Stephanie Nichols, PharmD, MPH, BCPP, FCCP, FAAPP
Saco, Maine 04072

March 11, 2025

Dear Chairs and members of the Committee on Health and Human Services,

My name is Stephanie Nichols and I have been a licensed Maine pharmacist for 18 years (License # PR5426) and a Board Certified Psychiatric Pharmacist for 11 years (credential #4133013). I sub-specialize in addiction medicine and am frequently invited to speak at national conferences on addiction medicine topics. I practice in the Portland area. I am providing written testimony today as a private citizen and respectfully ask you to **oppose LD219**: An Act to Limit Hypodermic Apparatus Exchange Programs to a One-for-one Exchange.

Maine had the highest rate of hepatitis C infections in the entire country in 2022[1]. Reducing the syringe exchange ratio to 1:1 in Maine will restrict access to unused syringes for people who inject drugs and increase risk of infection transmission from HIV and hepatitis C. Transmission of these diseases is extremely costly. Lifetime cost for medical care for HIV is about $300,000 – $600,000 per person and for hepatitis C is about $65,00 per person.[2,3] Median hospital charges for each endocarditis infection are about $200,000 per person.[4] A second endocarditis infection occurs in 32% of people who inject drugs and additional infections reoccur in 12%. Thus, for 1 in 3 people the $200,000 cost will be doubled, and for 1 in 8 people the cost will be at least tripled.[5] The cost of a needs-based syringe distribution pales in comparison to the cost of treating preventable viral, bacterial, and fungal infections.

People who use the syringe services program receive unmatched services well beyond provision of sterile syringes. While up to 10 syringes at a time can be purchased in Maine pharmacies by law, people who inject drugs often lack funding to buy these unused syringes. Further, pharmacists are permitted by law to elect not to sell syringes to a person which can further restrict access. Finally, even when funds are available to purchase syringes at a pharmacy, this leaves the person with significantly fewer resources and services than they would receive at a syringe service program, including other injection supplies that may otherwise be shared when not readily available, harm reduction education, comprehensive prevention services, and wound care.

One might argue that a person who injects drugs should simply stop injecting. That is akin to saying a person in an asthma exacerbation should stop trying so hard to breath. There is a disease process at play with substance use disorders and that causes profound brain changes resulting in a state of extremely low dopamine. People who inject drugs often inject to restore normal dopamine levels, in order to feel and function normally.

Consider this, if you hold your breath for 1 min, could you function normally as we get close to the minute mark or would your brain be pretty focused on getting that next “hit” (if you will) of oxygen? Similarly, people who inject drugs and who have low dopamine can only focus on

increasing dopamine in that moment; it is a medical problem. Consider now, if you were holding your breath in a fire and knew that releasing it would cause you to inhale harmful smoke. At some point your drive to breathe would outweigh your knowledge of the danger of breathing in smoke. The same happens here with very low dopamine and a primal brain drive to bring dopamine up via injection, which overrides the logic that sharing needles is harmful when unused syringe access is restricted.

According to the US CDC, an important way to prevent HIV and hepatitis C transmission via injection is by implementing a **needs-based distribution model** of unused syringes and other injection supplies for people who inject drugs, rather than a one-for-one exchange.

**I strongly urge you to vote "ought not to pass" on LD219**: An Act to Limit Hypodermic Apparatus Exchange Programs to a One-for-one Exchange.

Thank you,
Stephanie Nichols, PharmD, MPH, BCPP, FCCP, FAAPP

**Footnotes and references:**

[1] According to the most recent available state-by-state data published by the CDC: https://www.cdc.gov/hepatitis-surveillance-2022/hepatitis-a/figure-1-3.html#toc

[2]https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/antiretroviral-therapy-cost-considerations#:~:text=However%2C%20HIV%20treatment%20with%20ART,the%20costs%20attributable%20to%20ART.

[3]https://pmc.ncbi.nlm.nih.gov/articles/PMC3763475/

[4]Bhandari R, Abdulhay N, Wiener RC, Smith D, Fisher M. The rising cost of infective endocarditis in West Virginia. *Epidemiol Infect*. 2024;153:e9. Published 2024 Dec 26. doi:10.1017/S0950268824001869

[5]https://pmc.ncbi.nlm.nih.gov/articles/PMC6796994/

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LD 219

Please see my testimony attached which represents my personal views as a private citizen.