April 10, 2023

The Honorable Joseph Baldacci
Chair
Joint Committee on Health and Human services
Cross Building, Room 209
100 State House Station
Augusta, ME 04333

The Honorable Michele Meyer
Chair
Joint Committee on Health and Human Services
Cross Building, Room 209
100 State House Station
Augusta, ME 0433

Re: NNESAM's Support for LD 1159, An Act to Establish a Pilot Project Regarding Harm Reduction Health Centers

Dear Chair Baldacci, Representative Meyer , and honorable members of the Health and Human Services Committee,

My name is Kinna Thakarar, and I am here to **support LD 1159**. I am an infectious disease physician and addiction medicine physician researcher, and I am writing on behalf of the Northern New England Society of Addiction Medicine (NNESAM). I also serve on several national task forces for infectious diseases and addiction professional societies, including the Infectious Disease Society of America's (ISDA) national task force for substance use. I've presented nationally and internationally on harm reduction and have led research studies on substance use-associated infections here in Maine. Currently, I am the principal investigator of a $1.2 million federally funded harm reduction grant based here in Maine that focuses on collaborations with local syringe service programs and linkage to health services.

Not only can people who inject drugs experience fatal or non-fatal overdoses, but they face complications from injection drug use such as HIV, viral hepatitis, skin and soft tissue infections, as well as endocarditis, a serious heart infection that can be fatal. **These infections are also costly**; in a recent study here in Maine, the cost of treating substance use-related endocarditis was $150,000 per patient, and last year, we saw over 120 patients with these types of serious infections at the hospital where I work[1]. In 2020, Maine unfortunately had **the highest rate** of acute hepatitis C in the U.S., and the **second highest rate** of acute hepatitis B [2] [3], both of which can be very costly infections. These infections are also preventable.

It is a recommendation of NNESAM, IDSA [4], and many other professional societies, that we expand access to harm reduction centers, which can prevent overdoses, infections, and other adverse outcomes. I have had the opportunity to visit a harm reduction health center in Canada and have seen firsthand the incredible work the staff at these centers do to save lives. In this testimony, I provide the evidence for harm reduction health centers.

What are harm reduction health centers? They are programs that provide supervised and safe places for people to inject drugs, access to overdose prevention, health and disease prevention (such as sexually transmitted disease screening), and linkage to treatment. A primary goal is to **connect people to care and recovery services.**

What is the evidence for harm reduction health centers? Harm reduction health centers have been rigorously evaluated by scientific research teams across the world, including Canada, Australia, and Western Europe. Evaluations to date have revealed that harm reduction health centers:

- **Prevent overdose deaths**. A Canadian study found that community overdose mortality decreased by 35% after a harm reduction health center opened in Vancouver [5].

- **Increase use of addiction treatment programs**. Use of a harm reduction health center has been found to increase uptake of addiction treatment services , for example in one Canadian study, 57% of clients entered methadone treatment [6].

- **Reduce sexual and drug-related risk behaviors** that lead to HIV and HCV transmission [7] [8].

• **Reduce public disorder** associated with public drug use. One study found that the opening of the harm reduction health center in Vancouver was associated with significant reductions in public injection drug use, publicly discarded syringes, and injection-related litter [8] [9].

• **Are cost-effective** and **reduce burden on emergency medical services**. A recent report by the Institute for Clinical and Economic Review found that even one center in Boston could save the city over $4 million annually, primarily in averted EMS runs, ED visits, and hospitalizations [10].

Studies on harm reduction health centers have found **no** adverse changes in community drug use patterns, **no increases** in initiation into injection drug use among youth, and **no** increases in drug related crime. In fact some studies have showed reduced crime rates [11].

In July 2021, Rhode Island became the first state in the nation to authorize a two-year pilot program to establish a harm reduction health center. In December 2021, New York City opened the nation's first-ever harm reduction health center in Harlem and Washington Heights. In just two months, they saw hundreds of clients who had several thousand encounters, **no fatal overdose deaths**, and have been successful in linking people to care [12]. Within a month of opening, the syringes count in park near one of the harm reduction health centers dropped from 13,000 to 1,000 [13]. New York City has demonstrated that the operation of harm reduction health centers in the United States is possible.

With adequate support, I strongly believe we can implement a pilot harm reduction health center here in Maine. Our current harm reduction grant has shown that when trust is built between patients, community partners, and clinicians, people can be successfully linked to care. I understand that some people may have concerns about the bill, however, I and NNESAM, the organization I am representing today would be more than willing to have those discussions together to come up with a workable solution that can help the patients that need our help. Our grant team is also well-poised to conduct an evaluation of such a harm reduction health center and help to ensure that the evaluation is comprehensive, rigorous, and held to the highest possible scientific standards.

I also want to emphasize that there is **not one solution** to a problem as complex as the overdose crisis and infectious complications of drug use, but it is **imperative that we utilize as many tools as possible** in addressing this crisis. LD 1159 is an important step in expanding the tools in our toolbox here in Maine.

I'm available if any of you have any questions after this meeting. Thank you for all the work that you do.

Respectfully,

Kinna Thakarar, DO MPH
Contact email: kinnath@gmail.com

References

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