

Overdose Prevention Centers: An Essential Strategy to Address the Overdose Crisis

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In 2021, more than 107 000 people died from a drug overdose in the US,¹ a 15% increase from 2020. Deaths involving cocaine increased 23%, and deaths involving methamphetamines or other stimulants increased 34%.¹ Death rates are increasing the most rapidly among people experiencing homelessness² and among American Indian or Native American, Black, and Latinx individuals.³

These staggering numbers demonstrate an urgent need for immediate action. In recent years, there has been expansion of proven harm reduction strategies to reduce overdose deaths. Harm reduction is a way of approaching and caring for people who use drugs that centers people's dignity, humanity, and autonomy to reduce harms associated with substance use. It uses practical strategies to meet people where they are to improve individual and community well-being and health. Decades of robust research on harm reduction strategies, specifically syringe services and naloxone distribution, demonstrate that these strategies are associated with reduced morbidity, mortality, and transmission of infectious diseases and improved individual health outcomes and services engagement and that they have high cost-effectiveness.


The use of overdose prevention centers (OPCs) is an evidence-based harm-reduction intervention that, until recently, has not been available in the US. OPCs, which are sometimes referred to as supervised consumption centers, are places where people can consume preobtained drugs in a monitored setting where staff can immediately intervene in the event of an overdose. People who use the centers can be provided or linked to wraparound services, including other harm reduction services, basic needs (eg, housing or food), medical services, and addiction treatment. There are more than 120 OPCs in 10 countries across Europe, Australia, and Canada. Models range from peer-run facilities to mobile units and medical models colocated with addiction treatment programs. Regardless of model type, all OPCs provide a safe, nonjudgmental setting with staff trained to intervene in the event of an overdose and provide individualized support and linkage to services.^{4,5}

Research has found that OPCs are associated with benefits for individuals who use the centers and neighborhoods where the centers are located.^{4,5} OPCs have been found to be associated with reduced overdose deaths, substance use-related harms, and all-cause mortality among people who use drugs and to be cost-effective.^{4,5} OPCs have also been found to be associated with increased treatment engagement, with regular center use, but not with increased drug trafficking, initiation of substance use among people who did not previously use drugs, or resumed use among people in recovery. An evaluation of an unsanctioned US OPC that operated from 2014 to 2021 found high rates of center use without any overdose deaths.⁶ For surrounding neighborhoods, OPCs have been shown to be associated with reduced public drug consumption, litter of drug consumption equipment, and crime.^{4,5}

In November 2021, OnPoint NYC opened the first government-sanctioned OPCs in the US. Harocopos et al⁷ describe patient encounters at OnPoint NYC's 2 OPCs in the first 2 months of operation. There were nearly 6000 visits by more than 600 individuals. Among those who used the OPCs, more than one-third of participants were unhoused, a minority of participants (17.8%) had their own room or apartment, and three-quarters of participants reported that they would otherwise have used drugs in a public or semipublic location. Staff intervened 125 times to mitigate overdose risk, which included oxygen or naloxone administration for individuals using opioids, and hydration,

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cooling, or de-escalation for individuals with stimulant-related symptoms (eg, overamping). Individuals were transported to emergency departments 3 times. There were no overdose fatalities.

This first description of OnPoint NYC suggests not only that OPCs are feasible, but also that individuals who were unhoused, who are at extremely high risk of overdose death, were willing and interested in using OPCs. Interventions at the center to mitigate overdose risk suggest, as previously observed in other countries, that OPCs in the US may provide an effective strategy associated with reduced overdose deaths and reduced public drug consumption.

While OnPoint NYC is the first government-sanctioned OPC in the US, there have been prior attempts to open OPCs in the US that have encountered legal, financial, and logistic challenges. The most well-known of these is Safehouse in Philadelphia, which faces ongoing legal challenges about whether it would violate the federal Controlled Substances Act. Despite these legal challenges, multiple other cities and states have explored opening OPCs. In 2021, Rhode Island, where we work, passed a law allowing for the opening of pilot OPCs licensed and regulated by the state department of health. Two of us (E.A.S. and D.A.B.) had the opportunity to sit on the Rhode Island governor's advisory committee and help craft these regulations.

Stigma and discrimination toward people who use drugs intensify legal, financial, and logistic barriers to opening OPCs. Uncertainty about federal legality has hampered implementation efforts, although some municipalities and states have moved ahead with opening centers to stem devastating increases in overdose deaths. There are also important logistic considerations to opening OPCs, including location, zoning, and insurance. Given increasing death rates among people who use stimulants and racialized criminalization associated with crack cocaine, it is crucial that OPCs ensure space for different modes of drug consumption (eg, smoking, injection, and inhalation) and OPC engagement with community, local, and state stakeholders. OPCs must also be informed by the needs of people whom they aim to help and ensure accessibility and inclusivity to not only have the desired public health impact, but also prevent perpetuating or exacerbating racial and gender inequities. Having supportive laws, municipalities, and positive working partnerships among harm reduction, public health, medical, and government agencies will be key to OPC success.⁴ However, this is not sufficient. To build successful programs, organizations in a position to run OPCs will need funding to build these new programs. Existing harm reduction agencies and organizations already contend with constrained resources, and we cannot ask them to do even more with less.

Evaluation is critical to measuring and improving OPC health outcomes. Despite decades of evidence in other countries, US OPCs will be subject to heightened scrutiny and OPC evaluations will need to be rigorous, high quality, and thoughtfully designed. Inappropriate selection of outcome measurements or expectations for outcomes, for example, may produce measures that do not accurately reflect comprehensive public health outcomes associated with OPCs. Measured outcomes should be appropriate to OPC roles and functions. Previous evaluations conducted internationally and at the unsanctioned US OPC provide models for evaluation and go beyond center operations and individual health outcomes, such as overdose death and services engagement, to also examine neighborhood outcomes.⁴ These types of multifaceted evaluations may help assess OPC effectiveness, identify opportunities for improvement, and support implementation.

The opening of OPCs in the US is an important addition to our national overdose-prevention strategy. These centers alone will not solve the overdose crisis but are 1 component of a comprehensive, person-centered strategy to reduce overdose deaths. This includes treating people with dignity, rather than stigmatizing, criminalizing, and incarcerating them, and addressing root causes of substance use, particularly systems that produce health inequities. Since the 1970s, the US has primarily taken a criminal justice approach to substance use, and the country now has more deaths than ever. To prevent further increasing deaths, we can and need to fundamentally transform our approach—and urgently. We cannot afford to wait.

ARTICLE INFORMATION

Published: July 15, 2022. doi:10.1001/jamanetworkopen.2022.22153

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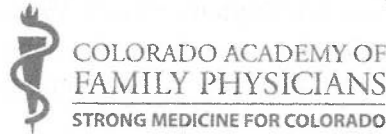
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Conflict of Interest Disclosures: Dr Samuels was partially supported by a grant from the National Institute of General Medical Sciences of the National Institutes of Health and by the Substance Abuse and Mental Health Administration New England Addiction Technology Transfer Center.

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March 30, 2023

Re: Medical Provider Support for HB23-1202

Dear Chairwoman Fields and Members of Senate Health and Human Services Committee,

As physicians, nurse practitioners, physician assistants, and nurses caring for people with substance use disorders across Colorado, we write in unified support of **HB23-1202, Local Control of Life-Saving Overdose Prevention Centers**.

Overdose Prevention Centers (OPCs) are safe sanctioned spaces with medical oversight designed to reduce fatal overdoses and other serious health problems associated with drug use, including endocarditis, skin infections, hepatitis C and HIV. In the context of an unpredictable drug supply that now often contains fatal amounts of fentanyl and, increasingly, xylazine, OPCs help keep people alive and provide them an opportunity for recovery. Amid the worst overdose crisis in history and while working in an overwhelmed healthcare system, we—frontline providers—are asking legislators to ensure we have every evidence-based tool available to us to do our jobs. OPCs are but one tool in our toolbox that will help us as we care for Coloradans.

The first modern OPC opened in Switzerland in 1986. There are now some 200 OPCs operating in at least 15 countries, including war-torn Ukraine and the United States. Evidence from across the globe demonstrates a decrease in crime, vagrancy, and discarded needles in communities with OPCs. Importantly, **there is no scientifically valid evidence that OPCs increase or enable drug use**. But there is ample evidence OPCs decrease overdose deaths. Since opening in December 2021, two New York City-based OPCs report having reversed nearly 700 overdoses and zero deaths. In addition to preventing fatal overdoses, OPCs prevent health conditions that commonly result in hospitalization, allowing healthcare providers to focus on other urgent health crises. People who regularly use OPCs have higher rates of initiating addiction treatment and counseling. Linking to treatment services is often a first step in the recovery cascade.

We deliver healthcare in diverse locations across the state and we know HB23-1202 will not itself establish any OPCs in Colorado. Instead, this bill will allow municipalities, with direction from government officials, community members, and public health and medical experts, to decide if this tool is right for their community. We understand that no funds will be allocated from the State as a result of this bill and no one will be forced to open, or even consider, an OPC if it is not desired by that community.

Finally, we are, by nature, hopeful people. We hope for a world where one day we won't need OPCs, where we take care of people before they experience a crisis. We hope for a day where everyone can experience life in optimal health. We want people and our communities to be whole – OPCs are a bridge to get us there. We hope you will work with us in helping make our communities whole. We enthusiastically and emphatically urge a yes vote on HB23-1202.

Thank you for your leadership on the critical issues impacting our most vulnerable patients.

Sincerely,

Organizational Signatories

Colorado Academy of Family Physicians
Colorado Association of Local Public Health Officials
Colorado Nurses Association
Colorado Psychiatric Society
Colorado Society of Addiction Medicine

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Senate Health and Human Services Committee

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PLEASE SIGN THIS LIST ONLY IF YOU WISH TO TESTIFY.

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