [18]. Research has also demonstrated that frequent use of an SCS is associated with a reduced risk of death among people who inject drugs [19].

Importantly, SCSs have been shown to reduce population overdose mortality occurring in their immediate vicinity. In Vancouver, establishing a SCS led to significant reductions in accidental overdose deaths occurring within 500m (approximately 550 yards) of the facility [20]. Especially as fentanyl overdose deaths continue to drive overdose mortality in Massachusetts, this research demonstrates that SCSs are an effective way to reduce overdose deaths.

Impacts on morbidity

SCS utilization reduces syringe sharing through the provision of sterile needles, syringes, and other paraphernalia, which lowers the risk of injection-related infections, such as HIV, hepatitis C (HCV), and skin and soft tissue infections [21]. Conservative models estimate that SCSs reduce short-term incident HIV infection rates by 6-11% each year [22,23]. In addition, SCSs can provide locations for people who use drugs to be connected with treatment for HIV and HCV [24], further reducing infectious disease transmission. Clients also more readily seek care for skin and soft tissue injuries—the leading cause of hospitalization among people who inject drugs [25]—at SCSs as compared to hospitals [26].

No fatal overdoses have ever been reported in sanctioned SCSs worldwide

SCSs can lead to the long-term adoption of healthier drug use behaviors outside of the SCS setting. People who use SCSs reduce syringe sharing and report increased use of sterile materials, even when using drugs outside of an SCS [27]. SCS use may also lead to safer sex practices to reduce HIV transmission, such as increased condom use [28]. Urban network studies suggest that harm reduction behaviors such as those promoted by SCSs are often transferred through dense social networks [29,30]. As such, SCSs have the potential to foster harm reduction behaviors in a population larger than their baseline clientele.

Introduction

A review of the evidence

Treatment impacts

SCSs are effective modalities for increasing access to treatment for substance use disorders. Closely integrating SCS services with referrals to addiction treatment programs and other social services has shown substantial signs of success. Previous studies have shown that SCS service utilization leads to increased uptake of detoxification services [31,32] and entry into evidence-based substance use disorder treatment programs [33,34], especially when referrals are facilitated by on-site counselors [35]. As such, researchers and clinicians propose including SCSs as part of the evidence-based continuum of care for people seeking treatment for substance use disorders [36,37]. Finally, evidence suggests that establishing an SCS does not lead to increased drug use initiation [38,39].

Neighborhood impacts

In addition to reducing local overdose mortality, SCSs enhance public safety, decrease public disorder, and improve the neighborhood conditions in which they are located [40]. SCSs contribute to public order by decreasing the number of people who inject drugs in public [40,41]. SCSs also decrease injection-related litter and publicly-discarded syringes by providing direct syringe disposal services for community members [40,41]. In reviewing the evidence on SCSs, the Massachusetts Harm Reduction Commission concluded that, "there is evidence that the neighborhood burden of drug use (e.g., public injections, discarded syringes, injection-related litter) is lessened after the establishment of a harm reduction site, especially when paired with outreach workers and syringe pick-up programs" [42].

Data from Canada and Australia demonstrate that the establishment of an SCS is not associated with local increases in crimes, such as drug dealing, drug possession, assaults or robberies [43–45]. In a recent analysis, documented criminal activity decreased rather than increased in the area around an unsanctioned SCS located in the US in the five years following the SCS opening [46]. Finally, there is no evidence that SCS have a negative impact on property values [47].

Economic impacts

An established evidence base from non-US settings indicates that SCSs are not only cost-effective, but can result in cost savings by reducing healthcare-related expenditures, averting emergency department visits, and preventing new cases of infectious diseases such as HIV and HCV [48,49]. Moreover, SCSs reduce the amount of outside medical care needed in the event of an overdose. Cost-effectiveness studies that model SCSs in a number of US cities, including New York City, San Francisco, Baltimore, and Seattle, consistently find that an SCS prevents overdose deaths and reduces healthcare costs by decreasing the need for overdose-related ambulance rides, emergency department visits, and hospitalizations, and increasing clients' uptake and retention of medications for the treatment of opioid use disorder [14,50–52].

Introduction

A review of the evidence

Economic impacts

Furthermore, SCSs generate cost savings beyond overdose-related health expenditures. By reducing syringe and needle-sharing among people who use drugs, SCSs reduce the incidence of HIV and HCV infections in the community, thereby reducing the need for costly, long-term medical treatment for these conditions [23]. In addition to the prevention of bloodborne diseases, skin and soft tissue infections currently represent the most common reason for hospitalization among people who use drugs [25]. Treating these infections can be a significant cost: in Florida, the average charge for a hospital admission for injection-related endocarditis was over $64,000 in 2017 [53]. By providing a sterile injection environment and educating clients on safer injection practices, an SCS reduces the incidence of skin and soft tissue infections among clients [54], thereby further reducing hospital costs. In light of these other potential cost-savings, savings found due to reductions in overdose-related care represent a conservative estimate of the overall benefits of SCSs.

SCS models

Integrated sites

Integrated SCSs are the most common SCS operational model. Under this model, SCSs are situated within an existing facility (e.g., a syringe exchange program, community health center) or network of services that provide health and social supports to people who use drugs as well as people who do not use drugs. In this capacity, integrated SCSs act as a 'one-stop-shop' on the continuum of care for people who use drugs, offering wraparound services such as counselling, housing case workers, basic medical services (e.g., HIV and HCV testing, wound care), food provision, and other harm reduction services (e.g., needle distribution, naloxone education), for people who use drugs and/or people who are unstably housed.

In integrated facilities, the consumption room is generally located in a designated area and is only one of a range of services provided. This allows individuals who do not use drugs or who may be in recovery to still access additional services within the facility, while avoiding areas where drug use occurs. Integrated models are often implemented in locations where people who use drugs are more dispersed as it can facilitate the uptake of additional health and ancillary services and improve continuity in care for individuals.

Examples of integrated SCSs include the Dr. Peter Center, an AIDS Service Organization in Vancouver, Canada [55] and the Queen West SCS located at the Parkdale Queen West Community Health Center in Toronto, Canada [56].

The Dr. Peter Centre facility in Vancouver, Canada. Source: Dr. Peter Centre facebook page

Queen West SCS, Parkdale Queen West Community Health Center, Toronto, Canada. Source: https://pqwchc.org/programs-services/harm-reduction/ops/

Introduction

SCS models

Stand-alone sites

Stand-alone SCSs, also referred to as specialized SCSs, are distinct facilities whose primary focus is on supervised consumption within a sterile and non-judgemental environment. While some additional services may be provided within these sites, such as food and primary care services, they more typically refer clients to other health and ancillary service programs (e.g., counselling, medication for opioid use disorder, housing supports). Stand-alone sites are often larger than other SCS models and are typically located near open drug scenes or where there is a large concentration of people who use drugs. Since the main purpose is for supervised consumption, these sites primarily serve people who use drugs.

Examples of specialized SCSs include Insite in Vancouver, Canada [57] and the Uniting Medically Supervised Injecting Centre (MSIC) in Sydney, Australia [58].

Embedded sites

Embedded SCSs are located within existing services and care systems that do not typically allow non-medical drug use, such as hospitals, shelters, and supportive housing facilities. Offering supervised consumption services in hospital settings can reduce risk of harm associated with drug use among people in acute care (e.g., using drugs in locked bathrooms) and reduce the risk of people leaving against medical advice. Examples of hospital-based SCSs, including the Royal Alexandra Hospital in Alberta, Canada [59]; St. Paul's Hospital in Vancouver, Canada [60]; and Gaïa-Paris in Paris, France [61].

Although embedded SCSs are less common, examples can be found in the Abrigado in Luxembourg City, Luxembourg [62], and the Eastside Facility in Frankfurt, Germany [63]. Notably, embedded SCSs have been increasingly implemented in shelters, hotels, and non-profit operated housing in Canada in recent years to address the increasing rates of fatal overdoses in these settings [64–66].

Mobile sites

Mobile SCSs offer consumption services from specially outfitted vans, buses, recreational vehicles (RV) or trailers. Mobile models are often implemented when working within a setting where the drug scene is not centralized, but dispersed across broader geographic areas. However, mobile SCSs are typically implemented alongside stationary SCS and are complementary to brick and mortar facilities. This model is often uncommon due to logistical considerations (e.g. expense, small size).

To our knowledge, there are few mobile SCSs in operation. However, examples include mobile sites in Montréal, Canada [67]; Glasgow, Scotland [68]; Barcelona, Spain [69]; and Berlin, Germany [69].

A mobile SCS van in Vancouver, Canada. Source: https://bit.ly/3fZK8KU

Introduction

Study context: Somerville, MA

Somerville is located in Middlesex County, two miles northwest of Boston. The city is located on the traditional, unceded lands of the Wampanoag peoples. With a population of approximately 81,000 residents within four square miles, Somerville is one of the most densely populated communities in New England [70,71]. The city is culturally diverse, with 25% of the population born outside of the US [71]. As of 2019, approximately 68% of Somerville's population was white, 12% were Hispanic or Latinx, 10% were Asian, 6% were Black or African American, with the remainder multi-racial and Indigenous [71].

Over the last decade, Somerville has continued to experience a housing affordability and availability crisis [72]. Between 2010 and 2017, average rents in Somerville increased by almost 30%, with almost 35% of renter households in the city cost-burdened [72]. Approximately 11.5% of Somerville residents were living in poverty [71] and during the 2018 point-in-time count, there were 134 unhoused individuals recorded in Somerville [73].

Current harm reduction programming and response in Somerville

Harm reduction services are currently limited in Somerville. The city has several outpatient treatment services that provide medications for opioid use disorder. However, at present, there are no permanent harm reduction drop-in facilities, such as syringe exchange programs, located in Somerville. Street-based syringe distribution operated by the AIDS Action's Access: Drug User Health Program (ACCESS) does occur in Somerville; however, they lack a brick-and-mortar presence.

City-level programming includes: the Community Outreach, Help and Recovery (COHR) program at the Somerville Police Department; the Office of Prevention at the Somerville Department of Health and Human Services; and naloxone training and distribution. Two other programs in the city operate on a limited basis and in partnership with Access: the Overdose Aftercare Community Teams Program and street-based harm reduction supply distribution.

Study objectives

The objective of the Somerville SCS needs assessment and feasibility study were to:

1) Determine the conditions under which an SCS would be used or deemed suitable for use by people who use drugs in the City of Somerville;

2) Determine the feasibility of an SCS in Somerville, including operational model type, location, consumption methods supported, and programmatic features; and

3) Identify concerns, challenges, and barriers that may be associated with opening an SCS in Somerville and discuss strategies to address them among the Somerville community.

Methods

Study design

This community-engaged needs assessment and feasibility study sought to document the perspectives of people who use drugs and community members on establishing an SCS in Somerville, Massachusetts. Needs assessments from similar-sized communities in Canada were reviewed in the development of survey questions for this study [74–76], as well as the British Columbia Centre on Substance Use SCS operational guidance document [77]. All information obtained was anonymous and recorded by the investigators in such a manner that the identity of participants cannot be readily ascertained directly or through identifiers linked to the participant. As such, this work was exempt from Institutional Review Board (IRB) approval.

This assessment was multi-phased. Phase one included analyses of existing data and primary data collection, which was completed in April 2021. In phase two, public feedback was sought through a virtual town hall held in June 2021. The final report with recommendations was submitted to the City of Somerville's Department of Health and Human Services in June 2021, during phase three.

The following primary data collection methods were used in this assessment:

1) A survey conducted with people who use drugs
2) An online community survey of Somerville residents
3) Focus groups conducted with people who use drugs

Of note, all surveys were conducted in 2021 for this needs assessment. However, focus groups with people who use drugs were conducted in January 2020. As these focus groups were undertaken to understand the perspectives of people who use drugs in relation to an SCS in Somerville, the study team also conducted an analysis of these existing data.

In addition to these primary sources of data, secondary existing data sources on overdose rates, opioid-related deaths, etc. were also analyzed.

Study oversight

Oversight was provided by the Somerville SCS Task Force. The Task Force was formed in 2019 to examine the financial, legal, and operational considerations of opening an SCS in Somerville, as well as the potential community impacts. The Task Force was chaired by the Director of Health and Human Services from its inception until October 2020, at which point it was chaired by Dr. Alexandra Collins as part of this needs assessment.

The Task Force is comprised of a range of stakeholders, including: Somerville community members, people who use(d) drugs, activists, health and social service providers, legal and legislative experts, representatives from the Somerville Police Department and Somerville Fire Department, and representatives from City of Somerville departments (e.g., communications, legal, health and prevention) and City Council. The Task Force was divided into four subcommittees: legal and legislative committee; communications committee; community outreach and education committee; and program development committee. Task Force meetings occurred monthly with attendance ranging from approximately 10 - 20 people per meeting, with sub-committees meeting on an ad hoc basis in the interim.

Methods

Study oversight

The Task Force provided feedback on study methodology, data collection tools, and recruitment methods. Four members of the Task Force administered the surveys with people who use drugs given their existing relationships with harm reduction and social service agencies. Each subcommittee also provided a series of recommendations that are included below. Additionally, the Task Force was provided a draft version of this report.

Quantitative data

Survey with people who use drugs

A survey was conducted with people who self-identified as currently using drugs from February to April 2021. A total of 47 participants completed the survey. The survey instrument was adapted from the British Columbia Centre on Substance Use SCS operational guidance document [77] and aimed to assess: demographic information; substance use patterns and practices; overdose experiences; SCS location and operational preferences; facilitators and barriers to using an SCS; and SCS programmatic and service needs (see Appendix 4).

Surveys were conducted by four staff and peer researchers from two Cambridge-based harm reduction and social service organizations who serve a large number of Somerville residents and people who use drugs. Participants were recruited using a verbal script during outreach and at each drop-in center space. Participants were eligible to complete the survey if they self-identified as a person who uses drugs, were at least 18 years of age, and were able to provide verbal consent. The survey contained 27 questions and took approximately 10 minutes to complete. Participants were compensated $10 cash for their time.

Surveys were conducted in-person and facilitated by a peer researcher or staff member. Surveys were available digitally using Qualtrics software or were conducted using a paper copy and later entered into the Qualtrics software.

Somerville community survey

An online community survey was developed in consultation with the Somerville SCS Task Force and was distributed by the City of Somerville through social media and listservs. Qualtrics software was used to design the survey which took approximately 10 minutes to complete. The survey was open for participation from March to April 2021. The survey was promoted through a range of outlets, including social media, emails to community networks and groups, and the City of Somerville's website.

Participants were eligible to complete the survey if they lived in Somerville and were 16 years of age or older. However, given the online distribution method, individuals who did not meet these criteria were still able to access the survey. Where appropriate, data from non-residents are summarized separately. A total of 615 surveys were completed and were included in this analysis.

The survey aimed to assess community members' perceptions and concerns of an SCS, recommended location of an SCS in Somerville, and implementation considerations. The survey also collected participants' demographics and suggestions for addressing concerns or questions related to an SCS in Somerville (see Appendix 4).

Results

Survey with people who use drugs

Demographics

A total of 47 participants who self-identified as people who use drugs were surveyed, of whom 77% were men, 17% were women (transgender-inclusive), 4% were non-binary or genderqueer, and 2% chose not to respond. Roughly half of participants identified as white (53%), 24% identified as Black, 14% identified as multi-racial and/or other, and 9% identified as Hispanic or Latinx. The median age of participants was 40 years, with ages ranging from 19 to 71 years. Housing instability was prominent among participants, with 87% of participants unhoused at the time of survey.

87%

of participants were unhoused at the time of the survey

Drug use patterns

All but one participant reported drug use in the 30 days prior to being surveyed, and the majority of participants (72%) reported daily drug use. The majority of participants (80%) reported consumption by either smoking or inhalation in the 30 days prior to being surveyed, followed by injection (63%), ingestion (55%), and snorting (55%). The most commonly used substances among participants in the previous 30 days were heroin (68%), followed by alcohol (64%), crack cocaine (62%), and fentanyl (62%).

Frequency of using drugs alone varied across participants, with 31% of participants reporting using alone all or most of the time, 37% using alone sometimes, 20% using alone occasionally, and 13% never using alone.

Figure 1

Frequency of drug use

72%

of participants reported daily drug use

Results

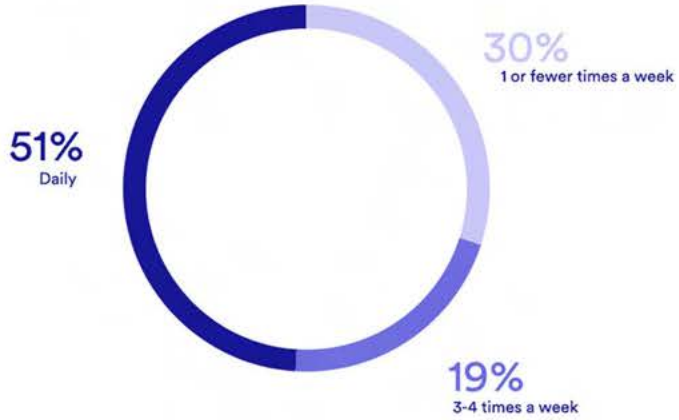
Survey with people who use drugs

Drug use locations

Notably, 65% of participants (n=46) reported typically using drugs outdoors, followed by public washrooms (48%), or where they were currently living or staying (46%). Of those who reported public use of drugs (n=37), 51% reported doing so daily (see Figure 2).

Figure 2

Frequency of public use

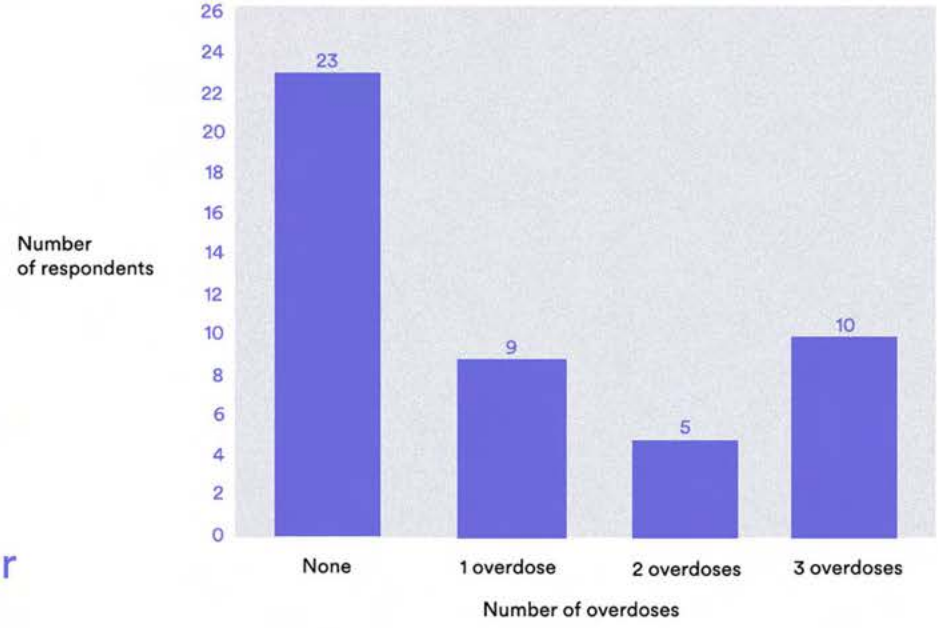


Previous overdoses

Half of participants (51%) reported having had at least one overdose in the past year (see Figure 3).

Figure 3

Overdose experiences in the last year



51%

of participants reported haiving at least one overdose in the past year

Results

Survey with people who use drugs

Supervised consumption site services

Importantly, 94% of participants said they would use an SCS in Somerville. Of those who said they would use a Somerville SCS (n=44), 24% reported that they would access the site every time they used, 33% reported they would access the site most of the time they used, 25% said they would use it sometimes, 9% occasionally, and 9% unsure of how often (see Figure 4).

94%

of participants said they would use a SCS

Figure 4

How often would you use a SCS

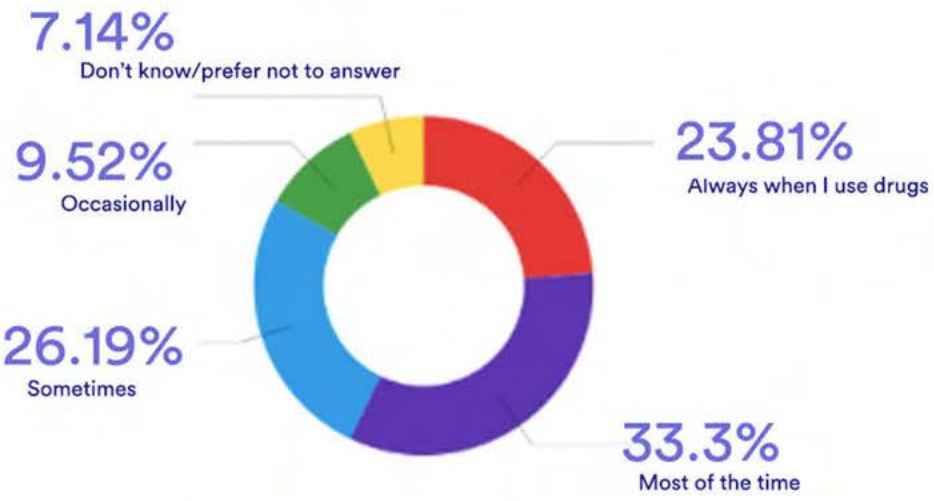


Table 1: Reasons for using a SCS

Reason for wanting to use a SCS (222)*	FREQUENCY	PROPORTION (%)
Overdose prevention or treatment	44	94%
Safety from being seen and/or arrested by police	35	75%
Safety from crime or violence	33	70%
Access to sterile injection and/or smoking equipment	31	66%
Access to health professionals and basic health services	26	56%
Ability to inject indoors rather than in public	26	56%
Access to referrals for treatment or social services	25	54%
Other	nr	nr

nr = not reported due to fewer than five responses
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

Participants overwhelmingly reported wanting to use an SCS for overdose prevention or treatment (94%). Other reasons for using an SCS included, safety from police (74.5%), safety from crime or violence (70%), access to sterile supplies (66%), ability to inject indoors rather than in public (55.5%), and access to health professionals (55.5%) (see table 1).

Results

Supervised consumption site services

Despite widespread support for a SCS in Somerville, participants highlighted potential barriers that may impede their uptake of this service. The main concern for participants was related to potential police interference at the SCS, followed by not wanting to disclose their drug use (see Table 2).

Participants who use drugs were also asked about the acceptability of potential SCS policies. The top three policies seen as most acceptable, included: use supervised by trained staff (74%); having to stay at the site after use to be monitored (38%); and having to register each time they use the site (30%).

Participants were also asked about a range of potential services that could be incorporated in an SCS, and the level to which they found services to be important. The services deemed most important were: access to contraception (82%); HIV, hepatitis C, and STI testing (80%); and assistance with housing, social assistance, and other support services (74%).

Table 2: Reasons for not using a SCS

Reason for not wanting to use a SCS (63)*	FREQUENCY	PROPORTION (%)
Concerned about police around the site	21	45%
Do not want to be seen/do not want people to know about my drug use	10	21%
Afraid SCS are not safe from crime or violence	7	15%
Other	7	15%
Concerns about confidentiality	6	13%
No concerns	5	11%
Prefer to use alone	nr	nr
Already have access to sterile supplies	nr	nr
Already have a place to use	nr	nr
Too many rules or policies	nr	nr
Legal consequences related to condition of probation or parole	nr	nr

nr = not reported due to fewer than five responses
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

Somerville community survey

For full results of the Somerville community survey, please see Appendix 2.

Demographics

A total of 615 community surveys were completed. Given the online distribution methods, the survey was accessible to Somerville residents and non-residents. Individuals who did not live in Somerville were included in this analysis given their range of relationships with the city (e.g., business owner, service user), which are important to consider in the development and implementation of an SCS.

Of 615 completed surveys, 557 (91%) participants were Somerville residents. The majority of participants were women (55%), 36% were men, and 6% were non-binary, transgender, or genderqueer. Participants overwhelmingly identified as white (85%), followed by Asian (4%), mixed, bi-racial, or multi-racial (3%), Black (1%), and Hispanic or Latinx (1%). The median age of participants was 37 years, with ages ranging from 16-78 years. All but two neighborhoods had participant representation. Union Square had the highest number of participants (18%) of participants, followed by Davis Square (16%), Spring Hill (13%), Winter Hill (13%), and Teele Square (7%). About one quarter of participants had lived in Somerville 5-10 years.

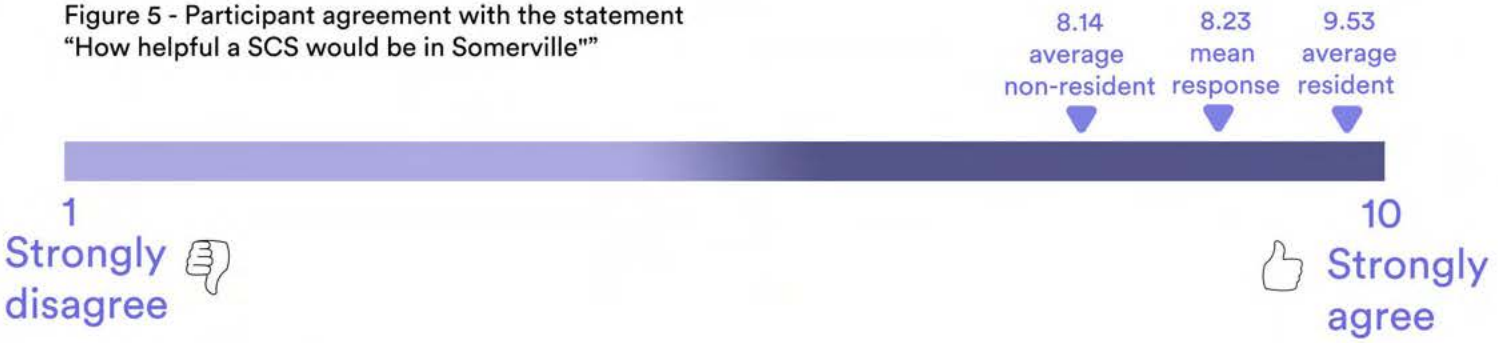
Results

Somerville community survey

Familiarity and usefulness of SCS

Approximately 86% of respondents stated that they were at least somewhat familiar with SCS, with the remainder not familiar. Survey participants were asked how helpful an SCS would be in Somerville on a scale from 1 (strongly disagree) to 10 (strongly agree). The overall average (mean) response was 8.23. Residents of Somerville gave an average agreement score of 9.53 and non-residents gave an average agreement response of 8.14.

Figure 5 - Participant agreement with the statement "How helpful a SCS would be in Somerville""



Opinions about SCS

Participants who ranked usefulness of a Somerville SCS between 5 and 10 were asked to describe why they thought a site would be beneficial. Participants could provide more than one reason in their responses. The top four themes that arose from participant text responses, included: connecting people to services and supports (32%, n=197); reducing overdose deaths (27%, n=167); overall public benefits (e.g., reducing drug paraphernalia litter, reduction of infection, provision of sterile supplies, 25.5%, n=158); and providing a safe place for people to use drugs (22.5%, n=139). Additional themes included, the importance of SCS as providing a space to treat addiction as a disease, addressing drug-related stigma, and the utility of SCS as being an alternative approach to addressing the overdose crisis.

Additionally, participants who ranked potential usefulness of a Somerville SCS from 1-5 were asked to describe why they thought it would not be beneficial in Somerville. Participants could provide more than one reason in their responses. A total of 70 participants responded, with the main themes including: SCS would negatively impact the community (e.g., decrease property value, increase litter, increase violence and crime, 40%, n=28); SCS enable drug use (23%, n=16); SCS are not effective public health interventions (19%, n=13); and SCS would increase in the number of people who come to use drugs in the city (19%, n=13). Additionally, there was a focus on the need for expanded access to treatment, recovery, and social supports for individuals before (or in lieu of) an SCS (17%, n=12). However, some participants reported that SCS were not needed in Somerville (16%, n=11) or that additional information would be needed before they could make a decision (13%, n=9).

Results

Somerville community survey

Respondents were asked to rank 7 potential outcomes of SCS from most to least important. The majority of respondents (78%) reported that the most important outcome of SCS is to prevent overdoses and save lives (see Figure 6).

Location

All neighborhoods were represented when asked where an SCS would be most helpful. Among the neighborhoods, 45% of participants (n=276) selected East Somerville, followed by Davis Square (41%, n=252), Winter Hill (33%, n=202), Union Square (30%, n=186), and Innerbelt (27%, n=167) (see Figure 7).

Among respondents (n=615), 56% of participants reported that they would have no concerns with an SCS located in their neighborhood, 19% reported that they would have concerns, and 25% were unsure. Top concerns (n=193) included: safety and impacts on crime; SCS implementation considerations and protocols (e.g., supervision after use, size of the space, security); location of the SCS (i.e., business vs. residential neighborhood); increased foot traffic outside the SCS; and an increase of people who use drugs coming to Somerville.

Figure 6

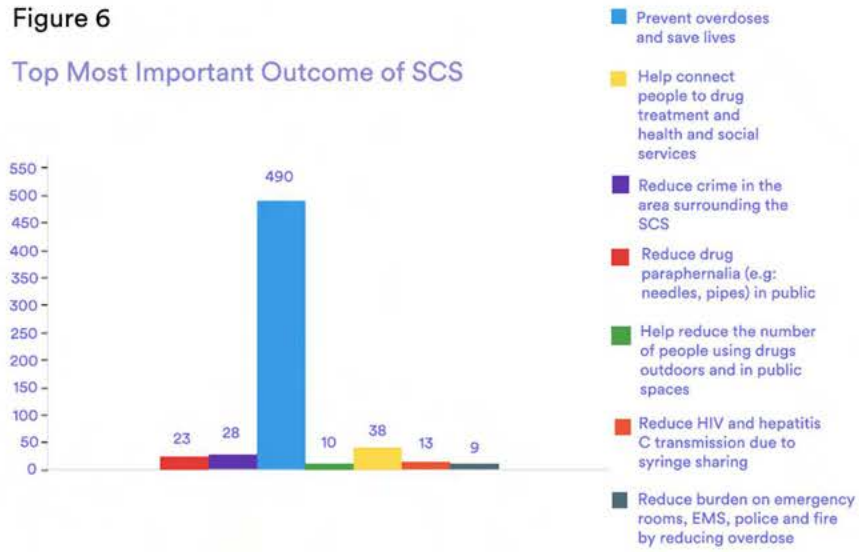
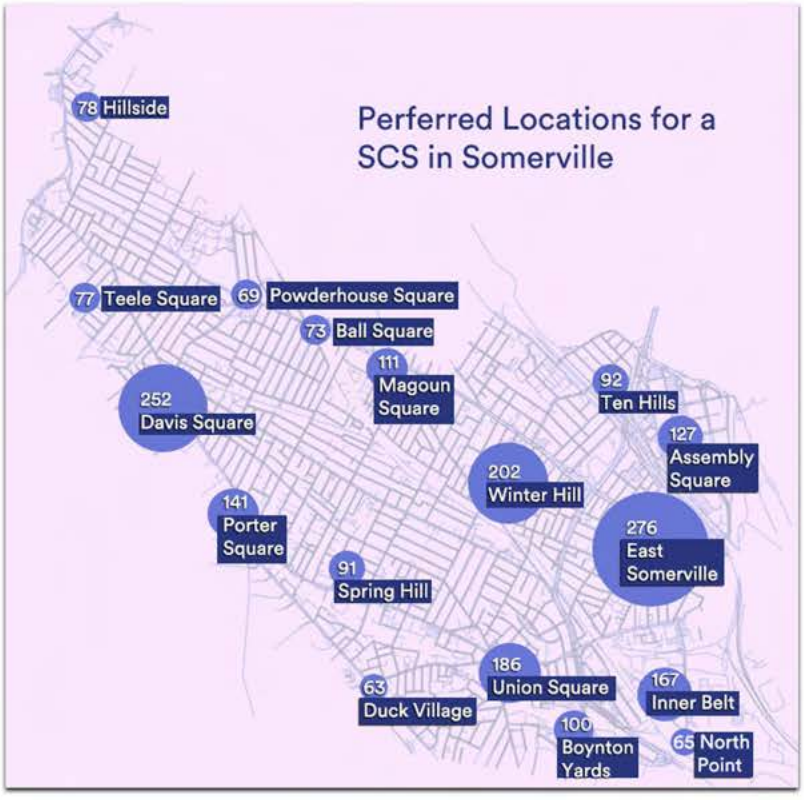


Figure 7



56% of participants reported they would have no concerns with a SCS in their neighborhood

Results

Somerville community survey

Additional Steps

While the City has undertaken a range of programming to address the overdose crisis, only 44% of participants had heard of these activities. Of these participants, 27% knew someone who had accessed these programs, but only 3% had ever accessed these programs themselves. Notably, the majority of participants (70%) were unsure how satisfied they were with the City's approach to addressing the overdose crisis, with 13% dissatisfied and 17% satisfied.

Survey participants were asked what the City could do to better address the overdose crisis in Somerville. The top three themes included: removing police from the response (e.g., decriminalizing drugs, diverting police funding); increasing community awareness and engagement related to the overdose crisis, including increased transparency of City efforts; and funding treatment and prevention programs.

Focus groups with people who use drugs

Demographics

A total of 17 participants took part in one of two focus group interviews. All but one participant was white and the majority of participants were cisgender, straight men. Participants ranged from 32-55 years of age. The majority of focus group participants were unhoused at the time of participation.

The primary themes from focus group discussions were related to social and structural factors that would impact engagement with an SCS in Somerville, and operational considerations. Importantly, participants from one focus group stressed the importance of including people who use drugs in the design and siting of an SCS to be effective.

Facilitators

Participants noted four main factors that would increase their engagement with an SCS in Somerville. Ability to maintain discreteness within the SCS and providing wraparound services were noted as the two most important facilitators.

Anonymity

Anonymity and discreteness were reiterated as key requirements to utilizing an SCS. Focus group participants stressed the need for a level of confidentiality and anonymity to be maintained for clients. However, participants also underscored the need for the SCS itself to be "discrete" to minimize stigma from the broader community. To achieve this, participants recommended that the SCS be located in a building where it could blend in with surroundings, such as a large office or multi-service building complex, and did not contain large signs denoting what the space was on the exterior. Multiple exits were also noted as important to help maintain the anonymity of clients.

Results

Focus groups with people who use drugs

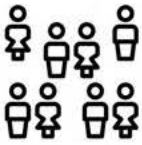
Facilitators

Wraparound services

Participants overwhelmingly agreed that the SCS should provide a range of wraparound health and social services on site, in addition to referrals. For many, having consumption being only one of many services offered would also help maintain some level of privacy for clients, in addition to meeting their co-occurring needs.

Support for multiple consumption methods

Focus group participants expressed the need for an SCS to support both injection and inhalation methods so as to not exclude individuals. A lack of inhalation support was explicitly described as a barrier to future utilization. While some participants expressed the need for smoking rooms within the facility, others described having a private outdoor space to smoke would also be suitable.



Interdisciplinary staffing model

Having an SCS be operated by a mix of people who use drugs, health professionals, and staff at existing harm reduction services would create a more "welcoming" and "comfortable" facility. Importantly, participants wanted at least some SCS staff to be outreach workers and support staff with whom they already have relationships.

Barriers

Two main barriers to accessing an SCS in Somerville were identified by participants: risk of arrest and SCS location.

Law enforcement

The risk of law enforcement interaction was noted as a major barrier. Focus group participants described concerns of police potentially 'targeting' SCS clients. Establishing legal rights to access the SCS, ensuring law enforcement did not enter the space, and providing a 'safety zone' (i.e. a predetermined area surrounding the SCS where individuals would not be arrested when entering or leaving the site) around the SCS was deemed critical to protect individuals using the space.

Location

The siting of an SCS was also described as a potential barrier impacting the accessibility and utilization of the service. Participants described how proximity to public transportation would likely dictate engagement. Additionally, participants described how their engagement may also be shaped by the need to manage withdrawal symptoms.

Results

Focus groups with people who use drugs

SCS model and location

When asked about how an SCS should be designed and operated, participants expressed a strong interest in a permanent, brick-and-mortar facility. In terms of siting, there was no consensus across focus groups. However, two main neighborhoods were described as potentially being ideal locations: Davis Square and Assembly Square.

SCS program and service needs

Focus group participants expressed the need to integrate a range of services into an SCS. The ability to access services that met their health and social needs was seen as important for engagement. Participants focused on four main areas of service integration: harm reduction, health services, social services, and basic needs.

Harm reduction services

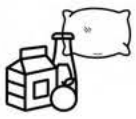
In addition to the provision of sterile equipment (injection and inhalation supplies) and naloxone, participants expressed a desire to have advanced drug testing technologies (e.g., spectrometer) available within an SCS. This was seen as important for providing a better understanding of what individuals were consuming. Additionally, focus group participants expressed the need for educational workshops, including safer drug use practices, safer injection practices, and harm reduction education.

Health services

Health services were seen as an integral component of services that should be provided at an SCS and included drug treatment options. Focus group participants stressed the importance of having a range of health services accessible on-site, rather than referrals to services at other organizations. There was a preference for having a weekly clinic integrated into the site, where individuals could access a wider range of medical care. In particular, the following services were listed as important to include at the SCS: HIV and STI testing; wound care; foot care; access to medications for opioid use disorder (e.g. methadone, buprenorphine); and hepatitis C treatment. However, participants noted that if the integration of treatment options was not possible, then it would be important for the SCS to include referrals to drug treatment and recovery supports.

Social services

Focus group participants denoted several social service supports that would be beneficial to include in an SCS such as: community support groups (e.g. grief group); an on-site social worker; and housing supports (e.g. housing clinic).



Basic needs

A range of services that meet individuals' basic needs were expressed as key components of the SCS, including in the waiting area. These included: food provision; a nap room or quiet room; and storage and bike lockers for use while on-site.

Results

Cost effectiveness analysis

Previous cost-effectiveness modelling considers the costs and benefits associated with a large, urban SCS, analogous to Insite in Vancouver, Canada. Because Somerville is considerably smaller than the cities considered in previous analyses, and may therefore benefit from different models of SCSs, an explicit cost-benefit analysis was not conducted for an SCS in Somerville. However, significant reductions in costs associated with overdose and infectious disease-related care are expected to reduce costs for the city.

One recent study conducted by the Institute for Clinical and Economic Review estimated the cost-effectiveness of a single standalone SCS in Boston. This analysis found that such a facility would prevent more than 700 ambulance rides, 550 emergency department visits, and 270 hospitalizations each year, resulting in cost savings in excess of $4 million annually [81]. Somerville and Boston share many of the same drivers of overdose-related costs, such as ambulance transportation, emergency department costs, and hospitalization costs [82]. These costs are significant, as Somerville Police Department and Somerville Fire Department responded to over 100 opioid-related overdoses in each year since 2015 [7]. Further, the reduced cost of commercial space in Somerville relative to Boston would reduce the operational costs of operating an SCS. By reducing the need for overdose-related ambulance transportation, emergency department visits, and hospitalizations, SCS could significantly reduce the cost of overdose deaths borne by the health system in addition to reducing overdose risk.

Analyses of existing data

The Somerville police and fire departments responded to 721 overdose-related calls from 2015 to 2020. Calls were categorized as overdose-related based on information available to first responders and were not validated against medical reports. While these data do not represent the full burden of drug overdose in Somerville, they offer some indication of where overdoses occur in the city. In a memorandum to the Somerville SCS Task Force, SomerStat reported the geographic distribution of where these overdose response calls were located, aggregated to 400 square meter blocks within the city [7].

Figures 8-9
Where overdose response calls occur in Somerville:

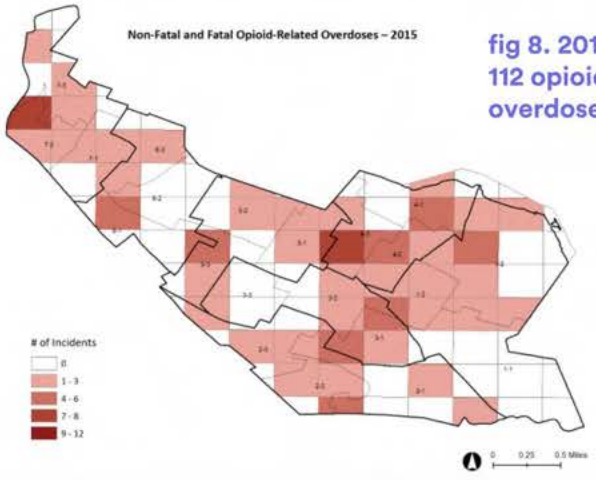


fig 8. 2015
112 opioid-related overdose calls

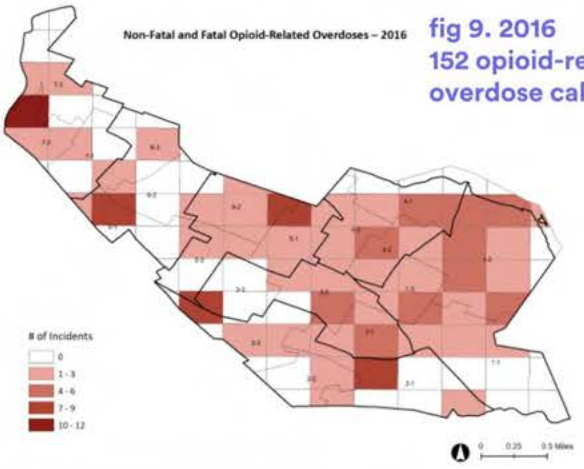


fig 9. 2016
152 opioid-related overdose calls

Results

Analyses of existing data

Figures 10-13:
Where overdose response calls occur in Somerville:

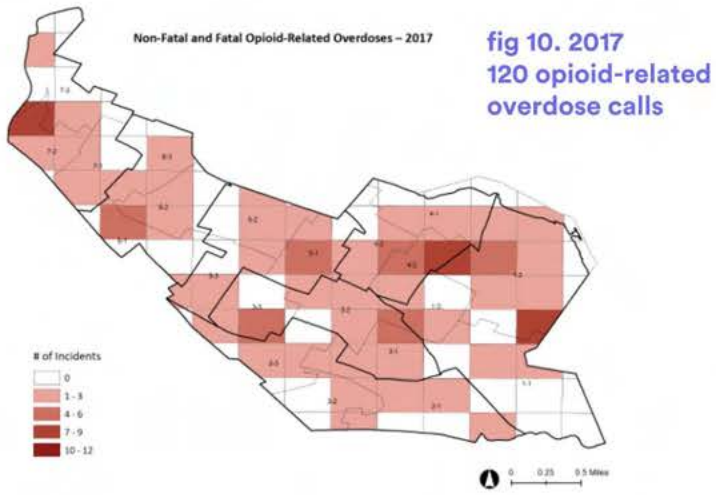


fig 10. 2017
120 opioid-related overdose calls

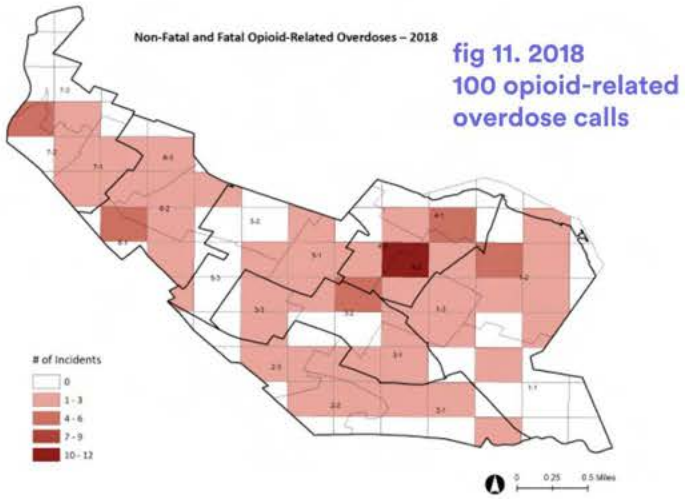


fig 11. 2018
100 opioid-related overdose calls

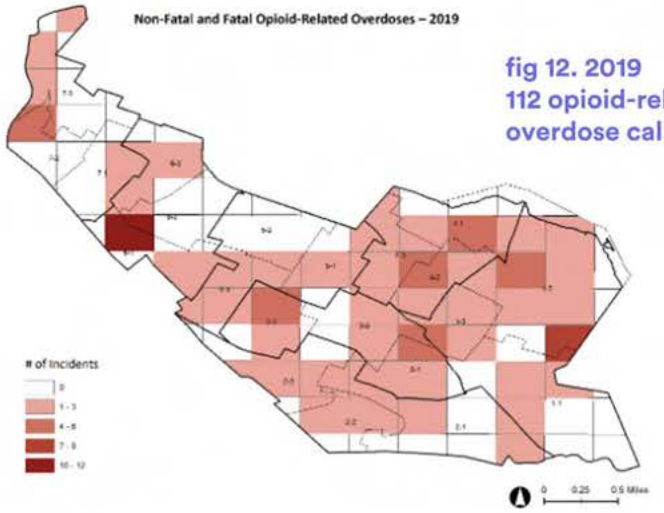


fig 12. 2019
112 opioid-related overdose calls

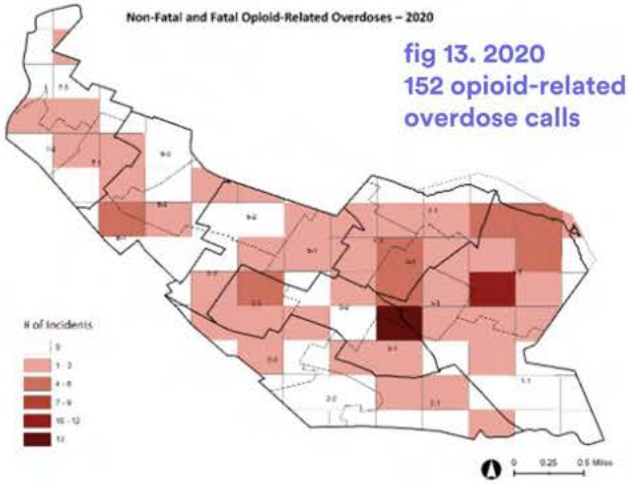


fig 13. 2020
152 opioid-related overdose calls

As shown in the figure, opioid-related overdose response calls are distributed spatially throughout Somerville, demonstrating that overdose prevention is a primary public health concern for residents throughout the city. The widespread burden of overdose has remained consistent for each year from 2015 to 2020.

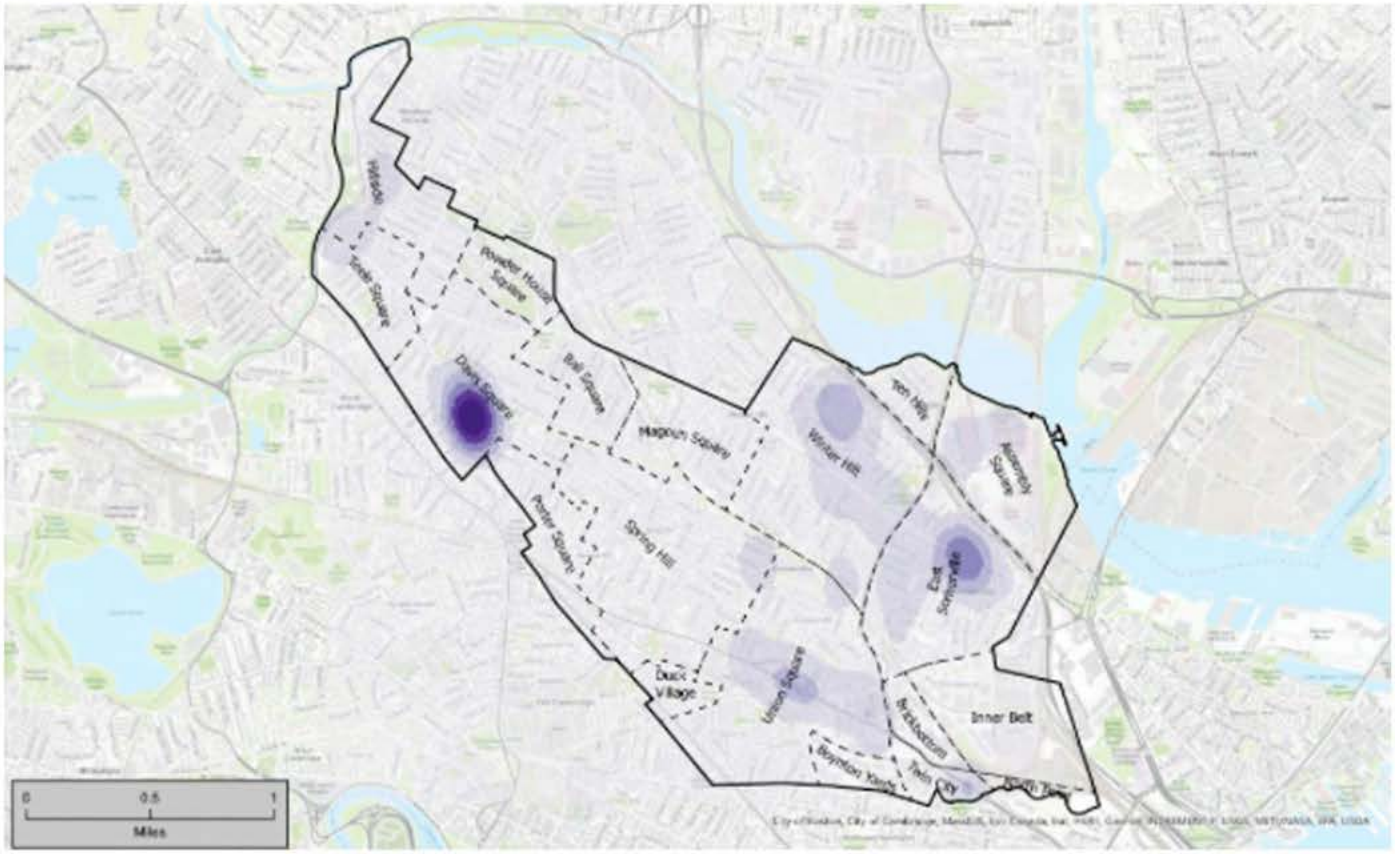
Despite this wide geographic spread, a few neighborhoods stand out as areas with higher overdose response needs. In particular, Teele Square, Davis Square, and Winter Hill have high counts of overdose response calls.

Results

Analyses of existing data

Moreover, quality of life call data from the Somerville Police Department highlights two primary neighborhoods (Davis Square and East Somerville) where hypodermic needles were found in public in 2020 (Figure X). These data could reflect increased public injection drug use in these neighborhoods, and thus locations in which an SCS might have a particularly positive effect on public order, health, and safety.

Figure 14:
Map of density of QOL cals to the Somerville Police Department for hypodermic needles found in 2020



Areas in purple represent density of quality of life calls to the Somerville Police Department for hypodermic needles found in 2020, with the darker areas signifying more calls.

Results

Study limitations

This study has several limitations that should be considered. First, this study began during the second wave of the COVID-19 pandemic in New England, which restricted in-person data collection by the researchers due to travel restrictions, and created challenges connecting with people who use drugs due to service closures. Additionally, several previously planned components of the project had to be adapted or postponed due to COVID-19 restrictions, including an in-person town hall and door-to-door canvassing. Despite these challenges, we feel that the adaptations have provided sufficient data to guide recommendations and next steps for the City of Somerville to consider and are in line with methods used in other feasibility studies conducted prior to SCS implementation elsewhere.

In addition to COVID-related study limitations, there are limitations to primary data collection methods that we have highlighted below.

Surveys with people who use drugs

The survey conducted with people who use drugs used convenience sampling, with most participants recruited through organizations who serve this population. While the majority of participants were clients at these organizations, peer researchers at these organizations also conducted street outreach in an effort to recruit people who use drugs that were not yet connected to their service organizations. As such, people who use drugs of lower socio-economic status are likely overrepresented in this survey.

Additionally, given the lack of existing harm reduction services in Somerville, data collected with people who use drugs was conducted in neighboring towns that house syringe exchange programs and other supports for this population. While these services supported a significant population of Somerville residents, the sample surveyed for this evaluation cannot be assumed to be representative of all people who use drugs in Somerville.

Moreover, surveys were interviewer-administered which may have introduced recall bias and/or social desirability bias. There was also an underrepresentation of women and gender diverse women surveyed. As such, gender-specific considerations, concerns, and needs may not be fully reflected. We recommend that more explicit attention to gender-specific needs be prioritized in the following planning and development phases.

Somerville community survey

Due to COVID-19 restrictions, community surveys only used online distribution methods through the City and Task Force networks and were only available in a digital format. Some community members may have been outside the network of people directly and indirectly contacted to complete the survey, and some community groups may therefore be underrepresented. Of note, people with limited digital literacy or lacking access to technology may have been unable to complete the survey. While we received a total of 844 surveys, 229 of those were incomplete and therefore excluded from the analysis. This suggests that while we aimed to create a survey that was as concise as possible, some respondents may have found the survey to be too burdensome to complete. As such, results from this survey may not be representative of all Somerville community members.

Results

Study limitations

Somerville community survey

Additionally, we found that white people accounted for 85% of respondents, while accounting for only 68% of Somerville residents. As such, individuals from other racial and ethnic backgrounds are therefore underrepresented in the survey as compared to census data for the city of Somerville [66]. Finally, while no duplicate surveys were identified, we cannot be fully confident that respondents did not submit multiple surveys.

Focus group data

Focus group recruitment was open to any individuals accessing two harm reduction and social support organizations that work with people who use drugs. As such, individuals who face significant socio-economic marginalization are likely overrepresented in this data. Further, women and gender diverse individuals were underrepresented in focus group data, and therefore important, intersectional considerations may not be included here.

Focus group data was collected in January 2020 by a peer researcher and was re-analyzed by the study team. While we had access to all notes and transcriptions, we were unable to collect audio recordings of the focus groups.

Town Hall Overview

Note: a summary of what was discussed at the Town Hall, held June 10, 2021 will be included here.

Recommendations

Disclaimer: These recommendations may be revised based on new findings that arise during the Town Hall.

Findings from our feasibility study support the need for at least one (but preferably two) integrated SCS that includes a range of health and social service supports to be established in Somerville. Survey data from both Somerville residents and people who use drugs point to the prioritized need to address fatal overdose risk through an SCS approach (78% and 94%, respectively).

Our recommendation for an integrated SCS is further driven by the fact that just over half of participants surveyed who use drugs have experienced at least one overdose in the prior year, and 30% use drugs alone all or most of the time, which increases risk of fatal overdose [13]. Additionally, 65% of participants reported typically using drugs outdoors, underscoring the need for a safer environmental intervention. Importantly, 51% reported that they would use an SCS most or all of the time they use if available. These data represent a significant need for an SCS to reduce risk of fatal overdose amongst participants.

In what follows, we provide our specific recommendations regarding the location, operational model, policies, and services that would best meet the needs of potential clients. While our recommendations are driven by the assessment's findings, we underscore the need for procedures and implementation considerations to be guided by the specific needs of clients. Therefore, we suggest the following as a starting point, but stress the importance of reshaping policies and procedures to better address clients' needs if required.

Geographic location

We recommend that at least one fixed, integrated SCS be located in Davis Square or East Somerville (see Figures 15 & 16), but that the City consider implementing an integrated SCS with broad wraparound services in both locations. These locations are not only reflective of the neighborhoods where an SCS would be most beneficial based on the surveys, but are also responsive to the areas that experience a significant amount of overdose-related EMS runs (see Figures 8-13 above) and quality of life calls to the Somerville Police Department for hypodermic needles found in public (denoted in purple on Figures 15 & 16). Davis Square and East Somerville are also locations where street-based outreach was regularly conducted by ACCESS, further outlining the need for expanded supports in these neighbourhoods.

In addition, these areas are generally accessible on the MBTA subway, a critical need reported by people who use drugs. While Winter Hill has also seen a significant rate of EMS-related overdose runs in recent years, it is further from rapid transit, which was noted as an important factor in locating an SCS by people who use drugs within focus groups. As such, we feel that an East Somerville location could support the need in Winter Hill as well.

Overall, 56% of Somerville resident survey participants reported that East Somerville would be best suited for an SCS, followed by 51% for Davis Square. Within these two neighborhoods, approximately 53% of East Somerville residents (n=34) agreed that an SCS would be helpful in their neighborhood, and 44% of Davis Square residents (n=85) supported an SCS in their neighborhood. However, we also want to note that while Union Square was not one of the top three recommended locations for an SCS, it was tied with Davis Square for having the most in-neighborhood support (n=37).

Recommendations

Geographic location

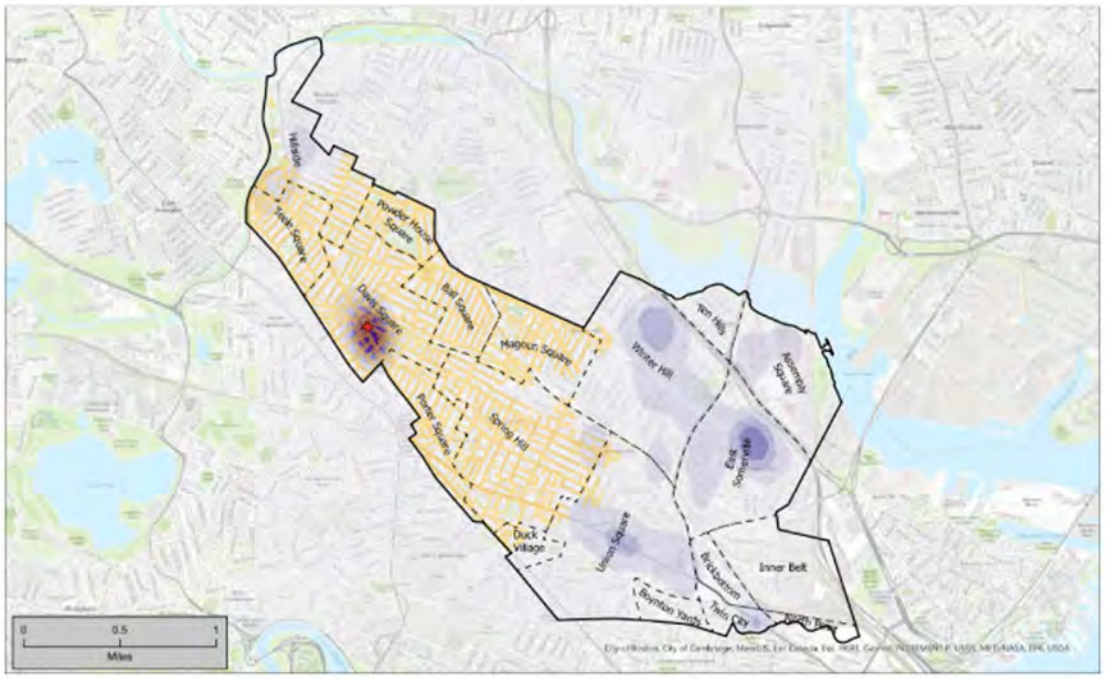


Figure 15:
Davis Square-based integrated SCS

This map highlights streets that are within 20 minutes from a potential SCS location in Davis Square by foot, public transit, or a combination.

Areas in purple represent density of quality of life calls to the Somerville Police Department for hypodermic needles found in 2020, with the darker areas signifying more calls.

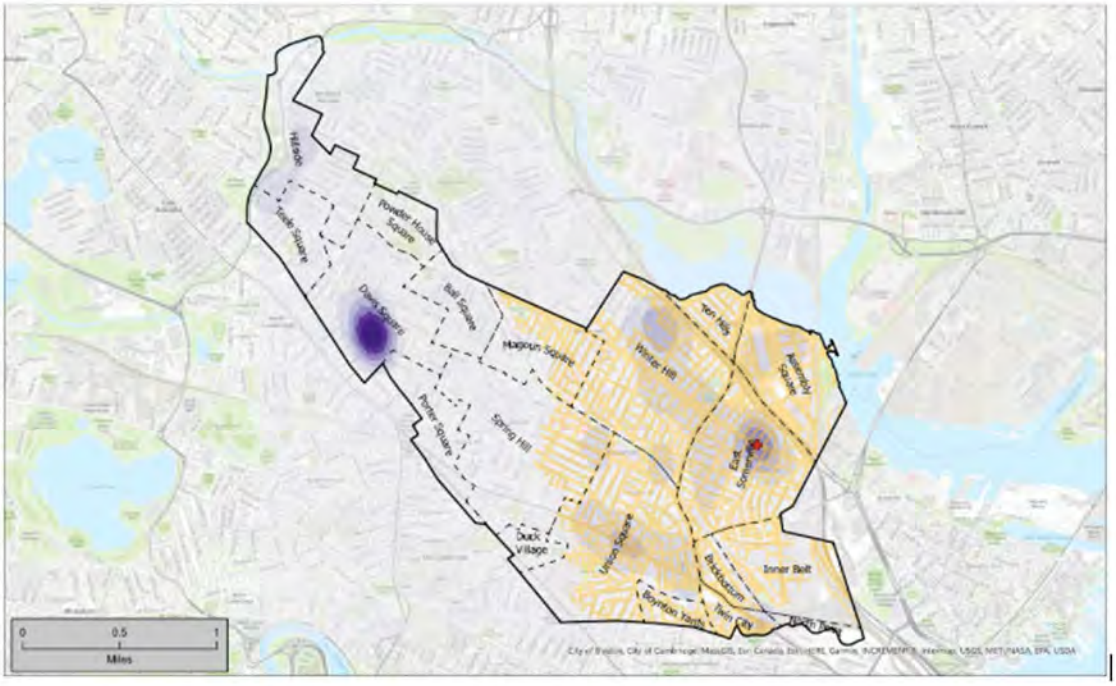


Figure 16:
East Somerville-based integrated SCS

This map highlights streets that are within 20 minutes from a potential SCS location in East Somerville by foot, public transit, or a combination.

Areas in purple represent density of quality of life calls to the Somerville Police Department for hypodermic needles found in 2020, with the darker areas signifying more calls.

Recommendations

Design and operational model

Overall, participants who use drugs reported preferring an SCS be included within a harm reduction center (e.g., syringe service program) or in a freestanding location. Given the lack of existing harm reduction services in Somerville, we recommend an integrated SCS be established as a freestanding location that provides a range of health and social services to clients. SCSs typically have three main components: a reception area, a dedicated consumption area, and a communal, post-consumption observation area. We recommend that in addition to these spaces, a Somerville SCS also have a dedicated drop-in space where individuals can access health and social service supports, harm reduction supplies (e.g. condoms, syringes, alcohol swabs), and other necessary resources (e.g. food, harm reduction education).

However, discreteness of an SCS was a key priority among focus group participants so as to minimize stigma from the broader community. To increase discreteness and to maximize accessibility of the site, including for individuals facing a range of structural vulnerabilities (e.g., housing instability, food insecurity) but who may not use drugs, we recommend that the SCS be designed to have multiple entrances, including one specific to access consumption services and one for the drop-in resource area. This will likely increase reach of the service and address clients' concerns of community-based stigma. Additional recommendations for confidentiality are included in the policy and procedures section.

Importantly, we recommend that the SCS be designed to support inhalation, in addition to other methods of consumption (e.g. snorting, injection, ingestion), given that 79% of participants reported using this method of consumption used in the 30 days prior to being surveyed. We therefore strongly recommend that the SCS be inclusive of individuals whose preferred method is inhalation, as well as those who consume through other methods of use (e.g. injecting, snorting, swallowing), so as to increase the reach and accessibility of the site.

Consumption room design

To meet the diverse needs of clients, we recommend that the consumption room be dynamic in design, including both private booths/private smoking stalls and more communal tables for use based on comfort and preference. More than half of survey participants who use drugs (52%) expressed a desire to have a range of options that allowed them to be more or less social if accessing the injection area, and 59% expressed having this flexibility when accessing inhalation services in the space.

For smoking stalls, we recommend that these be located indoors with specialized ventilation so as to increase accessibility during the winter months.

Post-consumption observation room design

We recommend that a post-consumption observation room be developed where clients can be further monitored in case of a medical emergency. While the specific design considerations were not captured in this evaluation, we recommend that this area be designed in collaboration with potential clients and informed by existing post-consumption observation spaces elsewhere. However, we do recommend that this area provides clients with access to food, beverages, and peer support, among other services.

Recommendations

Design and operational model

Staffing recommendations

We recommend that the SCS include a range of staff who can support clients on their clinical, mental health, and social needs, including nurses or healthcare professionals, counsellors, and peer support workers. However, we suggest that efforts be undertaken to include harm reduction and social service workers with whom people who use drugs in the community have existing relationships and trust. This is likely to improve engagement and facilitate uptake among individuals. We would also encourage the planners of a Somerville SCS to consider factors such as staff-to-client ratios to inform their staffing decisions.

Survey and focus group participants who use drugs overwhelmingly felt that people who use drugs (or peers) should be meaningfully included in the design and operation of the SCS. As such, we recommend that people who use drugs are included across all phases of design, implementation, and operation of the site. While no one space of an SCS was noted as being preferred for peer involvement, participants who use drugs did express interest in having peers involved in greeting and registering clients, supporting clients in the waiting area, monitoring the consumption room, and in providing support in the post-consumption room.

Hours of operation

While there was some variation in preferred hours of operation among people who use drugs, we recommend that the consumption area of an SCS be accessible 24 hours a day and the drop-in service area operate on more traditional 'business' hours, ranging from 8am - 6pm. Approximately 30% of participants who use drugs reported wanting an SCS open around-the-clock. As such, having access to the consumption area around-the-clock may increase engagement as it can meet the ongoing needs of individuals.

However, we recognize the logistical and staffing challenges of operating an SCS 24 hours a day. If around-the-clock access is prohibited by these limitations, then we recommend that the operational hours be responsive to clients' needs (e.g., 8am - 5pm and 8pm - 1am) and consider extended hours of operation during spikes in overdose events as revealed by overdose surveillance data.

It is important to note that women and gender diverse persons who use drugs were underrepresented in survey data. As such, gender-specific considerations for SCS operations may not be fully reflected. However, we recommend that the SCS is designed to be attentive to the diverse needs of individuals based on their gender, sexuality, and culture, as well as other intersecting social locations (e.g., ability). For example, women and gender diverse-only hours may increase accessibility for women and address safety concerns. We suggest that these needs be further explored in the SCS development phase.

Please see Appendix 3 for more details on potential design and operational considerations.

Recommendations

Policies and procedures

Accessing the SCS

Confidentiality was reiterated across participants who use drugs as an important factor in shaping their engagement with an SCS. Program policies and procedures must ensure the privacy of clients accessing the service and this must be transparent to clients. We recommend that clients need not provide their legal name, but can use an alias. Further, government issued IDs should not be required for accessing the space; this is often prohibitive for many individuals and may undermine the accessibility of an SCS. Rather, we recommend that no ID be required for use, with clients registering on their first visit and being provided a client ID number to use on subsequent visits.

While we recognize the community concerns related to a potential influx of people who use drugs in Somerville, we recommend that the SCS be open to anyone who uses drugs, including individuals who do not live in Somerville. This will be imperative for supporting clients in nearby areas (e.g., Cambridge). Data has demonstrated that individuals often do not travel more than one mile to access an SCS [14]. As such, eliminating the need for Somerville residency will likely have no adverse impact on the Somerville community.

Police involvement

Notably, concerns about police presence around the site was a primary driver for not wanting to use an SCS by participants who use drugs (see Appendix 1). Given these dynamics, it is imperative that the implementation and operation of a SCS involve transparent communication between the site and law enforcement so as to alleviate concerns among clients. Importantly, we recommend that the SCS and the police department develop a memorandum of understanding, in which participants going to, or leaving, the SCS will not be stopped or arrested.

A large body of research documents the negative impact of drug enforcement and policing activities (e.g. confiscation of drug paraphernalia, intensive surveillance) on the health and wellbeing of people who use drugs [83–88]. Research has also demonstrated how police presence and surveillance in areas surrounding SCSs act as a barrier to uptake, undermining programs aimed at providing public health services to these populations [89–91]. As such, we recommend that mechanisms for ongoing dialogue between the City, the SCS operating organization, and the police be established as soon as possible. This will be critical to developing cooperative relationships between these entities, which will be integral to the success of an SCS.

Specifically, we recommend that police liaisons be established, as these have been shown to be effective in other locations [89,92]. Within these relationships, dedicated officers would act as liaisons with the SCS to provide ongoing communication and dialogue to address challenges that may arise, as well as processes for resolving disputes.

Recommendations

Policies and procedures

Police involvement

We also recommend that a boundary agreement be developed between the police and the SCS. Under this agreement, we recommend that procedures and protocols be developed to establish a "safe zone" around the SCS in which police do not arrest or target individuals who are engaging in public drug use [92]. Rather, procedures could be developed to direct a person injecting drugs within the vicinity of an SCS (e.g., four block radius) to access the SCS instead so as to avoid future contact with the police. While the specifics of a "safe zone" should be developed between the police and the SCS, having a clear and consistently adhered to boundary is critical for building trust and security for clients.

Post-consumption observation and monitoring

Data from the Somerville community survey pointed to concerns regarding procedures following use in the SCS, including an increase in public intoxication and transportation concerns (e.g., driving under the influence). We therefore recommend that clear policies be developed regarding the length of time that clients should stay in the post-consumption observation area for monitoring in the event of an emergency. We also suggest that the recommended observation time be evaluated post-implementation and altered as needed.

Service and program recommendations

Notably, 88% of participants who use drugs were unstably housed at the time of their survey, underscoring the need for an SCS to include supports that address clients' basic needs (e.g., food, bathrooms), in addition to their health and social needs.

The data overwhelmingly underscores the need for wraparound health and social services to be provided at the SCS in addition to consumption services. Specifically, access to a range of contraception, HIV, HCV, and STI testing, and assistance with housing and social assistance onsite were the top three most important services noted by participants, followed by access to sterile injection equipment, bathrooms, food services, and a post-consumption room. This highlights that while overdose prevention and response is the leading reason for utilizing an SCS, this public health intervention can be a critical space to support clients in meeting other health and basic needs.

In addition to basic health and medical services (e.g., STI testing, wound care), we recommend that medications for the treatment of opioid use disorder be accessible in the SCS drop-in area. Approximately 60% of participants who use drugs reported that being able to initiate treatment services on-site was very acceptable. This integration would also help solidify the SCS as part of the continuum of care for people who use drugs.

We also recommend that the SCS provide the following services and programs:

Harm reduction supply access (e.g. condoms, pipes, syringes, alcohol swabs)

Naloxone training and distribution

Harm reduction education

Drug testing technologies (e.g. fentanyl testing strips, mass spectrometry)

Social service supports, including housing (e.g. housing referrals, support with applications), social assistance and disability (e.g. application support) supports, and employment programs

Basic food provision
Mental health support services onsite; and Peer-led support groups

Recommendations

Legal Recommendations

To ensure access to an SCS in Somerville, we recommend that the City work alongside the Massachusetts District Attorney's office to develop an understanding so as to not prosecute anyone should be arrested for accessing the SCS. We also recommend that the City establish protocols for working with probation and parole offices in the event that individuals with parole conditions access the SCS.

Additional recommendations have been provided by the SCS Task Force legislative and legal sub-committee (see next page) and are also described in the Next Steps section at the end of this document.

Recommendations

Task Force Recommendations

Legislative and legal sub-committee

The Legislative and Legal sub-committee recommends that a Somerville-based SCS offers referral and wraparound services, and includes a staffing model inclusive of peers, health navigators, and at least one medical professional when consumption services are being offered.

Key areas of focus included: property ownership and authorization; collaboration with local, state, and federal entities; and ongoing evaluation. Specifically, the sub-committee recommends:

1) The SCS is operated on City-owned property if state authorization for an SCS is not provided and/or private landowners are not protected from prosecution under the existing legislation;

2) The SCS is authorized by the City of Somerville through its Board of Health if state authorization for an SCS is not provided. However, if SCS are sanctioned at the state-level, we recommend that no local authorization be required;

3) There is cooperation and understanding with local law enforcement officials on the local and/or state authorizations related to the operation, access, and use of an SCS; and

4) The City maintains ongoing discussion with State and Federal delegations related to its City-level authorization and support of an SCS in the event that statewide legislation does not pass.

Program development sub-committee

The Program Development sub-committee recommends that any SCS be developed with careful attention paid to three key areas: safety, inclusivity, and integration. There are six basic components they suggest be included in the SCS:

1) A welcoming reception area;

2) Two supervised consumption areas: one for injections and a well-ventilated smoking area;

3) Drug-checking mechanisms available for people regardless of on-site consumption

4) Private clinical spaces;

5) Two post-consumption areas: a de-stimulating space for after stimulant consumption, and an observation area for use after consuming opioids; and

6) A common area where participants can receive support from support staff including social workers, clinicians, and peer support workers.

Please see Appendix 3 for the sub-committee's preliminary draft operational guidance document developed for the SCS.

Next steps

Development of advisory and oversight committees. We recommend that the City convene a community advisory committee to oversee the subsequent phases of this initiative. The community advisory committee should be composed of diverse stakeholder groups, including people who use drugs, health and social service providers, residents, business owners, and police. This committee should be responsible for overseeing community engagement processes and developing mechanisms to address community concerns as they arise. We also recommend that the community advisory committee develop procedures for maintaining transparency of the planning process within the larger community. All plans, procedures, and documents should be available to the public.

Determine the organization(s) that will implement and operate the SCS. A transparent process determining which service provider(s) will operate the SCS should be established. The SCS should be part of a comprehensive strategy to address the overdose crisis and should therefore be integrated into a continuum of services and supports for people who use drugs. We therefore recommend that organizations considered should ideally have existing relationships with potential clients, which will be important for client uptake.

Establish ongoing dialogue between the operating organization, the City of Somerville, and the police department. Engaging police in discussions about opening an SCS in Somerville is a necessary step and should be established early in the process. Protocols should be developed and implemented that clarify the role of the police in relation to the SCS. This dialogue should be transparent and ongoing, with decisions made available to the public. We recommend that these policies and procedures include determinations on how the community will be policed (e.g., developing "safe zones" around the site), mechanisms for diversion, plans outlining procedures for addressing potential emergencies within the SCS and outside the SCS, conflict resolution steps in the event a procedure is not adhered to, and other elements that will be necessary for successful implementation.

SCS site selection. A transparent site selection process should be undertaken to identify potential locations for an integrated SCS in Somerville. This process should include a range of stakeholders, including people who use drugs, to ensure the appropriateness of the space. Once potential locations are identified, we recommend that the City engage in targeted canvassing and community outreach to businesses and residents in the immediate vicinity to garner support and answer any questions or concerns. This support will be critical for a successful implementation.

Implementation and evaluation plans should be developed. Ongoing evaluation should be undertaken throughout the design and implementation process, as well as following implementation to ensure that the services offered are relevant and responsive to the needs of clients. This evaluation will also be important for measuring community impacts. The implementation and evaluation plans should be developed by the agency that will operate the SCS, with input from other stakeholders (e.g., service providers, people who use drugs), and be led by a group with expertise in conducting mixed-methods research with people who use drugs. We recommend that evaluations primarily measure client-centered outcomes. For example, it will be important to capture factors such as ease of access, operational facilitators/barriers of use, and whether programs are meeting clients' needs, in addition to neighborhood-level impacts. Focusing evaluations on health and social factors related to people who use the site will be imperative to allow for program modifications.

Next steps

Community education and communication strategy. A comprehensive approach to community engagement should be designed and implemented to ensure Somerville community members are well-informed about the need for a SCS in Somerville, the benefits of these services, and the SCS operational protocols and procedures. Improved communication between the City and the community was highlighted as a key theme in the community survey. These strategies should also explicitly provide information that addresses community concerns of public safety. The community engagement strategy should be an ongoing endeavor targeting potential clients, local residents and business, service providers, elected officials, police, and the broader public. These efforts will be critical to increase broader community support for a SCS, which is imperative for a successful integration.

Develop a legal strategy. We recommend that the City consider developing memorandums of understanding with the SCS operating agency related to City-level support that could be provided if requested by the SCS (e.g. city-funded medical equipment, biohazard waste disposal). We also recommend that the City seek pathways that allow the SCS to operate under the City's liability insurance. Additional administrative and logistical systems that aid in the SCS operations should be developed alongside the SCS operating agency.

Importantly, we recommend that the City of Somerville work with their legal department to develop an alternative approach to implementing an SCS in the event that state legislation on SCS (H.2088) is not passed. For example, we recommend that the City works with its legal team to consider establishing a system for authorization for SCS operation through the Department of Health and Human Services and/or Board of Health. As part of this plan, we also recommend that the City work with their legal team to take steps that ensure the protection of staff and clients of an SCS from police action and potential civil and/or disciplinary issues in the absence of state authorization.

Identify sustainable lines of funding. Prior to opening an SCS, we recommend that the City and operating agency identify sustainable lines of funding to support an integrated SCS and the range of services provided. Additional funding sources should be identified to operate a mobile SCS as well. We recommend that the City seek out a range of financial support through granting mechanisms, private donors, and City resources.

References

1. Drug Overdose Deaths [Internet]. 2021 [cited 2021 Apr 29]. Available from: https://www.cdc.gov/drugoverdose/data/statedeaths.html

2. 2019 Drug Overdose Death Rates [Internet]. 2021 [cited 2021 Apr 29]. Available from: https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2019.html

3. National Center for Health Statistics. Vital Statistics Rapid Release - Provisional Drug Overdose Data [Internet]. 2018 [cited 2018 Oct 3]. Available from: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

4. DiGennaro C, Garcia G-GP, Stringfellow EJ, Wakeman S, Jalali MS. Changes in characteristics of opioid overdose death trends during the COVID-19 pandemic [Internet]. bioRxiv. medRxiv; 2021. Available from: http://medrxiv.org/lookup/doi/10.1101/2021.02.01.21250781

5. Massachusetts Department of Public Health. Number of opioid-related overdose deaths, all intents by City/Town 2015-2019 [Internet]. 2020 Nov. Available from: https://www.mass.gov/doc/opioid-related-overdose-deaths-by-citytown-november-2020/download

6. National Health for Health Statistics. Products - Vital Statistics Rapid Release - VSRR No. 11 Dashboard [Internet]. 2021 [cited 2021 May 6]. Available from: https://www.cdc.gov/nchs/nvss/vsrr/vsrr11-dashboard/index.htm

7. SomerStat. Mapping Opioid Overdose in Somerville (2014-2020). City of Somerville; 2020 Feb.

8. Darke S, Mattick RP, Degenhardt L. The ratio of non-fatal to fatal heroin overdose. Addiction. 2003 Aug;98(8):1169–71.

9. Milloy M-JS, Kerr T, Tyndall M, Montaner J, Wood E. Estimated drug overdose deaths averted by North America's first medically-supervised safer injection facility. PLoS One. 2008 Oct 7;3(10):e3351.

10. Commonwealth of Massachusetts. HIV Treatment Guidelines and Clinical Advisories [Internet]. [cited 2021 May 30]. Available from: https://www.mass.gov/lists/hiv-treatment-guidelines-and-clinical-advisories

11. Linas BP, Savinkina A, Madushani RWMA, Wang J, Eftekhari Yazdi G, Chatterjee A, et al. Projected Estimates of Opioid Mortality After Community-Level Interventions. JAMA Netw Open. 2021 Feb 1;4(2):e2037259.

12. Saloner B, McGinty EE, Beletsky L, Bluthenthal R, Beyrer C, Botticelli M, et al. A Public Health Strategy for the Opioid Crisis. Public Health Rep. 2018;133(1_suppl):24S – 34S.

13. Hagan H, Campbell JV, Thiede H, Strathdee SA, Ouellet L, Latka M, et al. Injecting alone among young adult IDUs in five US cities: evidence of low rates of injection risk behavior. Drug Alcohol Depend. 2007 Nov;91 Suppl 1:S48–55.

14. Behrends CN, Paone D, Nolan ML, Tuazon E, Murphy SM, Kapadia SN, et al. Estimated impact of supervised injection facilities on overdose fatalities and healthcare costs in New York City. J Subst Abuse Treat. 2019 Nov;106:79–88.

15. Supervised Consumption Services [Internet]. [cited 2021 Apr 29]. Available from: http://www.drugpolicy.org/resource/supervised-consumption-services

16. Kennedy MC, Karamouzian M, Kerr T. Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review. Curr HIV/AIDS Rep. 2017 Oct;14(5):161–83.

17. Potier C, Laprévote V, Dubois-Arber F, Cottencin O, Rolland B. Supervised injection services: what has been demonstrated? A systematic literature review. Drug Alcohol Depend. 2014 Dec 1;145:48–68.

18. Salmon AM, van Beek I, Amin J, Kaldor J, Maher L. The impact of a supervised injecting facility on ambulance call-outs in Sydney, Australia. Addiction. 2010 Apr;105(4):676–83.

19. Kennedy MC, Hayashi K, Milloy M-J, Wood E, Kerr T. Supervised injection facility use and all-cause mortality among people who inject drugs in Vancouver, Canada: A cohort study. PLoS Med. 2019 Nov;16(11):e1002964.

20. Marshall BDL, Milloy M-J, Wood E, Montaner JSG, Kerr T. Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. Lancet. 2011 Apr 23;377(9775):1429–37.

21. Kerr T, Tyndall M, Li K, Montaner J, Wood E. Safer injection facility use and syringe sharing in injection drug users. Lancet. 2005;366(9482):316–8.

22. Pinkerton SD. How many HIV infections are prevented by Vancouver Canada's supervised injection facility? Int J Drug Policy. 2011 May;22(3):179–83.

23. Andresen MA, Boyd N. A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility. Int J Drug Policy. 2010 Jan;21(1):70–6.

24. Belackova V, Salmon AM, Schatz E, Jauncey M. Drug consumption rooms (DCRs) as a setting to address hepatitis C - findings from an international online survey. Hepatol Med Policy. 2018 Aug 22;3:9.

25. Ebright JR, Pieper B. Skin and soft tissue infections in injection drug users. Infect Dis Clin North Am. 2002 Sep;16(3):697–712.

26. Small W, Wood E, Lloyd-Smith E, Tyndall M, Kerr T. Accessing care for injection-related infections through a medically supervised injecting facility: a qualitative study. Drug Alcohol Depend. 2008 Nov 1;98(1-2):159–62.

27. Stoltz J-A, Wood E, Small W, Li K, Tyndall M, Montaner J, et al. Changes in injecting practices associated with the use of a medically supervised safer injection facility. J Public Health . 2007 Mar;29(1):35–9.

28. Marshall BDL, Wood E, Zhang R, Tyndall MW, Montaner JSG, Kerr T. Condom use among injection drug users accessing a supervised injecting facility. Sex Transm Infect. 2009 Apr;85(2):121–6.

29. Greer AM, Luchenski SA, Amlani AA, Lacroix K, Burmeister C, Buxton JA. Peer engagement in harm reduction strategies and services: a critical case study and evaluation framework from British Columbia, Canada. BMC Public Health. 2016 May 27;16:452.

30. Bouchard M, Hashimi S, Tsai K, Lampkin H, Jozaghi E. Back to the core: A network approach to bolster harm reduction among persons who inject drugs. Int J Drug Policy. 2018 Jan;51:95–104.

31. Wood E, Tyndall MW, Zhang R, Stoltz J-A, Lai C, Montaner JSG, et al. Attendance at supervised injecting facilities and use of detoxification services. N Engl J Med. 2006 Jun 8;354(23):2512–4.

32. Wood E, Tyndall MW, Zhang R, Montaner JSG, Kerr T. Rate of detoxification service use and its impact among a cohort of supervised injecting facility users. Addiction. 2007 Jun;102(6):916–9.

33. DeBeck K, Kerr T, Bird L, Zhang R, Marsh D, Tyndall M, et al. Injection drug use cessation and use of North America's first medically supervised safer injecting facility. Drug Alcohol Depend. 2011 Jan 15;113(2-3):172–6.

34. Kimber J, Mattick RP, Kaldor J, van Beek I, Gilmour S, Rance JA. Process and predictors of drug treatment referral and referral uptake at the Sydney Medically Supervised Injecting Centre. Drug Alcohol Rev. 2008 Nov;27(6):602–12.

35. Wood E, Tyndall MW, Montaner JS, Kerr T. Summary of findings from the evaluation of a pilot medically supervised safer injecting facility. CMAJ. 2006 Nov 21;175(11):1399–404.

36. Scheim A, Werb D. Integrating supervised consumption into a continuum of care for people who use drugs. CMAJ. 2018 Aug 7;190(31):E921–2.

37. Bruneau J, Ahamad K, Goyer M-È, Poulin G, Selby P, Fischer B, et al. Management of opioid use disorders: a national clinical practice guideline. CMAJ. 2018 Mar 5;190(9):E247–57.

38. Kerr T, Tyndall MW, Zhang R, Lai C, Montaner JSG, Wood E. Circumstances of first injection among illicit drug users accessing a medically supervised safer injection facility. Am J Public Health. 2007 Jul;97(7):1228–30.

39. Kerr T, Stoltz J-A, Tyndall M, Li K, Zhang R, Montaner J, et al. Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study. BMJ. 2006 Jan 28;332(7535):220–2.

40. Salmon AM, Thein H-H, Kimber J, Kaldor JM, Maher L. Five years on: what are the community perceptions of drug-related public amenity following the establishment of the Sydney Medically Supervised Injecting Centre? Int J Drug Policy. 2007 Jan;18(1):46–53.

41. Wood E, Kerr T, Small W, Li K, Marsh DC, Montaner JSG, et al. Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. CMAJ. 2004 Sep 28;171(7):731–4.

42. Harm Reduction Commission [Internet]. [cited 2021 May 9]. Available from: https://www.mass.gov/orgs/harm-reduction-commission

43. Myer AJ, Belisle L. Highs and Lows: An Interrupted Time-Series Evaluation of the Impact of North America's Only Supervised Injection Facility on Crime. J Drug Issues. 2018 Jan 1;48(1):36–49.

44. Freeman K, Jones CGA, Weatherburn DJ, Rutter S, Spooner CJ, Donnelly N. The impact of the Sydney Medically Supervised Injecting Centre (MSIC) on crime. Drug Alcohol Rev. 2005 Mar;24(2):173–84.

45. Wood E, Tyndall MW, Lai C, Montaner JSG, Kerr T. Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. Subst Abuse Treat Prev Policy. 2006 May 8;1:13.

46. Davidson PJ, Lambdin BH, Browne EN, Wenger LD, Kral AH. Impact of an unsanctioned safe consumption site on criminal activity, 2010-2019. Drug Alcohol Depend. 2021 Jan 11;220:108521.

47. Pardo B, Caulkins J, Kilmer B. Assessing the evidence on supervised drug consumption sites. RAND Corporation; 2018.

48. Bayoumi AM, Zaric GS. The cost-effectiveness of Vancouver's supervised injection facility. CMAJ. 2008 Nov 18;179(11):1143–51.

49. Enns EA, Zaric GS, Strike CJ, Jairam JA, Kolla G, Bayoumi AM. Potential cost-effectiveness of supervised injection facilities in Toronto and Ottawa, Canada. Addiction. 2016 Mar;111(3):475–89.

50. Hood JE, Behrends CN, Irwin A, Schackman BR, Chan D, Hartfield K, et al. The projected costs and benefits of a supervised injection facility in Seattle, WA, USA. Int J Drug Policy. 2019 May;67:9–18.

51. Irwin A, Jozaghi E, Weir BW, Allen ST, Lindsay A, Sherman SG. Mitigating the heroin crisis in Baltimore, MD, USA: a cost-benefit analysis of a hypothetical supervised injection facility. Harm Reduct J. 2017 May 12;14(1):29.

52. Irwin A, Jozaghi E, Bluthenthal RN, Kral AH. A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA. J Drug Issues. 2017 Apr 1;47(2):164–84.

53. Coye AE, Bornstein KJ, Bartholomew TS, Li H, Wong S, Janjua NZ, et al. Hospital Costs of Injection Drug Use in Florida. Clin Infect Dis. 2021 Feb 1;72(3):499–502.

54. Lloyd-Smith E, Wood E, Zhang R, Tyndall MW, Montaner JS, Kerr T. Determinants of cutaneous injection-related infection care at a supervised injecting facility. Ann Epidemiol. 2009 Jun;19(6):404–9.

55. Wood RA, Stewart P, Zettel W. Harm reduction nursing practice: the Dr. Peter Centre Centre supervised injection project. Canadian Nurse. 2003;99(5):20–4.

56. Supervised Consumption Services (SCS) – Parkdale Site [Internet]. 2018 [cited 2021 May 4]. Available from: https://pqwchc.org/programs-services/harm-reduction/ops/

57. Insite [Internet]. 2020 [cited 2021 May 4]. Available from: https://www.phs.ca/program/insite/

58. Uniting Medically Supervised Injecting Centre (MSIC) [Internet]. [cited 2021 May 4]. Available from: https://www.uniting.org/community-impact/uniting-medically-supervised-injecting-centre--msic

59. Dong KA, Brouwer J, Johnston C, Hyshka E. Supervised consumption services for acute care hospital patients. CMAJ. 2020 May 4;192(18):E476–9.

60. Overdose Prevention Site at St. Paul's Hospital [Internet]. [cited 2021 May 4]. Available from: https://www.catie.ca/en/pc/program/ops-stpaul

61. Salle de consommation à moindres risques [Internet]. Gaïa Paris. [cited 2021 May 4]. Available from: https://gaia-paris.fr/salle-de-consommation-a-moindre-risque/

62. Drogenhilfezentrum Abrigado [Internet]. Comité National de Défense Sociale. 2015 [cited 2021 May 4]. Available from: https://www.cnds.lu/abrigado/

63. Das Eastside - Europas größte niedrigschweillige Drogenhilfeeinrichtung [Internet]. idh - Integrative Drogenhilfe e.V. [cited 2021 May 4]. Available from: https://www.idh-frankfurt.de/eastside

64. Bardwell G, Kerr T, Boyd J, McNeil R. Characterizing peer roles in an overdose crisis: Preferences for peer workers in overdose response programs in emergency shelters. Drug Alcohol Depend. 2018 Sep 1;190:6–8.

65. Collins AB, Boyd J, Hayashi K, Cooper HLF, Goldenberg S, McNeil R. Women's utilization of housing-based overdose prevention sites in Vancouver, Canada: An ethnographic study. International Journal of Drug Policy. 2020 Feb 1;76:102641.

66. Victoria - Howard Johnson [Internet]. Island Health - Overdose Prevention & Supervised Consumption Locations. [cited 2021 May 4]. Available from: https://www.islandhealth.ca/our-locations/overdose-prevention-supervised-consumption-locations/victoria-howard-johnson

67. Kassam A. Montreal opens first mobile supervised injection clinic in North America. The Guardian [Internet]. 2017 Jun 19 [cited 2021 May 30]; Available from: http://www.theguardian.com/worldhttps://www.islandhealth.ca/our-locations/overdose-prevention-supervised-consumption-locations/victoria-howard-johnson/2017/jun/19/montreal-mobile-supervised-injection-clinic-north-america

68. Busby M. Inside Glasgow's Safer Drug Consumption Van. VICE World News [Internet]. 2020 Sep 14 [cited 2021 May 4]; Available from: https://www.vice.com/en/article/3azmpj/glasgow-safer-drug-consumption-van

69. Dietze P, Winter R, Pedrana A, Leicht A, Majó I Roca X, Brugal MT. Mobile safe injecting facilities in Barcelona and Berlin. Int J Drug Policy. 2012 Jul;23(4):257–60.

70. About Somerville [Internet]. City of Somerville. [cited 2021 May 3]. Available from: https://www.somervillema.gov/about

71. United States Census Bureau. QuickFacts: Somerville city, Massachusetts [Internet]. [cited 2021 May 3]. Available from: https://www.census.gov/quickfacts/somervillecitymassachusetts

72. City of Somerville. SomerVision 2040: Comprehensive Plan Update [Internet]. 2020 Dec. Available from: https://2xbcbm3dmbsg12akbzq9ef2k-wpengine.netdna-ssl.com/wp-content/uploads/2020/12/SomerVision-202012023.pdf

73. US Department of Housing and Urban Development. 2018 AHAR: Part 1 - PIT Estimates of Homelessness in the US [Internet]. HUD Exchange. 2018. Available from: https://www.hudexchange.info/resource/5783/2018-ahar-part-1-pit-estimates-of-homelessness-in-the-us/

74. Region of Waterloo Public Health and Emergency Services. Waterloo Region Supervised Injection Services Feasibility Study [Internet]. 2018. Available from: https://www.regionofwaterloo.ca/en/regional-government/resources/Reports-Plans--Data/Public-Health-and-Emergency-Services/SIS_FeasibilityStudy.pdf

75. T Kerr, S Mitra, B Krysowaty, Z Marshall, C Olsen, B Rachlis, J Bacon, K Murray, S Rourke. Ontario Integrated Supervised Injection Services Feasibility Study Study Report: Thunder Bay, ON [Internet]. 2017. Available from: https://www.ohtn.on.ca/wp-content/uploads/2017/02/OISIS-Thunder-Bay-Report-Online.pdf

76. Public Health Sudbury & Districts. A study to explore the need for and feasibility of implementing supervised consumption services in the City of Greater Sudbury [Internet]. 2020. Available from: https://www.phsd.ca/wp-content/uploads/2020/06/Need_for_and_feasibility_of_implementing_supervised_consumption_services_in_the_City_of_Greater_Sudbury_EN-3.pdf

77. British Columbia Centre on Substance Use. Supervised consumption services: Operational guidance [Internet]. 2017. Available from: https://www.bccsu.ca/wp-content/uploads/2017/07/BC-SCS-Operational-Guidance.pdf

78. Massachusetts Document Repository [Internet]. [cited 2021 May 9]. Available from: https://docs.digital.mass.gov/dataset/massgis-data-massachusetts-department-transportation-massdot-roads

79. Massachusetts Bay Transportation Authority. GTFS [Internet]. MBTA. [cited 2021 May 9]. Available from: https://www.mbta.com/developers/gtfs

80. City of Somerville. Quality Of Life Incidents [Internet]. 2020 [cited 2021 May 9]. Available from: https://data.somervillema.gov/Public-Safety/Quality-Of-Life-Incidents/62z4-avqc

81. Institute for Clinical and Economic Review. Opioid Epidemic: Supervised Injection Facilities [Internet]. 2020 [cited 2021 May 4]. Available from: https://icer.org/assessment/opioids-supervised-injection-facilities-2020/

82. Mallow PJ, Belk KW, Topmiller M, Strassels SA. Geographic variation in hospital costs, payments, and length of stay for opioid-related hospital visits in the USA. J Pain Res. 2018 Dec 4;11:3079–88.

83. Miller CL, Firestone M, Ramos R, Burris S, Ramos ME, Case P, et al. Injecting drug users' experiences of policing practices in two Mexican-U.S. border cities: public health perspectives. Int J Drug Policy. 2008 Aug;19(4):324–31.

84. Ti L, Wood E, Shannon K, Feng C, Kerr T. Police confrontations among street-involved youth in a Canadian setting. Int J Drug Policy. 2013 Jan;24(1):46–51.

85. Small W, Rhodes T, Wood E, Kerr T. Public injection settings in Vancouver: physical environment, social context and risk. Int J Drug Policy. 2007 Jan;18(1):27–36.

86. Volkmann T, Lozada R, Anderson CM, Patterson TL, Vera A, Strathdee SA. Factors associated with drug-related harms related to policing in Tijuana, Mexico. Harm Reduct J. 2011 Apr 8;8(1):1–8.

87. Sarang A, Rhodes T, Sheon N, Page K. Policing drug users in Russia: risk, fear, and structural violence. Subst Use Misuse. 2010 May;45(6):813–64.

88. Wagner KD, Simon-Freeman R, Bluthenthal RN. The association between law enforcement encounters and syringe sharing among IDUs on skid row: a mixed methods analysis. AIDS Behav. 2013 Oct;17(8):2637–43.

89. Bardwell G, Strike C, Altenberg J, Barnaby L, Kerr T. Implementation contexts and the impact of policing on access to supervised consumption services in Toronto, Canada: a qualitative comparative analysis. Harm Reduct J. 2019 May 2;16(1):1–9.

90. Collins AB, Boyd J, Mayer S, Fowler A, Kennedy MC, Bluthenthal RN, et al. Policing space in the overdose crisis: A rapid ethnographic study of the impact of law enforcement practices on the effectiveness of overdose prevention sites. International Journal of Drug Policy. 2019 Nov 1;73:199–207.

91. Foreman-Mackey A, Bayoumi AM, Miskovic M, Kolla G, Strike C. "It"s our safe sanctuary': Experiences of using an unsanctioned overdose prevention site in Toronto, Ontario. International Journal of Drug Policy. 2019 Nov 1;73:135–40.

92. Watson TM, Bayoumi AM, Hopkins S, Wright A, Naraine R, Khorasheh T, et al. Creating and sustaining cooperative relationships between supervised injection services and police: A qualitative interview study of international stakeholders. Int J Drug Policy. 2018 Nov;61:1–6.

Appendix 1 - Results from the surveys with people who use drugs

Data Notes

In total, 47 surveys were completed with people who self-identified as a person who uses drugs from February to April 2021. Participants were not required to answer each question and some questions allowed for multiple responses. Please note that the number of participants who responded to each question are noted below. Percentages have been rounded to the nearest whole percent.

To protect participants' privacy, responses that have less than five counts have been suppressed. These are denoted with a "nr" (not reportable).

Demographics

Characteristic (number of responses)	FREQUENCY	PROPORTION (%)
Gender* (47)		
Woman	8	17%
Man	36	77%
Non-binary, transgender, or genderqueer	nr	nr
Other	nr	nr
Average age (range) (47)	**42 (19 - 71 years)**	
Race and ethnicity* (50)		
Black, African, or African American	12	24%
White	26	52%
Mixed, bi-racial, or multi-racial	5	10%
Indigenous, Native American, Alaska Native	nr	nr
Hispanic or Latinx	nr	nr
Asian	nr	nr
Native Hawaiian or Pacific Islander	nr	nr
Missing	nr	nr
Current living situation* (60)		
Apartment/house rented or owned	7	15%
Family or friend's place, couch surfing	6	13%
Recovery or residential treatment center	nr	nr
Transitional housing program	nr	nr
Hotel/motel room	5	11%

Unsheltered, outside	13	28%
Car, abandoned building, or indoor public space	nr	nr
Shelter	16	34%
Tent	8	17%
Connection to Somerville (47)		
Yes	32	68%
No	12	26%
Unsure	nr	nr

nr = not reported due to fewer than five responses
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

Drug use patterns

All but one participant reported drug use in the 30 days prior to being surveyed.

QUESTION (number of responses)	FREQUENCY	PROPORTION (%)
Substances used in previous 30 days* (265)		
Cocaine	18	38%
Crack cocaine	29	62%
Crystal methamphetamine	28	60%
Heroin	32	68%
Fentanyl	29	62%
Opioids	15	32%
Marijuana	28	60%
Alcohol	30	64%
Hallucinogens	nr	nr
Benzodiazepines	22	47%
Other	nr	nr
Methods of use in previous 30 days* (116)		
Inject	29	62%
Smoke or inhale	37	79%
Snort	25	53%
Ingest or swallow	25	53%
Require help injecting[x] (29)		
Yes	9	31%
No	18	62%
Sometimes	nr	nr

Frequency of use (46)		
Daily	14	30%
Multiple times per day	19	41%
1-3 times per week	nr	nr
4-5 times per week	nr	nr
1-3 times per month	7	15%
Less than once per month	nr	nr
Frequency of using alone (46)		
Always (100% of the time)	nr	nr
Most of the time (>75%)	10	22%
Sometimes (26-74%)	17	37%
Occasionally (<25%)	9	20%
Never	6	13%
Overdoses in the last year (47)		
1 overdose	9	19%
2 overdoses	5	11%
3 or more overdoses	10	21%
None	23	49%

nr = not reported due to fewer than five responses
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.
[X]Skip logic resulted in only participants who reported this method of consumption being asked to respond.

Locations of drug use

QUESTION (number of responses)	FREQUENCY	PROPORTION (%)
Drug use locations* (107)		
Where you're currently staying	21	45%
Public washrooms	22	47%
Bus, metro, transportation depots	9	19%
Outside (e.g. park, alley)	30	64%
Friend's place	15	32%
Public building (e.g. library)	7	15%
Public drug use[x] (37)		
Daily	19	40%
3-4 times per week	7	15%
1 or fewer times per week	11	23%

nr = not reported due to fewer than five responses
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

[X]Skip logic resulted in only participants who reported this method of consumption being asked to respond.

Frequency of using an SCS in Somerville

The vast majority of participants (94%) reported that they would use an SCS if located in Somerville, with the remainder unsure.

Of those who reported that they would use an SCS (n=42), 24% reported they would always use an SCS, 33% would use it most of the time (>75% of the time), 26% would use it sometimes (26-74% of the time), 10% would use it occasionally (<25% of the time), and 7% were unsure or preferred not to answer.

Reasons for using an SCS

Reason for wanting to use a SCS (222)*	FREQUENCY	PROPORTION (%)
Access to sterile injection and/or smoking equipment	31	66%
Ability to inject indoors rather than in public	26	56%
Safety from being seen and/or arrested by police	35	75%
Safety from crime or violence	33	70%
Access to health professionals and basic health services	26	56%
Access to referrals for treatment or social services	25	54%
Overdose prevention or treatment	44	94%
Other	nr	nr

nr = not reported due to fewer than five responses
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

Reasons for not using an SCS

Reason for not wanting to use a nSCS (63)*	FREQUENCY	PROPORTION (%)
Do not want to be seen/do not want people to know about my drug use	10	21%
Lack of confidentiality	6	13%
Prefer to use alone	nr	nr
Already have access to sterile supplies	nr	nr

Afraid SCS are not safe from crime or violence	7	15%
Concerned about police around the site	21	45%
Already have a place to use	nr	nr
Too many rules or policies	nr	nr
Legal consequences related to condition of probation or parole	nr	nr
No concerns	5	11%
Other	7	15%

nr = not reported due to fewer than five responses
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

Location and SCS model

QUESTION (number of responses)	FREQUENCY	PROPORTION (%)
Distance willing to travel (walk, car, bike, or transit) to access a SCS (47)		
5-15 min	11	23%
15-25 min	14	30%
25-35 min	10	21%
35+ min	6	13%
Unsure/prefer not to answer	6	13%
Willingness to access the SCS if located in the following places* (242)		
Community health center	39	83%
Walk-in clinic, hospital, or doctor's office	35	75%
Social service agency (e.g. shelter)	38	81%
Harm reduction center (e.g. SSP)	43	92%
Trailer, RV, or mobile location	40	85%
Own, freestanding location	43	92%
Other	nr	nr

Factors that would help with access to a mobile SCS* (70)	34	73%
Located in the same location daily	12	26%
Located in the same location certain days/week	17	36%
Mobile text with location for that day	5	11%
Other (e.g. signage, word of mouth)	nr	nr
Unsure/prefer not to answer		

nr = not reported due to fewer than five responses
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

SCS logistics

Participants largely preferred having an SCS opened around-the-clock or open over spans of 8-12 hours from the morning (e.g. 8am) until early evening (e.g. 7pm). Further, there was a desire to have a range of inhalation and injection room designs - both communal and private - that allowed for flexibility of use.

QUESTION (number of responses)	FREQUENCY	PROPORTION (%)
Preferred hours of operation (47)		
12am-8am	nr	nr
8am-12pm	8	17%
12pm-4pm	nr	nr
4pm-8pm	nr	nr
8pm-12am	5	11%
24 hours	14	30%
Other	12	26%
Unsure/prefer not to answer	nr	nr
Preferred set-up for injecting spaces[x] (29)		
Private cubicles	9	31%
Open plan with benches at a large table/counter	nr	nr
Open plan with tables and chairs	nr	nr
Couches and chairs with side tables	nr	nr
Combination of above	15	52%
Other	nr	nr
Preferred set-up for inhalation spaces[x] (37)		
Private cubicles inside	nr	nr
Open plan room inside	5	14%
Private cubicles outside under roof	nr	nr
Open plan outside under roof	nr	nr

Combination of above	22	59%
Other	nr	nr
Unsure/prefer not to answer	nr	nr

nr = not reported due to fewer than five responses
[X]Skip logic resulted in only participants who reported this method of consumption being asked to respond.

Involvement of people who use drugs in SCS operations

Most participants (68%) thought that people who use drugs should be involved in the SCS (32 out of 47 participants). The remainder either disagreed with peer involvement (15%, 7 out of 47) or were unsure (17%, 8 out of 47).

How people who use drugs should be involved* (112)	FREQUENCY	PROPORTION (%)
At the entrance/greeting clients	21	19%
Registering clients	20	18%
In the waiting area	19	17%
Monitoring in the injecting room or smoking area	18	16%
In the post-use room or chill-out room	24	21%
Other	5	4%
Unsure/prefer not to answer	5	4%

*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

Acceptability of SCS policies and guidelines

Policy (number of responses)	Very acceptable (%)	Acceptable (%)	Neutral (%)	Unacceptable (%)	Very unacceptable (%)
Use is supervised by trained staff (47)	74%	19%	nr	nr	nr
30-minute time limit for use (47)	23%	43%	11%	21%	nr
Have to register each time you use the site (47)	30%	32%	17%	15%	nr
Required to show government ID (47)	11%	nr	nr	40%	36%

Required to show client number (47)	21%	55%	13%	11%	nr
Have to live in the neighborhood (47)	nr	nr	nr	45%	36%
Video surveillance cameras on site to protect clients (47)	19%	26%	19%	23%	13%
Prohibited from smoking drugs (46)	nr	20%	17%	37%	24%
Prohibited from assisting others with injection preparations (44)	nr	23%	18%	43%	nr
Prohibited from assisting others with injections (44)	nr	20%	25%	41%	nr
Prohibited from sharing drugs (46)	15%	28%	17%	30%	nr
May have to wait until there is space available (47)	26%	49%	17%	nr	nr
May have to stay 10-15 min after using so health can be monitored (47)	38%	51%	nr	nr	nr
Prohibited from using the site if pregnant (46)	30%	33%	nr	nr	22%
Dedicated site hours for women to use (45)	29%	36%	nr	24%	nr
Dedicated site hours for genderqueer, non-binary, and gender diverse persons to use (45)	29%	29%	13%	24%	nr
nr = not reported due to fewer than five responses					

Importance of SCS services

Service (number of responses)	Very important (%)	Important (%)	Slightly important (%)	Not important (%)
Nursing staff for basic medical care (47)	66%	30%	nr	nr
Bathrooms (47)	70%	30%	nr	nr
Showers (47)	53%	21%	13%	13%
Food (including takeaway) (47)	70%	23%	nr	nr
Social workers or counsellors (46)	59%	35%	nr	nr
Peer support (47)	60%	32%	nr	nr

Syringe distribution (45)	67%	29%	nr	nr
Injection equipment (44)	73%	25%	nr	nr
Smoking equipment (44)	64%	30%	nr	nr
Drug checking (e.g. fentanyl testing strips) (46)	63%	33%	nr	nr
HIV, hepatitis C, and STI testing (46)	80%	17%	nr	nr
Access to contraception (45)	82%	13%	nr	nr
Referrals to drug treatment or other services (46)	63%	28%	nr	nr
Being able to start buprenorphine or methadone on site (46)	59%	26%	nr	nr
Mental health services onsite or referrals (47)	66%	30%	nr	nr
A 'chill out room' to hang out in after using (46)	70%	26%	nr	nr
Assistance with housing, social assistance, etc. (46)	74%	22%	nr	nr
Assistance with legal services or DCF (46)	65%	26%	nr	nr
Harm reduction education (47)	66%	32%	nr	nr
nr = not reported due to fewer than five responses				

Appendix 2 - Results from the Somerville community survey

Data Notes

In total, 615 surveys were completed from March to April 2021 by Somerville community members aged 16 and older. A total of 557 participants were Somerville residents, with non-Somerville participants including business owners, service providers, people accessing Somerville-based services (e.g. schools, religious/spiritual spaces, health and social services, shops, transit), individuals working or volunteering in Somerville, and individuals who have friends and/or family that live in Somerville.

Participants were not required to answer each survey question. Additionally, some questions allowed for multiple responses; these are noted below alongside the total number of participant responses. Percentages have been rounded to the nearest whole percent.

To protect participants' privacy, responses that have less than five counts have been suppressed. These are denoted with a "nr" (not reportable).

Demographics

Characteristic (number of responses)	Somerville resident (n=557)	Non-Somerville resident (n=58)	Overall (n=615)
Gender* (603)			
Man	202 (36%)	20 (35%)	222 (36%)
Woman	306 (55%)	30 (52%)	336 (55%)
Non-binary, transgender, or genderqueer	28 (5%)	7 (12%)	35 (6%)
Average age (range) (571)	37 (16-78 years)	33 (17-75 years)	37 (16-78 years)
Race and ethnicity* (625)			
Black, African, or African American	7 (1%)	nr	8 (1%)
White	474 (85%)	50 (86%)	524 (85%)
Mixed, bi-racial, or multi-racial	17 (3%)	nr	19 (3%)
Indigenous, Native American, Alaska Native	nr	nr	nr
Hispanic or Latinx	5 (1%)	nr	7 (1%)
Asian	20 (4%)	nr	22 (4%)
Native Hawaiian or Pacific Islander	nr	nr	nr

nr = not reported due to fewer than five responses
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

Connection to Somerville

QUESTION (number of responses)	FREQUENCY	PROPORTION (%)
Relationship to Somerville* (1414)		
Resident	557	39%
Business owner	23	2%
Work in Somerville	135	10%
Family and/or friends live in Somerville	323	23%
Attend church in Somerville[x]	17	1%
Attend school in Somerville	7	1%
Child/children attend school in Somerville	90	6%
Use healthcare services in Somerville	145	10%
Use substance use treatment services in Somerville	nr	nr
Use housing/shelter services in Somerville	nr	nr
Use social or community services in Somerville	84	6%
Other	32	2%

nr = not reported due to fewer than five responses

*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

[x]The omission of other forms of religious services and spiritual groups by using "church" was an oversight in survey development. The authors would like to apologize for this error.

Somerville neighborhood of residence

Question (number of responses)	FREQUENCY	PROPORTION (%)
Neighborhood of residence (549)		
Hillside	11	2%
Teele Square	37	7%
Powderhouse Square	29	5%
Davis Square	86	16%
Ball Square	31	6%
Magoun Square	30	5%
Winter Hill	74	13%
Ten Hills	5	1%
Assembly Square	nr	nr
Porter Square	28	5%
Spring Hill	74	13%
Duck Village	10	2%
Union Square	98	18%
East Somerville	34	6%
Boynton Yards	nr	nr
Innerbelt	nr	nr
North Point	nr	nr
Duration living in Somerville (556)		
Less than 1 year	33	6%
1-2 years	68	12%
2-5 years	120	22%
5-10 years	131	24%
11-20 years	106	19%
More than 20 years	98	17%
nr = not reported due to fewer than five responses		

SCS familiarity and support

Characteristic (number of responses)	Somerville resident (n=557)	Non-Somerville resident (n=58)	Overall (n=615)

Familiarity with SCS (615)			
Very familiar	112 (20%)	12 (12%)	124 (20%)
Somewhat familiar	368 (66%)	39 (67%)	407 (66%)
Not familiar	77 (14%)	7 (21%)	84 (14%)
SCS would be helpful in Somerville[x] (615)			
Average (SD)	8.14 (2.68)	9.53 (0.98)	8.28 (2.60)
Most important ranked outcome of SCS[y] (611)			
Reduce drug paraphernalia	22 (4%)	nr	23 (4%)
Reduce crime in area surrounding SCS	28 (5%)	nr	28 (5%)
Prevent overdoses and save lives	434 (7%)	56 (97%)	490 (80%)
Reduce public use	9 (1%)	nr	10 (2%)
Help connect people to services	38 (6%)	nr	38 (6%)
Reduce HIV and HCV transmission	13 (6%)	nr	13 (6%)
Reduce burden on emergency rooms, police, fire, and EMS by reducing overdose-calls	9 (1%)	nr	9 (1%)

nr = not reported due to fewer than five responses

[x]Participants were asked on a scale of 1 (strongly disagree) to 10 (strongly agree) how helpful an SCS would be in Somerville.

[y]Participants were asked to rank a list of 7 outcomes of having an SCS from most to least important.

*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

Participants were asked to describe why they thought an SCS would be helpful in Somerville. The top five themes documented, included: connecting people to services and supports (n=197); reducing overdose deaths (n=167); overall public health benefits (e.g. reducing drug paraphernalia litter, reduction of infection, provision of sterile supplies) (n=158); providing a safe place for people to use drugs (n=139); and implementing a harm reduction approach to addressing the overdose crisis (n=47).

The five major themes documented as to why an SCS would not be beneficial in Somerville included: SCS would have a negative community impact (e.g. decrease property value, increase litter, increase violence and crime) (n=28); SCS enable drug use (n=16); SCS are not effective public health interventions (n=13); SCS would increase in the number of people who come to use drugs in the city (n=13); and there is a need for treatment, prevention, and wraparound services instead (n=12).

SCS location and siting considerations

Characteristic (number of responses)	Somerville resident (n=557)	Non-Somerville resident (n=58)	Overall (n=615)

Neighborhood where a SCS would be most helpful (490)			
Hillside	72 (16%)	6 (14%)	78 (16%)
Teele Square	71 (16%)	6 (14%)	77 (16%)
Powderhouse Square	62 (14%)	7 (17%)	69 (14%)
Davis Square	229 (51%)	23 (55%)	252 (51%)
Ball Square	67 (15%)	6 (14%)	73 (15%)
Magoun Square	101 (23%)	10 (24%)	111 (23%)
Winter Hill	182 (41%)	20 (48%)	202 (41%)
Ten Hills	84 (19%)	8 (19%)	92 (19%)
Assembly Square	120 (27%)	7 (17%)	127 (26%)
Porter Square	124 (28%)	17 (40%)	141 (29%)
Spring Hill	82 (18%)	9 (21%)	91 (19%)
Duck Village	56 (13%)	7 (17%)	63 (13%)
Union Square	168 (38%)	18 (43%)	186 (38%)
East Somerville	255 (57%)	21 (50%)	276 (56%)
Boynton Yards	91 (20%)	9 (21%)	100 (20%)
Innerbelt	147 (33%)	20 (48%)	167 (34%)
North Point	60 (14%)	5 (12%)	65 (13%)
Most important factors to consider when siting the SCS (607)			
Proximity to local businesses	37 (7%)	nr	37 (6%)
Proximity to residential areas	102 (19%)	nr	106 (17%)
Convenience for potential clients	398 (72%)	46 (81%)	444 (73%)
Proximity to other support services	326 (59%)	38 (67%)	364 (60%)
Proximity to schools and playgrounds	131 (24%)	6 (11%)	137 (23%)
Proximity to public transportation	307 (56%)	41 (72%)	348 (57%)
Rate of overdose in the neighborhood	437 (80%)	45 (79%)	482 (79%)
Other	26 (5%)	nr	30 (5%)
Concerns of a SCS located in own neighborhood (556)			
Yes	114 (21%)		
No	308 (55%	--	--
Unsure	134 (24%)		
Preferred method for addressing SCS questions or concerns* (635)			
Community town hall or forum	128 (22%)	9 (20%)	137 (22%)
Information on the goals of the SCS	119 (20%)	10 (22%)	129 (20%)
Information on how SCS can help communities	112 (19%)	10 (22%)	122 (19%)
Evaluations of the SCS once established	195 (33%)	16 (35%)	211 (33%)
Other	35 (6%)	nr	36 (6%)

nr = not reported due to fewer than five responses
[x]Participants were asked on a scale of 1 (strongly disagree) to 10 (strongly agree) how helpful a SCS would be in Somerville.
*Participants could select more than one answer. As such, the total proportion for these questions can exceed 100%.

Survey participants were asked to describe their concerns if an SCS were located in their neighborhood. Top five concerns included: impact on safety and crime (n=75); how the SCS would be operated (e.g. procedures following use, site capacity and overflow protocols) (n=56); location of the SCS and neighborhood type (e.g. business vs. residential neighborhood) (n=45); impact on congestion and foot traffic outside the SCS (n=42); and a potential influx of people who use drugs coming to access the SCS in Somerville (n=38).

Current Somerville supports

Question (number of responses)	Somerville resident (n=557)	Non-Somerville resident (n=58)	Overall (n=615)
Knowledge of overdose-related programs in Somerville (615)			
Yes	245 (44%)	25 (43%)	270 (43%)
No	245 (44%)	26 (45%)	271 (44%)
Unsure	67 (12%)	7 (12%)	74 (12%)
Have you ever accessed any of these programs[x] (269)			
Yes	6 (2%)	nr	8 (3%)
No	237 (97%)	23 (92%)	260 (97%)
Unsure	nr	nr	nr
Do you know someone who has accessed these programs[x] (270)			
Yes	62 (25%)	10 (40%)	72 (27%)
No	137 (56%)	11 (44%)	148 (55%)
Unsure	46 (19%)	nr	50 (19%)
Satisfied with the City's approach to combating the overdose crisis (612)			
Very satisfied	13 (2%)	nr	13 (2%)
Satisfied	80 (14%)	10 (18%)	90 (15%)
Unsure	387 (70%)	40 (71%)	427 (69%)
Dissatisfied	60 (11%)	5 (9%)	65 (11%)
Very dissatisfied	16 (3%)	nr	17 (3%)

nr = not reported due to fewer than five responses
[x]Skip logic resulted in only participants who reported "yes" to having knowledge of overdose-related programs in Somerville being asked to respond.

Participants were asked to describe suggestions they had for better addressing the overdose crisis in Somerville. The top five themes included: removing police from the response (e.g. decriminalizing drugs, diverting police funding (n=60); increasing community awareness and engagement related to the overdose crisis, including increased transparency of City efforts (n=46); funding treatment and prevention programs (n=39); addressing the social determinants of health (e.g. poverty, homelessness) (n=35); and unsure due to a lack of information about the overdose crisis and current efforts (n=33)

Appendix 3 - Preliminary SCS operational guidance document

Please note: *The following draft operational guidance document was developed by the Program Development sub-committee of the SCS Task Force.*

Somerville Supervised Consumption Site Conceptual Framework

This document was created by a coalition convened by Mayor Joseph Curtatone and the City of Somerville Department of Health and Human Services with representation from community based organizations including Safe Injection Facilities Massachusetts Now! (SIFMA Now!); the Material Aid and Advocacy Program; Community Outreach, Help & Recovery Unit (COHR); Boston University; and people with lived experience of drug use.

Contributors

Miriam Harris, Assistant Professor, Boston University School of Medicine, Member, SIFMA Now!; Cassie Hurd, Executive Director, Material Aid and Advocacy Program, Member, SIFMA Now!; Tj Thompson, Organizer, Material Aid and Advocacy Program, Member, SIFMA Now!; Steve Kelley, Organizer, Material Aid and Advocacy Program, Member, SIFMA Now!; Jennifer Korn, LICSW, Co-Director MB CIT TTAC, COHR; Danielle O'Hearn, Somerville Fire Department

Acknowledgements

The British Columbia Centre on Substance Use (BCCSU) supervised consumption services operational guidance were used to help craft the much of the language and recommendations included in this document. The BCCSU guidelines are evidenced based and include a detailed list of research references that support specific recommendations included here.

Mission statement

"We aim to create an inclusive, human centric, peer driven, and above all else, safe environment to foster and encourage the progression of personal autonomy with a 'come as you are and take a welcomed seat at the table' type of ethos.

The Somerville supervised consumption space should be a place where human life is valued with compassion and a place that dismantles stigma and the failing 'one size fits all' approach to criminalizing people who use drugs. Instead, the facility should value and respond to the multifaceted vast spectrum that encompasses the tapestry of experience within each individual human being.

Our hope is to create an environment that brings harm reductionists, counselors, doctors, social workers, people with lived experience, and people that want to help people

together with a unified goal of preserving life, dignity, and choice with the ever present cry that one death is too many, all life is valuable".

- Tj Thompson (identifies as a person with lived experience)
- Stephen Kelley (identifies as a person with lived experience)

1. Introduction

Supervised consumption sites (SCSs) provide safe environments in which people can use drugs under the supervision of a healthcare professional, a trained peer (i.e., person who formerly used or currently uses drugs), or a trained allied service provider without the risk of arrest for drug possession.[1] SCSs are evidence-based programs that, when well-integrated within a broad continuum of services for people who use drugs, reduce morbidity, mortality, and public disorder, as well as promote access to health and social services.[1] SCSs promote the dignity and well-being of people who use drugs. SCSs have also been found to be cost-effective and to reduce burden on emergency services.[1]

Here we describe the conceptual framework for a Somerville SCS based on a preliminary needs assessment and community consultation. This document was created by a coalition convened by Mayor Joseph Curtatone and the City of Somerville Department of Health and Human Services with representation from community based organizations including Safe Injection Facilities Massachusetts -Now! (SIFMA Now!), the Material Aid and Advocacy Program, Community Outreach, Help & Recovery Unit (COHR), Boston University, and people with lived experience of drug use from Somerville. This is designed to be a living document meant to be updated with ongoing community input. Specific operating procedures will evolve as the community, city, and state stakeholders needs are clarified and funding, and support mechanisms defined.

2. Goals

The overall goals of the Somerville SCS are to:

1. To improve the dignity and safety of people who use drugs in Somerville.
2. To reduce rates of non-fatal overdose and overdose-related deaths, and associated ambulance calls and health care utilization.
3. To reduce rates of drug-related transmission of blood-borne infections among people who use drugs (i.e., viral hepatitis and HIV).
4. To decrease the rates of acute health complications that are related to injection drug use (i.e., soft tissue infections, infective endocarditis).
5. To improve uptake of and access to health and care services among people who use drugs.
6. To improve people who use drug's knowledge and uptake of/access to harm reduction practices and services.

7. To improve people who use drug's knowledge and uptake of/access to drug treatment services, including recovery-oriented programs and a range of opioid agonist treatments, including injectable therapies.
8. To reduce drug use in public or semi-public spaces, including inappropriately discarded injection equipment and related litter.

3. Somerville Supervised Consumption Site Vision

Three key areas that should guide the development of an SCS for the community. These include safety, inclusivity, and integration (Figure 1).

Safety

An SCS in Somerville must be accessible, safe, and hygienic. Therefore, people who use drugs must be able to safely access an SCS without fear of arrest from the police, or violence from the police or other community members. This will require close internal safety procedures and collaboration with the local police department.

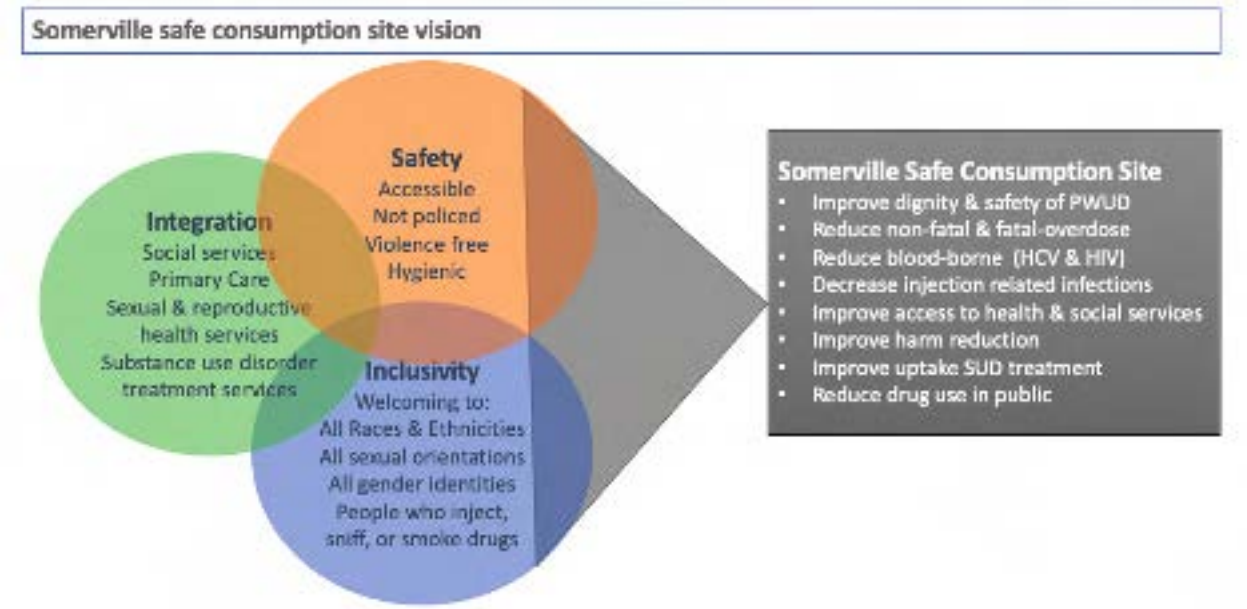
Inclusivity

A Somerville SCS must be inclusive. People from different racial and ethnic backgrounds, particularly Black, Latinx, and Indigenous people should feel welcome and safe at the SCS. People of all sexual orientations and people of all genders (including Non-binary and Transgender People) should also feel safe and welcome at the SCS. Therefore, Somerville SCS staff must include representation from different racial and gender backgrounds to make all community members feel welcome. The Somerville SCS will consider establishing certain days or times for specific communities, for example a women's only time, to concretely reach all Somerville community members depending on the communities' needs. The Somerville SCS will also address the needs of different types of drug use. This includes people who sniff or smoke their drug of choice. Therefore, the Somerville SCS will need multiple spaces to support the needs of people who inject drugs, sniff drugs, or smoke drugs.

Integration

The Somerville SCS must be integrated into other social and health services to meet the needs of people who use drugs. The SCS will be integrated with other services including housing, primary care, sexual and reproductive health, domestic violence, child protection services, and substance use disorder treatment services, and income assistance and return to work programs. The aim of the Somerville SCS is to provide comprehensive health and medical care, as well as social services, acting as a "one-stop-shop" for people who use drugs to meet their self-identified needs.

Figure 1. Supervised Consumption Site Vision



PWUD; people who use drugs, HCV; hepatitis C virus, HIV; human immunodeficiency virus; SUD; substance use disorder

4. Ideal type of SCS for Somerville

4.a. Basic Components

The basic components of Somerville's SCS should include:

1. A welcoming reception area, distinct from where substances are consumed, where potential SCS participants can learn about the service and its operations, their rights and responsibilities in the space, and complete an intake;
2. Two dedicated drug consumption areas:

a. A dedicated drug injection space, and injecting equipment, as well as a receptacle for the disposal of used equipment;

b. A dedicated space for smoking drugs, which is equipped with smoking equipment and is well ventilated;

3. A drug checking area for people who plan to use drugs at the SCS and for those that do not.
4. A separate, private clinical space for participants to access medical care;
5. Areas for people to be after they consume substances:

. A dedicated de-stimulating "chillout space" for people who use stimulants;

a. A dedicated area for people who may require observation after using opioids;

6. A common area for aftercare where participants can access support from healthcare professionals and peer support workers and receive after-care, referrals, education, and counseling.

4.b. Integrated Model

The staffing for the service would be multidisciplinary and would offer a team-based approach to maintaining a safe environment. Using a team-based approach to meet the complex social and clinical needs of the individuals who use the space, the program would offer a continuum of services within a nonclinical and informal setting that is welcoming and person-centered. Building an integrated multidisciplinary team with a shared mission would ensure better communication among staff and participants and would foster different perspectives and approaches to operating the program that would be essential to making this service succeed.

4.c. Staffing

The staffing model should balance budgetary concerns with patient safety and risk management, particularly in relation to possible scenarios of overdose and other emergencies.

Ideal models should include both medical and non-medical personnel. For example, staffing should include a supervising registered nurse or psychiatric nurse, who can be supported by other allied health professionals. Non-medical personnel, such as community mental health workers, case managers or social workers, and individuals identified as peers (i.e., people who formerly used or currently use illegal drugs) also play important roles in the planning and operation of SCSs and should be involved wherever possible and compensated appropriately. We recommend that at least two staff members (clinical and/or non-clinical) are working at a time.

The Somerville SCS peer staffing should include a variety of employment opportunities such as full-time, part-time, and flexible-time work. These should be appropriately compensated, and this includes reasonable pay and benefits.

Given the sometimes challenging nature of this work, staffing considerations must include behavioral health and wellness supports for SCS staff to mitigate staff trauma, burnout, and turnover.

4.d. Clinical and Other Services

The Somerville SCS should be integrated with other services that support the needs of people using the SCS. The SCS should aim to provide comprehensive health and medical care, as well as social services, as a “one-stop-shop” for harm reduction and health and social services. Including an SCS within a network of services offered within the same facility allows clients to access a range of services without having to travel outside of the facility premises, thereby helping to prevent loss to care, to decrease barriers in access to care, and to ensure continuity of care.

Harm reduction services beyond observed injection with sterile injection equipment should also be included. For example, harm reduction education and provision of sterile injection equipment (such as syringes, needles and other drug paraphernalia) for use outside the SCS.

The Somerville SCS should include case management to support pathways to housing, as well as referrals to detoxification facilities and residential treatment programs. The SCS should also provide access to harm reduction-oriented legal services onsite, in addition to connections to external legal services when needed. Services for those experiencing violence or abuse should either be onsite or have a clear referral and support pathway.

Urgent primary care services such as wound and abscess care management, HIV prevention, and contraception should be accessible at the SCS. Clinicians should also be able to help those interested to establish long term primary care, behavioral health services, HIV treatment, and HCV treatment through onsite care or designated referral pathways.

A complete list of possible clinical and other services that could be integrated into the Somerville SCS include:

- Primary care (e.g., immunization, STI screening, screening for other communicable diseases such as HIV and viral hepatitis C)
- Naloxone provision and training
- Residential services (e.g., overnight shelters, residential nursing care)
- Chronic illness management
- Psychosocial treatment interventions (i.e., cognitive behavioral therapy)
- Counselors/social workers
- Mental health care
- Women's health services
- Off-site outreach program
- Drug treatment programs (e.g., medically managed withdrawal management, opioid agonist treatment)
- Employment programs
- Peer support programs
- Recreational activities
- Meals, snacks, coffee/tea
- Possibility to use phone/Internet
- Shower, laundry
- Lockers, postal addresses
- Overnight shelter and other low-threshold housing
- Support recovery housing

4.e. Screening and Information of Participants

It is important for SCSs to be low-threshold and low-barrier, but it is equally important for these facilities to establish eligibility criteria for services and to inform clients about drug use and harm reduction strategies, in order to ensure the safety of clients and staff and to minimize risks, such as overdose.

Importantly, people must feel safe using the SCS with the knowledge that their personal health information will be protected and they will not face legal repercussions for using the SCS. Therefore, developing an intake system that ensures client anonymity while being used for screening/eligibility, tracking, linkage to care, and research purposes is key.

Eligibility and user agreement

There should be an intake procedure for first time clients to an SCS that includes:

- Screening for eligibility
- Informing the client about the risks of non-medical substance use
- Informing the client about expectations, rules and protocols for using SCS
- Informing the client about their rights and responsibilities when using SCS
- Informing the client about any data collection for monitoring, evaluation or research purposes, as well as appropriate ethical considerations
- Assessing clients for any need for specific physical care, their knowledge of harm reduction techniques and ability to apply these to drug-use, as well as their knowledge of harm reduction services

4.f. Security and the Safety of Participants and Workers

Although the vast majority of people who use drugs pose no threat to others; behavioral health, trauma, stimulant use, withdrawal, and chaotic situations can cause emotional dysregulation and result in escalated and unsafe behaviors. Such behaviors may place staff and other participants at risk. Further, overdose can occur anywhere in an SCS. Therefore, proper visibility and monitoring of participants at all times are also critical to preventing overdose deaths.

While ensuring that services are as accessible as possible, SCS operators should also ensure that the facility layout, staffing, training, and protocols minimize security issues and maximize safety.

Participants should be made aware of the security features during their initial screening intake, in addition to being informed of the social norms and boundaries. It should be emphasized that these features help to ensure the safety of both participants and staff. Demonstration of adequate site security may also help to increase the confidence and

buy-in of local stakeholders, such as neighbors, community groups and partners, police and policy makers.

There may be instances where SCS staff are required to respond to a crisis situation and/or aggressive behavior by a participant. SCS should create a triage protocol for staff to identify appropriate supports at each stage of an incident. Each situation will be unique and all facility staff should be trained in crisis management and de-escalation techniques to ensure the safety of all participants and staff.

For any SCS to be successful, people using the facility must not be targeted or penalized for using the service. The Somerville Police Department understands that addiction is a health condition, they are a member of Police Assisted Addiction Recovery Initiative and have implemented many programs to support individuals in active use including a partnership with ACCESS. The Somerville Police Department supports the goal of treatment over criminal pursuit for people who use drugs in most cases and as a law enforcement agency will work with SCS to create understanding with responsibilities to consider state and federal law. Legislative advocacy around the decriminalization of opioids at the state and federal level should continue in order to better align the goals of the SCS and the Somerville Police Department role to abide by these laws moving forward.

References

1. British Columbia Centre on Substance Use. Supervised consumption services operational guidance. Published online 2017.

Appendix 4 - Survey instruments

Survey with people who use drugs

Question	Response options
1. What is your current gender? (check all that apply)	Woman Man Non-binary or genderqueer Something else: [text entry]
2. Do you identify as transgender?	Yes No
3. How old are you?	[text entry]
4. What is your race or ethnicity (check all that apply)	Black, African, or African American White Mixed, bi-racial, or multi-racial Indigenous, Native American, Alaska Native Latin American Asian Native Hawaiian or Pacific Islander Something else: [text entry]
5. Are you of Hispanic or Latinx descent?	Yes No
6. What type of place are you currently living in? (check all that apply)	Apartment/house that you rent or own Friend or family's place Recovery or residential treatment center Transitional housing program Hotel/motel room rented on a daily, weekly, or monthly basis Unsheltered, outside, outdoor public space Shelter Tent Somewhere else: [text entry]
7. Do you have any connection to Somerville (e.g. have lived/stayed there)?	Yes (If yes, what is the connection? [text entry]) No

	Unsure
8. Which of the following substances have you used in the past 30 days? (check all that apply)	Cocaine (powder) Crack cocaine (rock) Crystal methamphetamine Heroin Fentanyl Opioids (not as prescribed, purchased off the street) Marijuana Alcohol Hallucinogens Benzos (e.g. Ativan, Valium) Something else: [text entry]
9. How often are you currently using drugs?	Daily Multiple times per day 1-3 times per week 4-6 times per week 1-3 times per month Less than once per month
10. How often are you using drugs alone?	Always (100% of the time) Most of the time (>75%) Sometimes (26-74%) Occasionally (<25%) Never
11. Where do you typically use drugs? (check all that apply)	Where you're currently living or staying Public washrooms Bus, metro, transportation depots Outside (e.g. park, alley) Friend's place Public building (e.g. library) Somewhere else: [text entry]
12. How often are you currently using in public?	Daily 3-4 times per week 1 or fewer times per week
13. What methods have you used to consume drugs in the past 30 days? (check all that apply)	Inject Smoke/inhale Snort Ingest/swallow
14. [If Q13=inject] **Do you ever need help injecting?**	Yes No

	Sometimes
15. In the last year, how many overdoses have you had personally?	1 overdose 2 overdoses 3 or more overdoses None
[Read]: **A supervised consumption site, or SCS, is a legally operated facility where people come to use their own drugs under the supervision of medically trained workers in safe and sterile conditions. At SCS, people can access sterile equipment (e.g. cotton, syringes, cookers, water), medical care, and/or be referred to health and social services.**	
16. How long would you be willing to travel (walk, car, bike, or transit) to access an SCS?	5-15 min 15-25 min 25-35 min 35+ min Don't know, unsure, prefer not to answer
17. Would you use the SCS if located in: (check all that apply)	A community health center A walk-in clinic, hospital, or doctor's office Social service agency (e.g. shelter) Harm reduction center (e.g. syringe exchange program) Trailer, RV, or mobile location Own, freestanding location Somewhere else: [text entry]
18. If the SCS was a mobile site, what would help you access it? (check all that apply)	Located in the same spot daily Located in the same spot on certain days each week Mobile text about where the site would be located that day Something else: [text entry] Don't know, unsure, prefer not to answer
19. [Prompt] I am now going to ask you a few questions about a hypothetical SCS in Somerville. **n SCS was available in Somerville, would you consider using this service?**	Yes No (If no, why not? [text entry]) Don't know, unsure, prefer not to answer
20. [If Q19=yes] **How often would you use an SCS in Somerville?**	Always when I use drugs (100%) Most of the time (>75%) Sometimes (26-74%) Occasionally (<25%) Don't know, unsure, prefer not to answer

21. What are the most useful hours of operation for an SCS?	12am-8am 8am-12pm 12pm-4pm 4pm-8pm 8pm-12am Other: [text entry] Don't know, unsure, prefer not to answer
22. [If Q13=inject] **What would be the best set-up for injecting spaces in an SCS?**	Private cubicles Open plan with benches at one large table/counter Open plan with tables and chairs Couches and chairs with coffee tables or side tables Combination of above Something else: [text entry] Don't know, unsure, prefer not to answer
23. [If Q13=smoke/inhale] **What would be the best set-up for smoking spaces in an SCS?**	Private cubicles inside Open plan room inside Private cubicles outside under roof Open plan outside under roof Combination of above Something else: [text entry] Don't know, unsure, prefer not to answer
24. Do you think people who use drugs should be involved in running the SCS?	Yes No Don't know, unsure, prefer not to answer
25. [If Q24=Yes] How do you think people who use drugs should be involved? (check all that apply)	At the entrance/greeting clients Registering clients In the waiting area Monitoring in the injecting room or smoking area In the post-use room or chill-out room Something else: [text entry] Don't know, unsure, prefer not to answer
26. What reasons would you use an SCS? (check all that apply)	Access to sterile injection and/or smoking equipment Able to inject indoors rather than in public Safety from being seen and/or arrested by police Safety from crime or violence

	Access to health professionals (e.g. basic medical care) Access to referrals for treatment or social services Overdose prevention or treatment Something else: [text entry]
27. What reasons would you not use an SCS? (check all that apply)	Don't want to be seen/don't want people to know about use Lack of confidentiality Prefer to use with friends, family, or partner Prefer to use alone Already have access to clean supplies Afraid SCS aren't safe from crime or violence Concerned about police around the site or getting caught by police Already have a place to use Can't wait for a space to open up Too many rules or policies Age limit Legal consequences related to condition of probation or parole (e.g. mandated abstinence) Something else: [text entry]
28. SCS can have numerous policies and guidelines. For each of the following, please let me know if these would be very acceptable, acceptable, neutral, unacceptable, or very unacceptable to you	

	Very acceptable	Acceptable	Neutral	Unacceptable	Very unacceptable
Use is supervised by trained staff who can respond to overdoses					
30-minute time limit for use					
Have to register each time you use the site					

Required to show government ID					
Required to show client number					
Have to live in the neighborhood					
Video surveillance cameras are on site to protect clients					
Prohibited from smoking drugs					
Prohibited from assisting others with injection preparations					
Prohibited from assisting others with injections					
Prohibited from sharing drugs					
May have to wait until there is a space available to use					
May have to stay 10-15 min after using so your health can be monitored					
Prohibited from using the site if pregnant					
Dedicated site hours for women to use					
Dedicated site hours for					

genderqueer, non-binary, and gender diverse persons to use					
29. Various services are being considered to provide in an SCS. For each of the following, please let me know if these would be very important, important, slightly important, or not that important to you.					
	Very important	Important	Slightly important	Not that important	N/A
Nursing staff for basic medical care					
Bathrooms					
Showers					
Food (including takeaway)					
Social workers or counsellors					
Peer support					
Syringe distribution					
Injection equipment					
Smoking equipment					
Drug checking (e.g. fentanyl testing strips)					
HIV, hepatitis C, and STI testing					
Access to contraception (condoms, birth control, etc.)					
Referrals to drug treatment (methadone,					

buprenorphine, or other services)					
Being able to start buprenorphine or methadone on site					
Mental health services onsite or referrals					
A 'chill out room' to hang out in after using					
Assistance with housing, social assistance, etc.					
Assistance with legal services or DCF					
Harm reduction education					

Somerville community survey

Thank you for agreeing to provide your thoughts about a supervised consumption site (otherwise known as an overdose prevention site) in Somerville. Please keep in mind that the specifics of what a supervised consumption site means for Somerville have not been decided. This survey is part of the process to determine the needs and concerns of the community. We want to understand your perceptions and questions so they can be addressed in the future.	
Question	**Response options**
1. How familiar are you with supervised consumption sites (sometimes called overdose prevention sites or drug consumption rooms)?	Very familiar Somewhat familiar Not familiar at all
2. [If Q1=Somewhat familiar or Not familiar] ***Supervised consumption sites are public health interventions where people can use pre-obtained drugs in a sterile environment with***	

access to sterile equipment under the supervision of health professionals who can respond in the event of an overdose. There are over 120 of these sites across the world, but no sanctioned supervised consumption sites exist in the US.	
On a scale from 1 (strongly disagree) to 10 (strongly agree), please indicate the extent to which you think a supervised consumption site would be helpful in Somerville. By helpful, we mean preventing overdose deaths, limiting the spread of HIV and hepatitis C, connecting people to treatment, reducing public drug use, and reducing drug-related litter.	
	
4. [If Q3=6-10] **Please explain why you think a supervised consumption site would be beneficial in Somerville.**	[text entry]
5. [If Q3=1-5] **Please explain why you think a supervised consumption site would not be beneficial in Somerville.**	[text entry]
6. **Supervised consumption sites have many proven public health and public safety outcomes in their communities. Please rank the following outcomes in order of their importance to you, with 1 being the *most* important and 7 being the *least* important.**	
To rank your answers, drag and drop each option	Reduce drug paraphernalia (e.g. needles, pipes) in public Reduce crime in the area surrounding the supervised consumption site Prevent overdoses and save lives Reduce the number of people using drugs outdoors and in public spaces Help connect people to drug treatment and health and social services Reduce HIV and hepatitis C transmission due to syringe sharing Reduce burden on emergency rooms, police, fire, and EMS by reducing overdose-related calls

7. What Somerville neighborhood(s) do you think a supervised consumption site would be most helpful in? Please select all that apply.	Hillside Teele Square Powderhouse Square Davis Square Ball Square Magoun Square Winter Hill Ten Hills Assembly Square Porter Square Spring Hill Duck Village Union Square East Somerville Boynton Yards Innerbelt North Point
8. Potential supervised consumption site locations in Somerville have not been selected yet. What do you think are among the most important factors when considering a location for a supervised consumption site? Please select all that apply.	Proximity of the facility to local businesses Proximity of the facility to residential areas Convenience for potential clients Proximity of the facility to other support services and agencies Proximity to schools and playgrounds Proximity to public transportation Rate of overdose in the neighborhood Other: [text entry]
9. Would you have any concerns if a supervised consumption site was located in your neighborhood?	Yes No Unsure
10. [If Q9=Yes or Unsure] **What concerns or questions would you have if a supervised consumption site was located in your neighborhood?**	[text entry]
11. [If Q9=Yes or Unsure] **How would you want your questions or concerns about supervised consumption sites addressed? Please select all that apply.**	Community town hall or community forum

	Information on the goals of the supervised consumption site Information about how supervised consumption sites can help communities Evaluations to determine what is or is not working if a supervised consumption site was established in Somerville Other: [text entry]
12. Current programs aimed at addressing the overdose crisis in Somerville include: the Community Outreach, Help and Recovery (COHR) program; the Overdose Aftercare Community Teams Program in partnership with ACCESS; ACCESS harm reduction supply distribution; the Office of Prevention at the Department of Health and Human Services; and naloxone trainings and naloxone distribution. Have you heard of any of these programs?	Yes No Unsure
13. [If Q12=Yes] **Have you ever accessed any of these programs?**	Yes No Unsure
14. [If Q12=Yes] **Do you know anyone who has ever accessed any of these programs?**	Yes No Unsure
15. How satisfied are you with the City of Somerville's approach to combating the overdose crisis?	Very satisfied Satisfied Unsure Dissatisfied Very dissatisfied
16. [If Q15=Unsure, Dissatisfied, or Very Dissatisfied] **What else do you think the City of Somerville could do to better address the overdose crisis in your community?**	[text entry]
17. What is your age?	[text entry]
18. What is your current gender? Please select all that apply.	Woman Man

	Non-binary, transgender, or genderqueer Something else: [text entry]
19. What is your race or ethnicity? Please select all that apply.	Black, African, or African American White Mixed, bi-racial, or multi-racial Indigenous, Native American, Alaska Native Hispanic or Latinx Asian Native Hawaiian or Pacific Islander Something else: [text entry]
20. What is your relationship to Somerville? Please select all that apply.	Resident Business owner Work in Somerville Family and/or friends live in Somerville Attend church in Somerville Attend school in Somerville Child/children attend school in Somerville Use healthcare or mental health services in Somerville Use substance use treatment services in Somerville Use housing/shelter services in Somerville Use social or community services in Somerville Something else: [text entry]
21. [If Q20=Resident] How long have you lived in Somerville?	Less than 1 year 1-2 years 2-5 years 5-10 years 11-20 years Greater than 20 years

22. [If Q20=Resident] What Somerville neighborhood do you live in?	Hillside Teele Square Powderhouse Square Davis Square Ball Square Magoun Square Winter Hill Ten Hills Assembly Square Porter Square Spring Hill Duck Village Union Square East Somerville Boynton Yards Innerbelt North Point