Strengthening Systems of Care for People with HIV & Opioid Use Disorder
SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

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The Case for Safe Consumption Spaces: Reducing Fatal Overdoses and Increasing Linkage to Care

Dr. Alex Walley:

In response to an increased risk of overdose several communities in the United States are considering establishing spaces for people to use substances safely. These spaces have been referred to as Supervised Injection Facilities, Safe Consumption Spaces, Harm Reduction Spaces, or Overdose Prevention Sites. Over the past few years, these spaces have garnered more support for their proven ability in other countries to reduce overdoses and meet other medical and psychosocial needs for people who use them.

Dr. Sim Kimmel:

The history of the HIV epidemic includes quite a bit of activism that really changed the direction in terms of policies, in terms of social services, in terms of drug development, and I think that this is the same kind of crisis where we really have an opportunity to get involved and to make changes.

Dr. Alex Walley:

You're listening to Connecting Care. I'm Alex Walley, an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. Today I'm joined by my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel for a conversation about Safe Consumption Spaces. We talk through the benefits that these spaces have on HIV prevention, linkage to care and needed support services, fatal overdose prevention, and what it takes to get a sanctioned overdose prevention space in the U.S.

Dr. Alex Walley:

Today the topic is Supervised Consumption Spaces or Drug Consumption Spaces or Safe Injection Facilities or Supervised Injection Facilities. I guess I'll start off by what should we call these things? What are they, and why are they needed? I'm going to go to Sim. Sim, what should we call these things, the topic of today's conversation, and why do we need them?

Dr. Sim Kimmel:

We should call them whatever will get them approved. And I've heard that the polling suggests that Overdose Prevention Sites pulls the best because there's still so much stigma related to injection and even to consumption. So these Overdose Prevention Sites or Supervised Injection Facilities, why do we need them? We need them because people are using substances in locations that are risky without people there to help them if there's an overdose. People are using substances without access to sterile syringes. And as other people have said, "We allow people to inject drugs anywhere but safe." And Supervised Injection Facilities, Overdose Prevention Sites are locations where we can really do a lot to minimize the harms of substance use that we know will happen. Regardless.

Dr. Alex Walley:

Jess, do you have a favorite term for these facilities?

Dr. Jessica Taylor:

I can get behind any of these terms, as long as we deliver the service, to be totally honest, but I think there's been a movement to use more general language like a Harm Reduction Space or a Safe Consumption—as opposed to a Safe Injection—Space to allow for use of substances that is not by injection, which could include smoking or intranasally, both routes of which have risk of overdose of transmission, potentially, of chronic viral infection through shared intranasal equipment or even smoking equipment if people are dealing with burns. So, I think that's a more inclusive term that encompasses all behaviors that could benefit from access to harm reduction in services. But I like Harm Reduction Space too, because I think that's really, that's what we're trying to do here.

Dr. Jessica Taylor:

We know that because of the unsafe supply that we deal with in the U.S that is unregulated, that is very unpredictable. When we think about potency of fentanyl and contamination of drugs, that these spaces are really needed. To Sim's point, we also know that we're kidding ourselves if we say that we don't already have public consumption sites. We know that these injection events, other substance use events happen in our public restrooms. They happen in our alleys. They happen in the bathrooms at our medical centers. They happen in private residences, but behind closed doors where people can't be accessed if they deal with an overdose to get the care they need.

Dr. Jessica Taylor:

So what we're talking about is something that is already happening and happening in a way that is extraordinarily unsafe. And thinking about providing a facility where risk could be reduced, where people could be linked to treatment and we'll get into evidence and sort of what we know about the benefits of Harm Reduction Facility, or Safe Consumption Spaces, but I just want to emphasize sometimes the discourse goes to these being very radical and very sort of new and different. This is something that's already happening and we just want to make sure that we offer people a safer space where they can get the support that they deserve and that they need.

Dr. Alex Walley:

Yeah. So I feel like sometimes I play the senior role with some historical perspective in this group and the name evolutions make me think a little bit about that history. I think that the rise of, I think what for a long time were known as Supervised Injection Facilities started in the 90s when there was a lot of concern around HIV transmission. There was some concern around overdose, but the major, I think, driver was around HIV transmission and having a place where people could inject drugs with supervision so that they could use safer technique. Yes, around overdose, but also around HIV transmission.

Dr. Alex Walley:

And I think that's also one of the reasons why the focus from the outset was really on injection in the beginning, but particularly with the rise of fentanyl, the overdose as a driving sort of public health, critical public health need, that has raised the potential and the profile of these spaces is it has more momentum than it has in the past, in more places.

Dr. Alex Walley:

So even in Canada where, in British Columbia, there were early adopters of this supervised injection facility. It's only almost 15 to 20 years later where these have actually caught on and spread across the country in the midst of the fentanyl crisis that Canada is seeing and the rise of overdose. And then once

you have these facilities focused on overdose prevention, and you have fentanyl in the drug supply, then the need to include, not just injection substance use, but also like Jess was saying smoking or even sniffing becomes much more, I think, prevalent. And that's when this idea of calling them Overdose Prevention Sites comes in.

Dr. Alex Walley:

I think that's more of a recent concept and there's also the part of it, which is supervised. And the supervised piece, I think, really meant for a long time, a nurse that was there in the facility, watching people and making sure that people were safe and we're far from, well, we're not far anymore, but there is, I think a movement among the people who run these spaces to think about not necessarily having them fully medicalized.

Dr. Alex Walley:

And so that's an issue that, I don't know if we want to dig into, I think the first ones that are going to happen in the U.S will most likely be medicalized because with the medical, a community, specifically nursing, I think supporting these sites that will reassure a lot of people who are concerned about the safety of these sites, but in Canada where they've proliferated, you're seeing them staffed by less medicalized personnel. People who are expert in reversing overdoses, people who are expert in safer substance technique, but who are not necessarily licensed as medical professionals. And so that's, I think, why we're seeing these more general terms, they're more acceptable, but they're also, they broaden sort of what happens at these place.

Dr. Alex Walley:

And why are they needed? For me, I can tell you I've been trying to, from a public health perspective, reduce the risk of overdose, reduce overdose deaths now for 15 years almost. And we've been able to implement a lot of things. Which include widespread distribution of Naloxone, better access to medication for opioid use disorder, even universal healthcare coverage. And we're still seeing really high levels of overdose. And I think it's despite those things, not because of those things, obviously. Particularly with fentanyl, it's really not safe to use fentanyl unless there's somebody right there with you observing you with Naloxone, capable of responding. And that's because the drug supply is really not safe.

Dr. Alex Walley:

As we can hear the sirens outside my office could well be transporting another person who's had an overdose to our hospital. The supply is really not safe. And so the only way to consume the supply we have now in the United States is to be observed with someone there equipped with Naloxone and ready to call for some help, if Naloxone's not enough.

Dr. Alex Walley:

So the reasons are compelling in the ways, they have been all along, but I think more, they're just more acute. So maybe we should talk a little bit about what we know about the evidence for these programs? I'm going to start with Sim today. Sim, what do you think of the evidence for Overdose Prevention Sites, Supervised Consumption Sites?

Dr. Sim Kimmel:

So I think there's a number of things that Supervised Injection Facilities, Overdose Prevention Sites have been shown to do. The first is to, and I think Jess will have a chance to go into more detail, but reduce the risk of HIV transmission. The second is to reduce the risk of overdose because there's people to respond, or I should say reduce the risk of fatal overdose. Because if somebody were to overdose, there's somebody present to respond.

Dr. Sim Kimmel:

There's often a lot of questions about these facilities. Does this enable substance use? Does it make more people use? And what does it do to treatment access? Researchers who have been very smart thinking about what the concerns might be have studied these questions and people who utilize Supervised Injection Facilities are more likely to access subsequent addiction treatment services.

Dr. Sim Kimmel:

Another concern that often gets raised, and this is a concern about community safety and the neighborhood around these facilities is, what does this do to criminal activity? What does this do to discarded needles? And study after study, including a recent study, looking at a unsanctioned Overdose Prevention Site or Supervised Injection Facility in the United States showed that there's lower discarding of syringes, or unsafe discarding of syringes.

Dr. Sim Kimmel:

So on all of these various fronts there's fairly strong evidence that these facilities provide benefit, not just to the individual who's using substances, but also to the community from which the person who's using substances comes from.

Dr. Jessica Taylor:

Thanks, Sim. And this is a podcast about HIV and HIV prevention. And so we really want to highlight the HIV prevention benefit of Safe Consumption Spaces, and just emphasize that in the era of fentanyl, which we've said is shorter acting so involves more injection events. It's really hard to avoid ever sharing a syringe. Many of our folks are injecting eight times, 10 times, 12 times per day. It's really difficult to have syringe access 24/7 because a lot of our public health services are frankly built around a business hour schedule that doesn't always align with the needs or times of day that our patients need services.

Dr. Jessica Taylor:

And so when you think about a Safer Consumption Space or a Supervised Injection Facility, where safe equipment is readily available, where a sterile syringe is used one time for one injection event, you really have the opportunity to do great things in preventing HIV transmission. And there are some data that help us start to put numbers to that.

Dr. Jessica Taylor:

So one study has estimated that a single site can prevent between five and 35 new HIV infections per year. And that in and of itself, that is a tremendous accomplishment, but because of the barriers that people with active substance use disorder face in getting into and staying into HIV treatment, the fact that those HIV infections are prevented means that the next infection is prevented, transmission to the next person is prevented. And so it's been modeled that over the course of a decade, a single facility could prevent up to 1100 new HIV infections. And you start to think about that community impact and community benefit to preventing those infections. And it becomes really, really profound.

Dr. Jessica Taylor:

So I think, as an HIV doc, I'm excited about all the things that we're talking about in terms of benefits. I think community benefit is incredibly important. Reducing the impact of substance use on our communities is a very important worthy central goal. Overdose prevention of fatal overdose, that is what we're here for. And as an HIV doc, the HIV prevention piece really is top of the list for me because we know that it's a priority in our communities. It's what we hear about from our patients and our community members that people want strategies to prevent HIV infection, and we should have them and we should make them available.

Dr. Alex Walley:

One piece of evidence, I guess, is that like Sim, I think alluded to, the Overdose Prevention Sites have overdoses every day, but there hasn't been a single fatal overdose in any of the sanctioned Supervised Injection Facilities or Overdose Prevention Sites worldwide. And at this point in time would add up to millions of injections across all the sites across the world.

Dr. Alex Walley:

So there are many countries now in Europe, in Australia and Canada, and I think in Asia? That have Supervised Injection Facilities or Overdose Prevention Sites where people are injecting multiple times every day, seven days a week, lots of overdoses that are managed, none that have resulted in fatalities.

Dr. Alex Walley:

Another piece that I think is important that doesn't necessarily fully reflect it in the research is the opportunity for engagement, which is a theme that we have talked about over and over again on this podcast, which is that creating a space where people feel comfortable where they don't feel stigmatized or judged, but where there's an opportunity for people to connect with each other and connect with service workers really allows for the opportunity to engage them in other services.

Dr. Alex Walley:

And the Supervised Injection Facility or Overdose Prevention Site that I visited, Insite, in Vancouver has a treatment facility right above it. It has a room that people hang out in after they use where they can interact with each other, where they have the opportunity to connect. And they have common and regular discussions about kind of what's next in people's lives.

Dr. Alex Walley:

So I think that this is a group of people, especially if you talk about the group of people who have both HIV and have an opioid use disorder, that are highly stigmatized. There are not many welcome places for them to be. Many of the folks as a consequence of their substance use, and the stigmatization, are living in poverty or homeless. And this really does provide a place for connection.

Dr. Alex Walley:

You know, each of us are clinicians. It's worthwhile for us to reflect in sort of realistic terms, are there patients who we are caring for, who we think that could really benefit from this? And I don't know, I'd like to invite either of you, or both of you, to describe the scenario in which you think a patient could really benefit from a service like this?

Dr. Jessica Taylor:

Sure. A bunch of examples come to mind. One just from the past couple weeks is someone that we've followed closely, who lives outside in our neighborhood or around the medical center who uses intravenously, but is not able to inject himself. So doesn't feel comfortable, doesn't know how to inject for himself. And so what means in practice, because he hasn't had the opportunity to be taught how to inject himself, is that he has to pay someone to inject him either through cash or through substances. And then he's really at the mercy of whoever has the syringe in their hand, in terms of the equipment that's used, whether it's a sterile syringe or not.

Dr. Jessica Taylor:

We know that anytime someone is not in charge of their own injection event, that the risk of use of non-sterile equipment goes up, of chronic viral illness transmission goes up, HIV, Hepatitis C. And so, I think that's a scenario where someone could come to a Safer Consumption Space, get teaching from a nurse, not to have the nurse do the injection event, because that's something that is typically not allowed to be done in these facilities. But you know, to be taught sterile technique, to be taught how to find a vein, to be taught what lower risk sites are.

Dr. Jessica Taylor:

So very commonly our patient says that people inject in his neck because that's a fast place to find a vein and to inject. But really to have some time and space with harm reductionist to talk through what are lower risk sites, how do you apply a tourniquet? How do you find a vein? How do you clean your skin? What equipment can make injection events lower risk? And I think someone like him could really, really benefit from the opportunity to spend time in a space like this.

Dr. Alex Walley:

You brought up the risks of being injected by other people and you focused, I think, and really clarified nicely the HIV and disease transmission risk, but it is also a known overdose risk factor, being injected by someone else does increase your risk of having an overdose. Although someone else being there is probably helpful. Still not having control over your own use is a risk factor. So, that's all important points. How about you, Sim?

Dr. Sim Kimmel:

You know, that kind of conversation that Jess described is really hard to happen in a setting where substance use isn't allowed, right? That kind of detail. This is where I might go. This is where I've had problems. I recall having a conversation with a patient who was hospitalized and she had a serious bone infection and she had been using, injecting, while she was in the hospital. And she had had a difficult encounter with a nurse around that injection. And then security came and searched her. And I was on the addiction consult service. And we came with the team and I said, "Well, would it be helpful if we provided you some sterile syringes?" And she said, "What's that going to do?" Right? "You gave me the sterile syringes and then you tell me to go inject in the hallway where I'll go overdose and die in the hallway."

Dr. Sim Kimmel:

And I think it's not lost on patients, the hypocrisy, when we're counseling them about overdose prevention, we're counseling them about harm reduction techniques. And then all of this other, all these other potential interventions are off the table. And I just remember her laughing at me when I suggested that and how absurd it was. Right? But can you imagine how different it would be if I said, "Well, we've got our in hospital Supervised Injection Facility down the hall. Maybe that would be a place

where you'd feel more comfortable? And that would keep you safer." It would just be an entirely different kind of conversation.

Dr. Sim Kimmel:

And not all Supervised Injection Facilities, most of them are located in community, but there are some that are located in hospitals because the hospitals are a particularly risky place for people who use drugs. So, that's one example.

Dr. Jessica Taylor:

That really hits home. When we think back to the really sort of traumatic events that our team has dealt with, and traumatic for our patients, we had one overdose event. A patient we know very well, who has had almost every complication of injection drug use, including an infection of the heart valves who come by to see us all the time, and had an overdose that caused a cardiac arrest. So a very severe overdose in the men's room that is, I don't know, it's 30 feet from the door of our program. We've got the [inaudible 00:19:21] clinic, that's staffed with a physician, a nurse, someone at the front desk, got a waiting room right there.

Dr. Jessica Taylor:

And because it's not allowable to inject in a hospital space, he used behind a door in the men's room, down the hall and our nurse ended up responding and doing CPR. And it just is one of those moments where you think, "What are we doing?" This is, I mean, it just defies human decency and logic and common sense that we had this entire medical team available that could have been providing monitoring. And yet because of the regulations and the rules and the stigma, our patient injected so close to us, but yet not immediately accessible in the event of an overdose, which happened.

Dr. Jessica Taylor:

And so I think those, at least for me as a clinician and someone in the community, those are the events that have moved the needle for me, in terms of how I think about this. That injection events are happening. They're incredibly unsafe. This doesn't make sense for anyone, and least of all our patient who was forced to inject by himself in a place that was scary and unsafe and had a really bad outcome. He survived his overdose, but just, it's a tragedy to have someone have an arrest, have to have CPR when had we, had he been even in our waiting room, we could have been providing, monitoring, and prevented this becoming such a traumatic event.

Dr. Alex Walley:

Yeah, that's, I think, a really important example. I think of my patients who aren't coming in for HIV care, because they're out using, and I try to destigmatize their use and make our clinic as welcoming as it can be. But you have to register, you have to sit in the waiting room, you have to take an elevator. So it's the patients that I'm not seeing that I'm really thinking. In fact, one of them came in today, who I haven't seen in a year and a half, and I know that if there was a place like this in the last year and a half, he would've been there and he would've made connections that in my medical clinic, it's just not going to feel as approachable or accessible.

Dr. Alex Walley:

He actually, this particular patient, did make connections in Sim's program and Jess's program in the meantime, when he was ready to think about initiating care again, but when he wasn't ready to initiate

care, I wish he had had a safer place to go. And I'm grateful that he made it through that time. And also hopeful that he will going forward in the future. I also think about my patients who do come into clinic, who are still actively using, many of them are housed and they are, in some ways, they're at higher risk for overdose in some ways than my patients who are unhoused because they are using alone in their rooms, alone.

Dr. Alex Walley:

And so another, I think important model, which I've seen again in Vancouver is sort of housing based supervised injection. So not just places that are established in what you know are currently open air drug spaces, but also places where people can live. They can get harm reduction they need in the place where they're housed, so they don't have to go out. And so they're not completely isolated when they're using.

Dr. Alex Walley:

I think that when it comes to overdose we actually, one area where we really need to get more creative and innovative is for those people who are using alone in their homes, isolated, because there's, well, because they're isolated. And so that really makes it so that there's no one there to respond.

Dr. Jessica Taylor:

Yeah. And Alex, one innovation that I think has been really remarkable and that I'm very excited to see grow that is within our current regulations has been virtual overdose prevention. And this is really as you were saying, targeting the overdose prevention piece and not necessarily the HIV or hepatitis prevention pieces because it's virtual and because the person and the equipment aren't co-located, but there are a couple of services. Some of which are app based one is called the Canary app.

Dr. Jessica Taylor:

And some of which are phone line based, Never Use Alone, is one hotline that's now available across the country. That essentially allow people to dial in and connect to an operator or a harm reductionist who stays on the line with them, or stays in contact with them, while they're using by themselves, and really makes a plan for what to do if they become unresponsive. That can include details that I think we've learned from some of our EMS colleagues and other disciplines, but may not think about as providers. Things like where's the key? Or how do you get through the door? Or how do you talk through sitting in a place where it's less likely to overdose against a door that someone would have to open to get to help you? And basically if someone is using one of these services and becomes unresponsive for a set amount of time, emergency services are activated and sent to the location where the patient can then hopefully receive care and to get overdose reversal services and transport if they need.

Dr. Jessica Taylor:

And I think when we talk about services like this, I think they're so remarkable. And they're so very often centered on the needs of people who are using substances as opposed to the medical model. And yet they seem like a workaround to the restrictions that we have on actually opening the physical space where the service delivery could be co-located and in the same place as someone who's using.

Dr. Jessica Taylor:

So I love to talk about them, but I think as we talk about them, we also need to think about why it is that we have these workarounds and how we could move the needle to actually open the space in a physical sense?

Dr. Alex Walley:

So Term Alert, a new term for this I've heard and I think it's now in some of the literature is called, spotting. So we have in Boston, we have a place called SPOT, which is the Supportive Place for Observation and Treatment, which is not a Supervised Injection Facility, but it is a place where people can go after they've used. And if they're over sedated without having to go to the emergency department, a harm reduction environment where they can be safe.

Dr. Alex Walley:

But this is, this spotting is used in the sense of, I think like it's the same term that weightlifters use when they're lifting weights and they have somebody whose right there with them to make sure that they don't lift more than they can. And I think here spotting is also can be applied to these virtual spotting, like Never Use Alone and the Canary app, where you use technology essentially to be there as your safety net, so to speak if things don't work out or if an overdose occurs.

Dr. Alex Walley:

So this gets a little bit to one of the quest that we had, which is what happens when the overdose prevention space is closed? You know, like people are not necessarily going to be able to access them at all times. And this gets to some of those virtual as well as sort of coupling up with people who can keep each other safe.

Dr. Jessica Taylor:

Alex, I'm wondering what it takes to open one of these in the U.S? We've talked about the evidence base. We've talked about the personal and community benefits. We've talked about the sort of medical rationale for making services immediately available, but what is it going to take for us to get a sanctioned Overdose Prevention Space in the U.S. in terms of stakeholders and political support?

Dr. Alex Walley:

Great question. And I think that there's a lot of communities that are trying to tick down the list of all the things that are required. And I think first of all, in the legal realm, there's what are so-called “crack house statutes" that make it illegal essentially to operate a physical location where people use drugs, and there are efforts in the courts to clarify whether or not those would apply to a Supervised Injection Facility. I think there's strong, legal arguments that they wouldn't, and there's different U.S. attorneys in different parts of the country who'd look at that differently.

Dr. Alex Walley:

Almost all states also have these laws that prohibit people from operating a location where people use drugs. Again, the idea is, I think, they were initially put into place in order to target people who were allowing people to use drugs in their spaces. And so either state attorneys, general, or local district attorneys need to, along with the courts, agree not to prosecute people who operate Supervised Injection Facilities under these laws. And I think a number of communities have been able to get that buy-in from the local law enforcement. Well, speaking of law enforce, then there's the police themselves.

Dr. Alex Walley:

And in my understanding every sanctioned Overdose Prevention Site or Supervised Injection Facility has been able to get the buy-in of local police to see that having places like this is in their interest of trying to maintain safety in the community. You know, oftentimes when people are either overdosing or using in the community, it is the police that respond when something goes wrong. And so this becomes a part of their job, but by having sites like this, those types of occurrences and the burden on the police can be substantially reduced.

Dr. Alex Walley:

Similarly, there's the local businesses that are in the area. You have a huge, as we see regularly with methadone treatment and other services for people who use drugs, there's a lot of, NIMBYism, Not In My Backyard stigma. And overcoming that, I think particularly that strong in the United States, having a way to overcome that is, I think, one of the things that really holds or is a challenge for these programs is getting that local neighborhood buy-in.

Dr. Alex Walley:

And the good news is like you've already mentioned the research shows that in communities where these programs have been established, there is less public disorder, less drug use trash, and less crime being committed. And so there is a research argument for getting the buy-in for local neighborhoods, but it really does take some negotiating and or conversation and education, I would say. So a community has to welcome that in, and in our example in Massachusetts, we now have a community that is interested in hosting one of these sites, which is a huge step forward. And we didn't have that for a long time.

Dr. Alex Walley:

Also, probably the most important thing is that in establishing these places, you really do need to take, you have to center the views and the interests of the people who use drugs themselves. And so having an active and engaged group of people who use drugs that can help design and potentially even help operate such a facility, I think is crucial. So that when you build it, people will come and use it. This is like real public health that needs resources. And I think in the U.S., in many cases we have a history of under resourcing public health interventions. So it needs to be funded consummate with the public health benefit that it's going to provide, which is quite a lot.

Dr. Alex Walley:

So that's my list of things that we need, which, on the one hand is daunting. On the other hand, I think there's a lot of progress that's being made in many communities to move down that list. I don't know if you guys feel like I missed anything or other thoughts that you all had on that?

Dr. Sim Kimmel:

I think you pretty much covered it. Thinking about where these sites get started, you mentioned that they tend to get started in places where there's kind of open drug use or there's open drug markets. And so I think thinking about the community that's living there, there's an argument about improving the circumstances of those communities. And I think we see some of that when the area around our hospital that is kind of one of those communities right now. And there's a lot of conversation about why it's allowed that there can be open drug use and tents around this hospital in this kind of industrial

neighborhood next to a Black community. And whether it would be allowed in a less industrial neighborhood, or next to a wealthy or white community?

Dr. Sim Kimmel:

So that's a kind of complicated dynamic, but one that I think needs to be contended with, for sure.

Dr. Alex Walley:

So another aspect to this that I think about is it's probably, once you establish one Overdose Prevention Site or Supervised Injection Facility, and this kind of dovetails with my comment about, you have to have people who use drugs, help you or have their voices centered in how this program is established. Another part of that is that the community of people who use drugs is quite diverse. And so it's quite possible that one Supervised Injection Facility or Overdose Prevention Site, Drug Consumption Space is not going to satisfy everyone. It's not going to be right for everyone. And there's a bunch of, everyone's unique of course, but there are also populations that have their own needs.

Dr. Alex Walley:

And, Sim, I think you are getting at some of the racial dynamics, the racist dynamics, of neighborhoods drug use and how things are allocated in communities. And so, I think it's really important that the kind of key stakeholders of people who use drugs are considered, as Overdose Prevention Sites or Drug Consumption Spaces are rolled out.

Dr. Alex Walley:

It might be that in a particular community, it makes sense to have let's say, for example, a women only Overdose Prevention Site. Or one that if you have one in a community of color that you ensure that it meets the needs of the people from that community. And isn't really something that's meeting the needs of people from other communities that are coming in.

Dr. Alex Walley:

So, I think that is, addressing those issues, I think are important to consider from the outset. We have a ways to go before we have even one sanctioned Drug Consumption Facility in the U.S. But once we're able to get them, I think that's kind of the next step is really trying to make sure that they have the reach and really meet the needs of the various populations.

Dr. Alex Walley:

So this was, I think, a good conversation on a topic that the three of us, I know, think about a lot. We talk amongst ourselves, I have to acknowledge it's a little bittersweet. I get excited talking about it, but then I also feel like frustrated with just the fact that we know that these work, that there's evidence, it's something that our patients need. It's something that our neighborhood needs, but we're not there yet. And so I guess I'll give you guys each the final opportunity to kind of comment on what's next in this, what can we do other than educate ourselves and how do we keep moving forward without getting frustrated?

Dr. Sim Kimmel:

I think, you know, this is an HIV podcast or at least partially an HIV podcast and the history of the HIV epidemic includes quite a bit of activism that really changed the direction in terms of policies, in terms

of social services, in terms of drug development. And I think that this is the same kind of crisis where we really have an opportunity to get involved and to make changes

Dr. Alex Walley:

Well said, Sim. Jess?

Dr. Jessica Taylor:

I think I'm, I mean, Alex, I'm frustrated too, by the fact that we don't have this in our toolkit. I don't think that Safe Consumption Spaces solves all of our problems. Far from it. I think this is one incredibly important available tool that we should be using as part of a comprehensive public health approach. But I think I've also been hopeful just by seeing the culture change in talking to our politicians and talking to our community stakeholders, even over the last one to two years.

Dr. Jessica Taylor:

I remember when I started doing this work in 2016, Safe Consumption Spaces even felt a little bit outside of the scope of what I would think about as a clinician, working at a hospital. And I personally have changed my sort of enthusiasm and support and activism in this space in just a couple years.

Dr. Jessica Taylor:

And you know, we're now talking to state senators and representatives that are interested in coming to the table and having the conversation and it can't come fast enough. And that's the part that's very frustrating, but I do think I'm seeing more openness to really have this conversation that I have in the past. And that makes me think that we're headed in a direction that is hopeful and can continue to be informed by the needs of people using drugs and supportive of what they say their community's need.

Dr. Jessica Taylor:

So I hope this is the start of a good direction, but it is that bittersweet feeling that you described.

Dr. Alex Walley:

Well, thank you both for this conversation today. And Jess, you cheered me up there at the end, so thanks for that. I look forward to coming back next month and take care.

Dr. Alex Walley:

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