Date of Hearing: January 11, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 57 (Wiener) – As Amended January 3, 2022

SENATE VOTE: 21-11

SUBJECT: Controlled substances: overdose prevention program.

SUMMARY: Permits the City and County of San Francisco (SF), the County of Los Angeles (LAC), the City of Los Angeles (CLA), and the City of Oakland (Oakland) to approve entities to establish and operate overdose prevention programs (OPPs) until January 1, 2028. Requires OPPs to provide a hygienic space supervised by trained staff, as specified, and provide sterile consumption supplies where people can consume controlled substances. Specifically, **this bill**:

1) Permits SF, LAC, CLA, and Oakland to approve entities within their jurisdictions to establish and operate OPPs that satisfy specified requirements.

2) Requires SF, LAC, CLA, and Oakland, prior to approving OPPs, to provide local law enforcement and public health officials and the public with an opportunity to comment in a public meeting, as specified.

3) Requires in order to operate OPPs, an entity must demonstrate that it will at a minimum:

    a) Provide a hygienic space supervised by trained staff, as specified, where people can consume controlled substances; provide sterile consumption supplies; collect used equipment; and, provide secure hypodermic needle and syringe disposal services;
    b) Monitor participants for potential overdose and provide treatment as necessary to prevent fatal overdose;
    c) Provide access or referrals to substance use disorder (SUD) and mental health treatment services, primary medical care, and social services;
    d) Provide access or referrals to HIV and viral hepatitis prevention, education, testing, and treatment;
    e) Provide overdose prevention education and access to or referrals to obtain naloxone hydrochloride or other federally approved overdose reversal medication approved by the United States Food and Drug Administration (FDA);
    f) Educate participants regarding proper disposal of hypodermic needles and syringes and provide participants with approved biohazard containers for syringe disposal;
    g) Provide reasonable security of the OPP site;
    h) Establish operating procedures for the OPP, including standard hours of operation, training standards for staff, a minimum number of personnel required to be onsite during hours of operation, the maximum number of participants to be served at one time, eligibility criteria for program participants, and an established relationship with the nearest emergency department (ED) of a general acute care hospital;
    i) Establish and make public a good neighbor policy that facilitates communication from and to local businesses and residences, to the extent they exist, to address any neighborhood concerns and complaints;

j) Require all staff present at the OPP during open hours to be certified in cardiopulmonary resuscitation (CPR) and first aid. Require demonstration of CPR and first aid certification by current and valid CPR and first aid cards issued by the American Red Cross, the American Heart Association or from an accredited college or university;
k) Require that all staff present at the OPP during open hours to be authorized to provide emergency administration of an opioid antagonist, and be trained for administration of an opioid antagonist under existing law; and,
l) Establish a plan for staff and workplace safety.

4) Requires an approved OPP to provide an annual report to the authorizing jurisdiction that includes information about the number of program participants, aggregate information regarding the characteristics of participants, the number of overdoses experienced and overdoses reversed onsite, and the number of persons referred to SUD treatment, primary medical care, and other services.

5) Prohibits a person or entity, including, but not limited to, property owners, managers, employees, volunteers, clients or participants, and city and county employees from being arrested, charged, or prosecuted pursuant to drug-related crimes, as specified; or otherwise penalized solely for actions, conduct, or omissions related to the operation of and on the site of an OPP; or for conduct relating to the approval of an entity to operate an OPP; or. the inspection, licensing, or other regulation of an OPP.

6) Allows the Medical Board of California or Osteopathic Medical Board of California (MBC) to take administrative or disciplinary action against a licensee for any action, conduct, or omission related to the operation of an OPP that violates the Medical Practice Act pursuant to each board's authority, as specified.

7) Sunsets the provisions in this bill on January 1, 2028.

8) Makes findings and declarations related to the urgent public health crisis of overdoses in this state; the success of OPPs in other countries; estimated cost savings; and, the sharp increase in overdose deaths being observed nationwide in 2020, exacerbated by the COVID-19 pandemic, compared to the same timeframe in 2019.

EXISTING LAW:

1) Classifies controlled substances into five schedules according to their danger and potential for abuse. Schedule I controlled substances have the greatest restrictions and penalties, including prohibiting the prescribing of a Schedule I controlled substance. ‘

2) Prohibits the possession of cocaine, cocaine base, heroin, opiates, opium derivatives, and other specified controlled substances and specifies a term of imprisonment in a county jail for 16 months, or two or three years for a violation.

3) Provides that it is unlawful to possess any device, instrument, or paraphernalia used for unlawfully injecting or smoking specified controlled substances. Provides that until January 1, 2026, this law does not apply to the possession of hypodermic needles or syringes solely for personal use.

4) Provides that it is unlawful to visit or to be in any room or place where specified controlled substances are being unlawfully smoked or used with knowledge that such activity is occurring. Applies this prohibition only where the individual aids, assists, or abets the perpetration of the unlawful smoking or use of the controlled substance.

5) Provides that every person who opens or maintains any place for the purpose of unlawfully selling, giving away, or using specified controlled substances is punishable by imprisonment in the county jail for a period of not more than one year or the state prison.

6) Provides that any person who has under their management or control any building, room, space, or enclosure, either as an owner, lessee, agent, employee, or mortgagee, who knowingly rents, leases, or makes available for use, with or without compensation, the building, room, space, or enclosure for the purpose of unlawfully manufacturing, storing, or distributing any controlled substance for sale or distribution is punishable by imprisonment in the county jail up to three years.

7) Makes the possession of methamphetamine and other specified controlled substances punishable by imprisonment in a county jail for a term not to exceed one year, except as specified.

8) Provides that it is unlawful to be under the influence of specified controlled substances, except as specified. Provides that the punishment is a sentence of not more than one year in a county jail, and the court may place a person on probation for a period not to exceed five years.

9) Authorizes any city, county, or city and county, to establish a clean needle and syringe exchange program upon approval by local officials.

10) Prohibits staff and volunteers participating in a clean needle and syringe exchange program authorized by the state, county, city, or city and county from being subject to criminal prosecution for violation of any law related to the possession, furnishing, or transfer of hypodermic needles or syringes or any materials deemed by a local or state health department to be necessary to prevent the spread of communicable diseases, or to prevent drug overdose, injury, or disability during participation in an exchange project. Prohibits program participants from being subject to criminal prosecution for possession of needles or syringes or any materials deemed by a local or state health department to be necessary to prevent the spread of communicable diseases, or to prevent drug overdose, injury, or disability acquired from an authorized needle and syringe exchange project entity.

11) Provides that until January 1, 2026, a physician or pharmacist may, without a prescription or a permit, furnish hypodermic needles and syringes for human use to a person 18 years of age or older, and a person 18 years of age or older may, without a prescription or license, obtain hypodermic needles and syringes solely for personal use from a physician or pharmacist.

12) Provides that until January 1, 2026, a pharmacy that furnishes nonprescription syringes is required to provide written information or verbal counseling to consumers at the time of furnishing or sale of nonprescription hypodermic needles or syringes on how to do the following: a) access drug treatment; b) access testing and treatment for HIV and hepatitis C; and, c) safely dispose of sharps waste.

13) Prohibits the prescription, administration, or dispensing of a controlled substance to an addicted person, except under certain circumstances.

14) Permits a licensed health care provider who is authorized by law to prescribe and issue standing orders for an opioid antagonist (to prevent fatal opioid overdose) to a person at risk of an opioid-related overdose or to a family member, friend, or other person if they receive training, as specified.

FISCAL EFFECT: None

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, California is in the midst of an unprecedented overdose crisis that must be treated as a public health crisis. Since 2011, drug overdose has been the leading cause of accidental death among adults in California.

In the context of the COVID-19 pandemic in the United States and in California, the already-alarming rate of drug overdose is worsening. A recent study of Emergency Medical Services data in the *Journal of the American Medical Association* found overdose rates were doubled in May of last year, compared to the year prior. More than 40 states have documented increases in opioid overdoses since the beginning of shelter in place.

In San Francisco, overdose deaths increased by 170% from 2018 to 2019, and have climbed even higher in 2020. San Francisco has seen nearly four times as many overdose deaths as COVID-19 deaths since March. African Americans continue to have the highest rate of overdose deaths, dying of opioid overdoses at nearly triple the rate of whites in 2018.

Oakland has seen similar increases; in 2019, the opioid-related overdose death rate in Oakland was 8.22 per 100,000, representing a 151% increase from the year before. Additionally, according to data from the LAC Medical Examiner-Coroner, death from opioid overdose in the LAC jumped by 26% in 2019 from the prior year. That trend continued in 2020, with the county on pace to see over one thousand opioid deaths this year. From the first stay-at-home order in mid-March to the end of June 2020, the daily rate of opioid deaths in LAC grew by a full 58%, compared to the rate for the prior 12 months.

As opioid use has increased, so have newly reported hepatitis C infections in California and nationwide. An analysis by the U.S. Centers for Disease Control and Prevention (CDC) found that increases in acute hepatitis C rates mirrored increases in drug treatment admission rates in which clients reported injection drug use.

The author concludes that while California has made great strides in addressing the needs of those experiencing SUDs, there is more work to be done. As the rates of both overdose deaths and spread of infectious diseases rise, it is imperative that we utilize every tool possible in order to combat this public health crisis. Current law hamstrings the ability of local jurisdictions to authorize the creation of OPPs that have been shown through rigorous studies to be very effective in preventing and mitigating overdose deaths.

2) BACKGROUND.

a) Opioids and consequences of abuse. Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, methadone, and many others. Taken as prescribed, opioids can be used to manage pain. However, opioids may also produce other effects, and according to the National Institute on Drug Abuse (NIDA), some individuals experience a euphoric response to opioid medications since these drugs affect the regions of the brain involving reward response. NIDA states that those who abuse opioids may seek to intensify their experience by taking the drug in ways other than those prescribed. For example, OxyContin is an oral medication used to treat moderate to severe pain through a slow, steady release of the opioid. However, NIDA states people may crush or dissolve the drug in order to snort or inject it, thereby increasing their risk for serious medical complications, including overdose. Prescription opioid misuse can lead to long-term health consequences, including limitations in daily activity, impaired driving, mental health problems, trouble breathing, overdose, and death. According to the CDC's website, drug overdose deaths and opioid-involved deaths from prescription opioids have more than quadrupled since 1999. The majority of drug overdose deaths (more than six out of 10) involve an opioid. The CDC states that overdoses from prescription opioids are a driving factor in the 15-year increase in opioid overdose deaths. Since 1999, the amount of prescription opioids sold in the U.S. nearly quadrupled, yet there has not been an overall change in the amount of pain that individuals report. According to the California Department of Public Health (DPH), in the past, opioids were prescribed to relieve acute, short-term pain. Today, they are increasingly being used for long-term, chronic pain management.

According to the California Opioid Overdose Surveillance Dashboard, 2020 saw a 69.6% increase in opioid overdose deaths from those in 2019 (5,502 in 2020 vs. 3,244 in 2019), a 146% increase in fentanyl related overdose deaths (3,946 in 2020 vs. 1,603 in 2019), and a 33% increase in emergency department (ED) visits related to any opioid overdose (15,644 in 2020 vs. 11,767 in 2019). This dramatic increase in opioid related deaths and ED visits occurred despite a 15.4% decline in the number of opioid prescriptions written in 2020 compared to 2019. Some of the counties most affected remain northern and large urban counties, including Lake, Shasta, SF, Orange, and San Diego. For example, Lake and Shasta counties have prescription opioid-related death rates that are two to three times higher than the national average while SF, Orange, and San Diego counties have higher than state average rates, accounting for a greater total number of deaths.

Data on ED encounters for individuals with heroin poisoning from the Department of Health Care Access and Information show dramatic increases since 2005. Overall, ED visits among heroin users of all ages increased, but the greatest was among the state's young adults aged 20 to 29. About 1,300 ED visits by that population poisoned by heroin were logged in 2015 compared with fewer than 1,000 in 2012. For individuals aged 30 to 39, ED encounter rates rose from approximately 400 in 2012 to 600 in 2014. All other age groups experienced a small increase in encounter rates.

In an April 21, 2017 a *San Francisco Chronicle* article, "Safe injection sites offer hope in scourge of discarded syringes," the SF Department of Public Works (SFDPW) reported collecting 13,333 syringes left on the streets in March 2017—an average of 430 every day—10,465 more needles than were collected in March 2016. These figures come only from SFDPW's "hot spot" crews, which mostly clean homeless camps, and do not

include the number of syringes found by other cleaning crews, which are not tracked, or the ones found on port property and in parks. The article reported on incidents of intravenous drug use in public spaces, including instances where a man was passed out on a bike rack in a busy public plaza with needles spread around him, and another man was injecting drugs between his toes in an area close to City Hall and other accounts of mothers with children encountering discarded needles near the ocean, busy public parks, and other public spaces. The article further stated that SF public health officials estimate there were 22,000 intravenous (IV) drug users in the city, and many choose to inject in public spaces in the hopes that somebody will help should they overdose. Public health officials estimated 85% of IV drug users would use supervised injection facilities (SIFs, referred to as OPPs in this bill) and that the city could save $3.5 million in medical costs.

b) Harm reduction. According to the National Institutes of Health (NIH) website, harm reduction is a strategy that aims to reduce the harms associated with certain behaviors. When applied to SUDs, harm reduction accepts that a continuing level of drug use (both legal and illegal) in society is inevitable and defines objectives as reducing adverse consequences. It emphasizes the measurement of health, social, and economic outcomes, as opposed to the measurement of drug consumption. Harm reduction has evolved over time, from its initial identification in the 1980s, as an alternative to abstinence-only focused interventions for adults with SUDs. At the time, it was recognized that abstinence was not a realistic goal for those with SUDs. In addition, those individuals who were interested in reducing, but not eliminating, their use were excluded from programs that required abstinence. NIH's website states there is persuasive evidence that harm reduction approaches greatly reduce morbidity and mortality associated with risky health behaviors. For example, areas that have introduced needle-exchange programs have shown mean annual decreases in HIV prevalence compared with those areas that have not introduced needle-exchange programs. Access to and use of methadone maintenance programs are strongly related to decreased mortality, both from natural causes and overdoses, which suggests that these programs have an impact on overall socio-medical health. The most recent addition to the harm reduction continuum is that of SIFs, which have been successfully implemented in over 100 sites around the world.

c) OPPs/ SIFs. SIFs, also known as safe consumption spaces (SCS) and safe injection sites (SIS), and referred to in this bill as OPPs, are legally sanctioned facilities where people who use intravenous drugs can inject pre-obtained drugs under the supervision of a health care provider. These facilities are designed to reduce the health and societal problems associated with injection drug use, and provide sterile injection equipment, information about reducing the harms of drugs, health care services, treatment referrals, and access to medical staff. Proponents of SIFs contend that the research on SIFs demonstrates that they reduce HIV and hepatitis transmission risks, prevent overdose deaths, reduce public injections, reduce discarded syringes, and increase the number of people who enter drug treatment. Opponents of SIFs argue that the existence of SIFs will lead to increased drug use and a general increase in drug-related antisocial behaviors in the areas in which SIFs are located. It is reported that there are more than 110 SIFs operating worldwide. Legislation authorizing the establishment of SIFs has been introduced in recent years in several states and cities across the country, including New York, Maine, Maryland, San Francisco, Seattle, and Denver.

i) **Undisclosed location in the U.S.** In September 2014, an organization in an undisclosed U.S. city opened an unsanctioned SIF. In August 2020, a letter was published in the New England Journal of Medicine containing the results of an evaluation of the first five years of operation of the SIF. Injections were monitored by trained staff and were conducted with sterile equipment. All syringes were used only once and were disposed of safely at the site. Site staff used an online data-collection system to document every drug injection, type of drug used, opioid-involved overdose, and related death that occurred during injections at the site.

   The evaluation found there were 10,514 injections and 33 opioid-involved overdoses between 2014 and 2019, all of which were reversed by naloxone administered by trained staff. Reportedly, no person who overdosed was transferred to an outside medical institution, and there were no deaths. Overdoses increased over the years as injections also increased over the same period. The types of drugs used at the site changed over the five years with a steady increase in the proportion of injections involving the combination of opioids and stimulants, from 5% in 2014 to 60% in 2019. The evaluation generally concluded that implementing sanctioned SIFs/OPPs in the United States could reduce mortality from opioid-involved overdose, and could allow participants to link to other medical and social services, including SUD treatment.

ii) **Vancouver, Canada.** Insite, in Vancouver, Canada, became the first SIF established in North America in 2003. Insite was designed as part of a continuum of care for people with SUDs, mental illness, and HIV/AIDS. There have been more than 3.6 million visits to Insite since 2003 with 48,798 clinical treatment interventions and 6,400 overdose interventions without any deaths. In 2015, Insite reportedly had 263,713 visits to the site by 6,532 unique individuals with an average of 722 visits per day and an average of 440 injection room visits per day. There were 5,359 clinical treatment interventions, and 5,368 referrals to other social and health services. Additionally, there were 464 admissions into their adjoining detox treatment facility, which recorded a program completion rate of 54%. Before the Public Health Emergency was declared in British Columbia on April 16, 2014 in response to the opioid overdose crisis there were 30 overdose interventions a month. There are now eight overdose interventions a month.

iii) **Alberta, Canada.** In response to a public health crisis with over 2,053 Albertans dying from a drug related overdose between 2016 and 2018, the government at that time established supervised consumption services sites in communities with a demonstrated need. At the height of operation, there were seven sites operating legally in Alberta — four in Edmonton, and one each in Calgary, Lethbridge, and Grande Prairie. Additional SCS sites were under consideration for Medicine Hat and Red Deer, as well as a mobile site in Calgary. In the spring of 2019, the new government of Alberta announced a review of the socio-economic impacts of existing and proposed SCS sites on their host communities. For the purposes of this review, socio-economic impact was defined as the overall effect (direct or indirect) of a SCS site on a community, from both an economic and social perspective. An expert committee was appointed to lead this review, which would include engagement with a broad range of stakeholders. The committee was comprised of experts in business, real estate, population economics, social demography, research ethics, lived

experience, addiction and recovery, harm reduction, First Nations health, mental health, trauma, pain management, law enforcement, crime reduction, and justice. The committee, under the government's direction, did not review the service's health benefits, including hundreds of reported overdose interventions every year. Instead, the review focused on crime rates, social disorder, property values, and business. The study did not evaluate the merits of SCS as a public health intervention.

The study, which has since been denounced by over 40 scientists and scholars for "poor methodological quality, lack of transparency, and biased presentation of results," detailed a "system of chaos" around the SCS. Since the report was released in March of 2020, at least one SCS has closed and another is being relocated because it has been "highly disruptive to the neighborhood." It is reportedly being relocated to a "more appropriate location."

iv) **Philadelphia.** In January 2018, Philadelphia health officials announced their plan to allow the opening of a SIF as one way to combat the city's opioid epidemic. Safehouse, a non-profit focused on providing a range of overdose prevention services, announced that it would open a SIF in the city. In February 2019, the U.S. Attorney for the Eastern District of Pennsylvania sued to block the facility from opening and sought a declaratory judgment stating that SIS violate federal law. The court denied the government's motion in October 2019, finding that the statute referenced does not prohibit Safehouse's proposed medically supervised consumption rooms because Safehouse does not plan to operate them for the 'purpose of' unlawful drug use within the meaning of the statute. The court held that Congress had not intended for the statute to apply to SIFs when the law was enacted in 1986 or when it was amended in 2003, because SIFs were not part of the public discourse on addressing drug use at either time. The court entered a final appealable order in February 2020, and the government filed an appeal while simultaneously filing an emergency motion to stay the district court's February order. In June 2020, the district court granted the stay in light of the impact of the COVID-19 pandemic and the civil unrest following the killing of George Floyd. In January 2021, a three-judge panel of the 3rd Circuit Court of Appeals issued a 2-1 ruling reversing the district court, finding that because Safehouse knows and intends that its visitors will come with a significant purpose of doing drugs, its SIS will break the law. Safehouse filed a Petition for Rehearing En Banc on February 26 requesting a rehearing before the entire panel. The petition was denied on March 24, although three judges issued a strong dissent to the denial. In October of 2021, the U.S. Supreme Court declined Safehouse's petition to review its case.

v) **San Francisco.** In June 2020, the SF County Board of Supervisors unanimously approved an ordinance that would create a system to issue permits to non-profit organizations that want to operate SIFs in SFco. In early 2020, the U.S. Attorney for the Northern District of California publicly stated that the government would file a lawsuit if SF moved forward with opening SIFs.

vi) **New York.** On December 1, 2021, New York City announced the opening of two overdose prevention centers. According to the city' health department at least 59 overdoses were prevented in the first three weeks that the two overdose prevention centers were open. During that time, there were more than 2,000 visits to the centers.

Operated by OnPoint NYC they are the first publicly recognized overdose prevention sites to open in the United States. The centers are located in Washington Heights and East Harlem.

d) Conflict with Federal Law. Two federal statutes are particularly relevant with respect to the activity occurring at a SIF. Title 21 United State Code section 844 provides that it is "unlawful for any person knowingly or intentionally to possess a controlled substance unless such substance was obtained directly, or pursuant to a valid prescription or order, from a practitioner, while acting in the course of their professional practice, or except as otherwise authorized." In addition, federal law provides that it is unlawful to:

i) Knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or **using any controlled substance**; and,

ii) Manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or **using a controlled substance**.

Arguably, these two statutes would criminalize both the behavior of the clients using the facilities as well as the owners or operators of the facilities. These statutes were the basis of the legal proceedings in Philadelphia's Safehouse case which the Supreme Court just recently declined to review. It is unclear whether the U.S. Department of Justice will continue to sue to block SIFs from opening.

3) DOUBLE REFERRAL. This bill has been double referred and should it pass out of this committee, it will be referred to the Assembly Public Safety Committee.

4) SUPPORT. The California Society of Addiction Medicine (CSAM), cosponsor of this bill states that this bill is consistent with the recommendation of the American Medical Association announced June 12, 2017, to support the: "development of pilot facilities where people who use intravenous drugs can inject self-provided drugs under medical supervision….Studies from other countries have shown that supervised injection facilities reduce the number of overdose deaths, reduce transmission rates of infectious disease, and increase the number of individuals initiating treatment for SUDs without increasing drug trafficking or crime in the areas where the facilities are located." CSAM further states that approximately 120 SIF's exist in Europe, Australia, and Canada and they have been shown to be a cost-effective intervention that reduces health and safety problems associated with drug use, including public drug use, discarded syringes, HIV and hepatitis infections, and overdose deaths. People who used these programs were more likely to enter treatment and to stop using drugs.

The National Health Law Program (NHeLP) also in support states that this bill is timely and urgent. The number of Americans affected by the opioid overdose epidemic has reached staggering rates. The CDC recently released data showing that drug overdose deaths in the U.S. surpassed 100,000 annually for the first time during the 12-month period ending in April 2021; over 75,000 of these deaths were opioid-related overdose deaths. In California,

over 2,400 individuals die each year due to an opioid overdose. In addition, the coronavirus pandemic has exacerbated overdose rates; a large cross-sectional study recently found that in 2020, overall ED visits for opioid overdose increased by nearly 29% compared to before the pandemic. In California, overdose deaths increased by 25% between 2018 and 2020, and the rates have increased particularly for Black Californians and state residents experiencing homelessness. NHeLP concludes that as hospital resources are stretched thin, we need a science-driven measure to prevent fatal and nonfatal drug overdose. California should lead the nation on the implementation of OPP pilot projects that have proven to be cost effective, act as essential points of health access to highly marginalized communities, and to contribute to the stability of communities as a whole.

5) **SUPPORT IF AMENDED**. The California Medical Association (CMA) in a support if amended position, states that OPPs, as would be allowed under this legislation, have been extensively researched and shown to reduce a plethora of health and safety risks associated with drug use, including public consumption, discarded syringes, HIV and hepatitis infections, and overdose deaths. Research from Australia found a reduction in paramedic and emergency room use in areas where OPPs were established, with the largest decrease during the facilities' open hours. Incredibly, concerning all OPPs across all countries, there has yet to be a single death reported in association with these programs. CMA requests that this bill be amended to include adequate liability coverage from disciplinary action from MBC for participation in the program. Currently, this bill contains liability protection from civil and criminal penalty, but should be expanded to include potential punitive measures from licensing boards, as well, so that physicians are able to provide patients access to this program without fear of discipline.

6) **OPPOSITION**. The California Narcotic Officer's Association (CNOA), in opposition states that this bill is, in effect, a re-introduction of AB 186 (Eggman) from the 2017-2018 session that was vetoed by Governor Brown. CNOA believe that Governor Brown's well-reasoned veto is as applicable to the deficiencies in this bill. CNOA goes on to state that rather than a robust effort to get addicts into treatment, this bill alarmingly concedes the inevitable and immutable nature of drug addiction and abuse. For example, missing from this bill are any strategies to appropriately utilize methadone alternatives, mandatory treatment protocols, on-site drug counseling, or even efforts to gradually wean an addict off the cycle of dependence. In effect, the unintended consequence of this bill is to normalize substance abuse and leave the addict at risk. CNOA concludes by stating that as well intended as this bill is, its consequence will be to enable addictive behavior.

7) **PREVIOUS LEGISLATION**.

   a) AB 362 (Eggman) of 2020 and AB 186 were substantially similar to this bill. AB 362 was held in the Senate Health Committee. AB 186 was vetoed by Governor Brown who stated, in part, in his veto message that:

      "I am returning Assembly Bill 186 without my signature.

      This bill authorizes the City and County of San Francisco to approve "overdose prevention programs," including the establishment of centers where illegal drugs can be injected under sanitary conditions.

> The supporters of this bill believe these "injection centers" will have positive impacts, including the reduction of deaths, disease and infections resulting from drug use. Other authorities-including law enforcement, drug court judges and some who provide rehabilitative treatment-strongly disagree that the "harm reduction" approach envisioned by AB 186 is beneficial.
>
> After great reflection, I conclude that the disadvantages of this bill far outweigh the possible benefits.
>
> Fundamentally, I do not believe that enabling illegal drug use in government sponsored injection centers-with no corresponding requirement that the user undergo treatment-will reduce drug addiction.
>
> In addition, although this bill creates immunity under state law, it cannot create such immunity under federal law. In fact, the United States Attorney General has already threatened prosecution and it would be irresponsible to expose local officials and health care professionals to potential federal criminal charges."

b) AB 2077 (Ting), Chapter 274, Statutes of 2020, extends until January 1, 2026, the authority of a physician or pharmacist to, without a prescription or permit, furnish hypodermic needles and syringes for human use to a person 18 years of age or older, and the authority of a person 18 years of age or older to, without a prescription or license, obtain hypodermic needles and syringes solely for personal use from a physician or pharmacist.

c) AB 2495 (Eggman) of 2016 would have decriminalized conduct connected to the use and operation of an adult public health or medical intervention facility that is permitted by state or local health departments and intended to reduce death, disability, or injury due to the use of controlled substances. AB 2495 was heard for testimony in the Assembly Public Safety Committee but no vote was taken.

d) AB 831 (Bloom) of 2013 would have required the California Health and Human Services Agency (CHHSA) to convene a temporary working group to develop a state plan to reduce the rate of fatal drug overdoses and would have appropriated $500,000 from the General Fund to CHHSA to provide grants to local agencies to implement drug overdose prevention and response programs. AB 831 was held on the Assembly Appropriations Committee suspense file.

e) AB 604 (Skinner), Chapter 744, Statutes of 2011, authorizes, among other provisions, DPH to authorize, as specified, certain entities to provide hypodermic needle and syringe exchange services in any location where it determines that the conditions exist for the rapid spread of HIV, viral hepatitis, or any other potentially deadly or disabling infections that are spread through the sharing of used hypodermic needles and syringes. Requires, until January 1, 2019, DPH to establish and maintain on its internet website the address and contact information of these programs.

f) SB 1159 (Vasconcellos), Chapter 608, Statutes of 2004, authorizes the Disease Prevention Demonstration Projects (DPDP) to evaluate the long-term desirability of allowing licensed pharmacies to sell or furnish nonprescription hypodermic needles or syringes to prevent the spread of blood-borne pathogens; authorizes a licensed pharmacist, until December 31, 2010, and subject to authorization by a county or city, to sell or furnish 10 or fewer hypodermic needles or syringes to a person for human use without a prescription if the pharmacy is registered in the DPDP with a local health department.

g) SB 41 (Yee), Chapter 738, Statutes of 2011, authorizes a county or city to authorize a licensed pharmacist to sell or furnish ten or fewer hypodermic needles or syringes to a person 18 or older for human use without a prescription.

8) COMMITTEE AMENDMENTS. In reviewing the studies, reports, and press surrounding OPPs, it is apparent that the issue this bill is trying to address is polarizing. If California were to establish a pilot program to create OPPs, it will be critical to have an unbiased, scientifically valid assessment of all aspects of the OPP pilot to evaluate its effectiveness. As such, the Committee recommends amending this bill to include a requirement for a comprehensive, independent, unbiased evaluation of the OPP pilot with a report to the Legislature and the Governor's office as follows:

a) Require local jurisdictions that choose to participate in the program to consult with one another and to select a single independent entity to do a peer-reviewed study of both of the following:

i) The statewide efficacy of the overdose prevention programs, including but not limited to, number of participants, aggregate information regarding characteristics of the participants, overdoses onsite, reversals onsite, participants referred to treatment, hospitalizations after been seen at the OPP, fatalities in hospitals after being seen at the OPP, and fatalities on site; and,

ii) Community impacts of the OPP, including but not limited to increases/decrease in crime, syringe litter, public drug use, and aggregate information on the attitudes and perceptions of nearby businesses and community members.

b) Require that the study be conducted by either a private, non-profit, non-partisan research organization or a research university in the United States classified as a Research University in the Carnegie Classification of Institutes of Higher Learning;

c) Require local jurisdictions and the selected entity to fund this study through private donations, grants, and local funds;

d) Require that prior to a local jurisdiction opting in to the OPP pilot project, they must consent to funding the component of the study relating to their jurisdiction/program; and,

e) Require the study be sent to the Legislature and Governor's office on or before January 15, 2027.

9) COMMITTEE COMMENTS: Moving forward, the author may want to consider providing immunity against disciplinary actions from licensing boards for licentiates' participation in

the program, to include but not be limited to physicians, nurses, nurse practitioners, and social workers.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Alcohol & Drug Program Executives (cosponsor)
California Society of Addiction Medicine (cosponsor)
Drug Policy Alliance (cosponsor)
HealthRIGHT 360 (cosponsor)
SF AIDS Foundation (cosponsor)
TarzanaTreatment Center (cosponsor)
Access Support Network
London Breed, Mayor of City & County of San Francisco
American Civil Liberties Union of California
AIDS Legal Referral Panel (ALRP)
American Academy of HIV Medicine, California/Hawaii Chapter
American Civil Liberties Union/Northern California/Southern California/San Diego and Imperial Counties
APLA Health
Asian American Drug Abuse Program, Inc.
Being Alive - Los Angeles
Bend the Arc: Jewish Action
Bienestar Human Services
CA Bridge
California Association of Social Rehabilitation Agencies
California Public Defenders Association (CPDA)
Californians for Safety and Justice
City of Los Angeles
City of Oakland
City of San Francisco
Community Clinic Association of Los Angeles County
Community Housing Partnership San Francisco
Community Legal Services in East Palo Alto
County Behavioral Health Directors Association of California
County of Los Angeles
Desert AIDS Project
Downtown Women's Center
Ella Baker Center for Human Rights
End Hep C SF
Friends Committee on Legislation of California
Getting to Zero San Francisco
Glide
Harm Reduction Coalition of Santa Cruz County
Harm Reduction Services
HIV Education and Prevention Project of Alameda County
HIVE
Housing California

Immigrant Legal Resource Center
Inland Empire Harm Reduction
Larkin Street Youth Services
Law Enforcement Action Partnership
Legal Services for Prisoners With Children
Los Angeles Community Health Project
Los Angeles Continuum Care
Los Angeles County
Los Angeles County Board of Supervisors
Los Angeles County Board of Supervisors, First and Third Districts
Los Angeles County District Attorney's Office
Los Angeles Homeless Services Authority
Los Angeles LGBT Center
Los Angeles Regional Reentry Partnership (LARRP)
Mendocino County AIDS/Viral Hepatitis Network
NAMI San Francisco
National Association of Social Workers, California Chapter
National Harm Reduction Coalition
National Health Law Program
Planned Parenthood Affiliates of California
Psychiatric Physicians Alliance of California
Rafiki Coalition for Health & Wellness
San Francisco Bay Area Rapid Transit District (BART)
San Francisco Black, Jewish and Unity Group
San Francisco Chamber of Commerce
San Francisco Community Health Center
San Francisco District Attorney's Office
San Francisco Marin Medical Society
San Francisco Public Defender's Office
San Francisco Senior and Disability Action
San Francisco Taxpayers for Public Safety
San Francisco Travel Association
SF Hepatitis C Task Force
Shanti Project
Sierra Harm Reduction Coalition
Smart Justice California
St. James Infirmary
Students for Sensible Drug Policy
Team Lily
The Gubbio Project
The Sidewalk Project
Transitions Clinic Network
Treatment Action Group
Treatment on Demand Coalition
UCSF Alliance Health Project
Valley Community Healthcare
We the People - San Diego
Women Organized to Respond to Life-threatening Diseases (WORLD)

Opposition

Alliance to Protect Children
California Association of Code Enforcement Officers
California Coalition Against Drugs
California College and University Police Chiefs Association
California District Attorneys Association
California Family Council
California Narcotic Officers' Association
California Peace Officers Association
California State Sheriffs' Association
Capitol Resource Institute
Congress of Racial Equality
Los Angeles Professional Peace Officers Association
Organization for Justice and Equality
Peace Officers Research Association of California (PORAC)
Riverside Sheriffs' Association
San Marcos Prevention Coalition

Analysis Prepared by: Judith Babcock / HEALTH / (916) 319-2097