Document 3 - Comparison of three Supervised Consumption Service (SCS) models

Model	Benefits	Considerations	Successes & Cost Analysis
1. **Fixed-Integrated within existing health services** • The most common type of SCS[1] • Physically located within addiction service centres, alongside other services such as needle and syringe services, testing for blood-borne infections (HIV and HCV), drug treatment, primary care, housing, and other social services etc.[1]	• Often seen as "best practice" because service users can access a wide range of services in one location[1] • May be more socially accepted if integrated into places already serving people who inject drugs[1] • Pre-established trust/ relationships with clients/people who use drugs[2]	• Co-location of people using SCSs as well as people accessing harm reduction, opioid substitution therapy or other treatment could be a trigger for relapse for those in various stages of recovery[1] • Important that service is set up close to where people use drugs[2] • Multiple locations rather than one central service may be needed to respond to community need[2]	Documented successes include: ✓ Reduced overdose deaths ✓ Reduced sharing of needles (reduced risk for HIV and hepatitis C) ✓ Reduced public injecting ✓ Increased use of withdrawal and treatment services ✓ Decrease in publicly discarded needles[2] • Research conducted in Ottawa estimated that one SIS would prevent approximately 6-10 HIV infections and 20-35 HCV infections per year, projected healthcare cost savings are significant[2]. (Lifetime health care costs for someone living with HIV are approximately $250,000 CAD[2] and $64,694 for someone living with hepatitis C[2].) • The cost of opening a supervised injection/consumption service (similar to Vancouver's Insite) in either Toronto or Ottawa was estimated to be an annual fixed cost of $1.5 million – based on the
2. Fixed-Specialized stand alone services • Focus is on providing a supervised, hygienic location for people to inject/consume drugs[1] • Usually set up close to other services for people who use drugs and located near open drug scenes[1] • Staff are available to refer service	• All people accessing the service are likely at a similar place in their drug use (i.e. all actively using), this provides a level of comfort for those accessing services and reduces trigger risks for those who may be trying to reduce use, who are in	• Services available on site are more limited to supervised injection/consumption , and therefore rely on referral and/or partnerships with other community service providers[1] • Risk that people "get lost in transition" (i.e. a client interested in accessing wound care is referred to treatment but because they have to	

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users to other community services like opioid substitution, drug treatment, primary care, housing, etc.[1]	treatment, or in recovery[1] • Referral and link to other services is still available, just not on- site[1]	go to another service location they don't end up making it there) • Important that service is set up close to where people use drugs[2] • Multiple locations rather than one central service may be needed to respond to community need[2]	supervised injection service portion of Insite (Insite's entire annual budget is $3 million)[4] • From current literature reviews and discussions with partners we know that this is likely an overestimation of the actual cost of integrating a SCS within currently established services
3. Mobile • Currently limited number of mobile SIS worldwide: ○ Montreal, Kelowna (Canada) ○ Barcelona (Spain); ○ Berlin (Germany); and ○ Denmark (Copenhagen) • All operate as adjunct to a fixed service operating in their respective cities[1] • The mobile services use a specially fitted van with 1-3 injection booths to move location across a city in the course of a day/night[1]	• Avoids making one building the focus of activity[1] • Can increase accessibility for people using drugs across a city[1] • Has potential to reach more hidden populations[2] • Has potential to reach more transient people, people who feel uncomfortable attending a fixed supervised injection facility, and people who do not want to travel to a fixed facility[2] • Can complement, connect and add	• Lower service capacity (a mobile service serves fewer people than fixed locations) [1] • Cost-Effectiveness: has lower throughput but requires similar levels of staffing and costs as fixed site, therefore cost/ client in mobile service is inevitably higher[1] • May be more difficult for law enforcement to ensure public safety in surrounding area compared to fixed services[2] • May have less predictable schedules/ hours of operation/availability for a given location with need compared to a fixed service[2] • Not able to provide	• Due to the rarity of mobile supervised injection services globally, there is limited evidence documenting costs and successes

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• Typically offers a range of harm reduction services including needle and syringe services, testing for blood borne infections (HIV and HCV), and referral to services as listed above[1]	value to fixed services[1]	the same scope of basic medical care and other services as fixed services[2]	

References

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