

# New Strategies Are Needed to Stop Overdose Fatalities: The Case for Supervised Injection Facilities

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Last summer, the lifeless body of a 26-year-old heroin-using man, Tim (not his real name), was discovered in the shadows of a side street in Boston. Ninety minutes before, he had come to our clinic at Boston Health Care for the Homeless Program, mere blocks away, pleading for help. He told us with certainty that he was going to relapse that day, ending 6 weeks of hard-earned sobriety. Our nurse offered to connect Tim to treatment at the nearby methadone clinic or our office-based addiction treatment program, but he refused. He said he wasn't ready to enter another treatment program: What he wanted, simply, was accompaniment while he used. "I'm just looking for a 'buddy' to go with me. I don't want to die."

The nurse made sure Tim had a naloxone rescue kit in his pocket and counseled him that his tolerance was lower than usual and he should start with a reduced "test" dose. With no friends available to accompany him, and without the legal authority to allow him to stay in our building, our staff watched Tim walk out the door for the last time. When he was found an hour and a half later—in the shadow of a world-class medical center and a large needle-exchange program, with naloxone at arm's length—alone, we found ourselves agonizing over the limits of our current options for helping people like him.

With the explosion of highly potent fentanyl and its analogues in the illicit drug supply, overdose fatalities are occurring with alarming frequency and speed—often within minutes or even seconds of injection, leaving little time for first responders to find and resuscitate victims. For this reason, we often advise people to use with a friend and recommend that persons who use drugs, or who are around those who use drugs, carry the overdose reversal drug naloxone. Most of them do, and thousands of "peer saves" in Boston and across the country have been credited to expanded naloxone education and distribution. We regularly connect patients to detoxification programs, residential treatment programs, medication for addiction treatment, and a host of other resources for treatment of substance use disorder. But in too many cases we are constrained in our ability to save people like Tim: the ones who are unable to stop using today but don't want to die.

It was this desperation that drove us to open the Supportive Place for Observation and Treatment (SPOT) in 2016 (1), where Tim had presented that day and where we'd gotten to know him over the previous months. SPOT is a nonjudgmental space focused on reducing the harms of drug use, where people who have ingested drugs nearby and who are oversaturated can walk in to be medically monitored and connected

to services and treatment. This program has allowed us to forge deep relationships with people who actively use drugs and be as close to them as possible while they are intoxicated. In the first year at SPOT, we saw 500 unique, high-risk people in more than 3800 encounters. In addition to preventing emergency department visits by providing medical monitoring on site and responding to overdose with supplemental oxygen, intravenous fluids, and naloxone as needed, we've used SPOT as a key conduit to treatment: In a sample of 409 patients who received care at SPOT, 23.5% were referred directly to substance use treatment, which could include inpatient detoxification, methadone treatment, office-based addiction treatment with buprenorphine or naltrexone, behavioral therapies, or some combination of these. Fifty-five percent of persons referred to treatment directly from SPOT successfully accessed it.

Yet, as Tim's case painfully reminds us, SPOT is not enough. In our urgency to bring an end to these senseless deaths, we now support a strategy that other countries adopted as early as 1984: supervised injection facilities (SIFs). Approximately 100 of these facilities in 11 countries across Europe, North America, and Australia have been studied for decades. They offer sterile equipment and a hygienic environment for medically supervised injection of drugs obtained off site. They also offer education about reducing harms; access to lifesaving naloxone; and connection to primary health care services, counseling, and treatment for substance use disorder.

More than 100 peer-reviewed studies on SIFs have offered compelling evidence that they reduce mortality (2) and overdose (3) while increasing the safety of injection behaviors (3) (which is linked to reduced infectious disease transmission) and access to addiction treatment (4, 5). At the same time, research has shown that they do not increase public disorder or attract drug-related crime to an area (3) or increase relapse rates (6).

The Massachusetts Medical Society and the American Medical Association now both support development of pilot SIFs in the United States (7, 8) as part of a multipronged approach to this devastating epidemic. Pilot programs would allow us to study the effect of these facilities while providing despairing communities with an additional strategy to mitigate overdose deaths and connect people to treatment.

Would widespread SIFs be accepted by people who inject drugs? From our experience, the answer is a resounding "yes." Not only do we hear this on a daily basis in our clinics, but in a survey of 237 people who use drugs at Boston's needle-exchange program, we

have found that 91% of participants reported they would be willing to use a SIF (9). Furthermore, Kral and colleagues (10) recently documented the high utilization of an unsanctioned SIF in an undisclosed U.S. city.

If the opioid overdose epidemic continues at anywhere near its current rate, more than half a million more persons will die in the United States in the next 10 years. As health care practitioners, we have a duty to advocate for the development and study of interventions that have shown promise in promoting health and saving lives. We endorse SIFs as 1 piece of a comprehensive continuum of care for this chronic, relapsing disease. Only by heeding the calls for help of those suffering with substance use disorder will we find a way out of this epidemic. As Tim's death demonstrates, sometimes, in the moment, treatment is not the only help that is needed: Sometimes it is bringing addiction out of the shadows.

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**Disclosures:** None disclosed. Forms can be viewed at [www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M18-0258](http://www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M18-0258).

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*Ann Intern Med.* 2018;168:664-665. doi:10.7326/M18-0258

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Provision of study materials and patients: J.M. Gaeta.