

The Whole is Greater Than the Sum of Its Parts: Overdose prevention sites, Barcelona, Baltimore, and the need for a comprehensive approach to the overdose crisis

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Executive Summary

Baltimore is losing more people to drug overdose than ever before. Between 2011 and 2018, there was a 500% increase in the number of people who died of an overdose. This stunning rise has led city and state officials to increase funding and programming for overdose prevention. Unfortunately, recent efforts to curb the epidemic have been disjointed and timid. To adequately address the crisis, the city must radically rethink the way it approaches substance use disorder and adopt a comprehensive approach.

As it moves forward, Baltimore can look to the success of Barcelona, Spain, an excellent example of a public health system that effectively engages, treats, and continuously engages people who use drugs. In the 1990s, Barcelona had some of the worst health outcomes in Western Europe among people who use drugs, including the highest rate of HIV infection related to drug use. Through a significant investment by the city government and other stakeholders, Barcelona created

a robust network of low-barrier services aimed at reaching people who use drugs and engaging them wherever they are in their drug use, in an effort to move people toward better health. Today, Barcelona serves as an international model of an effective public health system for people who use drugs, having greatly reduced rates of overdose and drug use-related HIV infection.

The key attributes of the Barcelona system are:

- Multiple access points into the system through diverse harm-reduction and drug treatment programs, all of which are low-barrier services.
- Geographic accessibility and local ownership of different programs.
- Services for people in all stages of drug use.
- Laws and political systems that allow for innovation and encourage collaboration among diverse stakeholders.

To replicate the success of Barcelona's drug system and decrease overdose deaths, Baltimore must identify the gaps in its own system by asking:

- Are people being engaged by the system at all stages of their drug use? This must include people who are actively using drugs, ready to stop using drugs, and maintaining their recovery.
- What programs exist, what programs need to be improved or expanded, and what programs need to be created?

In order to address any gaps and create a robust and comprehensive system, this report recommends that Baltimore do the following:

1. Greatly expand health and social services for people who use drugs and may continue to use drugs, including syringe exchange, drug checking, drop-in spaces, overdose prevention sites, and Housing First programs.
2. Diversify access points with multiple threshold levels, both in and out of the treatment system. This includes easy access to and long-term retention in high-quality treatment and harm-reduction programs.
3. Decriminalize personal drug use and possession. Any effort to destigmatize drug use and increase access to the public health system is undercut by a system that criminalizes users.
4. Approve and open overdose prevention sites, leaving room for innovation and community control.

Introduction

The debate over overdose prevention sites in the U.S. is trending. As government and mainstream perspectives of drug use are shifting from a personal moral failing, to a public health dilemma and responsibility, spaces where people can smoke or inject drugs under professional supervision are being offered as part of a solution to the many negative side effects of illegal drug use, including the spread of HIV and hepatitis C¹, overdose², injection-related infections³, and safety issues of public injection^{4,5}. Overdose prevention sites have been proposed as part of a solution to problematic drug use in North America, where a catastrophic convergence of higher rates of illegal opioid use and the arrival of fentanyl has spurred one of the deadliest epidemics of the 21st century.⁶

Many analyses of overdose prevention sites have focused on the feasibility and efficacy of legal spaces where people can use drugs, or have described the models (medical, social, etc.) and logistics of how spaces are run. Crucial to an understanding of overdose prevention sites, however, is how they fit into a larger health and social infrastructure for people who use drugs. Overdose prevention sites rarely operate as an isolated or stand-alone service; their efficacy is generally linked to other complementary services and a larger behavioral health infrastructure.⁷ Understanding the larger picture is crucial in valuing the role of overdose prevention sites as one of many access points into the health system for people, wherever they are in their drug use.

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In Western Europe, where widespread heroin use, high rates of HIV, and overdose peaked in the 1980s and '90s⁸, overdose prevention sites have been employed as a practical, cost-effective approach to mitigating the negative effects of illegal drug use. Countries like Switzerland have had overdose prevention sites since the 1980s, and overdose prevention sites are now open in the Netherlands, Norway, Denmark, Germany, and Spain, among others.⁹

Within these countries in Western Europe, cities have often pioneered the creation of small-scale models of effective public health interventions aimed at mitigating the harms of drug use.¹⁰ Barcelona in particular is an example of a city that has embraced overdose prevention sites as an essential service, and—crucially—part of a larger infrastructure for health and social services for people who use drugs. The result has been improved outcomes among people who use drugs in nearly every area: Overdose rates, HIV, and hepatitis C transmission have all dramatically decreased, while engagement of people who use drugs in the health care system has significantly increased.

In the United States, cities have also been at the forefront of the devastation of drug use and the war on drugs, as well as operating as testing grounds for systems-level solutions to the crisis. In Baltimore, this devastation has been felt particularly hard. Overdose rates in Baltimore have been higher than the national average for decades—long after the crack epidemic was considered under control and long before a national opioid epidemic was declared.^{11,12,13,14} In 2018, overdose killed more Baltimoreans than

any other cause of injury-related deaths. If Baltimore were a state, its age-adjusted rates of overdose deaths would surpass all states but West Virginia.¹⁵

Responses to the overdose epidemic in Baltimore have been fragmented and uneven, their urgency rising and falling based on political opportunity and public interest. In 1988, Baltimore Mayor Kurt Schmoke declared to Congress that drugs needed to be decriminalized, saying “the criminalization of narcotics, cocaine, and marijuana has not solved the problem of their use.”¹⁶ Along with Health Commissioner Dr. Peter Beilenson, Mayor Schmoke also introduced Maryland’s first needle exchange program in Baltimore, run by the Baltimore City Health Department. Innovation continued when, in 2006, the Baltimore City Health Department, under the leadership of Dr. Josh Sharfstein, created the Baltimore Buprenorphine Initiative to offer medication for opioid use disorder to the community. With increased access to methadone and buprenorphine, there was a 75% reduction in heroin overdose deaths from 1999-2010.^{17,18} From 2015-2018, however, overdose rates sharply increased, due to increased overall drug use and the growing presence of fentanyl in the drug supply.¹⁹ Health Commissioner Dr. Leana Wen brought new urgency to the opioid epidemic, emphasizing the need for bystander naloxone, and expanded access to buprenorphine, but failed to implement meaningful and systemic changes. On the federal level, the Affordable Care Act allowed Maryland to expand Medicaid

coverage, thus greatly increasing access to medication-assisted treatment (MAT) and shifting public funding for opioid treatment from an inefficient block grant to direct Medicaid reimbursement. Yet, all of these changes have not done enough; drug-related deaths in Baltimore have continued to rise—doubling, and then tripling—reaching an all-time high in 2018 with 888 deaths.²⁰

Since 2015, a small group of activists, public health officials, and community members have been organizing under the BRIDGES Coalition, advocating for overdose prevention sites as part of a solution to the complex web of the city's drug-related ills, including overdose deaths and over-policing of people who use drugs—in particular people of color. Can overdose prevention sites be part of the solution to Baltimore's overdose crisis? The answer is absolutely, but only as part of a larger shift toward a public health system that works to engage people in all stages of their drug use.

This report studies the case of Barcelona to show that overdose prevention sites are both an essential and minor component of a public health system that effectively serves people who use drugs. Barcelona effectively engages all people who use drugs by creating a public health system with multiple access points for people who use drugs so they can be engaged with the system, and have stability within that system despite the instability that comes with an individual's drug use. The report traces the historical origins of Barcelona's drug policy, details the full public health system and how it works, and outlines outcomes over time within the population of people who use drugs. Next, it seeks to make connections between Barcelona and Baltimore, and identifies themes that can be used to improve our own system. Finally, the report ends with recommendations for policymakers, advocates, and public health officials.

Context: History of drug use and drug policy in Barcelona

The capital of the province of Catalonia in northeastern Spain, Barcelona is a large metropolis of 1.6 million people. Its history of drug use is more recent, relative to other Western European countries. In 1975, the death of Francisco Franco marked the end of a 36-year dictatorship and the beginning of a major economic, social, and political transformation of the country. Young people began to experiment with drugs, particularly heroin, and by the 1980s and '90s, drug use was widespread across Spain.²¹ Incidence of drug-related infectious disease increased as well, and in 1984, Spain hit its peak for the highest rate of HIV infection related to injection drug use: 79 cases per 100,000, the highest in Western Europe.^{22,23}



Catalonia map: Where is Catalonia and why has it declared independence from Spain?, Express, 2017.

The Spanish central government in Madrid and the local Catalan government both responded to the AIDS epidemic and the emergence of drug use, but with distinct approaches that would impact policy for decades to come. The first Spanish National Drug Plan in 1985 addressed social and health problems related to drug use with an abstinence-focused approach. It reduced the availability of methadone, which had been permitted two years earlier, thus greatly reducing the number of people on methadone—from 5,000 in 1985 to fewer than 1,000 in 1987²⁴—despite the increasing incidence of HIV diagnoses among people

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who use drugs.²⁵ In contrast, Catalonia's 1985 drug plan focused more on social determinants of health, using a multidisciplinary approach to drug use, which included harm reduction.²⁶ Crucially, in 1987, it created *Centros de Atención y Seguimiento a las Drogodependencias* (CAS), which were outpatient, multidisciplinary drug treatment programs that today form the provincial infrastructure for substance use disorder (SUD) treatment. Over time, Catalonia continued to promote innovative approaches to addressing problematic drug use, embracing evidence-based approaches such as harm reduction and medication-assisted treatment.

Barcelona's harm-reduction programs have been created and impacted by the growth and development of the city itself. The embrace of overdose prevention sites was motivated by a combination of altruism, public health pragmatism, and concern about the city's public image. In 1992, in anticipation of the Olympics, the Barcelona government attempted to move its outdoor drug use scene from the city center, where it would be visible to tourists, into Can Tunis, a low-income neighborhood on the outskirts of the city. Can Tunis functioned as the city's open-air drug market until 2004, when the city shut down the neighborhood because of drugs and crime, and relocated its residents to multiple neighborhoods in Barcelona, in particular El Raval, in the city center, and La Mina, just outside the city borders.

Before Can Tunis was closed and its residents displaced, Barcelona's first overdose prevention site opened there in 2001 as part of the local harm-reduction program, *Programa de Reducción de*

Daños de Can Tunis. The site first operated in a tent with three injection spaces, and then later within a mobile unit with five injection booths.²⁷ As Can Tunis was being shut down in 2004, the city, fearful of public drug use returning to the downtown business and tourist districts, encouraged more overdose prevention sites to open. In 2003, the local Red Cross opened Barcelona's second overdose prevention site in the downtown neighborhood of El Raval, called *Servei d'Atenció i Prevenció Sociosanitària* (known as SAPS). In 2004, two additional overdose prevention sites opened in El Raval and La Mina, the two main areas to where Can Tunis residents had been relocated.

After the opening of the first three overdose prevention sites, the Barcelona Public Health Agency was wary of complaints from neighbors about overdose prevention sites bringing drug use to the neighborhood. In order to diversify the places in the city with overdose prevention sites, the city encouraged the outpatient drug treatment programs, CAS, to open more on-site overdose prevention sites across the city, and from 2007 to 2010, nine additional overdose prevention sites opened, all co-located in the outpatient treatment centers. In 2017, another overdose prevention site opened at Metzineres, a women-focused nongovernmental organization. Metzineres was the first overdose prevention site to be run outside the governmental programs and the first overdose prevention site in the city designed exclusively for women (for more information, see p. 11).

Barcelona Today: Overdose prevention sites and the public health infrastructure for people who use drugs

The key to Barcelona's public health system for those who use drugs is the inclusion of multiple access points for people to be linked to social and health care services, access hygienic spaces to use drugs, receive safer drug use equipment, and get medication for opioid use disorder. These diverse access points create a complementary network whose parts interplay to cover the full spectrum of drug use.

These access points include:

- 15 CAS: integrated, multidisciplinary outpatient substance use treatment programs where treatment for alcohol, tobacco, and other drugs can be easily accessed, without a referral from a primary care provider
- 4 hospital-based detoxification units
- 1 women-only harm-reduction center
- 1 inpatient drug treatment program
- 11 overdose prevention sites
- 13 supportive housing apartments
- 65 pharmacies and 5 primary care centers with syringe service programs
- 11 harm-reduction programs, which provide syringe exchange, naloxone distribution, and drop-in spaces
- 1 methadone mobile unit with multiple stops around the city and a set schedule
- Drug checking through a nongovernmental organization²⁸
- Take-home naloxone

Notably, the majority of these services are easy to access, a quality known as low-threshold or low-barrier services. These can be compared to high-threshold or high-barrier services, which may require an appointment, photo ID, daily check-ins, abstinence from all drugs, and or/following a rigid treatment plan. Some people benefit from the rigidity of a high-threshold program. However, for many, these requirements prevent them from accessing services to get what they need. In Barcelona, services are generally easy to access, with emphasis on engaging people with the most needs.

Theory in Action

There is a theoretical underpinning to the Barcelona model, which is James Prochaska and Carlo DiClemente's transtheoretical model known as "Stages of Change." The Stages of Change model is perhaps the most well-known theory in addiction science and behavior change. It has been used to explain patterns of behavior change from smoking cessation to exercise, and posits that people go through incremental cognitive shifts in readiness before making sustained behavior change.²⁹ The following are the five stages of change, using the example of smoking cessation:

- **Precontemplation:** Engaging in behavior without interest in stopping (smoking a pack of cigarettes a day without interest in stopping)
- **Contemplation:** Continuing behavior, with some considerations of how it may be negatively impacting the person's life (thinking about how smoking is making it harder to exercise and is costing a lot)
- **Preparation:** Logistically or mentally preparing to make the change (signing up for smoking cessation counseling or researching nicotine patches)
- **Action:** Taking concrete action to make a behavior change (engaging in smoking cessation counseling)

- **Maintenance:** Maintaining new behavior, avoiding temptations (continued use of nicotine patches, replacing morning cigarette with a cup of coffee, avoiding accompanying colleagues on cigarette breaks)

The Barcelona Public Health Agency has envisioned a system where multiple harm-reduction and substance use disorder treatment programs engage people at whatever stage of change they are in regarding their drug use.³⁰ Critically, each service is targeted to a particular stage of drug use and offers connections to higher- and lower-threshold services, depending on the person's needs. This enables the system to engage and retain people, despite normal changes (both increases and decreases) in their drug use.

For example, a person may come to a particular CAS to utilize its safer injection room and inject heroin. Over time, this person may inject less, and start to smoke heroin, at which point they may use the safer smoking room more often. After a while, they may start on the methadone program, located in the same building and with overlapping staff. At this point, they may cease all drug use,

with successful maintenance on methadone. But perhaps, a few years later they experience some stress at home and start to inject heroin again and cease visiting the methadone program. They are still able to come to the CAS and utilize the safer injection room and syringe exchange. Therefore, as a person experiences the normal ups and downs of life, and their drug use fluctuates accordingly, they never have to stop going to a CAS, and can maintain all of their connections to other participants and social workers, nurses, doctors, and therapists. This is truly a continuum of care recognizing that change is nonlinear.

Housed within a spectrum of services and settings, overdose prevention sites exist within this larger landscape of Barcelona's comprehensive plan to address drug use. For people who use drugs, overdose prevention sites serve as one of several access points into the system, which is specifically designed to engage and retain people wherever they are in their drug use. While providing a crucial service, overdose prevention sites also serve larger public health goals, such as increasing the dissemination of sterile drug use materials

Barcelona Model: Integrated drug addiction centers (Harm reduction + Treatment)

- Addiction is a chronic and recurrent disease.
- Not all people are at the same stage of change.



Source: Pares, O., G. Barbaglia, C. Vecino, T. Brugal (2018). "Drug resources in Barcelona Treatment and Harm Reduction" [PowerPoint slides].

and changing norms and customs around drug use. For many people, overdose prevention sites are a mere entry point into the system in which they get other services; for others, overdose prevention sites remain the only engagement they ever have with medical professionals.

Political and Legal Framework: Decriminalization and the Creation of Barcelona's Drug Action Plan

One of the reasons that the Barcelona Public Health Agency is able to run innovative and impactful public health programs is because drug possession is decriminalized in Spain (with some exceptions). Therefore, overdose prevention sites can operate without threat of law enforcement interference, and drug checking programs can provide accurate information to their participants without fear of legal ramifications.

Barcelona's Drug Action Plan is created and approved every four years, and involves multiple stakeholders to ensure accountability,

community buy-in, and data-responsive interventions. The plan is first drafted by the Barcelona Public Health Agency and summarizes data and outcomes from the previous four years, making recommendations for the next four years, including specific programs (such as new services to be opened at a CAS) and public education initiatives. Then, city officials and multiple committees review the plan. Committees include representatives from law enforcement, academia, health care, neighborhood associations, community-based organizations, and people who use drugs. After all the committees approve a plan, it then goes to the city council to be approved by consensus by all political parties. These layers of approval have multiple benefits: They decrease the likelihood that the drug plan is politically driven (since its introduction in 1987, no plan has been rejected by a political party) and create buy-in from multiple stakeholders for different initiatives (for example, the opening of overdose prevention sites across the city was approved in the plan and did not require any separate legislative changes).

Figure A. Number of overdose deaths in Barcelona, 1990-2017



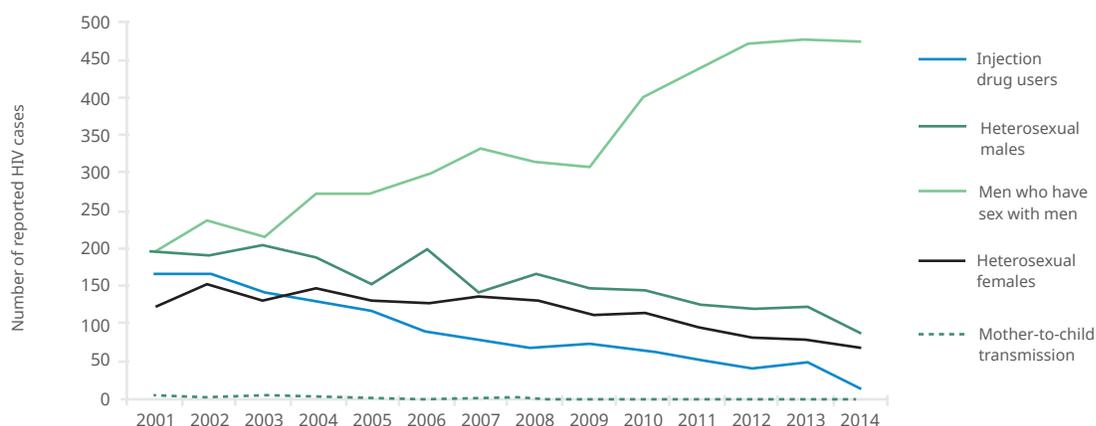
Source: Substance Use Information System, Public Health Agency of Barcelona.

Outcomes

The outcome of Barcelona’s system of care for people who use drugs has been the significant reduction in rates of fatal overdose and newly diagnosed cases of HIV. Since 1992, overdose deaths have decreased by over 60% (Figure A). In the province of Catalonia, from 2008 to 2017, newly diagnosed cases of HIV that were acquired by injection drug use have been reduced by

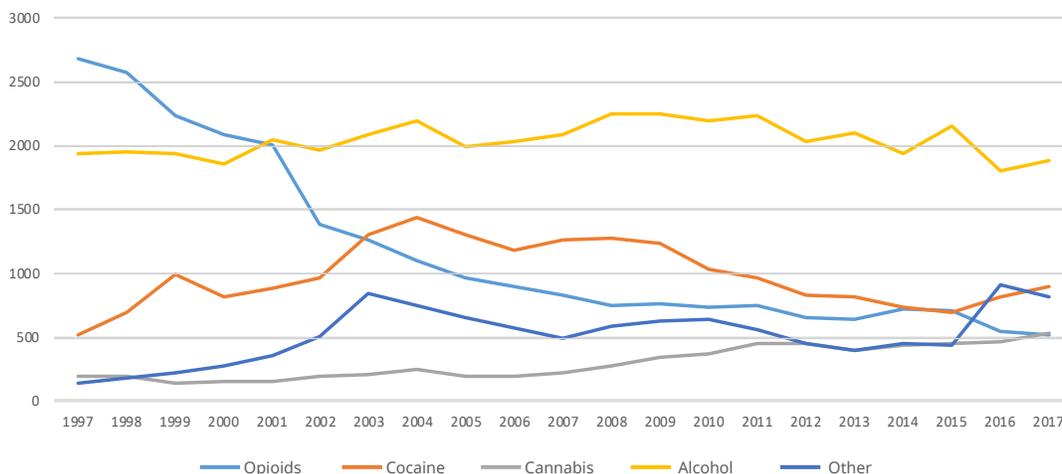
half (mirroring worldwide trends, the rate of infection among men who sleep with men has been increasing, in what has been described as a re-emergent epidemic)³¹ (Figure B). While rates of problematic drug use are not available, a common marker is initiation into treatment. From 1997 to 2017, rates of initiation into treatment for opiates decreased by over 80%, suggesting a major drop in overall problematic opioid use (Figure C).

Figure B. Newly diagnosed cases of HIV, by transmission route in Catalonia, 2001-2014



Source: Public Health Agency of Catalonia. Epidemiological surveillance of HIV infection and AIDS in Catalonia. Dec 31, 2014

Figure C. Trends in treatment initiation, by primary substance treated, 1997-2017



Source: Substance Use Information System, Public Health Agency of Barcelona.

Barcelona and Baltimore: Are the two cities comparable?

Barcelona stands as a successful model of a citywide substance use system that is overseen and funded by the public health agency and managed by a decentralized series of neighborhood-based outpatient SUD treatment programs. Before exploring what Baltimore can learn from Barcelona, it must be asked: Are the two cities comparable? While key policy differences abound—Spain has nationalized health care and a more robust social safety net—there are enough similarities, especially around how governments fund health programs, to make a strong case for comparing the two cities.

First, Barcelona faced—and Baltimore now faces—a major public health crisis related to drug use, exceptional even amid a national epidemic. And while Spain has a national health care system, the SUD treatment system runs outside of the national health care system and, like much SUD funding in Maryland, is overseen by the province and city, which determine budget priorities. The SUD system in Barcelona is also semi-privatized, meaning the local government puts out requests for proposals for nongovernmental

organizations to apply to run a local CAS. This semi-privatized model allows each CAS to be responsive to its neighborhood. For example, CAS in neighborhoods with less drug use focus more on alcohol treatment and smoking cessation. In Baltimore, opioid treatment programs are generally funded through a combination of insurance reimbursements, Maryland Department of Health funding, Baltimore City grants, and private foundations. Harm-reduction programs, such as the Baltimore City Needle Exchange Program, and some community-based recovery programs are funded through state and city funds and private foundations. Recent attention to the opioid epidemic has brought in a flood of federal funding for the state, in the form of grants such as State-Targeted Response and State Opioid Response grants, as well as other state funding. In other words, while funding mechanisms for addressing opioid use are different in each city, in Baltimore, there are ample resources for the city and state to address the gaps in local systems by directly funding programs through mechanisms that are already in place.

Barcelona is a majority white city and does not have the legacy of slavery, Jim Crow, mass incarceration, and myriad forms of

	Barcelona	Baltimore
Population	1,620,809	620,961
Land area (km ²)	101.4	
Life expectancy (years)	83.7	73.6
Rate of unemployment	17.24%	5.5%
Ethnic and racial diversity*	Spanish/Catalan: 82% African: 1% Latin American: 5% Asian: 4% Elsewhere in Europe: 6% Total non-Spanish/non-Catalan: 18%	Black/African American: 63% White: 30% Hispanic or Latino: 5% Asian: 2%

*Like other parts of Spain, the Barcelona Department of Data and Statistics does not distinguish among ethnic origins, only nationalities (citizenship).

CAS Baluard: A medical model overdose prevention site

CAS Baluard is a Barcelona Public Health Agency harm-reduction and outpatient drug treatment program and the city's most utilized overdose prevention site. Funded by the City of Barcelona and the Province of Catalonia—and managed by ABD, a local nongovernmental organization—CAS Baluard operates under a public health model to prevent infectious disease and provide psychosocial support for people who use drugs. Open to all people who smoke or inject drugs, the average participant at CAS Baluard is male, homeless, and between the ages of 36 and 40. The program offers a broad range of services including social services, case management, group and individual therapy, medications for opioid use disorder, psychiatry services, medical care (including wound care, and HIV and hepatitis C testing), a safe injection room, a safe smoking room, computer access, and showers.

CAS Baluard feels like a medical clinic: Surfaces are sterile, with little decoration, and all staff wear short-sleeve white coats or red vests for street outreach. The program's offerings are divided between two floors, which participants can access from the same entrance. The lower floor hosts all harm-reduction services: the safer injection and smoking rooms; a doctor's office; the syringe exchange; and a hangout area with tables and chairs, a small kitchen, showers, and computers for participant use. The upper floor hosts the treatment services, including individual and group therapy and methadone dispensing. Outside, a variety of staff conduct street outreach, engaging with local businesses and people who use drugs, as well as mediating between the community, people who use drugs, and CAS Baluard.

Metzineres: Holistic services for women

Programs for people who use drugs within Barcelona's CAS system tend to provide services to significantly more men than women: From 2013-2016, 73% of people initiating treatment were men. In 2017, women's health advocates—in partnership with XADUD, the network of women who use drugs—sought to address this gap by opening Metzineres, a program aimed specifically at women who use drugs and experience violence.

Metzineres offers a small Housing First program, therapeutic and leisure activities, professional training, case management, medical services, distribution of safer drug use supplies, safer consumption services, showers, laundry, and advocacy opportunities, among other services. Emphasizing a low-threshold approach, harm reduction, and trauma-informed care, Metzineres has created a program that embraces the complexities of women who use drugs and experience violence by offering exceptionally flexible programs, with staff focusing on the individual needs of each woman and adapting programming in accordance with the needs of the community.

The drop-in space, La Vidalegre, is conceptualized as a community space, not as a space for service provision and receipt. Women are encouraged to consider the space their own, to both contribute to the growth and direction of the center, and feel responsible for it. Nearly all activities offered by the center create opportunities for women to build networks and community both among themselves and with other civic organizations in the city. Given its holistic model, the safer drug use services at Metzineres—the safe injection space, the patio for smoking, and the available drug use equipment—are not the objective of the program, any more than the shower or the bathroom. Rather, they serve to accommodate the needs of women who utilize the space. With immediate needs taken care of, women can focus on leisure, rest, and community building.

institutionalized racism that have impacted urban cities and shaped the response to drug use in the U.S. Many drug programs and policies in Barcelona take a practical, public health approach that has only recently been seriously considered in the U.S. since more white people started dying of overdose.³² When drug use was thought of as an issue solely in cities and communities of color, funding for substance use disorder treatment was minimal and most resources went to increased criminalization and other punitive approaches, leading to over-policing and mass incarceration. As a result, the response to drug use in Baltimore has been as damaging as the drugs themselves. Moving forward, the overdose epidemic in Baltimore requires both a public health approach *and* intentional action to unwind the decades of damage caused by the war on drugs.

Recommendations for Baltimore: Identify the gaps

To effectively address Baltimore's overdose crisis, the city must create a holistic system for all people who use drugs. To do this, we must identify the gaps and ask:

- Are people being engaged by the system at all stages of their drug use? This must include people in precontemplation (actively using drugs), action (ready to stop using drugs), and maintenance (maintaining their recovery).
- What programs exist, what programs need to be improved or expanded, and what programs need to be created?

The process of creating a holistic system for people who use drugs does not need to start from zero. When Barcelona started its outpatient drug treatment system, there were several SUD treatment programs already in place. The government identified what programs existed, and where, then identified the gaps in service and worked to fill them.

To address the gaps in Baltimore's behavioral health system, the city must do the following:

1. **Greatly expand health and social services for people who use drugs and *may continue to use drugs*, including syringe exchange, drug checking, drop-in spaces, overdose prevention sites, and Housing First programs.**

By definition, overdose death happens to people who are using drugs. Our system has to allow access for all people, no matter their level of drug use. In fact, if the city is serious about ending overdose death, people who are sicker and at higher risk for overdose should be the priority for engagement.

2. **Diversify access points with multiple threshold levels, both in and out of the treatment system.**

Engagement and retention of people who use drugs should be the top priority for the behavioral health system. Entry to high-quality treatment should be as expansive as possible. Currently, many treatment programs in Baltimore present several barriers for people to enter and stay in treatment in the form of appointment times, strict abstinence requirements, rigid treatment plans not tailored to the individual's needs, and/or burdensome counseling requirements. As a result, our system caters to the highest functioning group—people who can clear these hurdles. Those who have the most need are often left behind. Baltimore and Maryland should do the following: Undergo a survey of people in and out of treatment to understand the barriers to entering and remaining in treatment; review current programmatic policies of government-funded treatment programs to identify the policies that are keeping people out of the system; and review the state and federal guidelines for

SUD treatment to create guidelines that emphasize easy access to and long-term retention in the treatment system. A similar project was undertaken in Missouri. As a result, the Department of Mental Health created guidelines for people to be easily engaged and retained in medication-assisted treatment, within state and federal guidelines.³³

Outside of the SUD treatment system, there must be additional access entry points for current drug users including syringe service programs and drop-in spaces for people who use drugs, Housing First programs, and mental health programs. The diversity of these programs will allow easy access to the system as needed over time, regardless of changes in life circumstances or drug use.

3. Decriminalize all drugs.

The government cannot treat drug use as a public health issue as long as it is being treated as a criminal justice issue. The criminalization of drug use is incompatible with a public health approach and inimical to recovery. Decriminalization, defined as the elimination of criminal penalties for drug possession, is essential. First and foremost, arrest and subsequent involvement with the criminal justice system creates trauma for the individual and significantly impacts the health of people who use drugs. This results in increased risks for homelessness, relapse, and overdose.^{34,35,36} Second, health and treatment outcomes are damaged because cycles of arrest and incarceration greatly disrupt an individual's recovery processes. Third, some of the most effective public health solutions to drug use, such as overdose prevention sites and drug checking, require that people have the ability to transport small amounts of drugs to programs without facing criminal charges. One of the reasons that the Barcelona Public Health Agency is

able to initiate innovative solutions to drug use is because drug possession is decriminalized in Spain (with small exceptions).³⁷

Because most drug laws are enforced at the state and city levels, local actions can be taken to move toward decriminalization or reduce the impact of criminalization even now while the federal law is unchanged. Recent changes are moving in that direction already. For example, the Maryland Good Samaritan Law provides protection for people who call 911 when there is a drug overdose so that there is no fear of arrest of either the caller or the patient. A second example is State's Attorney Marilyn Mosby's use of prosecutorial discretion to stop prosecutions of low-level marijuana cases. Similar steps could be taken for other drug possession cases. Drug decriminalization is increasingly mainstream, and has been endorsed by the United Nations,³⁸ World Health Organization,³⁹ American Public Health Association,⁴⁰ Organization of American States,⁴¹ and the Movement for Black Lives.⁴²

4. Approve overdose prevention sites with room for innovation and community control.

Overdose prevention sites are not an end goal nor are they monolithic. An overdose prevention site must respond to the specific needs of the community it is trying to serve; therefore, the legal authority to create an overdose prevention site must leave room for these programs to be shaped and then evolve as they need to. This is particularly true in thinking about replicating overdose prevention site models in Baltimore, where decades of racist drug policy have traumatized communities of color. Overdose prevention sites must be

created with a specific community in mind and with that community in control, and they must address both current needs and historical trauma.

Conclusions

Barcelona has come a long way since the public health emergency of the 1980s and '90s. Today it stands as a model of a holistic, robust public health system for people who use drugs—one that has increased engagement in medication-assisted treatment, and dramatically decreased rates of problematic drug use, HIV infection, and overdose. Overdose prevention sites in Barcelona are a small but indispensable part of this system that effectively engages, retains, and provides services for people who use drugs.

For people concerned about the overdose epidemic in the United States, there are several takeaways. First, to address the overdose epidemic, health systems must be considered as a whole, and people at all levels of drug use must be engaged. Systems in the United States tend to focus on people in drug treatment or people interested in or “ready for treatment.” The Barcelona system offers connections to higher- and lower-threshold services, depending on the person’s needs. This allows the system to engage and retain people, despite changes in their drug use, from more chaotic use to less—fluctuations that are not only possible, but also truly the norm. Moreover, people in chaotic patterns of drug use are at higher risk of fatal overdose and disease transmission and mental health crises, thus requiring more—not fewer—services. Overdose prevention sites and other harm-reduction programs, such as syringe exchange and take-home naloxone, have proven to be essential parts of these systems given their ability to both engage drug users and improve health outcomes.

It is possible to address this opioid epidemic and to curb the tide of deaths. It has been done in other cities; it can be done in Baltimore. But this will require political will and commitment to a public health system that engages and improves the health of all people who use drugs, at all stages of drug use. Public health experts now see the Barcelona model as a global point of reference for how to reduce overdose deaths while treating drug users humanely. Perhaps one day, Baltimore can be seen in the same light.

About the Author

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**The Whole is Greater Than the Sum of Its Parts:
Overdose prevention sites, Barcelona, Baltimore, and the need
for a comprehensive approach to the overdose crisis**

by Natanya Robinowitz, MSPH

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The Abell Foundation is dedicated to the enhancement of the quality of life in Maryland, with a particular focus on Baltimore. The Foundation places a strong emphasis on opening the doors of opportunity to the disenfranchised, believing that no community can thrive if those who live on the margins of it are not included.

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