SUPERVISED CONSUMPTION SITES: INEFFECTIVE AND ILLEGAL

A SUMMARY OF CURRENT RESEARCH

PUBLISHED APRIL 2026

Foundation for Drug Policy Solutions

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WHAT IS A SUPERVISED CONSUMPTION SITE?

Supervised consumption sites (also called safe consumption sites, safe injection sites, overdose prevention sites, or overdose prevention centers) are facilities where people can use drugs with overdose reversal tools—naloxone, oxygen, etc.—and staff nearby to administer them.[1] The first supervised consumption site (SCS) opened in North America opened in 2003.[2]

Today, there are numerous such sites across Canada and Europe.[3] In the United States, there are far fewer, in large part due to legal barriers (see below). Nonetheless, two operate in New York City with the city's tacit approval, and one has opened in Rhode Island with the state's approval. Other states, including Minnesota, are in the process of setting up their own sites. [4]

These sites are generally simple in their set up. Users are meant to bring their own drugs from outside, but most sites provide the requisite "equipment" (e.g., syringes). Users are given a "booth"—often a row of dressing-room-style chairs in front of a table—in which to use. Usually, users are supposed to remain on site, where they can be supervised for the course of their intoxication. Because of space and time constraints, SCSs often do not serve many clients at once—one estimate, for example, suggests that New York City's sites serve about six clients per hour. [5]

SCSs often offer individuals more than a place to use drugs. Many sites test for illnesses like HIV, provide wound care, and offer basic services like showers and food. They also serve as a referral source for additional services, including, in theory at least, addiction treatment, professional development, and housing.

One of the sites operated by OnPoint NYC.

Increased interest in SCSs stems from the overdose epidemic, which is still killing more than 70,000 Americans per year.[6] That is part of a broader increase in interest in "harm reduction," an approach to drug-control policy which aims to reduce the harms associated with drug use without necessarily reducing drug use per se. Additional tools that fall under the umbrella of harm reduction include naloxone, syringe services programs, fentanyl test strips, and the distribution of unadulterated drugs known as "prescribed alternatives" or "safer supply."

SUPERVISED CONSUMPTION SITES DO NOT REDUCE OVERDOSE DEATHS

Supporters of SCS adoption argue that allowing people to use substances in a supervised environment results in faster and more certain intervention, reducing the risk of a fatal overdose. To support this contention, supporters and operators often point to the few or no deaths that happen on-site.[7] A SCS in London, Ontario, for example, had more than 18,000 visitors and treated nearly 200 overdoses between April 21, 2023, and March 31, 2024.[8] Only one person has died at this SCS since it opened in 2018.[9]

These statistics, though, provide an incomplete picture of how SCSs may affect overdose death rates. For example, people who do not overdose (or who have their overdose reversed) in the SCS might overdose and die elsewhere later—a death delayed is not the same as a death prevented. Indeed, 15 percent of people administered naloxone will die within the next year, one study found.[10] That is a death rate 20 times higher than that of the overall population.[11]

Similarly, people who don't overdose at the site may overdose nearby. A report from the government of Alberta, Canada, noted that the number of drug or alcohol poisoning deaths within 500 meters of the province's sites increased by 64.3 percent after they opened, compared to a 29.7 percent increase in the area 501–2,000 meters.[12] The report also noted that opioid-related EMS responses increased by 74.4 percent within 500 meters of the sites, while they decreased by 10.5 percent in the area beyond them.

Furthermore, the sort of person who uses an SCS might otherwise engage in "safer" drug-use behavior—testing their drugs, using more slowly, not sharing needles, etc.—such that their risk of overdose was already lower. Low rates of mortality in-site might, in other words, reflect what social scientists call a "selection" effect, where something apparently caused by the SCS is actually a mirage produced by who uses the SCS. Indeed, studies generally find that using an SCS is associated with such behaviors.[13]

To disentangle these factors, research needs to look at the overall effect of SCS use in a population or area—not just at the site—and compare those using the SCS to a "control group" that doesn't (or uses it less). A number of studies have done so, and the consistent result is that SCSs have no statistically discernible impact on overdose death rates.

Several studies look at the effects of using an SCS on individual injection drug users (IDUs). Folch et al., in a survey of 730 IDUs, finds that greater use of Barcelona's SCS has no effect on rates of non-fatal overdose.[14] Similarly, Milloy et al. in a study of 1,090 users found no significant effect of greater use of Vancouver's Insite facility on non-fatal overdose either before or after adding statistical controls.[15] Lambdin et al., studying 494 drug users in an undisclosed American city, found that usage of an "unsanctioned SCS" had no significant effect on non-fatal overdoses.[16] Similarly, a March 2026 study examined the impact of the closure of the Red Deer site, a British Columbia SCS, and found no increase in opioid deaths during the period of post-closure observation compared to a similar site that remained open.[17]

Some of the best studies look at the effects of opening SCSs in Canada, comparing areas that receive them to areas that don't. Because they contain many "treatment" and "control" areas, these studies provide strong evidence about the effects of SCSs.

One study, by Panagiotoglou, compares "local health areas" (LHAs) in British Columbia with and without SCSs before and after the sites opened.[18] Pivotally, it uses statistical matching techniques to compare 18 LHAs that opened SCSs to control LHAs matched on "population-level age, sex, and income demographics and opioid-related overdose mortality rate." The study finds that there is no significant effect of SCSs on either rates of hospitalization or overdose mortality rates.

The second study, Panagiotoglou and Lim, similarly matches "public health units" in Ontario that opened SCS to control PHUs that didn't. They use a similar but more complicated algorithm to compare them, matching on factors including "provision of prescription opioids for pain management, opioid agonist treatment (OAT), and naloxone kits".[19] In results, they find exactly zero effect of SCSs on ER visits, hospitalizations, or deaths.

There are a handful of more supportive studies that SCS supporters routinely (and selectively) use to try to make their case. These are almost all methodologically weaker than the previously reviewed literature.

One commonly cited paper, Marshall et al., compares the change in overdose deaths surrounding Vancouver's Insite SCS before and after its opening to the rest of Vancouver in the same period.[20] The authors find that deaths decline 35% in the treatment area, relative to 9.3% in the rest of the city. There are two problems with this finding. One is that the surrounding city is not necessarily a good control group—it is not statistically similar to Insite's immediate vicinity. In particular, the larger relative decline in the area around Insite partly reflects that the area had a higher overdose rate before the site opened, meaning it had "further" to fall.[21] Marshall's results are also conspicuously right on the threshold of what social scientists consider statistically significant. That means their result may well be due to chance.

Another commonly cited study, Rammohan et al., similarly finds a significant reduction in overdose deaths in neighborhoods in Toronto that set up SCSs and a non-significant reduction in those that did not.[22] This approach suffers from the same problem as Marshall (that places with higher OD rates will have "further" to fall). The authors also report data from a narrow and oddly specific period, comparing two months in 2017 to two months in 2019. Lastly, they do not statistically compare neighborhoods with and without SCSs directly, instead estimating the effect of proximity to the SCS—a much weaker metric than that offered, for example, by Panagiotoglou and Panagiotoglou and Lim. These studies may be one reason for the recent signficant backlash to SCSs in Ontario and Alberta.

Lastly, supporters sometimes point to papers (including some of those already cited) that show SCSs reducing calls to emergency services. These same papers generally do not show reductions in actual overdose deaths. The effect on emergency service utilization, rather, is likely attributable to similar services being administered on site—doubtless useful, but not an actual cause of reduced overdose death as a whole.[23]

SUPERVISED CONSUMPTION SITES LIKELY VIOLATE FEDERAL LAW

21 USC 856 is a provision of the 1986 Anti-Drug Abuse Act commonly referred to as the "crack-house statute." Then-Senator Joe Biden led the expansion of section 856 in the late 1990s through the RAVE Act. As currently written, the crack-house statute makes it unlawful to:

1. Knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or using any controlled substance;
2. Manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.

Whether and to what extent 856 covers SCSs has been the subject of litigation.

In 2021's *United States v. Safehouse*, the 3rd Circuit agreed with the government that Safehouse, a Philadelphia nonprofit intending to open a city-sanctioned SCS, would violate the crack-house statute if it did so.[24] In so doing, it overturned a lower court, which had previously held that the purpose of an SCS is to reduce rather than facilitate drug use.

The Supreme Court declined to hear an appeal from the 3rd Circuit.[25] Safehouse is now in ongoing litigation over whether or not it can earn an exemption from 856 on the basis of its supposed religious interest in doing so, claiming protections under the Free Exercise Clause and federal Religious Freedom Restoration Act.[26]

That said, both the plain text of the law and the broadest available precedent support the conclusion that supervised consumption sites—including those operating in New York and Rhode Island and planned in Minnesota—violate federal law. Indeed, President Donald Trump's Executive Order from 2025, "Ending Crime and Disorder on America's Streets," specifically instructed the Attorney General to investigate whether recipients of "Federal housing and homelessness assistance that operate drug injection sites or 'safe consumption sites,'" are "in violation of Federal law, including 21 U.S.C. 856, and bring civil or criminal actions in appropriate cases."[27]

A CASE STUDY: NEW YORK CITY[i]

It's library quiet as you enter the reception area. You're greeted by a collection of large stuffed giraffes, the kind you want to hug. The children—from three months to four years old—are taking their midday naps. The walls are accented in bright hues of orange and yellow, along with the names of wealthy New Yorkers who have donated generously to make this place possible: the Association to Benefit Children, or ABC.

Indeed, this is the archetype of a safe and comfy daycare center—except for one unusual fact. Just across the street in a well-worn brick building—not even 50 yards away and in plain sight of the children and their parents—people struggling with addiction are smoking and shooting up illegal drugs. This is occurring with the blessing of the New York City government.

This is the first supervised injection site officially sanctioned in the United States, and its innocuous name—the New York Harm Reduction Educators' East Harlem site—obscures another fact. Its creation late in 2021 reignited a nationwide debate over what the New York Times called "the legal and moral implications of sanctioning illegal drug use."[28]

The supervised injection site is sandwiched between a bodega—a New York-style Spanish grocery—and a homeless shelter, and it does little to announce its presence. The weathered green awning gives away nothing, apart from the street address. The scuffed beige double doors offer not much more than a Covid reminder to wear a mask. Some down-and-out people huddle by the front, not far from a couple of other men hobbling down the street while inhaling something of unknown provenance.

[i] This passage is adapted from Kevin Sabet, One Nation Under the Influence (Polity, 2025)

The city authorized the site, along with a second one in Washington Heights—a neighborhood in the northernmost part of Manhattan—with the stated aim to stem the rising tide of overdose deaths caused by street drugs. This proposal came after New York City lost over 2,000 residents to overdose deaths in 2020, a 37% increase from 2019. Nearly 8 in 10 of these deaths were due to fentanyl.[29]

Justifying the new project, the office of then-New York Mayor Bill de Blasio pointed to the existence of supervised injection sites in Europe and Canada. De Blasio's successor, Mayor Eric Adams, also supported the project. Dr. Dave A. Chokshi, the city's health commissioner, told the Times: "Every four hours, someone dies of a drug overdose in New York City. We feel a deep conviction and also a sense of urgency in opening overdose prevention centers."[30]

The arrival of the East Harlem site was initially met with alarm and resentment by residents who worried that rather than combating drug use, the site would actually encourage more drug use and dealing—right in front of the children of the ABC daycare center across the street.

The pattern reinforces the white supremacist idea that addiction is a Black problem to be contained in Black neighborhoods," Shawn Hill, co-founder of the Greater Harlem Coalition, a grassroots organization of more than 20 Harlem neighborhood associations, said in an interview with one of the authors of this report. Here, a supervised injection site naturally attracts dealers who, in turn, attract more users in search of a hit. It's a vicious cycle; more arrests, a rise in drug overdoses, and more buying and selling of drugs.

His concerns are shared in the neighborhood. "As a parent, I was a little nervous," said a young mother one of us spoke with, Tara, who works at ABC and whose six-month-old son attends the center. Tara, off to fetch a cup of tea on a brisk winter day, said she'd noticed an increase in drug use and homelessness on 126th Street, a barren street marked by barbed wire and graffiti. But as time has gone on, there has been a gradual acceptance by many neighbors of the government-authorized injection site.

In response to an initial surge of controversial media coverage (including graphic images of people with addictions shooting up heroin or cocaine in mirrored booths), the people who run the Harlem site hired a public relations firm to curate who gets a view of the inner sanctum. They gave one to the *New York Times*, which glowingly featured the site's executive director wearing a shirt with "NJ GREEN SCENE" sprawled across it for the world to see—a website that bills itself, "a place for cannabis enthusiasts to share info about their favorite flower."[31] Several people were startled to see a person working with people with substance use disorder wearing a shirt encouraging drug use.[32]

The city's Department of Health and Mental Hygiene built support for the sites using messages like:[33]

- "New York City is in the middle of an overdose crisis. Our friends, neighbors, colleagues, and family members are dying. OPCs save lives;"
- "The OPCs are being run by established, trusted, skilled, and regulated professionals in programs that already exist and have ongoing relationships with the communities they serve;" and
-"These services also improve community outcomes. Evidence from OPCs worldwide shows that they help reduce public drug use, syringe litter, and drug-related crime."

In the sites' first year, 2,841 individuals visited a total of 48,533 times. The sites were open Monday to Friday from 8:30 AM to 4:30 PM, with additional weekend hours at the Washington Heights location. In general, they ran at a ratio of four clients to one "overdose prevention specialist." OnPoint, which had already been operating syringe services programs in the city, had provided services to 66.1% of the individuals prior to their first visit to the SCS.[34]

The most popular drugs used at the sites were heroin and/or fentanyl—used during 50% of visits—followed by crack (42.4%), cocaine (24.2%), and "speedball" (i.e., a mix of opioids and stimulants) (9.5%). 50.7% of the visits involved smoking, 50.4% involved injection, and 4.8% involved sniffing. The two sites responded to 636 overdoses in their first year. EMS was called 23 times, and no deaths were reported.[35]

While in theory SCSs are supposed to serve as an off-ramp for treatment, in New York they do not seem to. In one survey of clients, approximately half (52.5%) received additional support, which "included, but was not limited to naloxone distribution, counseling, hepatitis C testing, medical care, and holistic services (eg, auricular acupuncture)."[36] According to OnPoint's data, just 9% are getting medical treatment—which could include evidence-based medication-assisted treatment—and only 5% are receiving counseling services.[37] "While we don't talk about treatment as a goal," OnPoint executive director Sam Rivera said in an interview with STAT News, "almost all of our participants talk about it all the time," noting that OnPoint instead connects people to treatment once they are ready for it. [38]

Although many used the SCS, most did so only a few times—a small fraction of their total use sessions. In the first-year data, 946 (33.2%) of clients visited the SCSs only one time; 1,160 (40.8%) visited them an average of 3 or fewer times per month; 650 (22.9%) visited them between 4 and 19 times per month, and just 85 (3.0%) visited them 20 or more times per month.[39] The mean number of visits per participant was 17, and the median number of visits was 3. Three-fourths (74.7%) had a gap of at least 2 months between visits.

Interviews with twenty-two New York drug users cast light on why the SCSs were little used. [40] A top concern among interviewees was that the sites were often located far away; as one put it, "I would use it if it was close to where I was. I wouldn't go out of my way to get there." Others were concerned about the wait times at the sites, which could be an hour, with one explaining that "if maybe you want to get off [get high], you know at the moment, then it isn't gonna work...Because you got to wait until a spot comes up."

Several interviewees also noted that they preferred not to use their drugs in the facilities; one explained, "I always had the preference of doing drugs at my house. So, when the drugs do run out, I'm just home, you know what I mean? I would never."

The literature provides ambiguous results on how the SCSs affected local disorder. Chalfin et al. found no significant change in violent crimes or property crimes on the affected blocks.[41] However, Hall and Ratcliffe "identify a 167% increase in property crime after the introduction of the SCS at the Washington Heights site."[42] They attribute this difference to "differing definitions of property crimes. While Chalfin et al.'s study[43] limited its scope to major larceny, defined as theft of over $1000 in value in New York State, our analysis included all reported larcenies, both grand and petty," adding that they also employed different spatial and analytical approaches.[ii]

The Harlem and Washington Heights sites are the natural outgrowth of the more extreme corners of the harm reduction movement, some proponents of which favor legalizing all drugs. These ideas are also popular among some New York City officials. But many in the Harlem community appear to be more unhappy about how the supervised injection site was established than about the ongoing program. The community wasn't consulted before the site was approved and, as community leaders point out, there was already a saturation of programs aimed at addressing substance misuse in the neighborhood. Residents were concerned that these programs would concentrate the unwelcome side effects of addiction in their communities.

The sites are divisive among the general public. A 2024 poll from Sienna College asked nearly 1,000 residents of New York State whether they supported or opposed "increasing funding for supervised injection sites where it would be safe to use heroin and other injected opioids." Only 46% answered that they supported these sites, while 54% opposed them.[44]

THE OPPORTUNITY COST OF SCS

Supervised Consumption Sites are not free to operate. One estimate of the cost of a site in Rhode Island concluded that adding SCS services to a syringe exchange program would raise the programs cost to $1.6 million per year, slightly less than doubling the baseline cost of running the Syringe Exchange Program alone.[45] Another analysis, focused on an existing site in Calgary, Canada, pegged the facility's operating cost at over $3 million in 2019.[46] These figures may seem high, but make more sense when you consider the expense of operating and staffing a brick-and-mortar harm-reduction facility around the clock throughout the year.

Advocates generally argue that these high operating costs are offset by the health benefits of running the SCS. But—as previously argued—these benefits are somewhere between overstated and non-existent. If SCSs do not actually reduce drug overdose deaths, then it becomes harder to justify spending millions of dollars a year on them—especially as compared to the benefits associated with other harm reduction or treatment interventions.

ii In the comment section of JAMA, a UCLA doctoral student wrote that the positive claim by Chafin et al. was "overly rosy as not all crimes are equally severe, and a potential 'safe injection site' attributable increase in aggravated assaults is undoubtedly a matter of public concern."

For example, distributing the overdose-reversing drug Naloxone (also known as Narcan) generally is a cost-effective intervention,[47] with one estimate finding over $2,000 of benefit for every $1 expended on naloxone programs.[48] Medication-assisted treatment, e.g. with buprenorphine or methadone, is also generally assessed to be worth the investment thanks to evidence-based effectiveness at reducing use.[49] The benefits of interventions targeted at reducing substance use disorders accrue not only to patients but to society, for example by reducing criminal behavior associated with addiction.[50]

Policymakers have a fixed pool of dollars to spend on the still-pressing drug overdose crisis. SCSs are, even by generous estimates, expensive to operate. While that expense might be justifiable if they were effective, the limited evidence of their efficacy suggests those dollars could be better spent somewhere else.

CONCLUSION

Although enthusiasm for them has waned over the past several years, Supervised Consumption Sites remain a live topic of discussion among many state legislators and public health officials. Supporters extol their life-saving virtues, arguing that they are essential to addressing the ongoing drug overdose epidemic.

The truth is more banal: the best available evidence indicates that supervised consumption sites do little to nothing to reduce drug overdose deaths in their surrounding communities. They also face significant legal barriers to operation, particularly with a more hostile administration in the White House (and an arguably equal hostility from the previous White House administration). There is some reason to believe they increase disorder, petty crime, and other social problems in their immediate proximity. And while they may hypothetically serve as an offramp to treatment, in practice they seem often to simply enable continued drug use.

As drug trends evolve, adulterants such as xylazine—a non-opioid tranquilizer which is not responsive to naloxone—contaminate the drug supply, and use of stimulants like methamphetamine (also unresponsive to naloxone) increases, the ability for overdoses to be reversed at these sites may also decrease.

It is understandable on a basic human level that those who have a loved one struggling with substance use disorder would see Supervised Consumption Sites as a useful tool to forestall a fatal overdose.

But, when states face significant budget constraints in allocating scarce taxpayer, federal grant, and opioid settlement dollars, the question has to be: how can we help the greatest number of people with the resources we have? From the perspective of the smart spender, scarce resources are better used on other, more effective strategies—naloxone distribution, medication-assisted and evidence-based treatment, focused and deliberate law enforcement, and evidence-based prevention programming —than they are on supervised consumption sites.

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