Commentary

Overdose Prevention Centers: Advancing Harm Reduction and the Right to Health in the United States

Mary Russo[1], Nishita Dsouza[2], Louisa Gilbert[3]

1. Columbia School of Social Work, United States; 2. University of North Florida, United States; 3. Columbia University, United States

This paper advocates for Overdose Prevention Centers (OPCs) to advance the right to health among people with opioid use disorder in the United States. Despite a recent decline in overdose fatalities, the U.S. continues to face record-high deaths driven by polysubstance use, limited access to medication-assisted treatment (MAT), and persistent health disparities. OPCs provide supervised drug use, overdose reversal, and connections to health and social services. Research shows OPCs prevent fatal overdoses, reduce public drug use, and increase service engagement without increasing drug initiation. In addition, OPCs provide people with opioid use disorder with dignity and treat them with empathy, necessary prerequisites to engaging individuals in behavior change. There is a strong need for legal protections and sustained funding to expand OPCs as part of a comprehensive drug policy response.

Correspondence: papers@team.qeios.com — Qeios will forward to the authors

In 2025, drug policy in the United States is at a crossroads. In September 2024, overdose fatalities had declined by nearly 24% compared to the previous 12 months.[1] However, millions of Americans who have an opioid use disorder lack access to overdose prevention and treatment services. Overdose Prevention Centers (OPCs) are facilities that allow supervised drug use while offering life-saving care; they represent a powerful, evidence-based, and rights-affirming harm reduction response to the needs of people who use drugs. Implementation of OPCs in the U.S. is a public health imperative, supported by legal obligations under the international right to health.

The U.S. still outpaces other countries in overdose fatalities.[2][3] Declines in overdose deaths are uneven across racial and age groups and new challenges are on the horizon.[4] Communities are facing an

 doi.org/10.32388/ZMSIKO

accelerating polysubstance use crisis; most people who use opioids are exposed to other substances such as xylazine, or may use other types of drugs such as stimulants concurrently, increasing the complexity and unpredictability of overdose events,[5] and access to medication-assisted treatment (MAT) is limited. Contributing factors are stringent regulatory restrictions, uneven distribution of credentialed providers, financial barriers, lack of transportation and stigma.[6] In 2021, only one in five U.S. adults diagnosed with an opioid use disorder received medication,[7] underscoring the critical need for accessible harm reduction infrastructure, such as OPCs.

Harm reduction is "a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use."[8] Harm reduction includes services such as syringe exchange programs, naloxone distribution, and OPCs. Harm reduction is increasingly recognized as a core component of the right to health by the Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health.[9] OPCs are key harm reduction modalities that are increasingly recognized as vital services by drug policy experts.[10] OPCs provide a safe space to use drugs with specialists present to administer oxygen, naloxone, or other necessary supports to prevent overdoses and painful symptoms. OPCs are typically connected to service providers that offer additional health and wellness services and referrals to community-based resources and drug treatment.

The right to health is "an inclusive right, extending not only to timely and appropriate health care, but also underlying determinants of health; associated freedoms include control over one's health, and entitlements include the right to a system that provides equal opportunity to enjoy the highest standard of health.[11] The principles of harm reduction align with the stipulations of the right to health.[12] Applied to drug policy, the right to health includes access to harm reduction goods and services.[13]

Unlike most high and middle-income countries, healthcare is not a right afforded to all citizens of the U.S., and significant and deadly gaps in health care remain in terms of access, coverage, and affordability. People who use drugs face discrimination when accessing other essential healthcare services, which may deter them from getting treatment for other preventable diseases and contribute to shorter life expectancy.[14] Harm reduction is an alternative policy pathway that values the health of all people regardless of their choice to continue drug use.

Despite advancements in harm reduction in the U.S., progress remains hindered by fragmented policies across jurisdictions.[15] Available evidence and evaluation confirm that OPCs improve overall drug user health in addition to preventing overdoses.[16][17] In the more than 10 countries where OPCs are legally

sanctioned, millions of overdoses have been supervised with no reported fatalities.[18] Researchers in Vancouver found that the fatal overdose rate around an OPC dropped by 35%, while the citywide fatal overdose rate decreased by only 9.3% during the same period.[19] Critically, OPCs have not been found to be associated with increased drug use, increased overdoses, or initiation of drug use.[20]

Two OPCs in New York City opened in 2021 and remain in operation.[21] The first OPC authorized through state law opened in January 2025 in Rhode Island.[22] Each region has unique features, including social, legal, and political traits; OPCs are not a panacea, rather are tailored according to needs among the population, in engagement with community stakeholders.[23]

An evaluation of On Point's OPCs in New York City found that most individuals who used the OPC also accessed additional services there, such as naloxone distribution, counseling, and hepatitis C testing. Among all participants, 75.9% reported that without the OPC, they would have used drugs in public.[24]

Despite growing evidence and successful implementation of OPCs in New York, the future of OPCs in the U.S. remains uncertain. For advocates for drug user health, the current political climate raises questions about whether the U.S. will align with or diverge from human rights and drug policy expertise.[25] Recent history suggests that the Trump administration may pursue action against harm reduction service providers. The previous Trump administration's Justice Department leveraged the "Crack House Statute" to take legal action against Safehouse, an organization that sought to open an OPC in Philadelphia.[26]

Regressive drug policy that limits access to harm reduction services such as OPCs undermines the intent of the ICESCR, particularly in its guarantee of the right to the highest attainable standard of health. In the U.S. context, this includes the criminalization of drug use, barriers to medication-assisted treatment (MAT), withdrawal of federal and some state funding for naloxone as a life-saving drug, restrictions on harm reduction services such as syringe exchange programs, and Overdose Prevention Centers. These policies are inconsistent international human rights norms, including those articulated in the Universal Declaration of Human Rights (UDHR).

Recent political proposals suggest that abstinence-only treatment programs or "rehabilitation farms" are the most effective interventions for opioid use disorder.[27] History tells us that this approach would cause more harm than good. In the 1930s, the U.S. Public Health Service oversaw federal "narcotic farms" in Kentucky and Texas; studies showed a 90 percent relapse rate.[28] Such models have been widely discredited and are not culturally appropriate or evidence-based, especially for Black, Indigenous, and

Latinx communities disproportionately impacted by both substance use and the criminal legal system. [29][30][31]

OPCs may not be part of mainstream discourse around the opioid crisis, but they are not radical; they are evidence-based interventions that affirm the right to health for people who use drugs. Without strong legal protections and sustained funding, harm reduction services like OPCs could be weakened or undermined in a time when they should be implemented, evaluated, and expanded. With demonstrated impact, OPCs offer a path towards a more responsive, trauma-informed, compassionate, and pragmatic drug policy in the United States.

References

1. ^*Centers for Disease Control and Prevention (2025). "CDC Reports Nearly 24% Decline in U.S. Drug Overdose Deaths." Centers for Disease Control and Prevention. https://www.cdc.gov/media/releases/2025/2025-cdc-reports-decline-in-us-drug-overdose-deaths.html.*
2. ^*Steinzoer P (2025). "US Overdose Deaths Outpace Other Countries, Report Finds." Am J Manag Care. https://www.ajmc.com/view/us-overdose-deaths-outpace-other-countries-report-finds.*
3. ^*Harris RA (2022). "Drug Overdose Deaths Among Non-Hispanic Black Men in the U.S.: Age-Specific Projections Through 2025." AJPM Focus. 2(1).*
4. ^*Saunders H, Panchal N, Zitter S (2024). "Opioid Deaths Fell in Mid-2023, But Progress Is Uneven and Future Trends Are Uncertain." KFF. https://www.kff.org/mental-health/issue-brief/opioid-deaths-fell-in-mid-2023-but-progress-is-uneven-and-future-trends-are-uncertain/.*
5. ^*The Commonwealth Fund (2025). "U.S. Overdose Deaths Remain Higher Than in Other Countries—Trend-Tracking and Harm Reduction Policies Could Help." The Commonwealth Fund. https://www.commonwealthfund.org/blog/2025/us-overdose-deaths-remain-higher-other-countries-trend-tracking-and-harm-reduction.*
6. ^*Madras BK, et al. (2020). "Improving Access to Evidence-Based Medical Treatment for Opioid Use Disorder: Strategies to Address Key Barriers Within the Treatment System." National Academy of Medicine. https://nam.edu/perspectives/improving-access-to-evidence-based-medical-treatment-for-opioid-use-disorder-strategies-to-address-key-barriers-within-the-treatment-system/.*
7. ^*National Institute on Drug Abuse (2023). "Only 1 in 5 U.S. Adults with Opioid Use Disorder Received Medications to Treat It in 2021." National Institute on Drug Abuse. https://nida.nih.gov/news-events/news-release*

s/2023/08/only-1-in-5-us-adults-with-opioid-use-disorder-received-medications-to-treat-it-in-2021.

8. ^National Harm Reduction Coalition. "Principles of Harm Reduction." National Harm Reduction Coalition. https://harmreduction.org/about-us/principles-of-harm-reduction/.
9. ^Office of the High Commissioner for Human Rights (2024). "A/HRC/56/52: Drug Use, Harm Reduction and the Right to Health – Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Tlaleng Mofokeng." Office of the High Commissioner for Human Rights. https://www.ohchr.org/en/documents/thematic-reports/ahrc5652-drug-use-harm-reduction-and-right-health-report-special.
10. ^Samuels EA, Bailer DA, Yolen A (2022). "Overdose Prevention Centers: An Essential Strategy to Address the Overdose Crisis." JAMA Netw Open. **5**(7):e2222153. doi:10.1001/jamanetworkopen.2022.22153.
11. ^Office of the High Commissioner for Human Rights. "About the Right to Health and Human Rights." Office of the High Commissioner for Human Rights. https://www.ohchr.org/en/special-procedures/sr-health/about-right-health-and-human-rights.
12. ^International Guidelines on Human Rights and Drug Policy. "II. Obligations Arising from Human Rights Standards | 1. Right to the Highest Attainable Standard of Health." International Guidelines on Human Rights and Drug Policy. https://www.humanrights-drugpolicy.org/guidelines/obligations-arising-from-human-rights-standards/right-to-the-highest-attainable-standard-of-health/.
13. ^International Guidelines on Human Rights and Drug Policy (see note 11).
14. ^National Institute on Drug Abuse. "Stigma and Discrimination." National Institute on Drug Abuse. https://nida.nih.gov/research-topics/stigma-discrimination.
15. ^American Journal of Managed Care (see note 2).
16. ^Kennedy MC, Karamouzian M, Kerr T (2017). "Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: A Systematic Review." Curr HIV/AIDS Rep. **14**(5):161–83.
17. ^Rosen JG, Thompson E, Tardif J, Collins AB, Marshall BDL, Park JN (2024). "'Make Yourself Un-NIMBY-Able': Stakeholder Perspectives on Strategies to Mobilize Public and Political Support for Overdose Prevention Centers in the United States of America." Harm Reduct J. **21**(1):40.
18. ^Caulkins JP, Pardo B, Kilmer B (2019). "Supervised Consumption Sites: A Nuanced Assessment of the Causal Evidence." Addiction. **114**(12):2109–15.
19. ^Marshall BDL, Milloy M, Wood E, Montaner JSG, Kerr T (2011). "Reduction in Overdose Mortality after the Opening of North America's First Medically Supervised Safer Injecting Facility: A Retrospective Population-Based Study." Lancet. **377**(9775):1429–37.

20. ^JAMA Network Open (see note 9).

21. ^OnPoint NYC. "OnPoint NYC - Making History. Saving Lives." OnPoint NYC. https://onpointnyc.org/.

22. ^Freyer FJ (2025). "Do Overdose Prevention Centers Work in the U.S.? Researchers Want to Know." Harvard Public Health Magazine. https://harvardpublichealth.org/policy-practice/do-overdose-prevention-centers-work-in-the-u-s/.

23. ^JAMA Network Open (see note 9).

24. ^Harocopos A, Gibson BE, Saha N, et al. (2022). "First 2 Months of Operation at First Publicly Recognized Overdose Prevention Centers in US." JAMA Netw Open. 5(7):e2222149.

25. ^Mitragotri S, Zhu DT (2025). "Trump and the Overdose Crisis—The Need for Evidence-Based Policy." https://pmc.ncbi.nlm.nih.gov/articles/PMC11982947/.

26. ^Feldman N (2019). "Trump Administration Is In Court To Block Nation's 1st Supervised Injection Site." NPR. https://www.npr.org/sections/health-shots/2019/09/06/757484751/trump-administration-tries-to-block-nations-first-supervised-injection-site.

27. ^Kennedy RF Jr. (2024). "Recovering America — A Film About Healing Our Addiction Crisis." https://www.youtube.com/watch?v=liZq31HLnyA.

28. ^Courtwright DT (1992). "A Century of American Narcotic Policy." In: Gerstein DR, Harwood HJ (eds), Institute of Medicine (US) Committee for the Substance Abuse Coverage Study, Treating Drug Problems: Volume 2: Commissioned Papers on Historical, Institutional, and Economic Contexts of Drug Treatment. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK234755/.

29. ^Brookings Institute (2024). "Fentanyl's Impact on Native American Communities and Paths to Recovery." Brookings Institute. https://www.brookings.edu/articles/fentanyls-impact-on-native-american-communities-and-paths-to-recovery/.

30. ^Substance Abuse and Mental Health Services Administration (2020). "The Opioid Crisis and The Black/African American Population: An Urgent Issue." Substance Abuse and Mental Health Services Administration. https://library.samhsa.gov/sites/default/files/pep20-05-02-001.pdf.

31. ^Drug Policy Alliance. "Fact Sheet: The Impact of The Overdose Crisis on Latinx Communities in the United States." Drug Policy Alliance. https://drugpolicy.org/resource/fact-sheet-the-impact-of-the-overdose-crisis-on-latinx-communities-in-the-united-states/.

Declarations

Funding: No specific funding was received for this work.

Potential competing interests: No potential competing interests to declare.