Department of Legislative Services

Maryland General Assembly
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FISCAL AND POLICY NOTE
First Reader

House Bill 1212 (Delegate Morhaim)
Health and Government Operations

Public Health - Overdose and Infectious Disease Prevention Safer Drug Use Facility Program

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This bill authorizes a local health department (LHD) or community-based organization (CBO) to establish an Overdose and Infectious Disease Prevention Safer Drug Use Facility Program in one or more jurisdictions. A program must, among other requirements, provide a location supervised by health care professionals or other trained staff where drug users can self-administer preobtained drugs, as well as receive other services, education, and referrals. A CBO must receive approval from the Department of Health and Mental Hygiene (DHMH) to establish a program. The bill specifies program requirements, authorizes programs to offer other related services, establishes program reporting and evaluation requirements, and establishes legal protections for a person acting in accordance with the bill's provisions.

Fiscal Summary

State Effect: Assuming a small number of CBOs may apply, DHMH can approve or deny program applications with existing budgeted resources. To the extent that a significant number of CBOs apply, DHMH may require additional staff, as discussed below.

Local Effect: Significant operational and fiscal impact for those LHDs that choose to implement a program. Local expenditures may be offset by authorized funding sources established under the bill.

Small Business Effect: Meaningful for any small business CBO that elects to operate a program as authorized under the bill.

Analysis

Bill Summary: A CBO may apply to DHMH for program approval at any time, regardless of previous applications. DHMH must (1) make its decision to approve or deny an application based on whether the CBO can satisfy the bill's program requirements; (2) make a decision within 45 days of receiving an application; and (3) provide a written explanation of its decision to the CBO.

A program must, among other requirements, (1) provide secure sterile needle exchange; (2) answer questions about safe injection practices; (3) administer first aid, if needed, monitor for potential overdose, and administer rescue medications; (4) provide referrals; (5) educate participants on the risks of contracting HIV and viral hepatitis; and (6) provide overdose prevention education and access to or referrals to obtain naloxone. A program may offer additional direct services to participants, such as substance use disorder counseling and treatment. A program may, with permission, bill a participant's health insurance; accept specified outside financial assistance; and apply for grants.

A program must collect a range of data about its operations, including (1) the number of individuals served and the frequency with which individuals utilize program services; (2) specified demographic information; (3) the number of individuals who enter drug counseling and treatment; (4) the number of hypodermic needles and syringes distributed; (5) the number of program participants arrested for drug-related crimes; (6) the program's impact on crime rates in the neighborhood in which the program is located; (7) the number of program participants who adopt safer injection practices; and (8) the number of individuals rescued and the number of rescue drugs used. Data collection may be conducted by an independent entity. Each program must report data to DHMH by December 1 of each year.

The program administrator must develop and implement an evaluation plan for the program. The evaluation plan must include an analysis of the advisability of continuing the program and may address reported changes in participants' drug use.

Program participants, staff members, and program property owners are not subject to arrest, prosecution, or any civil or administrative penalty, including action by a professional licensing board, and may not be denied any right or privilege because of their involvement in the program. Further, a property owner, manager, employee, volunteer, or program participant who is acting in accordance with the bill's provisions is not subject to the seizure or forfeiture of any real or personal property used in connection with a program in accordance with State or local law.

Current Law:

Heroin and Opioid Emergency Task Force

In February 2015, Governor Hogan established, by executive order, the Heroin and Opioid Emergency Task Force. The task force was chaired by the Lieutenant Governor and consisted of appointees of the President of the Senate, the Speaker of the House, and the Attorney General, as well as seven members of the public. The task force issued its final report in December 2015, which included a recommendation for legislation authorizing any county in Maryland to establish an opioid-associated disease prevention and outreach program to provide outreach, education, and linkage to treatment services, including the exchange of sterile syringes to people who inject drugs.

Needle Exchange Programs

Chapter 251 of 1998 authorized Prince George's County to establish an AIDS Prevention Sterile Needle and Syringe Exchange Program. Statute mandates program components, including a one-for-one exchange of used needles for sterile needles, referrals to drug counseling and treatment, and outreach education on the dangers of contracting the HIV infection. Although authorized under law, Prince George's County never established a program.

Chapter 360 of 1994 established the AIDS Prevention Sterile Needle and Syringe Exchange Pilot Program in the Baltimore City Health Department. Initially scheduled to terminate in 1997, Chapters 177 and 178 of 1997 repealed the termination date and continued an annual reporting requirement. Chapter 396 of 2014 repealed the requirement that the program limit exchanges of used hypodermic needles and syringes for sterile hypodermic needles and syringes on a one-for-one basis. The program also educates participants about the dangers of contracting HIV infections through needle sharing practices and refers participants to substance use disorder treatment programs.

Background:

Opioid Maintenance Therapy Programs in Maryland

Methadone is a synthetic opioid used to treat heroin and other opioid drug addictions, specifically helping to mitigate withdrawal symptoms and drug cravings for heroin and opiate medications. A clinic that administers methadone as a drug addiction treatment is regulated as an opioid treatment program (OTP). These clinics are an important approach to treating opioid addiction in the State. OTPs are subject to strict regulation at the federal and state level; local jurisdictions also regulate OTPs, to a more limited extent.

The Behavioral Health Administration (BHA) and the Office of Health Care Quality within DHMH license and provide joint oversight over OTP programs at the State level. BHA advises that there are 74 licensed OTP programs in the State; almost half are located in Baltimore City (32 OTPs). Baltimore City has significantly more OTP programs than other jurisdictions in the State. Anne Arundel County has eight licensed OTP programs; the remaining counties have five or fewer programs each.

Intoxication Deaths in Maryland

DHMH's 2015 report, *Drug and Alcohol-Related Intoxication Deaths in Maryland*, indicated that drug- and alcohol-related intoxication deaths in Maryland totaled 1,039 in 2014, a 21% increase since 2013 and a 60% increase since 2010. Of all intoxication deaths, 887 deaths (86%) were opioid related, including deaths related to heroin, prescription opioids, and nonpharmaceutical fentanyl. Opioid-related deaths increased by 76% between 2010 and 2014. Heroin-related deaths more than doubled between 2010 and 2014, and they increased by 25% between 2013 and 2014. Preliminary data from DHMH shows that the number of intoxication deaths continued to increase in 2015, with 889 deaths from January through September 2015 compared to 767 deaths during the same period in 2014 (a 16% increase).

According to DHMH, increased heroin use also means more sharing and reusing of needles among heroin users. Sharing and reusing needles increases the risk for transmission of viruses such as HIV and hepatitis C. Syringe and needle exchange programs have been shown to reduce the spread of new infections. Since the launch of Baltimore City's program, the proportion of new infections attributed to sharing injection drug equipment decreased from 62% in 1994 to 12% in 2011.

International Supervised Injecting Facilities

According to a 2011 study published in *The Lancet*, internationally, more than 65 supervised injecting facilities (SIFs), sites where drug users can inject preobtained illicit drugs, have been opened as part of various strategies to reduce the harms associated with drug use. The study, which reviewed the reduction in overdose mortality after the opening of a SIF in Vancouver, found that SIFs are an effective intervention to reduce community overdose mortality and should be considered for assessment, particularly in communities with high levels of injection drug use.

State Fiscal Effect: LHDs receive blanket authorization to establish a program under the bill and do not need DHMH approval. DHMH is required to provide initial approval (or denial) of applications from CBOs and written justification for the decision. The bill establishes no enforcement or ongoing requirements for DHMH. Thus, although DHMH advises that one full-time employee is needed to implement the bill, the Department of

Legislative Services (DLS) disagrees. Based on the assumption that a small number of CBOs are likely to apply, DLS advises that DHMH can implement the bill's requirements with existing resources and staffing levels. To the extent that a significant number of CBOs apply, DHMH may need additional staff assistance to review and respond to these applications.

Local Fiscal Effect: Expenditures increase significantly for any LHD that chooses to implement a program as authorized under the bill. It is unknown how much such a program will cost, and there would likely be significant variations among programs depending on the size, number of health care professionals, hours, variety of services, and population served. DHMH advises, for comparison, that implementing a syringe exchange program for an average-sized LHD costs approximately $400,000. Thus, establishing a program under the bill likely costs at least $400,000. DLS notes that LHDs are *not* mandated to establish a program under the bill. These expenditures may be offset by billing insurance companies for certain services, donations, grants, or other financial assistance.

Small Business Effect: To the extent that a CBO is a small business and successfully applies to establish a program under the bill, expenditures increase significantly, as discussed under the local fiscal effect. These expenditures may be offset by billing insurance companies for certain services, donations, grants, or other financial assistance.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Marshall, *et al.* (2011), "Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study," *The Lancet*; Maryland Association of County Health Officers; Judiciary (Administrative Office of the Courts); Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

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