Maine Medical Association

Maine Osteopathic Association

MPHA
Maine Public Health Association

TESTIMONY OF THE MAINE MEDICAL ASSOCIATION,
THE MAINE OSTEOPATHIC ASSOCIATION,
AND
THE MAINE PUBLIC HEALTH ASSOCIATION

In Opposition To

LD 219 - An Act to Limit Hypodermic Apparatus Exchange Programs to a One-for-one Exchange

Joint Standing Committee on Health and Human Services
Room 209, Cross Building, Augusta, Maine
Monday, March 17, 2025

Good Morning, Senator Ingwersen, Representative Meyer, and Members of the Joint Standing Committee on Health and Human Services. My name is Kinna Thakarar, DO, and I am an infectious disease and addiction medicine physician in Portland, Maine. I am here on behalf of the Maine Medical Association, Maine Osteopathic Association, and Maine Public Health Association, testifying in opposition to LD 219: "An Act to Limit Hypodermic Apparatus Exchange Programs to a One-for-one Exchange."

The Maine Medical Association (MMA) is a professional organization representing over 4,000 physicians, residents, and medical students in Maine. MMA's mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine people. The Maine Osteopathic Association (MOA) is a professional organization representing more than 1,200 osteopathic physicians, residents, and medical students in Maine whose mission is to serve the Osteopathic profession of the State of Maine through a coordinated effort of professional education, advocacy, and member services to ensure the availability of quality osteopathic health care to the people of this State. The Maine Public Health Association (MPHA) is the state's oldest, largest, and most diverse association for public health professionals. MPHA represents more than 850 individuals and 70 organizational members across the state. MPHA's mission is to advance the health of all people and places in Maine.

MMA, MOA, and MPHA advocate on issues like this to ensure that the medical and public health communities address the opioid epidemic. Increasing resources and access for those with substance use disorder is a priority of all of our Associations. For example, the Maine Medical Association launched the 1,000 Lives Campaign to reduce opioid-related deaths in Maine by 1,000 from current predictions over five years.[1] MOA and MPHA have also signed onto this campaign.

I am the Vice Chair for Advocacy for the Infectious Disease Society of America (ISDA), have served on its national task force for substance use, and am the Chair of the Harm Reduction Subcommittee for AMERSA (Association for Multidisciplinary Education and Research in Substance use and Addiction). In these roles, I have presented nationally and internationally on harm reduction. Currently, I am co-director and principal investigator of a federally funded harm reduction grant based here in Maine called Project DHARMA (Distribution of Harm Reduction Access in Rural Maine Areas). I am also a mom to a seven-year-old and understand the importance of keeping the community safe.

The change in drug supply has led to an increased need in the number of syringes a person who uses drugs requires for injecting. The half-life of fentanyl, for example, is approximately 4-6 hours; thus, an individual who injects fentanyl may need new syringes several times a day (and may require several syringes for each time they inject if they inadvertently "miss" their vein). When patients can't access a clean needle or syringe each time they use it, they can get serious infections.

I continue to treat many patients with complications from injection drug use, including HIV, hepatitis, and other serious complications like endocarditis, which are heart infections. Those with severe infections, many of whom have to stay in the hospital for 6 to 8 weeks on IV antibiotics, require new heart valves and other extensive surgeries that are costly. The median cost to insurance companies, for example, was approximately $175,000 per patient at my hospital.[2] Additionally, treating HIV is a lifelong process that involves medication (antiretroviral therapy or ART) and regular checkups, with costs potentially ranging from $1,800 to $4,500 per month, mainly due to the high cost of ART medications.[3]

As you may know, Maine also has one of the highest rates of acute hepatitis B and the highest rate of acute hepatitis C, often due to unsafe injection practices[4] -- and these are infections that we can easily prevent with a less restrictive Syringe Services Program ("SSP"). It is also important to note that right now in Penobscot County, the Maine CDC has

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[1] Please see https://mainephysicians.org/1000-lives-campaign-for-maine/ for more information.

[2] Ramirez VN, , Carwile JL, Rokas K, Craig W, Thakarar K. Injection drug use and care charges for infective endocarditis, *Journal of Maine Medical Center*. 2020;2(1):12. Available at: https://doi.org/10.46804/2641-2225.1029

[3] Please see https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/antiretroviral-therapy-cost-considerations#:~:text=However%2C%20HIV%20treatment%20with%20ART%20is%20costly.,60%%20of%20the%20costs%20attributable%20to%20ART for more information.

[4] Please see https://www.cdc.gov/hepatitis/statistics/2021surveillance/hepatitis-b/figure-2.3.htm and https://www.cdc.gov/hepatitis/statistics/2021surveillance/hepatitis-c/figure-3.3.htm for more information.

identified 21 new cases of HIV and hepatitis C related to unsafe injection practices, in a county that typically sees only 1-2 new cases per year.[5] Most of these individuals are not yet engaged in care and can, therefore, transmit HIV. If we restrict SSP policies in Maine, we are no doubt going to have more cases of HIV and viral hepatitis. Several parts of Maine have already been deemed high risk for HIV and hepatitis outbreaks.

We know that people can substantially reduce their risk of getting HIV and other serious infections by using new equipment. Many patients I have cared for have been forced to reuse or share their equipment because of a lack of access to an SSP or restrictive SSP policies. Moreover, many SSP clients drive to programs from other cities and towns in Maine that don't have an SSP; thus, they need to stock up on supplies to ensure they use them safely – naturally, this can result in a more significant exchange but is essential from a preventive care perspective. Another reality is that some SSP clients may get their equipment confiscated by law enforcement or other institutional settings and thus require additional syringe exchanges.

Our research during the pandemic showed that expansion of harm reduction services through **mobile delivery**, **mail delivery**, and **elimination of the 1:1 needle exchange** were effective ways to improve access to harm reduction services.[6] I have cared for hundreds of patients — even several just last month – admitted to the hospital with serious, sometimes life-threatening infections related to injection drug use. Especially with our Maine hospitals being overwhelmed with patient volume (complicated by understaffed infectious disease groups), it's important to try and prevent serious infections and hospitalizations when possible.

Establishing a true needs-based model for syringe service programs, where SSP clients can determine for themselves how many syringes they need, will help reduce rates of infections, and it would also align with CDC's best practices[7] and the IDSA's recommendations.[8] The solution here is **not** to facilitate access to equipment. Instead, it **is imperative to enhance support for SSP harm reduction outreach workers/mobile-based work**, particularly to unhoused individuals, so 1) SSP clients can access essential equipment and 2) outreach workers can continue to facilitate syringe disposal services and linkage to care.[9] The science clearly shows that making syringe disposal services available reduces syringe litter. It is worth noting that overdose

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[5] https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/hiv-cluster.shtml.

[6] Thakarar K, Kohut M, Hutchinson R, Bell R, Loeb HE, Burris D, Fairfield KM. The impact of the COVID-19 pandemic on people who inject drugs accessing harm reduction services in a rural American state. *Harm Reduct J.* 2022 Jul 22;19(1):80. doi: 10 186/s12954-022-00660-2. PMID: 35869523; PMCID: PMC9305035.

[7] https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs

[8] Springer SA, Barocas JA, Wurcel A, Nijhawan A, Thakarar K, Lynfield R, Hurley H, Snowden J, Thornton A, del Rio C, on behalf of the Infectious Diseases Society of America and HIV Medicine Association's Infectious Diseases and Opioid Use Disorder Working Group. Federal and state action needed to end the infectious complications of illicit drug use in the United States: IDSA and HIVMA's Advocacy Agenda. *The Journal of Infectious Diseases.* 2020;222(S5):S230-S238.

[9] Perez A, Nieves S, Meisner J. Implementation of injectable cabotegravir/rilpivirine for treatment of Human Immunodeficiency Virus in patients With substance use disorders at a syringe exchange clinic, *Open Forum Infectious Diseases.* 2024;11(11):ofae640, https://doi.org/10.1093/ofid/ofae640

prevention centers have been associated with reduced public injection, in addition to reducing infections and overdoses, and I strongly encourage the committee to consider investing in an overdose prevention center in the future.[10]

I want to note that we understand the frustration that discarded needles have on the impacted communities. We would support all efforts to creatively solve this problem, like the needle buyback program in Portland, which shows promising results.[11] We can also offer more education about safely disposing of syringes and who to call if someone finds one on the ground. The City of South Portland Board of Health prepared materials that could be easily adapted for other municipalities in the state.[12] However, we cannot ignore the positive benefits of a need-based exchange and how everyone would be harmed if we were to enact this bill.

We know that SSPs are crucial in connecting people to services and care. On behalf of the Maine Medical Association, Maine Osteopathic Association, and Maine Public Health Association, as well as as a physician, public health professional, and mom, I support expanding, not restricting, the work of our local SSPs. This support is critical for the health and safety of our community members.

Thank you for considering the thoughts of Maine's physicians and public health professionals. We hope you will oppose LD 219.

Thank you,

Sincerely,

Dr. Kinna Thakarar
Portland, ME

[10] Dunham K, Hill K, Kazal H, et al. In support of Overdose Prevention Centers: Position statement of AMERSA, Inc (Association for Multidisciplinary Education and Research in Substance Use and Addiction). *Substance Use & Addiction Journal.* 2024;45(3):328-336. doi:10.1177/29767342241252590.
[11] https://www.pressherald.com/2025/03/13/portland-reports-significant-success-in-needle-buy-back-program/.
[12] https://www.southportland.org/639/Public-Health-Resources