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February 4, 2019

Hon. Shane Pendergrass, Chair
Members of the House Health and Government Operations Committee
Room 241
House Office Building
Annapolis, MD 21401

Dear Representative Pendergrass and Members of the Committee:

I appreciate the opportunity to submit information to this Committee, which is considering SB 1035, relating to the Overdose and Infectious Disease Prevention Site Programs, cross-filed with HB 1039.

I am a Senior Fellow at the Cato Institute where I work in the Department of Health Policy Studies and the Center for the Study of Science. My areas of scholarship and public policy research include the opioid overdose problem, the unintended consequences of drug prohibition, and pharmaceutical regulatory reform. I have published numerous articles as well as a recent policy analysis on these subjects.

I attended Brooklyn College of the City University of New York from 1969 to 1973 and received a BA (1969) in biology. I then attended New York Medical College from 1973 to 1976, in an accelerated three-year program, receiving an MD in 1976 at which time I was inducted into Alpha Omega Alpha (the national Medical School Academic Honor Society). Upon completing my residency training I began a solo private practice as a General Surgeon in Phoenix, Arizona. I received my certification by the American Board of Surgery as a specialist in General Surgery in 1982, and shortly thereafter became a Fellow of the American College of Surgeons. In addition to my private community-based practice, I served on the trauma team at the John C. Lincoln Medical Center Trauma Center from 1981 to 1983 and served on the voluntary teaching faculty of the Maricopa County Medical Center General Surgery Residency Program from 1981 to 1985. In 1986 I joined with two other General Surgeons to form Valley Surgical Clinics, Ltd., a group general surgery practice serving multiple hospitals in metropolitan Phoenix. I am currently the senior member of that group practice. My background in public policy scholarship, particularly as it relates to the opioid overdose problem, combined with my total of forty-two years of experience in the treatment of acute and chronic surgical illnesses, including infectious illnesses, qualify me as an expert on the matter in question.

In December 2019 the Cato Institute published my policy analysis entitled, "Harm Reduction: Shifting From a War on Drugs to a War on Drug-Related Deaths." In that paper, I examine the decades of evidence and experience that point to the advantages of Overdose Prevention Sites in reducing drug overdoses, reducing the spread of HIV, hepatitis, and other blood-borne infectious diseases, and promoting an facilitating the treatment and rehabilitation of patients suffering from substance abuse disorder. Variously referred to as Supervised Injection Facilities, Safe Syringe Sites, Safe Consumption Facilities, and Drug Consumption Rooms, Overdose Prevention Sites have been in operation since the 1980s.

While needle exchange programs seek to decrease the spread of infectious diseases, overdose prevention site programs have more ambitious goals.[1] Users are allowed to inject in clean and safe environments, with almost no chance of overdose death, free from harassment as well as the risks of theft and physical or sexual assault. These sites furnish sterile syringes and needles as well as a clean, clinical setting where intravenous drug users can inject illicitly obtained substances. Onsite health care professionals have naloxone available to treat overdoses and can refer patients for medical treatment and rehabilitation. Like needle exchange programs, they also prevent the patient from passing used needles and syringes to others. Approximately 120 overdose prevention sites operate in 66 cities around the world.[2] The first such site began in Rotterdam, Netherlands in the 1970s. In 1986 one began operation in Bern, Switzerland. During the 1990s and early 2000s overdose prevention sites opened in Switzerland, Germany (Berlin, 1994), the Netherlands, Spain, Luxembourg, Norway, Canada, and Australia. Australia opened its first facility in Sydney in 2001, and Canada's first facility, called "Insite," opened in the Downtown Eastside district of Vancouver in 2003.

The evidence is strong that overdose prevention sites reduce the transmission of HIV and hepatitis, prevent overdose deaths, reduce pubic injections, reduce the volume of shared or discarded syringes, and increase the number of drug users entering treatment programs. A 1996 report on "injecting rooms" in Switzerland concluded:

"Injecting rooms have enabled the adoption of less hazardous injecting practices, reduced the number of overdose deaths, minimised the nuisance to the community of injecting in public places and probably reduced HIV transmission. The Centres are well-tolerated in Swiss communities. Some [intravenous drug users] have entered treatment as a result of attending injecting rooms." [3]

The *Canadian Medical Association Journal* reported, "Twelve weeks after Insite opened in September 2003…the average daily number of drug users injecting in public dropped by nearly half while the average daily number of publicly discarded syringes and injection-related litter also fell significantly."[4] In 2010, the British Columbia Center for Excellence in HIV/AIDS summarized the research on the effects of Insite on "the public order and public health." It reported Insite "reduced HIV risk behavior" (e.g., sharing needles), promoted addiction treatment, provided "a safe space away from the dangers of the street-based drug scene," and "reduce[d] the risk of violence against women, particularly violence that occurs before or during the injection process."[5]

A 2011 retrospective analysis of the 25 "Drug Consumption Rooms" (DCRs) then operating in Germany summarized:

- "DCRs make a decisive contribution for survival assistance and risk minimization when consuming illegal drugs.
- "DCRs provide a bridge function towards further medical and psycho-social support with their low-threshold and acceptance-oriented contact opportunities.
- "DCRs make a significant contribution towards the reduction of problems related to the open drug scene in the cities.
- "DCRs significantly contribute to limiting the spread of infectious diseases such as hepatitis and HIV in addition to individual health protection."[6]

A 2011 paper found a dramatic decrease in overdose deaths in communities in Vancouver and Sydney served by these programs, areas with populations that typically are at higher risk of HIV and hepatitis transmission.[7] Another 2011 study found overdoses within the community dropped dramatically after the opening of the Vancouver site.[8] Positive outcomes from the safe injection

site in Sydney, Australia, has led to calls, endorsed by the Australian Medical Association, to expand the program throughout the country.[9] No overdose consumption site has yet to legally open in the US. However, one such site has been operating underground in the US since 2014 according to one popular[10] and one academic[11]article. Because of potential legal issues, the authors declined to identify its location. According to a study in the *American Journal of Preventive Medicine*, the underground site has resulted in the onsite reversal of four overdoses and has seen not deaths and no problems with community acceptance.

A study of an unsanctioned supervised injection facility (SIF) in Vancouver, British Columbia, concluded that the facility is highly cost-effective and reduces the transmission of deadly diseases:

"A conservative estimate indicates that the SIF location that provided assisted injections has a benefit-cost ration of 33:1:1 due to its low operational cost. At the baseline sharing rate, the facility, on an average, reduced 81 HCV [hepatitis C virus] and 30 HIV cases among PWID [people who inject drugs] each year. Such reductions in blood borne infections among PWID resulted in annual savings worth CAN$4.3 million dollars in health care expenditure."[12]

The study did not examine if the presence of staff equipped with naloxone generated any savings attributable to a reduction in emergency overdose calls.

Critics view overdose prevention sites as flouting the law, express discomfort with what they see as government sanctioning of intravenous drug use and other illegal activities, and argue that these sites do little to deter illegal drug use. These concerns are understandable, but the evidence shows overdose prevention sites save lives by reducing overdose deaths and have likely saved lives by reducing the spread of deadly diseases and violence against drug users.

In summary, it is my strong opinion that the overall health and well-being of the people of Maryland would benefit significantly if overdose prevention sites were to be implemented. They would see a reduction in drug overdoses related to intravenous drug use, a reduction in the risk of the spread of hepatitis, HIV, and other blood-borne infectious diseases, and would also likely see a savings to health-related expenditures funded by the taxpayers of the state.

Respectfully submitted,

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[2] http://www.drugpolicy.org/issues/supervised-consumption-services
[3] Kate Dolan and Alex Woodak, "Final Report on Injecting Rooms in Switzerland," BurgerForeningen, April 4, 2013, http://brugerforeningen.dk/2013/04/final-report-on-injecting-rooms-in-switzerland/?lang=en
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[11] Alex H. Kral and Peter J. Davidson, "Addressing the Nation's Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the U.S.," *American Journal of Preventive Medicine* 53, no. 6 (December 2017): 919–22, https://doi.org/10.1016/j.amepre.2017.06.010
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