CALIFORNIA DEPARTMENT OF PUBLIC HEALTH,
Plaintiff and Petitioner
v.
EL DORADO COUNTY BOARD OF SUPERVISORS; EL DORADO COUNTY; CITY OF PLACERVILLE; CITY COUNCIL OF THE CITY OF PLACERVILLE,

Defendants and Respondents

Excerpts from A.Ross Declaration

The Role and Responsibilities of the California Department of Public Health's (CDPH) Office of AIDS (OA) and Harm Reduction Units (HRU)

CDPH's OA has lead responsibility for coordinating state programs, services, and activities relating to the human immunodeficiency virus (HIV) and AIDS. The HRU oversees the Syringe Services Certification Program, by which CDPH authorizes new SSPs throughout California. SSPs provide sterile syringes and collect used syringes, and act as points of access to health education and care for people who inject drugs (PWID). At a minimum, all California SSPs provide access to sterile syringes and other safe injection equipment, collection and safe disposal of syringes, and HIV and viral hepatitis prevention education. In addition, programs provide the following services either directly or through referral to a community partner: substance use disorder treatment, HIV and viral hepatitis screening, hepatitis A and B vaccinations, screening for sexually transmitted infections, housing services, and education and materials for the reduction of risk associated with sexual behavior and drug use, including supplies for people who snort or smoke, rather than or in addition to injecting. Programs also provide overdose education and distribute naloxone and fentanyl test strips; overdose prevention efforts for both methamphetamine and opiates are key to their mission. SSPs are a critical part of the State's efforts to protect and improve the health of all Californians and prevent the spread of blood-borne infections among Californians. SSPs are one of the cornerstones of CDPH/OA's efforts to improve the health and wellbeing of people who use drugs.

Part of the HRU's work is to receive, review, and process applications from organizations that want to add syringe services to their harm reduction work. California law has allowed authorization by local governments since 2000, and established CDPH's authority to authorize SSPs in 2012. The HRU reviews each application, conducts consultation with the local health officer and local law enforcement, conducts a public comment period and reviews the results. Staff compile the information learned from the process and make a recommendation to the CDPH Director regarding the application. The HRU's staff are in frequent communication with the applicant during this process, and after authorization work with the program to ensure they understand the reporting and other requirements of the authorization. Authorization extends for two years, at which time the program can request reauthorization.

CDPH has authorized 28 SSPs since the program's inception, including clinics, community-based organizations, and health departments. The other 50 SSPs in California are locally authorized or operate under a physician's license.

SSPs Further the State and Public Interest in Preventing the Spread of Blood-Borne Pathogens

The evidence on the effectiveness of SSPs, as proven in hundreds of studies published in peer-reviewed journals, establishes the value of SSPs in preventing the spread of blood-borne pathogens by removing contaminated syringes from circulation. Blood-borne pathogens are microorganisms present in human blood that can cause disease in humans, and include but are not limited to HIV, hepatitis B virus (HBV) and HCV. Each of these infections can be fatal without treatment, can spread rapidly through networks of people, and can devastate an entire community.

The United States Public Health Service, which comprises the nine federal agencies concerned with public health, recommends that for those who are unable to stop injecting drugs, a new, sterile syringe should be used for each injection. When PWID are unable to access new syringes, they commonly resort to reusing their own syringes and sharing those of others. Not

only does syringe sharing and re-use increase the risk of transmitting HIV, HBV, and HCV, but these practices also increase the risk of other adverse health outcomes, including permanent vein damage, skin and soft tissue infections, and invasive disease caused by pathogens such as staphylococcus and streptococcus group bacteria. True and correct copies of the study and summary of information is attached to the Index as **Exhibits 2 and 3**.

SSPs have been rigorously evaluated since they were first introduced in the late 1980s in response to injection-related HIV transmission, and since the mid-1990s there has been consensus in the medical, scientific and public health fields that SSPs are highly effective in preventing blood-borne infections, are cost-saving, and serve as a key entryway for bringing PWID into medical, drug treatment and other essential care. See **Exhibit 3**.

The impact of SSPs has been most notable in terms of controlling the HIV epidemic. Between 2008 and 2014, annual HIV diagnoses among PWID in the United States fell by half, a decrease largely attributed to intervention by SSPs. In jurisdictions where SSPs were adopted early and publicly funded, injection-related HIV transmission was steeply reduced, such as in San Francisco where the number of infections decreased by two-thirds, or New York City where HIV prevalence among PWID fell from 54% in 1990 to 3% in 2012. True and correct copies of the publications are attached to the Index as **Exhibits 4**, **5**, and **6**.

A California study found that PWID with the most access to syringes were half as likely to report syringe sharing. See **Exhibit 2**.

Multiple studies that examined SSP efficacy in preventing blood-borne infections also investigated any possible negative effects of providing free access to sterile syringes. Between 1990 and 2000, more than 200 scientific studies, including many in California, were conducted to examine any such effects. Based on these studies, and on eight federally funded systematic reviews of the evidence, major health institutions, including the World Health Organization, the Centers for Disease Control and Prevention (CDC) and the U.S. Surgeon General concluded that SSPs reduce HIV infection without incurring unintended societal costs. As summarized in a CDC factsheet:

- SSPs prevent both HIV and viral hepatitis: SSPs are associated with an almost 50% reduction in HIV and HCV, and when SSPs are combined with medications for opiate use disorder, transmission is reduced by more than two-thirds. True and correct copies of the studies are attached to the Index as **Exhibits 7, 8, 9, and 10**.
- SSPs connect people to substance use disorder treatment. People who regularly attend SSPs are five times more likely to enter treatment for substance use disorder and almost three times as likely to reduce or stop their drug use compared to those who have never received these services. True and correct copies of the studies are attached the Index as **Exhibits 11, 12, 13, and 14**.
- SSPs do not increase crime. An early review of 16 programs found no evidence SSPs were associated with increased crime. Subsequent studies similarly found no association between SSP services and increase in local crime, including robbery, assault, and drug possession. True and correct copies of the studies are attached to the Index as **Exhibits 15, 16, and 17.**
- SSPs provide critically needed resources for syringe disposal. Syringe litter is a problem in many areas with high rates of homelessness, however studies have consistently found that syringes obtained from SSPs are more likely to be safely disposed than those from other sources. True and correct copies of the studies are attached to the Index as **Exhibits 18, 19, 20, 21, and 22**. A study comparing cities with and without SSPs found that PWID were 34 times more likely to safely dispose of used syringes if they had access to an SSP. A true and correct copy of the study is attached to the Index as **Exhibit 23**. A national study conducted by the CDC found that greater per capita availability of new syringes results in a greater proportion of people disposing of used

syringes safely. A true and correct copy of the study is attached to the Index as **Exhibit 24**. In many areas, the SSP is often the only location where people can properly dispose of sharps waste.

- SSPs do not attract PWID to new neighborhoods. Several studies have examined whether a new SSP will attract PWID into a new neighborhood. True and correct copies of the studies are attached to the Index as **Exhibits 25 and 26**. All have concluded that SSPs serve people already living in the immediate neighborhood. PWID do not travel far to receive services; one study found that program participants would walk a maximum of 2.75 miles from where they lived or camped to attend an SSP. A true and correct copy of the study is attached to the Index as **Exhibit 27**.
- SSPs do not attract young people to drug use. The concern that the presence of SSPs might influence youth to start using drugs has been investigated and is not supported by evidence. The majority of young people surveyed in one study did not perceive SSPs as promoting drug use; instead, most saw it as a deterrent, and listed peer and parental drug use as the most likely factors to influence youth drug use. Another study surveyed neighbors of an SSP and found that only 7% of young people were even aware that the program existed. See **Exhibits 17 and 26.**
- SSPs prevent overdose and overdose fatalities. SSPs play a critical role in responding to the overdose crisis by specifically serving the population at highest risk for overdose: people who are continuing to use drugs, particularly fentanyl. True and correct copies of the study and publication are attached to the Index as **Exhibits 28 and 29**. SSP core services include distributing naloxone and fentanyl test strips, and, importantly, training PWID in bystander administration of naloxone, rescue breathing

and other key components of overdose prevention and response. A modeling study that examined different methods of naloxone distribution estimated that a single SSP's naloxone distribution efforts could reduce community overdose deaths by 65%. See **Exhibit 28**. True and correct copies of the studies are attached hereto as **Exhibits 30 and 31**.

- SSPs save public funds. HIV, HBV, and HCV all have very high medical costs, consequences, and related conditions: people with HIV have a 50-100% increased risk of cardiovascular disease, for example, and are at elevated risk for a host of expensive-to-treat and potentially deadly infections including tuberculosis, pneumonia, Salmonella infection, candidiasis, and toxoplasmosis. Infection with HBV and HCV can lead to liver disease, liver cancer, and liver failure. A true and correct copy of the HIV publication is attached to the Index as **Exhibit 32**. SSPs may avert many of these costs: analyses have consistently found SSPs to be cost saving at any level of investment. The estimated cost of health care for people living with chronic HCV infection in the U.S. is $15 billion annually, and the lifetime cost of treating one person living with HIV is estimated at more than $500,000. True and correct copies of the studies are attached to the Index as **Exhibits 33 and 34**. A 2021 examination of the cost effectiveness of SSPs in preventing HCV compared to medication for opiate use disorder found SSPs had the highest cost savings at $363,821 per HCV case avoided, compared to no intervention. However, SSPs in combination with medication for opiate use disorder, although more expensive, resulted in more HCV cases averted. (Medication alone was neither more effective nor more cost-saving). A true and correct copy the study is attached to the Index as **Exhibit 35**.

- Based on the scientific evidence of effectiveness and benefits, scores of professional and government organizations have endorsed SSPs, including the American Medical Association, the American Nurses Association, the American Psychiatric Association, the American Public Health Association, the American Society of Addiction Medicine, the National Association of Counties, the National Institutes of Health, the United States Conference of Mayors, and the American Bar Association. These medical and public health associations have endorsed broad implementation of SSPs as a best practice in disease prevention. It is a core component of the national plan to end the HIV epidemic. Similarly, building harm reduction infrastructure is one of the key strategies in CDPH Integrated Statewide Strategic Plan for 2022-2026, Ending the Epidemics: Addressing HIV, HCV, and Sexually Transmitted Infections in California. This plan was developed over two years of regional meetings with stakeholders throughout the state. True and correct copies of the national, statewide plan, and endorsements are attached to the Index as **Exhibits 36, 37, and 38**.

As summarized in this section, the strong evidence of the effectiveness of SSPs supports the Department's oversight and authorization of SSPs as a critical, front-line tool in furthering the state and public interest in preventing the spread of blood-borne pathogens.

The Impact of the Opioid Epidemic on Rates of Injection Drug Use and Blood-Borne Infections

There has been a dramatic rise in opiate use and overdose in the past twenty years. An increase in prescription drug overdose deaths in the 2000s was followed by a wave of heroin overdoses in the 2010s. A further significant shift occurred in the illicit drug market as fentanyl permeated the drug supply beginning in 2013-14, and the number of annual overdose deaths in

the U.S. has more than doubled since then. Public health researchers have now characterized a "fourth wave" in the overdose crisis as attributable to polysubstance use, primarily fentanyl combined with stimulants such as methamphetamine, which is now driving overdose mortality. A true and correct copy of the study is attached to the Index as **Exhibit 39**.

The CDC has documented an increase in injection drug use accompanying these waves, and outbreaks of HCV and HIV have accompanied these alarming trends. In 2020, the CDC issued an advisory to state public health departments urging them to prepare for increases in HIV outbreaks as a result of the worsening opioid crisis. The advisory provides lessons learned from the 2015 Indiana outbreak, and alerts health departments to outbreaks that have occurred across the U.S. since then. According to the advisory: "Rural communities are disproportionately affected by the opioid epidemic and have been most affected by overdoses, new acute HCV infections, and are considered most vulnerable to rapid spread of HIV and HCV if introduced among uninfected communities of PWID. Identifying jurisdictions particularly vulnerable to an HIV or HCV outbreak can guide public health efforts to detect, prevent, and respond quickly to, potential outbreaks." True and correct copies of the advisories are attached to the Index as **Exhibits 40, 41, 42, and 43**.

Increasing Rates of HIV and HCV Infections Among PWID

In 2015, a small Indiana county that had previously reported less than one HIV infection per year experienced an unprecedented HIV outbreak, with 181 new HIV infections in three months. Public health investigators traced the surge in HIV infections to sharing of drug injection equipment in a setting with no access to sterile syringes. Of the 235 people ultimately identified with new HIV infections in Scott County, almost 95% were found to be co-infected with hepatitis C. True and correct copies of the studies are attached to the Index as **Exhibits 44, 45, and 46**.

The Scott County outbreak galvanized the public health community in the U.S. and resulted in rapid reexamination of the risk associated with injection drug use in areas with low

prevalence of HIV. The Scott County outbreak represented the first time the U.S. saw a rapid surge in HIV infection in an area that had virtually no underlying HIV infection in the population. Most states moved quickly to assess the risk in their own jurisdictions, and between 2016 and 2020 all but six states conducted these assessments. As a result of several studies, in 2016 CDPH/OA submitted a request to CDC to allow California to use federal funds to support SSPs. The federal criteria required California to provide data demonstrating that the state was experiencing or at risk for an increase in viral hepatitis or HIV infection due to injection drug use. After review of CDPH's submission, the CDC agreed that the entire state of California is at risk for an increase in viral hepatitis or HIV infections due to injection drug use, and that "the submitted data provide sufficient evidence to establish a need for SSPs within the jurisdiction." On that basis, it granted CDPH's request. See **Exhibit 44**. A true and correct copy of the CDC Determination of Need response is attached to the Index as **Exhibit 47**.

The CDC recently reported a 4% percent increase in HIV infections among PWID in the U.S. between 2017 and 2021, and clusters of injection-mediated HIV infection have been documented in Lawrence and Lowell, Massachusetts; Northern Kentucky/Hamilton County, Ohio; Seattle, Washington; Philadelphia, Pennsylvania; Portland, Oregon; and West Virginia. To identify and understand similar trends in California, CDPH monitors monthly for increased diagnoses among PWID in California, and in 2023 identified PWID HIV infection clusters in Sonoma, Stanislaus, Merced, Contra Costa, Riverside, San Luis Obispo, and San Mateo counties. HCV infections have also increased in the U.S. generally, particularly among young people. In California, chronic HCV infections rose more than 50% among people 15–29 years of age between 2014 and 2018. Public health experts have concluded that this increase was due to increases in injection drug use and have recommended expanding SSPs as a key preventive measure. These recent trends further underscore that the use of SSPs is a bedrock strategy both to prevent HIV and HCV outbreaks, and as a powerful mitigation measure when an outbreak does occur. See **Exhibit 42**. True and correct copies of the study and publication are attached to the Index as **Exhibits 48 and 49**.

SSPs Reduce Overdose Rates in California

The opioid overdose crisis has radically changed the frontline work of California's 78 SSPs, which offer services in 36 of the state's counties. One of the most critical roles SSPs now play is in preventing drug overdose, which is the sixth-leading acute cause of death in California. According to CDPH data, the drug-related overdose age-adjusted death rate in 2021 was greater than the age-adjusted death rates for lung cancer, kidney disease, and congestive heart failure. Health disparities associated with overdose are significant. In 2021, Native Americans had the highest rate of fentanyl-related overdose deaths compared to individuals of other race/ethnicities. Black/African Americans had the second highest death rate for fentanyl. People experiencing homelessness are disproportionately impacted. Overdose is the leading cause of death among people experiencing homelessness, as documented in mortality reports from Los Angeles, Orange, San Francisco, and Alameda counties, among others. True and correct copies of the studies and publication are attached to the Index as **Exhibits 50, 51, and 52**.

The housing and homelessness crisis has exacerbated the overdose crisis in the state. California's homelessness rate increased more than 40% between 2014 and 2020, more than in any other state. A 2022 CDPH survey of 1,500 clients of California SSPs found that 70% of program participants are now unhoused and unsheltered. Research has documented an association between prevalence of homelessness and overdose mortality rates, and SSP clients routinely report that any type of self-care, including taking cautious steps to reduce the risk of overdose, becomes significantly more difficult when they have no access to sanitation, privacy, or housing. True and correct copies of the studies are attached to the Index as **Exhibits 53, 54,** and **55**.

SSP staff, volunteers, and program participants play an outsized role in California's overdose response. Data show that California SSPs received one-third of the naloxone from the state Naloxone Distribution Project (NDP) in 2022 but reported almost two-thirds of the overdose reversals. In the 2022 CDPH survey of people who accessed SSPs, 54% reported having used naloxone to reverse an overdose. Ninety-five percent of those who reversed an

overdose reported receiving their naloxone from an SSP. A true and correct copy of the data is attached to the Index as **Exhibit 56**.

In El Dorado County (EDC), Sierra Harm Reduction Coalition (SHRC) was responsible for an even higher rate of naloxone distribution and overdose reversals. Data collected through the NDP shows that SHRC distributed 6,156 units of naloxone and reported 1,157 reversals between 2019 and 2023. In comparison, the 38 other programs in the county that received naloxone from NDP reported a combined 144 reversals. A true and correct copy of the data is attached to the Index as **Exhibit 57**.

The California Budget Act of 2023-24 solidified the state's recognition of SSPs as an essential, if not most important, component of the frontline response to the overdose epidemic. The Budget Act provided more than $61 million over 4 years to support staffing at SSPs to provide naloxone, overdose reversal training, and navigation to substance use disorder treatment. This funding represents the largest investment in harm reduction frontline staff in California history and recognizes the critical role that agencies like SHRC now play in overdose prevention. According to CDPH data, California SSPs reach over 100,000 people a year via clinics, mobile vans, storefronts, health departments, churches, encampment outreach, and home visits. They reach people who are often reluctant or unable to engage in other services due to experiences of stigma because of their homelessness or substance use, or due to lack of transportation, limited clinic operating hours, or other structural impediments. Evidence at all levels—national, state, and local—overwhelmingly supports the effectiveness of SSPs. A true and correct copy of the budget data is attached to the Index as **Exhibit 58**.

EXHIBIT NO.	EXHIBIT	BATES
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5.	Syringe Access and Disposal Services https://www.sfdph.org/dph/hc/HCCommPublHlth/Agendas/2018/May%2015/syringeprez.pdf	
6.	Comprehensive Harm Reduction Reverses the Trend in New HIV Infections https://www.health.ny.gov/diseases/aids/providers/reports/docs/sep_report.pdf	
7.	Aspinall, et al. (2014), Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis https://pubmed.ncbi.nlm.nih.gov/24374889/	
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