POLICY MEMO: Syringe Service Programs: Proposed Legislation (HB1245, 2023-24)

health policy network

To: Pennsylvania State Legislators **Date:** April 8, 2024 (draft)

RE: Legislation to expand Syringe Service Programs / HB 1245

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Defining Syringe Service Programs: Community-based programs that provide access to sterile needles and syringes, help safely dispose of used syringes, and provide and link to other important services and programs. Injecting of illicit drugs or other illicit drug use is not allowed on their premises, i.e. they are not the same as safe injection or consumption sites.

Question: *Should PA legislators support a law to legalize Syringe Service Programs?*

Reasons to SUPPORT Legalization of Syringe Service Programs:

- Over 40 years of research support Syringe Service Programs as a public health intervention that reduces disease, prevents overdose, is cost-effective, and is not associated with increased crime or litter.
- Reducing infectious disease spread: Pennsylvania is one of 44 states designated by the CDC as a high risk for increased Hepatitis C and/or HIV transmission due to injection drug use. SSPs are associated with a 50% decrease in HIV and Hepatitis C incidence.
- Reduce healthcare costs to taxpayers: Infectious disease transmission is extremely costly to taxpayers. An outbreak in one rural county (Scott County, Indiana) that infected 200+ people cost an estimated $100 million in related health costs.
- Large network of state health expert support: The Pennsylvania Medical Association, Pennsylvania Society of Addiction Medicine, Pennsylvania Pharmacist Association, the Deans of PA's six university public health programs, and over 185 other Drug & Alcohol, Nursing, Recovery, Treatment, and more signed on as supporters of this bill.
- A belief that "dead people can't recover" so reducing health harms while building relationships of trust will engage people in treatment and/or other social support services that will is a more successful policy choice than a punitive, criminal-legal approach to illicit drug use (i.e. shift from a War On Drugs to a War on Drug Related Deaths.)
- To open up funding streams – whether public or private: currently unsanctioned programs have difficulty accessing new streams of federal, state and local funds, or even donations from health systems. Even though SSPs explicitly named in the PA Opioid Settlement Agreements as a recommended intervention for funding, counties have declined to allow this until the law is changed.
- All Pennsylvanians deserve access to resources, including rural Central PA. SSP's are only operating legally in metropolitan Philadelphia and Pittsburgh, leaving 1.5 million other residents with limited access to life-saving supplies.

Reasons to OPPOSE Legalization of Syringe Service Programs;

- A belief that assisting the safe use of illicit drugs is wrong (**a "moral hazard")** even if it benefits public health or safety.
- Fear that "normalizing" illicit drug use in the community will cause future harms that outweigh the benefits.
- Enabling individual people to continue on a harmful path is unethical, and provision of any materials "enables" them to continue drug use.
- A belief that syringes should be only be used for medical purposes, under the guidance of a healthcare professional, and non-medical use is always abusive and harmful—making syringes an "instrumentality of abuse" even when balanced with a "net good" for public health. This has been described as a "slippery slope" argument.
- Prefer the status quo: As many as 20 SSPs are operating now with or without explicit municipal public health exceptions and have been for 30+ years in PA's two largest cities.
- Philadelphia's Kensington neighborhood has a notorious open-air drug use, and a high number of people experiencing homelessness who create a trash and litter problem, in the same neighborhood as the state's largest Syringe Service Program, and other smaller human services programs. Their "harm reduction" interventions do not seem to have improved the community's quality of life.

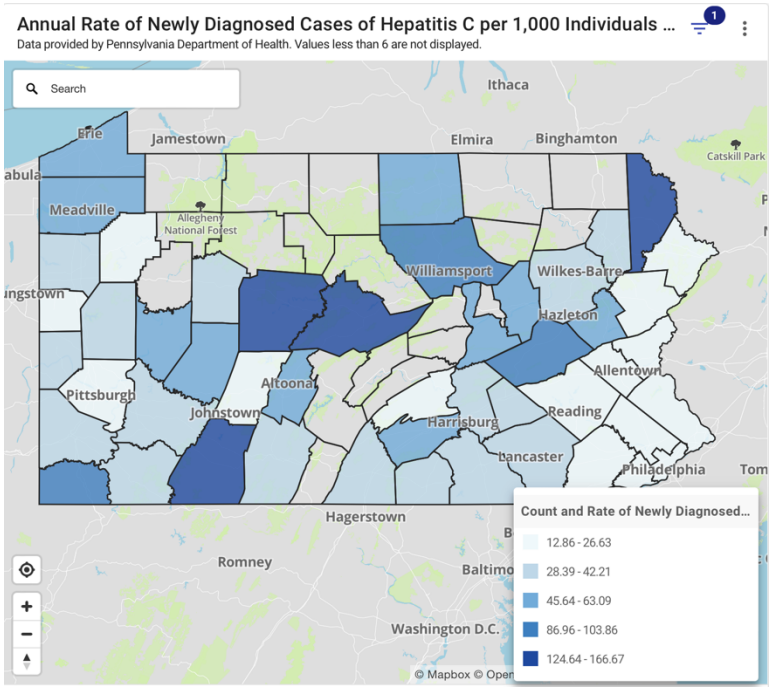
What are some Policy Alternatives?

1. Restrict the use of state taxpayer funds for syringe distribution but allow legalization.
2. Local opt-in or opt-outs: require local control and/or oversight via municipal/ local approval requirements for all SSPs, or other regulatory oversight, but allow legalization.
3. Support other harm reduction interventions already tested and established in the U.S., but not SSPs. Examples:
   A. Wider *community distribution of* naloxone (Narcan, the overdose antidote) & fentanyl test strips/ drug checking strips.
   B. *Sobering or Crisis Stabilization Centers* (facilities where people are taken while intoxicated or high, for safe, supervised sobering, rather than jails or emergency rooms, but no drug or alcohol use is allowed. People are connected to services.) These centers are operating in 40 states, but one hasn't yet been launched in PA.
4. Support increased treatment and /or recovery or peer support funding, housing, or services that are also evidence-based interventions.

Further discussion

Will syringe service programs cause harm by encouraging more drug use and needle litter, increasing risk of needle sticks and crime rates?

Multiple studies have found **no association** between SSPs and increased or decreased rates of drug use, drug sales, or crime in its neighborhood. SSPs have been shown to either have no geographically related increase, or to be protective against publicly discarded syringes or accidental needle sticks.



Why are new harm reduction efforts needed when we are seeing overdoses stabilizing or trending down?

Rates of overdose deaths are increasing among minoritized Pennsylvanians: our Black and Hispanic/Latino citizens. New cases of HCV are increasing across the state, as well as costly hospitalizations for injection-related infectious diseases and complications like heart, skin, blood, and bone infections or abscesses. Despite coordinated agency efforts, which seem to have finally slowed or decreased the mortality rate, statewide drug-induced deaths were still at 5,123 in 2022; 14 people a day, dying of drug overdoses, all preventable deaths.

Why not *require* people who use substances to get treatment when they seek services or overdose repeatedly?

1. We lack evidence that forced substance use disorder treatment reduces mortality downstream, and in fact, it may increase harm. One study showed 2.2x higher risk of fatal overdose in people civilly committed to treatment in Massachusetts vs. those in voluntary treatment.

2. Building trusted relationships engages people who use an OPS, due to their experiences with stigma and discrimination from healthcare systems and government authorities. Many have trauma and co-occurring mental health disorders. Established principles of treatment and recovery, such as self-determination and “stages of change,” do not align well with involuntary treatment, which generally requires carceral approaches.[i]

3. We lack on-demand capacity in PA’s publicly funded treatment and recovery support systems, especially for those needing housing; so forced treatment could supplant space needed for motivated people waiting for services now. Pennsylvania also does not have “locked” treatment facilities.

4. Complex medical needs: People who use drugs are having additional health complications due to the current drug supply, including cellulitis, osteomyelitis, endocarditis, viral hepatitis, and intracranial and intraspinal abscesses. This requires hospital-based care and/or medical

clearance before entering substance use disorder treatment. PA lacks treatment facilities who accept medically complex patients.

5. Legal issues/ litigation costs & system structure: A civil commitment process to force treatment, or any coercive court process will require timely hearings, addressing civil and disability rights protections, receive funding and address gaps in judicial and legal structural capacity. PA's current mental health commitment process isn't triggered by a substance use disorder diagnosis. Pennsylvania laws also require patient consent for medical treatment. "[P]roviding medical care to somebody against their will, except in a very narrow circumstance, is considered to be assault" according to testimony by Philadelphia's health commissioner in a 2023 hearing.

Do SSPs save taxpayers' money?

Reducing fatal overdoses & drug-related health complications does reduce emergency responder and health system services, expected to result in financial savings for publicly funded Medicaid and Medicare programs. Estimated lifetime cost of healthcare for one person living with HIV is $400,000, or for the newest HVC treatments is $70,000- $190,000/per person. The cost of Scott County, Indiana's HIV/HVC disease outbreak (235 infected after people sharing needles in one rural county) has been estimated at ~ $100 million.

What other "harm reduction" approaches to drug use are effective in the U.S.?

Broadly expanding access in the community to naloxone (Narcan) is viewed as a successful opioid overdose prevention strategy, despite a more limited empirical evidence base than sterile syringe provision. The use of fentanyl test strips has limited empirical evidence for reduction in overdose mortality, but does show positive changes in behavior.

PA pharmacies are able to distribute sterile syringes without a prescription, why can't they fill the distribution gap?

While pharmacies have an important role in providing addiction treatment medications, SSP participants have reported facing stigma and discrimination at pharmacies. A study from California, showed interviewees would rarely go to a pharmacy for syringe disposal. PA pharmacies typically do not accept used syringes for disposal, and they lack funding and staffing models to enable them to provide peer support to engage people who use drugs in multiple services like SSPs.

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