Report to the 132nd Maine Legislature
Joint Standing Committee on Criminal Justice & Public Safety

from the

Working Group
to Study Methods of Preventing Opioid Overdose Deaths
by Authorizing Harm Reduction Health Centers

February 28, 2025

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Governor's Office of Policy Innovation and the Future, pursuant to
Chapter 120, HP 878, LD 1364 Legislative Resolve

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ACKNOWLEDGEMENTS

The Working Group acknowledges and is grateful for the many individuals and organizations from around the world who shared their expertise and experiences with the people of Maine. Their contributions are an invaluable component of this report.

The findings and recommendations presented in this report reflect the views of the Working Group members, not their organizations or affiliations, unless otherwise indicated.

LEGISLATIVE RESOLVE

The Working Group to Study Methods of Preventing Opioid Overdose Deaths by Authorizing Harm Reduction Health Centers (also called "Working Group") was established by Legislative Resolve (LD 1364), which was passed by the 131st Legislature and signed by Governor Mills. The full text of the Resolve is as follows:

Resolve, to Study Methods of Preventing Opioid Overdose Deaths by Authorizing Harm Reduction Health Centers

Sec. 1. Governor's Office of Policy Innovation and the Future Working Group. Resolved: That the Governor's Office of Policy Innovation and the Future shall convene a Working Group to study methods of preventing opioid overdose deaths by authorizing harm reduction health centers. The office shall at a minimum invite as members of the Working Group the Department of Health and Human Services, the Department of Public Safety, a representative of the recovery treatment community, a municipal representative, a medical professional, a person who has experienced substance use disorder and a representative of an organization that advocates for persons with substance use disorder. The Working Group shall evaluate options for, identify barriers to and develop findings and recommendations regarding the prevention of opioid overdose deaths by authorizing harm reduction health centers in the State. As used in this section, "harm reduction health center" means a facility that provides health screening, disease prevention and recovery assistance services and that allows persons to consume previously obtained controlled substances on the premises.

Sec. 2. Report. Resolved: That, on or before February 15, 2025, the Governor's Office of Policy Innovation and the Future shall submit a report, including the findings and recommendations, as well as any proposed legislation, of the Working Group under section 1, to the joint standing committee of the Legislature having jurisdiction over criminal justice and public safety matters. After reviewing the report, the committee may report out legislation related to the report to the 132nd Legislature in 2025.

WORKING GROUP PROCESS

Terminology

While the Legislative Resolve that established the Working Group introduced the term "Harm Reduction Health Center" to designate "a facility that provides health screening, disease prevention and recovery assistance services and that allows persons to consume previously obtained controlled substances on the premises", this terminology is not widely used nationally and among currently operating facilities. For consistency and alignment, the Working Group has opted to use the term "Overdose Prevention Centers", or OPCs, synonymously in this report, with the intention of describing the same interconnected, multi-service facilities outlined in the Legislative Resolve.

Group Agreements

The Working Group met for the first time on October 11, 2024. Members believed it was important to meet together, in person, and hear from each other about why they were each participating, what they hoped would result, and how they wanted to do their work together. This first meeting was in-person only with no video component, so a written meeting report was produced by the facilitator and subsequently reviewed and finalized by the Working Group *(see Appendix B).*

As members shared why they had accepted the invitation to join the Working Group, several themes of common interest emerged, including: reducing fatal overdoses; creating more avenues for people using drugs to connect to treatment,

recovery, and other health and social services; supporting people who are unhoused and actively using drugs; protecting the safety of OPC participants, staff, and the public; reducing disorderly behaviors in neighborhoods; and gathering new information and promising practices from other states and countries.

The Working Group began its work by reviewing its charge as established by the Legislative Resolve and discussing what Maine legislators were likely most interested in learning, including 1) could OPCs work in Maine; 2) what is likely to happen if OPCs are allowed and established; 3) what could be changed in Maine law to make OPCs possible and 4) what else do lawmakers need to consider as they decide if and how to proceed.

Working Group members agreed on the following points regarding how they saw their roles and responsibilities, how they would make decisions, and other process considerations for their work ahead:

- The Working Group is not the ultimate decision-making body – that falls to the Maine State Legislature.
- The Working Group's role is to study the issue, evaluate options, and deliver findings and recommendations to the Criminal Justice and Public Safety Committee of the Maine Legislature.
- The Working Group does not require consensus, but it will seek consensus whenever possible.
- The Working Group has agreed by consensus to a set of "Meeting Agreements". These can be revisited at any time upon request of any member.
- The Working Group will consider the option of hosting a public forum as part of their information gathering.

Areas of Inquiry

After agreeing on their purpose and process, the Working Group identified the following initial areas of inquiry for themselves, including specific information sources and individuals they wished to invite to subsequent meetings. The Working Group used this framework as the basis for its meeting planning and discussions, and it augmented this outline as more was learned and considered:

- Statutory barriers, including federal and state barriers
- Authorization types, including state and municipal examples as well as permanent vs. temporary authorizations
- Ranges of potential outcomes, including potential data collection and evaluation designs
- Rural vs. urban models to determine if OPCs could work in areas of less dense population and development
- Mobile vs. bricks & mortar infrastructure to determine if a mobile model could mitigate stigma, reduce transportation barriers, and/or potentially respond to "hot spots" of a poisoned drug supply
- Phone/video "hotlines" for monitoring safe use
- Model examples and comparisons, including New York City Rhode Island, Canada, and Europe

Meetings, Special Guests, and Outside Reading/Viewing

Meeting #1: October 11, 2024, 10:00 – 12:00 PM, 109 Capitol Street, Augusta

- Agenda (link)
- Reading/Viewing
    - Legislative Resolve (LD 1364)
    - August 2024 Overdose Report
- Meeting report: See Appendix B

Meeting #2: November 22, 2024, 1:00 – 3:00 PM, via Zoom

- Agenda (link)
- Presentations and special guests
    - Jeff Sherman, attorney and Working Group member
    - Lauren Layman, General Counsel, Vermont Department of Health
- Reading/Viewing
    - Maine Law Review article by Jeff P. Sherman, "U.S. v. Safehouse: The Future of Supervised Consumption Sites in Maine and Beyond"
    - Vermont's enabling legislation; Vermont Biz article
    - Vermont Overdose Prevention Center Operating Guidelines
    - Rhode Island Department of Health: Harm Reduction Center Pilot Program fact sheet
    - Minnesota Department of Human Services: Safer Use Sites FAQ
    - Compilation of testimony from previous Maine legislation (LD 1159 and LD 1364)
    - Dr. Alex Kral webinar, USC, "Overdose Prevention Sites: Global and Domestic Research, Policy, and Implementation"
- Meeting recording (link)

Meeting #3: December 20, 2024, 1:00 – 3:00 PM, via Zoom

- Agenda (link)
- Special guests
    - Pia Marcus, Director of Overdose Prevention, OnPoint NYC
    - Toni Smith, Director, Drug Policy Alliance
- Reading/Viewing
    - Overview of OnPoint NYC
- Meeting recording (link)

Meeting #4: January 10, 2025, 10:00 – 12:30 PM, via Zoom

- Agenda (link)
- Meeting recording (link)

Meeting #5: January 24, 2025, 1:00 – 3:00 PM, via Zoom

- Agenda (link)
- Special guests
    - Christine Porter, Executive Director, Ally Centre of Cape Breton
    - Megan Peters, Operations Manager, Ally Centre of Cape Breton
- Reading/Viewing
    - Overview of Ally Centre of Cape Breton in Sydney, Nova Scotia
- Meeting recording (link)

Meeting #6: February 7, 2025, 1:00 – 3:30 PM, via Zoom

- Agenda (link)
- Special guests
    - Hugo Ameral Faria, Psychologist and General Coordinator of Ares do Pinhal, an NGO for social inclusion in Lisbon

    - Elaine Hyshka, PhD, Professor at University of Alberta in Edmonton and Committee Chair of Canadian Research Initiative in Substance Matters
    - Dalyce Salther-McNabb, RN, Executive Director, Northreach Society in Grand Prairie, Alberta
- Reading/Viewing
    - Rhode Island: "The Nation's First State-Authorized Overdose Prevention Center: Legal and Public Health Updates": https://www.nephtc.org/enrol/index.php?id=415 (NEPHTC webinar, 1/14/25)
    - Canada: "National Operational Guidance for the Implementation of Supervised Consumption Services", Canadian Research Initiative in Substance Matters, July 2023
- Meeting recording (link)

Meeting #7: February 21, 2025, 1:00 – 3:00 PM, via Zoom

- Agenda (link)
- Reading/Viewing
- Meeting recording (link)

INTRODUCTION

Situation overview

Since 2009, a staggering 5,800 Mainers have died from a drug overdose. And while there has been a 33% decline in fatal drug overdoses in Maine over the past two years, overdose deaths are still averaging more than one a day, with a total of 490 deaths in 2024. For comparison, Maine experienced 418 overdose deaths in 2017, which was considered at the time to be the peak of the epidemic. Clearly, this is not the time to decrease the state's investment in responding to the overdose crisis.

Among the four central pillars of prevention, treatment, harm reduction and recovery support, harm reduction always faces more barriers and opposition than the other pillars. But it is an evidence-based philosophy and is fundamental to our work here in Maine. Syringe service programs and the naloxone distribution initiative are both examples of harm-reduction, which is a practical approach that incorporates proven public health strategies to empower people who use drugs with the choice to live healthy, self-directed, and purpose-filled lives. Maine must consider all options for harm reduction and overdose prevention that are present under state and federal law and are proven to save lives without compromising public safety.

What is an Overdose Prevention Center (OPC)?

According to the National Institutes of Health, Overdose Prevention Centers (also called supervised consumption sites, or safe injection sites) are one of several harm reduction strategies to address the complex drug overdose crisis. At OPCs, participants may use substances obtained elsewhere in a controlled setting. Staff at such centers are trained to detect and respond to drug overdoses and may also provide health screenings as well as connections to other health and support services, including treatment for substance use disorder and mental health conditions.

Overdose Prevention Centers have been operational for over 35 years, with the first sites established in Europe and later expanding to Canada, Australia, and the United States. There are currently close to 200 OPCs operating in at least 17 countries across the globe. In the U.S., government-sanctioned OPCs began in 2021, with New York City's OnPoint OPC being the first. Rhode Island, Vermont, and Minnesota have all passed legislation advancing OPCs in their states. Despite a body of evidence demonstrating their many positive outcomes, opening an OPC often requires overcoming public, political, and legal resistance, especially in the United States.

Past Legislation

Legislative efforts for OPC authorization in Maine began in 2017 during the 128th Maine Legislature with LD 1375. The bill received a majority recommendation of "ought not to pass" in committee and subsequently failed on the House and Senate floor.

In 2023, during the 131st Maine Legislature, two bills were introduced regarding the authorization of OPCs. One bill, LD 1364, sponsored by Representative Lookner of Portland sought to authorize municipalities to approve overdose prevention centers for individuals to self-administer previously obtained drugs. The bill required the sites to satisfy certain requirements and also provided immunity from arrest or prosecution for participants and staff members acting in accordance with the provisions of the bill.

Additionally, the bill required municipalities that approve overdose prevention centers to participate in a peer reviewed study and required DHHS to submit reports related to the studies to the Legislature and the Governor's office. LD 1364 received a majority "ought to pass" recommendation from the Criminal Justice and Public Safety Committee, achieved a successful bipartisan vote in the House of Representatives, and was narrowly defeated in the Senate by two votes. Ultimately, a compromise was reached to approve a version of the bill that authorized this OPC Working Group.

The other bill, LD 1159, sponsored by Representative Osher of Orono, directed DHHS to create a 2-year pilot project establishing and operating an OPC to provide counseling and health service referrals and a place to use previously obtained controlled substances for participants of the center. The OPC would need approval by the municipality in which it would be located, and the bill provided immunity to the State, the municipality or employees and participants of the center from criminal or civil liability. The bill also created an advisory board to provide guidance to the department and required the department to report to the 132nd Legislature on the effectiveness of the project. The bill never received a vote on the House or Senate floor.

Public Testimony

The Working Group looked at the testimony submitted for the public hearings of LD 1364 and LD 1159. The testimony showcased diverse perspectives from various organizations, professionals, and members of the public.

LD 1364 Testimony

Fourteen (14) individuals and groups testified in favor, including the Maine State Nurses Association/National Nurses United, Maine Recovery Action Project (ME-RAP), Maine Association of Criminal Defense Lawyers, Northern New England Society of Addiction Medicine, a physician associated with the Infectious Disease Society of America, the American Civil Liberties Union (ACLU) of Maine, the Church of Safe Injection (COSI), and unaffiliated members of the public.

Eight (8) individuals and groups testified in opposition, including representatives of the Brewer Police Department, Maine Chiefs of Police Association, Gordon Smith (Director of Opioid Response) on behalf of Governor Mills, Maine Sheriff's Association, Maine Municipal Association, and residents from Bath, Auburn, and Windham.

LD 1159 Testimony

Forty-eight (48) testimonies supported the bill, with contributions from Recover2gether, Northern New England Society of Addiction Medicine, Maine Prisoner Advocacy Coalition (MPAC), India Street Harm Reduction Center (Amistad), Maine Recovery Action Project (ME-RAP), Scholars Strategy Network - Maine Chapter, Maine Family Planning, Maine

People's Alliance (MPA), the Church of Safe Injection (COSI), Maine State Legislators, Alliance for Addiction and Mental Health Services Maine, HEAL, the ACLU - Maine, Maine Drug Policy Lab at Colby College, Maine Access Points (MAP), Generational Noor, Bangor City Council members, the American Nurses Association of Maine, physicians, addiction and harm reduction specialists, Hope Brokers Inc., Augusta City Councilor Stephanie Sienkiewicz, a Preble Street Advocacy Outreach Team Leader, a USM faculty member, and unaffiliated members of the public.

Three (3) testimonies opposed the bill, including the Maine Chiefs of Police Association, Gordon Smith (Director of Opioid Response) on behalf of Governor Mills, and the Brewer Police Department.

Proponents of authorizing OPCs in Maine presented testimony highlighting several key benefits:

1. **Connection to Treatment and Support Services**: These centers serve as critical access points, linking individuals to substance use disorder treatment, medical care, and social services. For instance, Canadian OPCs have facilitated over 70,000 referrals for such services.
2. **Reduction in Infectious Diseases**: By providing sterile equipment and safe consumption spaces, OPCs help decrease the transmission of infections like HIV and hepatitis, as well as other drug-related complications
3. **Cost Effectiveness**: Preventing severe health complications through OPCs can lead to significant healthcare savings. For example, avoiding a single case of endocarditis, a serious heart infection, could fund an OPC for a year.
4. **Improvement in Syringe Waste, Public Safety, and Urban Environments**: OPCs contribute to safer communities by reducing public drug use and decreasing the presence of discarded syringes and drug paraphernalia in public spaces.
5. **Support for Vulnerable Populations**: These centers provide a non-judgmental environment where individuals can receive immediate medical assistance, access to clean supplies, and support from recovery specialists, thereby fostering trust and encouraging engagement with health services.
6. **Alignment with Harm Reduction Strategies**: OPCs are recognized as a critical component of harm reduction, aiming to keep people who use drugs alive and as healthy as possible, and are supported by major medical organizations.

Opponents of establishing OPCs in Maine articulated several concerns in their testimonies:

1. **Insufficient Evidence of Effectiveness**: The Maine Chiefs of Police Association expressed skepticism about the efficacy of OPCs in reducing drug use and overdose deaths, citing a lack of conclusive data supporting their success in achieving these goals.
2. **Legal Concerns**: Governor Mills' office highlighted that they believed federal law prohibits the operation of such facilities, creating potential legal challenges for municipalities that might establish OPCs (NOTE: It has since been clarified that OPCs operate in a legal gray area).
3. **Potential Increase in Criminal Activity**: Law enforcement officials, including the Maine Sheriffs Association, raised concerns that OPCs could attract drug dealers, increase property theft, and bring other criminal activities to the surrounding areas.
4. **Other Public Safety Concerns:** Maine's Department of Public Safety has consistently opposed OPC-related legislation and echoed the concerns raised by other law enforcement agencies as well as highlighting concerns of conflicting federal and state laws.

5. **Resource Allocation**: Some opponents, such as the Maine Municipal Association, argue that funds allocated for OPCs might be better spent on expanding treatment facilities and preventive measures, emphasizing the need for comprehensive solutions to address substance use disorders.
6. **Community Impact**: There are apprehensions that OPCs could negatively affect local communities, potentially leading to decreased property values and deterring business investments in areas where such centers are located.
7. **Normalization of Drug Use**: Some individuals fear that OPCs may inadvertently normalize or condone illicit drug use, sending a conflicting message about substance use and potentially undermining prevention efforts.

SUMMARY OF FINDINGS

Based on the information collected by the Working Group via reading, viewing, and guest interviews, followed by discussions among members, the following findings are provided:

1. **Federal Law and Policy Environment:** Federal law regarding the legality of OPCs is unsettled.
2. **State and Municipal Policy Environment and Statutory Considerations:** States can create statutory authority for OPCs, in spite of federal law, and three states have done so. Among Maine's municipalities, systems and capacities for public health, law enforcement, and community engagement vary greatly. Any statutory authority for OPCs must be responsive to local preferences, needs, and resources, and give communities the power to opt in to OPC implementation, if supported by community members.
3. **Outcome Data:** There are robust data indicating that OPCs can provide many immediate positive outcomes for their participants, with multiple studies also showing improvements in population-level health outcomes over time. While there is limited evidence that OPCs decrease population-level overdose deaths, there are some data that indicate improvements in population-level overdose deaths for communities located near the OPCs.
4. **Models and Innovations:** There are models and innovations within and outside the U.S. that could be well-suited to Maine's unique needs and environment, including models tailored for priority populations, rural settings, and public safety protocols.
5. **Community Engagement:** Community engagement is one of the most important determinants of successful implementation, reduced stigma and public safety concerns, and positive outcomes for participants.
6. **Gaps Remain:** Gaps remain in the Working Group's exploration and understanding, including gathering the perspectives and input from potential utilizers of various models being considered.

FINDINGS NARRATIVE

Finding #1: Federal Law and Policy Environment

There is no federal ruling that explicitly bans the authorization or operation of OPCs. To date, the U.S. Supreme Court has not ruled on whether the operation of an OPC directly violates federal law. Across the United States, some OPCs operate without authorization, while others are permitted through local ordinances or state laws. This legal ambiguity raised several federal statutes and questions that have been presented to the Working Group.

The group received a briefing on federal law by Jeffrey Sherman, J.D., a member of the group. Attorney Sherman authored an article for the Maine Law Review in 2022 entitled, *United States V. Safehouse: The Future of Supervised Consumption Sites in Maine and Beyond.* Most of the discussion focuses on whether such facilities, called in this case, safehouses, violate 21 U.S.C. section 856 (a) (2) which makes it a crime to "manage or control a place…and knowingly and intentionally…make (it) available for use…for the purpose of drug activity". In 2018, the federal Department of

Justice warned that supervised consumption sites and their staff would violate 21 U.S.C. section 856(a)(2), a provision of the Controlled Substances Act of 1970 that imposes criminal and civil penalties for making property available to others "for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance"

In 2018, the Philadelphia-based non-profit "Safehouse" attempted to become the first supervised consumption site in the United States but was prevented from opening as a result of a lawsuit brought by the Department of Justice (DOJ). That lawsuit, *United States v. Safehouse*, eventually became the only federal appeals court decision involving an interpretation of the so-called "crack-house" statute.

In *United States v. Safehouse*, the Third Circuit Court of Appeals overturned a district court's decision and held that supervised consumption sites violate section 856(a)(2). The court's reasoning, and the opinions of the dissent and the district court, centered around statutory construction and who must act "for the purpose of" drug activity. According to the majority's construction, Safehouse would violate the statute as long as the participants of the consumption room act with the requisite purpose. According to the dissent and the district court's construction, it is Safehouse which must act "for the purpose of" drug activity. Based upon their construction, both the dissent and the district court determined that Safehouse would not violate the statute because the purpose of a supervised consumption site is to provide access to live-saving medical treatment and to reduce, rather than facilitate, drug use.

Following the decision of the Court of Appeals, the United States Supreme Court declined to hear an appeal of the case. As a result, the Philadelphia site has never opened. While the case is a controlling precedent only in the Third Judicial Circuit (Maine is in the First Circuit), it has, nonetheless and among other factors, had an adverse impact on some state and municipalities which otherwise might have established OPCs. In the six years following the decision, the only operating sites are in New York City and Providence, Rhode Island (which just opened in January 2025). It is important to note that the Department of Justice during the Biden-Harris Administration did not take any action against the two sites in New York City which have operated since 2021. The Trump-Vance Administration has not yet announced its position with respect to the issue.

After hearing Attorney Sherman's remarks and following review of his law review article, it is the opinion of the Working Group that federal law regarding the legality of OPCs is unsettled. Prosecutorial discretion will likely determine whether sites in specific locations are permitted. Without clear direction from the new leadership at the Department of Justice or the soon to be appointed United States Attorney for the District of Maine, it will not be possible to know with certainty whether establishment of an OPC in Maine would be challenged by the federal government. Watching carefully the roll-out of the center in Providence, Rhode Island and the potential opening of a center in Burlington, Vermont later this year will provide further guidance as to the likely interaction between states and the federal government on this issue.

Finding #2: State and Municipal Policy Environment and Statutory Considerations

Despite the uncertainty of the application of the federal Controlled Substances Act to overdose prevention centers permitting safe use, several states and municipalities have taken steps to establish such sites. Other states have considered authorizing legislation, but those efforts have failed. Today there are only three operational sites in the U.S. - two in New York City and one in Providence, Rhode Island.

The two sites in New York have operated for more than two years and the Providence site welcomed its first participant on January 16 of this year. The Working Group received a presentation via zoom from staff from OnPoint NYC, which operates the two sites in New York City. The New York sites were integrated into two existing Syringe Service Programs and operate with support from the New York City Health Department.

The Working Group also watched a recorded presentation regarding Rhode Island's OPC and Working Group Chair Gordon Smith toured the Providence site in November prior to its opening. The Rhode Island Legislature authorized the Providence site, which has also received support from the Providence City Council.

Two other states, Vermont and Minnesota, have enacted legislation authorizing safe use sites, but neither state has opened a site. The City of Burlington, Vermont is actively working on a site that may open later in 2025. Minnesota regulators have expressed concern about the application of federal law. Many other states have considered authorizing legislation, but the proposals have been either defeated by the legislature or vetoed by the Governor (as happened in California). The Commonwealth of Massachusetts has considered legislation as recently as late 2024 but the legislation never received a final favorable vote in both chambers.

Should the Maine Legislature authorize such activity, local governments should have the authority to determine whether or not to allow OPCs to operate within their boundaries. In Maine, systems and capacities for public health, law enforcement, and community engagement vary greatly by municipality. Any statutory authority for OPCs must be responsive to local preferences, needs, and resources, and give communities the power to opt in to OPC implementation, if supported by its community members.

Statutory frameworks can also include allowable services and settings, equipment and infrastructure requirements, legal immunity to staff and participants, enforcement mechanisms, system integration, data collection, reporting requirements, and other operational considerations – some of which may be developed with rulemaking.

As with other harm-reduction activities, consideration of safe use sites will always be a difficult issue to manage in the current state and national milieu. The fact that only three state legislatures have enacted authorizing legislation could be an indication of this challenge. Maine can learn from these early adopters as data is collected and their successes and challenges are documented.

Citations to relevant state laws follow

1. Rhode Island: 216 RICR 40-10-25
2. Vermont: 18 V.S.A section 4256 (became law June 17, 2024 with legislative override of Governor's veto)
3. Minnesota: 2022 Section 179A.54, Chapter 61 S.F. No. 2934 (effective July 1, 2023)

Finding #3: Outcome Data

Scope of Peer-Reviewed Evidence on OPC Outcomes

Over 100 articles studying OPCs have been published in peer-reviewed medical and epidemiological literature from scientists across the globe. Articles studying the effectiveness of OPCs have been published in esteemed journals, such as the *NEJM, The Lancet, JAMA, AJPH,* and *The British American Journal.* There are robust data indicating that OPCs can provide many immediate positive outcomes for their participants, with multiple studies also showing improvements in population-level health outcomes over time. While there is limited evidence that OPCs decrease population-level overdose deaths, there are some data that indicate improvements in population-level overdose deaths for communities located near the OPCs.

Dr. Alex Kral, a leading expert on OPCs, notes that no peer-reviewed study has found negative impacts of OPCs. The Working Group has also not been able to find peer-reviewed studies that confirm a significant increase in new users, drug-related crimes such as property theft, or other negative consequences associated with the establishment of an OPC. The Working Group has noted that while the potential for negative consequences cannot be eliminated, many active OPCs have been able to mitigate consequences with forward planning and real-time management.

The following summarizes a range of outcomes evaluated by studies known to the Working Group:

Overdose Deaths

The impact of OPCs on drug overdose deaths (ODs) has been evaluated at both the individual (i.e. OD death rates for OPC clients) and the population level (i.e. OD death rates for the population of people using drugs in areas surrounding the OPC).

At the individual level, many studies have shown that OPCs have successfully reversed ODs that occurred onsite, with most showing no fatal ODs occurring at the OPC. In San Francisco's Tenderloin Center, for example, 333 overdoses were recorded, but there were zero fatalities. Since OnPoint opened in NYC in 2021, staff have intervened in 1700 overdose events with zero fatalities.

These OD reversals, however, while clearly important and as noted by a RAND evaluation published in 2018, "…do not equate to the net population-level effect of operating [OPCs] since it is impossible to know what would have happened had the [OPC] never been opened; however, people who use opioids who overdose in the presence of trained staff equipped with naloxone are much more likely to have it reversed than if they had overdosed on the same product without supervision".

The RAND report also notes that much of the research evaluating OPCs was conducted prior to the emergence of increasingly potent and synthetic opioids, such as fentanyl. "...the potency of these substances increases the risk of overdose during any given use event, increasing the number of overdoses prevented per use session supervised". According to the Maine Monthly Overdose Report for December 2024, 72% of fatal overdoses in 2024 involved fentanyl or an analog of fentanyl. Accordingly, OPCs may have more of a net-population effect on fatal overdoses when there is an increased lethality in the drug supply, as seen in places like Maine.

There have been at least two studies demonstrating an association of OPCs with decreased population-level OD death rates for the population living in areas proximate to the OPC:

- A study published in Lancet Public Health in 2024 used ecological and spatial analyses to identify differences in OD mortality in Toronto Canada, an area highly affected by drug OD deaths, in communities proximate to Supervised Consumption Service (SCS) sites. The study examined OD death rates for the period before, and one year after, implementation of the SCS sites. Study findings demonstrated that OD mortality decreased from an initial 8.10 deaths per 100,000 people in the period prior to implementation of SCS sites, to 2.70 per 100,000 people at one year in neighborhoods where SCSs were implemented. The following reductions in OD mortality rates were noted in neighborhoods surrounding a SCS:
    - within 250 m radius: 67% reduction
    - within 500 m radius: 67% reduction
    - within 1000 m radius: 69% reduction
    - within 2500 m radius: 60% reduction
    - within 5000 m radius: 59% reduction (NOTE: this area equates to approximately 30 sq. miles)

  These findings suggest that implementation of SCS sites was associated with significant reductions in OD mortality in the neighborhoods surrounding the site.
- An earlier study published in Lancet in 2011 examined OD deaths before and after the opening of a Supervised Injection Site (SIS) in Vancouver, Canada, and similarly demonstrated a decrease in OD deaths for individuals living near the site. Following implementation of SIS, OD death rates decreased from 253 to 165 deaths per 100,000 person-years for the area within 500 m of the site, and it was estimated that 1 OD death was prevented annually for every 1137 users.

Other Health Outcomes for OPCs Clients:

There also is considerable evidence that OPC sites provide a positive experience for participants, with significant reductions in health risks, ED visits, and hospitalizations, and all-cause mortality over time. Additionally, use of OPCs has been associated with increased engagement in SUD treatment, which has the potential to improve the health outcomes over time for individuals who use drugs.

A 2019 study of supervised injection facilities (SIF) in Vancouver, Canada observed a high burden of premature mortality among a community-recruited cohort of PWID, which was associated with a decrease in all-cause mortality rates for individuals who used SIFs. Study authors concluded "Frequent SIF use was associated with a lower risk of death, independent of relevant confounders. These findings support efforts to enhance access to SIFs as a strategy to reduce mortality among PWID".

A 2023 French study examined health outcomes for people who frequented a Drug Consumption Room (DCR) over a one-year period. The study found a 67% reduction in reported overdoses in this group, as well as decreases in the rate of infectious abscesses and ED visits for individuals who regularly used DCRs. In another study of unsanctioned OPCs, participants were found to be 27% less likely to visit the emergency department and 32% less likely to be hospitalized.

A 2011 study of a Supervised Injecting Facility (SIF) in Vancouver, Canada examined factors associated with the time between an individual's drug use and their entry into addiction treatment and found that regular SIF use was positively associated with initiation of addiction treatment. Study authors noted, "... these data indicate a potential role of SIF in promoting increased uptake of addiction treatment and subsequent injection cessation."

An earlier (2007) study of a specific Supervised Injecting Facility (SIF) in Vancouver, Canada found that the opening of the facility was independently associated with a 30% increase in use of drug detoxification services; additionally, the study found that use of these services was associated with increased rates of long-term addiction treatment initiation and reduced injecting at the SIF.

Additionally, participants in these centers show improved engagement with healthcare services, including substance use disorder (SUD) treatment, which contributes to long-term recovery outcomes. Participants also report feeling safer, with a lower likelihood of using drugs alone and less engagement in risky behaviors, such as syringe sharing. OPCs, by offering a safe space and a variety of health services, foster trust and long-term care for people with SUDs.

Beyond peer-reviewed articles, there are a number of studies and evaluations that are critical of OPCs. The Sanford-Lancet Commission on the North American Opioid Crisis published a report in Feb. 2022 (www.thelancet.com Vol 399, Feb. 5, 2022). On page 582 of the report, the Commission states as follows:

> *"Research on supervised drug consumption sites is methodologically weak but generally suggests that the risk of death from overdose is lower at such sites than outside of them. However, there is no evidence that accessing a site lowers an individual's risk of fatal overdose over time, or that sites lower community overdose rates." (cite to Pardo, B, Caulkins JP, Kilmer B. Assessing the evidence on supervised drug consumption sites. Santa Monica, CA: Rand Corporation, 2018)*

In the spring of 2019, the Government of Alberta, CA announced a freeze on funding new Supervised Consumption Sites (SCS) pending a review of the socio-economic impacts of existing and proposed SCS sites on their host communities. In September 2019, an SCS Review Committee was established to conduct a series of public consultations and to review the available documentation relating to those sites. Although the stakeholder feedback on the socio-economic impact was mixed, it was predominantly negative, except for the Edmonton town hall meeting. The issues raised ranged from increases in needle debris to increases in crime and increases in overall social disorder since the sites opened.

Many public health and harm-reduction organizations in Canada have since taken issue with the Alberta report and its lack of peer review. It could also be said that nearly every report reviewed by the Working Group has been subject to some level of criticism, which is to be expected given the complex issues and strong community feelings involved.

Outcomes for Neighborhoods Affected by OPCs

Notwithstanding the 2019 report from Alberta, Canada noted above, OPCs elsewhere have demonstrated clear benefits for the neighborhoods in which they are located, particularly in reducing public drug use, discarded syringes, and associated crime.

In San Francisco, for example, drug-related issues on the streets decreased by 19% from 2019 to 2022, and crime in neighborhoods with OPCs dropped significantly compared to areas without. Furthermore, these centers have helped alleviate the burden on emergency services and law enforcement by preventing overdose fatalities and reducing the number of overdose-related 911 calls. OPCs contribute to safer, cleaner neighborhoods by addressing the visible and dangerous effects of public drug use, improving community health, and fostering a more supportive environment for those affected by substance use disorder.

In a study conducted at an unsanctioned overdose prevention center in an undisclosed United States city in 2018-2020, the rate of improperly disposed syringes per number of injections in prior 30 days was significantly lower among people who had used the unsanctioned safe consumption site during the same period (incident rate ratio 0.42; 95% confidence interval=0.18, 0.88). The researchers concluded that when people used this unsanctioned safe consumption site, they disposed of significantly fewer syringes in public places, including streets, sidewalks, parks, playgrounds, or parking lots, than people not using at the site.

A study examining Vancouver's Insite, North America's first supervised injection facility, observed significant reductions in public drug use and injection-related litter following its establishment. Researchers noted decreased instances of public injecting and fewer publicly discarded syringes and injection-related litter in the surrounding area. These studies help allay concerns that implementing safe consumption sites in the US would lead to increases in improperly disposed syringes.

Early evidence from OnPoint NYC's two sanctioned overdose prevention centers demonstrates a significant reduction in improperly discarded syringes in public parks. Before the opening of OnPoint, NYC Parks reported collecting an average of 13,000 syringes per month in Highbridge Park, located directly across the street from the Washington Heights OPC location. In the month following the opening of the Washington Heights OPC, syringe collection in Highbridge Park dropped dramatically to just 1,000 syringes collected by NYC Parks.

Cost-effectiveness of OPCs

OPCs are highly cost-effective, with multiple studies showing significant savings in healthcare and law enforcement costs. For instance, it is estimated that a single 13-booth OPC in San Francisco saves approximately $3.5 million annually. New York City has also demonstrated cost savings, estimating $0.8 to $1.6 million saved per center annually, with four centers potentially saving up to $5.7 million. Rhode Island is on the verge of opening up its first OPC, and it is estimated that a Providence OPC will save $1.1 million annually compared to operating just a syringe service program alone.

These savings stem from reductions in emergency medical services, hospitalizations, and law enforcement interventions, making OPCs a financially viable part of a comprehensive harm reduction strategy. By investing in OPCs, communities can reduce the costs of overdose deaths, healthcare burdens, and calls for service to law enforcement, while also reducing the costs of responding to open drug use and improperly discarded syringes in communities.

On the other hand, the costs of establishing a fixed site are substantial and the opportunity costs are great as well. It took the vendor, Weber-Renew in Rhode Island, nearly four years from the time the statute passed to the opening of the site. Funding for both the open site in Providence and the proposed site in Burlington, Vermont has been largely through opioid settlement funds, rather than through state appropriations. The use of the settlement funds for OPC operations raises the issue of sustainability, as these funds are generally not perpetual. For this reason, settlement funds might be best used for OPC start-up costs or pilot projects, while private funds or mixed funding streams could be an option to assist with long-term sustainability.

OPCs and Law Enforcement

OPCs globally have shown to reduce drug-related crime and violence in communities, with neighborhoods seeing a decrease in crime rates after the establishment of OPCs. Law enforcement support is crucial for OPC success, as seen in New York, where police officers now bring participants to OnPoint's doors. Especially after opening, the New York Police Department has seen the value that OPCs provide in terms of being able to keep people safe and connect individuals with treatment and services. In Vermont, the coalition advocating for the legalization of OPCs had the support of the state's Attorney General.

Law enforcement support or resistance to OPCs varies at local and state levels but law enforcement officers in Maine remain almost universally opposed to the location of such sites in their municipalities. Whereas local law enforcement in Providence, Rhode Island are supportive of the upcoming opening of the state's first OPC, other sheriff's departments in the state have come out against OPCs. For an OPC to proceed successfully in Maine, early and regular engagement and information sharing with law enforcement professionals will be essential.

Finding #4: Models and Innovations

In its research, the Working Group was keenly focused on identifying operational models that could be well-suited and appropriately tailored for Maine's unique needs and environment, including Maine's priority populations, rural settings, and public safety expectations. The Working Group prioritized its reading and interviews accordingly, from which the following findings were gleaned:

a. Medical Model: Many best-practice harm reduction initiatives have their origins in peer-led models established in response to community need. The same is true for the development of safe use protocols among friends and family. While recognizing the importance of peer-to-peer strategies, the Working Group focused on the design and OPC models that include a medically trained workforce and protocols.

b. Scope of services: OPCs provide a wide range of services aimed at protecting users' health and connecting them to essential social and medical services. OPCs are places where people can use drugs they obtain prior to accessing the OPC under the supervision of health professionals equipped with oxygen, naloxone, and the training to save lives in the event of an overdose. OPCs offer access to harm reduction tools such as syringe service programs and naloxone. Many OPCs provide or offer referrals to other services, including substance use treatment, housing assistance, infectious disease testing, and mental health resources. Many also provide food, showers, and laundry options in acknowledgement of the high proportion of clients who are unhoused. It should be noted that while Maine has made significant progress in expanding options for treatment and recovery throughout the state, there is some concern that there still may not be enough treatment and support options available, especially in rural areas, which may set OPCs up for failure in providing individuals with treatment options upon request and in real time.

c. Fixed, Mobile, Remote: OPCs are going to be utilized most regularly by people who are unhoused. People who use drugs and have their own housing are more likely to use at home and not at an OPC. This indicates a need for at least two different models: 1) fixed locations in communities with higher risk and fewer housing resources, and 2) mobile or telehealth options for those more likely to use drugs in homes.

d. Mobile Pilot: The mobile model offers an intriguing opportunity for Maine, where mobile units are already successfully delivering other public health and health care services. Many fixed-location OPCs are in dense urban areas. Given Maine's overwhelmingly rural nature, the mobile model could more effectively serve more of the state. The mobile model might be a worthwhile pilot, given its temporary nature that can ease community concerns as well as its ability to move to "hot spots" where high risk and need have been identified by medical or law enforcement professionals. A mobile unit creates less stress on a community or neighborhood. It should also be noted that in at least one community in northern Canada, a mobile unit is used in the same location every day (and is garaged every night), which is next to a service center for people who are homeless. The result is predictability, moveability, and integration – a combination which some might consider ideal for a pilot project.

e. Integration: OPCs that are integrated within other settings and services are going to be less expensive to stand up and more likely to be utilized and normalized in a community. Depending on the setting, integrated OPC models can streamline connections to other health and social services and are less likely to experience challenges related to fear and stigma. The most successful integrated designs include an OPC space that is separated from other service areas by a "chill space" transition area. Settings that could be considered for an integrated and medically staffed OPC include community health centers, primary care practices, homeless service centers, pharmacies, and syringe program locations.

f. Ventilation: Many OPCs are grappling with how to accommodate the use of drugs that are smoked. The Working Group examined ventilation requirements and other smoking-related infrastructure guidance from Vermont and Canada, where workforce protections are taken as seriously as they are in Maine. This is an evolving technology that may be difficult or cost prohibitive to install in some settings, though lower cost options are also being successfully implemented. Any state authorization that includes smoking will need to take ventilation into account.

g. Other Operational and Safety Considerations: Many models from other states and countries that were examined by the Working Group include one or more of the following components for the protection of staff, participants, host organizations, and the public: 1) participant behavior contracts; 2) host organization liability agreements; 3) safety policies and protocols inside the OPC; and 4) public or community-based transportation to and from the OPC

Finding #5: Community Engagement and Buy-In

Community engagement is one of the most important determinants of successful OPC implementation, reduced stigma and public safety concerns, and positive outcomes for participants. In almost every interview with special guests operating OPCs, Working Group members asked about community engagement strategies, lessons learned, and recommendations for Maine.

The Working Group gleaned from these interviews that negative preconceptions of OPCs include concerns about increased drug trafficking; increased activities related to purchasing drugs, including sex trafficking; increased and more visible disorderly behaviors, which are often interpreted as an increase in crime; increased property crimes, such as theft; increased normalization and initiation of drug use among young people; and other stigma related fears. And while most of these concerns are ultimately not matched by substantiating data, leaving these negative community perceptions untouched can be difficult to overcome. It's possible that some OPCs have been authorized but not implemented at least in part because of a failure to secure community understanding and buy-in.

These unfortunate lessons learned were counterbalanced by a strong foundation of best practices that emerged immediately from research and interviews, including the importance and value of:

- Early and ongoing engagement of neighbors – both individuals and businesses
- Early and ongoing engagement of public safety and law enforcement professionals
- Model design that integrates and normalizes the OPC in the community
- Engaging in regular community service for community benefit, including syringe waste collection
- Hosting and joining community events
- Collecting data and sharing outcomes and stories with the community, including the positive bridges being built to treatment and recovery

Finding #6: Gaps Remain

The Working Group recognizes that their efforts were thorough but not exhaustive in the timeframe provided, so gaps in knowledge and areas of exploration remain. If the Maine Legislature chooses to seek additional data, the following areas or activities could be considered (in no particular order):

- Outcome data from Rhode Island
- Outcome data from Vermont
- Updated federal guidance and/or signals from the Trump Administration
- Additional examples and data from mobile settings
- Additional examples and data from virtual/hotline models, including SafeSpot at Boston Medical Center
- Deeper analysis of which settings might be particularly well-suited for establishment of an integrated model
- Identification of pilot criteria and potential locations and settings
- Focus groups among potential utilizers of various models
- Community engagement in priority areas

RECOMMENDATIONS

In its first meeting, the Working Group agreed on two key points related to their formulation of recommendations: 1) they are not the ultimate decision-making body so can focus their efforts on studying the OPC issue and providing options for Maine lawmakers to consider and 2) they do not require consensus but will seek consensus whenever possible. This approach recognizes that because there likely is not full consensus among stakeholders in Maine, the Working Group is not providing recommendations on whether or not to authorize OPCs – that is the purview of the Maine Legislature – but instead, is providing recommendations to assist the Legislature in making their decision and in the design of any statutory provision they choose to advance.

The following recommendations reflect a consensus agreement of the Working Group, based on their best interpretation of their charge and within their designated timeframe. Each primary recommendation is followed by one or more related recommendations. Each recommendation was considered and discussed by Working Group members at Meeting #7. Working Group members were given two additional opportunities to provide their input and positions via email before this report was finalized.

The Working Group provides the following consensus recommendations to the 132nd Maine Legislature:

1. **Federal Law and Policy Environment:** Because federal law is unsettled and the actions of the Trump Administration are unknown, the Maine Legislature should proceed with the understanding that implementation efforts and timelines may shift as they go.
2. **State and Municipal Policy Environment and Statutory Considerations:** Maine is well within its bounds to create statutory authority for one or more OPCs, should it choose to do so. Lawmakers would be well-advised to gather updated information and guidance from other states that have done so. Statutory authority or rulemaking should include:
    a. **Empower Municipalities with Local Control:** Ensure that municipalities have the authority to opt in to permitting OPCs within their jurisdictions. This should include appropriate control over design, placement, and operations guidelines. All state-authorized provisions related to implementation of OPCs must apply only to municipalities that have adopted the provisions of the relevant state statute.
    b. **Support Municipalities in Community Engagement:** Municipal systems and capacities vary, so ensure municipalities can conduct public hearings and engage stakeholders as part of their decision-making, design, and implementation processes for establishing OPCs. This sets OPCs up for success by ensuring transparency, establishing early relationships, and identifying suggestions, concerns, and innovations.
    c. **Provide Legal Immunity to Staff and Participants:** Grant legal protections to both staff and participants involved in OPCs to promote safety and encourage utilization, including authorizing staff as "dually authorized officers" of the state. The qualified immunity provided should be limited to drug-related offenses and should not shield medical or behavioral licensees from a medical malpractice claim or a disciplinary sanction from a licensing board (so long as the sanction was not for merely volunteering or working at the center).
    d. **Allow the Option of Funding OPCs with Opioid Settlement Funding and Private Donations:** Allow communities to utilize a portion of opioid settlement funds to support the establishment and early operation of OPCs. Encourage collaboration with private donors and foundations to supplement funding, ensuring the sustainability and expansion of these services.

3. **Recommendations to Maximize Outcomes:** For any model to be as effective as possible, the following should be included in any authorizing statute or rulemaking:
    a. **Include Expectations for Partnerships and Collaborative Efforts** that will maximize coordination among all government-funded programs and infrastructure.
    b. **Include Requirements for Addressing Public Safety Concerns**, including weapons restrictions inside facilities and the operation of vehicles upon leaving facilities.
    c. Include Funding for Data Collection, Evaluation, and Reporting that will benefit Maine's efforts and provide valuable information to other states and countries examining options for OPCs, as this Working Group has done.
4. **Models and Innovations:** The model with the most likelihood for success will be one that is designed and tailored for Maine's unique needs and environment, including our population, rural setting, and public safety necessities. Statutory authority or rulemaking should include:
    a. **Allow for Fixed and Mobile OPCs:** Facilitate the establishment of both fixed-location and mobile harm reduction centers to expand access to services across diverse communities.
    b. **Allow All Forms of Substance Use at OPCs:** OPCs should allow all methods of substance use, including injection and smoking with proper ventilation. This approach acknowledges not only that substance use varies by region and community, but that OPCs should be designed with maximize flexibility to ensure there are no barriers to participation, now or in the future.
    c. **Pilot a Mobile Unit with a Virtual Component that is Integrated with Existing Health and Social Service Infrastructure:** The Working Group believes a truly tailored-for-Maine model is one that is situated where participants are already likely to be, utilizing other health and social services. A piloted approach is both prudent and strategic, allowing for assessment and refinements before additional sites are implemented. If the Maine Legislature were to authorize a pilot OPC, the Working Group recommends an integrated mobile unit with a robust telehealth (virtual video) component. This approach will minimize cost and allow data to be collected and analyzed relatively quickly, without the extended design and construction processes that a fixed site could require. Any such pilot should only be operated within the boundaries of a municipality that has opted in to permitting an OPC.
    d. **Direct DHHS to Develop Guidance for OPCs:** Assign the Department of Health and Human Services the responsibility of convening a working group of medical professionals, public safety and public health professionals, harm reduction and social service providers, and people with lived experience, to draft comprehensive implementation guidelines, modelled after Vermont's, to ensure the effective and standardized operation of OPCs, including:
        i. Appropriate location and zoning regulations
        ii. Ventilation and other infrastructure
        iii. Operational and public safety guidance
        iv. Data collection
        v. Reporting
        vi. Enforcement
5. **Recommendations for Community Engagement:** Include a robust community engagement component in any authorization and implementation plan that includes resources for communities interested in exploring an OPC with potential participants, stakeholders, and their broader community. This one low-cost step can make or break the eventual success of a new OPC.

6. **Recommendations for Filling Gaps:** While the Working Group is pleased with what it has accomplished, a study of this scope by a dozen dedicated volunteers and one contracted facilitator has obvious limitations. These are complex issues and there are unresolved areas which ultimately the Legislature and regulators will have to consider prior to the implementation of any OPC. At a minimum, these include:
    a. Assessing the position of the new federal administration and whether the future will likely be non-enforcement through prosecutorial discretion or an aggressive enforcement of federal law.
    b. Assessing new data that will be emerging from Providence, Rhode Island and potentially Burlington, Vermont later this year.
    c. Learning from the organizations operating virtual sites in the Province of Ontario or from the sites in the nearby Province of Quebec.
    d. Hosting one or more public forums, which is an essential part of any successful project in the harm-reduction space.

Looking Ahead

If requested by the Joint Standing Committee on Criminal Justice and Public Safety, the Working Group is willing to continue our work and prepare a final report in December 2025. Realizing the funds appropriated for the study have been fully utilized, we are willing to seek outside resources to continue the work so there would be no expense to the State of Maine.

APPENDICES/RESOURCES

Appendix A: Resources

Background

- Legislative Resolve (LD 1364): link
- Compilation of testimony from previous Maine legislation (LD 1159 and LD 1364): link
- Maine Drug Data Hub: link

Authorization

- Sherman, J. Maine Law Review: "U.S. v Safehouse: The Future of Supervised Consumption Sites in Maine and Beyond", https://digitalcommons.mainelaw.maine.edu/cgi/viewcontent.cgi?article=1763&context=mlr

Models & Outcomes

- Alberta Health: "A socio-economic review of supervised consumption sites in Alberta", https://open.alberta.ca/dataset/dfd35cf7-9955-4d6b-a9c6-60d353ea87c3/resource/11815009-5243-4fe4-8884-11ffa1123631/download/health-socio-economic-review-supervised-consumption-sites.pdf
- Canadian Medical Association Journal: Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. Wood, E., Kerr, T., Small, W., Li, K., Marsh, D. C., Montaner, J. S. G., & Tyndall, M. W. (2004); 171(7), 731–734. https://doi.org/10.1503/cmaj.1040774
- Canadian Research Initiative in Substance Matters: National Operational Guidance for the Implementation of Supervised Consumption Services; Edmonton, Alberta; July 17, 2023. Version 1; https://crism.ca/wp-content/uploads/2023/09/scs-og-final-20-sept-2023-1.pdf
- Current HIV/AIDS Reports: "Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review"; 2017 https://link.springer.com/article/10.1007/s11904-017-0363-y
- Drug Policy Alliance: "Clearing the Path for Overdose Prevention Centers in the United States", https://drive.google.com/file/d/1T2RWuSEOSIY4xsbPgGKld_u2eChnt1le/view
- Harm Reduction Journal: "Implementation and sustainability of safe consumption sites: a qualitative systematic review and thematic synthesis", https://link.springer.com/article/10.1186/s12954-022-00655-z
- International Journal of Epidemiology: Impact of drug consumption rooms on non-fatal overdoses, abscesses and emergency department visits in people who inject drugs in France: Results from the COSINUS cohort. Roux, P, Jauffret-Roustide, M, Donadile, C, et al. 2023. 52 (2):562–576: https://doi.org/10.1093/ije/dyac120
- Kral, A. H., Lambdin, B. H., Wenger, L. D., Davidson, P. J., McNeil, R., & Bluthenthal, R. N. (2021). Improved syringe disposal practices associated with unsanctioned safe consumption site use: A cohort study of people who inject drugs in the United States. Journal of Substance Abuse Treatment, 129, 108407. https://doi.org/10.1016/j.jsat.2021.108407
- Kral, Alex webinar, USC: Overdose Prevention Sites: Global and Domestic Research, Policy, and Implementation, https://www.youtube.com/watch?v=EwurYVVcyGE
- Lambdin BH, Davidson PJ, Browne EN, Suen LW, Wenger LD, Kral; "Unsanctioned Safe Consumption Site: AH. Reduced Emergency Department Visits and Hospitalisation with Use of an Unsanctioned Safe Consumption Site for Injection Drug Use in the United States"; (2022) https://pubmed.ncbi.nlm.nih.gov/35020166/
- Lancet Public Health: Rammohan I, Gaines T, Scheim A, Bayoumi A, Werb D. Overdose mortality incidence and supervised consumption services in Toronto, Canada: an ecological study and spatial analysis. Lancet Public Health. 2024 Feb;9(2): e79-e87. https://doi:10.1016/S2468-2667(23)00300-6
- Lancet: Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. Marshall BD, Milloy MJ, Wood E, Montaner JSG, Kerr T. 2011: 377 (9775): 1429-37; https://www.researchgate.net/publication/51055852
- Minnesota Department of Human Services: Safer Use Sites FAQ, https://mn.gov/dhs/people-we-serve/adults/health-care/alcohol-drugs-addictions/programs-and-services/safe-recovery-sites.jsp

- NEJM: "Evaluation of an Unsanctioned Safe Consumption Site in the United States", Kral, A. H., Lambdin, B. H., Wenger, L. D., & Davidson, P. J. (2020), https://www.nejm.org/doi/full/10.1056/NEJMc2015435
- New York City Department of Health and Mental Hygiene: "Overdose prevention in New York City: Supervised injection as a strategy to reduce opioid overdose and public injection", 2017. https://www.nyc.gov/assets/doh/downloads/pdf/public/supervised-injection-report.pdf
- OnPoint: Overdose prevention centers: Baseline report; NYCGibson, B., See, K., Vargas Estrella, B., & Rivera, S. (2023) https://onpointnyc.org/wp-content/uploads/2023/12/ONPOINTNYC_OPCREPORT_small-web1.pdf
- RAND: "Assessing the Evidence on Supervised Drug Consumption Sites", 2018; https://drive.google.com/file/d/1OD1R_GfLO-rcRSrIYmiddYerYE6ojyNF/view
- Rhode Island Department of Health: Harm Reduction Center Pilot Program fact sheet, https://health.ri.gov/publications/factsheets/Harm-Reduction-Center-Pilot-Program.pdf
- RTI International. (2018.). Cost-benefit analysis of opening a safe consumption site in San Francisco. RTI International. https://www.rti.org/impact/cost-benefit-analysis-opening-safe-consumption-site-san-francisco
- RTI International. (2023). Cost-benefit analysis of opening a safe consumption site in Providence, Rhode Island, https://www.rti.org/impact/cost-benefit-analysis-opening-safe-consumption-site-providence
- Science Direct: Impact of an unsanctioned safe consumption site on criminal activity, 2010-2019, https://www.sciencedirect.com/science/article/abs/pii/S0376871621000168
- Science Direct: Supervised injection services: What has been demonstrated?, https://www.sciencedirect.com/science/article/abs/pii/S0376871614018754?via%3Dihub
- Vancouver, Canada: Supervised injection facility use and all-cause mortality among people who inject drugs in Vancouver, Canada: A cohort study, PLOS Med 16 (11): e1002964, Kennedy MC, Hayashi K, Milroy MJC, Wood E, Kerr, T. 2019. https://doi.org/10.1371/journal.pmed.1002964
- Vancouver: [Debeck K, Kerr, T, Bird L, et al. 2011. Injection drug use cessation and use of North America's first medically supervised safer injecting facility. Drug Alcohol Depend. 113 (2-3): 172-176. https://doi:10.1016/jdrgalcdep.2010.07.023
- Vermont Overdose Prevention Center Operating Guidelines, https://www.healthvermont.gov/sites/default/files/document/dsu-overdose-prevention-center-guidelines.pdf
- Wood E, Tyndall MW, Zhang, R, et al. "Rate of detoxification service use and its impact among a cohort of supervised injecting facility users", 2007, https://www.researchgate.net/publication/6308861

Appendix B: Report from Meeting #1

NOTE: All references to harm reduction health centers, or HRHCs, in the original meeting report have been changed to Overdose Prevention Centers, or OPCs, for the purposes of this report to the Maine Legislature.

Date: Friday, October 11, 2024; 10:00 AM – 12:00 PM

Location: Department of Health & Human Services, 109 Capitol Street, Augusta, ME 04330

Participants: Gordon Smith (chair); Rick Desjardins; Jennifer Gunderman; Shain Johnson; Lisa Letourneau; Dena Libner; Scott Nichols; Tess Parks; Rachel Solotaroff; Scott Stewart; Carol Kelly (facilitator)

Materials

- Legislative Resolve (LD 1364)
- August 2024 Overdose Report

Agenda Items and Meeting Notes

- Welcome & Member Introductions
- Overview of the Work Ahead
- Situation & Background
- Suggestions for Areas of Inquiry and Special Guests
    - General discussion
        - Overdose Prevention Centers (OPCs) are not currently possible in Maine
        - Maine legislators will want to know:
            - What can be changed in Maine law to make OPCs possible?
            - Can OPCs work in Maine?
            - What's likely to happen if OPCs are allowed and established?
            - What's else do legislators need to consider as they decide if and how to proceed?
    - Brainstorm: *SEE TABLE BELOW*
- Process & Logistics
    - Roles, responsibilities, general process, and decision making
        - The Working Group is not the ultimate decision-making body – that falls to the Maine Legislature
        - The Working Group's role is to study the issue, evaluate options, and deliver findings and recommendations to the Criminal Justice and Public Safety Committee of the Maine Legislature
        - The Working Group does not require consensus, but it will seek consensus whenever possible
        - The Working Group has agreed by consensus to a set of "Group Agreements". These can be revisited at any time upon request of any member.
        - In a future meeting, the Working Group will consider the option of hosting a public forum
    - Substitutions (agreed by consensus)
        - Any member can designate a substitute for a specific meeting, with the understanding that the substitute will be fully briefed and brought up-to-speed beforehand
    - Future meeting format and frequency (agreed by consensus)
        - In-person meetings are preferable; hybrid meetings are acceptable if they improve participation
        - Zoom meetings will be recorded and available for any members who are absent
        - The next meeting will be scheduled on a Friday in November and options for subsequent meetings will be explored via a scheduling "doodle"
    - Library of resources
        - An online Working Group library will be created for access by members and the public
        - A contact list of Working Group members will be maintained by the facilitator - not in the library
- Closing & Adjourn

Group Brainstorm: Areas of Inquiry, Research, and Special Guests

Areas of inquiry	Reading/Research	Guests/Site Visits
Authorization types	• State examples • Municipal examples	

Statutory barriers	• Federal
	  ○ Maine Law Review article (Jeff Sherman)
	  ○ Other aspects of criminal code to be considered
	• Maine
	  ○ Maine's conflicting statutes
	  ○ Links to testimony on past legislation
		• Maine AG willing to respond to Working Group questions

Areas of inquiry	Reading/Research	Guests/Site Visits
Scope of use	• Examples: inhaling, ingestion, injection • What other care and services can be offered?	• Other states' perspectives
Ranges of potential outcomes and (related) Potential data collection and evaluation design	Examples: • Nonfatal overdoses • Related issues (infection, etc.) • Referrals • Engagement with treatment, continuum of care • Recovery impacts • Trust and engagement with providers • Impacts on people who are unhoused • Shifts in perception of safety among people who use drugs • Changes in overall use • Health care cost savings • Community impacts, incl. syringe waste, disorderly behavior, and minor criminal activity in the vicinity	• Someone to provide information on current and potential data (and related or proxy data) • All Working Group members talk to colleagues and collect qualitative data • Philadelphia: why did they close – what worked and what didn't • For overview and evaluation considerations: Dr. Kral webinar, Institute of Addiction Science
Community conversations	Examples: • How do communities view the services being provided? • What messages are being used by advocates and opponents to describe OPCs? • What's the temperature of interest and potential acceptance in Maine? • How should beliefs and attitudes guide the Working Group recommendations, if at all?	
Rural vs. "urban" settings	• Could OPCs work in areas of less population density and less dense development?	• Vermont perspective
Mobile vs. bricks & mortar infrastructure	• Could mobile mitigate fear and stigma? • Could mobile mitigate transportation barriers in rural areas? • Could a mobile response to "hot spots" of poisoned drug supply be used as OPC pilots?	• Maine mobile health unit operator(s)
Hotlines for monitoring safe use	• How and who could fund and sustain? • How to embed with detox?	
Model examples and comparisons	• New York City report • Reports from other states and countries (there are over 100 around the world) • Master list of locations and models developed by Working Group team	• Portugal's Director of Opioid Response • New York City • Rhode Island (potential site visit in the future) • Boston (Health Care for Homeless model) • Montreal • Rowland Robinson (international perspective)