April 4, 2024

Senate Health & Welfare Testimony Comments

Thank you for providing me with the opportunity to offer testimony on OPCs today.

One thing we have learned from years of working to address the complex challenge of preventing overdoses and deaths is there is no one-size-fits-all solution. It's crucial to consider all evidence-based options that are proven effective. Public health practice indicates the most effective way to address a health concern, including overdoses, is to ensure a comprehensive set of strategies to meet the needs of those most impacted by the health concern. The nuances of if, where and how to introduce opioid prevention centers are important. And whether they are appropriate for a rural state like VT and would work here is the million-dollar question. As a thoughtful clinician and PH leader I have struggled with this. My position is framed by a review and critical appraisal of the literature. And that position is that while I acknowledge OPCs can have many potential benefits and be part of a multipronged approach to the opioid epidemic, they ultimately may not represent the best option for a state such as Vermont at this time.

I will spend the rest of my time exploring with you how I arrived at this conclusion and the challenges and data I took under consideration. It is not my intent here today to repeat all that you have heard from researchers about the evidence base. But I will note there is a difference between internal validity of studies = are the results valid for the population studied, and generalizability (also called external validity) = are they accurate for other populations, like Vermont.

I respect the opinion of the OSAC, of which I am the nonvoting chair. These are smart and compassionate people. I recognize OPCs can be considered to be part of a continuum of HR services, part of a multipronged approach to reducing opioid OD deaths. Helping people stay alive so they can get the treatment and supports they need for recovery is our highest priority.

The major reason cited for support of OPCs is Vermont’s current opioid overdose death rate. The ultimate test of OPCs is do they save lives? We know

that deaths within a facility are rare, and there seem to be improvements in fatalities in the immediate neighborhood, although Dr. Marshall et al's study, the only study of at least moderate quality to demonstrate this, is over a decade old and prior to the fentanyl crisis. However, we should be concerned that there is no evidence that accessing a site lowers an individual's risk of fatal OD over time or that sites lower larger community or regional OD rates. Studies report no consistent impact on community fatality rates, as the studies cannot control for the lethality of the drug supply and the combinations of drugs being used by clients. I continue to be very troubled by the vast experience of Vancouver and BC, where OD numbers continue to climb, where the OD death rate is 44/100,000 (c/w VT 37/100,000) despite 44 OPCs, and where the strategy is now Safer Supply (such as prescription heroin). And, for Vancouver Coastal Health Authority where Downtown Eastside is located (where InSite, two other SCSs and 9 OPCS are):

Opioid overdose deaths per 100,000:

2020 - 39.7

2021 - 50.8

2022 - 52.2

2023 - 55.9

Overall, in BC there were 2511 suspected unregulated drug deaths in 2023, the highest number ever recorded in a year, and 5% higher than 2022. However, we know there are other potentially favorable outcomes, which I acknowledge:

Similar to the experience with syringe service programs, frequent OPC users have safer injection practices (less syringe sharing) and shorter duration hospitalizations for injection-related infections.

There is increasing evidence (most recently from OnSite in NYC) that government-sanctioned OPCs are not associated with worsening crime or disorder outcomes or increased community drug use or use in public spaces and may be associated with decreases in injection-related litter.

OPCs can increase access to healthcare and provide another potential pathway to treatment, as they serve as a “trusted community” that leads to improved overall well-being. There are more qualitative outcomes that are difficult to measure that have also been proposed, such as humanizing people through providing essential services and improving sense of self-worth.

What is somewhat challenging to reconcile here are some significant potential limitations that may impact the effectiveness of these sites at this time in Vermont:

- In the fentanyl era, use is frequent and occurs around the clock, challenging the success of OPCs, which are generally not open 24 hours, especially in saving lives.
- One cannot reasonably site sufficient OPCs to meet demand outside of high use neighborhoods, or in rural areas. And we do not have an accurate representation of demand.
- While sleep and personal hygiene can be favorable outcomes from daytime use of these facilities, OPCs are generally not open 24 hours, they are not meant to reduce homelessness, and homelessness will remain problematic in the surrounding neighborhood.
- The services provided by the facilities are resource intensive and necessarily limited: both geographically and temporally, meaning most Vermonters with an OUD will not have access to the benefits these facilities may provide.

While not a panacea, OPCs play a useful role in a continuum of services for people who use drugs. Or as I have also been saying, they cannot and will not reduce the overall burden of tragedy, but they are an evidence-based prong in a multipronged approach to harm reduction. Expectations must be managed carefully as they are often unrealistic.

Finally, with regard to studies in more rural areas (mainly Canada) of mobile OPCs: if saving lives is indeed the metric of greatest concern that might potentially differentiate OPCs from other harm reduction strategies currently

in use, it is not clear how an occasional visit from a van can produce desired outcomes in a condition that requires frequent use, as well as maintain continuity and quality of services.

There is limited research about overdose prevention centers in rural settings. A recent analysis (Panagiotoglou, 2022) analyzed the population-level effects of Overdose Prevention Sites (OPS) and SCSs at the local health area (LHA) level in British Columbia from 2015-2017, with OPS and SCSs implemented in 2016 (one year pre- and post- implementation). These LHAs were defined as covering geographically dispersed clients; some of the LHAs had populations that were smaller than Vermont cities (in the teen to low twenty thousands) and were considered rural or remote. The results were, "Significant declines in reported overdose events, paramedic attendance, and emergency department visits were observed. However, there were no changes to trends in monthly hospitalization or mortality rates."

In a rural state like Vermont, we have seen how many barriers there can be to accessing services. Barriers can include (but are not limited to) hours of operation, transportation, comfort and levels of trust, safety concerns of the community, expectation of privacy and safety, and the ability to recruit and retain staff. Availability of workforce in the substance use system of care is currently a significant issue in Vermont and has impacted the viability of programs and the accessibility of services.

The committee should not lose track of the fact that syringe service programs are effective community-based programs that can also prevent infectious diseases, link clients to treatment for substance use disorders, and can reduce overdose deaths among people who use drugs. Mobile SSPs do exist and work in VT and expanding their scope makes sense.

Ultimately, I question the appropriateness of OPCs for VT. OPCs may work best for communities where people who need these centers can access them easily and quickly – typically these tend to be larger population areas, neighborhoods where injection drug use is more prevalent, similar to how NYC sited its two OPCs. They almost always serve an area of blocks rather than miles. People should never drive to the sites. It is challenging to site sufficient OPCs to meet demand outside of high use neighborhoods or in rural

areas. Siting OPCs in more rural areas may result in people driving to them, and then driving home while impaired. With the requisite density of potential clients, two other ingredients are essential: community support and political municipal leadership support, along with planning around related issues such as medical care, managing syringe waste, ensuring people are safe when they leave a facility, and the development of the appropriate regulations and guidelines. We are already seeing some of these conflicts play out in communities like Brattleboro. The OSAC has not seen communities lining up with expressed interest, other than our largest city, Burlington. Cost effectiveness in rural areas is unknown.

Another challenge is transportation. VT doesn't have the population density of people who use drugs and sufficient public transportation to facilitate people consistently using the sites. That gives people who don't live within walking distance the option of lingering near or in the site, having a designated driver, driving after use (completely unacceptable), setting up shuttles to transport people (apparently RI is planning to do this) or not using the OPC. If people attend a site and then drive, who has liability?

Finally, equity in a rural state is critical when rolling out any new and resource-intensive harm reduction strategy. While Burlington might enjoy the triad of a high density neighborhood, community support, and municipal leadership support required for success, it is obviously much smaller than the other international locations as well as New York City; Providence, RI, the location of the next US site, is over 4 times as populous. This suggests there will be challenges siting further OPCs in Vermont municipalities or rural areas, accepting the thesis that mobile capacity is unlikely to be frequent enough to save lives in a condition requiring dosing multiple times per day. Keep in mind our highest overdose death rates are in rural counties. Health equity is a consideration in virtually every public health decision made in Vermont, and OPCs should not be an exception.

Other data that should be acknowledged includes:

1) Although we need to wait until late April for the most comprehensive numbers, opioid overdose deaths for 2023 do not appear to be significantly different from 2022. There may well be a plateauing of

deaths and a departure from the significant increases of the previous two years, which may indicate a maturation of prior and recently added harm reduction strategies. Additionally, overdose events have been consistently below the prior years for almost one year now. I do not state this to minimize the ongoing crisis, but to point out that over the 2-3 years interval between now and the opening of an OPC in VT new trends may occur and we may see current evidence-based harm reduction strategies come to fruition.

2) The overdose crisis is evolving in new ways: in British Columbia the most common route of opioid administration in OD deaths is now smoking fentanyl. A recent CDC report shows that in 2020-2022 the percentage of OD deaths with smoking increased 73.7% and the percentage with evidence of injection decreased 29.1% across the entire country. Changes were most pronounced in deaths with IMFs detected, with or without stimulant detection.

   In Vermont, our experience is similar. In 2019, the most common methods of use were intravenous (51%), snorting (24%), ingestion (22%), and smoking (15%). In 2020, the most common methods of use were intravenous (41%), smoking (19%), and snorting (17%). In 2021, the most common methods of use were intravenous (37%), smoking (29%), and snorting (20%).

   Such considerations add new concerns – allowing inhalation in an OPC but still maintaining the safety of the workforce in such an environment. Dedicated rooms to allow for smoking may change the design and expense and other logistical considerations in planning.

3) Since over 40% of people who die of an overdose are alone when they die, and a high percent die at home, use of monies to address drug checking machines, or promoting new technologies or programs such as https://neverusealone.com/ might represent a compelling alternative strategy. A thoughtful assessment of how to use finite resources is imperative. We know that directing funding to the

operation of OPCs means there will be fewer resources spent on other Vermont SUD programs with demonstrably successful track records.

Should the legislature opt for OPCs, VDH has additional concerns:

a) The amount of money for research is inadequate. The NYC and RI research team (NYU Langone and Brown) is being funded by NIH at $1.4M/year over 4 years (as opposed to $300,000 total in H.72). If we have a contract in place on12/1/24 as proposed, it may be years before the sites are open can be evaluated resulting in an extended period of baseline data collection and decreasing the time available after implementation. We recommend the contract start date not be included in the bill to reflect the variability of start date of the OPCs (or it should at least be delayed to the same date as the completion of the guidelines, April 1, 2025). The sites will have to apply and VDH has to approve within 45 days. The funding should be increased significantly to approximately $300,000 per year if an actionable research-based evaluation is what is desired.
b) The administration is against using the education and research fund rate increase.
c) The literature is clear that stakeholder involvement in planning is critical to ensure greater uptake and should be incorporated. There are many individual preferences, and planning must include information from the community to understand where an overdose prevention center could be located, what services might be offered, and what partnerships are needed in the community for the center to be successful. Also consider what other harm reduction strategies might be prioritized to optimize the use of limited resources – such as increasing methadone access, transportation remedies for hub access, improving transitions of care after incarceration. And is sacrificing primary prevention activities a wise precedent to set for use of opioid settlement monies?

Thank you for allowing me to acknowledge the potential benefits of OPCs and their place in a multipronged approach to harm reduction and point out the concerns I have with their impact on what should be the most critical indicator of success (mortality). And finally, to discuss all the factors that have led me to conclude these may not provide sufficient benefits for all Vermonters with OUD at this time, including poor generalizability of existing studies to rural states, issues of access to sites that are traditionally neighborhood-based, transportation, and health equity. I suggest you factor into your decision-making the evolving overdose data in Vermont and the data surrounding routes of ingestion of opioids and the large percentage of Vermont overdose deaths occurring alone and in homes. I am happy to take any questions you might have.