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An Analysis of the Feasibility of an Overdose Prevention Center in the City of Worcester

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Abstract

The opioid epidemic raging across the United States is causing overdose deaths to skyrocket, prompting policy-makers across all levels of government to embrace non-traditional and sometimes controversial means of combating the worsening crisis. Overdose prevention centers (OPCs) represent one such method rapidly gaining prominence. Only emerging in North America relatively recently, these centers offer clients a supervised environment where they can use pre-obtained drugs, spaces designed to mitigate the risk of fatal overdose and increase access to other health services. This study investigates both the capacity of OPCs to reduce opioid-related overdose deaths and their derivative impacts as well as the political viability of one in the City of Worcester. The paper initially reviews the relevant literature surrounding the opioid crisis and the public health and harm reduction policy approaches that encompass OPCs. Then, it analyzes the outcomes of existing OPCs and the criticisms fueling opposition. The discussion subsequently turns to an exploration of Worcester's appropriateness for an OPC, determining that the City is a suitable candidate. Afterwards, a framework for building local approval of an OPC is applied to Worcester, which draws upon both successful and failed advocacy campaigns in other American municipalities. The study proposes a logistical framework for implementation before ultimately recommending that starting this stage is delayed until the state reforms current legislation inhibiting the establishment of an OPC in Worcester.

Keywords: Opioid Crisis, Overdose Prevention Center, Safe Syringe Program, Harm Reduction, Stakeholder Engagement, Policy Implementation, Public Health Policy

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Literature Review

Nearly a million people died in the U.S. from fatal overdoses between 1999 and 2021 (Mann, 2021). The age group hit the hardest by this crisis has been adults aged 35-44, with the rate of overdose deaths only having increased since the pandemic. The roots of the opioid epidemic extend back to the end of the 1990s when the pharmaceutical and healthcare industries began prescribing patients a highly addictive painkiller to the public; however, in recent years overdose deaths have skyrocketed due to the introduction of fentanyl to illicit drug markets. Since 1999, there have been three waves of opioid-related overdose deaths. The first wave began with the introduction of Purdue Pharma's OxyContin, a "gentler and less-addictive" (Georgetown Behavioral Health Institute, 2018) version of oxycodone, to the market in the mid 90's. Over the next two decades, OxyContin was increasingly prescribed by healthcare providers with the result of increasing rates of opioid-use disorder (OUD). The second wave began in 2010 with a general rise in heroin use. The third and last wave concluded with a rapid rise in overdose-related deaths in 2013 related to synthetic opioid use (CDC.Gov, 2023). In the U.S. today, overdoses are the leading cause of injury/accident related deaths, and the opioid epidemic disproportionately affects highly vulnerable populations.

According to the Joint Economic Committee, the opioid epidemic cost the United States 1.5 trillion dollars in 2020, a 37% increase from 2017(USJEC, 2022). The CDC reports that the cost per case of opioid use disorder is $221,219.00, not including the cost of a fatal overdose. In the state of Massachusetts alone, there are 67,000 individuals suffering from opioid use disorder. This opioid epidemic costs the state approximately 36 billion dollars: 14 billion is associated with the lowered life quality that accompanies OUD, and an additional 22 billion covers fatal opioid overdoses. The 36 billion dollar estimate is drawn from the derivative effects of OUD

including healthcare costs, substance use treatment, criminal justice costs, lost productivity, and reduced quality of life. According to Massachusetts state data, Between 2012 and 2022 20,343 individuals have fatally overdosed statewide, with 2,606 of them being in Worcester County.

Opioid use disorder (OUD) is a public health crisis in the United States. As the total death toll of the opioid epidemic has crossed a million, overall U.S. life expectancy has dropped (Brangham, 2022). Opioid use and overdose related deaths are a consequence of addiction, and contemporary strategies prove that. MAT (Medically Assisted Treatment) strategies include the prescribing of synthetic opioids, as well as treatment drugs like naltrexone, which block the effects of opioids on the brain. This prevents individuals from developing physical dependencies associated with opioid abuse. Stigmas around illicit drug use have proven to be a barrier towards substance abuse treatment, as negative attitudes towards individuals who use illicit drugs leads many to avoid seeking out treatment. Much of the blame in the opioid crisis has fallen on the individuals who use these substances rather than the pharmaceutical industry which began overprescribing painkillers, or the United States healthcare system which sat idly by while the rate of fatal overdoses began to increase nationwide (Cheeth, 2022).

Stigmas surrounding the epidemic are beginning to change, but have led to poorer health outcomes for those addicted due a lack of meaningful harm mitigation strategies or general understanding of OUD. The “War on Drugs” acted as a progenitor of this stigma; what resulted from it was a monolithic, largely punitive approach to dealing with OUD which ultimately left the federal and state level governments woefully underprepared to deal with the inevitable surge of opioid related deaths. While on one hand there are stigmas which act as a barrier to effective strategies, on the other hand our understanding of OUD is changing. Factors such as family and medical history, epigenetics, and economic circumstances all play a role in developing OUD as

they do with other addictions. Among many legal and illegal substances, opioids are one of the most addictive due to how they trigger the reward centers in the brain (Mayo, 2023). OUD is a disease, and to put it simply, many users cannot simply drop their substances like a bad habit.

Contemporary American Policy Responses to the Opioid Crisis

For at least seven years, opioid use and the resulting deaths that occur as a product of overdoses have been officially considered a "public health emergency" under section 319 of the Public Health Service Act passed in 2017 (FCC, 2024). The opioid crisis has arguably been at emergency levels for some time before its official reclassification as such in 2017. However, before 2017, the federal government's response to the crisis was more focused on restricting access to opioids and exercising punitive measures against opioid suppliers and users as opposed to addressing the issue as a public health concern (Congressional Budget Office, 2022).

Due to the wide proliferation of synthetic opioids such as fentanyl and the even stronger fentanyl analog carfentanil (Barlas, 2017), subsequent overdose fatalities have only increased, with the year 2021 witnessing 80,411 opioid-related overdose deaths nationwide. This is up 10,000 from 2020 (NIH, 2023). As a result, the federal government along with the several states have proposed or implemented a vast array of policies, measures, and programs aimed at addressing this public health emergency. Beyond the actions of federal and state governments, many nonprofits and community programs are also working to create recovery and harm reduction initiatives designed to combat the crisis.

The main way the federal government has addressed the crisis is through increased discretionary spending and grant money to the states as they see fit, beginning in 2015 when the Department of Health and Human Services launched its new "Opioid Initiative" grant funding

program. The program gave 11 different states 12 million dollars in total to assist in the creation and implementation of MAT programs (Barlas, 2017). More states were added to the list and the overall amount of financial assistance has steadily increased since then. In 2023, 47.8 million dollars was awarded to help states in their ongoing efforts of prevention, treatment, recovery support, and harm reduction, which are the five pillars of the HHS's "Overdose Prevention Strategy" (SAMHSA, 2023). In recent years Congress has passed three laws authorizing the appropriation of 10.6 billion dollars in spending to combat the opioid crisis. These laws include the Comprehensive Addiction Recovery Act (CARA), the 21st Century Cures Act, and the SUPPORT for Patients and Communities Act. Additionally, Congress is expected to increase mandatory opioid response spending by 2.5 billion dollars by 2028 (USA Facts Team, 2024).

Harm Reduction

Harm reduction is an evidence-based approach in the public health field that aims to prevent premature death and create positive changes in the lives of individuals who suffer from substance-use disorders (SUDs) (SAMHSA, 2024). Harm reduction is also one of the aforementioned pillars of the U.S. Department of Health and Human Services Overdose Prevention Strategy (SAMHSA, 2024).

Harm reduction is a practical approach to addressing the nation's opioid crisis. Harm reduction as a public health approach is practical in the sense that such a strategy acknowledges the realities that drugs are widely available in American society and that punitive law enforcement measures and abstinence-based approaches do not reduce the demand for, the use of, or the negative health as well as societal costs associated with narcotics (Coulson, 2022). Harm reduction as a strategy does not attempt to stop narcotic use but rather intends to alleviate

individual and social consequences that are produced as a result. Proponents of the approach do not view forcefully stopping illicit drug use as a realistic, cost-effective, or practical option to addressing the opioid crisis (Botticelli, 2018). Harm reduction relies on several community-driven public health strategies, some of the most common being preventing the spread of SUDs, reducing the risk of overdose and other dangers associated with SUDs, and promoting healthy practices through education and information sharing (SAMHSA, 2024) (CDC, 2024). The crux of this public health approach is the mitigation of the harmful consequences of drug use on individual, community, and societal levels.

Harm reduction strategies aim specifically to reduce the prevalence of lethal overdoses and to combat the transmission of infectious diseases common amongst individuals with SUDs, such as Hepatitis C and AIDS (CDC, 2024) (SAMHSA, 2024). Community-led organizations and health departments pursue the goals inherent in the harm reduction strategy by carrying out activities such as sterile syringe provision (needle exchange services), the distribution of [the anti-overdose medication] Naloxone (Narcan or Evzio), providing educational services explaining safer drug use practices, devising and implementing overdose prevention strategies, and Fentanyl testing. All of these methods aim to reduce the risk of harm associated with drug use (CDC, 2024). The CDC concludes that safe needle provision and disposal programs do not undercut public safety due to evidence showcasing that such programs are not correlated with an increase in crime in the areas in which they are present (CDC, 2024) (Marx Et Al, 2000) (Tooks Et Al, 2012).

Harm reduction strategies also emphasize direct engagement between program providers and the individuals they aim to serve. Another aspect of this direct engagement component is the offering of “low barrier options for accessing health care services, including

substance use and mental health disorder treatment" (SAMHSA, 2024). In short, harm-reduction activities comprise a wide array of strategies and practices aimed at improving the lives and health of people suffering from SUDs, including serving as a pathway to other social, health, and treatment services, such as recovery/rehabilitation services, especially for those populations who may have less access to such care services (SAMHSA, 2024) (CDC, 2024) (Hawk Et Al, 2015). Harm reduction improves lives of those suffering from OUD and helps to keep PWID alive.

The literature on harm reduction clearly suggests that such strategies effectively alleviate the personal and social consequences associated with the use of opioids, primarily opioid-related overdose deaths. Harm reduction, and specifically the establishment of an OPC, is a promising and evidence-based course of action that can and should be pursued in Worcester. Pursuing a harm reduction approach through establishing an OPC is likely to improve the quality of life for Worcester residents suffering from OUD and is the best available approach for ensuring Worcester residents don't suffer fatal opioid overdoses.

I. OPC Analysis

As mentioned, the United States has mobilized large amounts of funding to combat the opioid epidemic. According to recent survey data, the majority of U.S. citizens view the opioid epidemic as a major public health emergency (Gazda, 2022), yet the federal government has been wary of one particular method that has been implemented to great success throughout European countries, Australia, and Canada. These countries have created overdose prevention centers (OPCs) in order to combat the worst effect of the opioid epidemic, overdose deaths.

Overdose prevention centers go by many different names including safe injection sites (SIC), safe consumption rooms (SCR), and supervised injection facilities (SIF). In this capstone the term Overdose Prevention Centers (OPCs) will be used unless the quoted work differs. This

paper will almost exclusively use the term OPC because it locates the prime function of these cites within the theoretical context of harm reduction (the prevention of overdoses) as opposed to centering access to injection.

OPCs are one of several harm reduction strategies that have been used around the globe to address the opioid crisis. These sites offer many services, the most famous of which is the provision of clean needles to people who use drugs (PWUD). The distinction between OPCs and syringe service programs (SSPs) is that the PWUD consume the narcotics within the center where trained staff are on hand to prevent the occurrence of fatal overdoses through utilizing Narcan and other safety measures (U.S. Department of Health and Human Services, 2024).

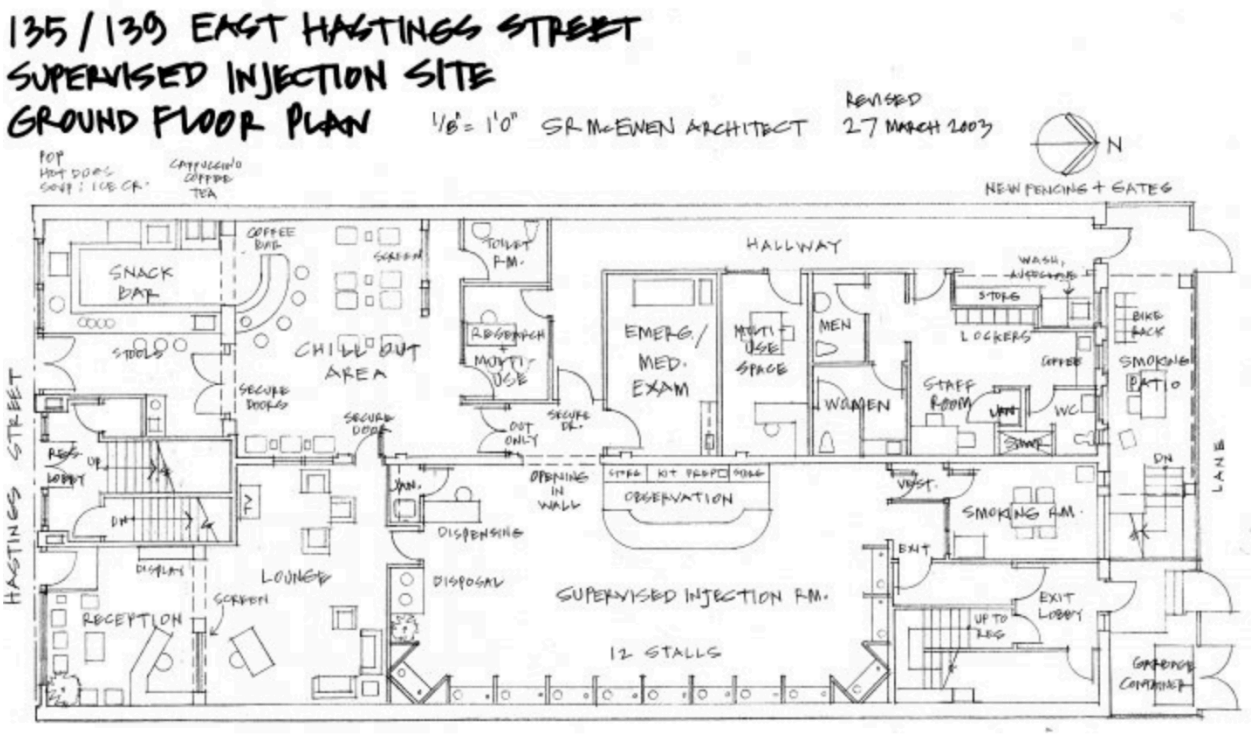
There are three main models for these facilities; these are the integrated, specialized, and mobile approaches (U.S. Department of Health and Human Services, 2024). Integrated OPCs are considered the most effective and are the main type used throughout Europe. These facilities allow supervised drug consumption while also providing other necessary services for those in need including food pantries, wound management, and vaccinations. By contrast, specialized OPCs offer a more narrow range of services which focus on providing sterile needles, a space to use the drugs, and trained staff who can take life-saving intervention measures in case of an overdose. Finally, mobile OPCs are geographically flexible but are only able to provide clean needles and medical attention to a fraction of those that could be helped by a permanent OPC (U.S. Department of Health and Human Services, 2024).

OPC Results

Overdose prevention centers have been used for decades around the globe. Although most of these sites exist in Europe there is one promising example in Vancouver, Canada and two

relatively new facilities in New York City. The site with the most relevant data is Vancouver's Insite facility. Insite opened their doors to patients in 2003 and became North America's first OPC (*Vancouver Coastal Health, 2024*). This facility provides several harm reduction services to patients. PWUD are offered clean equipment for drug consumption including needles, water, cookers, filters, and tourniquets. Spectrometer testing of drug contents is also provided at the facility. When an overdose occurs there is an immediate response from trained medical staff who can provide life saving interventions including but not limited to the use of Narcan. Insite additionally provides clinical care, including wound management and vaccinations. Finally, the facility provides connections to community, healthcare, and addiction services (*Vancouver Coastal Health, 2024*). Figure 1 displays the initial floor plan for the Insite facility; the supervised consumption area is just one small section of the facility (Lam, 2020). There are areas where users can sit down and relax, a medical exam room, a smoking room, and many other amenities (Figure 1). This is why Insite can be described as an integrated OPC. Since 2003, several studies have evaluated the effectiveness of the facility on metrics including overdose deaths, addiction rates, needle-refuse, cost-savings and crime rates.

Figure 1



Note: 135/139 East Hasting Street Supervised Injection Site Ground Floor Plan by SR McEwen

Overdose Rates

The main goal of the Insite facility is to reduce deaths caused by opioid overdoses. According to a study funded by Vancouver Coastal Health, Canadian Institutes of Health Research, and the Michael Smith Foundation for Health Research, the Insite facility does just that. The study investigated population-based overdose mortality rates for the period before (Jan 1, 2001 to Sept 20, 2003) and after (Sept 21, 2003, to Dec 31, 2005) the opening of the Vancouver SIF (Marshall et al, 2011). According to their research "the fatal overdose rate in this area decreased by 35% after the opening of the SIF, from 253.8 to 165.1 deaths per 100,000 person-years" (Marshall et al, 2011). This 35% reduction occurred within a 500m radius of the Insite facility, while a 9.3% decrease was seen in the rest of the city (Marshall et al 1, 2011).

Addiction Rates

There are many skeptics who argue that by providing OPC's for those that use drugs would enable their addiction. Based on the evidence available, the opposite is true. When researchers investigated drug use patterns of those that use Vancouver's Insite facility they found that "a significant proportion of PWUD (77%) had at least one episode of discontinuing SIF attendance, and that the majority of these episodes (58%) occurred in conjunction with drug use cessation" (Tran et al, 2021). Additionally, after data was collected about long-term SIF clients the researchers found that "there was an increase in the proportion of clients currently engaged in drug treatment (93% vs 61%) and use of local primary health care services had similarly increased (73% vs 33%)" (Tran et al, 2021).

Public Injection and Needle Refuse

A more tangible result of OPCs is the decrease in visible drug injections and discarded needles and syringes. A study analyzing the 5-year period after Sydney's OPC was opened found that "the proportion of residents and business owners who reported witnessing public injection decreased over time from 33% and 38% in 2000 to 19% and 28% in 2005, respectively" (Tran et al, 2021). Another study done in France confirms these results with a 15 point reduction in injection practices in public spaces with OPCs compared to those without OPCs (Su-Lyn, 2023). There was also an observed decrease in discarded needles and syringes reported by both residents and business operators in Australia. Finally, a 300% decrease in discarded syringes was also found after an OPC was opened in France (Su-Lyn, 2023).

Cost-Saving

One of the most important metrics to consider when evaluating a policy solution is its cost-effectiveness in relation to the current policy and other alternatives. A large study done in 2020 by the Institute for Clinical and Economic Review titled "Supervised Injection Facilities and Other Supervised Consumption Sites: Effectiveness and Value" took data from the Insite location in Vancouver, Canada and applied it to several large U.S. cities which already had syringe service programs to see how cost-effective implementing SIFs are compared to SSPs (Esther Armbrecht et al, 2020). The chart below displays the outcomes of Boston and Philadelphia with SSP-only and with SSP+SIF (figure 2).

Figure 2

Cost Benefit Analysis between SSP and SIF+SSP in Boston and Philadelphia

Outcome	Boston			Philadelphia		
	SIF+SSP	SSP-Only	Incremental	SIF+SSP	SSP-Only	Incremental
Total Cost	$2,261,000	$6,270,000	-$4,009,000	$1,896,000	$5,796,000	-$3,899,000
Annual Cost of Facility	$2,153,000	$1,641,000	$511,300	$1,794,000	$1,433,000	$361,500
Ambulance Costs	$7,100	$411,400	-$404,400	$6,600	$383,400	-$376,800
ED Visit Costs	$46,600	$1,947,000	-$1,901,000	$46,600	$1,947,000	-$1,901,000
Hospitalization Costs	$54,300	$2,270,000	-$2,215,000	$48,600	$2,032,000	-$1,983,000
Overdose Deaths	9	13	-3	43	58	-15
Ambulance Rides	14	787	-773	14	787	-773
ED Visits	14	564	-551	14	564	-551
Hospitalizations	6	271	-264	6	271	-264

ED: emergency department, SIF: supervised injection facility, SSP: syringe service program

Note. By International Center Economic Review in the report on Supervised Injection Facilities and Other Supervised Consumption Sites: Effectiveness and Value, page 13

Implementing SIFs in addition to SSPs would dramatically decrease the amount of emergency department visits, hospitalizations, and ambulance rides resulting from illicit drug use (Esther Armbrecht et al, 2020). Implementing SIFs in Boston could save the city around $3,833,000. Similar savings are seen in Atlanta, San Francisco, Philadelphia, Baltimore, and Seattle according to this study (Armbrecht et al, 2020). As mentioned before, the data taken to create the cost/benefit results came from the Insite facility in Vancouver.

Crime Rates

One of the biggest concerns from communities and law enforcement agencies around opening OPCs is an increase in crime around the facility. Based on several studies, crime rates appear to either stay the same or decrease when an OPC is opened in an area. Researchers conducted a study in France comparing two cities with OPCs to two cities without them. Based on this analysis, PWUD in OPCs engaged in crime 20 points less than the control group without OPCs (Su-Lyn, 2023). Additionally, according to data collected in a cohort study from the two NYC OPCs, there have been no significant increases in crime rates within the neighborhoods where the OPCs operate (Chalfin et al, 2023).

II. Legislation Surrounding about OPCs

The current position of the Department Of Justice (DOJ) is that the creation and operation of OPCs constitute a violation of federal laws (Gorin, 2023). Specifically, opponents of OPCs state that they violate the federal “Crack House Statute”. The “Crack House Statute” is defined under 21 U.S.C. 856, and essentially renders the practice of knowingly opening, leasing, renting, using, or maintaining any physical space for the purposes of manufacturing, distributing, or using

any controlled substance (Gorin, 2023). 21 U.S. Code 856 Maintaining drug-involved premises law states the following:

> *(a) Except as authorized by this subchapter, it shall be unlawful to —*
> *(1)* ***knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or using any controlled substance****; (2) manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.*" *(b) Criminal penalties;* ***Any person who violates subsection (a) of this section shall be sentenced to a term of imprisonment of not more than 20 years, a fine of not more than $500,000, or both, or a fine of $2,000,000 for someone other than an individual****. (c) Violation; as an offense against property A violation of subsection (a) shall be considered an offense against property for purposes of section 3663A(c)(1)(A)(ii) of title 18.* (Gorin, 2023)

Beyond the fact that OPCs are considered federally illegal by the DOJ in relation to the "Crack House Statute", OPCs also encourage the violation of 21 U.S. Code 844. This statute renders the act of any person intentionally possessing a controlled substance, unless the substance was obtained with a valid prescription from a practitioner while acting in the course his or her professional practice, or except as otherwise authorized in the subchapter, as federally illegal (U.S.Code.House.Gov, 2024).

Under the Biden Administration the DOJ has implemented the practice of evaluating OPCs and other related facilities, which includes discussing the appropriate safeguards for such sites with regulators (Gorin, 2023). As Gorin points out, these practices constitute a significant shift in DOJ's stance regarding OPCs from under the Trump Administration, when DOJ prosecutors actively fought against the opening of a safe consumption site in Philadelphia (Gorin, 2023). Following a complaint the DOJ made in 2019 concerning the opening of a Philadelphia OPC by the organization Safehouse, the federal district court concluded that the "primary purpose of safe house was to reduce drug use and encourage treatment, not facilitate

illegal activity" (Gorin, 2023). However, this decision was overturned when the DOJ appealed it in the Third Circuit Court of Appeals (Gorin, 2023). While there has been a counterclaim filed by Safehouse against the DOJ, this claim is still in the courts. The U.S. Supreme Court has thus far declined to take on the case, yet their current stance does not preclude them from making a ruling in the future (Gorin, 2023).

Despite this court battle, under the Biden Administration the DOJ is softening its overall stance on the creation and operation of such sites, as their current practices of evaluating such sites and discussing the "appropriate guardrails" for them implies (Gorin, 2023). Beyond the stance of the DOJ, other entities within the federal government have expressed explicit interest in learning more about the public health benefits (specifically their usefulness in reducing the risk of drug overdose deaths and the spread of infectious disease) of OPCs and similar programs. For example, the House Committee on Appropriations in their report on the fiscal year 2021 appropriations bill for the U.S. Department of Health and Human Services, stated the following:

> *"The Committee recognizes that Overdose Prevention Centers, or Supervised Consumption Sites, are part of a larger effort of harm reduction interventions intended to reduce the risk of drug overdose death and reduce the spread of infectious disease. The Committee directs [the National Institute on Drug Abuse (NIDA)], in consultation with the [Centers for Disease Control and Prevention's (CDC's)] Division of Injury Prevention and Control, to provide a report to the Committee and post publicly, no later than 180 days after the enactment of this Act providing an updated literature review and evaluation of the potential public health impact of Overdose Prevention Sites in the U.S." (House Report 116-450, pages 120-121)*

The Department of Health and Human Services (DHHS), National Institutes of Health (NIH), and the National Institute on Drug Abuse (NIDA) has since released an updated literature review and evaluation of OPCs. The evaluation concluded that existing OPCs have "largely fulfilled their initial objectives," that the creation of new OPCs in places with high rates of

injecting drug-users (IDUs) "appears to be supported by the existing evidence," that OPCs have the potential to provide health benefits to IDUs and economic advantages to the larger community, and that "the preponderance of the evidence suggests these sites are able to provide sterile equipment, overdose reversal, and linkage to medical care for addiction, in the virtual absence of significant direct risks like increases in drug use, drug sales, or crime" (DHHS, 2021). This evaluation serves to show that there is significant support for OPCs within the federal government.

The evaluation ultimately recommends that more research and rigorous academic evaluations of OPCs take place. The DHHS considers OPCs a novel method of addressing some of the many societal and personal costs associated with the overdose crisis, and states that such sites "could contribute reduced morbidity and mortality, and improved public health" (DHHS, 2021), in areas where IDU are common. The evaluation also supports the American Medical Association's recommendation "of developing and implementing OPC pilot programs in the United States designed, monitored, and evaluated to generate locality-relevant data to inform policymakers on the feasibility and effectiveness of OPCs in reducing harms and health care costs related to IDU" (DHHS, 2021), showcasing a level of agreement concerning their stances on OPCs between the two organizations.

More recently, in May of 2023, the federal government announced that they will allocate $5 million over the coming years to fund additional studies aimed at providing evidence to determine whether OPCs actually prevent overdoses (Gorin, 2023). Ultimately, while OPCs are still illegal under two specific federal laws, the federal government has been investing time, money, and resources into investigating whether OPCs can help to alleviate the opioid overdose crisis; although the DOJ is still actively involved in a court case opposing the establishment of an

OPC in Philadelphia, the department's stance seems to be softening. While the federal government will fund a study on OPC pilot programs, the stance of the federal government on directly supporting OPCs in their intended function remains as of yet noncommittal. Depending on the results of the presidential election this coming November, advocates of OPCs can expect either a continuation of the current trends or a reversal back to the more hostile stance of the Trump Administration.

In Massachusetts specifically, the legality of OPCs is similar to that of the federal government with some notable distinctions. The Controlled Substance Act § 856 regulates the production, possession, and distribution of controlled substances, and makes it a criminal offense to maintain a drug involved premises (BU, 2020), and many experts agree that the "Crack House Statute" prevents OPC implementation, as the courts as of yet have not rendered a decision on the extent to which they violate federal law. Proponents of OPCs have nonetheless appealed to state legislatures to move forward with laws which would pave the way for implementation, such as with Bill S.1258 introduced in 2022 which would have directed the Massachusetts Department of Health to evaluate the feasibility of such sites, but did not pass. A source of opposition in state legislatures is the fear that passing legislation related to OPCs would bring on a federal lawsuit classifying their actions as being in violation of §856. In Massachusetts, a Harm Reduction Commission established by the state legislature in response to the opioid epidemic recommended that an OPC pilot program be implemented as part of the Commonwealth's evolving strategy. The commission did note however that legal defenses based upon states rights and statutory interpretation, which supports the establishment of OPCs were untested at the time. Despite these challenges, the City of Somerville has since approved funding for a mobile OPC clinic which would be implemented once state level legislation paves the way (Bebinger, 2023). Although the

issue of The Controlled Substances Act remains, individual actors would feel far more comfortable setting up the operation of an OPC with state law as overhead protection.

While this quasi-guerrilla form of harm reduction is admirable, ultimately the most effective way to get OPCs setup is through modifications to state legislation. Although state governments can de facto sanction the operations of OPCs through non-enforcement, passing statutes that permit their existence explicitly endorses its ability to reduce overdose deaths(Beletsky et al. 2008). This legislation would legitimize the operation to subordinate government agencies such as the Department of Health and provide protection against police interference and civil consequences. Operating outside the bounds of state legislation means both clients and service providers are potentially liable for activities occurring in an OPC, disincentivizing clients from using an OPC and opening the door to overwhelming legal costs for providers. Additionally, putting state legislation in place would put OPCs in the best position to weather a challenge from the federal government (Beletsky et al, 2008). Public health has historically fallen under the domain of state governments, so permissive state legislation allows the state A.G. to go to bat for an OPC and mount a legal defense.

Rhode Island provides a template that Massachusetts should follow in the pursuit of OPCs. The Ocean State has already designated funding for a 2-year pilot study on OPCs (Smollen, 2023). Plans are currently underway to build a physical OPC in Providence by the end of the year, a project done in collaboration with local clinical partner “VICTA” to provide onsite staff, and using opioid settlement funding. The city council of Providence initiated the state's first official OPC, which will provide additional social services to its clients, including access to food, showers, housing support, as well as STD/STI testing (AP, 2024). This local plan would not have been possible without state legislation that paved the way.

The legislation passed by Rhode Island gives potential future Ocean State OPCs a distinct advantage over similar programs in Philadelphia and New York City, which is that OPC is now legal in the whole state and leaves it up to a local community to approve a facility (Arditi, 2022). Rhode Island's process demonstrates another essential component of OPC advocacy and implementation: getting local communities on board. Prior to creating legislative groundwork for an OPC, advocates built broader coalitions and engaged with different stakeholders in a prolonged period. This sustained engagement convinced the public and policymakers that OPCs were a viable policy solution to rising overdose rates. One advocate in Rhode Island of OPCs stated, "you have to start somewhere, even just a couple of years of having conversation and raising awareness of the situation and that there are other non traditional avenues people are taking in lieu of reverting to the things we have been doing for years as the number of deaths continues rising" (Rosen, 2024). The discussions usually involved emergency services personnel who can make an effective case to policy makers and the public about how OPCs are more cost effective than the alternative of dispatching ambulances repeatedly which do not always get there on time. OPCs accomplish this by having all encompassing staff such as social workers, and medical treatment on site ready and waiting.

As mentioned, involving the surrounding community in the planning and implementation is another essential component of creating an effective and long lasting OPC. Efforts in New York City provide another great example of the best way to do this; there, advocates believed that by inviting the press, officials, and the public into the planned facility to show them the evidence and allay fears was the most effective strategy and neutralizing NIMBY pushback. In NYC, key services that were extended as part of the OPC were also already in place, which helped to build community trust as they knew what to expect. New York City was, like

Philadelphia, hampered by the continued illegality of OPCs, but despite that they were able to establish a support network that will be able to effectively manage the integration of an OPC into their community if and when they become legal.

As implied, Philadelphia's OPC journey was far less fruitful than both Rhode Island's journey towards establishing an OPC, and New York City's. In summary, the Philadelphia OPC project failed because it was not passed with statewide legislation in place, nor did it include sufficient efforts to quell public backlash. Efforts in Philadelphia faced strong opposition in the form of threats of federal litigation, as well as State Bill 156 which banned OPC operation in the past year, and community backlash from landlords and residents within the general vicinity of the proposed OPC. Philadelphia advocates also made the mistake of not discussing plans with residents of the neighborhoods where OPCs were being planned. Local law enforcement revealed to the public the plan to create an OPC before a press conference could even be had, one advocate recounted how "people were screaming at us, and calling us sneaks" (Rosen, 2024). The community leaned into a NIMBY (Not In My Backyard) attitude due to the perception that the OPCs were going to be built with no regard for public transparency and no opportunity for discussion beforehand. On the other hand, New York City advocates believed that by inviting the press, officials, and the public into the planned facility to show them the evidence and allay fears was the most effective strategy and neutralizing NIMBY pushback (Rosen, 2024), the more the public understands about OPCs and their operations, the more likely they are to succeed. In Philadelphia, the absence of state legislation overshadowed a whirlwind of opposition arising from multiple camps that ultimately overwhelmed any momentum that the project had, culminating in the statewide OPC Ban. The failure of this project illustrates the potency of criticism to OPCs.

III. Criticisms of OPCs

The distinct veins of opposition to overdose prevention centers all reject the novel, provocative, and essential feature of OPCs; their primary function is to grant PWUD an opportunity to inject drugs they already possess in a safe environment. Harm reduction encompasses OPCs because of this feature, a philosophy embedded in the public health approach to the opioid crisis. As stated in the literature, harm reduction aims to mitigate the lethality of drug use. Harm reduction strategies operate under the assumption that since a level of drug use is inevitable, communities and governments aiming to help members of the population struggling with drug use should focus their energy on programs and policies that lessen the risks associated with SUD for those suffering from it (Lofaro et al. 2021). So-called "moral"arguments against OPC challenge the justifiability of interventions predicated on the assumption that some drug use is inevitable .

These arguments undergird Prohibitionist and Abstinence narratives that are critical of OPCs. The Prohibitionist label was applied to the opponents of an OPC in Australia, whose opposition campaign relied heavily on moral objections (Mendes, 2021). It is interchangeable with the Abstinence narrative critics in the U.S. and elsewhere have adopted, as both philosophies originate from the same ideological premise (Lofaro et. al, 2021); they frame drug use as immoral and illegal behavior, often denying its classification as a health issue (Mendes, 2021). As such, proponents of these ideologies claim it is wrong for governments' intervention strategies to take the form of permitting drug use in the pursuit of constraining its consequences (ibid). They argue harm reduction policies ostensibly overlook the preeminent wrongness inherent to the act of drug consumption itself by attempting to reduce associated harms (Lefaro, 2019). OPCs are therefore rendered complicit because they facilitate the immoral act of drug

consumption (ibid). According to these camps, interventions must instead focus on preventing access to drugs if they are to be morally justifiable; Critics of harm reduction argue that to do otherwise effectively enables drug use, and represents a belief that drug use is permissible (Lofaro et al, 2021). The former Attorney General for the Trump Administration, Rod Rosenstein, echoes this sentiment in a 2018 New York Times Op-Ed entitled "Fight Drug Abuse, Don't Subsidize it." In the piece, Rosenstein lambasts OPCs that "invite visitors to use heroin, fentanyl, and other deadly drugs without fear of arrest" instead of deterring them (Rosenstein, 2018). He claims that OPCs normalize drug use, invoking the aforementioned "abstinence narrative" to decry them (Lofaro, 2021). His article shows the importance of the act of drug consumption to moral objections to harm reduction strategies, objections which emphasize the illegality of the act to grant the objector the legal high ground to gain traction in the public sentiment (ibid). Research surveying the persuasiveness of prominent arguments for and against OPCs to American audiences revealed that highlighting the illegality of drug use and the ostensible inappropriateness of government "tolerance" of this act resonates with the majority of Americans; this indicates that the rhetorical strength of critiques tie moral sensibilities to legal prohibitions (Barry, 2021).

Rosenstein's Op-Ed is also notable because it demonstrates how moral denunciations complement consequential criticisms of OPCs. If the former revolve around the immorality and illegality of the act of drug use, the latter highlight that permitting it could endanger the well-being of the local community and perpetuate inherent problems with drug abuse. Rosenstein suggests that "when drug users flock to a site, drug dealers follow, bringing with them violence and despair, posing a danger to neighbors and law-abiding visitors" (Rosenstein, 2018). Accompanying public safety concerns is skepticism about the efficacy of OPCs in regard to their

ability to end addiction. This point builds directly upon abstinence framings of addiction as the primary harm stemming from the act of opioid use (Lofaro, 2021). For example, Australian prohibitionists wondered whether lives of PWUD were truly saved if the scourge of addiction still consumed them (Mendes, 2021). There, politicians argued that merely avoiding premature deaths was an insufficient result to justify establishing an OPC (ibid, 2021). Finally, criticisms about a lack of community involvement and consent fall under the umbrella of a NIMBY narrative opposing OPCs. NIMBYism reflects community fears that an OPC sacrifices the interests and well-being of local residents to the needs of PWUD. As mentioned, it fueled staunch opposition in Philadelphia and contributed to the eventual failure of the project.

The debate over OPCs is located within a broader ideological conflict between abstinence and harm reduction narratives. At the heart of this conflict lies a disagreement over whether reducing lethal effects of drug use is more appropriate and effective than efforts to prevent the occurrence of the illegal act. The aforementioned survey data from Barry et al. suggests that arguments which incorporate the latter are consistently more persuasive to Americans than those that favor mitigating the risks of drug consumption (Barry et. al 2021). Recognizing the potency of these objections is critical for designing effective messaging that can defuse them.

In Worcester specifically, residents echo these criticisms when questioned about their potential support of an OPC in their city. Just last month in March of 2024, reporter Drew Karedes from Boston 25 News interviewed Worcester residents to gauge the level of support or lack thereof for the establishment of an OPC in the city. One Worcester resident said the following about the establishment of an OPC in Worcester: “We’re doing all this stuff to save people who don’t want to be saved. As a taxpayer, I do not want to spend my tax money on that” (Karedes, 2024). Their comments reflect the belief that drug use is behavior that government

policies and funding should not encourage. To wit, another Worcester resident stated that "when you hear about it at first, you think it is enabling. Why are we helping these people stay high?" (Karedes, 2024). Their statements parallel abstinence-based criticisms condemning government-aided facilitation of drug use, representing the type of public skepticism OPC advocates must overcome.

IV. Suitability of Worcester for an OPC

The city of Worcester could benefit greatly from the establishment of an OPC and possesses many attributes that justify the creation of such a site. Most pressingly, Worcester has a clear need for the establishment of an OPC in terms of a preponderance of fatal opioid-related overdoses. Fatal opioid overdoses have clearly seen an increase in recent years and the most current data implies that this trend is continuing. From 2018 to 2022, opioid-related deaths in Worcester increased by roughly 18%, and preliminary data for 2023 shows that between January and September rates rose another 11% from the previous year (Turken, 2024), rendering Worcester second to only Boston (which is over double Worcester's size) in terms of fatal opioid overdoses in the state (Turken, 2024). In 2023, Worcester's Commissioner of Health and Human Services Matilde Castiel stated that the city had the highest opioid mortality rate in the state (SpectrumNews, 2023).

Figure 3

MA Opioid Related Deaths

County	Year of Death												
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total 2012-2022	Percent Change 2022 vs. 2021
Barnstable	24	43	53	67	81	67	71	73	76	80	87	722	8.8%
Berkshire	16	22	29	32	35	30	40	40	56	62	47	418	-24.2%
Bristol	95	115	145	172	243	239	218	260	233	293	276	2371	-5.8%
Dukes	0	1	5	7	3	2	4	3	6	5	6	42	20.0%
Essex	93	119	205	236	274	301	273	279	251	291	278	2657	-4.5%
Franklin	8	10	11	18	14	9	22	17	20	36	27	198	-25.0%
Hampden	59	69	64	98	130	113	209	199	215	213	230	1644	8.0%
Hampshire	11	30	26	16	36	28	38	39	34	44	37	349	-15.9%
Middlesex	118	152	273	341	402	350	322	304	297	360	382	3431	6.1%
Nantucket	0	0	1	1	2	3	1	2	1	4	2	17	-50.0%
Norfolk	70	82	125	164	213	167	170	130	154	163	160	1663	-1.8%
Plymouth	57	86	110	174	190	202	151	176	184	167	190	1755	13.8%
Suffolk	90	110	146	199	242	252	215	218	287	299	305	2448	2.0%
Worcester	91	115	162	222	246	250	281	267	278	281	331	2606	17.8%
Total Deaths	**733**	**954**	**1,356**	**1,748**	**2,111**	**2,013**	**2,015**	**2,007**	**2,092**	**2,299**	**2,359**	**20,343**	**2.6%**

Note: Number of Opioid-Related Overdose Deaths, All Intents, by County, MA Residents: 2012-2022 by Massachusetts Department of Public Health

As the above data indicates, Worcester County has one of, if not the, highest opioid overdose fatality rates in the state, only surpassed by the city of Boston. Worcester has a critical need for a public service designed to curb the alarming rates of fatal opioid overdose deaths. An OPC could provide just that service. Hundreds of Worcester citizens are dying from preventable overdoses, a startling trend that is getting worse by the year and shows no sign of improving. Support exists for the establishment of an OPC in the city from those analyzing the city's overdose epidemic from a public health perspective. One of the strongest supporters is the MA Department of Public Health, which as of December 2023 has been actively recommending that state leaders take steps to open OPCs throughout the state (Riley, 2023).

Beyond the stated position of the MA Department of Public Health, several local stakeholders, those being individuals interested in public health or those concerned with overdose rates in Worcester County, also support the establishment of an OPC in the city of Worcester. One such stakeholder is the aforequoted Health and Human Services Commissioner for Worcester Matilde Castiel, who has been very vocal in her support for more resources for

Worcester citizens suffering from opioid use disorder (OUD) and has been recorded saying that Worcester's opioid overdose deaths "are extremely high" (Turken, 2024). Castiel is a public health expert; she is the president and was a founding member of the Executive Committee of the Massachusetts Large Cities Health Collaborative, founder of the Latin American Health Alliance (LAHA), and just recently won the 2023 local public health leadership award (MAPublicHealth.org, 2024). Because the solutions being proposed find their roots in the public health sector, Castiel is a valuable source to draw information from considering her position as a Worcester-based authority in the field.

While she supports ongoing OUD-combatting programs and policies of the city of Worcester - such as distributing Narcan, ensuring that Spectrum Health Services Inc. can distribute medication for OUD (which provides over 100 people a day with free medication for OUD), and the fact that Worcester's ambulatory services now carry Suboxone - she suggests that more is needed. She further specifies her position as an interest in seeing the expansion of access to overdose reversal medication and addiction recovery medication, as well as the increase of awareness and decreasing stigma of those suffering from OUD by creating public campaigns on safe opioid-use (Turken, 2024).

In the same Worcester City Council meeting in 2023 when Castiel made her comments, District 5 Councilor Etel Haxhiaj concurred, explicitly asking the city of Worcester to "'consider establishing overdose prevention facilities where medical professionals monitor people as they use drugs to ensure they don't fatally overdose'... Haxhiaj argued that two such centers in New York City have saved lives and helped address addiction" (Turken, 2024). She sees OPCs as an "important public health solution to overdose deaths" (Boston 25 News Staff, 2024), which she stated in a post on social media. Haxhiaj's stated support for the establishment of an OPC in

Worcester serves to illuminate the fact that there exists considerable support in Worcester's local government for such a program.

Beyond the expressed support of these local stakeholders and policymakers, Worcester is also the first municipality in the Commonwealth of MA to officially approve a pilot OPC program (Karedes, 2024). This was done in March 2024, when the Worcester Board of Health unanimously approved the establishment of an OPC in the city (Karedes, 2024). Mayor Joseph Petty has also expressed interest in the topic and has called for a greater discussion in the community concerning the establishment of an OPC in Worcester (Karedes, 2024).

Clearly, many key stakeholders in the Worcester community are at least open to or explicitly approve of the establishment of an OPC. Such a site would have the express purpose of lowering opioid-related overdose deaths in the city. This harm reduction strategy would also be a cost-effective addition to the current measures the city has in place.

The cost of the opioid epidemic to Worcester County is massive. According to the CDC, the cost per case of Opioid use disorder as of 2017 was $221,219, which was derived from the total U.S. cost of opioid use disorder during 2018 by the number of opioid disorder cases the same year (CDC.Gov, 2018). Per Capita, the cost of each fatal overdose in Massachusetts is about $5,963 (CDC.Gov, 2018). From 2012 to 2022, 2,606 people overdosed fatally in Worcester County, meaning that fatal overdoses alone have cost the county $15,539,578. If the trend over the last two decades continues, the yearly death rate will continue to go up. This estimation does not take into account the cost of opioid use disorder itself before fatally overdosing, due to other factors such as rehab facilities, loss of housing, strain on healthcare providers, and lost productivity as a contributing member of society. According to one study which was estimating

the prevalence of opioid use disorder in Massachusetts, 5.34% of Worcester County's population has OUD (opioid use disorder) (Barocas, 2018).

The Massachusetts Department of Public Health already supports counties opening SSP, where people who inject drugs can access sterile needles to prevent the spread of bloodborne diseases, receive drug use education, dispose of dirty and used syringes, and receive free Narcan. AIDS Project Worcester is one such nonprofit that aims to educate the public and enhance the lives of those who are affected by diseases such as HIV/AIDS, Hepatitis C, and other diseases. Since one objective of OPCs is limiting the spread of blood-borne diseases, the OPC would benefit from working in conjunction with this kind of nonprofit. During the 2nd wave of opiate overdoses in the 2010s, Jesse Pack, a director at AIDS Project Worcester, said, “we have always worked with active drug users, we've always included education around overdose prevention, but we weren't able to offer naloxone/Narcan until late 2011, when we became part of the state pilot” (Schweigher, 2014). Because of this, a Worcester OPC would benefit from guiding state-level legislation. There are several other groups in Worcester that operate within a framework informed by harm reduction theory, like Chris’s Corner and Living in Freedom Together. These organizations acknowledge that they are serving a population that often is actively using illegal substances. As such they distribute resources like clean syringes, Narcan, provide MAT intakes, and provide post-overdose check-ins involving a police officer visit.

There is already a large amount of public discourse in Worcester related to OPCs, with the Worcester Board of Health supporting their implementation, and 70% of all Massachusetts residents supporting the creation of OPCs (Bebinger, 2023). However, despite the Board of Health unanimously approving the creation of an OPC pilot program, the Worcester City

Manager, Eric Batista, made it clear that the city of Worcester would not move forward with the policy as of now. The manager's office released the following statement:

"No action will be taken on the potential operation of an OPC in the City of Worcester until further guidance is provided by the State of Massachusetts. At such time, further conversations will be had among City officials, City Council, health providers, stakeholders, and the community at large" (Drysdale, 2024).

Despite large support for the creation of OPCs as a harm mitigation strategy, the City of Worcester is waiting for approval at the state government level, taking the top-down approach. As discussed, Providence, RI waited for state-level legislation first before beginning to implement its OPC pilot program. Despite no existing OPCs, a well established prevention and support network already exists in Worcester County. Formed at the behest of District Attorney Joseph D. Early, Jr, this network connects different stakeholders resources that could be useful in the fight against OUD. The two goals of this network is to reduce the number of people suffering from OUD, as well as reduce the number of opioid overdoses. If the goal is to keep people alive, then OPC should be a part of the solution, but not before the necessary state level laws are enacted.

V. Pathway toward Implementation in Worcester

The establishment of an OPC would be contentious in any community, even those whose residents are aware of the devastating effects of drug abuse. Although robust evidence suggests that OPCs will most likely dramatically reduce overdose fatalities and carry negligible harmful

externalities, the empirical justifications are nevertheless insufficient to combat opposition (Rosen et al, 2024) The willingness of policy-makers to implement them without popular approval is inhibited because the surrounding moral and legal ambiguities disrupt pragmatic discourse and imbue OPCs with stigma. Existing OPCs elsewhere have faced criticisms that they were imposed upon a community rather than established in conjunction with community input and ultimately, community support, undermining their legitimacy and decreasing their longevity (Mendes, 2021). To wit, an OPC in San Francisco California closed its doors after 11 months due to community backlash and declining support from the Mayor (Rosen et al, 2024). As they are highly visible to the public consciousness (even if the drug use is not) and present profound (yet apparently unlikely) risks to its community, officials are wary of supporting them despite believing they are good policy due to the potential political ramifications. Ultimately, establishment of an effective and long lasting OPC demands a strategic framework for gaining public approval that in turn emboldens officials to provide explicit support.

Fortunately, precedent exists for developing a network of supportive stakeholders and decision-makers that advances creating an OPC. Rosen et al performed a comprehensive study evaluating the promotional tactics used in previous efforts to establish an OPC. After conducting interviews with OPC proponents closely involved in such efforts, both successful and unsuccessful, the authors identified a suite of five effective advocacy strategies. As the authors derive their recommendations from the first-hand experiences of people intimately tied to a wide range of past attempts to establish an OPC, their study illuminates the set of best practices that can be applied to a local campaign. The following sections apply and integrate these strategies into a framework for building the necessary foundation of local support in Worcester.

The first strategy they recommend is to “embed” the OPC movement into larger extant harm reduction coalitions composed of healthcare providers, nonprofits, businesses, and if possible law enforcement (Rosen et al, 2024). Doing so helps legitimize OPCs as an extension of existing responses to the overdose epidemic, “sensitiz[ing] policymakers and the public to OPCs as viable policy solutions” (ibid). Furthermore, these coalitions provide channels of engagement that foster communication with pivotal actors. They have superior resources and existing connections that can be easily accessed, positioning them as ideal allies for those seeking to establish an OPC .

There are a few such allies that proponents for an OPC in Worcester could target to be members of a coalition. Primarily, needle exchange programs, or safe syringe programs (SSP), are apt partners because they are based on the same harm reduction philosophy underlying OPCs. SSPs are similarly provocative interventions that invite some of the same fears as OPCs by ostensibly enabling drug use, ultimately facing comparable political and legal challenges. The ability of these already established programs to navigate those obstacles carves a path that OPCs can follow, and the security of that path increases the longer an SSP has existed in a community. AIDS Project Worcester has administered an SSP for nearly a decade, where they seek to educate those with OUD on the risks involved and provide fresh syringes in exchange for used ones to try and limit the spread of bloodborne diseases such as HIV, Hepatitis C, and Syphilis. Local advocates should pursue a partnership with this program, thereby gaining access to the networks they have leveraged to establish themselves in Worcester’s community. Chris’s Corner is another member of this potential coalition. They offer support services to those struggling with OUD in conjunction with the Worcester District Attorney's office, such as rehab meetings, therapy, individual coaching, and a community of support. Additionally, within the City of

Worcester there already exists an opioid task force with the goal of tackling heroin and prescription drug addiction and preventing fatal overdoses, spearheaded by the Worcester DA's office. An alliance with the District Attorney's office is ideal, mainly because it helps defuse a likely source of opposition, law enforcement.

The second strategy expands upon the first. Advocates suggest building rapport with a plurality of influential power brokers, such as public health officials (Rosen et al, 2024). Cultivating these relationships raises awareness of OPCs as a feasible and effective solution among policymakers and is conducive to successful implementation. Alliances with these actors helps insulate an established OPC from interference, erecting a firewall that protects the service providers from criticism and lends the project institutional legitimacy. For example, OnSite, the New York City OPC, formed connections with city public health officials. The officials attended each community board meeting regarding OnSite, redirecting public scrutiny towards the health department instead of the OPC. As a result, OnSite could continue to operate while the health department addressed public concerns. The powerbrokers effectively formed a bulwark between OnSite and local skeptics, allowing them to focus on producing results that would alleviate concerns. Policymakers could similarly build a rapport with power brokers in Worcester, such as the Worcester Department of Health, law enforcement, city councilors, the mayor's office, and healthcare providers.

The third recommendation is that communications are adjusted for specific audiences. In New York City, advocates found that highlighting the non drug related services that OnSite offered, such as free meals and prescription services, were points that resonated among the community. Rhode Island advocates deployed substance abuse and recovery narratives to their community for the most success, and lawmakers in various districts responded positively to

pragmatic arguments demonstrating that OPCs significantly reduce the healthcare costs associated with overdoses. The lesson is that there is not a one-size-fits-all argument in support of OPCs that will appeal to all audiences, so it is the job of proponents to design messages that respond to the specific concerns of local stakeholders.

A messaging framework for Worcester advocates should target specific lines of arguments to the type of audience they are most likely to persuade, including community members, public health affiliated stakeholders, and policy-makers. In closed-door discussions with policy-makers, proponents of OPCs have garnered support using evidenced-based arguments highlighting the results of extant facilities (Rosen et al, 2024). Results that could alleviate policy-maker concerns include those showing no noticeable increase in proximate criminal activity, reductions in healthcare-related costs, and a significant decline in overdose fatalities. Specifically, invoking the ICER data indicating that the addition of an OPC to an SSP significantly lowers total health-care costs for the city is a useful point to emphasize, freeing up resources to divert elsewhere. These results appeal to public health stakeholders as well. In particular, the estimated dramatic decrease in overdose deaths will be especially persuasive to this group, given their current harm-reduction practices.. Public health stakeholders managing an SSP have already bought into harm reduction strategies, but emphasizing that their current mission would be better served by an OPC can only increase the chance they support one. Finally, crafting public-facing communications is challenging because of the diverse nature of their concerns, but centering messaging around emotional appeals to empathy is a useful guiding principle (Lawrence, 2018). Additionally, the research from Barry et al. is instructive here, showing which arguments in favor of OPC were most compelling to American audiences (Barry et al, 2019). Specifically, highlighting the holistic services OPCs offer and their superior impact

on mitigating addiction compared to arrests was especially persuasive (ibid). So local advocates should emphasize to the public the capacity of OPCs to address the underlying reasons people use OPCs in addition to effectively reducing overdose deaths.

Fourth, advocates emphasize the need to maintain transparency throughout the entire process, from formulation to execution. As mentioned, the feeling that an OPC was imposed on a community without their consent poses one of the largest threats to an OPCs viability, as it has derailed previous efforts to establish and maintain one. If the public feels that advocates are using underhanded methods or disguising their intentions, as residents in Philadelphia felt, then they are more likely to be skeptical that an OPC will be beneficial for the community. By contrast, fostering an open and accessible dialogue between local pro-OPC stakeholders demonstrates that the latter are acknowledging the public's concerns and provides OPC advocates with an opportunity to refute them.

Local advocates should therefore hold periodic public forums in Worcester to discuss the possibility of an OPC. Municipal meetings around OPC must be publicized and made easily accessible to the public, paying particular attention to residents of the proposed area of the OPC. This paper suggests bringing in testimony from healthcare workers and PWUD at the forums, because their testimony invites empathetic engagement with the opioid crisis and helps reframe it as a public health issue rather than a public safety one (Lawrence, 2018).

Finally, OPCs are plagued by vehement objections often based on misinformation, and advocates state that vigorously challenging these objections is critical to stoking public and legislative approval. Recognizing where a given objection comes from can inform who should voice the responses. Typically, law enforcement is opposed to OPCs, often claiming authority over the best way to administer treatment. Advocates have found that inviting testimony from

healthcare workers espousing support for supervised consumption is particularly conducive to centering a public health perspective instead of the criminal justice one promoted by law enforcement. Framing substance abuse as a public health issue is essential for interventions like OPCs that are founded on harm mitigation.

These five principles offer a detailed roadmap for advocacy efforts that foster the creation of an OPC in Worcester Massachusetts. Advocates should embed an OPC within pre-existing harm reduction coalitions, contact specific allies such as needle exchange programs and power brokers, communicate to diverse audiences while emphasizing transparency in the process, and create meaningful relationships with other organizations will lay the foundation for a successful OPC program. Through vigorously challenging misguided criticism will build the necessary trust and consent from within the community.

VI. Implementation Plan

The best way to establish an OPC is to attach it to a pre-existing Syringe Exchange Service (Beletsky et al, 2008). The addition of an OPC to an SSP can be seen as an extension of preexisting services as SSPs are already legal in Massachusetts. PWUD are already coming to SSPs to receive clean needles and other services such as STI testing and counseling, designating a portion of the facility as an OPC would allow them to safely inject drugs in the facility and receive life saving medical intervention (Beletsky et al, 2008). As mentioned earlier, Worcester already has an organization with an SSP, AIDS Project Worcester. Therefore, AIDS Project Worcester's existing SSP is the best location for a Worcester-based OPC.

The attachment of an OPC to AIDS Project Worcester would increase their operating expenses. Although an accurate estimate cannot be calculated without access to their records, the

Institute for Clinical and Economic Review estimated the increase in operating costs for adding OPCs to SSPs in Boston, Philadelphia, San Francisco, Atlanta, Baltimore, and Seattle. According to their data, the average increase in operating cost would be 26% (Esther Armbrecht et al, 2020). The cost of operation for AIDS Project Worcester in 2022 was $2,630,190, which included funding for housing assistance, transportation, STI treatment services, counseling and testing for HIV/HCV (among other diseases), the Syringe Services Program, Narcan training, among other services (AIDS Project Worcester, 2023). With a 26% increase it would cost an additional $631,245 per year to operate an OPC in the facility. An additional large capital expense would have to be made to acquire more land in order to build an appropriate facility for PWUD to use. Although extracting a rough cost is possible, detailed information on savings is not available because the City of Worcester has collected insufficient data. Other cities collect data on fatal and non-fatal overdoses, ambulance rides, PWUD concentrations, and other vital information, but Worcester does not.

This paper recommends drawing funding from the Massachusetts Opioid Recovery and Remediation Fund to fund the implementation of an OPC in concert with AIDS Project Worcester. The Executive Office of Health and Human Services provides funding and the fund's 21 person advisory council is responsible for administering said funding (Mass.gov, 2024). This fund is an appropriate source to draw from because it was created with the express purpose of mitigating the impacts and negative societal effects of the opioid epidemic in the Commonwealth, "including, but not limited to, expanding access to opioid use disorder prevention, intervention, treatment and recovery options" (Mass.gov, 2024). OPCs fall under this category by encouraging PWUD to begin moving towards seeking treatment and recovery. The

OPC that is going through the implementation process in Providence, RI will be funded using opioid settlement money as well (Casey, 2024).

VII. Final Recommendation

Despite anticipating that the establishment of an OPC would significantly lower overdose deaths in Worcester, this paper cannot recommend the city move forward with a project until state legislation changes and permits one. Although an OPC is an optimal policy tool in the fight to lower the death toll of the opioid crisis, such a project in Worcester faces potent existential threats without this legislation. As learned from the respective successful and failed attempts in Rhode Island and Philadelphia, permissive state legislation plays a significant role in the ultimate viability of an OPC. It insulates clients and service providers from civil and criminal liability that could discourage utilization of an OPC and impose destructive financial repercussions. Illegality also hampers efforts to build community support, increasing the likelihood of public backlash. Finally, the absence of a protective state legislation raises the risk a hostile DOJ poses, exacerbating the opportunity cost of establishing an OPC. Expending political and financial capital on an ultimately doomed project could forfeit any public goodwill advocates have fostered, risking a permanent elimination of OPCs from local discourse. Instead, this paper advises delaying earnest development in Worcester until state legislation reforms and creates a legal bulwark against these threats.

However, without the inhibiting condition of operating outside the protection of state law, the implementation framework outlined shows how an OPC is feasible in Worcester and evidence from existing sites suggests it would provide a great deal of public good. That being said, it is essential to state that holding off on the actual implementation of an OPC does not mean that advocacy efforts cannot start immediately. In fact, in order for an OPC to be best

positioned to start saving lives when the political climate allows, they must, so that when the time is right an OPC can start saving lives.

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