Public Policy Statement on Overdose Prevention Sites

Background

The United States has seen staggering increases in drug overdose deaths since the beginning of the 21st century. The 12 months ending in May 2020 witnessed the largest number of drug overdose deaths for a 12-month period ever recorded. Synthetic opioids, likely illicitly manufactured fentanyl entering the drug supply, are the primary driver of the increase in overdose deaths, but overdose deaths involving cocaine and psychostimulants have increased significantly as well.[1] The persistence and severity of the drug overdose epidemic calls for innovative and patient-centered strategies to prevent deaths and reduce other harms from drug use, while expanding access to evidence-based treatment.

A comprehensive approach to this crisis must include the full continuum of evidence-informed services ranging from primary prevention and early intervention to treatment and recovery support. Throughout this continuum, harm reduction principles that focus on an individual's humanity, preferences, and needs can be applied to maximize patient engagement and support their health goals. People who use drugs (PWUD) and are at risk for overdose may or may not meet the diagnostic criteria for a substance use disorder (SUD). Even among those who meet diagnostic criteria for an SUD, some may not be seeking treatment or may not be interested in abstinence from drug use. Accordingly, an array of harm reduction-based approaches and proven tertiary prevention strategies focused on reducing overdose and infection transmission (such as naloxone access and syringe services programs) are needed outside of treatment settings to help mitigate the negative consequences of drug use.

Overdose prevention sites (OPS), also known as supervised injection facilities (SIFs) or safe consumption sites (SCS), are places where people may consume previously obtained drugs in a hygienic, monitored environment without fear of arrest. The term OPS focuses on the overall purpose of these sites, and the shift to refer to them as OPS rather than SIFs or SCS reflects an effort to reduce stigma and emphasize their public health goals. Where they exist, these sites have been established in response to community recognition of local need. The goals of OPS are primarily to prevent deaths and reduce harms from drug use (e.g., HIV, hepatitis B and C, and skin infections), as well as provide linkages to treatment and/or other services, and reduce public disorder.[2] OPS are located primarily in high drug-use areas and serve marginalized and hard-to-reach populations facing barriers to good health and/or safe living, including people who engage in sex work, people who are experiencing homelessness or housing insecurity, and people with a history of incarceration.[3]

Internationally, OPS are typically staffed by health professionals and case management specialists, although some OPS also employ PWUD for peer coaching and support. These peers

support program participants in a number of ways, including educating on safer consumption practices; distributing sterile equipment and condoms; providing naloxone kits and overdose prevention education; facilitating access to testing for hepatitis and HIV infections; providing supplies to test for drug contaminants; supervising the injection of pre-obtained drugs; referring program participants to treatment and other community support services; and assisting in the event of an opioid overdose through naloxone and/or oxygen administration and calling for emergency medical services.[3]

As of 2018, more than 100 legally sanctioned OPS have been established in Europe, Canada and Australia. Studies of their effectiveness demonstrate that these facilities successfully attract the most marginalized PWUD, promote safer injection conditions, enhance access to primary care, and reduce overdose frequency.[4] Additionally, the evidence suggests that these facilities have not led to any increases in drug use or crime in the area around the OPS.[3] Rather, an evaluation of an OPS in Australia found that local residents and business operators perceived significant community improvements five years after its opening.[5]

Studies assessing the acceptability of OPS among PWUD in U.S. cities have revealed high acceptability and willingness to use an OPS. [6,7] Studies of community members and businesses show an openness to OPS, provided that they are established with significant community collaboration and they yield community public health and safety benefits. [8,9,10] Models of potential OPS' cost-effectiveness in U.S. cities estimate that OPS would not only be highly cost-effective, but that they would contribute significant public health benefit. [11,12] While no sanctioned OPS exist in the U.S., at least one unsanctioned OPS has existed in an undisclosed city in the U.S. since 2014. Findings from the site show that there have been over 10,514 injections observed at the OPS, with 33 documented overdoses, all which were reversed by volunteer staff and none of which resulted in transport to a hospital.[13] An analysis of five years of crime data prior to and five years post-implementation of the unsanctioned OPS found that, on average, the number of incident reports relating to assault, burglary, larceny theft, and robbery in the post-intervention period steadily decreased in a 500-meter radius area around the site.[14] Crime decreased significantly faster in the intervention neighborhood as compared to control neighborhoods.

Critics of OPS argue that their presence in a community represents a tacit acceptance by public authorities of drug use, and that they do little to alleviate the non-medical consequences of drug use, such as family and work-related difficulties. Moreover, in the United States, the establishment of OPS faces several legal and regulatory barriers, at the federal, state and local levels. Proponents of OPS point to state-level authority to legislate the creation of OPS because of the government's duty to protect and preserve the welfare of their citizens, including providing reasonable public health interventions to address the host of problems associated with drug use.[15] However, the federal Controlled Substances Act (CSA) prohibits the unlawful possession of controlled substances (21 U.S. Code § 844), and makes it illegal to knowingly open or maintain a place that is for the purpose of using controlled drugs (21 U.S. Code § 856). Federal authorities have argued that OPS violate these sections of the CSA,[16] but federal judges have issued conflicting opinions and OPS' legal uncertainty remains.[17] These legal conflicts have kept state and local authorities from establishing OPS even where support may exist.[18]

In 2017, the American Medical Association (AMA) called for development and implementation of pilot SIFs that are designed to generate the data needed to inform policymakers about the feasibility and effectiveness of SIFs in reducing the harms of injection drug use.[19] In 2020, public health and medical associations, including the AMA, filed an amicus brief in support of a proposed OPS in Philadelphia, calling OPS "a critical component of a comprehensive solution to addressing the harms of drug use."[20]

Recommendations

Considering the rapidly rising rates of overdose deaths and currently available data on OPS, ASAM recommends:

1) Pilot OPS should be developed and implemented in communities where there is perceived need and local support by PWUD and other community members. Pilot programs should be designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of OPS in reducing harms and health care costs related to drug use.

    a) Pilot OPS should be considered a health service for PWUD that is integrated with a larger continuum of health services, including evidence-based SUD treatment.
    b) OPS staff should be trained to forge trusting relationships with PWUD and to help link them to a range of services, including evidence-based SUD treatment.

2) The federal, state and local governments should take action to ensure state- or locality-sanctioned pilot OPS can operate without fear of prosecution.

3) State and local health departments should provide regulatory oversight of any established OPS to ensure that best practices are implemented and maintained, and that outcomes are continuously measured.

4) Studies of OPS should seek to answer the following questions:

    a) Are international outcomes replicable in the United States (for example impact on fatal and non-fatal overdoses; emergency service calls; injection use behaviors; crime rates in surrounding area)?

    b) How does the establishment of an OPS impact the community's health care system and what are the best models for integration of services with area health care systems including emergency services (EMS/Emergency Department), hospitals and health care systems?

c) What staffing models (e.g., healthcare professionals, peer coaches, etc.) and available services (e.g., linkages to housing or employment support, other healthcare services, etc.) lead to the best outcomes based on the metrics above?

5) Funding for OPS should not reduce resources that support effective evidence-based treatment and social services needed by program participants.

Adopted by the ASAM Board of Directors July 22, 2021.

American Society of Addiction Medicine
11400 Rockville Pike, Suite 200, Rockville, MD 20852
Phone: 301.656.3920 | Fax: 301.656.3815
www.ASAM.org

[1] CDC Health Alert Network. Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic. CDCHAN-00438. December 17, 2020. Available at: https://emergency.cdc.gov/han/2020/han00438.asp

[2] Kilmer B, Taylor J, Caulkins JP, Mueller PA, et al. Considering Heroin-Assisted Treatment and Supervised Drug Consumption Sites in the United States. Santa Monica, CA: RAND Corporation, 2018. https://www.rand.org/pubs/research_reports/RR2693.html.

[3] Otter D, Safe Consumption Facilities: Evidence and models, Seattle, WA: King County Heroin and Opiate Addiction Task Force, 2016.

[4] Potier C, Laprévote V, Dubois-Arber F, Cottencin O, Rolland B. Supervised injection services: what has been demonstrated? A systematic literature review. *Drug Alcohol Depend.* 2014;145:48-68. doi:10.1016/j.drugalcdep.2014.10.012

[5] Salmon AM, Thein HH, Kimber J, Kaldor JM, Maher L. Five years on: what are the community perceptions of drug-related public amenity following the establishment of the Sydney Medically Supervised Injecting Centre?. *Int J Drug Policy*. 2007;18(1):46-53. doi:10.1016/j.drugpo.2006.11.010

[6] Kral AH, Wenger L, Carpenter L, Wood E, Kerr T, Bourgois P. Acceptability of a safer injection facility among injection drug users in San Francisco. *Drug Alcohol Depend*. 2010;110(1-2):160-163. doi:10.1016/j.drugalcdep.2010.02.009

[7] Park JN, Sherman SG, Rouhani S, et al. Willingness to Use Safe Consumption Spaces among Opioid Users at High Risk of Fentanyl Overdose in Baltimore, Providence, and Boston. *J Urban Health*. 2019;96(3):353-366. doi:10.1007/s11524-019-00365-1

[8] Wenger LD, Arreola SG, Kral AH. The prospect of implementing a Safer Injection Facility in San Francisco: perspectives of community stakeholders. *Int J Drug Policy*. 2011;22(3):239-241. doi:10.1016/j.drugpo.2011.01.001

[9] Kennedy-Hendricks A, Bluestein J, Kral AH, Barry CL, Sherman SG. Establishing Sanctioned Safe Consumption Sites in the United States: Five Jurisdictions Moving the Policy Agenda Forward. *Psychiatr Serv*. 2019;70(4):294-301. doi:10.1176/appi.ps.201800398

[10] Roth AM, Kral AH, Mitchell A, Mukherjee R, Davidson P, Lankenau SE. Overdose Prevention Site Acceptability among Residents and Businesses Surrounding a Proposed Site in Philadelphia, USA. *J Urban Health*. 2019;96(3):341-352. doi:10.1007/s11524-019-00364-2

[11] Irwin A, Jozaghi E, Weir BW, Allen ST, Lindsay A, Sherman SG. Mitigating the heroin crisis in Baltimore, MD, USA: a cost-benefit analysis of a hypothetical supervised injection facility. *Harm Reduct J*. 2017;14(1):29. Published 2017 May 12. doi:10.1186/s12954-017-0153-2

[12] Irwin A, Jozaghi E, Bluthenthal RN, Kral AH. A Cost-Benefit Analysis of a Potential Supervised Injection Facility in San Francisco, California, USA. Journal of Drug Issues. 2017;47(2):164-184. doi:10.1177/0022042616679829

[13] Kral AH, Lambdin BH, Wenger LD and Davidson PJ. Evaluation of an Unsanctioned Safe Consumption Site in the United States. *N Engl J Med* 2020; 383:589-590. DOI: 10.1056/NEJMc2015435

[14] Davidson PJ, Lambdin BH, Browne EN, Wenger LD, Kral AH. Impact of an unsanctioned safe consumption site on criminal activity, 2010-2019. *Drug Alcohol Depend*. 2021;220:108521. doi:10.1016/j.drugalcdep.2021.108521

[15] Burris S, Anderson ED, Beletsky L, Davis CS. Federalism, Policy Learning, and Local Innovation in Public Health: The Case of the Supervised Injection Facility. St Louis Univ Law J 2009;53:1089-1154

[16] Burris S, Anderson ED, Davis CS, and Beletsky L. Toward Healthy Drug Policy in the United States — The Case of Safehouse. N Engl J Med 2020; 382:4-5. DOI: 10.1056/NEJMp1913448

[17] Henry TA. Will the U.S. get its first supervised drug consumption site? American Medical Association. Dec. 15, 2020. Available at: https://www.ama-assn.org/delivering-care/opioids/will-us-get-its-first-supervised-drug-consumption-site Accessed February 22, 2021

[18] Baltimore City Health Department. Supervised injection sites aimed at cutting opioid overdoses risk wrath of DEA, prosecutors (McClatchy). March 21, 2018. Supervised injection sites aimed at cutting opioid overdoses risk wrath of DEA, prosecutors (McClatchy) | Baltimore City Health Department; Rosenstein Rod J. Fight Drug Abuse, Don't Subsidize It. *The New York Times.* Aug. 27, 2018. Opinion | Fight Drug Abuse, Don't Subsidize It - The New York Times (nytimes.com)

[19] American Medical Association. Pilot Implementation of Supervised Injection Facilities H-95.925. Res. 513, A-17.

[20] U.S. v. Safehouse, et al., Appeal No. 20-1422. Brief amicus curiae of Aids United, American Medical Association, Association for Multidisciplinary Education and Research in Substance Use and Addiction, Association of Schools and Programs of Public Health, California Society of Addiction Medicine, Drug Policy Alliance, Foundation for Aids Research, Harm Reduction Coalition, National Alliance of State and Territorial Aids Directors, Network for Public Health, Pennsylvania Medical Society, Philadelphia County Medical Society, Positive Women's Network, Treatment Action Group, and Vital Strategies. 3 July 2020. https://www.safehousephilly.org/sites/default/files/attachments/2020-07/amicus%20in%20support%20amended%20brief%20of%20AIDS%20United%20et%20al.%207.3.20.pdf