Baltimore City Council Public Safety Committee Hearing July 29, 2025

Opening Statement – Dr. Megan Buresh

Hello, My name is Dr. Megan Buresh. I am a primary care and addiction medicine physician at Johns Hopkins Bayview, and an Associate Professor at Johns Hopkins School of Medicine. Everyday, I work on the front lines of the opioid crisis. As a primary care doctor at Bayview, I prescribe buprenorphine (Suboxone) to over 100 patients. On Wednesday mornings, I work on the BHLI CARE van outside the Baltimore City Detention Center providing buprenorphine to our city's most vulnerable.

Since 2017, I have been the medical director of Bayview's inpatient addiction consult service. At Bayview, over 10% of patients have opioid use disorder. I lead a team of addiction medicine physicians, social workers and peer recovery coaches who provide evidence-based addiction treatment and linkage to treatment for people with OUD, including the life-saving medications methadone and buprenorphine. Since it started, our team has treated over 5000 people.

This is personal to me. I lived in the North Patterson Park neighborhood for 13 years and still own a home there. I grew up in the Baltimore area and specifically returned after my residency to provide treatment where it's most needed. I've picked up used needles from my alley, and warned my nephews not to play in the leaves due to fear of a needle stick. I have lost friends and neighbors to overdoses. Everyday, I see that treatment saves lives. I think of B, who I met 8 years ago during a hospitalization for liver disease. Through our consult service, he started buprenorphine. I still see him for buprenorphine and primary care. He still uses fentanyl occasionally but is alive and now has housing. He's stayed out of the hospital despite many chronic health conditions, and has stayed out of jail. This is just one story of hundreds that I could share.

Every overdose death represents a person lost and a family left behind. Every overdose death is preventable and is a tragedy, particularly because we have the tools to treat overdoses, like naloxone.

While the treatments are life-saving, we need to keep people alive until they're ready and able to access treatment. We need to fight the shame and stigma that leads people to use drugs alone, which is the situation leading to most fatal overdoses. With an increasingly deadly drug supply, dominated by fentanyl and adulterants like xylazine and medetomidine, we need harm reduction measures like drug checking programs so people using drugs know what they're using, and first responders can treat them appropriately. We need greater transparency of real-time overdose data and hot spots so that we can respond with targeted resources.

We need **Overdose Prevention Centers** where people can use drugs safely and overdoses can be responded to. Widely use in Canada and Europe for decades, OPCs have been shown to be an effective way to decrease overdoses, as well as improve safety in surrounding neighborhoods by decreasing drug use in public spaces and the hazardous waste, like needles, that are left behind. In 2021, OnPoint NYC, the first legal OPC in the US, opened 2 locations. Since it opened, OnPoint NYC has had an amazing impact – both on the lives of people who use drugs, and the surrounding neighborhoods.

This includes:

- 1,825 overdoses treated.
- Zero fatal overdoses
- 3 million units of hazardous waste collected
- Estimated $53 million in savings to taxpayers, through measures like responding to overdoses so police don't have to.

In the 1990s, Baltimore was at the forefront of harm reduction through syringe service programs, also known as needle exchange. At the time, syringe service programs were criticized as encouraging drug use, but have saved lives, and led many people to eventually stop using drugs. Overdose Prevention Centers are similar – they don't encourage or increase drug use, but help make it safer, decrease city spending and make our communities safer.

We also need to address underlying structural inequities that lead to deadly drug use. Most importantly we need safe and affordable housing, including family-friendly and flexible housing-first options for people who may still use drugs. This includes strategic partnerships with coalitions like BUILD, to address the vacant housing crisis.

Funding needs to be structured with a view to supporting and creating programs that offer long-term, sustainable infrastructure, rather than short-term grants. With strategic investment in these evidence-based public health tools, Baltimore can become a leader in addressing the opioid overdose crisis. Thank you.

I would like to thank the esteemed members of the Baltimore City Council for the opportunity to speak about the role of public safety on addressing the overdose crisis in Baltimore.

My name is Javier Cepeda and I am an Assistant Professor in the Department of Epidemiology at the Johns Hopkins Bloomberg School of Public Health and I am speaking in my capacity as an independent investigator. I have been studying substance use, infectious disease, and public safety for over 15 years in both domestic and international settings and have received multiple grants as a principal investigator. I am also co-investigator on the AIDS Linked to the Intravenous Experience (ALIVE) Study, which has been working to understand drug use in Baltimore for nearly forty years.

I have dedicated most of my research career to studying the intersection of public safety and public health because I want people to be both safe and healthy. Today, I would like to make 3 points.

First, traditional policing has historically posed a risk to public health.

Second, innovative policing alternatives can improve health.

Third, strengthening public health and public safety together is mutually beneficial.

Let me explain each of these points in turn.

First, traditional policing has historically posed a risk to public health. Over-policing of low level, non-violent drug offenses resulted in explosive growth of jails and prisons across the nation. Release from incarceration is a strong risk factor for subsequent overdose, particularly within the first few weeks after re-entry to the community. This is because tolerance to opioids decreases during periods of abstinence, such as when someone is incarcerated. It is also important to recognize that regardless of arrest, even the perception of fear of arrest keeps people from treatment and other essential services..

These problems are why many police officers will say “we can’t arrest our way out of this problem” as this revolving door of people constantly cycling through the justice system does not help public health or public safety and fuels burnout among law enforcement officers.

Let me turn to my second point: innovative policing alternatives can improve health. From my own research, we have built capacity in multiple law enforcement organizations on the science behind addiction, occupational safety, evidence-based harm reduction and

treatment. Through this training, we have shown significant declines in occupational stress and burnout and greater self-efficacy for law enforcement officers to make referrals to health and social services for people who use drugs. The overall goal of my research is to improve the interface between public safety and public health by task shifting the role of street-level policing to behavioral health services.

Which brings me to my third point. Strengthening public safety and public health together is mutually beneficial. If pathways exist for law enforcement officers to efficiently refer people who use drugs to behavioral health services, then law enforcement will have more time to focus on fighting violent crime and making communities safe. And more people who use drugs will get the help they need.

I would like to conclude by saying that it is critical that everyone involved in this response hear the success stories. First responders often see individuals at their most vulnerable and can reach the conclusion that there is no hope. But many individuals do recover from substance use disorder. It's just thatthese stories are rarely told. But my research has demonstrated that these success stories can not only help destigmatize drug use but might also help ensure sustainability of these evidence-based interventions.

Thank you and I look forward to our discussion.

(My disclosures- I am on the boards of BHLI (Behavioral Health Leadership Institute) and Charm City Care Connection, and on the steering committee of BCORE)

Thank you for allowing me to share my insights. The last time I was here was in 2006, when I was standing next to Mayor O'Malley as he announced the Baltimore Buprenorphine Initiative.

For the past 35 years, I have been on a mission to provide compassion, non-stigmatized care to individuals in Baltimore with addiction. I am a Professor of Medicine and Public Health at Johns Hopkins, but most important to me is all the clinical work I do. In 1994, I created a primary care practice, the Comprehensive Care Practice, at Johns Hopkins Bayview Medical Center, that focuses on providing compassionate primary care to individuals with addiction. We prescribe buprenorphine to over 650 individuals with opioid use disorder-I see patients there 3 sessions/week. By providing integrated care, we have shown that for patients with Medicaid, providing integrated, rather than siloed, care we save money. Within the clinic, we have a food pantry, provide food from the Maryland Food Bank, and have a Hopkins Community Connection office- a group of 16-20 Hopkins undergraduates who help our patients with the social determinants of health.

However, I have always realized that we cannot always expect patients to come to us (meaning a typical medical setting) and have worked on establishing community based low threshold sites for care. In 2009, I worked with BHLI to create a buprenorphine program at Dee's Place in East Baltimore. (We subsequently created the PCARE van that sits outside the detention center) There was work to establish trust and to educate about the utility of medication, buprenorphine, as there was significant anti-medication stigma. (This requires continued conversation in the recovery community). The majority of individuals we reached had never been in treatment previously and none had been on buprenorphine. This program has since moved to Amazing Grace Church–where on Monday mornings I care for individuals with opioid use disorder by prescribing buprenorphine- we are a team consisting of a nurse, a peer counselor and myself. Most of the individuals seen have never been in treatment for opioid use disorder previously, and most are black men over the age of 50. One gentleman I saw yesterday is age 71 and came to us 3 years ago, seeking treatment for the first time. He avoided going for medical care for fear of being judged related to addiction. Pastor Gary Dittman has been a wonderful partner at the church, which also hosts Safe Streets, and we have people from Charm City Care Connection come and help the community by removing drug paraphernalia from the areas around the Church.

I am also a Maryland Addiction Consult Service consultant (all day Thursday), helping providers by phone, in their care of individuals with addiction. In my work on the boards of Charm City Care Connection and BHLI, I try to provide guidance in reaching as many individuals with addictions as possible, using touch points which are key to creating hope for making the current day better than yesterday- for me the definition of recovery. This type of work now will continue as I work on the BCORE steering committee, setting up effective entry points of care, including all city emergency rooms, EMS calls, the BCHD Spot Van (to be led by a physician who just finished her addiction medicine fellowship with us), and the BHLI van outside the detention center (where every person with opioid use disorder should be receiving medication and is not) and via a telephone access line.

In my Hopkins faculty role, I cover our inpatient addiction medicine consult service and our inpatient addiction medicine unit 8 weeks/year. This work informs me on current trends in drug use and what is happening on the street. Finally, in order to create new compassionate clinicians and researchers in addiction, I teach and mentor students at the medical school and the Bloomberg School of Public Health.