WRITTEN TESTIMONY for the BEHAVIORAL HEALTH COMMITTEE
Michigan House of Representatives

of Kim Gannon, PhD Candidate in Health Policy, Yale University School of Public Health
In Support of HB 5178

Thank you, Madame Chair and members of the committee, for the opportunity to submit written testimony. My name is Kim Gannon. I come to you as a person in recovery from substance use disorder (SUD) with eight years of continuous sobriety, a PhD candidate at the Yale University School of Public Health, a former emergency medical technician, a proud Michigan State University alumna, and somebody who calls Michigan home. I am writing to testify in **strong support of HB 5178**. Specifically, I urge the committee to:

- **Bring the bill to the floor as soon as possible, and**
- **Approve the language which protects second- and third-party distribution.**

First, on a personal note: This bill is close to my heart. My recovery began as a student at Michigan State on April 4th, 2015, when I used my last drug. Quickly, I was embraced by the recovery community in Lansing who, despite my personal shortcomings, loved me back to life. It was this spirit of meeting me "where I was at" that helped me find the resolve I sorely needed to recover. By the grace of God, I soon earned my bachelor's degree and was eventually accepted into a PhD program to study policies that combat the overdose crisis. I am living proof that no life, regardless of drug use, should be neglected. In exactly that spirit, I urge this committee to support this bill, which provides legal support and promotes best practices for syringe service programs (SSPs) in Michigan.

Background: Why we need SSPs in Michigan

The evidence supporting SSPs is overwhelming. This base, which spans over three decades, indicates that in both rural and urban areas, SSPs are successful[1] in:

- Preventing the spread of infectious diseases like the HIV and Hepatitis C, by up to 97%[2–5];
- Dramatically reducing the societal cost associated with HIV infection and transmission (up to a $243.4 million return on investment in one city)[6];
- Reducing syringe litter, thereby averting community needlestick injuries for first responders[7,8],
- Facilitating access to naloxone[9–11], a life-saving overdose prevention drug; and
- Facilitating access to SUD treatment for those who want it[12], while all the while
- Showing *no demonstrable increase* on drug use[13] or crime[14,15].

This is especially important for Michigan, where the CDC estimates that eleven Michigan counties are particularly vulnerable to HIV outbreaks due to drug injecting behavior: Ogemaw, Clare, Oscoda, Montmorency, Lake, Presque Isle, Alcona, Roscommon, Crawford, Kalkaska, and Cheboygan[16]. In these rural counties, SSPs can be particularly useful in averting danger. One only need to review the cautionary tale of Scott County, Indiana's 2014 HIV outbreak – where between 90 and 97%[2,3] of the 237 infections within a three month span could have been prevented had an SSP been in place – to understand both the magnitude of potential crisis and the near certainty that SSPs can help avert it. In fact, Jerome Adams, Indiana native and former Trump-appointed surgeon general, has been a vocal advocate for SSPs, both then and now[17].

Why we specifically need HB 5718

However, without the passage of HB 5178, Michigan will not be able to reap these benefits. Currently, hundreds of municipalities effectively curtail SSP operation under local drug paraphernalia laws, particularly in the rural counties most vulnerable to HIV outbreaks. Without state legislative action, SSPs will be unable to operate effectively and reliably where we most need them. Most recently, in West Virginia[18], a lack of legal protection for SSPs have resulted in their closure – closures associated with increased rates of rebound HIV infection.

These closures are devastating, especially when considering the multitude of other SSP services that communities rely on – including overdose prevention, access to health care and social services, and referrals to treatment. In Michigan alone, over 2000 overdoses were reversed in an SSP in 2020, and while impressive on its own, this feat is made even more impressive by the scarcity of SSPs throughout the state. Moreover, SSP participants were found to be five times more likely to enter treatment for substance use disorder – a fact highlighting the value of SSPs in connecting people to care and recovery[19]. As we continue to lose thousands from drug overdose and infection in the midst of the overdose crisis, we cannot afford to lose these vital services. HB 5178 would outline a much-needed process under which these centers can be implemented without fear of legal retribution.

Why we need language that protects second- and third-party distribution

Decades of research have demonstrated that SSPs have maximal impact when they remove as many barriers as possible to distributing materials beyond SSP walls. Second- and third-party distribution – a system that allows SSP clients, peers, and social service agencies to distribute safe injection materials – are so well-supported by research that the CDC recommends this model as standard practice[20]. A colleague of mine, who has been studying SSPs for decades, recently suggested that we are lucky if even 3.33% of people who inject drugs ever directly make contact with an SSP. The *vast majority* of what makes SSPs effective in reducing overdose and the spread of infectious disease, therefore, comes from secondary and tertiary distribution of their life-saving supplies[11,21,22].

One of the most profound case studies for secondary and tertiary distribution comes from our own backyard: the case of the Chicago Recovery Alliance. What makes Chicago's program successful is that it focuses on the needs of people who used drugs and removes barriers to helping people obtain clean injection equipment. Measures that remove these barriers include secondary and tertiary distribution, no limit on the amount of equipment that can be obtained at any one time, and meaningful engagement of SSP clients in program operations. Research on the Chicago program and programs like it, particularly when contrasted with more restrictive programs, underscore the importance of including specific language that facilitate the use of these best practices. Without them, SSPs cannot realize *nearly* the positive potential that they can otherwise[5,23].

Conclusion

The overwhelming consensus among public health research is that SSPs prevent deaths due to overdose, HIV, Hepatitis C, and other infectious diseases in a way that does not increase drug use, crime, nor syringe litter. SSPs are **evidence-based**, **cost-effective**, and – most importantly – **life affirming**. As a researcher, this evidence alone makes it abundantly clear that these programs are worth protecting. But as a person in recovery, still heavily involved in Michigan's Twelve Step communities, **HB 5178 means so much more.** ***It means at, at 28 years old, I may not have to wake up every month to the news that yet another friend has died a death that could have been prevented.***

Thank you again for the opportunity to testify, and please me with any questions at my email below. Please also let me know if you need access to any of the literature cited here, and I will happily email copies.

Respectfully submitted by,

Kim Gannon, PhD(c)
PhD Candidate, Health Policy and Management
Yale University School of Public Health
Kim.gannon@yale.edu

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