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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*, 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 six weeks of hard-earned sobriety. Our nurse offered to connect Tim to treatment via the nearby methadone clinic, or our office based addiction treatment program, but he refused. He said he didn't feel ready to enter another treatment program, as he'd done in the past; 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 if he did use heroin, his tolerance was lower than usual and he should start with a lower "test" dose. With no friends available to accompany him, and without the legal authority to allow him to stay safely within our building while he used, our staff watched Tim walk out our door for the last time. When he was found an hour and a half later, virtually in the shadow of world class medical centers 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 analogs 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 people who use drugs, or who are around those who use drugs, carry the overdose reversal drug, naloxone. The majority 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 detox, residential treatment programs, medication for addiction treatment, and a host of other resources for substance use disorder (SUD) treatment. But in too many cases, we are constrained in our ability to save people like Tim—the ones who don't feel able to stop using today, but who 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 well over the previous months. SPOT is a non-judgmental space focused on reducing the harms of drug use, where people who have ingested drugs nearby and who are over-sedated can walk in to be medically monitored and connected to services and treatment. SPOT 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 over 3,800 encounters. In addition to preventing emergency room visits by providing medical monitoring on site, and responding to overdose

with supplemental oxygen, IV 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 detox, methadone treatment, office based addiction treatment with buprenorphine or naltrexone, behavioral therapies, or some combination of these. Among those referred to treatment directly from SPOT, 55% successfully accessed it.

Yet, as Tim's tragic case made us painfully aware, SPOT is not enough. In our urgency to bring an end to these senseless deaths, we now support a strategy that other countries around the world have been adopting since as early as 1984—supervised injection facilities, or SIFs. Approximately 100 SIFs in 11 countries across Europe, North America, and Australia have been studied for decades. SIFs offer sterile injecting equipment and a hygienic environment for medically supervised injection of drugs obtained off-site. SIFs also offer education about reducing harms, access to life-saving naloxone, and connection to primary health care services, counseling, and treatment for SUD.

Over 100 peer-reviewed studies on SIFs have offered compelling evidence that they reduce mortality², reduce overdose³, and increase safer injection behaviors³ (which is linked to reduced infectious disease transmission), while increasing access to addiction treatment.^{4,5} At the same time, research has shown that SIFs do not increase public disorder or attract drug-related crime to an area² or increase relapse rates.⁶

The Massachusetts Medical Society and the American Medical Association have now both come out in support of the development of pilot SIFs in the United States,^{7,8} as part of a multi-pronged approach to the devastating epidemic. Pilot SIFs would allow us to study the impact of these facilities while providing despairing communities with an additional strategy to mitigate overdose deaths and connect people to treatment.

If the opioid overdose epidemic continues at anywhere near its current rate, over half a million more deaths will occur in America in the next ten 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 one piece of a comprehensive continuum of care for this chronic, relapsing disease.

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 et al.¹⁰ recently documented the high utilization of an unsanctioned SIF in an undisclosed United States city.

Only by heeding the calls for help of those suffering with SUD will we find a way out of this epidemic. As Tim's death painfully demonstrates, sometimes, in the moment, treatment for SUD is not the only help that is needed; sometimes it is bringing addiction out of the shadows.

*Name has been changed to protect patient confidentiality.

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