FENWAY HEALTH

Somerville Supervised Consumption Site:

Conceptual Design & Location Assessment

Report produced and submitted to the

City of Somerville by Fenway Health

July 2022

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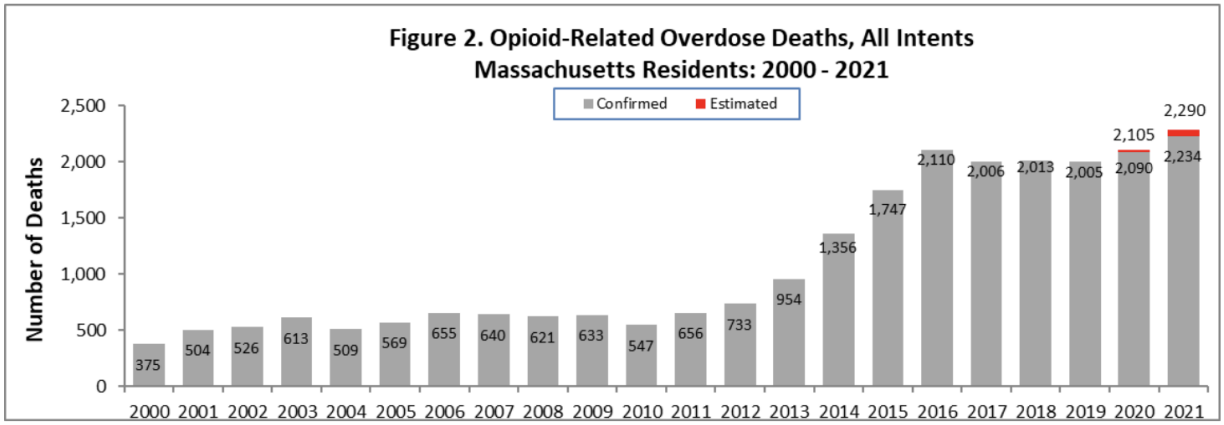
Executive Summary

As part of Somerville's effort to explore opening a supervised consumption site (SCS), in December 2021, the City of Somerville hired Fenway Health to further explore key questions raised in the 2021 Needs Assessment and Feasibility Study. The work commenced in January of 2022 once the new mayoral administration was sworn in. The purpose of this phase of work was to a) develop a conceptual design of an SCS, including aspects such as policies, staffing models, and budgets, and b) assess potential locations in Somerville that might be suitable to host an SCS. Both of these tasks called for continued engagement of a range of stakeholders, including an advisory group, people who use drugs, and local community members.

The 2021 Needs Assessment and Feasibility Study identified the scope of need in the city, and the locations of greatest need. It also laid out key elements important to those engaged in the development of an SCS, including some aspects of program design. That report was foundational as a starting place, and can be found at www.somervillema.gov/scs. Our process, discussed in more detail below, incorporated learnings from additional engagement and feedback from residents, people who use drugs, advisory group members, city staff, and touring and meeting individuals leading New York's SCS.

Somerville has strong reasons for opening an SCS. In addition to the findings of the 2021 Needs Assessment and Feasibility Study, the most recent data on overdose fatalities also indicates a significant impact on the city and its residents. According to recently published data from the Massachusetts Department of Public Health[1], in 2021 there were 15 Somerville residents who died from an overdose, and a total of 108 residents have died of fatal overdoses just since 2015. And the 2021 data, released this month, showed a record high number of 2,290 deaths statewide. This is an issue that has confronted this community with tragic consequences for years, affecting many Somerville families.

[1] https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-june-2022/download



Source: https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-june-2022/download

Somerville's Health & Human Services Department already makes an investment in harm reduction through a partnership with the Somerville Homeless Coalition, collaboration with Fenway Health's ACCESS Drug User Health Program, and community education programs such as overdose prevention training as well as Narcan & fentanyl test strip distribution. Additionally, the Somerville Police Department's Community Outreach, Help, and Recovery (COHR) program, directed by a Licensed Clinical Social Worker, assists individuals in crisis including connecting residents with substance use, harm reduction, and mental health services. We heard repeatedly that while harm reduction services for people who use drugs do exist in Somerville, they are insufficient, and need to be expanded regardless of opening an SCS. That pressing need is reflected in the data of continuing high rates of fatal overdoses.

The people experiencing the greatest number of overdose deaths are white and male, but there has also been a disproportionate rise in Massachusetts in opioid-related overdose deaths among Black and Hispanic people. A recent article published in the Journal of the American Medical Association (JAMA) found excess mortality increasing among Black people, and indicated this "may be associated with an exacerbation of pre-COVID-19 trends stemming from disproportionate harms at the intersection of the opioid crisis, COVID-19, and the structural racism present in health care and law enforcement systems."[2] The 2021 Needs Assessment and

[2]https://www.researchgate.net/publication/360262616_Racial_Disparities_in_Opioid_Overdose_Deaths_in_Massachusetts

Feasibility Study named the underrepresentation of individuals from non-white racial and ethnic backgrounds as a study limitation. This phase of assessment took intentional steps to engage women and people of diverse racial and ethnic identities. Continued outreach and engagement will be necessary to ensure an SCS in Somerville effectively meets the needs of a diverse community.

Community engagement will be a critical part of the success of this program. The City, and eventually the organization selected to operate the SCS in partnership with the City, will both need to continue efforts around community education and engagement. There will be a need to address any fears, concerns, or impacts that may arise with the opening of an SCS site. Local residents, businesses, and first responders will be essential for helping ensure people who need the services of the SCS know how to access it.

This report is being submitted to the City of Somerville, but we hope it will be an informational resource for other audiences: Somerville residents interested in learning more about how the SCS might work in their community; City departments who may be involved in implementation and oversight; other communities looking to learn from Somerville's process and experience; and the organization ultimately selected to operate Somerville's SCS.

The residents of Somerville should be proud of the thoughtful process that is going into this vitally important project. This has been a multi-year, comprehensive assessment of need, feasibility, program design, and location options and considerations. This process has included feedback from a wide variety of stakeholders, including City officials, local residents, business owners, people with lived experience currently using drugs, people in recovery, local families who have lost loved ones to overdoses, and researchers and experts who work in harm reduction and public health.

The findings of this report help to set a foundation for important upcoming decisions around implementation, including final determination of a site as well as what to take into account in the selection of an organization to operate an SCS in Somerville. With commitment of time and resources, we believe that Somerville is well positioned to open a temporary site for an SCS

within the current fiscal year. The following is an executive summary outlining some key findings related to our assessment of location options and the conceptual design of the program.

Location

A significant barrier for Somerville is the limited physical locations available in which to open a SCS. There is limited commercial real estate that would be suitable. In addition, there is still legal uncertainty and risk to private property owners. Even though the legal context is shifting towards recognizing SCSs as a legitimate and legal public health intervention, finding a private landlord willing to rent space is extremely unlikely. As a result, the City of Somerville has agreed the best approach will be to utilize City-owned property.

We evaluated a number of City-owned brick-and-mortar buildings. The City's building stock is limited, heavily occupied, and in many instances in need of significant repairs or renovations that will take time and resources before being possible to consider for an SCS. Renovating existing properties or identifying other brick-and-mortar solutions will take longer than the urgency of the need to prevent fatal overdoses demands at this moment.

While there are no brick-and-mortar facilities that could quickly be made available for an SCS in the short-term, there are City-owned parking lots that could accommodate a fixed modular unit to serve the purpose quickly. This process assessed City-owned lots in Davis Square and East Somerville, the two neighborhoods recommended in the 2021 Needs Assessment and Feasibility Study, and determined there are viable options for implementation.

Modern modular units are customizable in size and shape, design, and can include the necessary utilities to serve as a temporary facility from which to operate a SCS, such as running water and sewage, thermal regulation, and ventilation. Our report shares a non-exhaustive selection of possible layouts to help the city, program operator, and community visualize how these might be set up.

The use of City-owned parking lots as the site for a modular SCS will require further site planning by the City of Somerville to determine which is best able to accommodate an SCS from an operational and logistics standpoint. Fortunately, the City has experience using fixed modular units - they were deployed for classroom space during Somerville High School construction. Various departments will need to be involved to look at questions such as the practicality of where to physically place a trailer, accounting for variables such as connectivity to utilities, the safe flow of pedestrians and vehicles, and mitigation needed for any current existing uses that would be associated with the loss of parking spaces and parking revenue in highly utilized lots. None of these factors are outright barriers or prohibitions to opening, but they will require additional planning in preparation for opening an SCS.

It is critical to note that the majority opinion of the Advisory Group was that a brick-and-mortar location would allow for more dignified and comprehensive services to be offered. Finding a more permanent location, with sufficient physical space to operate a more comprehensive and robust program, should continue to be explored. This may also be aided by solidification of the legal status of SCSs at the state and federal level, which may make private property, not just City-owned property, a more viable option.

Conceptual Program Design

This phase of planning was tasked with doing a conceptual design of an SCS in the City of Somerville. In the 2021 Needs Assessment and Feasibility Study there was significant consideration given to aspects of the program design important to members of the Advisory Group, and in particular to people who use drugs who were surveyed and participated in focus groups. That work was foundational to this stage of planning, and was our starting place from which we hoped to go one level deeper on some key aspects of program design.

Supervised consumption sites are often defined as places where people can use pre-obtained drugs under the supervision of staff who are trained and equipped to intervene and save lives to ensure overdoses don’t result in fatalities. No one has ever died of an overdose in an SCS

anywhere in the world. An effective SCS does not just provide a space to use drugs, but serves as an engagement center bringing critical services to people who use drugs.

Somerville should ensure that what is established is based on an integrated services framework, where clients' broader social and health needs are met directly and/or by referral. This can and should include access to substance use disorder treatment, Medications for Opioid Use Disorder (MOUD), screening, prevention, and treatment of infectious diseases such as HIV, Hepatitis C, and sexually transmitted infections. Participating in an SCS should be seen as a point of entry to broader primary care. This requires health navigation to assist with getting into primary care, connecting with financial assistance counselors and health services that are competent in serving people who use drugs, and helping clients with health navigation. It should also be a point of access for broader social services, such as housing and food services that already exist in the community.

Designing a model program, given the local context, includes looking at factors such as policies & procedures, staffing, hours of operation, the range of services offered to clients, and the budget required to support safe and effective operations. It is important to note that location selection, physical layout and capacity, and the selection of the program operator will all have impacts on many of these factors for the SCS. There are, however, best practices and practical realities for any SCS, regardless of where it opens or who is operating it.

The final location chosen will determine, and be determined by, the size of a modular unit able to be utilized by the program staff and clients. This in turn affects what scale of programming can be offered on site, versus what support services will need to be offered by partner referral. A modest-sized modular unit that can fit in the footprint of available locations will have a limited footprint from which the program can operate. We have explored this dynamic and recommend implementation in several phases. A fixed modular unit, able to be opened relatively quickly to start saving lives, will need to be viewed as the first step.

There is a practical benefit to a phased approach from a program perspective. In the first phase, starting with a smaller program will give it time to build up its operations, staffing, and

community understanding of the SCS. It takes time to build a program from scratch. There will be a lot of initial operational details to determine, including refining program protocols, staff hiring and training, client and community outreach, evaluating the program as it opens to monitor and make any adjustments, and others.

From the outset, the program will require a core of staff, including individuals responsible for program direction, site management, safety, client engagement, and clinical support. The hours of operation will need to be quickly established as seven days a week, with consistent access for clients, but the specific hours of operation will require flexibility based on budget, staff capacity, and client need, each of which may evolve over time to allow greater coverage and access.

Staff will have a responsibility to continue to actively engage the community including local residents and businesses. This can be achieved through a specific engagement strategy that sees community as a partner, not something to be managed, mitigated, or ignored. The program will need to identify a point person, likely the SCS Program Director, to serve as a point of contact to establish and maintain those relationships.

Staff will all require training specific to overdose prevention and working with cultural competencies in working with clients coming from diverse backgrounds, languages, and a history and current reality of living with trauma and stigma in most other settings. The program should utilize technical assistance and training specifically from other operators of supervised consumption sites, particularly as it relates to best practices in how to effectively intervene in responding to overdoses in an SCS setting, which can be different from other harm reduction settings that rely almost exclusively on nasal Narcan.

The opioid epidemic has affected people of all races. Black and LatinX communities have experienced disproportionately higher rates of fatal overdoses in our region. LGBTQ communities have also reported higher rates of substance use. Staff recruitment and training, as well as the types of services and engagement strategies employed by the SCS, will require specific focus to ensure clients of diverse backgrounds receive the care and services they need,

regardless of background or language. Consideration should be given to the gender, sexual orientation and gender identity, race/ethnicity, and linguistic capacity of staff hired, and programming at the site should include specific strategies focused on particularly at-risk and underserved communities. This need is not unique to SCSs, it is a need that confronts all service provider agencies, and the program selected should be expected to demonstrate both a commitment and a track record of equity in staffing and program outcomes.

Operating an SCS will be a new experience in the Boston area, but is not new as a concept or practice in other jurisdictions. During this conceptual design phase we have begun to learn about the experiences of SCSs in other places. The agency selected to operate an SCS will need time before opening its doors to finalize the program design, write policies and procedures, hire and train staff, and establish some level of partnerships for service delivery. During this pre-opening phase, the City and program should partner to solicit support from other SCS operators, and learn from their experiences.

There is one particularly useful resource that should be reviewed and utilized, the "Supervised Consumption Services Operational Guidance"[3] report published by the British Columbia Ministry of Health and British Columbia Centre on Substance Use, that outlines a range of considerations and best practices. Somerville has established the beginning of a relationship with OnPoint NYC which is operating the two SCSs in their community. No other program's policies and procedures can be cut and pasted and adopted without adequate consideration of our local community needs and context, but these will be essential resources for the city and the SCS program to utilize before opening to see clients. The goal of saving lives has been met consistently by every SCS in the world, with not a single overdose fatality in any of them. Somerville's program will need to learn and grow deliberately to ensure that continues to be the case.

[3] https://www.bccsu.ca/wp-content/uploads/2017/07/BC-SCS-Operational-Guidance.pdf

Finally, for program considerations, our report goes into detail on what it might cost to operate an SCS. We accounted for various staffing models and hours of operation, and concluded that a full annual operating budget for an SCS in Somerville will have a starting cost of $1.4 million. If a larger space becomes available, additional staff and services could be added to enhance the services available to clients on site. Such an expansion would require additional resources. There will also be capital and startup costs to acquiring and equipping the modular unit.

Funding is finite, but the city has already identified its Marijuana Stabilization Fund, primarily comprised of medicinal marijuana impact fees, as a potential source of funding. Before this analysis was completed, the City announced an additional allocation of $500,000 to this fund for this purpose. The City of Somerville has a public health interest in reducing the human toll of the overdose crisis. There are also financial benefits to making this investment. SCSs have been well researched and documented to reduce costs in significant ways. The Institute for Clinical & Economic Review (ICER) published a cost benefit analysis of SCSs in 2020[4]. It estimated the cost of running an SCS in Boston at $2M, but an SCS could potentially prevent other costs from being incurred. Examples include a reduction of $411,000 in ambulance costs, $1.9M in emergency department visit costs, and $2.2M in hospitalizations.

The City of Somerville should not be expected to bear the full cost of this endeavor Other public and private funders should be engaged to contribute, financially or through the provision of necessary program supplies, including private foundations and Commonwealth of Massachusetts harm reduction resources.

[4] https://icer.org/assessment/opioids-supervised-injection-facilities-2020/

Acknowledgements

This phase of planning and report development was supported and involved many individuals.

Fenway Health Staff & Consultants

The core team of Fenway Health staff involved in this project and development of this report came together as an interdisciplinary team, including individuals whose roles are focused on public health, harm reduction, clinical care of people who use drugs, community engagement, and advocacy.

- Michelle Bordeu, Vice President of Public Health
- Julia Fleming, MD, Medical Director of Public Health
- Carrie Richgels, Manager of Policy & Advocacy
- Carl Sciortino, Executive Vice President of External Relations

Our team was grateful to be joined by three project consultants who brought expertise in Geo mapping, site & spatial analysis, engagement of people who use drugs, and advocacy related to SCSs, and each of whom contributed immensely in critical areas to this project and report.

- Stephen Kelley
- Jonathan Lee
- Tj Thompson

City of Somerville Staff

This entire project was only possible because the City of Somerville has made it a priority. Mayor Ballantyne was sworn in as a new mayor in January 2022. A change in administration could have stalled or stopped this effort, but Mayor Ballantyne made it clear that this effort was important to the new administration. She expressed genuine curiosity and helpful guidance, and made sure we had regular access to and involvement from her Chief of Staff and other city personnel to ensure the project could advance without delay. This was a true partnership, and we are grateful to these individuals who met with us regularly to inform this effort:

- Matthew Mitchell, Prevention Services Manager
- Nikki Spencer, Chief of Staff to Mayor Ballantyne
- Aneesh Sahni, Director of Intergovernmental Affairs to Mayor Ballantyne
- Meghann Ackerman, Deputy Director of Communications (Former)
- Denise Molina Capers, Director of Racial & Social Justice, City of Somerville
- R. Mason, Department of Racial & Social Justice, City of Somerville (Former)
- Lauren Spengler, Commissions Coordinator, Department of Racial & Social Justice, City of Somerville

Other department staff who met with us to help inform this project include:

- Nicholas Antanavica, Superintendent of Inspectional Services
- Jill Lathan, Department of Public Works (DPW) Commissioner
- Suzanne Rinfret, Director of Traffic and Parking
- Melissa Woods, Director of Capital Projects

Somerville is also fortunate to have strong support for this effort on the City Council, and we want to express appreciation to City Councilor Willie Burnley Jr for his contributions and for serving as a liaison during this phase of planning between this project team, the Advisory Council, and the City Council.

Advisory Group Members

Over the last several years, Somerville has engaged an external Advisory Group to guide its planning process. Some individuals have been there since the group was first convened informally in 2019. Others were deeply involved in the 2021 Needs Assessment and Feasibility Study, and some joined the effort when we reconvened the Advisory Group in 2022. Our gratitude to each of these individuals for contributing their perspectives, whether as a person who uses or has used drugs in the past, City official, Somerville resident, harm reduction specialist, or advocate for the establishment of SCSs. Here is the roster of the Somerville SCS Advisory Group in 2022:

- Allison McBride
- Leo Beletsky
- Bill Fried
- Mark P Eisenberg
- Carl Sciortino
- Mary Cassesso
- Carrie Richgels
- Matthew Mitchell
- Cassie Hurd
- Megan Knetemann
- Colin Beatty
- Meghann Ackerman
- Daniel Hogan-Rigg
- Michelle Bordeu
- Danielle O'Hearn
- Miriam Harris
- Denise Molina Capers
- Nikki Spencer
- Elizabeth Davis
- R. Mason
- Hannah O'Halloran
- Jeff DiGregorio
- Rivkah Lapidus
- Jennifer Korn
- Sarah Casey
- Jim Stewart
- Stephen Kelley
- Jonathan Lee
- Tj Thompson
- Julia Fleming
- Todd Kaplan
- Kathy Keegan
- Willie Burnley Jr
- Laura Spengler

OnPoint NYC

We want to give our deep gratitude to the staff of OnPoint NYC, in particular Sam Rivera, Executive Director, and Brittney Vargas-Estrella, Director of Operations. They opened up their space for a tour and learning experience that was critical to our project, and offered their experience, passion, and vision that should inspire others as much as it did us. We are grateful to other staff, and in particular the clients at OnPoint, who welcomed us in and shared their experience with us including Sam's participation in a Somerville community forum.

Participation from People Who Use Drugs

Having an SCS that meets the needs of people who use drugs requires that the planning process engage the perspective and be accountable to people who use drugs. We are deeply grateful to individuals on the Advisory Group who showed courage and leadership in sharing their own range of experiences with substance use, addiction, overdose, loss of loved ones, recovery, and harm reduction services and gaps in services.

We were also fortunate to have individuals who currently use drugs who were willing to participate in focus groups. They shared the experiences they have on our streets and the

barriers that exist for them in daily life. These are people who know what it is like, in 2022, to be living on the streets of Somerville, navigating an inadequate service delivery system in the region, without stable housing, and in the face of deep stigma and mistreatment from many people they encounter day to day. Our heartfelt appreciation to each of them for taking a risk and opening themselves up to us in this process.

Participation from Residents of Somerville

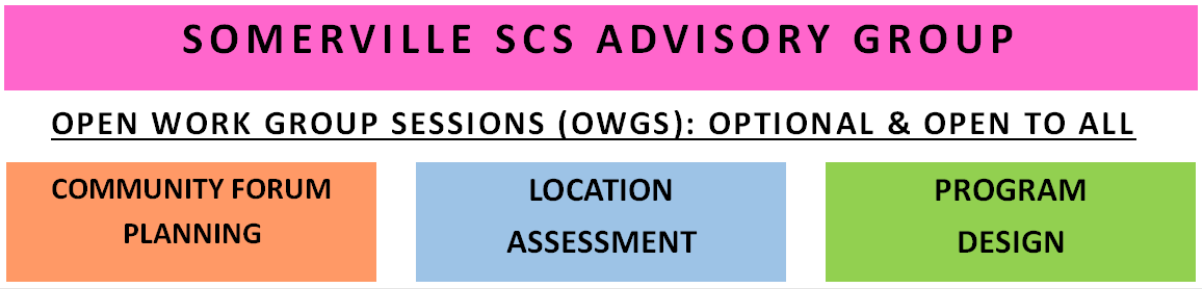
In order for the opening of an SCS to be successful, Somerville has made a commitment to community education and engagement. This project was made stronger through the voices and feedback from many Somerville residents with a range of lived experiences, expertise, and perspectives on the topic of supervised consumption. We learned from individuals who have fears, concerns, or simply questions, and we learned from individuals who have experience, sometimes tragically, with the impacts of the opioid overdose epidemic in Somerville. We want to offer thanks to those who agreed to have individual outreach conversations, who participated in our community forum, and to those who found other ways to share their perspectives with us.

Process

Advisory Group

The Advisory Group was composed of people who participated in the previous phase of this work with the city of Somerville as well as a few new members. It was made up of official staff from the City of Somerville, staff from Fenway Health, harm reductionists, advocates, clinicians, service providers, and people who use drugs.

The whole Advisory Group met virtually four times through this process. Work related to location assessment, program design, and community forum planning was delegated to open work group sessions, which were open to all Advisory Group members but were not mandatory. They met virtually as needed.



Team

In addition to monthly Advisory Group meetings and open work group sessions, Fenway Health staff held the following meetings:

- Bi-weekly with a larger team of internal Fenway staff with expertise in program operations, harm reduction, and clinical engagement with people who use drugs
- Weekly with City of Somerville staff
- Weekly with the team of consultants, who completed additional work on location assessment and community engagement

Individual Interviews

From March 21st, 2022 until the first week of June, we spoke with community members about drug use, harm reduction, and SCSs in the context of their neighborhood. All of the participants were Somerville residents who either lived or worked in the areas of Davis Square or East Somerville.

We began with our personal contacts and the contacts given to us from members of the Somerville SCS Advisory Group. We asked each participant who else should be part of the conversation, which yielded suggestions but not contact information. We spoke with residents, local politicians, two local business owners, and people engaged in community work. There is a need to continue outreach and conversation with residents who are not part of usual civic discourse but whose neighborhoods may be impacted by this project.

Most residents we spoke with were aware of drug use in Somerville but stated that it was not visible in their neighborhood in the same way it is in other communities (like Boston or Cambridge). Over half of those we spoke with had a basic understanding of harm reduction and the concept of SCSs. Despite this basis of understanding, many asked about the specifics of how a site operates.

See Appendix for more details on the content of these conversations (major themes, details of note, and recommendations).

Community Forum

The Somerville SCS Advisory Group scheduled topic-specific open work group sessions, one of these was a series dedicated to planning the community forum. This was facilitated by Fenway staff and the working group met weekly from April 15th to June 3rd. These meetings were open to all the members of the Somerville SCS Advisory Group but were not mandatory.

The working group had hoped to plan an in-person forum in addition to a virtual one, but COVID safety restrictions led us to focus on just a virtual forum. Speakers were recruited through the networks of Advisory Group members and the community members we talked to in our individual interviews, with a specific focus on Black, Indigenous, and other People of Color (BIPOC) voices from Somerville.

Below are the speakers and panelists selected by the Advisory Group members who attended and participated in the open work group sessions for community forum planning:

Moderator:

- Carl Sciortino, Executive Vice President of External Relations, Fenway Health

Speakers:

- Katjana Ballantyne, Mayor, City of Somerville
- Matthew Mitchell, Prevention Services Manager, City of Somerville

- Dr. Miriam Harris, Assistant Professor of Medicine at Boston University School of Medicine and an addiction expert at Boston Medical Center
- Sam Rivera, Executive Director, OnPoint New York City

Panelists:

- Daniel Hogan-Rigg, MPH, LICSW, In Recovery, Social Worker focused on Substance Use and Health
- Tj Thompson, Peer Research Associate, Harm Reductionist
- Stephen Kelley, Peer Research Associate, Harm Reductionist
- Stephen Murray, BBA, NRP, Community Implementation Specialist, Boston Medical Center

The open working group made the decision to hold this event in a webinar format. This required attendees to register beforehand, and allowed attendees to submit questions and comments ahead of time. Only the speakers and panelists were able to talk, but the live Q&A function allowed participants to submit comments and questions during the event.

The open work group members debated and carefully considered the webinar format. Members repeatedly acknowledged that the goal of the event was genuine community engagement, not just an "echo chamber of support." We wanted to hear the sincere concerns of community members, give them the opportunity to voice those concerns in a public forum, and offer solutions when possible. Ultimately, the webinar format was chosen to ensure a respectful environment for this conversation, free from stigmatizing language.

Outreach for the event was done through the communications departments of Fenway Health, the City of Somerville, and the networks of all the Advisory Group members. 200 people registered for the event; Of those 200, 167 were Somerville residents. 93 of those residents were supportive (55%), 31 were curious (18%), and 22 were opposed (13%).

The agenda and topics for the forum were planned in the open working group sessions, with intentional emphasis on building off of the forums held in the summer of 2021 and including all

community voices regardless of knowledge base and level of support. The recording of the event can be found on the City of Somerville website - www.somervillema.gov/scs.

A summary of this forum including the agenda, major themes, questions that were not covered during the event, with their corresponding answers, and the material that was sent to all registrants as a follow up, can be found in the Appendix.

Engagement of People Who Use Drugs

One area that required targeted focus was the perspectives of people who use drugs (PWUD). The 2021 Needs Assessment and Feasibility Study included the results of surveys and focus groups previously conducted to assess the needs, priorities, and barriers facing people who are at risk of overdose and for whom an SCS could be a life-saving intervention. The COVID-19 pandemic has had a chilling effect on the delivery of harm reduction services to this community, and while life changed for all residents, this population was particularly susceptible to worse outcomes.

We wanted to assess whether and how people currently using drugs, including people whose daily life includes living on the streets of Somerville right now, were impacted by any changes since the last surveys and focus groups. Two individuals who have lived experience as well as deep expertise in working within this community were brought onto this project team to focus on engagement of PWUD. Two focus groups were conducted, one in Somerville in partnership with the Somerville Homeless Coalition, and the other in Harvard Square.

Participants were compensated with $50.00 Clincards. This method of payment was used specifically because these cards can be used to withdraw actual cash which is crucial when connecting with people who use drugs. Participants gave feedback on this point; it made a real difference in the ability to conduct effective outreach. This is a critical recommendation for any organization who moves forward with this project.

Tour and Meeting with OnPoint New York City's SCS Program

This project also aimed to begin to learn from and establish a relationship with another operator of an SCS in the United States. OnPoint NYC opened their doors and shared their expertise with us on their experiences both in operating an SCS and in engaging the community around their two locations. In the first six months of operations, OnPoint reported reversing 314 overdoses and safely disposed of 472,670 syringes that may have otherwise ended up on the nearby streets and playgrounds. We visited and met with Executive Director Sam Rivera and Director of Operations Brittney Vargas-Estre.

Our visit aimed to learn about OnPoint in two areas: 1) how their services are being run, including from the perspective of clients, staff, and community, and 2) how their site is physically set up and operating. Our team toured one of their two sites, a multi-story building in Harlem that has been operating as a harm reduction program for years and in November 2021 was officially established as the first SCS known to be operating in the United States. Their facility and operations can be viewed in a video "Inside America's First Drug Consumption Site" published in March 2022, available online at https://www.youtube.com/watch?v=h4nMm8dJH8g.

Our discussions with their staff covered a range of topics, including how their program has been received by the neighborhood, how they staff and fund the site, what their policies and procedures are on everything from client enrollment to clinical care to consumption monitoring and overdose intervention. It was clear by the end of our conversations that we could learn an immense amount from ongoing dialogue with them and other SCS operators. We also learned that any program's policies and operations are largely dependent on their particular physical space and local context. Learning from one program does not mean cutting and pasting their practices but taking them into account to ensure a new SCS is both using best practices while adapting to local needs and barriers.

Location

Introduction

1. Accessibility: the SCS must be accessible. This includes being American Disability Act (ADA) compliant, within walking distance of public transit, and being consistent and reliable in its service delivery operations.
2. Safety: the SCS must be safe for all, both users and neighbors.
3. Sensitive abutters: the SCS must be cognizant of any neighboring uses that may be important to take into account both for neighbors and for SCS clients. These include uses frequented by children, such as schools, playgrounds and libraries as well as public safety buildings.
4. Legality: the operation of a SCS also requires careful navigation of the legal issues surrounding the location of this service. The federal Controlled Substances Act has been interpreted differently in different courts, and the Trump administration's Department of Justice threatened legal action, while the Biden administration's Department of

Justice appears to be taking a more lenient approach, recognizing these programs as legitimate.

5. Visibility: the SCS must be carefully constructed to protect the privacy of the users while also not attracting unwanted attention. We recommend a nondescript facade that blends in with the surrounding area.
6. Community buy-in: the operation of a SCS must be rested upon active and engaging community buy-in to ensure its longevity. Therefore, any current uses of potential sites must be considered as key factors in deciding where to locate the site.
7. Recommended locations: the 2021 report identified Davis Square and East Somerville as recommended neighborhoods of a potential site. The reasoning is based on data including where overdose calls and discarded needles are spatially distributed, access to transportation, and community need.

City-owned buildings

As of this report, the City of Somerville owns 33 brick-and-mortar buildings around the City. We excluded schools and libraries from this analysis from the outset. In a 5-block radius of Davis Square and East Somerville neighborhoods, excluding schools and libraries, there are only two City-owned buildings, both in Davis Square: the Traffic and Parking Building (133 Holland St.) and 45 College Ave. With no options immediately within the East Somerville study area we also considered City-owned buildings around Union Square. Excluding schools and libraries, Union Square adds two additional properties reviewed: 19 Walnut St. and 90-92 Union Square.


Medford/Tufts
Traffic and Parking Building
West Branch Library
45 College Avenue
Davis
Alewife
Ball Sq.
Magoun Sq.
Wellington
Assembly
Porter
Gilman Sq.
East Branch Library
Sullivan Square
Capuano School
Recreation Building
East Somerville
SCAT Building
Argenziano Elementary
Union Sq.
Harvard
Community College
Lechmere
0 0.2 0.4 Miles
N


Tufts Day Care Center
133 Holland St.
HOLLAND ST
West Branch Library
45 College Ave.
MORRISON AVE
COLLEGE AVE
Community Baptist Church
Davis
HIGHLAND AVE


19 WALNUT ST.
WALNUT ST
BOW ST.
SOMERVILLE AVE
Argenziano Elementary
WASHINGTON ST.
90-92 UNION SQAURE
SOMERVILLE AVE
St. Joseph Catholic Church
PROSPECT ST.
Union Sq.

Building 1: 45 College Ave.

This building, located about three blocks northeast of the Davis MBTA station, used to be a church that is now vacant due to significant structural issues. The City already identified that there are $2.3 million worth of repair of equipment failure and code violations that must be fixed before it can be used. There is an additional $4.5 million in repairs required for items in poor condition, such as ADA accessibility issues, structural and foundational issues, utilities, roofing and electrical issues.

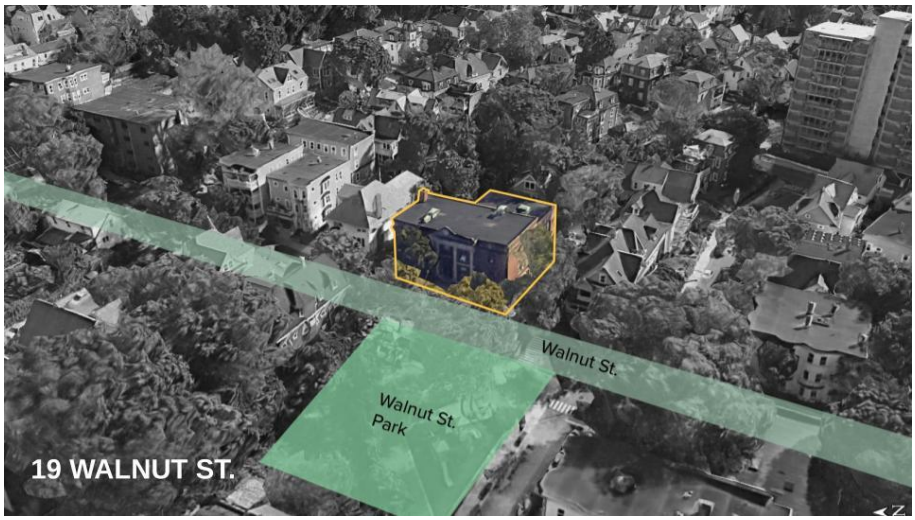
The City has identified this site in the 2021 Community Services and Activities Master Plan for future use that includes rebuilding to include space dedicated for Council on Aging and other administrative spaces. The zoning allows for four stories to be built as-of-right and thus can accommodate other uses.

In order for an SCS to be placed in this location, there will need to be long-term planning to accommodate the various uses already planned for this location as well as the significant capital needed to redevelop the building.

Building 2: 133 Holland St.

This building is located further down Holland Street northwest of the Davis MBTA station. It is currently being used by the City of Somerville Department of Parking and is planned to continue housing the department. The building is already at capacity and thus cannot accommodate any other uses. Therefore, if an SCS were to be located in this building, significant planning will need to happen to shift locations for the Department of Parking, which will be difficult to do as the City is already pressed for space for administration.

Building 3: 19 Walnut St.



This building is located a few blocks north of Union Square. The Community Services and Activities Master Plan (2021) recommends that a community process define the desired use of the building and that the City find a development partner to gut renovate the building. The building is not ADA-compliant, needs $3.5 million worth of repair in urgent issues, such as equipment

failure and code violations and an additional $4 million worth of repair of items in poor condition, such as the exterior brickwork, windows and doors, interior finishes and bathroom renovations.

Building 4: 90-92 Union Square

This building is located in the heart of Union Square and also known colloquially as the SCAT TV building. This building hosts two tenants and requires at least $2.3 million worth of external repairs, including the exterior envelope, the roof and the clocktower, plus over $4 million of interior code and ADA compliance updates. In 2021, the City released a Request for Proposal seeking to release the building with the requirement that the tenants would fund the building renovation.

Other brick-and-mortar options

Other than the City-owned buildings, there are a few other brick-and-mortar options to consider, including churches and other places of worship, other buildings, such as those owned by the Commonwealth of Massachusetts, the MBTA, or privately-owned buildings that the City could then acquire or lease. All of these options would require a considerable amount of time, coordination, and capital as well as a clear legal landscape that allows for the operation of an SCS with less risk.

The Advisory Group recently identified a privately-owned vacant building in Davis Square that was available for sale. It is located on Holland Street, a few blocks north of the Davis Square MBTA station, and was offered for sale for $1.1 million. In order to acquire the building for the

SCS, the City must follow required public procurement laws, which often are time consuming and can prevent the City from acting as nimble as private parties. In this heated real estate market, the City might lose out on fleeting opportunities.

Modular units

Outside of brick-and-mortar buildings, another option the City may consider is the use of modular units to house an SCS. The City already has experience using modular units for their operations, most recently with the Somerville High School renovation project. As the building was being renovated, classrooms were set up using modular units, complete with plumbing, heating/cooling and ventilation.

Modular units have the advantage that they can be set up relatively quickly in an accessible location. Therefore, they can provide an adequate short to medium-term solution to the overdose crisis in the City. As the crisis continues to claim more and more lives, it is crucial to establish life-saving solutions as soon as possible, while still planning for a longer-term solution.

Parking lots

For a modular unit setup, a City-owned parking lot has been identified as an appropriate location to house the modular unit. This would still be a considerable investment from the City, as any use of City-owned parking spaces will impact parking revenue and capacity. There are 11 different parking lots owned by the City. We examined the lots located in Davis Square, East Somerville, and Union Square. One of these lots is located right next to a school, which does not meet the requirements of housing an SCS. Below are the tradeoffs and considerations of the remaining parking lots that were assessed.

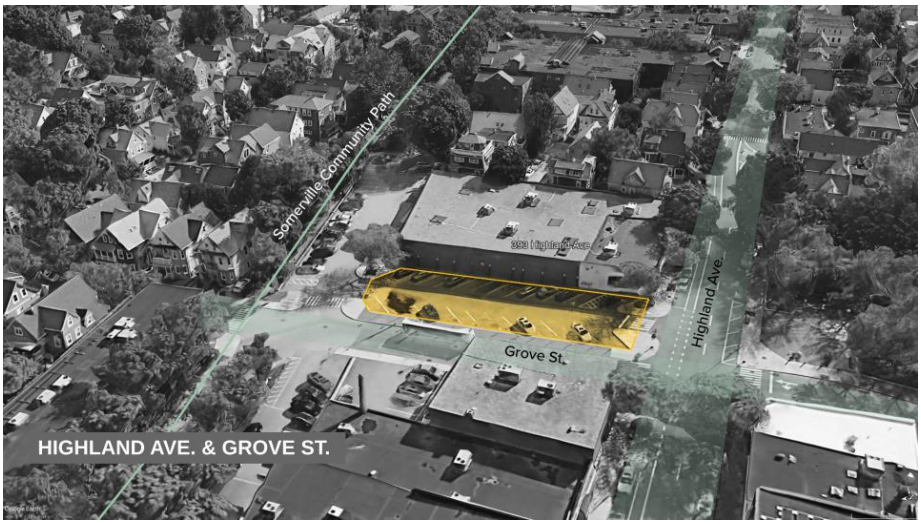
Lot 1: Holland St. and Buena Vista Rd.

This parking lot was not viable and is not feasible for consideration due to structural limitations precluding the placement of a modular unit on the upper surface.

Lot 2: Day St. and Herbert St.

This parking lot is fairly big and spacious, with a total of around 60 parking spots. It is located south of the Davis MBTA station and is a block behind the main square. Currently it hosts the Farmers Market every Wednesdays in the summer months, using half of the lot. In the community engagement process for the Davis Square Neighborhood Plan this parking lot has been identified as a potential year-round indoor famers market with start up space in the upper stories. Any changes in use may require additional community process.

Lot 3: Highland Ave. and Grove St.



This parking lot is medium-sized, with about 20 spaces. Sandwiched between the Somerville Community Path and commercial lots along Highland Ave., there is a sizeable amount of foot traffic around the area. It is also located across the street from Kenney Park. In the Davis Square Neighborhood Plan community engagement process and in current discussions with the adjacent property owner, this parking lot is potentially planned for supporting commercial development. Any changes in use may require additional community process.

Lot 4: 9 Grove St.

This is a medium-sized lot, with about 20 spots. It's located directly adjacent to Kenney Park.

Lot 5: Broadway and Lombardi St.

This parking lot is located in East Somerville, next to I-93 where the highway meets Broadway. It is a small lot, with less than 10 parking spots and is also used by Zipcar and BlueBikes.

Lot 6: Somerville Ave. and Rossmore St.

This parking lot is located southeast of Union Square, down a few blocks along Somerville Ave. It is currently an undeveloped lot with plans to be turned into a park. It is unlikely a SCS can be located here.

Program Physical Layout

This section outlines potential layout options for an SCS in Somerville. Depending on the final site and location, the actual floor plan and layout will need to be adapted. Therefore, the following is only meant to be a diagram of a possible layout that includes necessary considerations.

Figure 1.0 depicts a smaller potential floorplan. The first room when entering the site will function as both a check-in and check-out area. Clients will be greeted in this space, connect

Figure 1: 18' x 25' 6" (3 parking spots)

with peers and staff, receive referrals to other resources and relax and be monitored post-consumption. There will also be a private meeting room available for crisis management and other private conversations. Doors will separate the check-in/check-out room from the main consumption room, thus providing privacy and security for clients. The main consumption room will have a sink for handwashing, stalls for consumption, an ADA accessible bathroom, a smoke room and a clinical room. There will also be emergency exits in the main consumption room and the clinic room for easy transport of clients.

In a more spacious scenario, the potential floorplan can look like Figure 2. below. In this case, the check-in and check-out spaces will be separated out, with a separate entrance and exit. It will also include more meeting rooms for private conversations.

Figure 2: 18' x 34' (4 parking spots)

Neighborhood Outreach

Outreach and engagement of a variety of stakeholders has been a hallmark of the planning process in Somerville to date, and will need to continue prior to and beyond the opening of an SCS. The work of doing outreach to the community is not done. Residents, businesses, and other local stakeholders are still learning about and informing this process. The success of a program, once open, will also depend on maintaining positive relations and open communication with the surrounding neighborhood.

The 2021 Needs Assessment and Feasibility Study included community surveys, focus groups of people who use drugs, and community forum feedback. This new 2022 report is the result of individual outreach interviews and meetings, focus groups of people who use drugs, and community forum feedback. During each successive phase of engagement, more stakeholders

have learned about SCSs and expanded their understanding of the need for an SCS based on current patterns of drug use and overdoses in Somerville. The City of Somerville's efforts have been and should remain deeply informed by feedback and questions raised from a variety of perspectives.

We also learned from the experience of OnPoint NYC that partnership with the community will be key even once a program is open and running. They view community members, whatever their perspective on supervised consumption, as partners. Upon opening, they brought the community in, conducted tours, and continued to meet with residents. This included groups that were initially opposed.

Somerville's SCS program should have both the responsibility and the adequate resources to continually engage the community. We heard through many of our interviews an openness to an SCS in the community, but naming of specific fears of how things would be handled if things didn't go as planned or if the neighborhood was negatively impacted in significant ways. The community needs and deserves to know it has a mechanism to connect and convey ongoing feedback once the program is operational.

It is our recommendation that a staff person of the SCS be identified publicly as a liaison, likely the Program Director. This person should be accessible to residents, businesses, and other service providers to help answer questions, establish and maintain important partnerships, attend or organize community meetings, and respond to any concerns or issues that arise. They should proactively inform the community on progress, setbacks, or any significant changes in the program.

Regardless of who ultimately runs the SCS, they should also not be on their own in conducting neighborhood outreach. The City of Somerville should continue the approach it has taken to date. The City should continue to clearly identify a point person to maintain open communication with the program and the community to manage questions or concerns as they arise. And just as we have reached out and received support, guidance, and technical assistance from other program operators, it is likely other communities will seek Somerville's guidance

and want to learn from this experience. The City should clearly identify who will accommodate those inquiries and partner with the program to ensure such engagements are done with the best interest of the clients being served in mind.

When the SCS opens, the community should be welcomed in to see the site, tour the facility, and meet the staff. This can be done during hours when clients are not being served, although clients may wish to participate and should be supported and empowered to make that decision for themselves. Demystifying what the program is, how it works, and who is involved will help lay a foundation for ongoing communication. We also learned the value of having community members, City officials, and first responders being aware of how to access the program, as they can be a valuable resource to connect people who use drugs to the program.

The OnPoint NYC program informed us that they provide local police with referral cards. The police partner with the program by helping connect people they encounter directly with the program. Their program staff also attend meetings with the NYC Police Department, specifically with the precinct officers who are working the streets around the program, to maintain open communication. Special attention needs to be given by the City of Somerville to build a partnership between the SCS and first responders. Police, Fire, and EMTs working in Somerville should be invited to meet together with the SCS, establish an ongoing communication plan, and support each other as each of these entities works to save the lives of those at risk of overdose deaths.

Comprehensive Service Offerings

We recommend that any SCS site should include a full range of wrap around services. A SCS's central task is to prevent fatal overdoses by providing a hygienic environment for safe consumption of pre-obtained drugs under supervision of staff trained to intervene and maintain the life of a client in the event of an overdose. At a minimum, any SCS must provide the space and staff for fatal overdose prevention. There is also an opportunity to provide clients

with supportive services around their health and wellbeing, particularly concerning housing, economic, and legal barriers.

The 2021 Needs Assessment and Feasibility Study identified a range of wrap-around services, including other medical and social services such as access to contraception, HIV/STI/HCV testing and treatment, housing services, wound care, food, substance use disorder treatment, medication assisted therapies, and testing of drugs. This approach is consistent with the program design of other SCSs around the world, as well as many harm reduction programs in the United States. Programs offering comprehensive drug user health services have the ability to engage, build trust, provide basic needs, and connect clients to clinical and social services.

The harm reduction model, of which SCSs are but one example, are all aimed at improving the health and well-being of people who use drugs. SCSs are not dissimilar to other existing comprehensive drug user health programs, such as syringe service drop-in centers, with one obvious exception: SCS staff are allowed to be present with a client in their most vulnerable moment of consuming drugs that, when consumed alone, may in some cases result in an overdose and death.

This phase of planning examined, and affirmed, the importance of establishing a comprehensive program. One approach explored is the Integrated Services Framework (ISF)[5]. The current systemic approach to engaging people who use drugs often occurs through emergency departments and the criminal justice system. These are financially costly ways to manage the opioid epidemic, and not effectively reducing its impacts. The ISFs are designed to prevent the need for those systems to be involved, and provide a range of services needed by people who use drugs.

[5] Wahbi, Rafik and Johnson, Sterling and Beletsky, Leo, From Crisis Response to Harm Prevention: The Role of Integrated Service Facilities (September 3, 2020). Northeastern University School of Law Research Paper No. 388-2020, The Justice Collaborative, Data for Progress, Health in Justice Action Lab, Available at SSRN: https://ssrn.com/abstract=3685890

The experience of our group in touring the SCS in NYC affirmed the importance of a comprehensive approach. Their facility offers on-site access to medical care, social services, food, laundry, showers, holistic wellness including massage and acupuncture, and a community space. Their facility serves as a community center for people who use drugs, welcoming them in without stigma or shame and helping meet some of their basic needs. Clients who experience trauma in other clinical or public settings are greeted with empathy, support, empowerment, and a level of kindness that clients might not see in any other part of their lives.

One limitation of this comparison is that the OnPoint NYC program has the benefit of a multi-story building with room for multiple on-site services. The program in Somerville will not have the benefit of that much space, but the Somerville SCS should certainly emulate the client-centered approach and comprehensive service model to the greatest extent feasible. Somerville will need to be creative in exploring ways to expand access to services even with those limitations. With a smaller footprint, the result will be a limit on the number of staff and clients who can be in the space at any one time. This means the City and the SCS, in direct consultation with clients served, will need to prioritize whether some of the integrated services can be co-located or offered by an effective referral system with partner agencies.

Partnerships will become important regardless of what services are offered. On-site services could be provided by SCS employed staff, but can also be offered on-site through establishing certain hours where other partner agencies can be scheduled to meet with clients and provide additional support for specific health or social needs. The SCS will need to have clearly streamlined pathways to assist clients in accessing other services not offered on-site, which might include establishment of Memoranda of Understandings (MOUs) with partner agencies that outline the referral arrangement, expectations, and procedures. These are commonly utilized by many service providers already in many contexts.

There are already several agencies involved in Somerville's planning process that will likely have important roles to play, whether through on-site presence or by referral agreements. The Somerville Homeless Coalition, Fenway Health and its ACCESS Drug User Health Program, Column Health, the Material Aid and Advocacy Program, Cambridge Health Alliance, and the

Somerville Police Department's Community Outreach, Help & Recovery unit have already established connections to this project, and will likely be important partners. There are an array of other agencies serving Somerville residents health and social needs that can be explored as well.

The program should also consider ways in which it serves individuals from diverse backgrounds. It will be important to engage clients on what would best suit their needs, but there are models for how to create a welcoming environment for particularly stigmatized and underserved communities. The program should explore the utility and feasibility of creating designated hours for particular populations, utilizing outreach materials in multiple languages with diverse individuals depicted in images, partnering with other agencies that serve unique populations both for outreach and additional programming, service provision, technical assistance, and training.

Client / People Who Use Drugs (PWUD) Engagement

Supervised consumption is one tool in the harm reduction approach. The National Harm Reduction Coalition lays out a set of foundational principles, which can be found in the Appendix, central to harm reduction, but defines this approach succinctly:

> Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Somerville's SCS should be a place of innovation and learning, and the clients themselves are in the best position to inform the program and the City. Respecting the experiences of people who use drugs, and having the program be accountable to their lived experience, will ensure the program effectively meets their needs and improves the health and well-being of the clients and the community. Program staff should engage clients in assessing what is working well, or where the program needs to be refined. This might include a formal client advisory board, focus groups, evaluation surveys, and other feedback mechanisms. Empowering clients in the

program design, services needed, hours of operation, and policies and procedures of the program will help ensure buy-in and utilization of the SCS by those it is aimed at serving.

People who use drugs are also one of the most important sources of learning about how things are changing in the streets and in their personal networks. Harm reduction programs often learn first from clients whether there are changes affecting their health, such as changes in drug supply impacting overdose patterns, sweeps of homeless camps that impact outreach efforts, and other environmental factors that impact the program and inform staff of adjustments that maybe necessary. Effective engagement of people who use drugs starts with a respect for their perspective and experience, and outreach and engagement strategies informed by people served by the program will enhance the program's impacts.

The importance of engagement of people who use drugs was reinforced in one of our recent focus groups conducted in June 2022. The focus group was conducted in Somerville, with participants who were homeless and using drugs in and around the Davis Square area. The most surprising finding was that the participants largely were unaware of efforts to open an SCS, and many were unfamiliar with the concept or that such a site was even a possibility.

The focus group voiced strong support for the concept, as we've seen in previous surveys and focus groups, but a key takeaway is that even in establishing an SCS the program will need to ensure potential clients know of its existence. This can be done through street outreach, partnering with other agencies and first responders, and facilitating word-of-mouth communication among the community of people who use drugs. It will also require outreach that is specifically tailored to reaching clients of diverse backgrounds, including women, BIPOC, and LGBTQ individuals and non-English speakers who will need additional trust building to ensure they have access.

We have confidence that people who would benefit from the SCS will utilize it. The support and need are both there. It will still require proactive education, outreach rooted in trusting relationships, and ongoing efforts to connect the services with those who would benefit.

Staffing

Different SCS models vary in both staffing and setting, some fully embedded in clinical spaces with licensed staff, others in community-based settings staffed primarily by varying forms of non-licensed but well-trained peers and community health workers. The 2021 Needs Assessment and Feasibility Report clearly documented the desire of people who use drugs to have access to an array of services, some of which require licensed clinicians. There was also a clear desire to have non-clinical staff, which could include a combination of health navigators, peers, community health workers, or case managers. These types of culturally competent staff are called by many names and serve different functions at existing service agencies and health centers, so for the purpose of this report we'll refer to them as Client Services Specialists. Clients who have experienced stigma and mistreatment in other clinical settings benefit from knowing there are staff who can relate to their experiences. We also learned from our focus groups that engaging peers was desirable because it may also provide professional development opportunities for people who often find it difficult to find work. When employment is paired with adequate training, people who use drugs can develop the stability and skills that may open up additional career options. More details on this feedback from the focus groups regarding the opportunity for training and professional development can be found in the Appendix.

The Somerville SCS should include an Interdisciplinary staffing model, including access to health professionals as well as non-clinical staff. Our budget modeling, discussed in detail below, outlines the recommendation for having on site, during all client-serving hours, at least one RN who can support clients with their medical needs and help triage their care to other providers as appropriate. All client-serving hours should also have two Client Services Specialists, who can serve multiple roles including check-in and registration, overseeing the consumption space and post-consumption space, and navigating clients to an array of services available to them both on site and by referral.

One core service we identified as important to offer is access to low-threshold behavioral health clinicians, such as a licensed clinical social worker. Similar models exist at Fenway Health and other health centers that enable clients who have erratic lives and schedules to seek support without the barrier of making appointments. This client-centered approach is another way for people who use drugs to build trusting relationships with health professionals. This service might not be necessary at all client-serving hours, so our budget scenarios assume a single full-time social worker who would be accessible on a fixed regular full-time schedule.

The program will require oversight and management as a whole, as well as onsite leadership during all hours of operation that are open to clients. We are recommending a staffing model that includes a single full-time Program Director, responsible for leading the program's operations, management, and evaluation, and serving as a point of contact for the community and the city. This individual will require support from Site Managers, who can be present during client hours when the Project Director is not working or available.

There will also need to be a person tasked with maintaining the site's safety and security. Working with people who use drugs requires recognition that they often have had traumatic experiences with people in uniforms, whether that be first responders, clinical staff, or the judicial system. Maintaining the safety of the program staff and clients requires hiring of a Safety Specialist. This should not be a traditional uniformed security guard, but someone culturally competent in working with this community. They will need to be trained and competent in trauma informed response techniques and de-escalation best practices and who understand the sensitivities involved in building trust with clients who typically experience stigma in most other contexts.

If there are sufficient resources and physical space, possibly in a subsequent phase of operations, the SCS may also want to add additional service capacity. This could involve the contracting or hiring of a medical provider, someone with at least a Nurse Practitioner or Physician Assistant licensure, to provide limited hours of on-site basic clinical care. Treating wounds, prescribing antibiotics for various skin infections and STIs, evaluating and prescribing medication to cure Hepatitis C, HIV infection treatment and prevention regimens, and

medication assisted therapies, are all services that are needed by this community and could be provided. In an expanded service model, there may be a need to add additional non-clinical staff who have particular expertise in meeting the needs of people who use drugs, such as staff who specialize in housing assistance, more health navigation capacity, and other social services.

There are important considerations in hiring a workforce to staff the SCS, both in competencies and in the diversity of staff. Core competencies vary by roles outlined above, but it is insufficient to hire staff based on technical skills. Public health and other programs that are aiming to reach underserved or otherwise marginalized communities should aim to hire employees that are of and from the communities being served. This should include people who have lived experience dealing with substance use and addiction, a workforce that is racially and ethnically diverse, and experience with LGBTQ communities will all be important to ensuring the program has individuals working there with important perspectives and abilities to connect to clients of diverse backgrounds. Linguistic capacity of the workforce will also be important to prioritize, with Somerville having a rich diversity of immigrant experiences and languages spoken. The program will also benefit from having access to a language interpretation line, commonly used by community health centers and hospitals to support seeing clients in languages other than those spoken by staff.

While the legal landscape evolves, special consideration will need to be given to providing liability protection to not just clients and the program operator, but also to the staff. Licensed clinical staff may be at risk of or concerned they are at risk of losing their license if the state decides to take a punitive approach to dissuade programs such as this from opening. There is no indication that the state would take such actions, and SCSs have begun to receive more mainstream support in the medical and recovery fields, such as support from the Massachusetts Medical Society and the Massachusetts Association of Addiction & Recovery.

While the legal context shifts, the City and program should be transparent to prospective employees what the knowns and unknowns are about risks they may be taking, what protection the City and program can or cannot offer, and allow individuals to join the workforce with a full understanding of the current landscape. It will be essential for the City to advocate

for the passage of legislation pending before the State House and State Senate that would formalize the legal framework for opening an SCS. That legislation includes provisions specifically addressing licensure and liability of the workforce.

Staff Training

Staff will need a set of onboarding and ongoing training in order to effectively serve people who use drugs and people who are homeless or unstably housed. The training should be specific and unique to working in an SCS, and training should focus on the diverse populations being served in the program. Working with people who use drugs, as well as people who are homeless or unstably housed, is not new to the Boston area. This should be a prerequisite to the selection of the agency running the SCS. Standard training exists to support staff in harm reduction principles and best practices, basic health and safety, trauma informed care, de-escalation, cultural humility, and recognizing and responding to overdoses. In addition, trainings and best practices already exist, and are likely being utilized by area service providers already, in how to effectively engage and serve diverse populations.

Somerville has already established a relationship with OnPoint NYC, and they or other operators of SCSs in other jurisdictions should be engaged and hired to provide additional training and technical assistance. The British Columbia “SCS Operational Guidance” publication also outlines specific clinical and non-clinical considerations for staff training that should be reviewed by the Somerville SCS. One specific example of a unique SCS skillset observed in our tour of OnPoint was how staff intervene when an individual overdoses. Responding to an overdose in an SCS is different than responding to an overdose in a hospital, syringe exchange, or on the streets. In those settings, the standard practice is the administration of nasal naloxone spray. It is effective at saving a life by blocking the effect of opiates and restoring breathing. In OnPoint NYC, they use oxygen as the primary intervention, and use a lower dose of intramuscular naloxone.

There is a skill and competency in already established SCSs that should be learned from, and the Somerville program would benefit from in partnering with other programs already in existence. There will be a sense of urgency to open the doors as quickly as possible, but that will need to be balanced by ensuring staff are properly hired, trained, and equipped to effectively operate and save lives.

Safety

Safety of the program participants, staff, and the surrounding community is an important consideration. SCSs are designed to work with populations needing low-threshold services in a harm reduction framework that respects the rights of people who use drugs, and ensuring the safety of the space is not in conflict with those frameworks if implemented properly. Working with people who use drugs requires an understanding of how drug use affects human behavior, and establishment of protocols that account for the unique experiences of operating an SCS.

As addressed in the Staffing section, there will need to be training for all staff on how to operate the program, including responding to potential threats or behaviors that could put individuals in harm's way. There will also need to be safety personnel on site during all operational hours where clients are being served. This is an experience and skillset that exists in other public health and harm reduction programs, and all public-facing facilities such as health centers and hospitals, and experience with other SCSs operating around the world demonstrate these can be run safely with the right procedures, training, and personnel in place.

The British Columbia Supervised Consumption Services Operational Guidance addresses how to accomplish this:

> Although the vast majority of [People Who Use Drugs (PWUD] pose no threat to others, mental health issues, stimulant use, withdrawal, and chaotic situations may occasionally lead to uncontrolled behaviours in some clients. Such behaviours may place staff and other clients at risk. Further, overdose can occur anywhere in a SCS. Therefore, proper visibility and monitoring of clients 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.

Their guidance includes best practices and sample policies on conflict management, non-violent crisis management, management of escalating aggressive behaviors, refusal of services, and establishment of a code of conduct or "house rules." The Somerville SCS should be open only once these protocols are in place and staff are effectively trained.

Hours

The 2021 Needs Assessment and Feasibility Study outlined a preference for a 24-hour per day SCS, while acknowledging that may be challenging at least initially. There were two other scenarios of hours of operation suggested for consideration, including a split shift of 8am – 5pm and 8pm – 1am scenario, or at a minimum 8am-6pm. Each scenario was envisioned as seven days. There are two barriers we identified in achieving a 24-hour, 7-day per week program.

First, the hours of operation will of course be a main driver of cost of operating an SCS. This is outlined in detail in the Budget section below, but operating and staffing this model requires hiring additional personnel for consistent coverage, which adds to the budget in a significant way. Second, whatever agency is selected to operate Somerville's SCS will need time to build its program capacity. Staff will need to be hired, in a very tight labor market. These two factors lead us to the conclusion that a 24-hour operation will not be feasible in the initial phase of operations, but should be evaluated for feasibility and need for future possible program improvements. This is consistent with the experience of OnPoint NYC, which has plans to move to a 24-hour operation but has taken the time to get established and secure the funds necessary for expanded hours.

The hours of operation are a factor we would recommend allowing the program operator flexibility to determine and adjust over time during the initial phase of operations. The SCS program will need to evaluate staff capacity and client needs and adjust based on initial client

feedback, experience, and staffing levels which may need time to build up the capacity. A 7-day per week program is recommended to ensure daily access, and should be an expectation from the City of the SCS program. The hours of operation for each day of the week may need to vary, such as longer or shorter days on weekdays or weekends, and this will need further evaluation based on real-time experience once operational.

Policies and Procedures Development

There will be time needed for the agency selected to operate an SCS to develop policy and procedure documents, and to train staff once hired in their implementation.

A number of policies were identified in the 2021 Needs Assessment and Feasibility Study as important to the community, the Advisory Group, and to people who use drugs that were engaged. These included:

- Establishing a protocol with the Somerville Police Department, such as a buffer zone and designating a program liaison
- Ensuring anonymity of clients, utilizing a unique user ID system or client alias
- Safety protocols
- Utilizing community voices in the selection of the service provider to run the SCS
- Serving any individual regardless of residency or immigration status
- Post consumption monitoring time

We evaluated whether it was feasible in this phase to begin writing sample policies, but concluded that it was not yet advisable for two reasons. First, the agency selected to operate the SCS will need to engage the services of an existing SCS for a range of training and technical assistance. We learned in our visit with OnPoint NYC that others have inquired about getting copies of policies, and they identified the risk of trying to cut and paste another program's policies without a true understanding of what they mean, how to implement them effectively, or giving critical consideration of how the local context may require changes. We agree with that concern. Policies developed for a free-standing small community-based organization may

differ significantly from policies developed for a program that is being created as a part of a larger institution, which may have its own institutional resources, policies, or considerations to take into account.

As referenced above, in addition to in-person technical assistance and training, the program selected to operate Somerville's SCS should look to published best practices such as the British Columbia Supervised Consumption Services Operational Guidance report. This should be used as a tool, but will require careful consideration of how each component is applicable to Somerville and to the agency operating the SCS. We would urge the City to set realistic timetables between the time an agency is selected and the time the doors are expected to open for this work to occur, which we believe would be a minimum of three to six months' time.

We would additionally advise the program to work expeditiously, but not open until they are confident that they can safely operate, and the City should consider establishing a verification process requirement before the doors open. Traditional health centers and clinics are required to be licensed, and syringe exchange programs work under the guidance of the Massachusetts Department of Public Health in most instances, so they come with some standards and expectations meant to protect the safety and integrity of their programs, staff, and clients. With Somerville poised to open the state's first SCS, the City will need to be an active partner with the program to ensure it is ready to begin seeing clients.

Program Evaluation

There are two important reasons for the Somerville SCS to collect and report relevant data. First, program evaluation is an effective and essential tool to any public health program to ensure the goals are being achieved and to make adjustments as needed. Second, there is a need for accountability, as the City and the community as a whole deserve to know that their investment in the program is achieving its desired outcomes and monitoring the impacts on the community.

There will be two different primary sources of data available to evaluate the success and impacts of Somerville's SCS. First, the program itself will be able to collect its own data, and second, the City already has access to extensive data relevant to both program evaluation and addressing community concerns.

The City should determine what information it would require of the program for its own evaluation purposes, but the program itself should determine if other information would be useful to collect in order to ensure it is effectively achieving its goals and that it is meeting the needs of its clients. OnPoint NYC utilized a few key forms to collect relevant data: 1) their new client registration form, 2) the form used for a client's first visit to the SCS each day, and 3) a shorter form used if a client returns for subsequent visits in the same day. They include questions that will help inform the program on who they are serving, as well as information that will be useful for public reporting. These are a useful starting place to evaluate what is important to Somerville and to its SCS.

For the program, data collection is essential, but can also be a barrier to client engagement if not implemented properly. Clients need to know they can access services on a regular basis without having to fill out extensive and invasive questionnaires. Clients should be engaged not just through the collection of data, but they should be a part of the ongoing evaluation process. We recommend that the program and the City share data and findings with clients, and seek their perspective on how to interpret the results. This can be a beneficial practice that aids the program and the City's understanding of what is being learned and what if anything should be changed.

Sharing data with the community will also assist with building trust with neighbors. This requires an openness on the part of the program operator and City to learn from initial experiences, and it requires community to be seen and to act as a partner. Understanding how the program is affecting overdose rates, the public discarding of syringes, calls to 311, and overdose related 911 calls are a few examples of the kind of data the City already has access to, and utilizing that broader set of information will help inform the City on how well the program

is establishing itself in the City and improving the well-being of both the clients and the community as a whole.

Budget

In order to assess what it will cost to operate an SCS and develop a budget, we had to make some assumptions based on some key variables. The main determinants of cost are the staff needed to effectively run the SCS and the hours of operation during which staff coverage will be required. Space will be a large determinant of the programmatic model; a larger physical footprint would allow for greater number of staff and clients to be present on site, and a smaller physical footprint will limit the number of individuals who can be accommodated.

We chose to look at two programmatic scenarios: 1) a limited core services model, and 2) an expanded services model.

Scenario 1, the limited core services model, is what we believe would be the minimal staffing to run an effective yet modest standalone program. This scenario would be sufficient to provide consistent coverage of client-facing staff during all hours of operation. It assumes that not all wrap-around services clients would benefit from would be provided on site by staff employed by the SCS, but rather those needs would be met by referral and partnership with other agencies in the area.

Scenario 2 envisions a context with additional financial resources and sufficient space, for more staff. This would still be a modest program with a small complement of additional wraparound services provided directly on site with staff employed by the SCS program. For the purpose of this scenario, we assumed adding two additional non-clinical Client Support Specialists, which might include staff who specialize in services such as housing assistance which can be a labor-intensive specialty in the Boston housing market. It also assumes adding a medical provider licensed at the Nurse Practitioner (NP) or Physician Assistant (PA) licensure level to provide enhanced clinical services above which a registered nurse is able to provide.

A snapshot of the staffing models in each scenario:

Limited Core Services	1 nurse	All client hours	Basic clinical care, testing, and triage
	2 Client Support Specialists, non-clinical	All client hours	Peers/health navigators - staffing registration, post-consumption areas, support clients with health and service navigation
	1 BH clinician	Full time role, designated client hours	Psychosocial support and BH services
	1 Program Director	Single full-time position	Oversee program, staff, operations, community liasion
	1 Site Manager	Provides oversight, covers hours when Program Director not on site	Coverage when Program Director not on site
	1 Safety Support Specialist	All client hours	Non-uniformed, training in de-escalalation & trauma informed response

Expanded Services	1 nurse	All client hours	Basic clinical care, testing, and triage
	4 Client Support Specialists, non-clinical	All client hours	Peers/health navigators - staffing registration, post-consumption areas, support clients with health and service navigation; expanded staffing for additional direct in-house services (e.g. housing specialist)
	1 BH clinician	Full time role, designated client hours	Psychosocial support and BH services
	1 Program Director	Single full-time position	Oversee program, staff, operations, community liasion
	1 Site Manager	Provides oversight, covers hours when Program Director not on site	Coverage when Program Director not on site
	1 Safety Support Specialist	All client hours	Non-uniformed, training in de-escalalation & trauma informed response
	0.5 Medical Provider	Half-time role, designated client hours	NP or PA (expanded clinical services, e.g. MAT, wound care)

In addition to the number and type of staff present, the hours of operation will be the other main driver of cost. The 2021 Needs Assessment & Feasibility Report identified an ideal of a 24-hour per day operation, but also recognized that might not be possible at least in the early phase of operations. The report suggested the possibility of expanded business hours.

For Scenario 1, Limited Core Services, the resulting budgets range from $1.4M to $2.9M depending on the hours of operation:

Scenario 1a		Operating hours	FTE	Cost
Space	1) Limited: core service offerings in-house, more by referral arrangements	70	11.77	$1,424,664
Hours	a) Business hours: 8am-6pm 7days/week			

Scenario 1b		Operating hours	FTE	Cost
Space	1) Limited: core service offerings in-house, more by referral arrangements	69	11.62	$1,409,105
Hours	d) WHCP model: 9am - 8pm Mon-Fr, 9am-4pm Sat-Sun			

Scenario 1c		Operating hours	FTE	Cost
Space	1) Limited: core service offerings in-house, more by referral arrangements	98	16.08	$1,860,322
Hours	b) Split shift: 8am-5pm, 8pm-1am 7 days/week			

Scenario 1d		Operating hours	FTE	Cost
Space	1) Limited: core service offerings in-house, more by referral arrangements	168	26.85	$2,949,466
Hours	c) Continuous: 24 hours/day			

For Scenario 2, Limited Core Services, the resulting budgets range from $1.9M to $3.9M depending on the hours of operation:

Scenario 2a		Operating hours	FTE	Cost
Space	2) Expanded: additional wrap-around services in-house	70	16.58	$1,918,764
Hours	a) Business hours: 8am-6pm 7days/week			

Scenario 2b		Operating hours	FTE	Cost
Space	2) Expanded: additional wrap-around services in-house	69	16.36	$1,897,925
Hours	d) WHCP model: 9am - 8pm Mon-Fr, 9am-4pm Sat-Sun			

Scenario 2c		Operating hours	FTE	Cost
Space	2) Expanded: additional wrap-around services in-house	98	22.61	$2,502,262
Hours	b) Split shift: 8am-5pm, 8pm-1am 7 days/week			

Scenario 2d		Operating hours	FTE	Cost
Space	2) Expanded: additional wrap-around services in-house	168	37.68	$3,961,006
Hours	c) Continuous: 24 hours/day			

In addition to the assumptions made regarding staff composition, staffing levels, and hours of operation, the budgets include several additional assumptions. While the main driver of total budget will be personnel, there will be a need for safe consumption supplies, sterile equipment, hazardous waste disposal, and other basic site supplies. Clients will also likely need access to food as well as transportation to/from other partner agencies to access a broader array of services.

These budgets are not intended to be overly prescriptive in the exact number of full time equivalent (FTE) staff or the precise hours the program will operate or the exact supplies needed, but they should be useful to the City in considering the level of resources it will take to effectively operate. We used area benchmarks for assuming salaries and benefit costs, and used

information available to us in operating Fenway Health's ACCESS Drug User Health Program to get a reasonable estimate of supplies and other expenses.

The City and program will need to monitor spending and priorities to ensure that whatever amount of funding is allocated is meeting the needs of the program, but we believe these numbers will be useful as a guidepost. These numbers also assume a 12-month operation with the program fully staffed and operational, so adjustments within a fiscal year may be warranted depending on the timing of procurement processes and how long it will take to move from program selection to opening.

Revenue Source

We heard from some residents during our forum and interviews a concern about the use of City tax revenue to pay for this service. The City is exploring the use of funds from the City's Medical Marijuana Stabilization Fund as a potential source, subject to appropriation by the City Council. A Stabilization Fund is an accounting entity designed to reserve funds for future operating and capital needs. The Medical Marijuana Stabilization Fund has collected approximately $1 million to date in impact fees assessed upon Somerville Medical Marijuana Dispensaries. In addition, the City has appropriated $500,000 from "Free Cash" to the Medical Marijuana Stabilization Fund as the City explores next steps for a future supervised consumption site. "Free Cash" represents surplus city funds realized through excess general tax revenue and unspent appropriations.

While the City is taking a leadership role in advancing this effort, Somerville should not be the only entity funding this program regardless of funding source. The Commonwealth of Massachusetts has established a harm reduction line item in the state budget, and the Massachusetts Department of Public Health currently funds numerous syringe exchange and drug user health programs to reduce the transmission of infectious diseases and prevent overdose fatalities. The City may need to make an initial investment to get this program operational, but there should be ongoing dialogue with the Department of Public Health on whether some of the basic supplies and potentially some of the staffing costs could be covered

by the state as a part of their ongoing network of harm reduction services. There are also private foundations that have prioritized harm reduction and the opioid crisis that might assist with contributions of supplies, equipment, and some startup costs and ongoing operational expenses. Multiple funding options should continue to be explored.

Appendix: Budget – Scenario 1 Detailed Views

SCENARIO 1A		
Space	Limited, core service offerings in-house	
Hours	Business hours: 8am-6pm, 10 hrs/day 7days/week	
	Client coverage time, hours per week:	70
	1FTE = 6.5 hrs client coverage/day, hrs/week:	32.5

Staff	Positions	Client hours/week	FTE	Dollars
	1 Nurse	70	2.15	$161,538
	2 Client Support Specialists	140	4.31	$236,923
	1 BH	32.5	1.00	$72,000
	1 Program Director	32.5	1.00	$100,000
	1 Site Manager	37.5	1.15	$92,308
	1 Safety Support Specialist	70	2.15	$127,400
			Salary Total:	$790,169
	Fringe benefits (30%)			$237,051
			Total Staff:	$1,027,220
Supplies	Sterile syringes, hygiene kits, client snacks, outreach materials			$125,000
	Client transportation			$6,000
Other	Hazardous waste disposal			$4,000
	Misc supplies & expenses			$25,000
			Subtotal:	$1,187,220
	Indirect 20%			$237,444
			TOTAL:	$1,424,664
			Total FTE	11.77

SCENARIO 1B		
Space	Limited, core service offerings in-house	
Hours	WHCP model: 9am - 8pm Mon-Fr (11hr), 9am-4pm (7hr) Sat-Sun	
	Client coverage time, hours per week:	69
	1FTE = 6.5 hrs client coverage/day, hrs/week:	32.5

Staff	Positions	Client hours/week	FTE	Dollars
	1 Nurse	69	2.12	$159,231
	2 Client Support Specialists	138	4.25	$233,538
	1 BH	32.5	1.00	$72,000
	1 Program Director	32.5	1.00	$100,000
	1 Site Manager	36.5	1.12	$89,846
	1 Safety Support Specialist	69	2.12	$125,580
			Salary Total:	$780,195
	Fringe benefits (30%)			$234,059
			Total Staff:	$1,014,254
Supplies	Sterile syringes, hygiene kits, client snacks, outreach materials			$125,000
	Client transportation			$6,000
Other	Hazardous waste disposal			$4,000
	Misc supplies & expenses			$25,000
			Subtotal:	$1,174,254
	Indirect 20%			$234,851
			TOTAL:	$1,409,105
			Total FTE	11.62

SCENARIO 1C		
Space	Limited, core service offerings in-house	
Hours	Split shift: 8am-5pm (9hrs), 8pm-1am (5 hrs), 7 days/week,	
	Client coverage time, hours per week:	98
	1FTE = 6.5 hrs client coverage/day, hrs/week:	32.5

Staff	Positions	Client hours/week	FTE	Dollars
	1 Nurse	98	3.02	$226,154
	2 Client Support Specialists	196	6.03	$331,692
	1 BH	32.5	1.00	$72,000
	1 Program Director	32.5	1.00	$100,000
	1 Site Manager	65.5	2.02	$161,231
	1 Safety Support Specialist	98	3.02	$178,360
			Salary Total:	$1,069,437
	Fringe benefits (30%)			$320,831
			Total Staff:	$1,390,268
Supplies	Sterile syringes, hygiene kits, client snacks, outreach materials			$125,000
	Client transportation			$6,000
Other	Hazardous waste disposal			$4,000
	Misc supplies & expenses			$25,000
			Subtotal:	$1,550,268
	Indirect 20%			$310,054
			TOTAL:	$1,860,322
			Total FTE	16.08

SCENARIO 1D		
Space	Limited, core service offerings in-house	
Hours	Continuous: 24 hours/day, 7 days per week	
	Client coverage time, hours per week:	168
	1FTE = 6.5 hrs client coverage/day, hrs/week:	32.5

Staff	Positions	Client hours/week	FTE	Dollars
	1 Nurse	168	5.17	$387,692
	2 Client Support Specialists	336	10.34	$568,615
	1 BH	32.5	1.00	$72,000
	1 Program Director	32.5	1.00	$100,000
	1 Site Manager	135.5	4.17	$333,538
	1 Safety Support Specialist	168	5.17	$305,760
			Salary Total:	$1,767,606
	Fringe benefits (30%)			$530,282
			Total Staff:	$2,297,888
Supplies	Sterile syringes, hygiene kits, client snacks, outreach materials			$125,000
	Client transportation			$6,000
Other	Hazardous waste disposal			$4,000
	Misc supplies & expenses			$25,000
			Subtotal:	$2,457,888
	Indirect 20%			$491,578
			TOTAL:	$2,949,466
			Total FTE	26.85

Appendix: Budget – Scenario 2 Detailed Views

SCENARIO 2A		
Space	Expanded: additional wrap-around services in-house	
Hours	Business hours: 8am-6pm (10 hrs) 7days/week	
	Client coverage time, hours per week:	70
	1FTE = 6.5 hrs client coverage/day, hrs/week:	32.5

Staff	Positions	Client hours/week	FTE	Dollars
	1 Nurse	70	2.15	$161,538
	4 Client Support Specialists	280	8.62	$473,846
	1 BH	32.5	1.00	$72,000
	1 Program Director	32.5	1.00	$100,000
	1 Site Manager	37.5	1.15	$92,308
	1 Safety Support Specialist	70	2.15	$127,400
	1 Medical Provider, half time	20	0.50	$57,500
			Salary Total:	$1,084,592
	Fringe benefits (30%)			$325,378
			Total Staff:	$1,409,970
Supplies	Sterile syringes, hygiene kits, client snacks, outreach materials			$125,000
	Client transportation			$6,000
Other	Hazardous waste disposal			$8,000
	Misc supplies & expenses			$50,000
			Subtotal:	$1,598,970
	Indirect 20%			$319,794
			TOTAL:	$1,918,764
			Total FTE	17

SCENARIO 2B		
Space	Expanded: additional wrap-around services in-house	
Hours	WHCP model: 9am - 8pm (11hr) Mon-Fr, 9am-4pm (7hrs) Sat-Sun	
	Client coverage time, hours per week:	69
	1FTE = 6.5 hrs client coverage/day, hrs/week:	32.5

Staff	Positions	Client hours/week	FTE	Dollars
	1 Nurse	69	2.12	$159,231
	4 Client Support Specialists	276	8.49	$467,077
	1 BH	32.5	1.00	$72,000
	1 Program Director	32.5	1.00	$100,000
	1 Site Manager	36.5	1.12	$89,846
	1 Safety Support Specialist	69	2.12	$125,580
	1 Medical Provider, half time	20	0.50	$57,500
			Salary Total:	$1,071,234
	Fringe benefits (30%)			$321,370
			Total Staff:	$1,392,604
Supplies	Sterile syringes, hygiene kits, client snacks, outreach materials			$125,000
	Client transportation			$6,000
Other	Hazardous waste disposal			$8,000
	Misc supplies & expenses			$50,000
			Subtotal:	$1,581,604
	Indirect 20%			$316,321
			TOTAL:	$1,897,925
			Total FTE	16.36

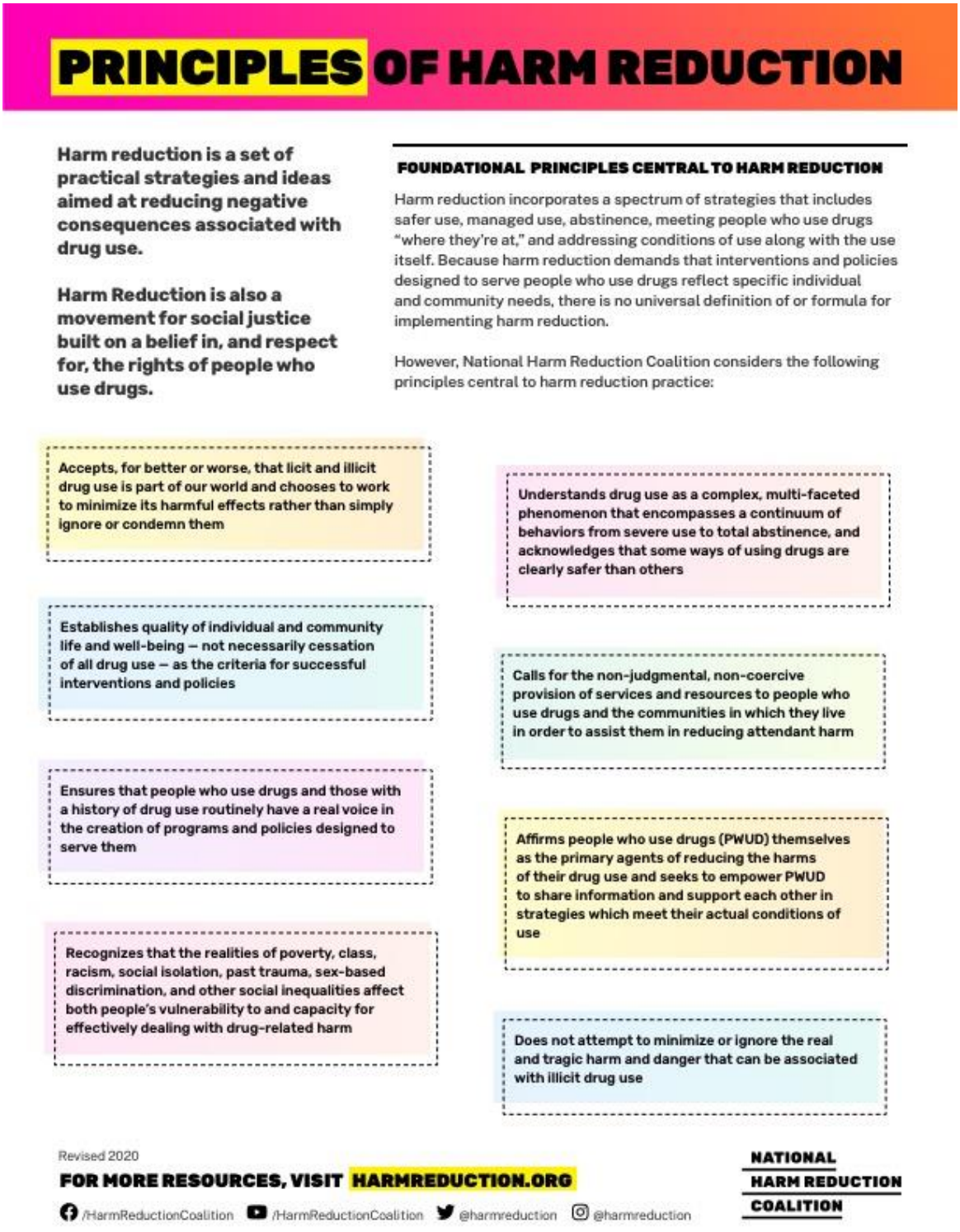
SCENARIO 2C		
Space	Expanded: additional wrap-around services in-house	
Hours	Split shift: 8am-5pm (9hrs), 8pm-1am (5 hrs) 7 days/week	
	Client coverage time, hours per week:	98
	1FTE = 6.5 hrs client coverage/day, hrs/week:	32.5

Staff	Positions	Client hours/week	FTE	Dollars
	1 Nurse	98	3.02	$226,154
	4 Client Support Specialists	392	12.06	$663,385
	1 BH	32.5	1.00	$72,000
	1 Program Director	32.5	1.00	$100,000
	1 Site Manager	65.5	2.02	$161,231
	1 Safety Support Specialist	98	3.02	$178,360
	1 Medical Provider, half time	20	0.50	$57,500
			Salary Total:	$1,458,629
	Fringe benefits (30%)			$437,589
			Total Staff:	$1,896,218
Supplies	Sterile syringes, hygiene kits, client snacks, outreach materials			$125,000
	Client transportation			$6,000
Other	Hazardous waste disposal			$8,000
	Misc supplies & expenses			$50,000
			Subtotal:	$2,085,218
	Indirect 20%			$417,044
			TOTAL:	$2,502,262
			Total FTE	23

SCENARIO 2D		
Space	Expanded: additional wrap-around services in-house	
Hours	Continuous: 24 hours/day, 7 days per week	
	Client coverage time, hours per week:	168
	1FTE = 6.5 hrs client coverage/day, hrs/week:	32.5

Staff	Positions	Client hours/week	FTE	Dollars
	1 Nurse	168	5.17	$387,692
	4 Client Support Specialists	672	20.68	$1,137,231
	1 BH	32.5	1.00	$72,000
	1 Program Director	32.5	1.00	$100,000
	1 Site Manager	135.5	4.17	$333,538
	1 Safety Support Specialist	168	5.17	$305,760
	1 Medical Provider, half time	20	0.50	$57,500
			Salary Total:	$2,393,722
	Fringe benefits (30%)			$718,116
			Total Staff:	$3,111,838
Supplies	Sterile syringes, hygiene kits, client snacks, outreach materials			$125,000
	Client transportation			$6,000
Other	Hazardous waste disposal			$8,000
	Misc supplies & expenses			$50,000
			Subtotal:	$3,300,838
	Indirect 20%			$660,168
			TOTAL:	$3,961,006
			Total FTE	37.68

Appendix: Harm Reduction Principles



Appendix: Individual Interviews

Common Themes from one-on-one conversations with Somerville residents

- There does not seem to be a drug use/drug "problem," it is not highly visible in Somerville, the way it is in other neighboring communities (particularly Boston's "Mass and Cass" area).
- Discarded needles in some specific areas.
- Gathering community input needs to be on-going.
- Visible cases of Substance Use Disorder (SUD) seem to overlap with the un-housed population and the housing crisis probably contributed to this.
- General knowledge of harm reduction as a part of healthcare and connection to healthcare.
- High-level knowledge about what SCSs do—keep people alive. Some knowledge about wrap-around services.
- Even those who are supportive are concerned about
    - an increased number of people congregating in public spaces: will people from outside of Somerville travel to this site?
    - their NIMBY ("not in my back-yard") neighbors
    - the issue of legality, the role of government and law enforcement, whether or not this will bring conflict to community spaces
- A desire for more communication, information, and education efforts from the City of Somerville as well as more engagement with locally owned businesses.
- The site should be located in an urban (not residential) area, with easy access to public transportation.
- What types of data and evaluation will the city implement to measure the impacts (crime, discarded needles, overdose deaths, 911 calls, etc.) of this site on the community?

- When asked to answer questions on a scale of 1 to 5, support from interview subjects who were initially enthusiastic (answering 5), waned slightly when asked about support for a site in their own neighborhood. When asked about the atmosphere of support created by their neighbors, interview subjects were slightly more skeptical that there was a substantial amount of understanding for the need.

Unique but relevant quotations from respondents

"The way in which people understand addiction matters deeply before you can address a safe use site."

"There will always be pushback from people who do not understand the disease model…at one point Cambridge wanted more naloxone and those who gave push back said that it encourages use. Putting more fire extinguishers everywhere does not cause more fires…This is a part of our society; it is a disease."

"My only doubts are around capacity--is the site 24/7? What does that staffing look like? What are impacts on neighborhood?" This resident was especially interested in programmatic details, staffing, and implementation, saying that "the devil is in the details," and public education about those details could help people understand more.

"Right now {****} is working with the cannabis industry to use their resources to help folx recover from the effects of the war on drugs. People showed up for the redemption narrative—this feeling of getting something done. Other times you put the call out for help for someone with addiction...instead it is a call to the police and hide this person away. The same level of community organization needs to be involved, it's a cycle with homelessness and joblessness that traps people who have a CORI for example. We need to take that level of energy and excitement for the opportunity to get clean and sober and housed, we have the resources."

Recommendations from residents that emerged from these conversations

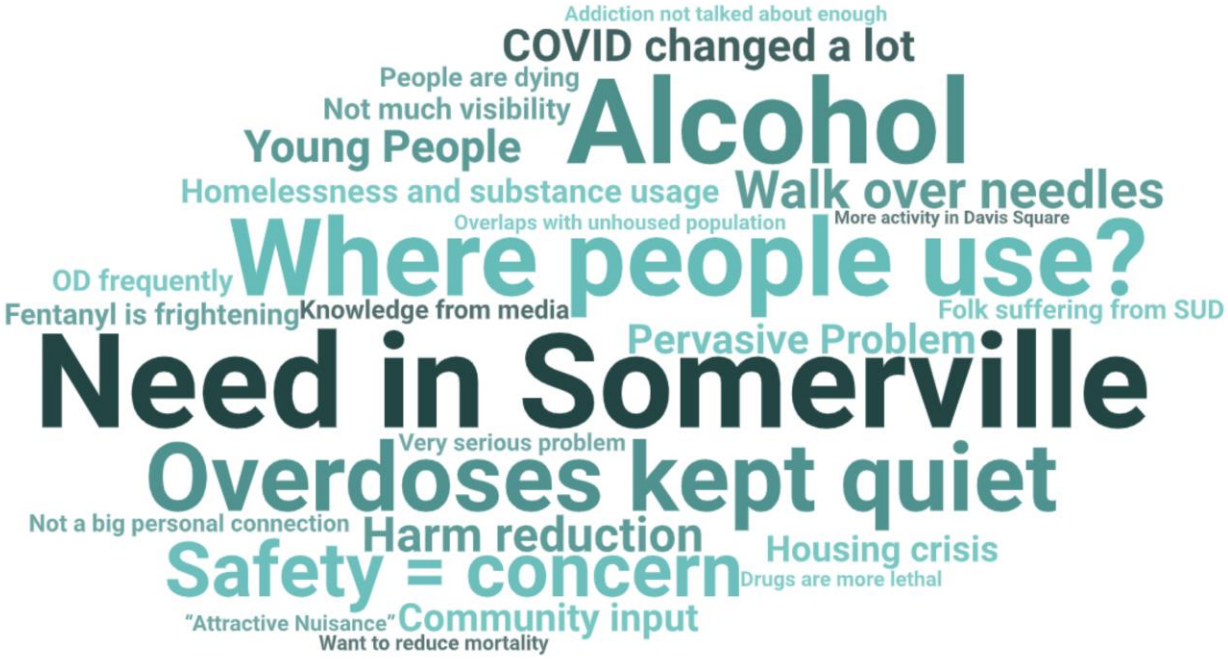
- Ongoing public education and community engagement, possibly through a community advisory board (C.A.B.) that includes residents, business owners, and people

affected/people who use drugs. There was particular interest in the changing legal landscape.

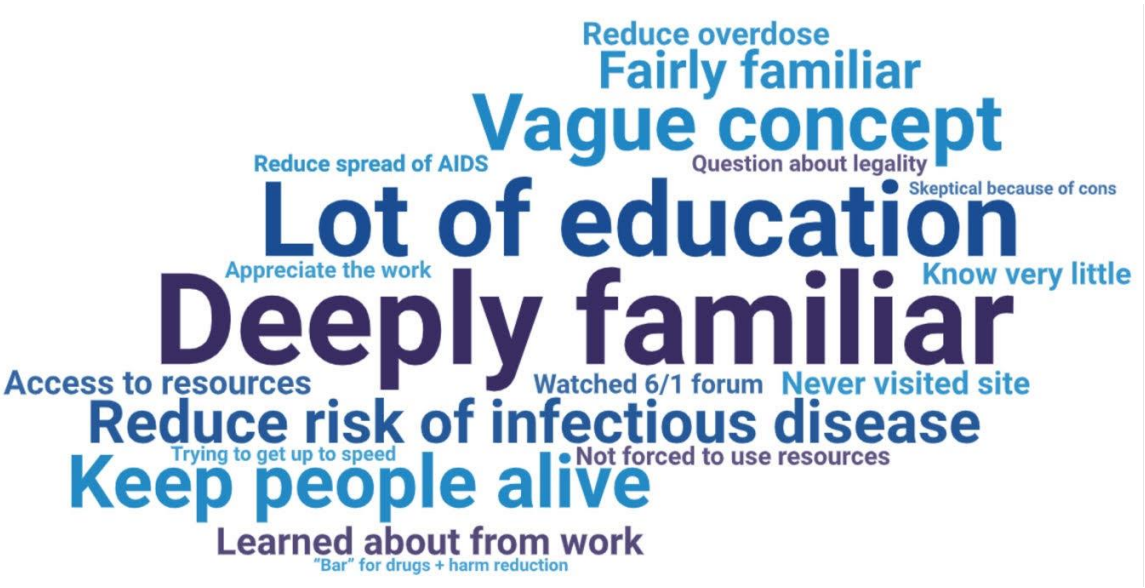
- Clear, transparent, and frequent communication from the City of Somerville about the process and funding.
- Data and evaluation before and after the site is established to accurately measure, monitor, and respond to impacts on the community.

Summary of responses

1. What is your perception of addiction and drug use in Sommerville?



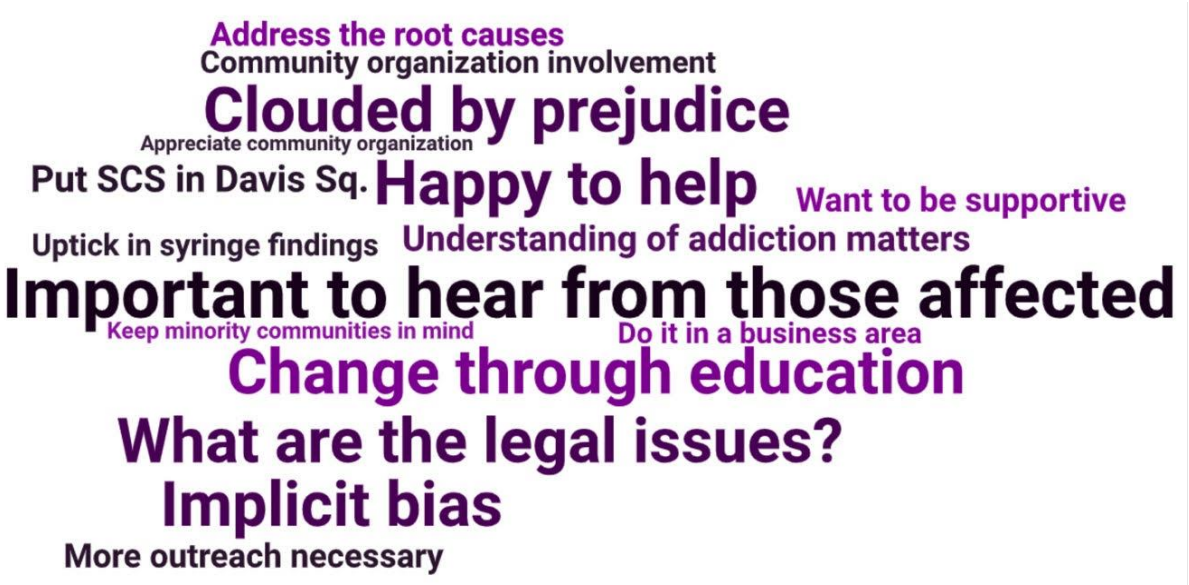
2. What's your familiarity with the concept of supervised consumption sites?



3. What have you heard about this effort?

4. What do you think the impacts are of opening an SCS in Davis Square or East Somerville?

5. Anything else you'd like us to know?

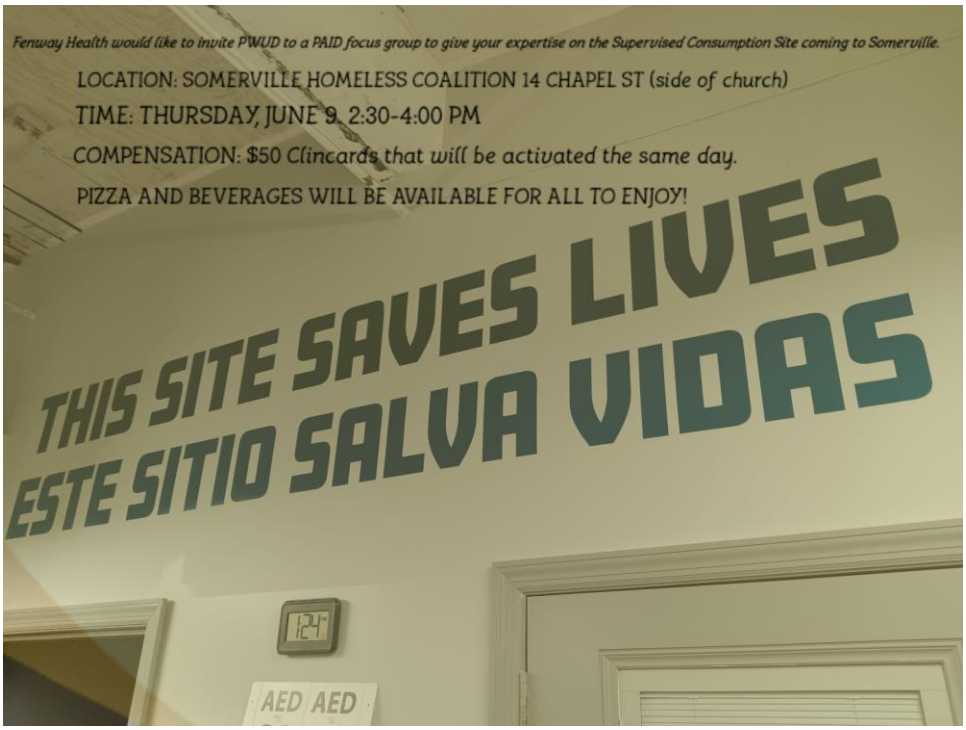


6. Are there any ways you would like to be involved going forward to make sure we get this right?

Appendix: Focus Groups with People Who Use Drugs

Focus Group 1: Thursday, June 9th, 2:30pm

Held at the Somerville Homeless Coalition in Davis Square, Somerville; Conducted by TJ Thompson and Stephen Kelley



Outreach for this focus group was done by TJ Thompson, Stephen Kelley, and staff of the Somerville Homeless Coalition. Participants were given $50 ClinCards for their time and feedback.

There was a lack of knowledge among participants on harm reduction overall: only 1 of the 8 participants knew what an SCS was. The purpose of the session ended up being more about sharing information than about asking questions of the participants. Lack of knowledge made it

challenging to engage participants about what kind of services they would like incorporated into an SCS.

Of the eight participants, 2 were Black, one was a woman, and the remaining 5 participants were white men. The group age range was 35-61.

The geographic range of participants seemed to be limited to the Davis Square area. Only one person talked about receiving services at the ACCESS drug user health program in Central Square (Cambridge). Most participants seemed to stay in the Davis Square neighborhood, except for one person, who lived in Arlington.

Questions from participants were about the location of the site, the timeline for the City to open a site, and the amenities offered in the space (for example, couches). Participants also asked about wound care and harm reduction practices to prevent infection.

Facilitators of the focus group identified a definite need for more harm reduction services in Somerville as the dominant theme of the conversations. They also noted that a community setting (like the drop-in spaces in other parts of the Boston area) cultivates a harm reduction knowledge base and access to care. A safe, trusted, and respectful space allows for communication and sharing of information. This is the basis of harm reduction networks that have been successful in other settings.

There are services and harm reduction information available in neighboring communities (Cambridge and Boston) but the lack of knowledge in this group shows that access to those services and information is not reaching Davis Square.

This limited spread of information points to a need for staff in the Somerville site to conduct focused street outreach. People in the community will need to be informed about the site and what services are offered. This work should be done in coordination with the Somerville Homeless Coalition, located in Davis Square, whose street outreach team already does this.

Focus Group 2: Tuesday, June 21st, 12-2 pm

Held outside in Harvard Square, Cambridge; Conducted by TJ Thompson and Stephen Kelley

Outreach for this focus group was done by TJ Thompson and Stephen Kelley. Participants were given $50 ClinCards for their time and feedback.

There was some difficulty in connecting with unfamiliar people, participants were re-directed to the focus group via M.A.A.P. staff.

Of the 11 participants, one was Hispanic, six were white, four were Black, five were women, six were men. The group age range was 23-61.

Only one participant was familiar with the concept of SCSs, so this group also spent time exploring and explaining what they are and what they do.

There is a marked difference in the spread of knowledge compared to 2 or 3 years ago, before COVID. Previously, dissemination of information amongst people who are unhoused occurred in protected community spaces, where connections could be made to share knowledge. Impacts on this community due to COVID include isolation, a stifling of the spread of information, a rise in new cases of HIV, and an increase in deaths from overdose.

Participants in this focus group were receptive to the idea of SCSs and were very willing to come to Davis Square or Union Square for these services.

Participants were very focused on staffing, particularly on the need for paid peers receiving training, education, and professional development. This could provide a structure for people from the community to staff the site in a way that fosters genuine trust with clients as well as a pathway forward for people experiencing SUD and/or housing instability.

Examples of this include training to become a certified medical assistant, a recovery coach, or a peer counselor. All of these options could lead to further careers in the public health/SUD space. There is a great need for this kind of staff: people who are properly trained but who also possess the cultural competency skills, from personal experience, to forge trusted relationships with hard-to-reach populations. These trusting relationships are the foundation for keeping people engaged in harm reduction and healthcare. This staffing structure is an excellent opportunity for the service providing organization to provide a pathway for empowerment and engagement.

Appendix: Community Forum Notes and Q&A

The City of Somerville and Fenway Health hosted a virtual community meeting on June 1st, 2022, from 6-7:30pm.

A full recording of this forum can be found at **somervillema.gov/scs**

Agenda:

- Carl Sciortino (Fenway Health): welcome, acknowledgements, expectations for the space, context setting
- Mayor Ballantyne and Matthew Mitchell (The City of Somerville): welcome, overview of services the city is involved in and the additional needs of the community
- Dr. Miriam Harris: Harm reduction basics and what is a supervised consumption site (SCS)
- Sam Rivera (OnPoint New York): introduction to his work, since opening and operating the country's first SCS in December of 2021, what services they offer, relationships with surrounding community members
- Video from Bill Fried on need for SCSs in Somerville
- Panelist introductions: What brings you to this work?
- Q&A: Questions and comments gathered from participants' registration as well as live questions and comments received via Zoom.

Questions asked by community members and corresponding answers, compiled by Fenway staff and reviewed by the City of Somerville:

Q	A
Why is Fenway Health not owning the supervised consumption site directly?	Fenway Health was hired by the City of Somerville for this phase of the work, not opening the site itself. This phase includes location assessment, community outreach, and program design. A report with this information will be completed and released later this month.

With the Needs Assessment and Feasibility Report mentioning that only 56% of respondents would not have a problem living in a neighborhood with an SCS, property values will surely be diminished as a significant portion of the population now wouldn't want to live here. It is likely that new businesses will be deterred from opening in the area, and current businesses will take financial hits as people are more likely to avoid the area. This will result in a decline in economic opportunity which is closely linked to an increase in deaths of despair. What is the concern level that opening this site will increase deaths of despair for people who do not use illicit drugs?	Research consistently shows these sites do not have a negative impact on robbery, property crime or drug offences. SCSs were not found to increase drug injecting, drug trafficking or crime in the surrounding environments and were found to be associated with reduced levels of public drug injections and improperly disposed syringes.
If people drive to use SCS cites, they either stay in the area until the effects of the drug wear off, or they drive home immediately and endanger the lives of a community already experiencing high levels of pedestrian tragedies by cars (East Somerville). There isn't any data to my knowledge analyzing the effect of an SCS on pedestrian traffic safety or general automobile safety. Are you worried about flooding local communities with impaired drivers departing the SCS?	SCSs are designed to provide a safe space for clients to stay after they have injected. There is a notable overlap in the populations of people who use drugs (who would potentially use these sites) and people who are unhoused and do not own a car. When surveyed in last years' Needs Assessment and Feasibility Report, people who use drugs requested that a site be near public transportation for this very reason.
Who are the members of the SCS Somerville Advisory Council? or where is that information accessible?	Members of the Advisory Group are listed in this report. It includes staff of the City of Somerville, harm reduction advocates, and people who use drugs.

1) What is the predicted cost of setting up a safe consumption site in the Davis area? 2) What about the East Somerville area? 3) What is the predicted cost to operate it for the first 3 years? 4) How much has Mayor Ballantyne proposed to spend on this initiative in Fiscal year 2023?	This report includes several different program layouts and design options, including corresponding budgets. Estimates are between $1M and $4M annually, depending on the space available. During the FY23 budget process, the City appropriated $500,000 from "free cash" to the Medical Marijuana Stabilization Fund. The Medical Marijuana Stabilization Fund has also collected approximately $1 million to date in impact fees from Medical Marijuana Dispensaries. The City is exploring using this fund as potential source for the SCS, pending appropriation by the City council.
Data from the Massachusetts Department of Health states that of the 8368 opioid related deaths from 2013 to 2017 in Massachusetts, 71 occurred in the city of Somerville. Why should a city where 0.85% of opioid related deaths occur be the first to open an SCS? -	The latest data shows that 15 Somerville residents died from on overdose in 2021. 108 have died since 2015. These data can be found here: https://www.mass.gov/doc/opioid-related-overdose-deaths-by-citytown-february-2019/download In Mayor Ballantyne's opening remarks to the forum, she noted that if 15 people died of traffic accidents every year, the community would undoubtedly come together swiftly to find a solution. In fact, the City already has a Vision Zero Action Plan with a goal of bringing the number of traffic related deaths down to 0. She noted that it has been harder to discuss the topic of opioid and substance use because of stigma and the painful history of how our society has approached addiction. On the night of the forum, Mayor Ballantyne proposed the creation of a new Vision Zero, a vision toward comprehensive services, public health solutions, and most of all, a future with 0 fatal overdoses. One preventable fatal overdose is too many.
What State and Federal Government departments support SCSs for cities?	Current federal law (The Controlled Substances Act) puts people inside a SCS at risk (both those working there, providing harm reduction services, and those using the services). The current federal administration has recently demonstrated an increased understanding of the need for evidence-based harm reduction. Massachusetts U.S. Attorney, Rachael Rollins, has previously publicly stated her support for SCSs. While the current environment holds, we can hope that U.S. Attorney Rollins utilizes her prosecutorial discretion to not pursue an SCS operating in MA. Staff on these sites would be protected by state law if state legislation (H.2088 and S.1272) passes, enabling a pilot program for the state. These SCS bills have support from Representatives and Senator across the state, including your delegation members from Somerville.

I noticed that in Alberta, the Calgary SCS is located at the Sheldon M. Chumir Health Center. Has Somerville considered locating the SCS at an existing health facility, like Cambridge Health Alliance?	The City of Somerville is currently looking at city-owned property, to limit the liability risks of the organization and staff who will run it. Relationships with surrounding healthcare delivery organizations and institutions will be critical to connecting clients to care and keeping them engaged in care.
is there now or /will there be a modality for communication with the committee?	Community engagement will be ongoing, please watch the City of Somerville website for more updates and opportunities to communicate.
Will proximity to schools and playgrounds be considered in site selection?	Yes, each potential location has taken many factors into consideration, including proximity to schools, playgrounds, and residential neighborhoods. A full explanation of the location assessment process is located in the Location section of this report, with all of the factors and trade-offs for each site.
What is being done to coordinate with Cambridge and Boston to ensure Somerville is not left being the only city in Metro Boston to provide a SCS?	City officials are in communication with surrounding communities and supportive of state legislation that would enable a pilot program in MA, allowing other municipalities to follow Somerville's lead and begin offering supervised consumption space in addition to harm reduction services.
Does the feasibility and needs report take into account residents' opinions or just a rally of statistics?	Yes, engagement of neighborhood residents is certainly taken into consideration, through this forum, please continue to participate in this process!
Are the proposed SCSs for residents of Somerville use only?	As many of the potential clients for this site are likely to be unhoused, Somerville residency will not be required to use the site.
Where in Somerville is the SCS being proposed?	Please see the Location section of this report.
As a supporter of creating more SCSs, what are the most effective ways to advocate for them in my community/in general?	The best way to advocate for SCSs is to continue these conversations with your neighbors! Be public with your support and write letters to the editor or your local representatives in government. Get involved with advocacy for the state legislation that supports SCSs through the MA4SCS coalition (sign up to join the email list here: https://forms.gle/gUw94v7ttArJUfyHA)
Alcohol is a drug. Would you recommend serving alcohol to someone who is addicted to alcohol? I don't understand how safely injecting drugs help a person who is addicted to that drug.	The tenets of harm reduction acknowledge that drug use happens as well as the opportunity to reduce the harm from behavior that is happening anyway. Treating people who use drugs with dignity and respect is the first step in allowing them space to make decisions about their own bodies. When people are trusted and empowered to make decisions about their healthcare, they are more engaged and willing to enter treatment if that is what they want. Not everybody is ready for treatment when we want them to be--harm reduction gives them one more day. SCSs provides a space for that opportunity; people are more likely to be ready when they are in a trusted space and treated with respect.

Given that political climates often change, how do you plan to protect those who operate an SCS from legal prosecution if an unsympathetic governing body is put in office?	If passed, state bill H.2088/S.1272 "An Act relative to preventing overdose deaths and increasing access to treatment" would provide a state-level of protection for those operating and working in an SCS, similar to the way in which marijuana dispensary staff are not being prosecuted under federal law.
No recovering addict I have spoken with said they would ever seek recovery if they were allowed to use without any consequences of being arrested (because this remains illegal) or fear of death. Some, in fact, would have preferred death then to live in a life of addiction. Why aren't we really doing something to help with the addiction instead of enabling it? We're not solving anything, we're trying to compartmentalize the individuals suffering from this disease...let's just throw them in a corner, keep them alive in their darkness, and let's pretend we're helping. That's disgraceful! I want to see REAL help for the individuals with this awful disease!	SCSs are one tool to add to the array of supports needed to adequately address the current public health crisis that is the opioid epidemic. While we support SCSs, that does not mean that we oppose all other efforts to prevent and treat the disease of addiction. That is why these sites are considered a gateway to treatment and other healthcare interventions, and refer clients to those services whenever possible. People cannot be forced into treatment, the data overwhelming shows that it is not effective and it is dangerous, actually increasing the likelihood of death from an overdose. Keeping an individual alive gives them the chance to make that choice for themselves.

Why don't you also address what happened in Philadelphia where the "plan" has been canceled? It would be nice to hear another side, not just NY which is the only state that has a site.	Safehouse is a non-profit, privately financed organization in Philadelphia, which has been trying to open its doors since 2018. Before it had a chance to open, Safehouse was sued by Pennsylvania's U.S. Attorney at the time, William McSwain, a Trump appointee. In October of 2019, U.S. District Judge Gerald McHugh ruled that Safehouse's plan to allow people to bring in their own drugs and use them in a medical facility to help combat fatal overdoses does not violate the Controlled Substances Act. U.S. Attorney McSwain appealed that decision. In January of 2021, a three-judge panel of the 3rd U.S. Circuit Court of Appeals issued a 2-1 ruling that reversed McHugh's decision. Judges Stephanos Bibas and Thomas L. Ambro called Safehouse's motives "admirable" but said that while "the opioid crisis may call for innovative solutions, local innovations may not break federal law." In September of 2021, Safehouse filed a complaint with the federal Department of Justice (DOJ). The DOJ under Attorney General Merrick Garland has shown signs of being amenable to the sites. Safehouse has been engaged in talks with the Biden administration since September. "Although we cannot comment on pending litigation, the department is evaluating supervised consumption sites, including discussions with state and local regulators about appropriate guardrails for such sites, as part of an overall approach to harm reduction and public safety," the department told the AP. (https://whyy.org/articles/safehouse-is-in-settlement-talks-with-the-u-s-department-of-justice/)
As a tax payer, I have zero interest in paying, staffing, and/or supporting a safe consumption site.	Please see the Revenue Source section in the report above.
Will medical doctors and/or nurses be on site at all times?	Recommendations so far point to an integrated services model, which includes medical staff as well as peer harm reductionists.
How can medical organizations in Mass (for example Mass Medical Society) foster acceptance of the SCS model on a member level and state governmental level? Programs, medical education of members, legislative lobbying? In Mass for example medical education on	Please join Mass Medical Society (MMS) in its advocacy for H.2088/S.1272! See more about their support and ways to access education resources here: https://www.massmed.org/News/MMS-Landmark-Accomplishments/MMS-becomes-first-state-medical-society-to-endorse-pilot-supervised-consumption-site/

opiate use is required for MD license renewal, and now also courses on disparities and bias in health care.	
If this is safe, why would there be a concern or risk of overdose?	The last 10 years have seen a dramatic increase in the presence of Fentanyl in the drug supply. This is dangerous because of several reasons: • The effects of Fentanyl occur quickly. If someone was experiencing an overdose from opiates free from Fentanyl, the effects (depressed breathing) would take several minutes to appear. The person experiencing the overdose might be able to signal for help or someone with them might be able to identify the signs soon enough to intervene. Now, with the prevalence of Fentanyl, effects of an overdose are so swift that intervention (via the use of Oxygen, Naloxone, and/or rescue breathing) needs to occur immediately. Most who use alone are not able to get help before their breathing stops. • The effects of Fentanyl are short. The half-life of the drug in the system is much shorter, and so people need to use it more often to keep symptoms of withdrawal (feeling very sick) at bay. This means more needles are needed for more frequent injections, creating more opportunity for the re-use of needles. This is why we are seeing a considerable increase in new cases of HIV in people who inject drugs. This can be prevented if sterile supplies are available. The undiscounted cost of a lifetime treatment of HIV is $1,079,999. • If a person using drugs is doing so in an SCS, they are under close supervision and interventions to prevent death from an overdose can be administered quickly and effectively, making it a “safe” place to use. Sterile needles and supplies are also provided, to prevent the spread of disease like HIV and Hep C.
Have you made sure that all Somerville residents are aware this is being discussed? Especially families?	The Mayor and City of Somerville have shared updates in the media for each stage of this project. You can see up-to-date news on its progress on the City of Somerville website. The City Council actively participates in the conversation around SCSs and you can reach out to yours to hear more.
Question to Sam and congrats on the success of his program. Do participants live near the NYC program locations or do they travel there?	Most of OnPoint's clients are from the surrounding neighborhood.

What sort of liability protection do employees at sites have?	State bill H.2088/S.1272 must pass for the following protections: Notwithstanding any general or special law or rule or regulation to the contrary, the following persons shall not be arrested, charged, or prosecuted for any criminal offense, including, but not limited to, charges pursuant to sections 13, 32I, 34, 43 or 47 of chapter 94C of the General Laws, or be subject to any civil or administrative penalty, including seizure or forfeiture of data records, assets or property or disciplinary action by a professional licensing board, credentialing restriction, contractual liability, and action against clinical staff or other employment action, or be denied any right or privilege, solely for participation or involvement in a supervised consumption site licensed by the department of public health pursuant to this section: (i) a participant; (ii) a staff member or administrator of a licensed supervised consumption site, including a health-care professional, manager, employee, or volunteer; (iii) a property owner who owns property at which a licensed supervised consumption site is located and operates, (iv) the entity operating the licensed supervised consumption site. Entering or exiting a licensed supervised consumption site cannot serve as the basis for, or a fact contributing to the existence of, reasonable suspicion or probable cause to conduct a search or seizure.
Two questions: Are there prohibitions against safe consumption sites coexisting with health care facility/hospital? And what governing entity permits/licenses a safe consumption site?	There are prohibitions on SCSs in general, so specifics of location proximity to healthcare are not currently stated. If state bill H.2088/S.1272 passes, the Department of Public Health will provide licensure, mirroring the successful model of needle exchange implementation process, through local boards of health.
Is there any plan to offer Suboxone or methadone to try to ween people who use the facility of the drugs they are using?	Yes, healthcare navigation and connection to treatment or recovery will be available when participants are open to it.
The study by the city recommends East Somerville and Davis sq. as recommended sites; What public and privately owned locations are being considered?	Currently, the City of Somerville is only considering city-owned property. Community engagement in potential neighborhoods will be ongoing. Connection and navigation to healthcare service organizations will be critical to the program design of the SCS. We have attempted a lot and conducted a few interviews with local business owners, including the Somerville Chamber of Commerce.

Will there be public meetings in these neighborhoods? Will there be cooperating nonprofits like Somerville Hospital and Cambridge Health Alliance, and others similar service providers involved? Has the business community been involved?	Engagement will be ongoing.
There are many unhoused people in this population. How will the housing of this population be handled? You cannot expect the residents that neighbor this proposed facility absorb an unhoused population.	Connection and referral to housing programs will be part of the wrap-around services we recommend to the City.
What has been the response from MA attorney general office or the US attorney?	The current Massachusetts U.S. Attorney, Rachael Rollins, has previously voiced support for SCSs. The Massachusetts Attorney General (and current candidate for Governor), Maura Healey, has recently voiced support for opening sites where individuals could use drugs under medical supervision to prevent deadly overdoses.
Dear Mayor and Alderman, please do not permit a consumption site in our city. I lived through those "Slumerville" days when the underworld was very involved throughout the city and now, we finally have a seat at the table - - people are proud to say they are from the, "Ville" - - it is THE place to live, we have become a cultural mecca. Also, the rise in real estate value is a welcome compliment. I find it difficult to believe a consumption site will be a benefit to our economic win column.	Indeed, Somerville has become a "cultural mecca," known as an inclusive city who is a leader in progressive politics. Harm reduction and supervised consumption sites are progressive issues and Somerville has a chance to set an example for cities and towns across the state by implementing ground-breaking public health policy.
Would you please remind people this is federally illegal so no funding will come from the government or State?	Please see the Revenue Source section in the report above.

Currently, how many safe consumption sites are in Massachusetts? Curious to know why other MA cities/towns weren't invited to the panel. Please advise.	There are currently no official SCSs in the state. There are many unofficial supervised consumption sites across the state, when people who use drugs make sure not to do so alone and support one another, when family members keep Narcan in the house so that they can revive a loved one if necessary, and when harm reductionists put themselves at risk to supervise people who use drugs. A sanctioned site would reduce stigma and bring this issue into the light, where those affected can more easily access the care they need. Unsafe consumption sites also exist across the state, in public bathrooms, alleyways, and underpasses where people die from overdoses because they are alone.

Forum Themes and Topics

Staffing models for these sites are often a blend of peers, harm reductionists, and clinical staff. Additional staff with expertise in wrap-around services (housing assistance programs, holistic health, nutrition, mental health, etc.) are also either on site or there is a staff member who is able to set up referrals and connections to care.

City of Somerville staff as well as Fenway Health staff reviewed the variables taken into consideration for the location assessment process.

Speakers reviewed research that shows no increase in crime in the areas around these sites. There was acknowledgement of the need for cooperation with the police in order to assure the safety of clients and to ensure a welcoming environment free from the dangers of arrest. We heard about the collaboration between the OnPoint site in New York and the police precincts in their area. OnPoint staff invested time and energy into developing a partnership with police—from D.A.s all the way to beat cops. Area police now distribute OnPoint business cards to potential clients instead of arresting them.

Metrics to measure impacts on the neighborhood should be established and data should be collected in collaboration with the city of Somerville.

The legal landscape is changing and we heard an overview of the current view. More of the details on that can be seen in the Q&A section above.

The layout of a SCS includes space for participants to connect with each other and additional services. It is a welcoming space that resembles a community center, which also happens to provide overdose prevention. It is a place where people can be treated with dignity and respect, connect with services, and find community.

Finally, we heard about the pitfalls of approaching this as a moral issue—we are in the middle of a public health crisis and this is a medical intervention to keep people alive. First responders regularly intervene to provide medical attention to those who have just broken the law. We must do the same here to begin saving lives.

Links to follow up material sent to all who registered for the June 1st Community Forum

- The Needs Assessment and Feasibility Report from the previous phase of this work, posted on the City of Somerville website. This is also where the recording of the June 1st forum will be posted.
- Inside America's First Supervised Drug Consumption Site, a video tour of the OnPoint sites in New York city, the first in the nation to officially offer supervised consumption space. We heard from OnPoint's Executive Director, Sam Rivera, during the June 1st forum. OnPoint has been open for 6 months and has reversed 314 overdoses so far, and safely disposed of 472,670 syringes that may have otherwise ended up on sidewalks and in playgrounds.
- Some of you requested the slides from Dr. Miriam Harris' presentation on harm reduction and supervised consumption sites.
- The 2019 Harm Reduction Commission website offers a comprehensive list of studies, reports, and research on the efficacy of these sites as well the benefits that they offer the surrounding community. This legislative commission, ordered by Governor Charlie Baker, recommended in its report (also on that website) that the state of Massachusetts implement a SCS pilot program.
- The Institute for Clinical and Economic Review (ICER) report on the effectiveness and value of SCSs, including research on community impact of these sites, concluding that the quality of life “increased for the community due to decreased public drug use."