Testimony of Whitney A. Parrish Perry
Augusta, ME
LD 219, An Act to Limit Hypodermic Apparatus Exchange Programs to a One-for-one Exchange

Dear Senator Ingwersen, Representative Meyer, and Members of the Joint Standing Committee on Health and Human Services:

My name is Whitney Parrish Perry, and I am a lifelong resident of Maine–born and currently living in Augusta. I am writing to express strong opposition to **LD 219**, ***"An Act to Limit Hypodermic Apparatus Exchange Programs to a One-for-one Exchange."***

I am writing to you as a deeply concerned resident, as well as someone considered by some as having "subject matter expertise" on this important topic. While I am the past employee of two Maine-based syringe service programs and provide technical assistance for two Maine-based overdose prevention projects, I do not represent these entities or my current employer(s) in this testimony.

Today you will hear from extremely capable providers and public health leaders discussing the benefits of needs-based harm reduction services, as well as the critical health and fiscal importance of disease prevention and access to services. Instead of focusing on those areas, I will highlight below the impacts of syringe distribution restrictions on the prevalence of improperly discarded syringes. It is my understanding that this issue is the driving force behind this legislation.

**Lack of Housing Increases Prevalence of Improperly Discarded Syringes**

Improperly discarded syringes are closely linked to housing instability. If I have a place to live, I have a place to privately do my business and throw away my trash. One can compare this to drinking alcohol. If I have a place where I can drink alcohol, like my home, I have the opportunity to safely consume that product and appropriately discard the trash. However, **if I do not have a place to go or stay, I may drink it outside and throw the bottle on the ground**. People experiencing homelessness often lack safe, private places to store and dispose of used syringes, or any of their waste or trash.

People with diabetes use the exact same medical devices, but they are given resources to discard them (biohazard waste boxes, instructions on how to safely discard in the trash, etc.). So, what is the difference? **We moralize certain drugs and the people who use them and that moralization does extend to insulin or people with diabetes**. One could infer that a homeless diabetic person who requires insulin injections may have to make similarly impossible choices about what to do with their used medical equipment, especially if they cannot focus on their health or health care. **Safe and affordable housing should be attainable, and adequate disposal options should be available to everyone**.

When individuals are forced to live in unsheltered environments, public spaces, or vehicles, they lack fewer options for proper disposal. A study from the University of California San Francisco,[1] found that areas with high rates of homelessness and limited harm reduction services experienced **significantly higher rates of improperly discarded syringes**, while cities that invested in housing support and syringe service programs saw **lower rates of improperly discarded syringes**.

The city of Sanford's efforts to reinstate the statewide one-for-one rule began in earnest **following a large encampment sweep in the city**.[2] As with most encampment sweeps, residents–and providers–were not provided adequate notice. Subsequently, they did not have an opportunity to gather their belongings, let alone clean up the area. To my knowledge, they were not provided trash receptacles at any juncture.

Additionally, it should come as no surprise that the prevalence of improperly discarded syringes in places like Washington County–where people may couch surf or all live in one house together–looks very different than in places like Sanford, where unhoused folks rely heavily on outdoor, visible encampments for shelter and safety.

Should the city of Sanford, for example, choose to work in an enhanced capacity with providers on this issue, the installation of adequately sized and placed community sharps boxes could have a **significant positive impact**. Building trust by working with participants themselves on mitigation plans and efforts is one way to establish buy-in, empower our neighbors, and create meaningful dialogue and change that is not predicated on punishment or stigma.

**One-for-One Syringe Exchange Does Not Reduce Improperly Discarded Syringes**

Contrary to the assumption that limiting syringe access will decrease the prevalence of improperly discarded syringes, evidence suggests that restrictive policies actually increase the likelihood of unsafe syringe disposal. Studies have found that areas with restrictive syringe exchange policies had **higher** rates of improperly discarded syringes compared to areas with more accessible syringe distribution.[3] This occurs because individuals who inject drugs (PWID) are less likely to return used syringes when access is limited, leading to increased public health hazards.

The significant and critical trust and rapport built by syringe service programs is effectively diminished when participants are no longer trusted to identify their own needs. This may lead to folks reusing syringes (their own, their peers', or ones picked up off the ground, etc.), not

---

[1] Higher syringe coverage is associated with lower odds of HIV risk and does not increase unsafe syringe disposal among syringe exchange program clients. 2007. https://pmc.ncbi.nlm.nih.gov/articles/PMC2562866/.

[2] Officials say thousands of needles were picked up at former Sanford homeless encampment. 2024.https://wgme.com/newsletter-daily/maine-housing-crisis-officials-say-thousands-of-needles-were-picked-up-at-former-sanford-homeless-encampment-drugs-recovery-safety

[3] Consequences of a restrictive syringe exchange policy on utilisation patterns of a syringe exchange program in Baltimore, Maryland: Implications for HIV risk. https://pubmed.ncbi.nlm.nih.gov/25919590/

showing up to the program as often, or simply not caring to properly discard. We see this with any kind of trash. Obviously this result has ramifications far beyond syringes on the ground.

In contrast, states and municipalities with **needs-based** syringe distribution—where participants receive as many syringes as needed to avoid reuse—see lower rates of improperly discarded syringes. By ensuring individuals have access to sterile syringes at all times, they are more likely to return used syringes to SSP sites rather than dispose of them improperly. However–and this is especially important in Maine–programs must have **adequate funding for disposal**–the containers themselves, the organizational capacity and infrastructure to educate participants and build disposal plans, and the biohazard disposal (incineration) itself.

With any restrictive policy, there are certainly instances of an initial decrease in syringes found on the ground. However, this cannot be used to evaluate the long-term efficacy of a policy or program. There may be an initial dip, and then things fall apart with far graver consequences, like an HIV cluster for example. **Our health care infrastructure simply cannot shoulder that kind of devastating blow, nor should our residents who use drugs.**

**Syringe Service Programs Are the Solution**

A 2023 study compared the frequency of improperly discarded syringes in a city with SSPs (San Francisco, California) vs a city without SSPs (Miami, Florida) and found fewer improperly disposed syringes in San Francisco (44/1000 blocks) vs Miami (371/1000 blocks).[4] Furthermore, 95% of people who inject drugs (PWID) in Miami self-reported improperly disposing of syringes in the last 30 days when compared with only 13% of PWIDs in San Francisco, where there was access to SSPs.[5] These data clearly demonstrate that access to SSPs actually provides places for proper disposal of needles and that people who inject drugs use these services effectively.

I believe a shift in this conversation is necessary: **how do we adequately fund these programs so they can do the best work possible, which keeps all of our communities safer, and how do we bolster and scale our public health infrastructure to ensure that all communities have these resources?** Placing arbitrary restrictions that are not based in reality or evidence only stands to hurt our communities, not make them safer or free of improperly discarded syringes.

**Conclusion**

A one-for-one syringe exchange policy is not based on science or public health best practices. Ultimately, it would **increase syringe litter** and further harm our communities. Maine has an opportunity to follow the evidence and continue supporting **effective, needs-based** harm reduction strategies that protect public health and safety. We did it well during the COVID-19 pandemic, and we can do it well now. I respectfully urge this committee to reject the proposal at

[4] Tookes HE, Kral AH, Wenger LD, et al. A comparison of syringe disposal practices among injection drug users in a city with versus a city without needle and syringe programs. Drug Alcohol Depend. 2012;123(1-3):255-259. doi:10.1016/j.drugalcdep.2011.12.001
[5] Ibid.

hand to ensure the sustainability of healthy, safer communities. Thank you for your time and consideration.

***Respectfully submitted,***

Whitney Parrish Perry

Resident of Augusta, ME