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

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.

Research has found that OPCs are associated with benefits for individuals who use the centers and neighborhoods where the centers are located. 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. 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. For surrounding neighborhoods, OPCs have been shown to be associated with reduced public drug consumption, litter of drug consumption equipment, and crime.

In November 2021, OnPoint NYC opened the first government-sanctioned OPCs in the US. Harocopos et al 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. 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. 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
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