Clinical Education Initiative
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USING SUPERVISED INJECTION FACILITIES TO REDUCE HARM AND IMPROVE ACCESS TO CARE

Speaker: Sharon Stancliff, MD

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Using Supervised Injection Facilities to Reduce Harm and Improve Access to Care
[video transcript]

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- [Jim] Welcome to Physician's Research Network. I'm Jim Braun, the course director of the monthly meetings of PRN in New York City. Since our beginning in 1990, PRN has been committed to enhancing the skills of our members and the diagnosis, management and prevention of HIV disease as well as it co-infections and complications.

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We hope this recording of Sharon Stancliff's presentation “Using Supervised Injection Facilities to Reduce Harm and Improve Access to Care” will be helpful to you in your daily practice and invite you to join us in New York City for our live meetings in the future.

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PRN is a not-for-profit organization dedicated to peer support and education for physicians, nurse practitioners, and physician assistants, and membership is open to all interested clinicians nationwide at our website PRN.org.

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And now allow me to introduce Sharon Stancliff, Medical Director of the Harm Reduction Coalition in New York City.

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-[Sharon] Good evening, I'm really glad to be here talking to you about this really interesting topic. And it's very timely, as we'll see. Every other day there's something in the news about the topic at this point and I think that's going to continue for some time.

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I'm going to go through some of the evidence for the effectiveness of Supervised Injection Facilities in reducing overdose, HIV, Hepatitis C, and other harms of injection drug use. After I tell you a little bit about what they are. Consider a little bit about how they fit in to a continuum of care. We'll talk a little bit about a couple different models for Supervised Injection Facilities. And talk a little bit about the legal barriers that there are to having Supervised Injection Facilities and some of the things that that can be done to address the same problems that are currently legal in the United States.

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Just setting the scene to remind you, we have a huge problem with overdose deaths around this country. This just came out from NIDA recently and you can see the trajectory of deaths from heroin is continuing to rise right up through 2015. I'll bring it home a little bit to New York City.

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Here, we saw some decreases in heroin deaths when we first started doing naloxone in New York City, but we've had a steady increase of them since that time. I want to call out to your attention the fact that we've suddenly have an influx of fentanyl, illicitly manufactured fentanyl, into the heroin supply across the state from Erie, to New York City, to Suffolk County. And, as of 2016 it's up to 50% of the deaths that are associated with fentanyl as at least one of the drugs.

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I don't know if you've seen this New York City campaign. This poster, if it's appropriate to your clinic, can be downloaded at the New York City Department of Health, it's a harm reduction-oriented poster suggesting people use with other people not use all at the same time, carry naloxone, and be careful mixing drugs. So, if it fits your clinic, go to the Department of Health, City Department of Health website and you can put it up on your walls.

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And just a reminder, we're also seeing a change in the epidemiology of Hepatitis C. It used to be that it was just sort of the baby boomers marching across. As they got older, the bell curve of Hepatitis C moved across. But now, and this is New York City, New York State data from outside New York City, we're seeing this group of younger people that are diagnosed with Hepatitis C. And this is probably just the tip of the iceberg. And it's also interesting that it's women, equal to men, pretty much, unlike the older data. So we're seeing a lot of consequences of people injecting drugs and using opioids out there.

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I hope New York State is covered well enough with access to drug treatment and access to clean syringes, but, I don't think it's impossible, we could see an epidemic like that scene in Indiana. Where about 150 or more people became infected with HIV in a very small community sharing Opana that they injected. We always need to be mindful that there's more to do even though as I'll show you, we've done quite well in New York State. So, that's the problem that we're seeing out there. And let's look at where people are injecting a little bit.

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This is a study that was just published 2017 where some researchers associated with John Day did a survey of 86 business managers in the five boroughs, and it was somewhat of a convenient selection but they did try to choose areas with high overdose rates and low overdose rates. Some of the businesses were fast food places like McDonald's, bodega, shopping malls and a variety of other places. And they asked, have you been seeing evidence of injection drug use in your restrooms? 58% of the 86 had seen some evidence of drug use in their bathrooms. And of those, 17 people had found syringes in the restrooms. Twelve had called 911, including seven for an unresponsive person. I could tell you a number of anecdotes about this but we are certainly seeing medical literature evidence of this here in New York City.

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This is a little bit more of the gray literature. First of all, the 10th annual report on homeless deaths in New York City just came out from the New York City Department of Health. And they found that overdose deaths inside, and outside of the shelters, is the leading cause of death among homeless New Yorkers. Coming in second is cardiovascular disease. Now, the Department of Homeless Services is in the midst, or maybe have completed a major campaign of making sure that they have staff in every one of the shelters able to recognize an overdose and use a naloxone. There's a group called the Injection Drug Users Health Alliance that again, engaged with John Jay and did a survey of people that were injecting drugs around the city. And you can see, first, where they're injecting. Private residence is the main site, but public bathroom follows that. Streets and parks, and you can see all the way down to the subway and the buses. Syringe exchange bathrooms. And when we look at the people that are unstably housed as compared to stably housed, not surprisingly, we see more public injection among that group. Have people seen public injection out there in your neighborhoods? I'm seeing some nods. Anybody been to Schenectady? There's a parking lot there that is just it's a picture of public injection. And we're hearing those reports from a variety of places around this state. As I'm gonna show you, first of all, I'm not gonna hit you over the head with absolutely unassailable evidence that supervised injection facilities are the answer to all these problems. I'm gonna show you a scattering of the various studies, there are numerous studies, that probably add up to something. But if you want to go and pull the studies you will certainly find, well it could have been this, or it could have been that that caused the difference. I'll just be upfront about that. The strongest evidence that we've really got is prevention of overdose.

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In looking at overdose, we have evidence that increased access to naloxone, or Narcan, does reduce overdose rates in communities. We have powerful evidence that expansion well the presence of opioid agonist treatment with methadone buprenorphine works. And, the other of these interventions that we have evidence for is supervised injection facilities. We're hopeful about the other interventions. But I can't really show you any evidence that I've seen on any of the rest.

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And just a reminder, to prevent HIV and Hepatitis C among people who inject drugs or that might inject drugs, we have, as I'll show you very quickly, access to sterile injection equipment is key for people that are injecting. Methadone maintenance and buprenorphine maintenance both can help people stop injecting and you can see that people maybe don't advance to injecting. It's kind of exciting to see some data on young people not getting Hepatitis C if started on buprenorphine earlier. Perhaps even before they begin to inject.

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Just a real quick look, we do know that people who inject drugs can respond to these interventions. This is a quick look at how many syringes were going out in New York City from 1990, starting with the illegal needle exchange that rapidly became wavered. And this is the annual incidence of HIV among people who inject drugs over that same set of years. And again, lots of other things happened. I showed up in New York in 1990, maybe that's what made the difference. But we do have strong association of syringe

access with decreases, significant decreases. In 1990, 50% of people injecting in New York City were infected with HIV. Now it's around 10 to 12%. And, what else do people do that gets them HIV? Did somebody say sex, I hope? There is a certain amount of sexual transmission among that group, as well.

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This is sort of the background of where we are with initiatives. You know we have Syringe Exchange it started in 1992 in New York State, legally, it was before that. We expanded to pharmacies in 2000. The Overdose Prevention Project with naloxone started in 2006. Now we actually have an Office of Drug User Health at the Department of Health, which among other things I'll get back to at the end, is working on increasing access to buprenorphine in primary care and other sites, at this point. This is the background that we've got which is a little different than the background that we saw where some of the supervised injection facilities were located.

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Everybody's seen it in the news a little bit? It's out there, de Blasio and the city counselors studying. I've asked the New York Society of the New York Department of Health, and New York Academy of Medicine to look at supervised injection facilities. The former president of Switzerland was just in Ithaca, which was very interested in opening facility. I'm just gonna say SIF to save time. Supervised Injection Facilities, or SIF. San Francisco's been looking at it, I'll show you some cost-effectiveness studies. Seattle said they're gonna do it. They're gonna two. Montreal, either today or yesterday said they're going to open two more. And I think keep your eye on the news, where we'll be hearing more.

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So what are these? Well, they're places, I'm gonna talk about injection facilities, but there are also are drug consumption rooms where people can go and consume drugs that they purchased illegally. Or, I suppose they might have a prescription and inject it, but primarily illicitly attained drugs somewhere else, and go to a place which has appropriate supervision and protection from arrest. The main goals are, first of all, to provide an environment for safer drug use with the goal of improving the health status of the target group. But also to reduce public order. Most of these, as I'll mention more about, were really set up in places where public injection was a major issue.

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It's intriguing that they started in Switzerland in 1986, where they did have major problems with public injection. But that really was prior to them having methadone as far as I know. They were doing a little bit of syringe access, but, I think, I mean you can probably buy them at pharmacies but Needle Exchange didn't exist until a little bit later. We now see them in 11 countries. There is at least 100 sites functioning. France opened in 2006. I hear tell that Vancouver has expanded from their one major site to several other sites because of fentanyl. And as I mentioned, Montreal just threw in their hat on it.

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What do they look like? And I do have a couple pictures. They are all supervised by somebody with some kind of training. The ones that I'm gonna show you, the studies on at least have actual medical

supervision with nursing staff on site, and physicians somewhere else. There are those that are non-medically supervised and when we get to the one that's illicitly operating in the United States, that's an example. As is the basement of the church I visited in Rotterdam. They just had people that knew what to do. Interestingly enough, the one in Switzerland does not have naloxone on site which is pretty stunning to me, but most of them do. Some of them are very closely integrated with other services and I'll say more about that with a photograph. Some of them are more standalone, such as the one in Australia. And then in addition to fix sites, Spain, Berlin, and Denmark have mobile units. The drug consumption room, some of them include smoking faculties. To make that truly okay for staff it's pretty high tech to protect people from smoke. And then there are, and have been, underground supervised injection facilities, drug consumption rooms, in various places around the world in various times. And I'll talk about one of those. They're generally, as I said, created in the setting of concentrated public injection. For example, the first one in Germany was in Frankfurt in the business district. The Deutsche Bank got tired of it so they actually helped sponsor one of the first ones because they wanted people off the street corners.

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Really, they target very marginalized people. It's really hard to develop these without a true collaboration of public health, law enforcement, local businesses. Because it does make people a target for law enforcement if it's not legal. I believe all of them require some initial evaluation and registration. Maybe you need to reside nearby, you may need to be a certain age. Some of them, for various reasons, actually don't include people that are enrolled in methadone. So there is initial evaluation. All of them have links with other services. And just to kind of give a sense most of them have, you walk in, there's an area where you wait to see if there's room, you check in. There's an injection area. And then there's an area where you go after you're done injecting to chill out, drink coffee, maybe get services. Sometimes it's just two rooms, but the injection part is usually separate from the general area.

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As I say, they target marginalized people. This is from a systematic review. Mostly men. High rates of housing insecurity, unemployment. Many have recently been incarcerated. Many participate in sex work. They tend to arrive already with HIV or HCV infection. And many, not surprisingly, have had non-fatal overdoses. That's the meta-analysis, this is a quick look at the Sydney, Australia one where 70% weren't accessing health services before they walked in the door. Most were unstably housed. I imagine homelessness looks a little different in Sydney. Lots of mental health diagnoses. And like all of them that have at least been evaluated with over 930,000 injections they've had plenty of overdoses, but not one fatality. And that's true of those that are being evaluated, in general.

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I hope you can see this, but it just sort of gives a sense. Most of them provide syringes, health education, coffee, tea, bread, referrals to care and treatment if you go to the other end. Maybe they allow them to actually store belongings there. But there's a lot of other services associated with these services.

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This is the picture of the injection room in Vancouver. I went there and I thought, oh, I'm going to a Supervised Injection Facility. Honestly, this was one small part. They had so many services there. Upstairs were places where people could get counseling. Another floor up was detox if people wanted to go. Around the corner was place for people that had been hospitalized to have step down care so they could continue to get their antibiotics. I was like, whoa, there's so much going on here that I'm not even hearing about.

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This is a German one, I haven't been to but it's a little lower tech.

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And this is just an example of in Amsterdam they have smoking rooms. Obviously, I'm not sure I'd want to be in there with a lot of people smoking crack. But it seems to be working out for them because it doesn't have any great ventilation. But just to give you a sense of what kind of different facilities can look like. The people in Vancouver, they've got a couple researchers, there are several researchers up there that have done a ton of evaluations.

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And this is to give you a sense and then I'm gonna break out a few, but public disorder, reduction in injection behaviors, access to services. I didn't pull out the one on reductions against violence against women. Overdose deaths averted is really the key one.

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Haven't seen any negative changes in community drug use patterns. This isn't that sort of place you go, like, oh I think I want to go try injecting drugs, let me go down there. That doesn't seem to happen. They do have partnerships with police. And I'll show you a cost-effectiveness study not on insight, but a modeling study from San Francisco. Now I'm gonna delve into a few of these in a little bit more depth once I get this under control.

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This, I think, is one of the better studies and it's a fairly key study looking at the number of overdoses. They looked at the overdoses in the months after they started the facility between 2001 and 2005. In the 500 meters around the Supervised Injection Facility and then the rest of the city. Number of overdoses, person-years at risk, let's really concentrate on the overdose rate. Prior to opening the facility, they had a rate of 253.8. Afterwards it dropped to 165. Now of course, the rest of the city wasn't a part of concentrated injection. They had a rate of 7.6, which dropped a little bit over time. The area around the SIF, and it's a pretty intense area in Vancouver, had a rate difference of 88.7 where in the rest of the city they had a minor difference. Percent reduction 35% and nine percent. This looks at the fact that things were changing in the city but suggests that having the SIF available and somebody asked me the other day how many hours a day. That one's open from 10 in the morning 'til four in the morning. So they're pretty comprehensive.

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They also looked at people entering services. They actually enrolled a cohort of 1,031 people and then were able to follow about 86% of those that they enrolled. This is those they were able to follow. And they found, looking at entry into detox programs the folks that had the most uptake of it were probably the most needy. First of all, people that go into treatment tend to go back. I think that's part of the process. But they also saw that homeless folks, binge drug users, weekly use of the SIF, and having an addiction counselor in both sides, were associated with a greater likelihood of entering detox. But I think my main point is that they can be a route to other services and I think that's an important point. Let's walk outside. They started counting, or looking at public injection in the area around the Supervising Facility.

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This is when they opened here. This is how the sort of numbers of people crept up over the first 18 weeks of the facility. And this is what public injection looked like in the, I forget the east side of Vancouver. And they saw a decrease over time as people started going into the injection facility. Now you still do see it, I saw some of it when I was there just a couple years ago. But it's certainly been a decrease. What about medical care? Well, this is the same cohort. I searched so hard for studies that are outside Vancouver, they've been so prolific and they're great. But, they just, they really kind of have the corner in the market.

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They looked at the hospitalizations among the SIF participants, and of the hospitalizations 49% of them were related to cutaneous injection-related infections. So we're thinking soft tissue infections, abscesses, cellulitis. And what was interesting is they compared the people that were actually referred by the nurse at the SIF to the people that just walked in to the hospital by themselves, and this suggests that having the nurse refer somebody got them there earlier. Four-day hospital stays, versus 12 day hospital stays. I don't know that they had their place where people could transfer for continued antibiotics at that time, or not. But, as we'll see later, this could be a significant life and money saver. So, there's not great actual data on reductions in HIV and Hepatitis C associated with SIFs. Now, if you really think about how can one do those studies— it's not easy. At the time that the SIF opened in Vancouver and Australia they had easy access to syringes. So hard to separate out. Interestingly, I think one of the reasons we got some overdose data, and I do have a little from Australia, as well, is because we were the leaders in naloxone. Australia and Canada adopted distribution of naloxone way after we did, which is kind of interesting, but they had less community overdose prevention, at the time.

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This is actually a study from Denmark looking at self-reported behaviors for injection after they started going to the new SIF. And I think the main ones we want to look at-- people rushing is a dangerous way of injecting. But, they were more likely to clean their injection site. Less likely they stopped sharing needles 54 percent, on reported stopping sharing needles. Using clean water. And, they didn't see a lot of changes in injection behavior in this. We would love to see, oh everybody decreased injection. A few

did. Very few increased it. But, it's sort of data like this that the modeling studies that I'll try to explain to you are based on.

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This is from a study that just got put out online recently, this is a look at the mathematical modeling studies predicting HIV and Hepatitis C infections averted by a SIF or a consumption facility. As you can see, Vancouver is of course, represented. Toronto's been looking at it, I forget if they've passed it. Ottawa, Montreal now has done that. Victoria looked at it. And they all suggest that they would have some number of HIV, or Hepatitis C infections averted. And we'll come back to that when we look at the Irwin study a little bit more.

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Irwin and Company estimated the economic costs and benefits of establishing a SIF in San Francisco, using models based on some of the numbers I just showed you. And they looked at potential savings from averted HIV and Hepatitis C infections, reduced skin and soft tissue infection, averted overdose deaths, and increased access to medication assisted treatment.

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This is what they looked at, and so this is the range and then I'll show you what numbers they sort of came up as middle ground. We've got the cost of the injection facility up here. We'll come back to that. Suggesting that if they reduce cases a lot, they would save a lot of money in millions if they reduce cases a little less. So, 1.3, 1.8, 1.3, 1.8, on SSTI savings. Again, that whole range there. And what we're looking at, we're looking at low numbers. Like, starting at 19 low case would be averting 10. High case would be averting 27. They looked at the whole range, as those cost-effectiveness people do.

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And they came up with the idea that if you averted 3.3 cases of HIV each year in San Francisco, that would come out to 1.3 million dollars a year. 19 cases of Hepatitis C, these are modest numbers. We're not talking about hundreds. But 1.3 people entering into medication-assisted treatment, 110 per year. Reducing stays, I showed you the study on reducing stays related to soft tissue infections by a certain number, by 415 per year, another 1.7. And finally, overdose deaths saving $284,000 a year. If you take these savings and subtract the cost of facility, they suggest that it could in a relatively conservative way, save the city 3.5 million a year. Cost savings is rather amazing compared to just cost-effectiveness. Many things were very happy with cost-effectiveness. So, is it legal? Well, we've got Ithaca saying that they want to legalize it. Seattle has just said that they are going to legalize it. That they can do that.

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States could legislate that it's legal or have an administrative act by a governor. Both of those things have been done. Anybody think about what's been parallel there might be there? Marijuana. I think it's rather similar to marijuana. But, these regulations or laws that states or local governments might put in are superseded or contravened by federal law.

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There's a variety of things in the controlled substance act but really specifically the one that was put in in the 1980s at some point called The Crack House Statute to make it illegal to run a crack house saying that it became illegal to knowingly open or maintain, or manage a place that people are using illegal drugs for the purpose of unlawfully using controlled substances. So, it will be interesting to see how things progress in places like Seattle and Ithaca. In Canada, this was challenged in many ways. And, finally was taken to the Supreme Court of Canada. Their facility in Vancouver was a pilot for 16,000 years. Well, maybe only 16. And they tried to shut it down, but it finally went to the Supreme Court of Canada who decided that it was a public health emergency and that this was a human right. I don't know what would happen here. But just so you know, that's kind of where we are with legality. There is an underground Supervised Injection Facility that is in an undisclosed place in the United States.

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There is essentially no funding. There's a couple of researchers that are doing some research basically in the form of data collection.

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They've provided a little bit of assistance. It's sort of a proof of concept thing. So, they looked at it. They started, we're gonna come to bathroom policies in a little bit. But for awhile there, the staff allowed people they made the bathroom a safe place to inject if people chose to inject in there. We'll come back to that, because that, we'll come back to that. But they found that to be really stressful and they decided we just, we don't want to have people doing it behind a closed door. We just want to be able to make sure people stay safe. It really was stressful. So, now they're collecting data. So what does it look like?

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It's got a couple rooms, one for injection, one for chill out. They've got stainless steel stations that I assume look rather like what we saw in the pictures earlier. It is by invitation only, so people are registered in some way. They don't allow smoking, I don't know if you can smoke cigarettes in there, or not, but not crack. There's a staff person there at all times. And then, the biggest difference from sort of a low-level place in Rotterdam is there's somebody there with a tablet to do evaluation questions. And there's safe sterile equipment. The numbers are really small, I didn't ask. I know they're very small.

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One of the questions that they ask them is if you weren't here, where would you have gone? 35%, so at each injection, so they don't have 2,574 people attending a Supervised Injection Facility somewhere in the United States. But they asked each time they injected and 35% said a public restroom. 57% said a street, or a parking lot. Very few had other places to inject at that given injection.

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They've had over 2,500 injections there at the time that that RTI put out this set of slides. They haven't had any negative consequences. They've had two overdoses, both of which were reversed by staff,

which is essentially comparable to the number of overdoses that they've had at the Vancouver site of one per 1,200 injections. No acute health complications. No violence. People like it, but it's scary. The police could, if they found out about it-- it's putting a very vulnerable group of people at a certain level of risk. Therefore, it's very small. And this is the only one that's been evaluated but I've been vaguely aware of various other such set ups in various parts of the United States that people do for some period of time.

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The political environment right now might be really hard to make some changes that will be there on the part of the medical community and the law enforcement and the public health communities, which seems to be growing. But in the meantime, there's other things that we can think about doing to reduce risks of public injection. Some of which sort of sprang from looking at what we can't do Supervised Injection Facility but maybe we can do this. Some of this can be a springboard to new ideas that I haven't thought of. Maybe you all will.

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I want to again call attention to the activities of the New York State Department of Health, the Office of Drug User Health is seated at the AIDs Institute. Where Needle Exchange and naloxone came from. And then the New York City Department of Health and mental hygiene in their drug and alcohol program is doing a lot of stuff. Both are working really hard to increase access to naloxone. If you aren't aware, you can now obtain naloxone under a standing order from some physician or other at almost every chain pharmacy in New York State. Although some of them, corporate's up here, the people in the pharmacies don't always know. And you yourselves can write prescriptions for naloxone, for your patients at risk whether they happen to be injecting heroin. Or taking say, more than 50 millequivalents a day of morphine. So, think about that. And we have a huge prison project going on of getting naloxone into the hands of people leaving prison, or are already on parole that's spreading. Anybody seen the buses in New York City with the naloxone on them? That's a New York City campaign that's going on out there. Both the state and the city are working hard on that to reduce the risk of overdose. Both are working hard to increase access to buprenorphine. If you haven't been trained, watch out. There are going to be free trainings across the city and the state going on over the next year. The city's going to train 1,000 people. Any physician assistants or PA and NPs in here interested in prescribing naloxone? Thank you. Now you will be able to do so very soon. That's really exciting. Free trainings all over the place. And the hope is to get it to novel environments into the Syringe Exchange Programs. It's already in two downtown under grant funding. Into emergency departments. A guy in Syracuse has started a bridge clinic. They come in with an overdose, he gives them a list of phone numbers it just wasn't working for him because they had no spots. So now he took over the hyperbaric rooms of the emergency room and he sees them until they can get a spot in treatment. There's lots of ways that we can expand access particularly to the more vulnerable populations. There's peer navigators that will be put into emergency rooms to see people that have had a non-fatal overdose. And New York State now has three hubs to try to connect services in Ithaca, Buffalo, and Albany area. And those will be expanding and sort of a partial one on Staten Island. To begin to get law enforcement, emergency departments, Syringe Exchanges, drug treatment, all to be sort of in a network instead of siloed, as much as we can get some of the

players to really cooperate. But Albany, for example, has a law enforcement program where, pick up somebody for a low-level offense well, I could arrest you but I could also drop you off at Catholic charities and you can start to get some services. And they've already enrolled a bunch of people. There's lot of innovative things going on that can begin to deal with this really vulnerable population that we're taking care of. And now I turn to Massachusetts which is appropriate because of our next speaker.

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Boston is doing actually a lot of really cool things and I need to visit. This is a campaign on the part of the Boston Public Health Commission where they're recognizing that overdoses are happening in restrooms. And so it's not totally clear, but this is targeting the McDonalds, the Burger Kings, the various places where people go to inject saying, you want to be aware of what's going on in your restrooms. I only did page one, but it also points out hygiene is important. But to just be aware people may be injecting in there. Watch out for what's going on, know who's using the bathroom. And try to devise ways to make sure nobody is in there for a really long time.

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In New York State they have revised the Syringe Exchange regulations. They are pretty highly regulated. But they've added this in, the New York State Department of Health AIDS Institute under their policies and procedures for needle syringe exchange programs put out this past September. Under section on staying safe with the syringe exchange program, first, I mean they've always had naloxone, they had it before anybody else did. But it's a regulation that they must have naloxone on site. And they are not regulated, but they offer the option of making sure, well they are told that they must have procedures to reduce the incidence of overdose, fatalities, or other medical emergencies particularly in the bathrooms. So it is recommended, they make sure their bathrooms are particularly hygienic. In fact, it's really nice to have stainless steel place to put your insulin syringes and your insulin or your purse. Lots of emergencies can happen in bathrooms. Private but time-monitored making sure nobody's that they've been in there 20 minutes and nobody knows what's going on. And accessible in an emergency. And they've got some real specifics about it. But sitting up and taking notice of the fact that we do have people in that study that inject in syringe exchange bathrooms. If it's going to happen, let's make sure there's no tragedy that happens. To my knowledge, nobody has ever died in a bathroom at a syringe exchange. I think I would know.

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And finally, I think I'm ending with the Supportive Place for Observation and Treatment that the Boston Health Care for the Homeless opened, it's called SPOT in April of 2016. And it is not a supervised injection facility. But it's a place that people can go to themselves. Or be dropped off at when they're intoxicated, whether it's because of heroin, alcohol, whatever substance. They have an RN there and they have a rapid response clinician that can be called. They have people that can refer people to services. Injection is not allowed there. The Syringe Exchange is right next door, but they like to say they're not a syringe exchange. But it's right there. And honestly, when I first heard about this, I was like why would people go there? They do. There is, I'm sort of aware that there's much more data out there but I didn't even want to look at it because I wasn't allowed to talk about it.

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But here is the very first part of the data they had. Evaluation is in progress so I don't know maybe at CROI. Maybe they'll be releasing some there. But in the first 15 weeks they had 218 people visit it for a total of 983 visits. It's popular. Now some of them go there themselves. It's very much in the neighborhood maybe you can say something about the neighborhood. But I'm told that there's street injection there. And they're working towards medicated billing because we do have a lot of, I don't know I have a hard enough time with DSRIP in New York I can't begin to talk about Massachusetts and their billing. But this is the kind of service that doesn't necessarily need to be grant supported and supported on shoestrings. It is the kind of service that can conceivably be part of our overall healthcare plan. There are a couple of the really innovative ideas that are coming up. And there's probably other ideas. Maybe there is the political and the medical will to do supervised injection facilities in this new national environment that people are very worried about what's gonna happen to medical and recreational marijuana at this point with the new administration and what we've heard so I'm not gonna make any political predictions. But other ideas can come from it, as well. To deal with the problem of overdose and public injection.

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To conclude, and I hope I didn't talk too fast. We've got plenty of time for questions. We do have a problem with people with marginalized housing going on, whether it's here in New York City, in the Bronx, in Ithaca, in Schenectady. Ithaca's not just saying this, it's nice college town they're not just saying this 'cause they're cool. They really do have a population in downtown that is around enough, we also talked a little bit about the possibility of dilaudid maintenance would be similar to heroin maintenance. It's just a little easier 'cause dilaudid is legal in this country. But we are, some people have said this ought to be in Albany. I doubt it will be at the governor's doorstep. But we are having this problem of increasing fatalities really exacerbated by this problem of fentanyl and the homeless people are particularly vulnerable to it. I'm really interested to hear your opinions and your questions. But there is some evidence that these sorts of facilities can help to ameliorate this problem in addition to some of these other solutions that I've mentioned. And I'm so embarrassed I forgot to put in an acknowledgement slide. I really have to acknowledge the people that are working on some of these issues the New York State and City Departments of Health. I really appreciate, we had a consultation here in New York that brought in people from the Vancouver, the Sydney and the German supervised injection facilities to help teach us about it. There is a document about that consultation and I owe all of this to lots of other people.

[Video End]