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Envisioning the evolution of substance use services: Social work and the establishment of overdose prevention centers

Jeffrey Steen PhD, LCSW and Carla B. Monteiro MSW, LICSW, LADC-1

School of Social Work, Simmons University, Boston, MA, USA

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Where we were

'Some days are better than others, some bags are better than others. And when I get the hit, I usually feel like you do after you devour ice cream. That look on your face says it all.' We both chuckled. 'Spaced out and bloated?,' I quipped. 'Both of those things, definitely. And of course there's the high. For an instant, I'm empty and euphoric. And those moments are worth it all.' Jerry [name redacted] and I [J. Steen] first became acquainted near a grove of trees where he had been living for quite some time. As I reflect on our times together, I have fond memories of our visits to local ice cream shops followed by walks in nearby parks. The green spaces we frequented provided rest, invited conversation, and aided digestion after we devoured excessive sweets. Although there were challenges, our relationship was mostly easy and amicable.

As a caseworker in the early 2000s, my role was to build relationships with people who used substances and were chronically unhoused. Although the agency was cash-strapped, we had a small pool of funding that allowed us to coordinate outreach efforts and contribute meager financial assistance for substance use treatment and temporary housing. Complex challenges repeatedly emerged, however, when Jerry and clients decided they wanted to access support from other institutions. Staff and programming at many human service organizations reinforced stigmatizing social values that moralized and criminalized substance use. As those who desired treatment knew so well, eligibility requirements were strict, costs were prohibitive, and waiting lists were long. If services were eventually delivered, they were routinely terminated when individuals 'didn't want to change' or 'failed' their treatment. I quickly came to realize that this usually meant they did not adhere to expectations that reflected the organization's goals, rather than their own. These regulations often required clients to maintain total abstinence and remove themselves completely from the 'people, places, and things' that were sometimes associated with their substance use – and that often sustained their livelihood. Along with my clients, I was especially aggravated that my social work colleagues did not foreground collaborative relationship-building that allowed people to safely discuss their substance use. For me, their derogatory language and actions directed toward people who used drugs was a betrayal of the profession's legacy, an abandonment of our claims that we were dedicated to human rights and dignity (National Association of Social Workers, 2021). Many social workers fervently disagreed with my views.

CONTACT Jeffrey Steen steen@simmons.edu School of Social Work, Simmons University, Boston, MA, USA

Decades later, I still hold social workers partially responsible for Jerry's passing. The last hours I spent with him, we rapidly devoured gelatos on a scorching summer afternoon, laughing as most of the treat melted instead on our t-shirts. Jerry had just been discharged from an intensive outpatient program. A social worker had noticed fresh track marks on Jerry's arm, and required him to provide a urine sample. Reluctantly, Jerry informed staff that he had experienced overwhelming triggers over the weekend, and eventually succumbed to urges when he was offered a speedball. At the insistence of social work staff, security roughly removed him from their office. After expressing dejection about losing the behavioral healthcare and lunches that the organization had been providing – at a time in which he actually needed more support and empathy – Jerry shared that he might want to reduce his substance use but not eliminate it entirely from his life. When he made those statements, I recalled Prochaska and DiClemente's stages of change, recognized that Jerry's statements were consistent with contemplation, and framed my responses accordingly. Heroin and cocaine reduced his depression and anxiety, but using them reinforced shame and made him want to withdraw from others. We identified the many efforts he hoped to make in the days ahead: calling his sister for guidance, as she had recently starting working as an addictions counselor; visiting his temple, to see if they were able to donate clothing or money; scheduling intakes, to see if he could again receive food from the soup kitchens that the community had cobbled together; and, contacting an HIV service provider, to inquire about the status of his request to access peer support. Unfortunately, Jerry needed to cancel his upcoming appointment at a local recovery home, as we knew that results from the recent toxicology screen would make him ineligible for housing. Sensing my worry, he reassured me that he would continue to use as safely as possible. As he was on his way to meet a dealer, I encouraged Jerry to get high with a couple friends who were also staying in the park, as they could intervene if he accidentally overdosed. However, he was concerned about using with others, fearful that congregating in a public place would make it more likely to be noticed, exposing himself to risks of ridicule or arrest. He appeared troubled as we parted ways, but was still able to incite my laughter. 'Remember that the new ice cream parlor opens on Friday afternoon. We both need to escape this humidity. The lines will be long, so if you're late, we're done!' The playfulness of his wink lightened my mood as I returned to the office. Later that week, I knew something was wrong when Jerry didn't join me in line at the gelateria. I rushed to the park with a cone of his favorite flavor, dulce de leche. As I sprinted, I anticipated the news that I would soon learn: Jerry was found dead earlier that day, poisoned by a tainted drug supply, alone, and with a needle in his arm.

Where we are

It has been years since Jerry passed. Our moments together remain vivid. Eager for inspiration when I work late hours, I recently ordered a midnight dispatch of ice cream. I thought of Jerry when it arrived several minutes later – he would certainly share my enthusiasm for the modern conveniences of app-based dessert delivery. Regarding substance use, a great deal has also changed since Jerry and I savored sweets and lamented about social ills. Sadly, tragedies such as Jerry's untimely passing have become increasingly common. During the past several years, the number of overdose deaths has skyrocketed. At the current time, over 200,000 people in the United States die each year as a direct result of alcohol and other drugs. This is due to numerous factors, such as

pervasive stigma, the deleterious consequence of harshly criminalizing people who use substances, the COVID-19 endemic, racial disparities in healthcare and addiction treatment, and contaminated drug supplies – mostly linked with the trafficking of fentanyl and xylazine. Differently informed by practice wisdom, science, and a more humane stance, there are promising evolutions in the substance use treatment ecosystem. Well-versed in motivational interviewing, trauma-informed care, evidence-based treatments, and interprofessional collaboration, social workers are increasingly adopting practices that recognize people have a variety of goals related to their substance use. Partnership is more effective than punishment. Many of the structural challenges that Jerry and I contended with continue to plague substance use services, but innovative programs are differently engaging people who use drugs (PWUD) in prevention, assessment, treatment, and ongoing recovery support efforts. There are numerous examples of strategies that are consistent with these principles, such as client-centered programs offering options for clients to have mixed substance use goals, recovery coaching, pharmacological interventions, integrated behavioral healthcare, syringe services programs, distribution of overdose reversal agents, community education about safer substance use, low threshold housing, expanded access to basic needs such as food and clothing, and advocacy for policies that focus on reducing risks associated with substance use. The commonly-used harm reduction slogan, 'Any Positive Change,' reflects well the values guiding these priorities – informing services that would have made it possible for Jerry to experience the world in a very different way. While some social workers remain reluctant to understand and implement these pragmatic public health approaches, there is growing recognition of the natural fit between the priorities of harm reduction and the values of the profession: valuing human relationships, respecting clients' self-determination instead of providers' self-interest, and championing social justice.

To counter the alarming number of overdose deaths, the United States must evaluate and institute innovative models of care. Overdose prevention centers (OCPs), also referred to as supervised consumption sites, consistently achieve outcomes that are desperately needed in communities throughout the US: substantially reducing overdose deaths, targeting substance use-related comorbidities, sharply decreasing transmissions of HIV and HCV, and improving access to medical, behavioral health, housing, and community-based services (Levengood et al., 2021; Shorter et al., 2023). Around the world, hundreds of OPCs have been operating for decades, offering PWUD a safe place to do so. Many OPCs are staffed with social workers, healthcare providers, and peers who are committed to 'meeting people where they're at' while preventing and responding to overdoses. By the nature of their mission, OPCs are also concurrently focusing on social issues related to substance use, such as contesting stigma, saving communities significant costs due to minimized utilization of emergency services, reducing public consumption of substances, preventing exposure to hazardous waste, and facilitating local discussions about health and safety. In the face of fierce backlash, courageous US cities and states are recognizing the great potential of OPCs, exploring – and sometimes enacting – legislation that authorizes their funding, implementation, and evaluation. In fact, a nonprofit organization is now operating OPCs in New York City, making it the site of the country's first recognized supervised consumption center.

Where we went

I [C. B. Monteiro] am a licensed independent clinical social worker (LICSW) and a licensed alcohol and drug counselor (LADC-1). Through my leadership role with substance use and women's health programs in a hospital system in Boston, I have opportunities to be involved with a great variety of impactful projects. Reminded of social workers' simultaneous engagement in micro, mezzo, and macro level practice, I am responsible for overseeing assessment and screening, staff and student supervision, community engagement, policy and advocacy efforts, and research. Most importantly, I am a first-generation Black Cape Verdean American who grew up in Fields Corner in Dorchester, a neighborhood in Boston, Massachusetts. Throughout my childhood, I witnessed individuals in my community who were battling addiction, specifically as a result of alcohol or crack cocaine use. However, despite this reality, as a teenager many of my Black peers in my community held on to the false belief that only marijuana was consumed by Black people. Some of my friends' parents were struggling with addiction, but as a teenager, I was not aware of the signs. I wondered why some of their parents spent much time in their bedrooms or behind locked doors, as I was accustomed to seeing my mother active around the house. I visited their apartments without realizing that a few were 'crack houses.' Despite their parents' struggles, it was apparent that they loved their kids and cared for the neighborhood children who came to visit. I have also witnessed the devastating impact of substance misuse in my more immediate circle, losing family members, friends, and patients. The heart-wrenching experience of seeing neighborhoods torn apart by the War on Drugs and the criminal justice and child welfare systems sparked my interest in becoming a social worker in addiction treatment settings.

In 2023, I traveled to Upper Manhattan with a group of social work and nursing colleagues and students to visit a local nonprofit, OnPoint NYC. This community-based organization achieved a significant milestone in 2021, when it became the first in the country to establish an overdose prevention center. This groundbreaking initiative is making a substantial impact in the lives of PWUD, individuals who are struggling with addiction, and people who engage in sex work. These full-service harm reduction wellness hubs provide safe spaces for people to use pre-obtained substances, in addition to delivering a variety of health services. During my visit, I learned that OnPoint uses a peer-led model, offering people with lived experience opportunities to contribute to organizational leadership, programming, and case management. Upon entering the OPC, I noticed that nicely-designed private stations were set up with works and other supplies, and volunteers and employees were nearby, ensuring participants had what they needed and were comfortable. A staff member pointed out mirrors that were strategically placed at the stations. The mirrors allow participants to look behind themselves, creating a sense of safety. This is especially important for the agency's service users, as I was informed that 80% have experienced traumatic events before, during, and after using drugs, and a majority have also been diagnosed with a mental health disorder. The staff member also reminded us that many participants at OPCs are experiencing homelessness and may not have seen themselves in years, and the mirrors provide an opportunity to do just that. For me, this was a powerful reminder of the things we often take for granted. I also visited the agency's drop-in center, which offers access to laundry, showers, bathrooms, hot meals, syringe exchange, peer support, yoga, aromatherapy, and other complementary services. I was most impressed

by this holistic approach, which was informed by Lincoln Detox, an avant-garde clinic in the South Bronx that was founded by members of the Black Panther Party and Students for a Democratic Society.

Since I made the return trip from New York City to Boston, I have frequently thought about my visit to the OPC. The dedication of the staff was inspiring, and the people I met who utilized the OPC described transformative experiences. I often wonder if accessing an OPC would have saved the lives of my loved ones and patients – and Jeff's client, Jerry. I have also assessed how OPCs might operate within the substance use service ecosystem in Boston and other communities. Findings from OnPoint NYC's recently-published annual report (Gibson et al., 2023) have convinced me that this model is working, and that OPCs in other regions of the US could also enrich the lives of PWUD. In its earliest days, the NYC OPCs had already served 3,000 participants who used the sites over 40,000 times. Among the service users, 79% identified as men, 15% identified as LGBTQIA+, 50% were Hispanic/Latino, 25% were Black Non-Hispanic/Latino, and 20% were White Non-Hispanic/Latino. Approximately one-third of the agency's clients were 'street homeless,' and nearly one-quarter lived in a hotel, shelter, or single-room occupancy unit. Reviewing these statistics, I am reminded about the social determinants of health and the importance of offering comprehensive services to individuals who have been the most disenfranchised. As a treatment provider, I am also encouraged to learn that 20% of the OPC participants were directed to detox, substance use treatment, primary care, housing, or employment. Wrap-around services were provided to 75% of participants, which entailed educating them about harm reduction and health promotion strategies, providing supportive counseling, tending to physical injuries, and addressing other healthcare needs. Not a single person died at the OPC; in fact, staff prevented 600 overdose deaths (McAteer et al., 2024).

Where we need to go

Through our personal and professional experiences, we have come to believe that substance use services need to be shaped by the recommendations of people who use drugs, the practice wisdom of service providers, and research about the efficaciousness of emerging interventions. As social workers, our views about PWUD and our roles in delivering services to address alcohol and other drug problems have shifted greatly over time. In her publication about the past, present, and future of substance use treatment, Lala Straussner (2012), the founding editor of the *Journal of Social Work Practice in the Addictions*, wrote, ' . . . treatment of substance abusing clients reflects the wisdom of its time and has never been static. Just as a variety of mood and mind enhancing substances come and go (most never go, just become less popular), so have treatment approaches. In thinking about my clinical work with substance abusing clients, and my teaching on this topic for the past 25 years, it is clear that it is the constant evolution in the field that has kept me enticed with it (or perhaps "addicted" to it)' (p. 127). A powerful statement from a pioneer in our profession (and yet another example of how the field continues to evolve, as the term 'substance abusing' can be stigmatizing and we no longer use it in our professional practice)! At this point in time, there is great urgency to champion cutting-edge, harm reduction-inspired initiatives. Compelling evidence indicates that overdose prevention centers are viable models of care that have the potential to ameliorate the nation's current public health crisis, reducing the risks associated with substance use and strengthening the wellbeing of our communities.

How, then, can we respond? Social workers are often taught to simultaneously address complex issues at the macro, mezzo, and micro levels, a framework that could steer how we explore and advance OPCs. As federal laws do not support the establishment of OPCs, we have the training to effectively guide national organizations that advocate for drug policy reform. Community-informed, multilevel, mixed methods research conducted by social workers and allied professional will be needed to assess facilitators and barriers of implementing OPCs. Tactically disseminating these findings through a biopsychosocial-spiritual lens may convincingly convey benefits that communities are likely to experience upon establishing holistic harm reduction services. Rosen et al. (2024) conducted interviews in four US jurisdictions where efforts have been made to establish OPCs and found that building rapport with a plurality of stakeholders, utilizing the expertise of frontline respondents to counter resistance, and linking OPC advocacy with affiliated causes can increase support for supervised consumption sites. As community organizers, activists, and services providers, social workers are adept at cultivating relationships and leveraging change. While attending to these mezzo-level issues, social workers can also provide substance use and harm reduction education to colleagues, communities, neighborhoods, and families. One intention of these campaigns should be to reduce stigma about PWUD, a factor that impacts the acceptability of OPCs (Grisamore & DeMatteo, 2024). In regard to education, it is vitally important for schools of social work to provide more training and practicum opportunities that equip students with expertise in harm reduction values and skills. As many municipalities prepare to develop OPCs, social workers would be well-served to form interprofessional collaborations with colleagues at health and human services organizations to review lessons learned from the pre-implementation, implementation, and post-implementation efforts in New York City (Giglio et al., 2023). This will likely entail partnering with local OPC leaders to assess feasibility and operational readiness, shape implementation plans, and design and deliver services at OPCs that are attentive to a range of participant goals, such as continued use, managed use, and abstinence. As this is an emerging model of care in the US, it will be especially important for social workers to evaluate short-term and long-term client-, program-, and community-level outcomes, so that challenges and opportunities for improvement are measured and addressed.

As social workers, we are entrusted with a unique opportunity – and obligation – to boldly contribute to the progression of theories, knowledge, and practices related to substance use and addictions. Recognizing that our approaches to behavioral health services must continue to adapt, the burgeoning movement to launch overdose prevention centers is a once-in-a-lifetime moment to revolutionize how we understand and provide services for PWUD. A comment that Jerry made during an ice cream run is especially relevant at this time. He was angered and humiliated by the many times he had been discharged from substance use, medical, and housing services. With penetrating eyes and a captivating voice, he passionately declared, 'It's dangerous out here on the streets. Do you want me to live or die? Do you even like me? Then you need to do things in a different way. Listen to what I need, and help me! That's your job, isn't it?'

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