

MAY 2024

FINDINGS FROM OPC ADVOCATE FOCUS GROUPS

BACKGROUND

Drug overdose is one of the most critical public health crises in the United States, killing more people per year than car crashes.¹ Overdose deaths have increased fivefold over the past two decades, with a notable 30 percent increase occurring in 2020 (the year the COVID-19 pandemic began in the U.S.).² Since 1999, more than a million people have died from drug overdose in the U.S.³ Nearly 108,000 people died from overdose in 2022 alone: the highest number ever recorded in a calendar year.⁴

Overdose death rates have steadily increased in every major demographic group, with the largest annual increase occurring in 2019–2020: Black people experienced the highest increase in overdose death rate at 56 percent, followed by Hispanic people at 41 percent and white people at 28 percent.⁵ Overall, non-Hispanic American Indian or Alaska Native people had the highest rates of overdose death in both 2021 and 2022, and rates increased in this population and in Black, Hispanic, and Asian populations from 2021 to 2022.⁶

Driving the recent increases in overdose deaths has been synthetic opioids, most notably fentanyl. Synthetic opioids (excluding methadone) were involved in nearly 70 percent of all overdose deaths in 2022.⁷ Notably, the rate of overdose deaths involving psychostimulants like methamphetamine has also increased.⁸

Overdose prevention centers (OPCs) are interventions designed to reduce the potential risks of drug use, including overdose and unwanted public use. Also called safe consumption sites, OPCs

provide a safe and hygienic space for people to consume drugs with trained staff on hand to provide sterile supplies and intervene if an overdose occurs. Participants bring their own drugs, and OPCs help bring public drug use indoors. OPCs provide a loving, inclusive, non-stigmatizing space for people who use drugs to have many of their needs met. In addition to providing a safe consumption space, this includes providing low-barrier health and wellness services and connecting people with addiction services and social supports, including voluntary treatment.⁹

The Drug Policy Alliance (DPA) convenes a network of nearly 200 advocates from jurisdictions across the United States striving to expand OPC access. The network agreed to develop a set of principles to serve as a guide for policymakers as they develop policies pertaining to OPCs. To this end, the network established a working group comprised of eight volunteer members of the network and supported by DPA staff.

The working group formulated a set of questions intended to elicit responses on what the guidance should include. Over June and July of 2023, DPA convened eight focus groups where the questions developed by the working group were discussed. The focus groups were comprised of 51 participants from across the country who are involved in advocacy to establish OPCs, are in the process of establishing an OPC, or are currently operating an OPC. DPA synthesized the information gathered from the focus groups into this document over the fall of 2023. The document was brought back to the working group for revision and approval in January 2024, and then presented to the full OPC advocates group and approved in April 2024.

TOP FINDINGS

As the focus groups discussed many different aspects of OPC design and operation, a few key throughlines materialized. **The primary takeaway was that OPCs should be given the flexibility to adapt their programs and policies to fit the needs of the communities served.** Overregulation, even if well-intentioned, may stifle innovation and prohibitively increase cost. Such concerns are especially salient for peer-led models, which are more cost-sensitive.

OTHER KEY TAKEAWAYS INCLUDE:

- Prioritizing people with lived expertise in the provision of OPC services
- Tailoring OPC services to the needs of specific populations
- Ensuring accommodations for varying modalities of drug use, including safer smoking and inhalation spaces
- Respecting privacy and eliminating barriers to service

More details and takeaways are provided in the responses to the focus group questions below.

WHAT TYPES OF MODELS ARE ADVOCATES PURSUING?

Focus group participants distinguished between peer-led OPC models and clinical models. Peer-led models emphasize programming directed and carried out by peers (people who have current and/or past experience with substance use), although they do not preclude the presence or colocation of medical professionals onsite. Clinical models, on the other hand, emphasize the leadership of licensed medical providers, like nurses, and are often housed in bright, sterile settings. Considering both models is key to providing jurisdictions with options for implementing the model that best suits the needs of the community served based on available resources.

While both peer-led and clinical models are valuable, there was a strong preference in the focus groups for peer-led models. Many group members described the physical spaces at peer-led models to be warmer and more inviting. Peer-led models are likely to be less expensive to operate, easier to recruit staff, quicker to deploy, and easier to maintain in non-urban areas. Overall, peer-led OPCs were viewed as most likely to be able to adapt to changing drug trends and needs of participants and most welcoming for all participants.

Focus group participants also considered non-brick-and-mortar OPC models. These could include mobile, pop-up, or virtual OPC services. These models may be especially effective in rural areas, where distance is more of an issue. Policymakers should consider how these types of OPCs can be included in regulation, or alternatively, how to ensure that regulation does not prevent these types of models from operating.

WHAT POPULATIONS ARE ADVOCATES STRIVING TO SERVE

There was agreement among focus group participants that OPCs should be welcoming to all, but also that OPC services can be tailored to meet the needs of certain populations, including people living with HIV, trans people, women, and/or sex workers.¹⁰ OPCs can be built into a hospital or other existing health structures, such as primary healthcare clinics.¹¹ OPCs can also be located within a supportive housing structure.¹²

In all settings, focus group participants identified the role of the OPC provider as being present and building trust with the clients served. Focus group participants emphasized the need for OPCs to be able to adapt to changing conditions to meet the needs of marginalized populations. Policymakers should recognize that there are a variety of settings where OPC services could be incorporated and should avoid restrictions that hinder innovation.¹³

WHAT SERVICES AND STANDARD OF CARE SHOULD PARTICIPANTS EXPECT REGARDLESS OF THE OPC MODEL OR POPULATION SERVED?

Whether peer-led or clinical, all OPCs should provide basic harm reduction supplies, monitor people before and after substance use, and be equipped to intervene in cases of overdose. To the extent possible, they should provide comprehensive wraparound services, including but not limited to:

- Health services such as wound care, HIV/hepatitis care, onsite or connection to substance use disorder treatment, including methadone and buprenorphine for opioid use disorder, mental healthcare, sterile syringes, medication/pharmacy, and acupuncture.
- Amenities such as a respite room and sleeping area, laundry, showers, case management, clothing, computer access, childcare, and hot food.

These categories and services are not exhaustive, and they should be continuously updated and adjusted based on new evidence and community needs.

To the extent possible, OPCs should be able to support safer smoking and inhalation. This is especially important given changes in use patterns and racial equity concerns. From 2020 to 2022, the percentage of overdose deaths involving smoking increased by nearly 75 percent.¹⁴ About half of the participants who use the OPCs operated by OnPoint NYC in New York smoke crack.¹⁵ Smoking has also become a more prevalent method of use for fentanyl across the country, highlighting the need for OPCs to accommodate people who smoke.¹⁶ Further, a greater proportion of Black and Brown people who use drugs smoke rather than inject when compared to their white counterparts, making the provision of safer smoking spaces a racial justice issue.¹⁷ This is an especially important consideration given that overdose death rates among Black and Indigenous people outpace the

overdose death rate among white people. Smoking spaces could be outdoors in an enclosed space, with consideration of how to operate in places with exposure to extreme cold or heat, or indoors in a room with ventilation.

OPC participants are entitled to a welcoming and safe environment. OPCs must protect participants' privacy regarding identity and substance use to the extent possible from law enforcement activity and nonconsensual research projects. In furtherance of these goals, OPCs should never be required to conduct ID checks. In addition to jeopardizing privacy, requiring identification would be a barrier to receiving services for people who do not have or have lost their ID.

OPCs have been shown to be effective in connecting people to substance use disorder treatment, including as an access point for people who have been historically disenfranchised.¹⁸ OPCs attain this effectiveness by following the lead of participants' goals. OPCs should never coerce participants to initiate treatment or pressure participants towards abstinence goals. Initiation in treatment should not be a primary indicator of an OPC's success. OPC participants should receive the support they need and want without being unduly pressured towards services they do not want.

WHAT POLICIES SHOULD PARTICIPANTS BE EXPECTED TO FOLLOW?

Focus group participants expressed the importance of clearly communicating conduct expectations to OPC participants. While focus group participants recognized that street level sellers are part of the community and should not be villainized, drug sales are not tolerated on an OPC's premises. Focus group participants also endorsed exploring complementary interventions such as safer supply,¹⁹ which remain outside the current scope of OPCs.

SHOULD OPCs BE LICENSED BY THE CITY, COUNTY OR STATE IN ORDER TO OPERATE?

While focus group participants were open to licensing structures for OPCs, there were concerns that strict licensing requirements would prevent OPCs from getting approval and opening. These regulations could include requirements like having a medical doctor on the premises during all operating hours or expensive licensing fees. These concerns are heightened among peer-led OPC models.

On the other hand, licensing could be a means to ensure that OPC operations are aligned with authentic harm reduction values. OPCs may consider having a community advisory board and/or steering committee comprised of peers to help ensure the OPC is meeting the needs of the people it serves. If a licensing scheme is adopted, it should be structured in a way to allow OPCs to become operational as soon as possible. This could entail a process for approval at either the state or local level (but not a requirement for both). Regulations should also consider how to minimize local politics from hindering an OPC from opening, including prohibitions on local opt outs. Licensing should be controlled by health agencies with protections from law enforcement interference.

In consultation with harm reduction service providers, regulations and authorizing legislation should give maximum flexibility to design and implement OPC models that best serve the needs of the community and should be able to adapt quickly to emerging drugs and conditions on the ground.

An alternative to licensing could be a system where organizations intending to operate an OPC notify a designated government agency prior to opening, then begin operations after satisfying a short waiting period.

WHAT TYPES OF GOVERNMENT REGULATION SHOULD BE AVOIDED?

While regulation will likely vary in differing jurisdictions, the focus groups identified several policies that should be avoided if possible. Many of these would hinder the ability of OPCs to be flexible and to adapt to the needs of the communities they serve. Restrictions on who can be served undermine the harm reduction goals of OPCs. So can the presence of police or armed security onsite, so this should not be mandated. There should not be a policy of mandated reporting based on drug use, and considerations of how to protect against this in facilities like hospitals needs to be considered.

Collection of identifiable data and overly burdensome data collection requirements can hinder both participation in and administration of services. For communities exposed to structural violence and trauma caused by systemic racism and classism, overly intrusive data collection can reinforce trauma and deter service participation. Intensive data collection also requires OPC staff to spend a larger share of their time performing administrative tasks rather than providing OPC services.

Evaluating the success of OPCs based on connection to treatment should not be prioritized. This metric can unduly create an expectation to enter treatment among participants, which will likely discourage OPC participation.

There should be no or only limited background checks for staff, nor should staff be required to submit to drug testing. Government-imposed staff qualifications should be minimized. Even peer certification has been found to be too onerous in several jurisdictions, as it may require GEDs, passing a background check, or other prerequisites. Requiring medical doctors or other medical professionals to be onsite at all times may also make operation too onerous in many places. Thus, these should not be requirements for hiring staff or operating OPCs.

Regulations should also consider how existing laws may apply to OPCs. For instance, requiring the retrofitting of facilities to comply with smoking regulations, limiting where an OPC can be located, and onerous zoning and/or citing requirements may all pose significant barriers to establishing and maintaining OPCs.

CONCLUSION

DPA's process of convening 8 focus groups comprised of over 50 OPC advocates, researchers, and practitioners identified several key considerations for regulating and operating OPCs. Throughout their responses, the focus groups emphasized the need to allow flexibility for OPCs to adapt to the needs of the communities they serve. The focus groups communicated a strong preference for peer-led OPC models, although there was a recognition that models will vary by jurisdiction and available resources. Regardless of the model, OPCs should be able to mold their

services to fit the specific challenges and needs of the populations served. Including the ability to smoke in OPCs is important given changing use patterns and racial equity implications. Barriers to OPC access should be eliminated or minimized, both in government regulations and within OPC operational policies.

We do not consider the focus group findings to be exhaustive, and certainly more lessons will be learned as more OPCs open across the country. However, we hope that policymakers and potential OPC operators will take to heart the considerations outlined here to help ensure that OPCs can best provide lifesaving services to communities in need.

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END NOTES

1. Spencer, Merianne Rose, Garnett, Matthew F, and Miniño, Arialdi M. "Drug Overdose Deaths in the United States, 2001–2022." *NCHS data brief*, no. 491 (2024). Accessed April 11, 2024. <https://dx.doi.org/10.15620/cdc:122556>; "Injuries and Violence Are Leading Causes of Death." Centers for Disease Control and Prevention. February 11, 2021. <https://www.cdc.gov/injury/wisqars/animated-leading-causes.html>.
2. Kariisa, Mbabazi, et al. "Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020." *MMWR Morbidity & Mortality Weekly* 71, no. 29 (2022): 940–947. Accessed April 11, 2024. <http://dx.doi.org/10.15585/mmwr.mm7129e2>.
3. "Drug Overdose Deaths." Centers for Disease Control and Prevention. August 22, 2023. <https://www.cdc.gov/drugoverdose/deaths/index.html>.
4. Spencer, Merianne Rose, Garnett, Matthew F, and Miniño, Arialdi M. "Drug Overdose Deaths in the United States, 2001–2022." *NCHS data brief*, no. 491 (2024). Accessed April 11, 2024. <https://dx.doi.org/10.15620/cdc:122556>.
5. Centers for Disease Control and Prevention. "QuickStats: Death Rates for Drug Overdose Among Persons Aged 25–44 Years, by Race and Ethnicity— United States, 2000–2020." *MMWR Morbidity & Mortality Weekly* 71, no. 46 (2022): 1485. Accessed April 11, 2024. <https://www.cdc.gov/mmwr/volumes/71/wr/mm7146a4.htm>.
6. Spencer, Merianne Rose, Garnett, Matthew F, and Miniño, Arialdi M. "Drug Overdose Deaths in the United States, 2001–2022." *NCHS data brief*, no. 491 (2024). Accessed April 11, 2024. <https://dx.doi.org/10.15620/cdc:122556>.
7. Ahmad, F.B, Cisewski, J.A, Rossen, L.M, and Sutton, P. "Provisional drug overdose death counts." Centers for Disease Control and Prevention. March 13, 2024. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.
8. Ibid.
9. For more information on OPCs, see "Facts about Overdose Prevention Centers." Drug Policy Alliance. June 12, 2023. https://drugpolicy.org/wp-content/uploads/2023/06/DPA-OPCs_FactSheet.pdf.

10. Rouhani, Saba, White, Rebecca Hamilton, Park, Ju Nyeong, and Sherm, Susan G. "High Willingness to Use Overdose Prevention Sites among Female Sex Workers in Baltimore, Maryland." *Drug and Alcohol Dependence* 212 (2022): 108042. Accessed April 12, 2024. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9426862/>; Vaccaro, Mary. "Safer Drug Use Spaces for Women, Trans and Non-Binary People." Canadian Observatory on Homelessness. August 29, 2022. <https://www.homelesshub.ca/blog/safer-drug-use-spaces-women-trans-and-non-binary-people/>; Very few existing OPCs tailor their services for specific populations, but as OPCs become more numerous, a wider variety of tailored services will hopefully become more available.
11. Dong, Kathryn A, Brouwer, Jennifer, Johnston, Curtis, and Hyshka, Elaine. "Supervised consumption services for acute care hospital patients." *Canadian Medical Association Journal* 192, no. 18 (2020): E476–E479. Accessed April 12, 2024. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7207181/>.
12. Bardwell, Geoff, Collins, Alexandra B, McNeil, Ryan, and Boyd, Jade. "Housing and overdose: an opportunity for the scale-up of overdose prevention interventions?" *Harm Reduction Journal* 14 (2017): 77. Accessed April 12, 2024. <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-017-0203-9>.
13. One focus group participant also raised integrating safer bathroom practices where OPC services do not yet exist. See "The Safer Bathroom Toolkit." Canadian Institute for Substance Use Research, University of Victoria. Accessed April 12, 2024. <https://www.uvic.ca/research/centres/cisur/projects/active/projects/safer-bathrooms.php>.
14. Tanz, Lauren J, et al. "Routes of Drug Use Among Overdose Deaths - United States, 2020-2022." *MMWR Morbidity & Mortality Weekly* 73, no. 6 (2024): 124-130. Accessed April 12, 2024. https://www.cdc.gov/mmwr/volumes/73/wr/mm7306a2.htm?s_cid=mm7306a2_w.
15. Gibson, Brent, See, Kailin, Vargas Estrella, Brittney, and Rivera, Sam. "OnPoint NYC, Making History. Saving Lives: A Baseline Report on the Operation of the First Recognized Overdose Prevention Centers in the United States." OnPoint NYC. Accessed April 12, 2024. https://onpointnyc.org/wp-content/uploads/2023/12/ONPOINTNYC_OPCREPORT_small-web1.pdf.
16. Kral, Alex H, et al. "Transition from injecting opioids to smoking fentanyl in San Francisco, California." *Drug and Alcohol Dependence* 227 (2021): 109003. Accessed April 12, 2024. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10790652/>.
17. Rodriguez, McClaren, et al. "Differences in Substance Use and Harm Reduction Practices by Race and Ethnicity: Rhode Island Harm Reduction Surveillance System, 2021-2022." *Journal of Public Health Management and Practice* 30, no. 2 (2024): E84-E93. Accessed April 12, 2024. https://journals.lww.com/jphmp/abstract/9900/differences_in_substance_use_and_harm_reduction209.aspx.
18. Gibson, Brent, See, Kailin, Vargas Estrella, Brittney, and Rivera, Sam. "OnPoint NYC, Making History. Saving Lives: A Baseline Report on the Operation of the First Recognized Overdose Prevention Centers in the United States." OnPoint NYC. Accessed April 12, 2024. https://onpointnyc.org/wp-content/uploads/2023/12/ONPOINTNYC_OPCREPORT_small-web1.pdf; DeBeck, Kora, et al. "Injection Drug Use Cessation and Use of North America's First Medically Supervised Safer Injecting Facility." *Drug & Alcohol Dependence* 113, no. 2-3 (2011): 172-176. Accessed April 12, 2024. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5590717/>.
19. See Kalicum, Jeremy, Nyx, Eris, Kennedy, Mary Clare, and Kerr, Thomas. "The impact of an unsanctioned compassion club on non-fatal overdose." *International Journal of Drug Policy* (2024): 104330. Accessed April 12, 2024. <https://www.sciencedirect.com/science/article/pii/S095539592400015X>.

ENDORSEMENTS



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ENDORSEMENTS (CONT.)



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