My name is Dr. David Kispert. I am a board-certified internal medicine and addiction medicine specialist practicing as medical director at two Portland-based opioid treatment programs. I speak in support of the passage of LD 1159 – An Act to Establish a Pilot Project Regarding Harm Reduction Health Centers.

Harm reduction health centers are over-seen by healthcare personnel who provide sterile injections supplies, counseling on safe injection techniques, emergency care in the event of an overdose, and referrals to appropriate social and addiction services. The personnel in the facilities are able to offer services to people who would otherwise inject drugs in public spaces. There has never been a fatal overdose in a harm reduction health center.

Currently lack of public support has prevented harm reduction health centers from operation on a more global scale. A 2019 study described several concerns shared by much of the general public that prevented support of the initiative. I would like to dispel each one individually.

They should be illegal because funding should be spent instead on opioid use treatment and recovery.

I have been practicing in multiple addiction treatment settings in New England since 2019. I've responded to overdoses in the clinic parking lot and found patients injecting drugs in treatment center bathrooms. No matter how many treatment centers open, individuals early in recovery will frequently continue to use. Harm reduction health centers will be utilized by both treatment and non-treatment seeking individuals.

They should be illegal because they would lead to more illegal activities in the neighborhoods where they are located.

A study in Vancouver observed an abrupt, persistent decrease in crime after the opening of a harm reduction center. 90% of people using the site reported that they would otherwise be injecting in a public restroom, street, park, or parking lot.

They should be illegal because use of heroin and other opioids is illegal.

States have clear legal authority to authorize harm reduction centers, just as they can legalize the cultivation, distribution, and possession of marijuana. The federal Controlled Substances Act prohibits drug possession, but federal law enforcement rarely, if ever, target simple possession by individuals. Additionally, the Crack House Statute was created in response to a crack epidemic and is unlikely to apply to a legally authorized public health intervention.

They should be illegal because they allow people to continue using opioids.

Suffering from a chronic disease, individuals with an addiction to opioids will continue to use drugs in an effort to stave off the devastating opioid withdrawal syndrome rather than simply get high. Harm reduction health centers allow individuals to do this in the safest manner possible.

They should be illegal because they would increase illegal drug use by making it easier for people to use opioids.

In a study of over 1000 participants at harm reduction health centers, the median number of years of injection drug use was 15.9. This suggests that addictions to opioid and other illicit drugs develop well before any entry into the doors to a harm reduction health center.

Additionally, a cost-benefit analysis of a hypothetical site predicted that it would generate $7.8 million in savings at an annual cost of $1.8 million.

Harm reduction health centers are currently implemented in over 100 centers in over 60 cities across 11 countries – and growing. New York City and Rhode Island are the only places in the United States that offer this innovative and proven public health intervention. Passage of this bill will cement Maine as a leader in the opioid epidemic fight. More importantly it can represent a strong response to the devastating fact that 716 Maine residents died from overdose in 2022.

Finke J, Chan J. The Case for Supervised Injection Sites in the United States. Am Fam Physician. 2022;105(5):454-455.

Barry CL et. Al. Arguments supporting and opposing legalization of safe consumption sites in the US. Int J Drug Policy 2019 Jan;63:18-22.

The Case for Supervised Consumptions Services. amfAR. Issue Brief June 2017.