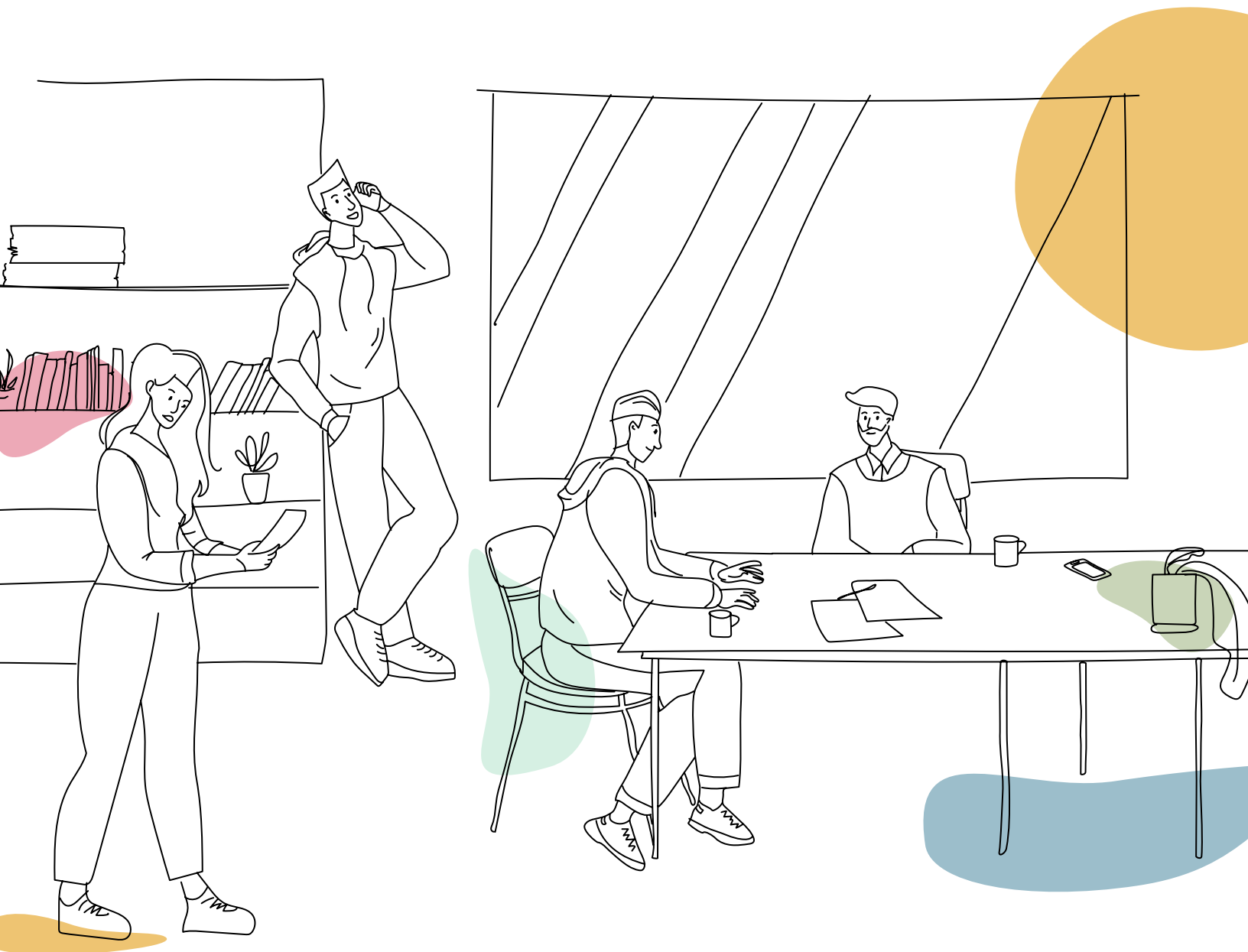


Expanding Spaces for People Who Use Drugs in Massachusetts:

Harm Reduction Drop-In & Overdose Prevention Centers



December 2023

Prepared for:
Massachusetts Department of Public Health
Bureau of Substance Addiction Services

Prepared by:
JSI Research & Training Institute, Inc.



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Acronyms

BIPOC	Black, Indigenous, and other people of color
BSAS	Bureau of Substance Addiction Services
DPH	Massachusetts Department of Public Health
EMS	emergency medical services
EMT	emergency medical technicians
HRAC	Harm Reduction Advisory Council
HCV	hepatitis C virus
JSI	JSI Research & Training Institute, Inc.
LGBTQ+	lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more
NYC DOHMH	New York City Department of Health and Mental Hygiene
OPC	overdose prevention center
PWUD	people who use drugs
RFI	request for information
SSP	syringe service program
STI	sexually transmitted infection

Acknowledgements

This work could not have been completed without the harm reduction experts, agency staff, and participants across Massachusetts who generously gave their time and welcomed us into their spaces. We thank them for their unwavering commitment to their communities and for sharing their expertise with us.

Executive Summary



Background: In 2022, the Massachusetts Department of Public Health, Bureau of Substance Addiction Services (BSAS) partnered with JSI Research & Training Institute, Inc. (JSI) to gather information about promising practices for providing harm reduction drop-in services, challenges agencies face related to providing these services, and resources needed if there was the opportunity to expand harm reduction drop-in centers to become overdose prevention centers (OPCs) where individuals can consume pre-obtained drugs under the supervision of trained staff and without fear of arrest. Thirty years of research show that OPCs reduce overdose and improve drug user health, increase access to addiction treatment programs, reduce public drug use and syringe litter in neighborhoods, and are cost effective. In 2019, the Massachusetts Harm Reduction Commission recommended the state pursue establishment of one or more OPCs.

Methods: Over a period of 12 months (November 2022 to October 2023), JSI spoke with staff at six agencies that provide drop-in services, 356 individuals (called “participants”) receiving services from harm reduction drop-in centers, and five harm reduction experts (called “key informants”). In May 2023, through a request for information, BSAS sought information from harm reduction agencies on the expansion of harm reduction drop-in centers across Massachusetts and received 22 responses.

Findings: Key findings are organized into three categories:

Overdose Prevention Center Interest, Staffing, Model, and Location

- Two agencies said they were ready to operate an OPC, if funding was available.
- Participants were largely supportive of OPCs. A majority (77 percent) would go to an OPC if one was available. Sixty-five percent of participants interviewed wanted an OPC and a harm reduction drop-in center to be in the same room/place, very close by, or in the same building. They wanted it to be in an accessible location, near public transportation.
- When asked what types of staff participants would want at an OPC, 47 percent mentioned some kind of medical professional (e.g., nurse, doctor, emergency medical technician [EMT], mental health care provider) present and/or on staff. Participants also wanted harm reduction specialists or staff with some type of lived experience with substance use. They wanted staff who were non-judgmental, understanding, respectful, helpful, and passionate about helping people.
- When JSI spoke with OnPoint New York City staff, they stressed that the most important resources to invest in are space and staffing, including training and professional development.

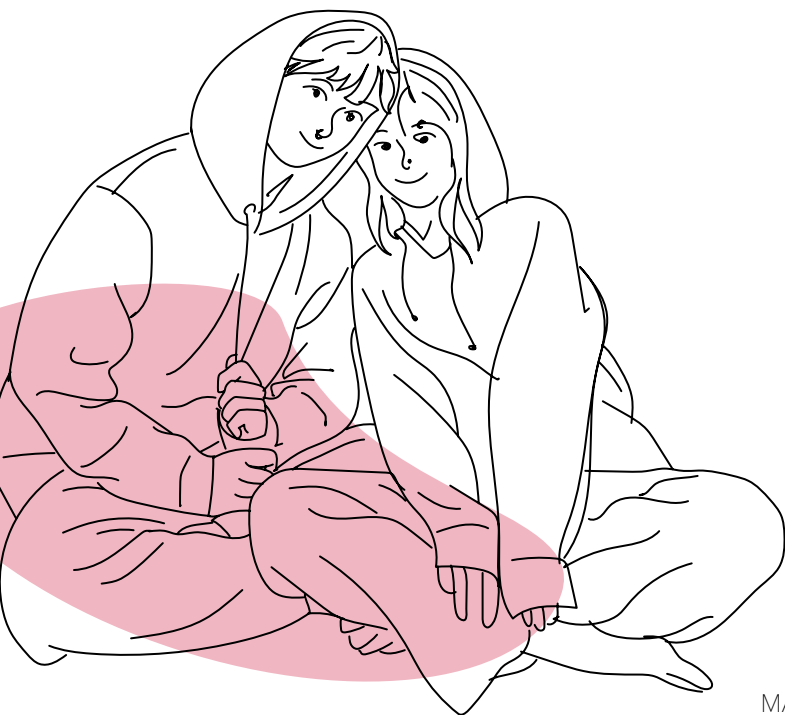


Time is of the essence because the longer we go without the services that we need, we’re talking lives. And every life does matter.”

– Harm reduction drop-in center participant

Harm Reduction Drop-in Space, Services, and Staffing

- Agencies need capital investments in physical space, including more space and separate rooms for different activities.
- Eighty-six percent of participants said they had additional service needs. Of those who did, they mentioned laundry, a place to rest, showers, hygiene supplies (e.g., soap, toothpaste, clothes), food, computer/phone access, meetings/support groups, and safer consumption supplies. They also wanted harm reduction drop-in centers to expand their hours (e.g., 24-hours, weekends).
- Agencies identified critical gaps in services, including low-threshold housing support, testing and treatment for infectious diseases, and access to inpatient recovery treatment options for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more (LGBTQ+) and Black, indigenous, and other people of color (BIPOC).
- All of the six agencies stated that they had challenges recruiting and retaining qualified staff, and that they needed to increase salaries. In addition, with the increasing numbers of participants, staff are overworked. Five of the six agencies did not have enough staff to manage their current workload, and three agencies were acutely understaffed.
- Participants felt safe, supported, and respected in a harm reduction drop-in center when they were treated well. Participants wanted more privacy or a private space to have conversations with staff or just be alone. They also wanted a space free of violence.



Equity & Community

- Creating and maintaining an equitable harm reduction drop-in center for staff and participants was a high priority for all six agencies. They noted the importance of understanding ways that different people (e.g., BIPOC, women, LGBTQ+) use and interact with drugs.
- Agencies, key informants, and participants expressed the need for more services for women and female-identifying individuals. Participants requested more LGBTQ+ services, including visually welcoming cues such as flags, rainbows, and posters; and trans-inclusive services. They also asked for more recovery groups hosted in Spanish, Spanish-speaking therapists and mental health providers, and increased signage in Spanish.
- Agency staff discussed the importance of community support for harm reduction services and OPCs. Many participants had lost close family and friends to overdose, and were concerned about fentanyl and xylazine in the drug supply. Lack of stable and secure housing was a source of suffering for participants. They advocated for more shelter spots and the creation of accessible and affordable long-term housing.

Conclusion:

Overall, substantial financial investment would improve the delivery and accessibility of services in harm reduction drop-in centers, so that they meet the basic needs of participants (e.g., hygiene, food, place to rest). All programs reported needing additional resources for operating their harm reduction drop-in centers, specifically funding for staff and additional physical space. Agencies that JSI spoke with were at different levels of readiness to operate OPCs; as of January 2023, two were ready. Participants interviewed largely support OPCs. Investment in harm reduction drop-in spaces and OPCs will save lives and support communities across the Commonwealth.

Introduction

Harm reduction community spaces provide low-barrier and dignified care to people who use drugs (PWUD) and individuals who are experiencing homelessness or unstable housing. These spaces include but are not limited to harm reduction drop-in centers, syringe service programs (SSPs), and overdose prevention centers (OPCs).

While there are no OPCs operating in Massachusetts, there are harm reduction drop-in centers and SSPs. Harm reduction drop-in centers in the state focus on providing welcoming and comfortable places for people to escape the elements, rest, eat, use the bathroom, take a shower, make a phone call, access services, and spend time with other members of their community. Syringe services programs offer access to and disposal of sterile syringes and injection equipment; vaccination, testing, and linkage to care and treatment for infectious diseases; and linkage to substance use disorder treatment. Some programs in Massachusetts are both harm reduction drop-in centers and SSPs.

OPCs, also referred to as supervised consumption sites, safe consumption sites, supervised injection facilities, and drug consumption rooms, provide a safe space for people to consume pre-obtained drugs under the supervision of trained staff and without fear of arrest. While this report will use “OPC,” the term is limiting because its focus on overdose may resonate more with people who use opioids than those who use other substances. See Table 1 for a summary of services by type of program.

Table 1. Examples of Services Provided, by Program Type

Type	Harm reduction drop-in center	Syringe service program	Overdose prevention center
Services	<ul style="list-style-type: none"> • Place to rest and stay indoors • Food • Bathrooms/showers • Phone/computer access • Overdose education and naloxone distribution • Harm reduction counseling • Infectious disease testing • Referrals to health and social services including substance use disorder treatment 	<ul style="list-style-type: none"> • Access to and disposal of sterile syringes and safer consumption supplies (e.g., sterile pipes, safe use supplies, fentanyl test strips, naloxone, safer sex supplies) • Overdose education and naloxone distribution • Harm reduction counseling • Access to first aid, including wound care • Drug checking services, including analyzing samples provided by participants and telling them what drugs are present • Infectious disease testing • Referrals to health and social services including substance use disorder treatment 	<ul style="list-style-type: none"> • Area(s) for people to consume pre-obtained drugs in a variety of ways (e.g., injection, inhalation) under the supervision of trained staff • Access to and disposal of sterile syringes and safer consumption supplies (e.g., sterile pipes, safe use supplies, fentanyl test strips, naloxone, safer sex supplies) • Overdose education and naloxone distribution • Harm reduction counseling • Access to first aid, including oxygen and pulse monitoring as needed • Drug checking services, including analyzing samples provided by participants and telling them what drugs are present • Infectious disease testing • Referrals to health and social services including substance use disorder treatment

Research and evaluation show that OPCs have individual and community benefits, including reducing fatal overdoses, improving injection behavior and harm reduction practices, improving access to addiction treatment programs, and causing no increase in crime or public nuisance.¹ In addition, OPCs are shown to be cost effective.² Cost-benefit analyses conducted in Boston, San Francisco, Baltimore, and Rhode Island show significant estimated savings.^{3,4,5,6} OPCs also provide a potential downstream intervention to mitigate health inequities experienced by people who inject drugs, particularly for rebuilding program participants' connections with health care and community-based services.⁷

The Massachusetts Harm Reduction Commission recommended an OPC pilot in March 2019. The Commission was established by Section 100 of Chapter 208 of the Acts of 2018. It comprised mayors, police chiefs, medical directors, researchers, members of the state legislature, and residents. This group published a report⁸ in March 2019 that outlined the Massachusetts overdose crisis, responses to it, and recommendations based on other states and countries that established harm reduction strategies. In the report, the Commission recommended an expansion of harm reduction resources across the state and an educational component for the broader public and health care providers. It also recommended a pilot program of one or more OPCs, and stated that the pilot programs must receive local approval and include an evaluation component to monitor participant outcomes and effects on surrounding communities. The Commission said that widespread naloxone distribution, SSP expansion, and fentanyl testing strips/drug checking were important harm reduction interventions alongside OPCs.



What is an overdose prevention center? It's a community center for people who use drugs where they can get a variety of services."

– Key Informant

In 2022, the Massachusetts Department of Public Health (DPH), Bureau of Substance Addiction Services (BSAS) contracted with JSI Research & Training Institute, Inc. (JSI) to explore supporting agencies to operate and expand harm reduction drop-in centers. The purpose of this work was to inform a future procurement, pending appropriations, that reflects and aligns with community goals and needs.

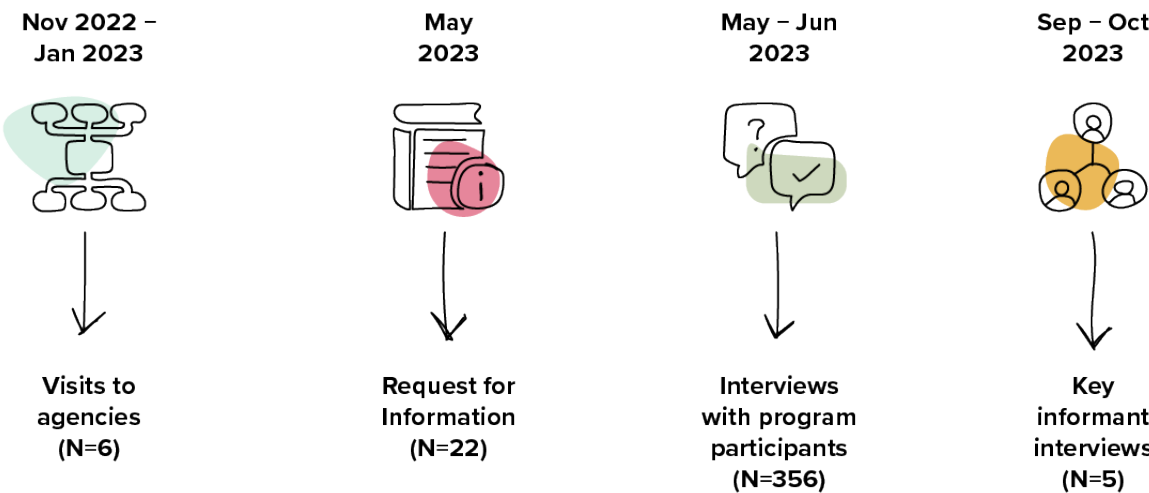
JSI aimed to document: 1) promising practices from agencies in Massachusetts providing harm reduction drop-in services; 2) challenges to providing these services; and 3) resources needed to expand the centers to OPCs. The three communities of focus for JSI's outreach were the Massachusetts Harm Reduction Advisory Council (HRAC), staff at agencies providing harm reduction drop-in services, and individuals receiving services from harm reduction drop-in centers (called "participants" throughout this document).

This report includes a review of the past 25 years of literature and reports on OPCs, as well as perspectives from harm reduction experts. The information gathering of the past year, when staff from JSI interviewed both harm reduction service providers and their participants, is summarized to demonstrate the perspectives of the people most likely to operate or use harm drop-in services and OPCs. Finally, the report addresses the limitations of the data collection and offers considerations for future planning.

Methods

JSI gathered information using four methods: harm reduction drop-in center visits and conversations with staff; BSAS’s request for information (RFI) solicitation; participant interviews; and conversations with local experts. See Figure 1 for the timeline of activities.

Figure 1. Timeline



Agency Visits

From November 2022 to January 2023, JSI team members traveled to agencies to learn about promising practices, challenges to providing services, and resources needed to expand and optimize their agencies. Based on BSAS’s recommendation, JSI visited six agencies that offered a variety of services and spoke to 17 staff. Each 90-minute visit included a tour of the facility and a discussion using prewritten protocol questions. Three JSI staff (two facilitators and one note-taker) attended each visit. The six agencies represented geographic diversity across Massachusetts, including Boston, Brockton, Holyoke, Lowell, and Springfield. Four of the six agencies operated a harm reduction drop-in center. The other two were SSPs.

During the visits, JSI asked site staff about services including reimbursement models and workflows; key functions of a harm reduction drop-in center; what works well; challenges/barriers; key partners to involve in implementing a harm reduction drop-in center; what agencies need to expand services to accommodate a harm reduction drop-in center; how agencies are meeting the needs of people who are Black, Indigenous, and other people of color (BIPOC) who use drugs; and how can they continue to expand these services.



Request for Information

In spring 2023, BSAS solicited information from state harm reduction agencies on the operationalization and/or expansion of harm reduction drop-in centers across Massachusetts via a RFI (COMMBUYS BD-23-1031-BSAS0-BSA01-87989).⁹ It was posted on May 2 and the submission deadline was May 31. BSAS received 22 written responses. Of the six agencies that JSI visited, two submitted an RFI response. See Appendix 1 for the RFI questions.

Participant Interviews

From May to June, JSI conducted in-person interviews at four agencies (five sites total) based on geography and services offered. The JSI Institutional Review Board reviewed the interview protocol and determined that this activity was exempt from human subject oversight. JSI held calls with each agency to discuss planning and approach prior to implementation. One agency asked JSI to train a few of its staff to conduct interviews to maximize the number of interviews that could be conducted on site.

Before visiting, JSI sent a flier to each agency with information about the interview opportunity (both onsite and by phone) and asked that it be posted. When JSI

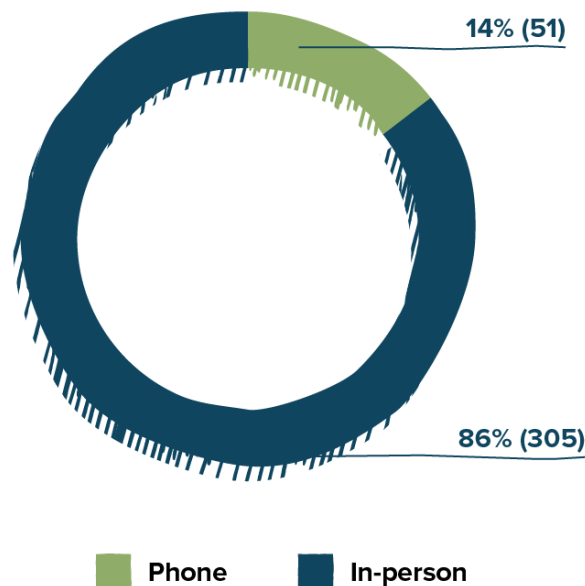
staff were on site to conduct interviews, they approached participants to convey information about the interview and gauge their interest in participating.

JSI conducted 15-minute intercept interviews with a convenience sample. Verbal consent was obtained. Interviews were conducted in English and Spanish. Exclusion criteria were <18 years of age; unable to obtain informed consent; and/or limited ability to communicate in English or Spanish. Compensation for participation was a \$25 Visa gift card. No personal identifying information was collected as part of the interview. Four JSI team members were present for all data collection sessions. Each session was 2–3 hours, with JSI conducting a morning and afternoon session at each agency.

Interviews were recorded using audio devices per individual consent. If the person did not consent to recording, JSI took notes. During the data collection period (May 26 to June 30), JSI also conducted interviews via Zoom for those who wanted to participate in an interview but could not do so during the on-site times.

JSI interviewed 356 participants about their perspectives on services, use, and staffing at harm reduction drop-in centers and interest in OPCs. The majority (86 percent) of interviews were completed on site (Figure 2). Sixty-six percent of interviews were conducted in Holyoke and Springfield (Figure 3).

Figure 2. Participant Interviews, by Modality (N=356)



Two agencies (representing three sites) were SSPs, representing 58 percent of participant interviews. Two agencies (representing two sites) were not SSPs (Figure 4). Interview transcripts were analyzed using standard, manual qualitative techniques. Responses were reviewed, coded, and grouped by theme in relation to each question. Illustrative quotes were selected to describe each theme.

Figure 3. Participant Interviews, by Location (N=356)

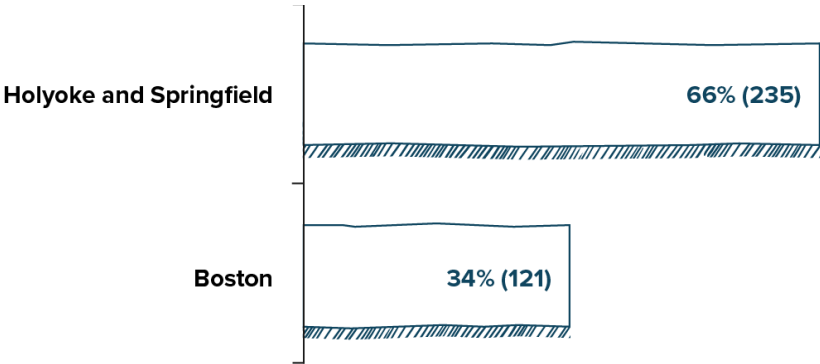
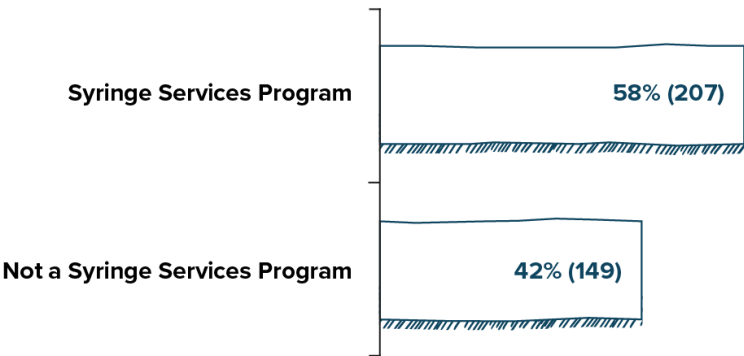
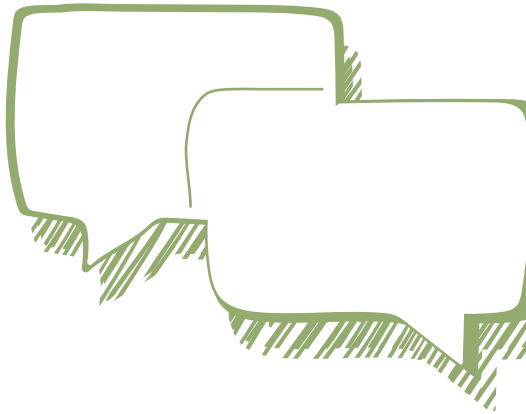


Figure 4. Participant Interviews, by Program Type (N=356)



Key Informant Interviews

Following the completion of the participant interviews, JSI worked with BSAS to identify harm reduction experts to speak with. JSI asked about their perspectives on the needs of harm reduction drop-in centers in Massachusetts, and the challenges and opportunities related to opening OPCs in Massachusetts. JSI spoke with five individuals, including a representative from OnPoint NYC, an organization that operates two OPCs.



Literature Review and Background on OPCs

Overdose prevention centers have been researched and evaluated for the last 30 years. They are an evidence-based strategy to reduce overdose rates in an area, link PWUD to relevant services, and improve community life. This literature review assesses known and projected impacts of OPCs on overdose rates, addiction treatment program access, cost and public safety, support, and education. At least four systematic reviews have been published in the past 10 years.^{10,11,12,13}

Overdose Rates

OPCs reduce overdose and improve drug user health. OPCs are associated with a lower risk of death in a population that has a high burden of premature mortality.¹⁴ One study showed that fatal overdoses in the area around the OPC decreased 35 percent after implementation of the site.¹⁵ OPCs can reduce the transmission of HIV and hepatitis C (HCV), and provide education on safer use practices and how to avoid soft-tissue infection.^{16, 17} Another study showed that people who used an OPC were able to change substance use behaviors and form positive relationships with health care providers.¹⁸ When the first OPC in Canada opened, more than half of its participants used it for other health-related services, indicating that these centers can increase participant involvement within health care and substance use recovery systems.¹⁹

Addiction Treatment Program Access

Overdose prevention centers provide increased access to withdrawal services and medication for addiction treatment in a safe, non-judgmental space. PWUD who were surveyed in Boston were most interested in OPCs if they knew they would be protected from police involvement, and if the OPC provided access to withdrawal management and substance use treatment services.²⁰

Cost Effectiveness

Overdose prevention centers are cost effective; they are an investment into a both short- and long-term savings project. Study results from Baltimore, MD have found that over one year, an OPC can generate \$7.8 million in savings by preventing 108 overdose emergency medical services (EMS) calls, linking an estimated 121 people to substance use treatment, and preventing 3.7 HIV infections, 21 HCV infections, and 374 days in the hospital for skin and soft-tissue infections.²¹ It has been estimated that each dollar spent on an OPC would generate \$2.33 in savings for the United States.²² An Institute for Clinical and Economic Review study estimated that an OPC in the Boston area could save \$4 million annually, prevent three overdose deaths, 551 fewer visits to the emergency department, and 264 fewer hospitalizations.²³

Public Safety

Overdose prevention centers keep drug use away from public spaces while providing a sense of community for the people who use the sites.²⁴ Business owners and nearby residents reported less syringe litter and public drug use after the opening of an OPC and OPCs have not been shown to increase crime or drug trafficking.^{25,26}

Public Support and Education

Public support for OPCs can be bolstered through multi-sectoral education. OPCs have documented benefits for individuals and the surrounding community, and a recent Beacon Research poll shows that 70 percent of Massachusetts residents support OPCs.²⁷ One survey showed that people were more supportive of OPCs when the community messaging focused on their ability to reduce needle litter, prevent fatal overdose, and increase access to substance use treatment.²⁸ Another study discussed how stigmatizing attitudes toward PWUD affect willingness to support OPCs.²⁹

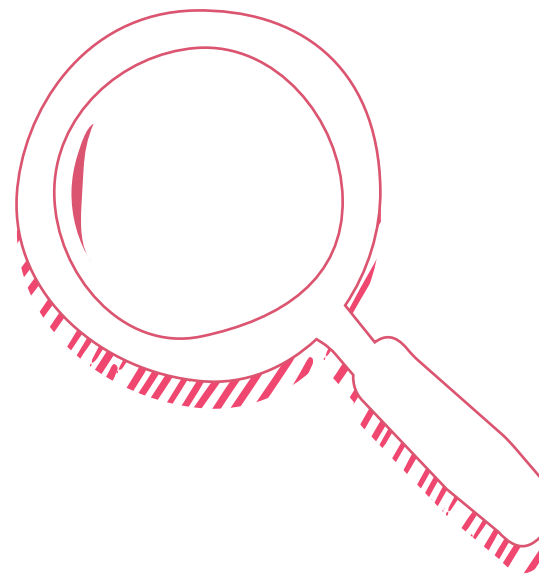
There is research that demonstrates supportive perspectives on OPCs from professionals who work with PWUD. One study that conducted intensive interviews with emergency service providers found that emergency medical technicians (EMTs) and firefighters saw many benefits to their own safety, knowing that there would be fewer overdoses and that an OPC is a place they would feel comfortable administering aid.³⁰ While many peer recovery coaches support use of OPCs, a preference for abstinence-only treatment among some recovery coaches suggests a need for greater education about the comprehensive services provided.³¹ Educating and convening a larger group of community members and taking their concerns seriously would increase support for OPCs.³²

In a study conducted in Boston, most PWUD—especially those with increased vulnerability to overdose, homelessness, and frequent medical issues—demonstrated a willingness to use an OPC. Results indicate that this intervention would benefit the people who need it most.³³ Participants value both easy access to OPCs and increased access to substance use treatment services. Including input from PWUD in the OPC design process so that the sites favor harm reduction principles can increase service uptake.^{34,35}

Findings

Findings from all methods (agency visits, RFI responses, participant interviews, and key informant interviews) are described below in four sections:

- Overdose Prevention Center Interest, Model, Location, and Staffing
- Harm Reduction Drop-in Space, Services, and Staffing
- Equity & Community
- Lessons from OnPoint NYC Overdose Prevention Centers



Overdose Prevention Center Interest, Staffing, Model, and Location

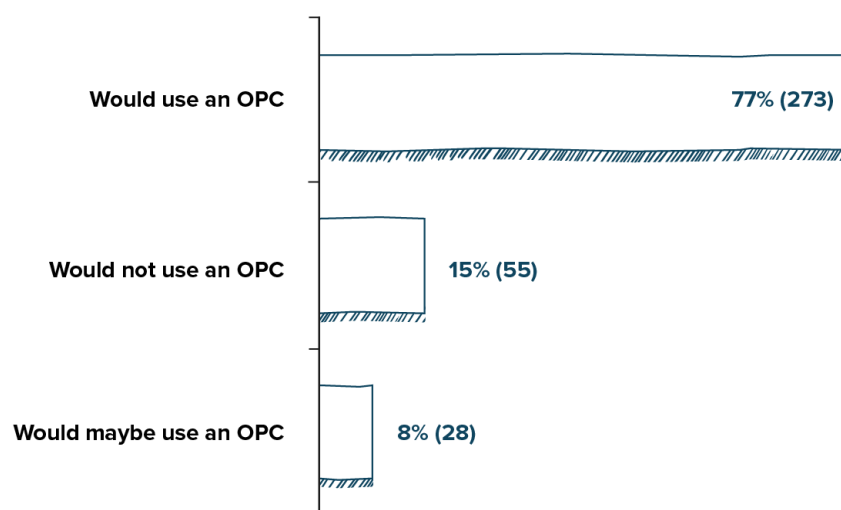
Interest

All agencies that JSI visited were interested in offering OPC services, but four wanted to focus on offering and/or expanding community-centered harm reduction drop-in services before moving to supervised consumption. Staff from two agencies said that they were ready to start offering supervised consumption if the state authorized OPCs. Staff from all agencies recognized that building support for overdose prevention services would be challenging, especially in areas where even syringe service programs are still not widely supported.

A majority (77 percent) of participants interviewed stated they would utilize an OPC if one was available to them. Fifteen percent said they would not use an OPC. Of these, 5 percent said that an OPC would help other people, even if they didn't use it themselves. A few (8 percent) participants were conflicted about whether they would come to or use an OPC. Of these, many said "yes and no." See Figure 5.

Of participants who explained why they would use an OPC, almost all said that having staff watch over people and provide medical attention if needed would prevent overdose deaths and tragedy. Participants said that OPCs would be places to relax and feel safe. OPCs would also be warm in the winter and cool in summer, and clean places where people wouldn't catch illnesses.

Figure 5. Participants Who Would Use an OPC (N=356)



*Figure displays coded qualitative information.



Harm reduction, it's like we talked about. [A] safe place to use, it's very much needed. I hope this helps get it done.... it's needed. And I think it would help any amount of overdoses and deaths. I really do, especially with the Xylazine I really do, because that's just making people fall asleep mid-step."

– Participant

Almost all participants who said they would go to an OPC would be comfortable coming to a place where other people are using drugs. Many said this was because they were already around drug use every day.

A small proportion (3 percent) said that staff could protect them and their belongings while they were using drugs so they wouldn't get robbed. Of these, a few said that they would feel safer using drugs there because there wouldn't be police and they wouldn't get in trouble.

"Especially if this [...] place had the general rules of respecting other people's boundaries. [...] if there was a safe place, judgment-free, control free, but controlled in safety where people could do their thing, I think that would be an open door for healing too."

– Participant





I feel like my anxiety would be down a little bit more due to the fact that I'm not looking over my shoulder and worrying about getting caught getting high. [...] I think that it not only takes away from the stigma [...], it also creates a space where you know that you can be cared for, especially in an environment where you are so [...] vulnerable."

– Participant

Many participants who said they would not use or weren't sure if they would use an OPC could not explain why. Of those that could explain why, reasons included:

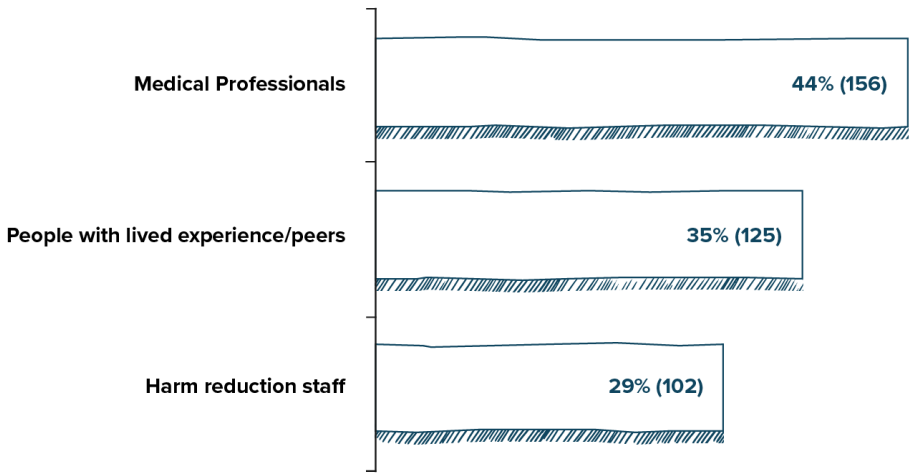
- They preferred to use drugs alone in private (not in groups) or with their family.
- They wouldn't be comfortable or didn't want to be watched while using.
- They wouldn't want to be next to someone else who was using. Of these, some said that separate booths would help them feel more comfortable. Others said they did not want to be around syringes or others injecting.
- They were concerned about other people's behavior while high.
- They feared the police would watch OPCs so they could arrest people who were carrying drugs into the building.
- They feared that people going into the building might be robbed.
- They thought that people would use it as an opportunity to sell drugs.
- They were worried about fights related to splitting and sharing drugs.
- They said that people might expect it to be unsafe because they've experienced stigma for so long. OPCs would have to help people overcome this fear.
- They thought it would be hard to find a location the community would accept.
- They thought that the drop-in they visited would not want to run an OPC.
- They felt that OPCs legitimized or encouraged drug use, and would not help people move toward recovery.



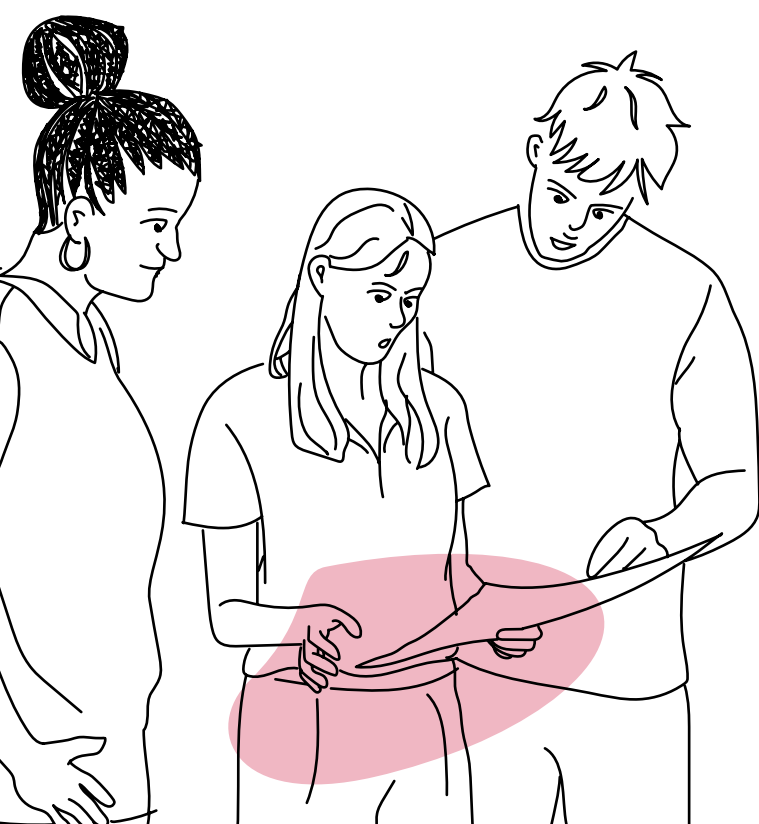
Staffing

Participants were also asked what types of staff they would want at an OPC. As shown in Figure 6, the top three staff types mentioned were medical professionals, people with lived experience, and harm reduction staff. Figure displays coded qualitative information.

Figure 6. Staff Types Participants Wanted at an OPC (N=356)*



*Figure displays coded qualitative information. Percentages will not add to 100%; participants reported more than one type of staff.



Forty-four percent of participants mentioned that they would want some kind of medical professional present and/or on staff. Specific types included nurses, doctors, EMTs, medical and nursing assistants, and phlebotomists. Participants said that they would want medical staff on site to respond to overdoses and help meet other needs such as wounds. Many also said that even if staff were not medical professionals, they should be trained in first aid and overdose response or have other qualifications or certifications.

Lived experience was important to participants who discussed OPC staffing. Thirty-five percent wanted staff members to have some type of lived experience with substance use. Some also mentioned wanting staff members who were in recovery. Participants wanted an OPC to be staffed by people who they could connect with and relate to on a personal level because they had the same experiences or been through similar things. They said that people with lived experience tend to be more understanding and less judgmental. Several people also emphasized that the knowledge gained by lived experience cannot be learned or replicated through education or training.

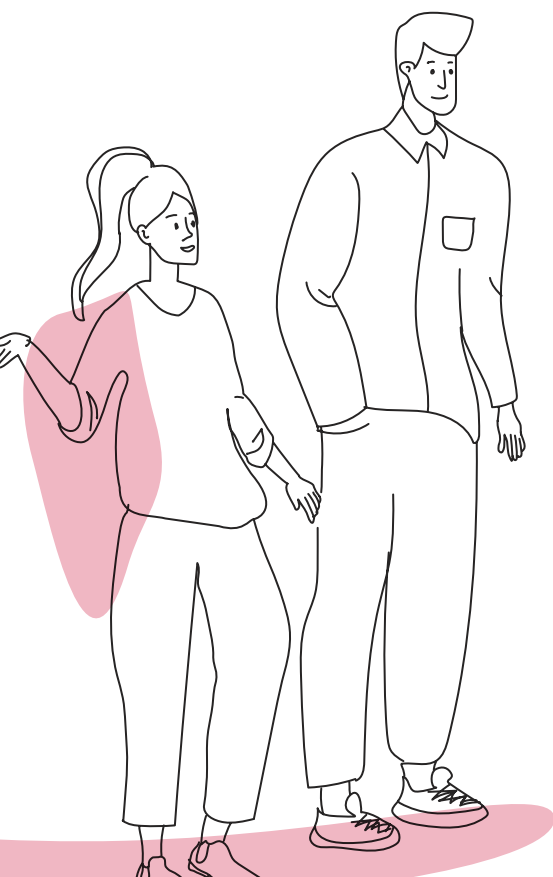
"I'd be comfortable with that, somebody that they've done it [...] When they speak to you, you know it's coming from a real place because they experienced it ... They're not just saying stuff just to say it. They lived it, so you can mark their word because you know they're telling the truth ... because you've been with it. I mean, you are where they have been ... [if] I was listening to an ex-user that's employed by the facility. I would listen to them before I listen to a doctor, somebody with a PhD or whatever, because of the experience of it. [...] So that's the difference. Not saying the professional doesn't have the knowledge or anything, ... but having the knowledge and actually living through it and going through it, is a totally different thing."

– Participant

Twenty-nine percent of participants wanted harm reduction specialists or staff who work at harm reduction drop-in centers to work at an OPC. Participants said that they trust and feel safe with these staff and that their harm reduction experience would qualify them to work at an OPC.

Key informants emphasized that OPCs should be staffed by a combination of clinicians and peers with lived experience. Many people who use syringe service programs also need immediate clinical resources provided by licensed clinicians (medical and mental health) at an OPC. Peers and harm reduction staff could be responsible for outreach, safer consumption needs, and daily interaction with the community. The division of power within a combined clinical/peer model should be equal, with all parties involved in decisions about how the space is run, how data are collected, and how to best serve the community. Peers should be considered a full part of the OPC team, not treated as volunteers or of lesser value than the clinical staff. Staff should be representative of and responsive to the community that it serves.

In addition to naming specific staff types or qualifications, participants mentioned specific attributes or attitudes that they wanted OPC staff to possess. Nearly one-quarter mentioned that they wanted OPC staff who were non-judgmental, understanding, respectful, caring, compassionate, supportive, helpful, trustworthy, and passionate about helping people. Many participants also said that they wanted staff to be knowledgeable about and understanding of substance use and addiction. Several participants wanted OPC staff to be supportive of and provide referrals to recovery services. They emphasized the importance of providing more treatment and recovery options in addition to OPC services.



A small number of participants said they would not want medical providers, people in recovery, or peers at an OPC due to concerns about being judged or stigmatized. These participants described experiences of being judged by such individuals.

Fewer than 10 percent of participants specifically mentioned wanting the following staff types: mental health clinicians (therapists, counselors, psychologists, and psychiatrists); security and/or police; people with various identities (LGBTQ+, multicultural, bilingual, women); case managers; outreach workers; and members of religious communities. Although some participants wanted private security or police to be present at an OPC to promote safety for participants and staff, others did not want police to be present. They mainly cited concerns about arrests and other repercussions for going to the OPC. Several participants had concerns about law enforcement activity increasing in the area of an OPC or that going to an OPC would make them vulnerable to arrest.

“There needs to be compassion, there needs to be consideration, there needs to be no judgment, there needs to be help, there needs to be safety, there needs to be more nurses to be at the ready to save [...] people’s lives.”

– Participant

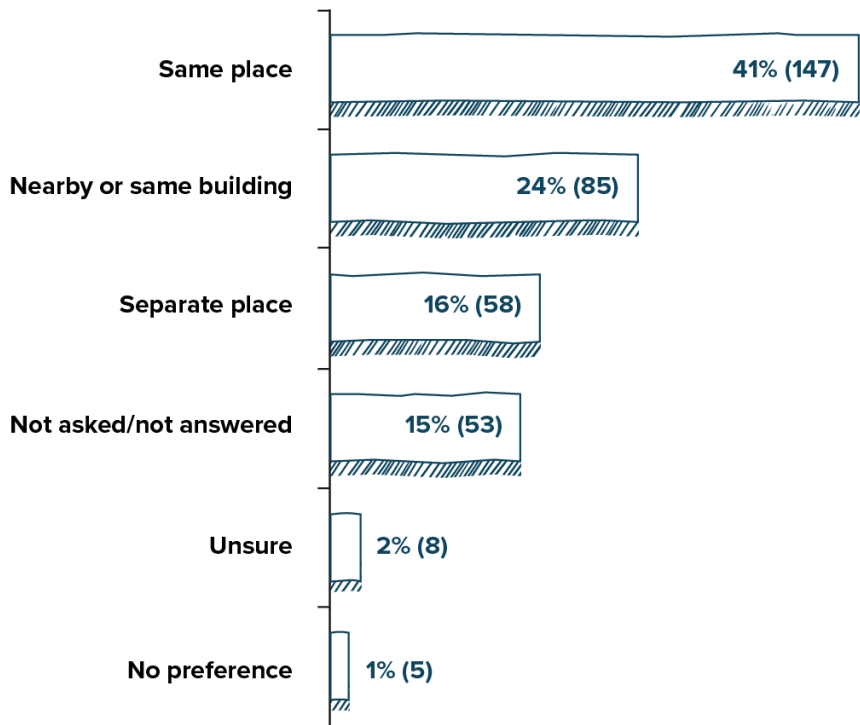
Model

Participants differed in preferences for the level of integration that an OPC should have with a harm reduction drop-in center. Of those who commented, 65 percent wanted an OPC and a harm reduction center to be in the same room/place or building or close to each other (Figure 7). Figure displays coded qualitative information. Participants who wanted an OPC and harm reduction drop-in center in the same place said that having the services co-located would promote safety and fast overdose response. Additionally, participants said that having the services in one location would be convenient and meet many needs at once.

The same themes of ease of access, convenience, and safety were also present in responses from people who wanted an OPC and harm reduction drop-in to be separate but nearby or in the same building.

Figure 7. Integration of OPC and Harm Reduction Drop-in Center (N=356)

*Figure displays coded qualitative information.



"[...] there is more to life even when you're using than using. You still eat food. [...] You still have your laundry to do. You still have to figure other stuff out. So [it would] be nice if, in a harm reduction space, you could get other things done."

– Participant

"[...] I mean, ain't nobody want to go from one place to the next. [...] If I was going to exchange needles here, I want to just go two doors down and it's here, instead of going to grab an exchange needle here, and I have to drive all the way, one mile, just to go to a safe spot."

– Participant

Participants also explained why they would want an OPC and a harm reduction drop-in center to be separate. They said that being around people who were using drugs would be uncomfortable or triggering to themselves or other participants, particularly people who are in recovery. A few indicated that they would want an OPC to be separate from a harm reduction drop-in to expand access to services into different parts of the community.

Participants also had thoughts on OPC structure and layout. Many suggested that an OPC could consist of one or several rooms connected to or within a harm reduction drop-in center. Others envisioned this same structure but with the OPC and harm reduction drop-in center on different floors of the same building. Both of these models would allow participants to access a variety of services in one location while maintaining some separation between the OPC and harm reduction drop-in center.

Other layout considerations mentioned by participants included having a large enough space for all participants and ensuring participant privacy. OPCs should accommodate the different types of substances that participants want to use (e.g., opioids, stimulants) and different routes of administration (i.e., injection, inhalation, intranasal, ingestion). An ideal OPC would meet the needs of all participants and include observation and resource provision that is responsive to the use of different substances and routes of administration. Participants suggested structuring the space to have several small rooms, booths, or cubicles.

“Maybe if they had a multi-level building of some sort so you had one thing on the first floor and the other on the second—I mean that’d be pretty cool—or at least next door to each other, within the same vicinity. Yeah. That would be awesome.”

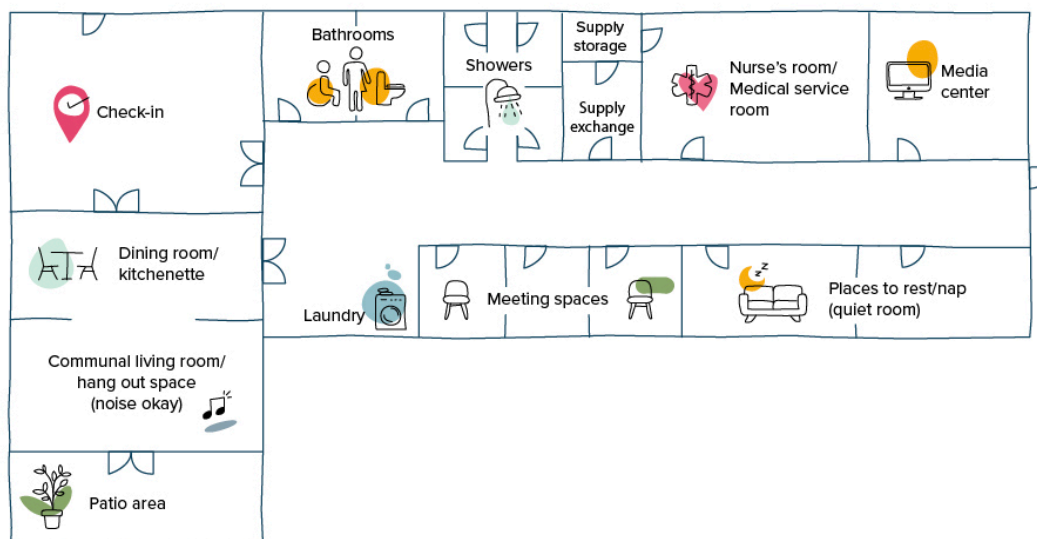
– Participant

One key informant also provided several layout examples. In New York City, On-Point has material distribution and a staff member responsible for collecting intake data located at the front of the building. There is a community room with snacks, bathrooms, and space to socialize, with consumption spaces in the back of the building. This key informant also mentioned that in Europe, where smoking drugs is the more common consumption method, many OPCs have a room for injection and others for smoking. Smoking rooms are designed for socializing, with users sitting around a large table, rather than cubbies facing the wall for injection.

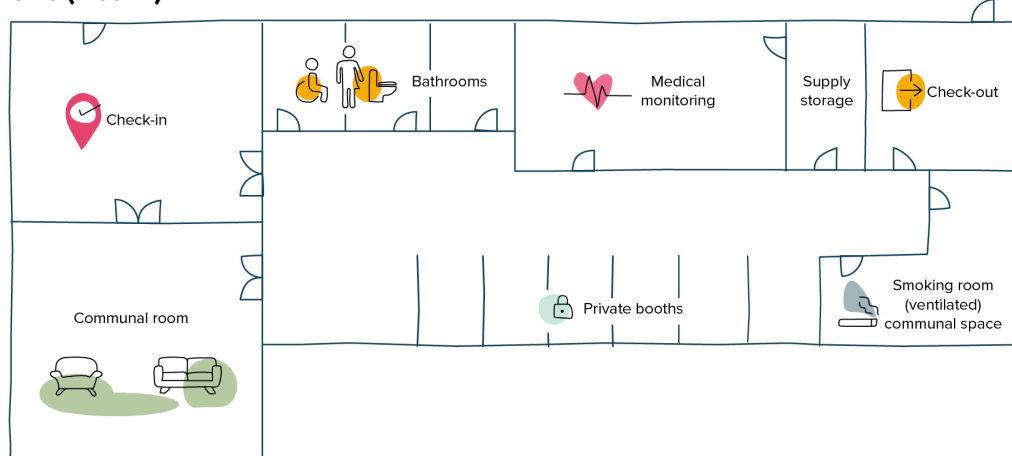
See diagrams of potential harm reduction drop-in center and OPC layouts. Each visual (Figures 8 and 9) represents an estimated 5,200 square foot space. Specific requirements will depend on location, volume, and construction options. No floor plans were drawn to create these visuals.

Figures 8 and 9

Drop-in (Floor 1)



OPC (Floor 2)



Location

Interview participants said that the proximity of an OPC to other community resources is important. Those who commented on the potential location of an OPC said it should be at or near an existing harm reduction drop-in center or located near hospitals or other health care facilities, homeless shelters, opioid treatment programs, or police stations.

Both interview participants and key informants discussed accessibility and transportation. Many participants mentioned that having many community resources, including an OPC, within walking distance of each other is best, especially for people who have minimal access to transportation. Several participants said that an OPC should be located in a central area of the community and near public transportation routes or bus and train stations.



When you have to go over here for this and go over here for this and [...] I don't have a car. [...] I just got a job. I [...] take the bus with no money and no bus pass. It makes it really difficult and I'm less likely to utilize anything."

– Participant

One key informant mentioned that evidence shows that most people won't travel to access an OPC. Thus, when considering the needs of rural communities, an option could be mobile consumption units, a model that has been used in cities such as Montreal, Canada. Another key informant noted that mobile health care units also provide important primary health care services. While people initially come for harm reduction services, they may access treatment for other health needs at the same time. In Massachusetts, there has been a lot of effort to build primary care and sexual and reproductive health services into harm reduction services. With this model, OPCs can facilitate access to other health care resources.

Participants also said that the location of an OPC should be determined based on community needs. Almost one-quarter (22 percent) said that an OPC should be located in places where drug use and overdose are more prevalent or there is a generally high need for services.

"...in the spot in the community that's most poverty-stricken, that has the most drug and opioid use, maybe a little bit of a research where the overdoses are happening. Right in the thick of it. [...] That's where it should be. That would be something positive."

– Participant

Many participants said that multiple OPCs were needed in their community or in many different locations or cities. One reason for this was concern about high rates of overdose and related deaths. Participants said that having more than one OPC within the same community or city would ensure that people living in different parts could easily get to an OPC.

A small group of participants said that OPCs should be secluded and far from schools, playgrounds, libraries, parks, and residential areas. Some participants perceived their drug use as shameful and did not want onlookers, especially children and families, seeing people who were high or using drugs. Many preferred a private and separate area to use drugs, which would be provided by an OPC.

"I think every city should actually have one because it's so much going on right now. And we're losing a lot of people."

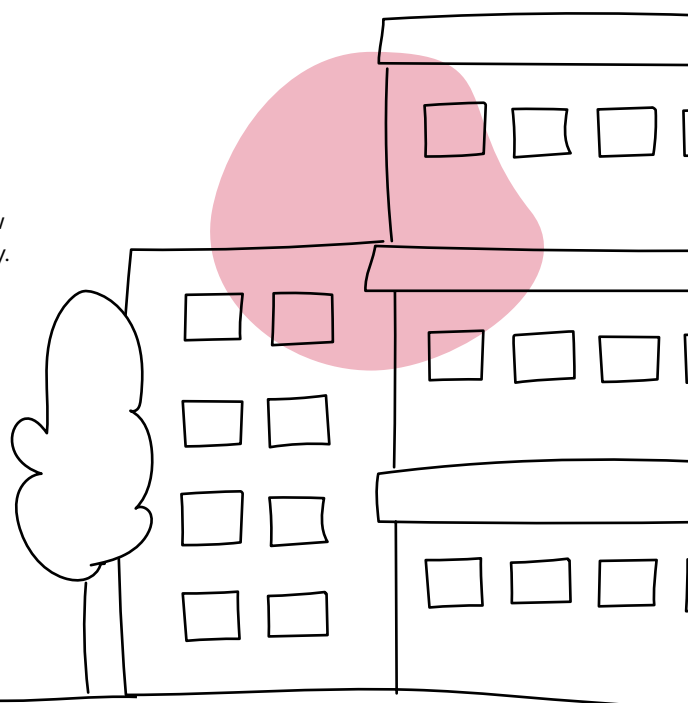
– Participant



Without being in the streets where people can see, kids, stuff like that. And that's one of the big things I don't like. I don't know, I don't want kids seeing that or anyone. It's a shameful thing. It makes me feel [ashamed of] myself."

– Participant

Key informants emphasized the importance of community collaboration and communication when opening an OPC. One noted that community opposition to OPCs can be a barrier. Thus, diverse, representative community advisory boards are crucial in the planning process so that people feel included and heard in the creation of what may be an unfamiliar resource. Key informants suggested hosting open houses for members of the public to chat with staff and see the space itself. Inviting leaders such as members of municipal government, local clergy, and law enforcement can build trust, increase visibility, and decrease stigma. One key informant emphasized the need to work collaboratively with law enforcement and ensure that planning discussions focus on public safety. It is important to highlight that data show that there are no increased safety risks in areas surrounding an OPC.³⁶ A recent study of OnPoint NYC found that there were no changes in crime or disorder in the area surrounding its two sites.³⁷



Harm Reduction Drop-in Center Space, Services, and Staffing

Significant investments in space, services, and staffing are needed to expand harm reduction drop-in services in Massachusetts. Agencies visited (n=6) and those that submitted an RFI response (n=22) emphasized a desire for capital investments in their space and sustainable funding to hire additional staff. Without these, agencies will be unable to expand services.

Expansion and Enhancement of Space

Participants and agencies hold paramount the importance of keeping harm reduction spaces safe with a significant community feel. The space needs to be warm, welcoming, and easy to access so that participants can feel both comfortable and a sense of ownership. Agencies visited with existing harm reduction drop-in spaces (n=4) noted that they do not have the space to provide the breadth of services needed or reach the number of people who could use them, a sentiment shared by those interviewed. Participants frequently mentioned a desire for the drop-in to have physical space and/or have separate rooms for different activities or services. Agencies want to own a stand-alone building or rent a space owned by a supportive landlord with supportive neighbors.

In addition to expanding the physical space, participants requested expanded hours and improvements to the environment at the harm reduction drop-in center. They wanted expanded hours during the week and on weekends; 24-hours-a-day facilities; and services that are currently only offered on certain days to be available every day.

Participants want a quiet, comfortable, clean, and calm environment. Many mentioned noise levels; that harm reduction drop-in centers can be too loud when crowded or lots of people are talking. Some participants suggested guidelines about respecting each other's space and boundaries to provide more structure.

Some said that the space was already comfortable and welcoming, while others wanted it to feel more "homey" and suggested hanging pictures or playing TV/movies to make it feel more like a living room.

Participants were asked "What would make you feel the most safe and supported when you come to a harm reduction space like this one?" (Participants interviewed over the phone were asked about the harm reduction drop-in center that they identified as frequenting). Sixty percent provided suggestions on what would make them feel most safe and supported in the space. The majority of comments were about how participants were treated while there.

"I wish they... could somehow make it bigger. But I mean, that's obviously because it gets crowded. I mean, they do their best with the space, but it gets real crowded."

– Participant

"I know they do overnights now, but I really wish they did it more often... [...] They do a really great job during the day but if they're not here at night, then it's like no one's here to pick up the pieces for when it's gone."

– Participant

**"I love it. I love it because they're doing it for the community.
They make us feel wanted [...] I love what they do.**

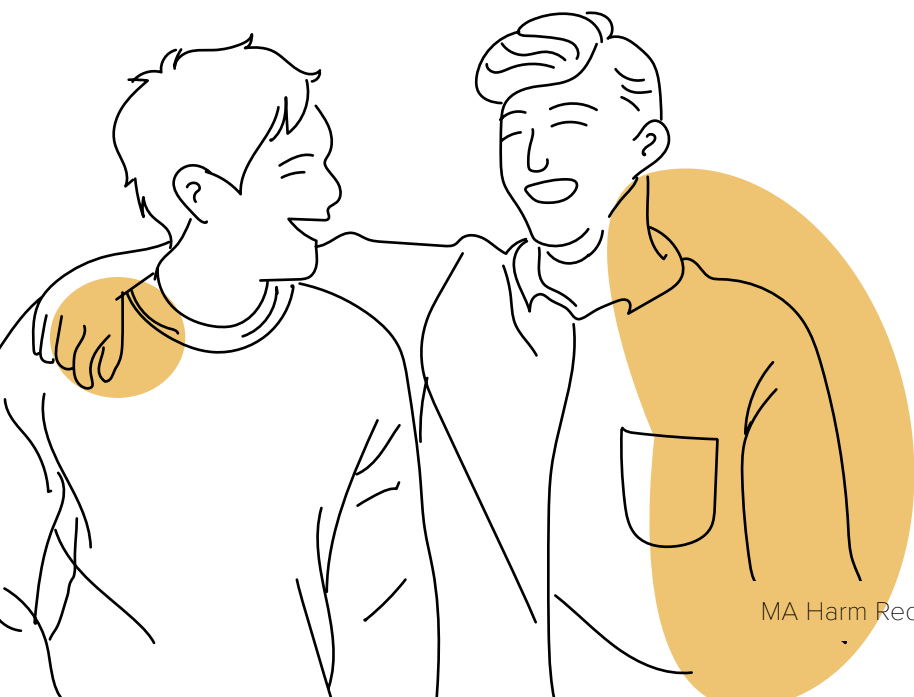
– Participant

**And I don't know if I speak for everybody, but this place is a
godsend. This place is very important to me. [...] And this is
a place of solace."**

– Participant

Some participants wanted more privacy or a private space to have personal conversations with staff, or just a place to be alone when having a bad day. Privacy was mentioned both inside the drop-in and outside (where staff offer outreach services). At times, participants were asked to share identifying information with outreach workers in places where other people could overhear. Participants wanted their information kept confidential. Multiple participants appreciated the anonymity that they were provided when site staff generated an anonymous code, rather than recording identifying information.

Relatively few comments were made about other participants, but those that were typically had to do with being around people who were using drugs. In a few instances, they were related to a particular staff member who was rude or unfriendly. Some participants said that seeing familiar faces at the harm reduction drop-in center was something that would help them feel safe. Some wanted the harm reduction drop-in centers to be free of violence and weapons and for individuals to experience repercussions for violence or theft there.



Services and Programming Needs

In addition to hosting an essential community space, harm reduction drop-in centers in Massachusetts offer a variety of services, including but not limited to:

- Basic needs (food/drinks, space to rest/sleep, access to technology [including phones/computers], bathrooms, showers, and laundry).
- Harm reduction supplies and equipment.
- Medical testing and treatment (vaccinations, wound care, testing for HIV, HCV, sexually transmitted infections [STIs]).
- STI prevention and education.
- Overdose education, naloxone distribution training and education.
- Meetings and support groups.
- Referrals to other supports and services.

When asked about critical gaps in support and unmet needs for PWUD in Massachusetts, those who responded to the RFI identified access to health care, easily available testing and treatment for infectious diseases, and access to LGBTQ+ and BIPOC-specific inpatient recovery treatment. Additionally, all staff at the program visits and many participants mentioned housing and low-threshold housing support as an important need that isn't being met. Agencies need significant increases in funding to expand their current service offerings and provide additional services.

To assess unmet service needs, participants were asked “When you come to spend time at [name of drop-in], is there anything that you wish this space provided that it doesn't currently?” Interviewers asked about interest in laundry, places to take a nap, showers, food and drink, computer/phone access, and meetings/support groups.

Of participants who did have additional service needs, they noted services that address basic needs, access to technology, meetings/support groups, education, and job skills and services among others (Figure 10).

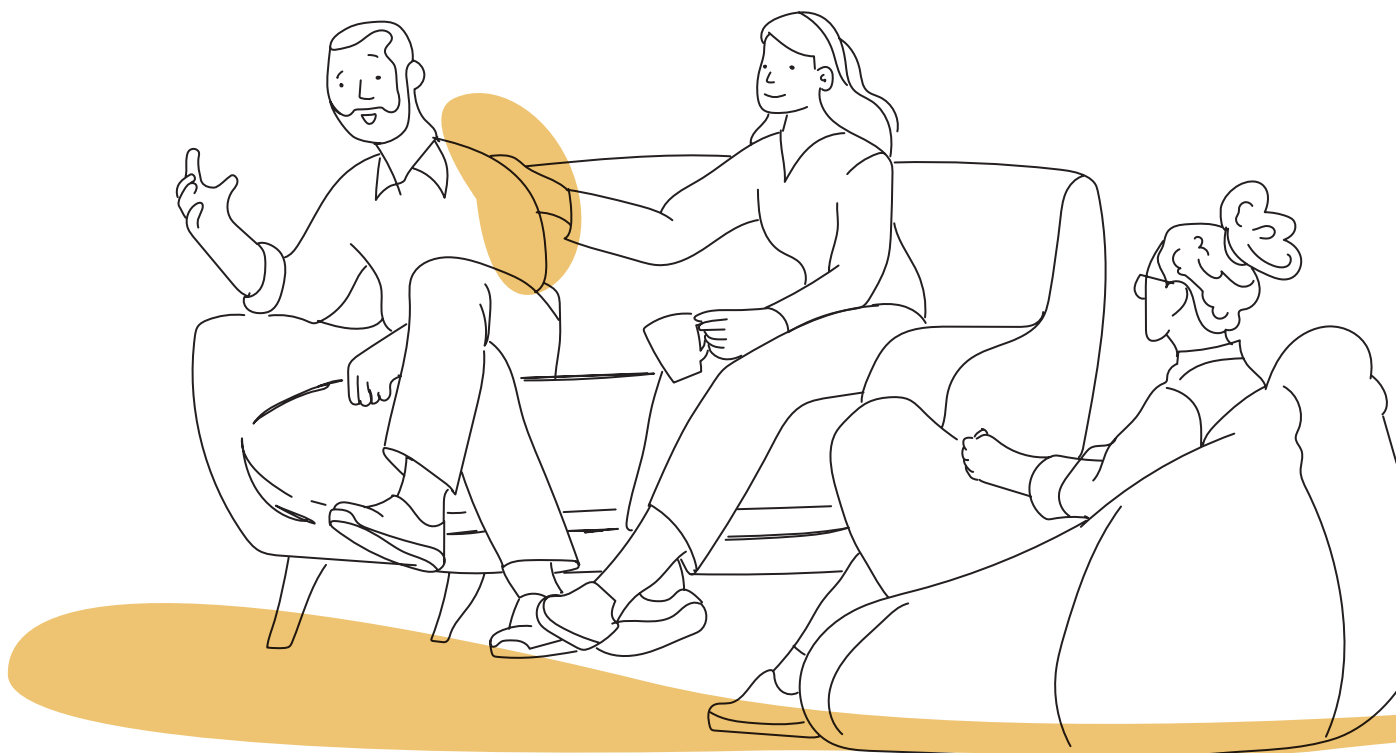
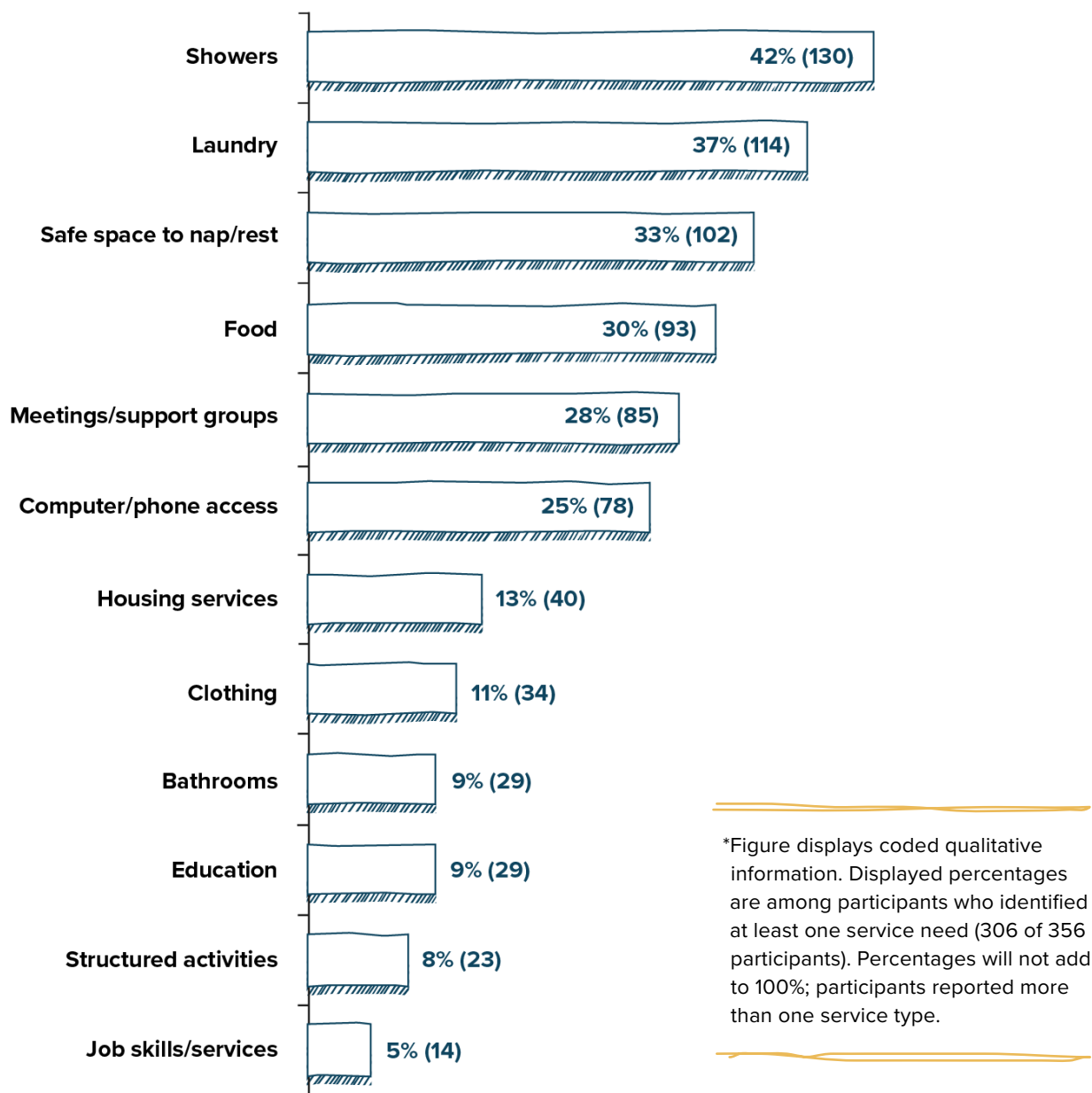


Figure 10. Top Services Participants Wanted at a Harm Reduction Drop-in Center (N=306)*



Fourteen percent of participants said they had no additional service needs. Many said they had access to the services they needed and appreciated this. Some participants who did not need access to these services mentioned they would be valuable for others who may be experiencing homelessness or unstable housing. Participants also wanted to access food/meals, bathrooms, and blankets when the harm reduction drop-in center was closed because it is one of only a few places that has those items/services available.

Bathrooms are essential to meeting self-care and hygiene needs. A key informant noted the importance of bathroom policies and procedures for harm reduction programs. Many harm reduction drop-in center bathrooms closed at the beginning of the COVID-19 pandemic to reduce incidences of overdose fatalities and other medical emergencies. Some of these bathrooms have not reopened due to lack of staff resources to monitor them. An official policy could encourage and standardize staff investment for bathroom monitoring, allowing people at the site to meet their basic needs while ensuring everyone's safety and wellbeing.

Participants wanted access to shower and laundry services and hygiene products, although a few were concerned about bed bugs and lice if an agency were to offer laundry. Participants asked for shampoo/conditioner, soap, toothpaste/toothbrushes, and feminine hygiene products. They also wanted more men's clothing, sneakers, underwear, bras, socks, blankets, and tents. At the same time, some people did not have a place to store their belongings and were at increased risk of having belongings stolen.

Participants also requested increased access to a variety of foods. Although people acknowledged that harm reduction drop-in centers offer food in varying capacities (snacks, some meals, coffee, etc.), most wanted more. This included full and to-go meals, bottled water, healthier options, and greater variety. A few suggested alternatives like pantries, kitchens where people could prepare food for themselves or all participants, and vouchers for elsewhere in the community.

"Something to eat. Sometimes they have, and sometimes they don't. Many people are ashamed to ask."

– Participant

“I mean, they do have so much they already offer, but I just, I guess I wish they also had maybe [...] things like feminine products, clean underwear, and socks even. Even just basic stuff like that. That would be huge. [...] Toothbrush, toothpaste. [...] Maybe not clothes necessarily other than underwear and socks. [...] Because that kind of goes hand in hand with harm reduction in a way. Staying clean and cleanliness... Plus it makes you feel better about yourself.”

– Participant

Many participants expressed interest in resting and/or napping at harm reduction drop-in centers. While some allow people to nap in chairs and/or with their heads on tables, participants wanted a more comfortable place to rest while knowing their belongings are safe. Ideas related to napping included separate resting areas, day shelters, lockers to store belongings, staff monitoring the space, nap pods, and couches/reclining chairs.

“Something like reclining chairs for you to take a nap in. They really don’t have anything for you to lay down like that. I sleep in the chair. [...] And some of us like me, I’m in the shelter next door. And I can’t sleep there because I’m not comfortable because it’s too many people moving and noises and I can’t sleep, so I come over here to get my sleep on over here because I feel comfortable over here.”

– Participant

Participants were interested in harm reduction drop-in center-hosted peer support groups, recovery meetings (in Spanish and English) and sobriety groups including Narcotics Anonymous and Alcoholics Anonymous, men’s fellowship meetings, and support for survivors of domestic violence. At the same time, there were concerns about hosting meetings/support groups at the harm reduction drop-in center, including people coming and going causing distractions and people being there to access other services and not wanting to partake in a meeting.

Participants wanted access to phones, chargers, internet/Wi-Fi, and/or computers. A few were worried about giving access to phones, including that people would take advantage of, monopolize, damage, or use them for inappropriate calls.

Another theme was offering educational opportunities, structured activities, and job services. Participants wanted education on harm reduction, substance use disorder, overdose prevention and naloxone distribution, trends in the current drug supply, transgender health, and infectious disease prevention. Some suggested educational courses and classes on skills like budgeting and computers. Options for structured activities included art/crafts or art therapy, recreational games, movie nights, and meditation. A few participants requested support related to learning job skills, job placement, and assistance filling out government forms.



“But computers—the phone especially—like, nowadays, it’s like, essential and crucial. You know, everything runs through email, like even social security. [...] Even bank accounts now you know, a lot of it all digital. That’s almost like a necessity at this point.”

– Participant

In a follow-up related to services not offered/to be expanded at the harm reduction drop-in centers, participants were asked “Would you want the space to have [or keep having (depending on site)] safe injection and/or smoking supplies?” Most participants were supportive of offering or continuing to offer safer consumption supplies. Reasons that people supported these services included reduced hazardous waste on streets, crime, and public drug use; and making the community safer for children and the elderly. Participants also noted health benefits related to reduced needle and other drug use equipment reuse; reduced transmission of infectious diseases, and fewer fatal overdoses.

“Because of [the SSP], they’re the reason why I only use a needle one time. I used to use a needle multiple times, a whole week with one needle. But because of [the staff] giving me information on why I shouldn’t use the same needle, because of the supplies that they give us, there’s no reason why we should use the same needle over and over.”

– Participant

Although the majority of participants interviewed were supportive, some were conflicted and a handful were against providing safer consumption supplies because they did not want to enable drug use. Other reasons for not being in support were that it would cause trouble or wasn’t necessary because other agencies in the community offered these supplies.

Agencies wanted to be able to implement and expand enhanced harm reduction services and programming. Options included OPCs, low-barrier housing, wound care clinics, mobile outreach services, and on-demand drug checking. A participant suggested having a program function as a harm reduction drop-in center offering services during the day, and as a shelter for people who are experiencing homelessness at night.



Staffing Needs

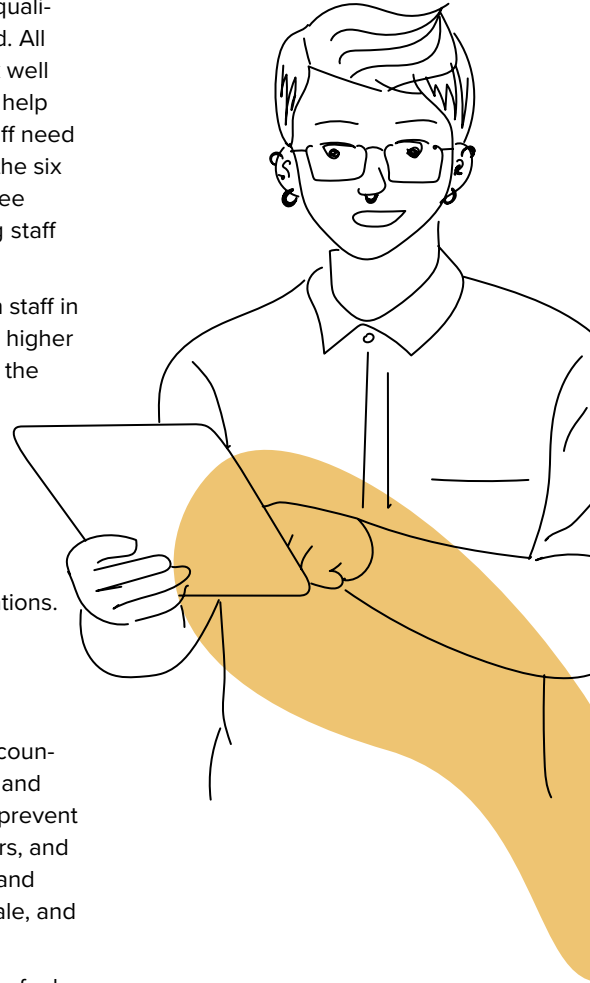
Harm reduction programs in Massachusetts have significant staffing challenges. More qualified harm reduction staff who are appropriately compensated are essential and needed. All agencies visited described having staff who are passionate, resilient, flexible, and work well together under pressure. Staff who are from the community and have lived experience help maintain a judgment-free space and connect participants to services. All stated that staff need to be paid more and, with increasing numbers of participants, are overworked. Five of the six agencies visited did not have enough staff to manage their current workload, and three agencies were acutely understaffed. One agency discussed the difficulty of recruiting staff from the region who understood harm reduction principles.

RFI responses showed similar perspectives on the acute need for more harm reduction staff in Massachusetts. Resource needs related to staffing included more training and support, higher salaries, and payment mechanisms for volunteers and peers. RFI responses also noted the need to hire a range of more staff including:

- Staff who speak languages other than English.
- Data management and administrative staff.
- Development and advocacy staff.
- Harm reduction trained medical staff who can assess wounds and prescribe medications.
- Outreach staff.
- Staff to support ordering and inventory of materials.

When participants were asked about staffing needs, they expressed a desire for more counseling and mental health staff, medical staff including nurses and primary care doctors, and case management staff. One participant suggested having an on-call nurse who could prevent overdoses at night. Some participants wanted psychiatrists, drug and alcohol counselors, and case managers or other staff who would provide education and referrals on treatment and recovery programs. Participants requested staff who were more diverse, bilingual, female, and easy to identify (through a uniform or some other visual).

Participants also affirmed that helpful, knowledgeable, and professional staff make them feel safe and supported. Many validated the work of the staff at harm reduction drop-in centers.



“Everyone here goes above and beyond to help you. If you need socks, if you need a drink, if you need to be walked to a detox, anything, they really go above and beyond. They’re the most caring people ever. I come in here and I love it here because of the staff.”

– Participant

Equity and Community

Creating and maintaining an equitable harm reduction drop-in center for staff and participants was a high priority for agencies, participants, and key informants. Agencies noted the importance of understanding ways that different groups use and interact with drugs. They described the challenge and importance of building trust within specific populations and said that hiring staff who are diverse and represent the community can be challenging. Trauma-informed services for staff and participants were noted as needed to increase equitable delivery of services.

Participants were asked “Are there specific services needed to support any identities you may have? (i.e., racial, sexual, gender).” Seventy-seven participants (22 percent) said that they had specific service needs to support their identity, described below. Many participants had positive experiences related to their identities at harm reduction drop-in centers. They said that the staff “protect women,” welcome gay and lesbian people, and “do amazing” work with BIPOC participants.

"I just want to say that I love the staff [...], they do a really good job, [...] they are always very welcoming. [...] I've never felt like I was being judged."

– Participant

Women and Female-identifying Individuals

Agencies visited, key informants, and participants stressed the need for more services for women and female-identifying individuals. Many participants appreciated women-only days or hours that are currently offered at drop-in centers.

Women needed clothes along with hygiene and other products (e.g., purses, hair styling aids). They also needed housing and parenting services and support for domestic and/or sexual violence.

"I always come here on Wednesdays with my mom just because I love what they do I probably have a little rack of clothes, they put on certain music it's just nice to see because I know the girls down here my mom's friends with so I've been seeing them for years now...it's nice to come down here and see that they're okay that kind of thing. So that's something I really like."

– Participant

One key informant emphasized the need for safe and separate spaces for women or female-identifying individuals, people who engage in sex work, and members of the LGBTQ+ community. They noted that models that use “women-only” hours in predominantly male-dominated spaces with large male security officers are not enough to ensure true equity and access to services.



"[...] It's Women's Day and last week I had my hair cut. Washed, cut, and blow dried and it felt good, actually. I didn't really think about when I was going to take my next hit or anything like that. I was actually zoned out and just enjoying the service. I felt normal, actually, for a little while. I actually won the first raffle and it was a basket with hairspray. There was a Vera Bradley little pocketbook. It was actually nice. It feels good to have people who care about you and want to take care of you."

– Participant

LGBTQ+ Individuals

Agencies, key informants, and participants also stressed the need for more services for LGBTQ+ individuals. One key informant noted the lack of LGBTQ+-focused services in the state and that many harm reduction centers have a gap in these offerings. Requests for LGBTQ+ services among participants included visually welcoming cues such as flags, rainbows, and posters, and trans-inclusive services (e.g., clothes that may not match sex assigned at birth and hormone therapy support).

"With gender identity, I think they could definitely do more with the posters and flyers of LGBTQ, even some flags."

– Participant

Spanish Language Services

Agency staff noted the need for materials that meet participants' language needs. Participants requested additional services as well. Many affirmed the ability of harm reduction drop-in centers to provide Spanish-speaking staff to converse with and administer supplies, but some said that more services need to be provided in Spanish. These included recovery groups, therapists and mental health providers, and increased signage.

"I think all kinds of people go [...] and they're all treated equally. And every time I've been in there, there's never been anything about, you know, their religion or just anything. They treat everyone equally and the same."

– Participant

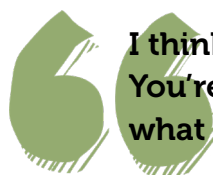
Services for People who Engage in Sex Work

Key informants, agencies, and some participants spoke of the need for additional services for people who engage in sex work. Multiple key informants spoke of the need for women-centered harm reduction spaces, and one noted that those should include spaces specifically for women who engage in sex work.

Equal Service Access

Participants expressed a desire for equal access to services regardless of identity. Ensuring that services are provided to everyone in the same way helps participants feel safe and supported.

These comments reflect the fact that addiction and substance use affect people of all identities (e.g., racial, gender, sexual orientation) and spaces serving them must be open to all.



I think that's something that kind of goes hand-in-hand with the drug users... You're already isolated. And that's kind of like an identity of its own, you know what I mean?"

– Participant

Additional Services

Participants expressed interest in ethnic meals, cultural appreciation events, and religious services. They mentioned services for people who are aging and some requested affinity groups and services for people who are deaf/hard of hearing and physically handicapped. Agencies that were visited noted methods and policies in place to support BIPOC individuals such as offering written materials in multiple languages, providing translation services, and offering safe smoking supplies and risk reduction counseling in culturally sensitive ways. Agencies also noted the importance of hiring more BIPOC staff, contacting and partnering with other local organizations that serve these populations, and offering culturally sensitive food, music, and community events.

Community Partnerships and Experience

Agencies responding to the RFI also highlighted the importance of community support and partnerships. In addition to partnering with other local service agencies, the importance of strong relationships with government, police, and medical professionals were noted for both urban and rural settings. Responding agencies indicated that having a relationship with their local police can help participants feel safer using the center's services without fear of being arrested; that relationships with local government can help spread the message of harm reduction's efficacy; and that relationships with local medical providers can create strong referral pathways for participants.

Most agencies responding to the RFI also noted that the biggest challenges to expanding harm reduction drop-in services were lack of community support and funding, and increased stigma against people who use these services. Agencies felt that overcoming these challenges involves educating community leaders and treatment providers on the ways that harm reduction can benefit their communities by lessening syringe litter and increasing public safety and services for vulnerable populations. Participants provided additional context to their experiences of stigma and lack of community support. Many talked about how traumatic experiences shaped their life paths and led to their engagement with harm reduction services. They also emphasized the benefits of advocacy work, community engagement, and harm reduction services that provide support and save lives.

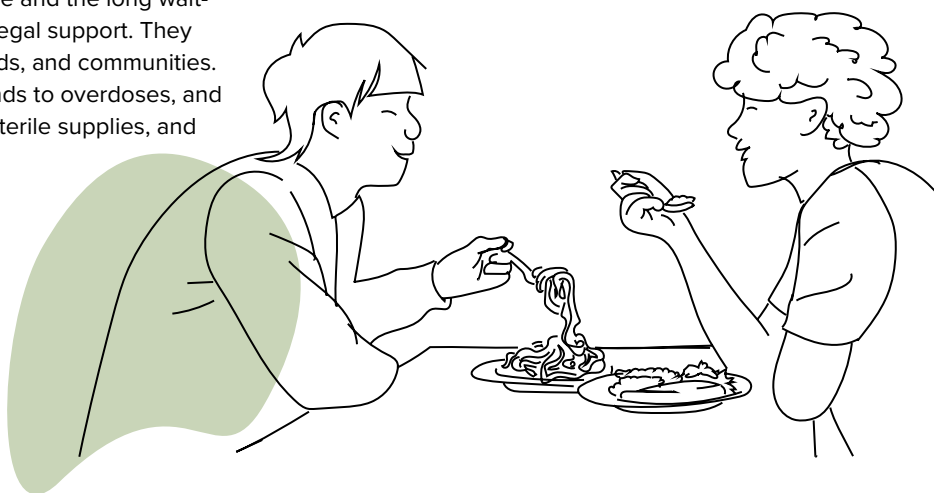
Participants also expressed frustration with limits to the assistance that harm reduction services can currently provide and the long waitlists for services such as long-term housing and legal support. They were concerned about loved ones, neighborhoods, and communities. Many participants have lost close family and friends to overdoses, and stressed the importance of naloxone, access to sterile supplies, and outreach work.

"I was brought up in an environment from all my aunts and uncles and mothers and fathers who did drugs, so it's sad to say, but it's like normal to me."

— Participant

"...I think it's a beautiful thing [...] what you do, it's helpful for the towns and, you know, the addicts and [...] even the people that don't use [...] You don't see all these needles around on the ground anymore, and you don't see people [catching] HIV like [they] used to. They get a lot more help and a lot more education on it. So people aren't getting sick like they used to—there's a lot more, you know, education and a lot more help."

— Participant



"And this is crazy. Too many people are dying; not enough people are checking if they're alive. I can't do it alone. Literally, that's what I do. I'll go around at night for days at a time and just go check on everyone. [...] We're running into dead bodies all the time now, people I know."

– Participant

"And I don't use alone either anymore. Never. And I use a little bit now because I've been going out a lot, so I've only been using a little bit, like 20 milligrams, and just testing it because it has the Xylazine in it. And that's scary."

– Participant

"Some people say they're not judgmental, but they are judgmental. Going to the doctor or the ER, sometimes it's okay but sometimes it's not okay. They only see your past or if you're messed up. It's hard to deal with."

– Participant



Many participants were very concerned about the drug supply, particularly because of fentanyl and xylazine, the harm it had on the community, and the services needed to counter that harm.

Participants also expressed concern for their neighborhoods. They advocated for better treatment of people who experience homelessness and use drugs; programs to maintain neighborhood cleanliness and safety; and more education for children on drug use and its effects. Some participants felt that hiding drug use from young people can create a mystery that makes it more appealing. They would like to help the next generation by seeing that it has more exposure to and education about the topic at a younger age.

Unfortunately, many participants had negative experiences in clinical settings before they came to the harm reduction agency.

Participants expressed gratitude that they are able to access clinical care and services such as syringe exchange at the harm reduction agency without feeling judged or othered as they do elsewhere in the community. They said that harm reduction spaces are among the few where, when seeking services, they feel understood and respected as individuals.

"We save each other every day"

– Participant

Housing

Participants and many key informants noted housing as needing immediate attention. Participants said that:

- Their health issues and lack of access to medical care are exacerbated because they are experiencing homelessness.
- The lack of stable and secure housing is a major source of frustration and suffering in daily life.
- They need more shelter spots and accessible and affordable long-term housing.
- Many have experienced crime, violence, and abuse in shelters and therefore opt to sleep on the street and avoid shelters altogether.
- Housing services and coordinators are needed at harm reduction drop-in centers.

Multiple key informants described the acute need for harm reduction housing across Massachusetts. They suggested housing-based spaces to use drugs such as residential treatment centers with an OPC built in; venue-based drug consumption spaces that have a dedicated room in an existing housing community; and harm reduction housing that is within or near other supportive resources for people using drugs.

Housing. There is no one to help us in the procedure of how to fill out the applications and try to plan for housing. There are a lot of people living in rented rooms or in places that are not nice. Most of them are in a shelter, and I don't think it's fair. There should be more help, no matter what house it is, for people who have addictions and don't have a place to live. Right now I'm living in a place where I have one foot in and one foot out. I feel intimidated, scared. Sometimes I feel uncomfortable where I am, I would like to have my own place and it has become very difficult for me."

– Participant



Lessons from OnPoint NYC Overdose Prevention Centers

OnPoint NYC's (referred to as "OnPoint" below) mission is to improve the health and quality of life of PWUD and people who engage in sex work, with concerted outreach to and services for people who identify as Black and/or Latino/Hispanic and people at risk of contracting or living with HIV in Northern Manhattan and the Bronx—two New York City areas with the highest rates of HIV incidence and opiate-related overdose deaths. OnPoint operates harm reduction drop-in centers and two OPCs. OnPoint offers harm reduction and health and wellness services (e.g., STI/HIV/HCV testing/treatment, wound care, medication for opioid use disorder, counseling), mental health care, outreach, and public safety and other supportive services (e.g., respite, holistic services, showers/laundry, food and nutrition services, case management, benefits navigation, drug checking, and education groups).

In 2022, the New York Harm Reduction Educators (founded in 1992) and Washington Heights Corner Project (founded in 2005) merged to create OnPoint. Over 99,000 unique participants have been served through its programs since 1992 and, as the largest harm reduction service provider on the East Coast, it serves more than 10,000 individual participants per year.

Though the organization is larger than the two OPCs it operates, its insights and lessons on financial and operational sustainability are incredibly valuable for programs considering opening an OPC.

Activity and Expense Tracking

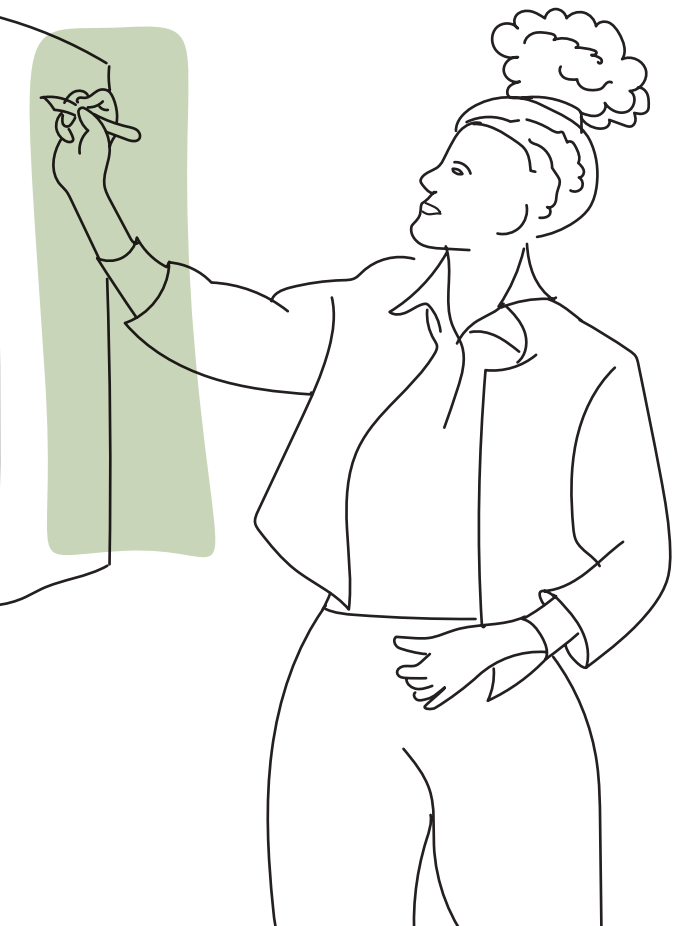
OnPoint OPC programs are funded primarily by the New York City Department of Health and Mental Hygiene (NYC DOHMH), with additional support from foundation and philanthropic gifts. OnPoint operates the OPCs using a time and effort allocation structure in which eligible and ineligible activities under federal law are qualified by a percentage of effort. The only activity in the OPC that is ineligible under federal law is the observation of illicit substance consumption. OnPoint conducts quarterly time and effort sampling audits to assess the percentage of time staff spend observing consumption (usually 2–5 percent) and uses private foundation and philanthropic funds to pay for staff time conducting this activity.

All other activities conducted within the OPC are publicly funded by NYC DOHMH. Additionally, OnPoint receives state and federal funding for non-OPC programming such as testing and linkage to care.

Staffing and Space

Staffing and space are the most significant costs for an OPC. OnPoint has five staff per shift assigned to the consumption space to achieve at least a 4:1 participant-to-staff ratio. The maximum capacity in the East Harlem OPC is 16 participants and 18 in the Washington Heights OPC. When participants experience challenges or incidents that demand greater staff attention, capacity is reduced to ensure staff maintain safety.

As a 140-person organization, OPC staff are part of a larger service model. The majority of funding for the OPCs goes to personnel. Wages are \$45,000–\$55,000 for overdose prevention specialists; managers make \$60,000–\$70,000. Staff assigned to the consumption space are given "opt out" privileges, meaning that when they are ready to move from their work at the OPC they are offered another position within the organization at their same salary.



OnPoint has 30-year leasehold condo agreements for both buildings it operates from, and is the only occupant. A leasehold condo agreement allows OnPoint to operate like the owner of the building for the duration of the lease.³⁸ This gives OnPoint more flexibility in the programs it runs and how it operates them. OnPoint is in the process of renovating both sites to establish the first 24/7 harm reduction wellness hubs in the United States. It installed specialized ventilation, custom stainless-steel booths, medical-grade flooring, crash carts, handwashing sinks, and oxygen tanks.

OnPoint believes the space should be reflective of those who are going to use it. Its two OPCs use different models—participant-led (Washington Heights) and medical (Harlem), described below. There is a \$1.5 million-dollar operational difference between them, with the medical model being more expensive. The National Institute on Drug Abuse is evaluating these models.

- **Washington Heights:** Staffed by paraprofessionals who identify as people who use drugs and are paid \$45,000–55,000 per year. There are no professional licensing considerations. It is furnished with chairs, mirrors, seven tables, and two inhalation vestibules. More than 900 participants are enrolled in the program and there are an average of 100 visits per day.
- **Harlem:** Staffed by registered nurses, phlebotomists, EMTs, and care coordinators. It has stainless steel booths, a communal inhalation room, an individual inhalation vestibule, and specialized ventilation. More than 3,000 participants are enrolled, and there are 150–250 visits per day.

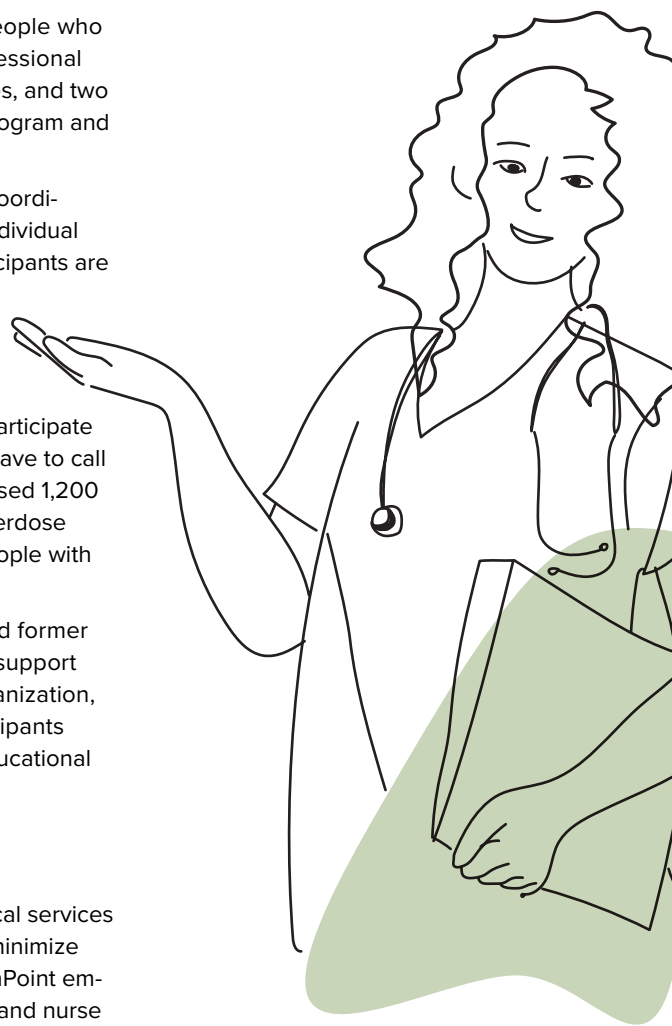
Staff Training and Professional Development

OPCs should invest in staff training and professional development. Staff participate in rigorous training to respond to emergencies so that OnPoint does not have to call EMS unless absolutely needed. As of November 2023, OnPoint had reversed 1,200 overdoses and only had to call EMS 40 times. When EMS is called, the overdose usually has been resolved but there are other medical conditions (e.g., people with pacemakers, seizure conditions, insulin issues) that need EMS attention.

OnPoint prioritizes hiring from its participant base and has 39 current and former program participants on staff in salaried positions with benefits. To help support staff to succeed in their positions, and achieve promotion within the organization, OnPoint's internal professional development program for staff and participants includes free computer, business writing, and financial literacy classes; educational support; and a host of harm reduction-specific training opportunities.

Clinical Services

Though OnPoint partners with large hospital systems for referrals, its clinical services are a program of the larger organization. OnPoint designed programs to minimize referrals externally and provide as many services in-house as possible. OnPoint employs medical doctors, registered nurses, licensed clinical social workers, and nurse practitioners who are all available to OPCs when needed. Although New York State has not issued protections for professionally licensed health care providers working in OPCs, at the time of this writing, no licensed staff had reported licensing board problems as a result of work at OnPoint. Consultants provide clinical supervision to the nurse practitioners and licensed social workers. Clinician salaries are included in OnPoint's budget, rather than operating a clinic that generates revenue from Medicaid billing to cover personnel or operating costs. This is similar to Massachusetts, where organizations operating harm reduction drop-in centers and SSPs do not bill MassHealth and other carriers for health care-related services.



Sustainability

Longer contracts, autonomy, and leadership support sustainability. Beyond the specifics of operation and financing, OnPoint offered the following ways to support sustainability:

- Longer contracts (beyond 1 or 2 years) are important for program planning, scaling, and growth. OnPoint's current contract with the DOHMH is for six years but has existed and been renewed for more than 10.
- Programs need to maintain some authority and discretion to operate the way they need to, rather than being over-regulated.
- Programs must have trusted leaders and experts and be well-represented to the public. Working relationships with the government leaders and police are essential.

OnPoint provides technical assistance to several jurisdictions working to expand harm reduction services or open OPCs. This includes traveling to other cities to assess readiness and train providers; working with health departments, law enforcement, and politicians; and hosting people at OnPoint to work with staff in the OPCs to gain experience and training before they open their own programs.

OPC Equipment and Purpose

- **Mirrors** where participants are injecting so that staff members can monitor them.
- **Specialized ventilation** in smoking rooms to avoid distributing smoke to other parts of the building.
- **Stainless steel booths** are sanitized between each use to prevent infectious disease transmission.
- **Medical-grade flooring** resists against slipping, easy to maintain and disinfect.
- **Crash carts** for medical emergencies, including basic airway equipment (oxygen masks), and intravenous access equipment (tubing and fluid).
- **Handwashing sinks** for staff sanitary purposes.
- **Oxygen tanks** for medical emergencies in which individuals need oxygen.
- **Inhalation/smoking vestibules** where participants can smoke.

Limitations

While the interviews with harm reduction program staff and participants attempted to reflect a range of perspectives and voices, there were several limitations. Interviews with agency staff were conducted in November 2022 and participants in June 2023. They reflect the sentiments of a particular time period, and people's opinions can change over time for a variety of reasons. Language service requests did not mention other languages; this could be because interviews were only conducted in English and Spanish. Because participants who were interviewed were in Boston, Springfield, and Holyoke, the perspectives of more rural residents and people in the northeast, southeast, central, and far west parts of the state were not captured.

Conclusion

Massachusetts has a foundation of harm reduction services for PWUD through a network of SSPs and harm reduction drop-in centers; however, as this report has illustrated, more investment is needed. As the state continues to bolster services, investment in harm reduction drop-in centers and OPCs would be welcomed and encouraged by local experts, staff, and participants, and supported by a global evidence base. The success, cost effectiveness, and life-saving ability of OPCs has been proven in Europe, Canada, and now in New York City.

A community-centered approach is paramount to supporting PWUD across the Commonwealth. Harm reduction drop-in center staff seek to prioritize investment in community spaces that can provide a safe place to rest and get out of the elements, eat and spend time, use the phone or computer, and as one participant put it, be “a place you can go and just be a human.” Expanding services in Massachusetts will require significant investment in staff and physical space.

Ultimately, the experts on the service needs of PWUD are those individuals themselves. Participants expressed deep gratitude for the services they receive and the staff who provide them. The need for basic services such as hygiene products, food, clothes, bathrooms, and showers indicate the lack of supportive places for PWUD and/or live without stable housing across Massachusetts.

People who use drugs in Massachusetts largely support OPCs. They acknowledge and desire the safety that an OPC would provide. While concerns were raised about triggering people in recovery and whether OPCs will truly be safe spaces, participants trust that the staff who serve them will create a model that will benefit the community. Their comments indicated that PWUD know which service models will meet their own and their peers’ needs.

Recommendations for Next Steps

- The Commonwealth of Massachusetts should identify and allocate funding opportunities to expand harm reduction models, including establishing new or expanding existing harm reduction drop-in centers to meet basic needs by offering bathrooms, showers, laundry, food, clothing, and access to phone/computers. This could include funding for service provision, staff training and technical assistance, and assistance with capital investment to expand space. All agencies that JSI spoke to needed additional support and resources for operating their harm reduction drop-in centers.
- The Commonwealth should support harm reduction agencies to expand harm reduction drop-in centers to include OPCs, including funding for clinical staff and supplies. Agencies that JSI spoke with are at different levels of readiness to operate OPCs; however, two agencies were interested and ready as of January 2023.
- DPH and JSI should work together to prepare scope of services for a range of services including harm reduction drop-in center and OPC services. These can be incorporated into a future procurement. When considering funding amounts, DPH can consider the importance of fully funding and supporting the harm reduction workforce and staff, including the potential for wage increases.

Strengthening harm reduction services, workforce, and infrastructure, and bringing OPCs to Massachusetts will prevent overdose deaths across the Commonwealth, meet participants’ basic needs, and foster healthier communities.

“If you change the lives of drug users, you can change the community landscape. We need to get to a place where you take the drug use out of it completely, talk about it like a service people are receiving, and that this service shouldn’t happen behind a dumpster.”

– Key informant

“Thank you very much [...] That’s a wonderful, wonderful thing to hear that they’re trying to do this. It really is. I think a safe space would be a very good addition to supporting [...] people. Because eventually, you do wake up and you do realize that you want better. And you can’t do that if you’re dead.”

– Participant

Appendix

Department of Public Health/Bureau of Substance Addiction Services

Request for Information (RFI):

Harm Reduction Centers in Massachusetts

Please respond by 05/31/2023

Background: The Massachusetts Department of Public Health, Bureau of Substance Addiction Services (BSAS) seeks information on the operationalization and/or expansion of drop-in harm reduction centers across Massachusetts.

Harm reduction centers (HRCs) are low-threshold, drop-in, open, and welcoming brick & mortar spaces that serve people who use drugs (PWUD). People who use these spaces are not expected to be sober or abstinent from substances in order to enjoy the space and be treated in a respectful and kind manner by staff and volunteers. HRCs typically have open drop-in hours and a communal area where participants may access supplies and services if they are interested, or just hang out in a safe and supportive environment for as long as they'd like. Services provided include supply distribution (naloxone, syringes, condoms, etc.), drug checking services, HIV/HCV/STI testing, linkage to treatment, service navigation, basic needs (food, showers, laundry, etc.), and more. HRCs typically are one component of a harm reduction program, that may also include street outreach, mobile outreach, home visits, and more.

Instructions: Please provide a written response to any or all of the following questions along with any additional information you think would be helpful to further our understanding of the need for harm reduction centers to support the health and wellbeing of PWUD in Massachusetts.

- What harm reduction drop-in centers are currently operating in Massachusetts? Where are they located?
- Using the list below, what services are available for PWUD in Massachusetts in the brick & mortar spaces you named above?
 - Harm reduction supply distribution (syringes, naloxone, condoms, etc.)
 - HIV/HCV/STI testing & treatment
 - Primary and preventative medical care (treating wounds, abscesses, foot care, skin infections, etc.)
 - Drug checking services using test strips and technology
 - Outreach & education
 - Basic needs (food, showers, laundry, etc.)
 - Monitoring individuals who are intoxicated, over-sedated, and/or over-amped, including using oxygen to support breathing
 - Navigation of housing, employment, benefits, and other social supports
 - Social activities & support groups
- What are the critical gaps in support or unmet needs for PWUD in Massachusetts?
- What promising practices and/or innovative programs for PWUD would you like to see available in Massachusetts?
- What resources are needed to operate an HRC (staffing, space, etc.)? What does a full-service HRC cost annually to operate?
- What community partnerships are needed to support an HRC in a Massachusetts neighborhood? Are there different partnerships needed based on whether the HRC is in a rural, urban, or suburban environment?
- What resources and support are needed for an HRC to offer medical monitoring, overdose response, and supportive supervision of individuals who are intoxicated, over-sedated, or over-amped?
- How are current HRDC programs addressing specific needs for Black, Indigenous, People of Color (BIPOC) in Massachusetts? What are the gaps in services/programming? How could we best address these gaps?
- What additional challenges or opportunities do you foresee in expanding harm reduction drop-in services across the state of Massachusetts?

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