

Testimony on H.72

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This bill proposes to eliminate criminal and civil penalties for operation of a safer drug consumption program; repeal the crack statute; repeal the sunset of the decriminalization of small amount of buprenorphine; establish the Drug Use Standards Advisory Board within the Vermont Sentencing Commission for determining benchmarks for personal use dosage and personal use supply for regulated drugs; and require the Sentencing Commission to use benchmark recommendations from the Drug Use Standards Advisory Board to make recommendations regarding adjustments in the amounts for possession, dispensing, and sale of regulated drugs.

Section 1 = Immunity from liability for participation in or with a safer drug consumption program (also known as SCS, OPS, SIF):

These sites are designed to be spaces where people can use pre-obtained drugs, with sterile supplies and safe disposal, and there are staff available to provide interventions should there be an overdose or other adverse drug reaction. In some parts of the world these sites can also incorporate low barrier housing, primary or mental health care, and connection to other services. They certainly can provide a trusted community resource for an individual with SUD.

Without providing an exhaustive review, I can state that there is an increasing literature, still predominantly from Vancouver and Sydney, striving to provide an evidence base for the benefits of SCS. The only US experience is from NYC, where 2 sites opened a little over a year ago – we are eagerly awaiting peer-reviewed literature from their academic partner, NYU. Here is what is known:

- A) There are variable reports of improvements in fatalities in the immediate neighborhood of an SCS. However, studies report no consistent impact on community fatality rates, especially because the studies can't control for the lethality of the drug supply and the combinations of drugs being used by clients.
- B) A recent report by the British Columbia Coroners Service stated: 2022 was the deadliest year on record = 2314 deaths, and in the first 3 months of 2023 nearly 600 lives lost. BC currently has 44 SCS. Where are their deaths occurring? Like in VT, 47% were in private residences; 36% were in supportive housing or shelters; 15% outdoors; and the first time I've ever seen this, 2 deaths were in SCS. The coroner advocated, as did several review panels, for a safe regulated supply of substances in concert with access to life saving treatment options. I say this not to diminish the potential impact of SCS, but to note that multipronged approaches to preventing OD deaths must be implemented, a continuum of harm reduction services. It is not fair to uphold one as the missing link, "If we had only had or done..."

- C) Stakeholder involvement in the planning process is critical to ensure greater uptake, as there are many individual preferences, and with so many factors to take into account it does not seem possible to create a single location that would accommodate all the varying preferences (location, layout, proximity to other services, times of operations, integrated vs. standalone, clinical vs. informal, additional services offered).
- D) Studies investigating crime show neither drug-related incidents nor interpersonal crime increased in the area of SCS, and may have decreased post-opening, along with public drug use.
- E) Studies in rural BC show reduced paramedic and ED use but no changes to trends in monthly hospitalization or mortality rates. Studies of mobile SCS are emerging showing them to be a viable alternative to a permanent site but with many challenges that undermined the continuity and quality of service. These require a needs assessment to guide operations.
- F) There is evolving evidence that SCS can lead to increased access to treatment. There is clear evidence that risky injection behaviors are reduced, much like with SSPs, though not conclusive evidence showing reduced viral infections.
- G) Bottom line for me: Harm reduction takes a multipronged approach, much like the suite of recommendations the Opioid Settlement Advisory Committee just made to the Appropriations Committees. I have concerns about the way the outcomes of the studies in the literature are being portrayed.
- H) But beyond validity, I am concerned about generalizability to Vermont: scaling to viable size, practical considerations about numbers of injections per day (often 3-5) and needing to “live” in an SCS to be safe, the viability of a lifestyle requiring planning of SCS use in a way that does not take into account the complexity of living with an OUD, and the whole issue of geographic equity in a state with some of the highest OD death rates in rural areas. Along with workforce concerns, facility siting concerns, and ease of rapid implementation, knowing what has transpired (or failed to transpire) on the national level.
- I) Should the decision be made that these are right for VT now, I do agree that following in Rhode Island’s path and legislating immunity from liability, is an important first step. Ideally this would occur after the OSAC takes comprehensive testimony on the topic in coming months. Also, ideally, Vermont would not enter the SCS arena without an academic partner to impartially examine outcomes and other research goals.

Section 3 = Repeal of the sunset of decriminalization of a small quantity of buprenorphine: Having reviewed the findings of the colleagues from John Hopkins in the analysis commissioned by the Buprenorphine Task Force, of which I am a member – I have no objections to this. The study demonstrated that while no major benefits were realized (especially in OD deaths), and that neither prescribers nor users of the drug were especially aware of the legislation, no harm was done either, and the potential for benefit remains.