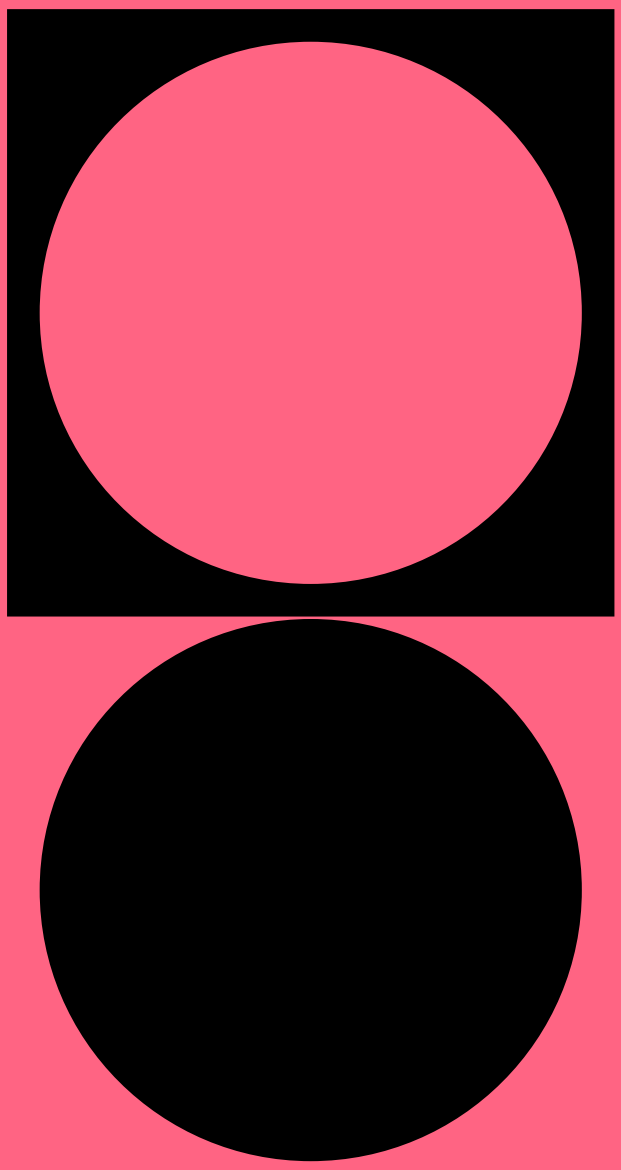
REGIONAL OVERVIEW: NORTH AMERICA



THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION INTERNATIONAL

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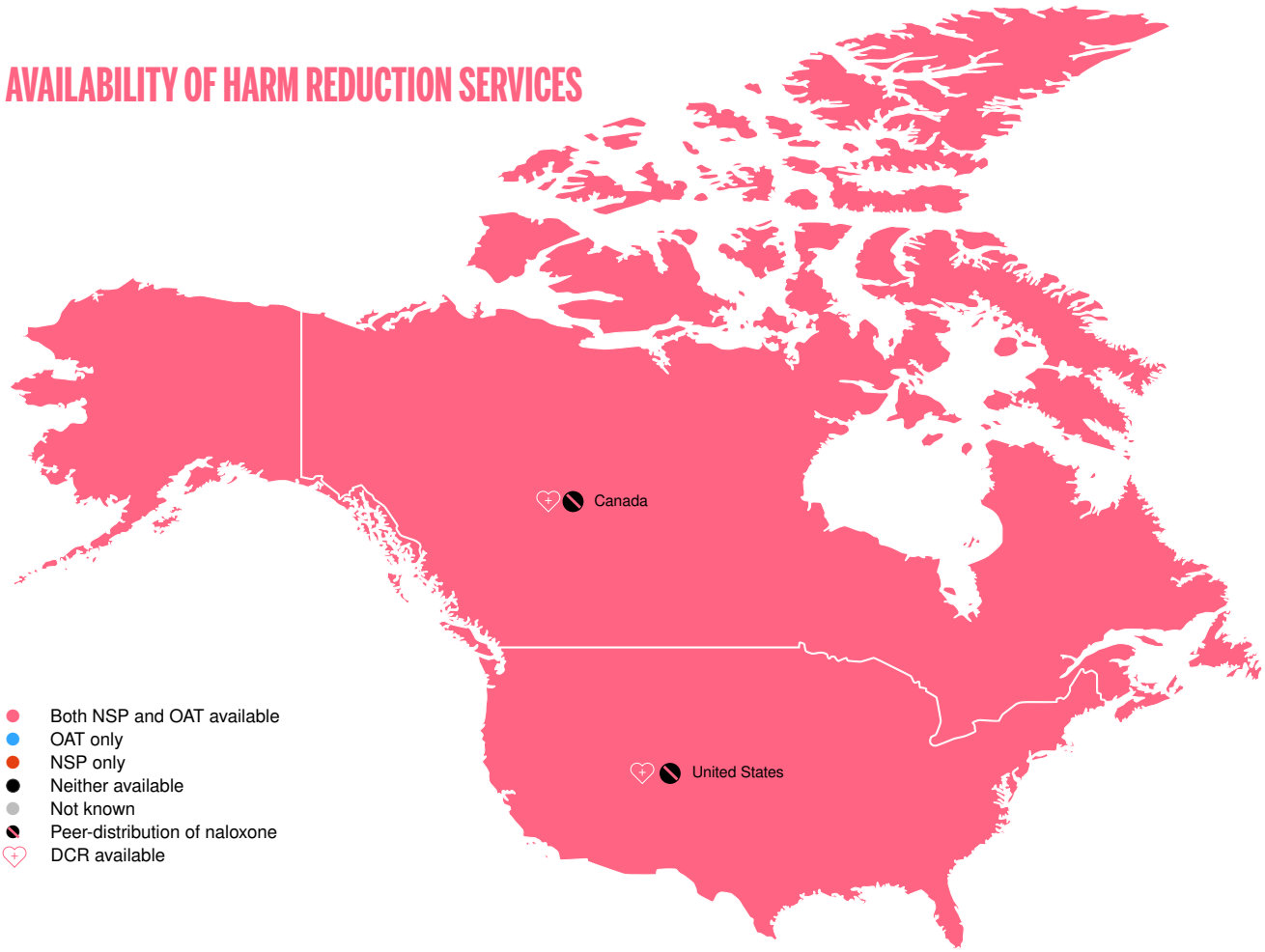
TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN NORTH AMERICA

Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Canada	174,500	10.3	64.2	nd[f]	✓	✓ M B	✓	✓ 41[g]	✓
United States of America	3,695,400	5.9	53.5	4.8	✓	✓ M B	✓	✓ 2	✓

AVAILABILITY OF HARM REDUCTION SERVICES



a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone.
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (DCR) (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
g This includes one prison DCR in Drumheller, Alberta.
f nd = no data.
g This includes three DCRs in prisons.

NSP, OAT, DCRs AND SAFER SMOKING KITS

2 countries (100%) in North America provide **needle and syringe programmes** (no change from 2022)

2 countries (100%) in North America provide **opioid agonist therapy** (no change from 2022)

2 countries in North America provide **drug consumption rooms** (no change from 2022)

2 countries in North America provide **safer smoking kits** (no change from 2022)

TABLE STATE-BY-STATE ACCESS TO HARM REDUCTION IN THE UNITED STATES

State	Needle and syringe programmes	Is possession of syringes criminalised by drug paraphernalia laws?	Licensed opioid treatment programmes	Licensed drug consumption rooms
Alabama	1	Yes	Yes	No
Alaska	4	No	Yes	No
Arizona	15	Yes	Yes	No
Arkansas	2	Yes	Yes	No
California	58	No	Yes	No
Colorado	13	Yes, but NSP clients exempt	Yes	No
Connecticut	9	No	Yes	No
Delaware	1	Yes, but NSP clients exempt	Yes	No
Florida	6	Yes, but NSP clients exempt	Yes	No
Georgia	6	Yes	Yes	No
Hawaii	1	Yes, but NSP clients exempt	Yes	No
Idaho	5	Yes	Yes	No
Illinois	14	Yes, but NSP clients exempt	Yes	No
Indiana	12	Yes	Yes	No
Iowa	1	Yes	Yes	No
Kansas	0	Yes	Yes	No
Kentucky	35	Yes, but NSP clients exempt	Yes	No
Louisiana	6	Yes	Yes	No
Maine	8	Yes, but NSP clients exempt	Yes	No
Maryland	8	Yes, but NSP clients exempt	Yes	No
Massachusetts	15	No	Yes	No
Michigan	23	No	Yes	No
Minnesota	13	No	Yes	No
Mississippi	0	Yes	Yes	No
Missouri	4	Yes	Yes	No
Montana	4	Yes	Yes	No
Nebraska	0	Yes	Yes	No
Nevada	2	No	Yes	No
New Hampshire	9	No	Yes	No
New Jersey	3	Yes, but NSP clients exempt	Yes	No
New Mexico	5	Yes, but NSP clients exempt	Yes	No
New York	25	Yes, but NSP clients exempt	Yes	Yes 2
North Carolina	32	Yes, but NSP clients exempt	Yes	No
North Dakota	5	Yes, but NSP clients exempt	Yes	No
Ohio	20	Yes, but NSP clients exempt	Yes	No
Oklahoma	4	Yes	Yes	No
Oregon	13	No	Yes	No

State	Needle and syringe programmes	Is possession of syringes criminalised by drug paraphernalia laws?	Licensed opioid treatment programmes	Licensed drug consumption rooms
Pennsylvania	7	Yes	Yes	No
Rhode Island	2	No	Yes	No
South Carolina	4	No	Yes	No
South Dakota	0	Yes	Yes	No
Tennessee	9	Yes, but NSP clients exempt	Yes	No
Texas	8	Yes	Yes	No
Utah	6	Yes, but NSP clients exempt	Yes	No
Vermont	4	Yes, but NSP clients exempt	Yes	No
Virginia	3	Yes, but NSP clients exempt	Yes	No
Washington	29	Yes, but NSP clients exempt	Yes	No
West Virginia	8	Yes, but NSP clients exempt	Yes	No
Wisconsin	16	No	Yes	No
Wyoming	0	Yes	No	No
Washington DC	4	Yes, but NSP clients exempt	Yes	No

KEY ISSUE

DRUG CONSUMPTION ROOMS

Drug consumption rooms (DCRs), also known as overdose prevention centres, supervised injection sites or safe injection facilities, are spaces where individuals can consume pre-obtained drugs under the supervision of healthcare providers or other trained staff.[1] DCRs typically provide emergency overdose response, primary medical care and referrals to internal and external services, including treatment for substance dependence and housing.[2] DCR objectives are to reduce infectious disease transmission, reduce deaths and ill-health associated with overdose, connect people who use drugs to the services they need and reduce risks associated with the consumption of drugs in public spaces.[3,4]

Insite, the first DCR in North America, opened in 2003 in Vancouver, Canada.[4] This DCR was subjected to rigorous evaluation; over 40 peer-reviewed studies indicated that

Insite was successful in meeting its objectives and was associated with declines in overdose deaths, infectious disease transmissions and risks associated with the consumption of drugs in public, and increased uptake of substance use treatment.[5,6]

The success of Insite prompted the establishment of DCRs throughout Canada. Now, 39 federally sanctioned DCRs operate in five provinces.[7] DCRs operate as stand-alone facilities, integrated within other facilities, or as mobile sites such as vans.[8]

In response to the worsening overdose crisis in Canada, around 50 'urgent public health needs sites' or overdose prevention centres have been opened.[9,10] These are often temporary facilities, which makes numbers difficult to track. They also tend to be simpler in operation and design than conventional DCRs and have a primary focus on overdose prevention and response.[5] The expansion of DCRs in Canada has generated some backlash. The province of Ontario recently announced a ban on DCRs within 200 feet of schools and childcare centres, which may result in the closure of 10 DCRs by 31 March 2025.[11]

The USA has been slow to adopt DCRs despite over a decade of advocacy efforts focused on their establishment, as well as the operation of unsanctioned DCRs in some places.[12] Two locally sanctioned DCRs currently operate in New York City, and another two are scheduled to open in Rhode Island and Vermont as both states have enacted authorising legislation and allocated state funding to support their operations.[13,14] Minnesota has also enacted legislation allocating funding for establishing and operating DCRs.[15] A DCR also operated in San Francisco in 2022 with city approval, which reversed 333 overdoses during its existence. However, it was closed after one year for vague political reasons.[16]

The DCRs in New York were opened by OnPoint NYC in November 2021.[17] Both DCRs operate within a Harm Reduction Wellness Hub which provides a range of wrap-around services under a single roof.[18] In addition to the DCR, services at the hub include syringe services, drug checking, clinical care, mental health services, case management, food and nutrition and peer support.[19]

The OnPoint DCRs include booths and tables for injecting (eight spaces per site), as well as enclosed, communal, ventilated rooms for inhaling/smoking.[20] As of July 2024, 5,330 people have used the DCRs, engaging in around 149,700 drug consumption episodes, and OnPoint staff successfully intervened in 1,570 overdoses.[21] One in five people who have used an OnPoint DCR were referred to housing, detox, treatment, primary care or an employment opportunity.[22] Initial evidence from the evaluation of the New York City sites indicates that establishing the DCRs did not result in increased disorder or crime.[23]

Plans to establish DCRs in other US cities have not been realised, typically as a result of political or legal barriers.[24,25] The federal Anti-Drug Abuse Act prohibits operating spaces 'for the purpose of…using a controlled substance'[26,27] and was recently used by the Department of Justice to prevent the opening of a DCR in Philadelphia.[28] Efforts to open other DCRs have also been met with considerable political opposition in some regions, while jurisdictions like Rhode Island, Vermont and Minnesota continue to move forward.[29,30]

The evidence concerning the effectiveness of DCRs has grown substantially in recent years. There are now three peer-reviewed systematic reviews of the evidence specific to DCRs.[31,32,33] These reviews all reach the conclusion that DCRs are effective in meeting their objectives, and do not produce feared consequences, such as enabling further drug use, undermining treatment efforts or exacerbating crime.[34,35,36] Importantly, no one has ever died of an overdose in a DCR anywhere, and peer-reviewed research indicates that the establishment of DCRs is associated with declines in overdose deaths within neighbourhoods,[37,38] and all-cause deaths.[39] Available evidence also indicates that, if people can access a DCR they are more likely to enter into detoxification and drug dependency treatment programmes[40,41] and cease injecting drug use.[42] Given that consuming drugs in DCRs is clearly safer than consuming drugs in other spaces, it has been deemed unethical for studies to randomize individuals to DCR access or no DCR access.[43,44] This has resulted in never-ending questions regarding the research specific to DCRs,[45] despite an accumulation of high quality and consistent observational evidence, including data derived from longitudinal cohort studies and studies relying on administrative data (e.g., treatment admissions, police-collected crime statistics).[46,47,48]

The evidence concerning the effectiveness of DCRs continues to grow.[1] Although several studies indicate that these services do not exacerbate crime or drug dependency,[49,50,51] they continue to be politicised and misrepresented by a range of stakeholders.[52] This has constrained their implementation in some settings.[53,54] But the way forward is clear: DCRs meet their objectives without causing negative consequences, and they have high potential to contribute to preventing people from overdosing across the world. And as the following section shows, widespread DCRs are urgently needed across the region to help prevent increasing overdose deaths.

“ In many settings, crime, people experiencing homelessness and a lack of affordable housing is being attributed to the existence of harm reduction programmes, despite a lack of evidence to demonstrate such relationships.”

KEY ISSUE

DRUG OVERDOSES

North America is contending with a public health crisis driven by accidental drug-related overdose deaths which has only worsened in recent years. A range of interventions and policies designed to prevent overdose deaths have been implemented, but they remain limited in terms of scale and coverage. At the same time, punitive approaches to drug use have continued to dominate in many settings. The epidemiology of overdose in North America is highly gendered and is having a disproportionate impact among certain racial and ethnic minority groups, as well as people of Indigenous, Native and Indian ancestry.

In the USA, according to the US Centers for Disease Control, an estimated 107,941 people died from a drug overdose in 2022 (32.6 per 100,000 people).[55] This represents a greater than 600% increase from 2000, when 16,849 people died from overdose (6.1 per 100,000).[56] Similar dynamics are evident in Canada, where 11,528 deaths occurred in 2023 (34.8 per 100,000 people).[57] This represents a greater than 500% increase since 2018, when 2,297 deaths occurred (7.8 per 100,000).[58]

Males in North America continue to die of overdose at higher rates than females. In the USA, the rate of overdose death in 2022 was 45.6 per 100,000 for males and 19.4 per 100,000 for females.[59] In Canada, males accounted for 72% of those who died of an overdose in 2023.[60] In the USA, Black and Indigenous people have experienced the highest rates of death due to overdose of any racial or ethnic group (47.5 deaths per 100,000 among Black people, and 65.2 deaths per 100,000 among Native American/Alaskan Native people),[61] while people of Indigenous ancestry in Canada are also disproportionally affected.[62]

The factors driving the current overdose crisis are similar in the USA and Canada. Both countries have witnessed a large and growing increase in the presence of illegally manufactured synthetic drugs, as well as the rising co-use of stimulants and opioids.[63,64,65] For example, while synthetic opioids such as fentanyl were involved in only 9% of overdose deaths in 2014 in the USA, this increased to 68% in 2022. Likewise, in Canada in 2023, 82% of all overdose deaths involved fentanyl or related

Overdose death rate per 100,000 people (USA)

- **Male (45.6)**
- **Female (19.4)**
- **Black people (47.5)**
- **Native American / Alaskan Native (65.2)**

analogues, while only 44% did in 2016.[66,67] More recently, other synthetics, including xylazine and synthetic benzodiazepines, have entered the drug supply and complicated overdose risk and response and the delivery of harm reduction services.[68,69,70] Aside from the growing contamination and toxicity of the drug supply, other factors continue to drive overdose deaths, including various social and economic conditions such as poverty and economic disadvantage, structural racism, pain, drug market policing, unstable housing and people experiencing homelessness.[71,72,73,74,75,76]

In the USA, the Department of Health and Human Services' *Overdose Prevention Strategy* seeks to address four core areas: prevention, evidence-based treatment, harm reduction and recovery.[77] Spanning the areas of treatment and harm reduction, medications for opioid agonist therapy (OAT), such as methadone and buprenorphine, remain primary approaches. While in some settings OAT is more widely available,[78] access is more restricted in other areas.[79] Barriers to OAT persist, with factors such as distance, stigma, insurance and restrictive programme delivery practices constraining access and retention.[80] Naloxone distribution appears to have increased in the USA, although coverage is generally regarded as inadequate.[81,82] However, stigma and financial constraints still act as barriers to access in some settings.[83] Recently, as discussed above, two DCRs opened in the USA and two more are set to open, but this form of intervention remains controversial, and attempts to open such services in some states have been denied.[84,85,86,87] There have also been significant increases in the availability of drug checking services in the USA, although their impact remains unclear.[88]

Canada's national Drugs and Substances Strategy seeks to balance prevention and education, evidence, substance use services and supports and substance controls (i.e., drug laws, enforcement). Substance use services span harm reduction, recovery and treatment programmes.[89] A variety of harm reduction programmes exist in Canada, including needle and syringe programmes, naloxone provision, drug checking, DCRs and safer supply.[90,91,92]

Safer supply involves providing prescribed medications to people who are at high risk of overdose as a safer alternative to the toxic illegal drug supply [93]

including by providing medications such as hydromorphone, fentanyl powder and patches, dexedrin and clonazepam. Safer supply programmes have been the subject of much controversy, including concerns about diversion.[a,94] However, a growing body of evidence indicates that safer supply programmes reduce overdose risk and healthcare costs, and help people reduce their reliance on an unregulated and contaminated drug supply.[95,96,97]

Throughout North America, there are growing concerns regarding the politicisation of the overdose crisis and backlash against harm reduction policies and interventions in particular.[98,99,100] The government of Ontario's decision to close several DCRs is a prime example of this.[101] In the USA, another example can be seen in the rolling back of Oregon's drug decriminalisation laws.[102,103] In many settings, crime, people experiencing homelessness and a lack of affordable housing is being attributed to the existence of harm reduction programmes, despite a lack of evidence to demonstrate such relationships.[104]

There are also growing concerns about inaction by governments and a lack of funding needed to address the current crisis.[105] Given the ever-worsening epidemic of overdose death in North America, greater investment and action is needed to ensure access to evidence-based harm reduction programmes reach the people most at risk of overdosing. This should include novel interventions that address the rapidly evolving toxic drug supply and approaches designed to address the intersections of overdose with gender, race and Indigenous ancestry.

a Diversion is the non-intended or non-medical use of a prescribed medication, or its use by any individual other than the person for whom it was prescribed.

“ Aside from the growing contamination and toxicity of the drug supply, other factors continue to drive overdose deaths, including various social and economic conditions such as poverty and economic disadvantage, structural racism, pain, drug market policing, unstable housing and people experiencing homelessness.”

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