In Support of Overdose Prevention Centers: Position Statement of AMERSA, Inc. (Association for Multidisciplinary Education and Research in Substance use and Addiction)

Authors

Katherine Dunham, MPH[1]
Katherine Hill, MPH[2]
Hannah Kazal, MD, ScM[3]
Jenna L. Butner, MD[4]
Ilana Hull, MD, MSc[5]
Kimberly Sue, MD, PhD[4]
Li Li, MD, PhD[6]
Kristin Doneski[7]
Beth Dinges, PharmD[8]
Tessa Rife-Pennington[9, 10]
Sunny Kung, MD[11]
Kinna Thakarar, DO, MPH[12,13,14,15]

Affiliations

[1] Department of Epidemiology, Brown University School of Public Health, Providence, RI, USA
[2] Department of Epidemiology of Microbial Diseases, Yale School of Public Health, New Haven, CT, USA
[3] Division of Addiction Medicine, Department of Family Medicine, Maine Medical Center, Portland, ME, USA
[4] Department of General Internal Medicine, School of Medicine, Yale University, New Haven, CT, USA
[5] Department of Medicine, University of Pittsburgh Medical Center, Pittsburgh, PA, USA
[6] Department of Psychiatry and Behavioral Neurobiology, University of Alabama at Birmingham, Birmingham, AL, USA
[7] Harm Reduction Program / Needle Exchange, Portland Public Health, Portland, ME, USA
[8] Pharmacy Service, Veteran Affairs Illiana Healthcare System, Danville, IL
[9] Pharmacy Service, San Francisco Veterans Affairs Health Care System, San Francisco, CA, USA.
[10] School of Pharmacy, University of California, San Francisco, San Francisco, CA, USA.
[11] Mass General Brigham Community Physicians, Haverhill, MA, USA
[12] Center for Interdisciplinary Population & Health Research/Maine, Portland, ME, USA
[13] Department of Medicine, Maine Medical Center, Portland, ME, USA
[14] Tufts University School of Medicine, Boston, MA, USA
[15] Maine Medical Partners Adult Infectious Diseases, South Portland, ME, USA

Contact Information

Kinna Thakarar (ORCID ID: 0000-0003-4689-0240)
Phone: 207-661-7901

Email: Kinna.Thakarar@mainehealth.org

ORCID ID:
Kinna Thakarar 0000-0003-4689-0240

Abstract
Given increasing rates of fatal overdoses in the United States and the rapidly changing drug supply, overdose prevention centers (also known as safe consumption sites) have been identified as a vital, evidence-based strategy that provide people who use drugs' (PWUD) the opportunity to use drugs safely and receive immediate, life-saving overdose support from trained personnel. In addition to providing a safe, supervised space to use drugs, overdose prevention centers (OPCs) can house further essential harm reduction drop-in services such as sterile supplies, social services, and medical care. There are established national and international data demonstrating the lifesaving services provided by OPCs, inspiring a groundswell of advocacy efforts to expand these programs in the United States. Thus, the Association for Multidisciplinary Education and Research in Substance Use and Addiction (AMERSA) endorses OPCs, in addition to other harm reduction strategies that protect PWUD. Ultimately, it is imperative to increase access to OPCs across the United States and support key policy changes at the local, state, and federal levels that would facilitate urgent expansion.

Highlights

- Overdose prevention centers (also known as safe consumption sites or harm reduction centers) provide supervised, safe places for people to use drugs, immediate overdose prevention services, and linkages to health and wellness services.
- Extensive research has demonstrated that overdose prevention centers contribute to numerous positive public health outcomes including overdose prevention, reduced transmission of infectious diseases, access to healthcare services, and social connection.
- Key policies at the community, state, and federal levels can help support the creation and sustainability of overdose prevention centers.
- It is critical that overdose prevention centers meet the needs of the specific communities they serve, involve people who use drugs in all phases of their design and operations, and center principles of equity and anti-racism in their implementation.

Key Words
Harm reduction; overdose prevention centers; substance use; public health; policy

Background
In 2021, more than 106,000 Americans died of drug-related overdoses, a 14% increase from the year prior.[1] Infectious diseases among those who use drugs (e.g., hepatitis C virus, human immunodeficiency virus (HIV), infective endocarditis) have also been rising nationally and continue to be of concern.[2–4] In this context, overdose prevention centers (OPCs) are a vital resource.[5] OPCs provide supervised, safe places for people to use drugs, immediate overdose prevention services, and linkages to health and wellness services. In OPCs, people are able to

use their pre-obtained drugs in the presence of trained staff who can intervene in the event of an overdose or other health emergency. Globally, these spaces are also known by other names — such as safe consumption sites, safe injection sites, or harm reduction centers — and are often co-located within larger harm reduction drop-in centers. Herein, we will utilize the term "overdose prevention center" because of the widespread use of the term nationally and the existing literature recommending such phrasing.[6–9]

The Association for Multidisciplinary Education and Research in Substance Use and Addiction (AMERSA) endorses harm reduction strategies that protect persons who use drugs.[10] This position statement has been developed on behalf of the AMERSA Board of Directors.

OPC Operations

OPCs operate in many different ways based on the needs of their clients and local communities. Based on these needs, existing OPCs have operated out of tents,[11] have been integrated into existing brick-and-mortar harm reduction organizations,[12] and have been located inside of hospitals.[13] Mobile sites have also operated out of vans or buses, bringing overdose prevention services directly to high priority locations.[14,15] Furthermore, some sites have tailored their services to specific populations, acknowledging that these populations face unique barriers when trying to access harm reduction services. For example, SisterSpace in Vancouver, an OPC exclusively for women and non-binary individuals, has been designed and implemented to address gender-based discrimination and violence.[16] Existing sites have also found it important to include clients in developing guidelines and rules for the space, making the site more relevant and accessible for clients while also creating a sense of buy-in.[17] Additionally, OPCs can operate under a variety of staffing models based on available resources and client preferences. Staff at existing OPCs have included healthcare professionals (i.e. nurses, paramedics), counselors, as well as staff with lived or living experience of substance use.[15] Notably, OPC clients have felt that having staff members with lived experience improves comfortability in the space.[11] Finally, OPCs can offer many different health services based on clients' needs and preferences, including safer use equipment and education,[15] drug checking services,[18] and connection to other healthcare services (e.g. substance use treatment, primary care, mental health, sexual health services, HIV and hepatitis C testing and treatment, wound care, etc.[15,19]).

OPCs In Context

Globally, OPCs have existed for over 30 years – whether sanctioned or unsanctioned by local governments – and are currently operating in at least 16 countries.[20,21] Insite, the first sanctioned site in North America, opened in Vancouver in 2003.[22] Currently, two sanctioned OPCs are operating in New York City, and two states — Rhode Island and Minnesota — have legalized OPCs at the state level. In other locations across the United States, unsanctioned sites are also providing lifesaving care.[23–25]

While OPCs will not be a panacea for the ongoing overdose crisis, they are an important tool in our larger harm reduction toolbox. There are numerous complementary approaches that similarly support PWUD's ability to use safely — the creation of a safer supply, drug decriminalization, telephone and digital-based overdose monitoring services like Never Use

Alone and the Massachusetts Overdose Prevention Helpline, community-based drug checking services, and syringe service programs — all of which should be promoted.[26–35]

Public Health Outcomes of OPCs

In the absence of randomized controlled trials on OPCs, current evidence about their efficacy and potential causal effects are inferred from associations discovered during quasi-experimental studies and observational studies, and theorized from descriptive studies.[36] Through such research, OPCs have consistently demonstrated – for decades – overwhelmingly favorable outcomes related to overdose.[23,37–44] For example, at The Molson, an OPC in Vancouver that had almost 130,000 visits from September 2017 to August 2019, not only did no fatalities occur, but 770 overdoses were reversed.[18] This benefit has also been found in OPCs in the United States, with OnPoint NYC — the organization operating the nation's first two publicly recognized OPCs — averting 636 overdoses during their first year of operation.[45] During this time, the majority (83%) of opioid overdoses were resolved without naloxone and, rather, utilized protocol-based response strategies (oxygenation, agitation, monitoring, etc.) that do not induce precipitated withdrawal.[45] Furthermore, OPCs' overdose prevention benefits may extend to the surrounding community. For example, at an OPC in Vancouver, authors found a statistically significant reduction in fatal overdoses within 500 meters of the site but not in other parts of the city.[39] The implementation of OPCs has also been associated with a significant decrease in ambulance attendances at opioid-related overdoses in the community.[46]

OPCs contribute to numerous positive public health outcomes beyond overdose prevention, as PWUD can readily access harm reduction services, medical care referrals, and social connection in these spaces. Some of these positive public health outcomes are described below:

Reduced Transmission of Infectious Diseases: Numerous studies have demonstrated that OPCs are associated with safer use practices, largely because OPCs can provide PWUD access to harm reduction supplies (i.e., sterile syringes, alcohol wipes, sterile water, sharps containers for used syringes, etc.) in a safe and hygienic environment (i.e., sanitized surfaces, protected settings without fear of violence or arrest, etc.) where individuals can take their time to use in a sterile fashion.[47] The provision of safer use supplies to PWUD reduces the risk of acquiring drug use-associated infections, such as HIV and hepatitis C, as well as skin and soft tissue infections and endocarditis.[48–51] As such, multiple studies have shown improved infectious disease related outcomes among those with access to an OPC.[44,52–54] Additionally, OPCs facilitate opportunities for (a) education from trained staff on safer use practices and vein care, (b) connections to testing and treatment for infectious diseases such as HIV and hepatitis C, and (c) screening for other infections such as sexually transmitted infections.[47]

Increased Access to Healthcare Services: Not only does data show decreased emergency care utilization and hospitalizations among PWUD who access OPCs,[55] but these centers can improve access to additional healthcare services through care provided on-site or by referral.[19,44,56,57] Of note, if clients are interested, OPCs can facilitate connections to substance use treatment (e.g., medications for opioid use disorder, counseling services, etc.) and medical

withdrawal management.[56,58–60] This has been a key outcome of OPCs, as has subsequent cessation of injection drug use – identified during follow-up evaluations of OPC outcomes.[38,56] Moreover, with the increased prevalence of xylazine-contaminated fentanyl across the United States, many PWUD need access to wound care services given the debilitating nature of xylazine-associated wounds.[61–63] Given that OPCs are healthcare settings with trained staff, these environments are well positioned to address the medical consequences of an unpredictable drug supply; this is especially important for people who might not be able to access – or might feel uncomfortable in – traditional medical settings due to established barriers such as the cost of care, anticipated stigma, and access to health insurance.[64,65] Additionally, OPCs can provide broader health and wellness services to clients such as food, clothing, and showers.[15,64]

Improved Social Connection: OPCs create a safe, shared space for community and social connection. Access to OPCs has allowed PWUD to have an increased sense of belonging, provided a refuge from dangerous conditions on the street (e.g. assault, theft, criminalization, etc.), improved perceptions of support, and reduced feelings of stigma and shame around drug use.[19,41,44,66–68] In addition to these significant social and mental health outcomes, having access to social support and larger networks has been found to be protective against overdose.[69,70] One qualitative study in Ottawa, Canada found that PWUD came to think of their OPC as a "social hub" and "safety net" where they became connected to a community that cared about them.[19] However, it is important to recognize that these feelings of belonging and enhanced social connection may vary among clients. Evidence has shown that PWUD from marginalized groups (e.g., people of color, LGBTQIA+ individuals, women etc.) do not always experience such social benefits.[16,19,71] Therefore, OPCs must identify and implement mechanisms to equitably extend these benefits to all clients.

Expanded Community Benefits: Ultimately, with the improved health outcomes associated with OPCs, many studies have shown them to be cost-effective.[54,72–75] At the community level, OPCs have also been associated with reductions in both local syringe litter and public drug use.[76–79] OnPoint NYC, for example, has a community hotline to address syringe litter and/or public drug use, with a mobile team of community specialists that quickly respond to sightings of syringe litter and/or public drug use.[45] Importantly, it has been demonstrated numerous times that OPCs do not lead to increased drug use, crime, or drug selling in the area of the site.[36,37,44,80–85]

Policy Options

In the United States, state legislatures have the authority to sanction an OPC's operation, as states hold the power to make decisions that protect their citizens and public health.[86,87] Such state power has a clear precedent, for example with the state-by-state legality of cannabis.[88] Beyond the legislature, states can utilize executive authority from the governor or commissioner of health, depending on the state's specific laws, to create administrative action that allows an OPC.[86] The state-level sanctioning of OPCs would prevent local and state police from legally interfering with activities critical to the OPC's success (i.e. threatening arrest for PWUD entering and exiting the OPC) and would provide protection for OPC staff. Recently, through respective state governments, both Rhode Island (2021-H 5245A, 2021-S 0016B) and Minnesota (SF2934)

have sanctioned the operation of OPCs.[89–91] Other states' lawmakers, including Connecticut, Colorado, Illinois, Nevada, New Jersey, New Mexico, Massachusetts, and Vermont, are in the process of creating and advocating for legislation that would allow them to join these pioneering states in the formation of legally sanctioned OPCs. That being said, significant state-level barriers still exist; in California, for example, Governor Newsom vetoed a 2022 bill that would have authorized the establishment of OPCs in the state.[92]

Additionally, some local governments have also made strides in implementing OPCs through their limited police power (i.e., ability to enact laws for the good of public health), from officials such as mayors or the city council.[86,93,94] Locally-sanctioned OPCs such as OnPoint NYC have been successful despite lacking state-sanctioned protections through (a) assurances by law enforcement and local attorneys that no criminal prosecutions will be brought upon staff or clients, (b) involvement of health department officials, and (c) community-based buy-in through adequate and transparent communication.[12] Unfortunately, barriers at the local level can also impede OPCs; for instance, Philadelphia's city council passed a bill in late 2023 that created zoning rules that significantly hinder OPCs path to implementation.[95]

At the federal level, the Controlled Substances Act is a federal law that prohibits (a) "illicit" drug possession (Section 844) and (b) the opening or management of a place that is created for the purpose of using an illicit drug (Section 856, or the "Crack House Statute").[96,97] When Safehouse, a Philadelphia-based nonprofit, announced that they planned to open an OPC in 2018, the federal government stepped in and sued this group, citing Section 856 of the Controlled Substances Act.[98] *United States v. Safehouse* was taken to a district court in 2019 which ruled the OPC opening would *not* be in violation of Section 856 of the Controlled Substances Act.[99] Accordingly, after the Final Declaratory Judgement in 2020, Safehouse prepared to open its doors. However, just days after this judgment, a Notice of Appeal was filed by the federal government to the Court of Appeals for the Third Circuit.[100] An emergency motion to stay, which blocked Safehouse from opening their OPC, was eventually approved.[101] Subsequently, the Third Circuit court overturned the original district court decision by a 2-1 split in 2021, arguing that the OPC *would* be in violation of Section 856.[102] Currently, Safehouse continues to explore options in the court that would allow them to legally operate their OPC.[103] Thus, unfortunately, whether or not an OPC has been sanctioned by a state or local government, federal laws place sanctioned OPCs under the threat of federal interference.

Ultimately, movements toward the formal sanctioning of OPCs will require sustained activism and advocacy on every level: local, state, and federal. In order to support these efforts, it is crucial that clinicians, researchers, educators, and community members stand with the decades of evidence supporting OPC implementation. Further, it remains paramount to not only codify protections for OPC clients, staff, and clinicians, but to ensure OPC sanctioning (a) does not lead to any further criminalization of drug use and (b) addresses racial inequities created by existing laws and policies. Specifically, it is imperative to combat laws created and maintained by the War on Drugs which systematically target, dehumanize, and disproportionately incarcerate people of color. Thus, the sanctioning of OPCs — which would provide newfound and unprecedented legal protection to people of color, allowing them a space to use drugs

safely and free of prosecution and harassment — exists in stark opposition to the country's historical, racialized criminalization of drug use.

AMERSA's Position

In the context of the worsening overdose crisis and increasingly lethal drug supply, it is imperative that we support PWUD's right to use drugs safely, supporting and expanding evidence-based harm reduction strategies such as OPCs. To do so, we must advocate for the sanctioning and expansion of OPCs in the United States, leveraging our privilege and positions as leaders in our fields to increase public support for OPCs among key stakeholders (e.g., our local communities and legislators). Moreover, it is critical that we support the thoughtful, sustainable, and community-driven implementation of these programs. An OPC's implementation and operation should be tailored to and driven by local community needs. Therefore, potential clients should be involved in all phases of the planning, design, implementation, and evaluation of these sites. Additionally, OPCs should consider operational recommendations and best practices already substantiated in both national and global contexts. Finally, principles of equity, intersectionality, and anti-racism must be prioritized in the implementation of these sites. This will involve accommodating multiple methods of use (e.g, injection and inhalation) and ensuring that the OPC space is comfortable and accessible for marginalized populations that may face additional discrimination and risks when utilizing these services.

Recommendations

Given this evidence and the demonstrated public health benefits of OPCs, we propose that we leverage the position of AMERSA as interdisciplinary leaders in substance use education, research, care, and policy to:

- Disseminate accessible, relevant, and evidence-based information on OPCs — including data that address common misconceptions regarding their establishment and use — to key groups such as legislators, policymakers, clinicians, researchers, and community members.
- Support and advocate for the legalization and expansion of OPCs at the local, state, and federal levels.
- Prioritize the thoughtful, sustainable, and community-driven implementation and evaluation of OPCs. It will be critical that OPCs meet the needs of the specific communities they serve, involve PWUD in all phases of their design and operations, and center principles of equity, intersectionality, and anti-racism in their implementation and evaluation.
- Create opportunities for members to discuss barriers and facilitators to OPC implementation and support the dissemination of qualitative and quantitative research on OPCs, including via AMERSA's annual conference and official journal.
- Explore and support the use of complementary overdose prevention strategies such as syringe service programs, virtual overdose monitoring services, and community-based drug checking programs.

Author Contributions

K.T. conceived of the present idea. K.D. and K.H. prepared the manuscript. All authors provided feedback and edits to the manuscript. All authors approved of the final version of the manuscript.

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The Authors declare that there is no conflict of interest. The opinions expressed in this article represent those of AMERSA and the authors, not necessarily the institutions they are affiliated with.

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