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Steven Nisi

Indiana University McKinney School of Law, nisis@iu.edu

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Syringe Service Programs in Indiana: Moving Past the “Moral” Concerns of Harm Reduction Towards Effective Legislation

Steven L. Nisi*

INTRODUCTION

Drug overdose fatalities in the United States increased by almost thirty percent during the twelve-month period ending April 2021. The marked increase is the first time the United States exceeded 100,000 overdose deaths in one year, a doubling since 2015. According to the Center for Disease Control (CDC), this trend holds steady in the state of Indiana, where 2,663 overdose deaths were reported during the twelve-month period ending September 2021. In the same twelve-month period from 2020, Indiana recorded 2,160 deaths due to overdose. Indiana’s inadequate Syringe Service Program (SSP) law has done little to address the additional 503 preventable deaths from the previous year.

These numbers are even more staggering when we look to the past. Indiana reported the overdose-death toll was 1,210 in the twelve-month period ending in September 2015. The majority of these deaths are attributed to the presence of synthetic opioids, such as fentanyl, adulterating common street drugs like heroin to increase potency and dependency. Fentanyl, a drug 100 times as powerful as morphine, fuels the run-away death toll of the opioid overdose epidemic in the United States. However, fentanyl is easily detected with test strip kits and the fatal effects can be reversed by the lifesaving drug naloxone.

Test strip kits and naloxone are just a few examples in a long list of services provided by SSPs in the fight to end the opioid overdose epidemic. While SSPs differ across communities, of the 185 currently operating in the United States,

* J.D. Candidate, 2023, Indiana University Robert H. McKinney School of Law; B.A. 2014, Kenyon College—Gambier, Ohio.


2 Rabin, supra note 1.


4 Id.

5 Id.

6 Rabin, supra note 1.

7 Id.; Naloxone is one of several overdose reversal drugs. Narcan, a common alternative for Naloxone, is another drug administered to reverse an opioid overdose.

ninety-seven percent of these programs provide various public health services beyond sterile needles, test strip kits, safe smoking kits, and naloxone such as “substance abuse treatment, preventative education for sexually transmitted diseases, HIV counseling and testing, tuberculosis screening, and primary health care.”

On March 11, 2021, Congress enacted the American Rescue Plan Act (ARPA). The ARPA appropriated over four billion dollars to assist the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration in expanding “access to vital behavioral health services.”

Sections 2706 and 2707 of ARPA allocate as much as eighty million dollars to support state and local community-based organizations committed to primary and mental health services, overdose prevention programs, SSPs, and other harm reduction services.

ARPA lists seven goals to removing obstacles for drug treatment that highlight the commitment to the human rights approach: (1) integrate and build linkages between funding streams to support SSPs; (2) explore opportunities to lift barriers to federal funding for SSPs; (3) identify state laws that limit access to SSPs, naloxone, and other services; (4) develop and evaluate the impact of educational materials featuring evidence-based harm reduction approaches; (5) examine naloxone availability; (6) amplify best practices for drug testing kits; and (7) support research on the clinical effectiveness of harm reduction practices in real world settings. While federal policy is not controlling on state law, it does serve as a rough outline of state action that Indiana should take to improve SSP performance and access within the state. Furthermore, taking these steps would expand SSPs in Indiana through federal funding, thereby reducing the burden on the State.

This Article argues that Indiana SSP law is mistaken on a fundamental level. The singular focus on reducing the transmission of bloodborne diseases has produced law that treats drug misuse as a punishable “moral” shortcoming rather than a medical condition requiring compassionate, consistent medical care. Indiana SSP law must reflect the national trend of growing awareness around the dual HIV

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9 Needle Exchange Programs Promote Public Safety, ACLU, https://www.aclu.org/fact-sheet/needle-exchange-programs-promote-public-safety#9 (last visited Oct. 22, 2021); The number of stated SSPs in the United States vary substantially by study depending on methodology. This Article uses 185, one of the more conservative counts of SSPs.

10 American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 2706, 135 Stat. 47 (2021); Biden-Harris Administration’s Statement on Drug Policy Priorities for Year One, 2021 DAILY COMPILATION PRES. DOC. 4 (Apr. 1, 2021). (“Harm-reduction organizations provide a key engagement opportunity between people who use drugs (PWUD) and health care systems, often employing peer support workers. Regular engagement between harm reduction staff and PWUD builds trust, allowing for an ongoing exchange of information, resources, and contact. This relationship can encourage individuals to further pursue a range of treatment options including [medications for opioid use disorder] induction, psychosocial treatment, and long-term recovery. Harm reduction staff can build trust over time with patients and are in a unique position to encourage PWUD to request treatment, recovery services, and health care.”)

11 The Biden-Harris Administration’s Statement on Drug Policy Priorities for Year One, supra note 10.


13 The Biden-Harris Administration’s Statement on Drug Policy Priorities for Year One, supra note 10, at 4–5.
and opioid overdose epidemics as well as public health measures aimed at long-term drug misuse care over emergency intervention. Furthermore, this Article responds to the Biden-Harris administration’s call to action by identifying state laws that limit access to SSPs, naloxone, and other health care services.

Part II offers a general overview of SSPs used throughout the United States. The analysis of SSP efficacy and economic viability underscores the sustainability of SSPs as a mechanism for addressing the dual HIV and opioid overdose epidemics. The economic viability of public health initiatives aimed at saving lives cannot and should not be the prevailing reason for adopting these programs. It should be but one of them. Part III of this Article is a brief history of Indiana’s first SSP which started in Scott County as a response to high community transmission rates of HIV and hepatitis C among intravenous drug users that led to the enactment of SSP laws in the state. The State’s failure to act with urgency in Scott County offers some historical context in which SSP law came to be.

Part IV closely examines relevant Indiana Code sections regulating SSPs to show that current state law has arrested the development of SSPs, thus limiting access to their lifesaving and life-changing services to communities most in need. It then offers legislative changes that would alleviate the administrative burden of opening and running SSPs. It also puts forth several pragmatic steps advocates can take to enhance the SSP’s positive community impact while realizing the larger goal of human-rights-informed SSP law in Indiana. Part IV also outlines the controlling case of *Leatherman v. State* and its detrimental, contradictory effect on the intersection between criminal justice and SSPs, specifically the criminal charge of possession of drug paraphernalia.

I. AN OVERVIEW OF SYRINGE SERVICE PROGRAMS BY THE NUMBERS

SSPs take on a critical public health role due to the inextricably linked nature of HIV and intravenous drug use. Of the approximately 950,000 United States residents living with HIV/AIDS, more than a quarter of those aged thirteen years or older contracted the infection through a direct link to injection drug use.\(^{14}\) Roughly sixty one percent of AIDS cases among women are linked to injection drug use or sexual contact with an HIV positive injection drug user.\(^{15}\) When mother-to-child HIV infection is considered, about thirty-five percent of all AIDS infections can be traced back to intravenous drug use.\(^{16}\)

The National Institutes of Health observed that SSP participants reduced risky behaviors (*i.e.*, sharing used needles and other injection materials) by as much as eighty percent and were five times more likely to enter drug treatment.\(^{17}\) As providers of both drug misuse treatment and primary health care, SSPs effectively address the interconnected HIV and opioid overdose epidemics through targeted

\(^{14}\) ACLU, *supra* note 9.
\(^{15}\) *Id.*
\(^{16}\) *Id.*
\(^{17}\) *Id.*
efforts, such as sterile needle exchanges. They also provide access to primary care that gives individuals an increased chance at sustaining long-term positive health outcomes by increasing contact between intravenous drug users and health care providers as well as sharing informational material on substance abuse treatment options.

A single SSP costs an average United States city about $160,000 per year in operational expenditures. A single AIDS patient who contracted the illness from intravenous drug use will cost the community nearly $120,000 per year in public health costs. Estimates predict that an additional 12,350 individuals will contract HIV without increased access to sterile needles provided by SSPs for intravenous drug users. An additional 12,350 HIV cases would translate to $1.3 billion dollars in future medical care costs. The United States could run all 185 of its SSPs for more than thirty years with the cost savings alone. Alternatively, these cost savings could support a doubling of SSPs for over fifteen years and create an expanded network of drug misuse and primary health treatment facilities across the United States.

As mentioned above, the economic advantages and reduction of bloodborne illnesses are not the only or most compelling reasons for increasing access to SSPs. Often, those suffering from substance use disorders forego necessary medical treatment due to the stigma associated with their diagnosis. One Indiana SSP participant observed that these programs are where some suffering from substance use disorder “get love for the first time in a long time . . . [someone says] I don’t want you to die!” Participants come to SSPs for medical care but continue to utilize these services because they are treated as people, not criminals.

Policymakers have been resistant to legislative action creating and expanding access to SSPs in part because of their status as a harm reduction tool and the associated stigmas that come with this designation. Harm reduction is a blanket term for public health services aimed at the reduction of problematic behavior such as the intravenous use of drugs. “Most frequently associated with substance use, harm reduction also applies to any decisions that have negative consequences associated with them . . . . At its core, harm reduction supports any steps in the right direction. Critics may contend that harm reduction somehow

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18 Id.
19 Id.
20 Id.
21 Id.
23 Id.
25 Id. at 29.
26 Wodak & Cooney, supra note 22.
enables or excuses poor choices.” 27 This prevailing criticism has been debunked time and time again, but the moral element of this criticism persists. 28 In the following section, you will see several examples in Indiana where moral justification overshadowed science and led to the shuttering of successful SSP programs.

Resistance to harm reduction legislation stems from the ingrained misconception that a zero-tolerance drug policy is always the best approach and that anything less is somehow promoting unsafe drug use behaviors. 29 This misconception exacerbates the stigma associated with SSPs by positioning drug use as a “moral” shortcoming rather than a symptom of a treatable medical issue. Opponents of SSPs often cite international drug treaties as the source of legal authority for a zero-tolerance or abstinence approach to drug misuse treatment, but the Narcotics Control Board in 2004 recognized that Article 14 of the 1988 International Drug Treaty “requires parties to adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering.” 30

It took the federal government almost twenty years to heed its own advice, but the Biden administration has earmarked $80,000,000 for drug treatment and mental health services in ARPA. 31 Most of those dollars fall under funding meant for behavioral health needs rather than drug treatment programs such as SSPs. 32 The pool of funding allocates $30,000,000 to “community-based overdose prevention programs, syringe services programs, and other harm reduction services,” and $50,000,000 for “mental health needs (including co-occurring substance use disorders),” 33 as well as other community behavioral health needs. Taken together, the ARPA statutes indicate that funding is available for SSPs from both pools of money, since most programs provide both harm reduction services as well as behavioral health care. SSP participants come to these facilities for sterile using materials, but often leave with more: an important contact with a compassionate primary and mental health provider.

Public health advocates might argue over how these funds should be dispersed, but the reality is that SSP funding, in large part, must be focused on the primary and mental health care of their participants as well as reduction of risky behavior. 34 The public health model of harm reduction “seeks to justify these

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28 See id.
29 Wodak & Cooney, supra note 22, at 779.
30 Id. (emphasis added) (quoting INT’L NARCOTICS CONTROL BD., REPORT OF THE INTERNATIONAL NARCOTICS CONTROL BOARD FOR 2003 36 (2004)).
32 Id.
33 Id.
34 See Nicholas B. King, Harm Reduction: A Misnomer, 28 HEALTH CARE ANALYSIS 324, 325 (2020); Logan & Marlatt, supra note 27, at 7–8.
strategies purely from a disease prevention approach,”35 but there is another way. When looked at through the human rights model, harm reduction justifies SSPs because “drug users are deserving of the health care, safety, and freedoms of other members of the public.”36 While the Biden-Harris administration’s statement on drug policy37 and ARPA reflect a growing acceptance of the human rights approach, many harm reduction intervention methods are governed by the State rather than the federal government.38

II. A BRIEF HISTORY OF INDIANA’S FIRST LEGAL SYRINGE SERVICE PROGRAM

In January 2015, the Indiana State Department of Health (ISDH) identified an outbreak of HIV in Scott County tracing back to intravenous drug users in the area.39 Within one year, almost 235 people were infected with HIV.40 In response to growing pressure to address the HIV epidemic in the county, Governor Mike Pence issued Executive Order 15-05,41 allowing the local health commissioner to declare a public health emergency, triggering an emergency response that allowed for the temporary use of the ISDH syringe service and harm reduction program.42 The executive order was renewed in April 2015, extending temporary legal status for SSP in the state.43 Later that month, the Indiana General Assembly passed Senate Enrolled Act (SEA)61, allowing for the use of SSPs across the state under certain circumstances and upon declaration of an emergency by the local and state commissioners.44

Another important development in 2015 by the Indiana legislature was the escalation of possession of a syringe from a misdemeanor to an Level 6 felony.45

36 Id.
37 Biden-Harris Administration’s Statement on Drug Policy Priorities, supra note 10.
42 Chapman, supra note 39.
44 See Chapman, supra note 39.
More on this point will be explored later in this Article, but it is serves as another example of the state legislature, consciously or otherwise, diminishing the impact of SSPs in Indiana. In the same legislative session SSPs were incorporated into law, but in the same Act the needles they provided were subjected to heightened criminal liability for simply possessing that same needle.46 Possession of drug paraphernalia charges for needles limit the effectiveness of SSPs in the community by perpetuating a contentious relationship between law enforcement and intravenous drug users.47

The Scott County SSP, widely credited as the first rural SSP in the United States to be employed as an emergency measure to curb an HIV epidemic, exemplifies the issues of Indiana’s poorly drafted SSP laws. The Scott County SSP managed to reduce syringe sharing to inject in the county by 88%, syringe sharing to divide drugs by 79%, and the injection equipment sharing (i.e., cookers and fillers) by 81%.48 Along with the reduction in risk behaviors, HIV rates in the county plummeted from 235 reported cases over the course of the epidemic to just one confirmed case in 2020.49 Critics of the state response to the HIV epidemic attribute Governor Pence’s slow reaction to the public health crisis as the primary driver of the outbreak.50 If an SSP had existed as a preventative measure in Scott County during the years preceding the outbreak of 2015, estimates state roughly 90% of HIV cases could have been avoided.51 If these estimates were correct, about 211 HIV infections could have been avoided.

46 IND. CODE § 16-41-7.5-5 (2016).
47 Carol Y. Franco, Angela E. Lee-Winn, Sara Brandspigel, Musheng L. Allshahi & Ashley Brooks-Russell, “We’re Actually More of a Likely Ally Than an Unlikely Ally”: Relationships Between Syringe Services Programs and Law Enforcement, 18 HARM REDUCTION J. 1, 2 (2021) (“Prior studies have described how law enforcement actions can have a negative influence on the ability of a SSP to provide services. This could be by direct interference with operations and access to SSPs or through other practices such as charging PWUD with paraphernalia in contradiction to the law. Negative interactions with law enforcement can deter PWUD from using SSP services. One reason for law enforcement practices that undermine harm reduction programs operated by SSPs could be lack of awareness on the part of law enforcement and perception that the harm reduction approaches are counterproductive.”).
49 Legan, supra note 40.
51 Id. (citing William C. Goedel et al., Implementation of Syringe Services Programs to Prevent Rapid Human Immunodeficiency Virus Transmission in Rural Counties in the United States: A Modeling Study, 70 CLINICAL INFECTIONOUS DISEASES 1096, 1098 (2019)).
In April 2017, Governor Eric J. Holcomb signed into law House Bill 1438, modifying existing legislation on SSPs. The bill largely left the decision to implement SSPs to local commissioners in each county or municipality. Scott County officials, citing moral concerns with the local SSP, voted two-to-one in June 2021 to end the hugely successful program that halted the HIV outbreak in the area. This vote calls into question Scott County commissioners’ ability to accurately assess the need for SSPs in their communities, but local advocates remained determined to help their communities. On November 9, city council members from Austin, Indiana, a municipality within Scott County, voted to approve an SSP. While this might appear as a win, Parts IV of this Article will address some of the administrative hurdles this approval has created for the new SSP clinic in Scott County as well as the statutory language leading to this ambiguous approval process.

Legal justification for SSPs in Indiana, tracing back to the State response in Scott County to the HIV epidemic, focuses almost exclusively on reducing the transmission of blood-borne illness and evaluating the effectiveness of SSPs by these same metrics. This public health model was an essential tool in establishing the effectiveness of sterile needles and syringes to reduce rates of HIV and hepatitis through data-driven analysis. This type of data driven analysis was pivotal in advancing novel forms of harm reduction but has proven to be a small piece of the puzzle. As SSP implementation has progressed across the country, programming has expanded far beyond just supplying sterile injection equipment and taken on a wider view of what is necessary to effectively address the dual opioid overdose and HIV epidemics.

No movement develops in a vacuum, and Indiana SSPs are no exception to this rule. Indiana policymakers’ emphasis on the reduction of blood-borne illnesses, while still critical to the function of all SSPs, lacks the necessary scope because it all but necessitates a reactionary health emergency response. Policymakers have

53 Chapman, supra note 39, at 6.
54 Alex Norcia, Austin, Indiana to Restart Syringe Access After Scott County Shutdown, FILTER (Nov. 15, 2021), https://filtermag.org/austin-scott-county-syringe-program/ [https://perma.cc/NPZ3-WWGC].
55 See Legan, supra note 40.
56 Norcia, supra note 54.
57 See generally Hoss, supra note 35.
58 See generally Logan, supra note 40.
59 Josiah D. Rich & Eli Adashi, Ideological Anachronism Involving Needle and Syringe Exchange Programs: Lessons From the Indiana HIV Outbreak 2 (July 7, 2015) (unpublished manuscript) (available at https://europepmc.org/lookup/doi/10.1016/j.jinf.2015.07.004) (“NSEPs are not limited to the provision of sterile hypodermic needles to injection drug users and the safe disposal of used paraphernalia. Instead, NSEPs offer counseling, testing, and treatment for HIV as well as for hepatitis, tuberculosis, and sexually transmitted infections. In so doing, NSEPs reduce the risk of spread of HIV and related diseases, especially when coupled with safe sex measures. Equally important, NSEPs facilitate referral and entry of injection drug users into substance abuse treatment programs. NSEPs also provide the opportunity for overdose prevention (>10,000 documented overdose rescues in 2010 alone) as well as referral to housing and employment services.”); see also King, supra note 34; Logan & Marlatt, supra note 27, at 7–8.
thwarted SSPs from actualizing their core public health function: prevention, not reaction. The prevention in this case being proactive measures to reduce HIV/AIDS and sustainably address drug misuse’s root causes in a community.\(^{60}\) Remember, 90% of HIV cases in Scott County could have been avoided if an SSP had been used as a preventative measure rather than a reactive emergency order.\(^{61}\) If Indiana policymakers kept this core function of prevention in mind while drafting and enacting legislation, perhaps the Scott County vote would have gone the other way.

In turn, the discourse must be broadened beyond the current reality that SSPs are triage tools to reduce the spread of disease in communities during crisis. In Part IV, this Article will examine the narrow scope of Indiana’s current legislative perspective that all but requires a reactionary response, as reflected in Indiana Code section 16-41-7.5-5, requiring the declaration of a public health emergency because of a current HIV or hepatitis C epidemic.\(^{62}\) The existing approach has simultaneously promoted acceptance of novel drug misuse treatment while pandering to the misguided discourse on SSPs at the state level.\(^{63}\) A closer look at Indiana law surrounding SSPs will reveal the inadequacies that hinder the effectiveness of these programs in communities across Indiana.

III. Analysis of Indiana Law on SSPs

A. SSPs are More Than Emergent Care: Indiana Code § 16-41-7.5-5

Indiana Code section 16-41-7.5-5 is antithetical to the human rights approach to harm reduction because it confers no right to healthcare.\(^{64}\) Indiana Code section 16-41-7.5-5 remains in effect until July 1, 2026. It states in part:

Before a qualified entity may operate a program in a county, the following shall occur:

(1) The local health officer or the executive director must declare to the executive body of the county or the legislative body of the municipality the following:

(A) There is an epidemic of hepatitis C or HIV.

(B) That the primary mode of transmission of hepatitis C or HIV in the county is through intravenous drug use.

\(^{60}\) See Robert Brooner, Michael Kidrorf, Van King, Peter Beilenson, Dace Svikis & David Vlahov, Drug Abuse Treatment Success Among Needle Exchange Participants 113 PUB. HEALTH REPS. 129, 129 (1998).

\(^{61}\) Facher, supra note 50.

\(^{62}\) IND. CODE § 16-41-7.5-5 (2021).

\(^{63}\) See generally Maggie Coan, Starving or Stoking a Drug Addict’s Addiction?, 50 CUMB. L. REV. 563 (2020).

\(^{64}\) See Leslie London, What is a Human-Rights Based Approach to Health and Does it Matter?, HEALTH AND HUM. RTS. J. (Sept. 13, 2013), https://www.hhrjournal.org/2013/09/what-is-a-human-rights-based-approach-to-health-and-does-it-matter/ [https://perma.cc/5T5W-2FKT] (“This article has argued that civil society mobilization must underlie all the different modalities by which a human rights approach can work for health, whether it involves holding government accountable for delivery on the right to health, pro-actively developing policies and programs, or securing redress for those whose rights have been violated.”).
(C) That a syringe exchange program is medically appropriate as part of a comprehensive public health response.65

Subsection (1)(A) cuts to the heart of one major issue with Indiana law surrounding SSPs. It requires that an epidemic of hepatitis C or HIV exists, and that it be attributed primarily to the intravenous use of drugs. Practically speaking, this restriction seems reasonable on its face, but the Scott County epidemic serves as a haunting reminder that SSPs, when used most effectively, are a tool to prevent risky drug use behaviors and increase positive health outcomes to avoid an HIV and hepatitis C outbreak. Additionally, even if the county or municipality meets the metrics for emergency designation, it remains at the discretion of local commissioners to accept an SSP proposal. There is little to no guidance on what qualifies as an “emergency.”

The most comprehensive guidance released by the Indiana Department of Health consists of the last five pages of the fifty-page manual on syringe service and harm reduction programs.66 These five pages include an outline essentially restating the pertinent language in the Indiana Code on SSPs and offers a few helpful pointers on documentation for approval and continued lawful status to remain operational.67 When read in the most favorable light, the law allows for communities who might not meet the emergency threshold to rally political support for an SSP near them.68 In doing so, the interests of community members can be aligned with their local politicians and create an environment of acceptance in which a SSP would thrive. Unfortunately, the real outcomes of this law indicate otherwise. Ambiguous guidance and unclear legislation lead to unpredictable results and burdensome legal outcomes for SSP operations.69

This issue played out in the 2021 vote to approve a new SSP in Austin, Indiana, a city located in Scott County.70 While renewed approval for an SSP in Scott County remains a success story for advocates in Indiana, the program should never have been closed in the first place. Local commissioners, led by President Mike Jones, initially voted to close the SSP in Scott County because they could not condone a program they saw as a promotion of drug use.71 Jones said, “I know people that are alcoholics, and I don’t buy him a bottle of whiskey, and . . . I have a hard time handing a needle to somebody that I know they’re going to hurt [themselves] with.”72

66 See generally Chapman, supra note 39.
67 Id. at 46.
68 Id.
70 Norcia, supra note 54.
71 Id.
72 Id.
Advocates such as Kelly Hans, who ran the SSP program in Scott County beginning in 2017, went back to the drawing board to figure out a way to keep an SSP going in the area.\textsuperscript{73} Hans and others realized that Indiana Code section 16-41-7.5-5 allowed for the individual municipalities within the county to approve an SSP regardless of local county approval.\textsuperscript{74} Paradoxically, the closure and opening of these SSPs were both approved, meaning different health officials and county officials within the same county agreed the HIV and hepatitis C epidemics had ceased to be a health emergency in Scott County but remained a health emergency in the municipality of Austin.

While this legal workaround allowed for the opening of a new SSP in Austin, the vote led by Commissioner President Jones still required the closure of the existing SSP by the end of 2021.\textsuperscript{75} Because of this required closure, Hans had to quit her job with the county health department and create a new non-profit, Holding Space Recovery Project, and seek new funding from the Indiana Recovery Alliance.\textsuperscript{76} Scott County officials are responsible for this odd legal outcome producing a gap in access to drug treatment care for those in Scott County. But the situation could have been avoided with clear legislation and better guidance for public health officials unfamiliar with legal jargon. The law inadvertently confers power to local counties and municipalities to create an administrative nightmare in which SSPs can be closed at the county level then reopened by city councilors within the same jurisdiction.

The law leaves more questions than answers on this issue as well as several others. Indiana Code section 16-41-7.5-4 clearly states that “a qualified entity may not operate a program outside of the jurisdictional area of the governmental body that approved the qualified entity.”\textsuperscript{77} This statute is clear in that the new SSP must operate within the Austin city limits, but what happens if Scott County officials attempt to prevent access to those in the county not living in Austin? Admittedly, this is a much better situation for Scott County residents than no access to an SSP at all, but this cannot be the long-term solution. Indiana Code section 16-41-7.5-5 must be clarified so that public health officials operating SSPs know exactly where they can operate, how long they can operate, and who they can serve.

Additionally, Indiana Code section 16-41-7.5-6 also makes it clear that no characteristic or identification can be documented by an SSP that would reveal the participant’s identity.\textsuperscript{78} As a matter of policy, this should encourage participant interaction with SSPs by reducing the fear of being identified as an intravenous drug user.\textsuperscript{79} An SSP has no clear guidance on the population they can service and no way of verifying their identity creating a precarious legal grey area. They must

\textsuperscript{73} Id.
\textsuperscript{74} Id.
\textsuperscript{75} Id.
\textsuperscript{76} Id.
\textsuperscript{77} IND. CODE § 16-41-7.5-4 (2021).
\textsuperscript{78} IND. CODE § 16-41-7.5-6 (2021).
\textsuperscript{79} Franco et al., supra note 47, at 5.
demonstrate they are not operating outside their jurisdiction, but then are required by law to avoid recording this information. These legal ambiguities put SSP existence in jeopardy because they produce serious day-to-day difficulties that make a challenging situation worse. The law leaves the Austin SSP existing along precarious legal lines within a county intent on shuttering its doors.

On top of these readings of Indiana Code section 16-41-7.5-5, the law is only effective until July 1, 2026. While this point is not articulated in the statute itself, Indiana lawmakers have already placed a time stamp limiting the future for SSPs in Indiana.80 Regardless of a SSP’s effectiveness, on July 1, 2026, existing programs will have no way of predicting or planning for the future. As this date approaches, lawmakers will have the choice of whether or not to allow SSP law in Indiana to lapse, ending years of advocacy work.

**B. Indiana Code Sections 16-41-7.5-6 and 16-41-7.5-7**

The following two code sections list the legal requirements that a qualified entity must meet to continue running an approved SSP81 and the ramifications of not meeting these requirements.82 For all intents and purposes, Indiana Code section 16-41-7.5-6, when isolated from sections around it, is an excellent example of sound policy. It holds SSPs accountable through a yearly registration with the state department but does not require an extended renewal process.83 It also does not require any personal identification for the exchange of needles.84 Notably, it does not include a provision mandating the one-for-one exchange of needles at SSPs in Indiana.85

While the renewal process and lack of one-to-one exchange of needles seem minor, both play a key role in maintaining and extending the reach of SSPs within a community by reducing the fear of entry by first time participants. Identification requirements can deter potential participants who fear legal consequences for simply walking through the door to exchange old needles for new ones. The legal implications are further explored later in the analysis of Indiana law, but it is worth mentioning here that ID requirements may deter first time participants from making initial contact and play on the fear of those already struggling with the criminal justice system. Indiana has made it illegal to “collect and maintain identifiable information on participants in a SSP.”86 The State has gone through great lengths to create a “passcode” system to identify classes of individuals for the

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81 Ind. Code § 16-41-7.5-6 (2021).
82 Ind. Code § 16-41-7.5-7 (2021).
83 Ind. Code § 16-41-7.5-6(1) (2021).
84 Ind. Code § 16-41-7.5-6(6) (2021).
85 Id.
86 Chapman, supra note 39, at 19.
purposes of accessing an SSP’s results within a given demographic without collecting personal information specific enough to identify a particular participant. \(^{87}\)

Additionally, the one-for-one exchange of needles adopted by other states caps the effectiveness of a SSP. \(^{88}\) “Allowing clients to choose the number of needles they receive—syringe ‘access’ as opposed to one-for-one ‘exchange’—has been found to be the most effective to prevent infections and the best way for people who inject to protect their own health.” \(^{89}\) Critics of the syringe “access” model, the one codified in Indiana law, claim that unfettered access drastically increases the presence of improperly discarded needles and syringes. \(^{90}\)

These claims have been debunked time and time again. For example, Chicago, a city with a syringe “access” policy, had the highest return rate of syringes when compared to other major cities. \(^{91}\) A similar study of twenty-four SSPs in California found that “the greater the access to syringes, the more likely people are to dispose of them in safe locations.” \(^{92}\) Practically speaking, the one-to-one approach seems to require additional administrative tasks because of the additional clerical work required to report each individual needle dispersed and received. In contrast, the “access” policy mitigates time spent on clerical tasks without sacrificing the collection of data (i.e., the number of sterile needs and syringes dispersed) over privacy concerns that are difficult to avoid in the one-to-one exchange approach. To the Indiana General Assembly’s credit, Indiana law adopted the more progressive “access” approach that serves their communities if these SSPs can remain open. \(^{93}\)

While Indiana Code section 16-41-7.5-6 deserves its due credit, the following section negates any marked progress in reducing limitations on SSPs. Indiana Code section 16-41-7.5-7 states:

(a) The following may terminate the approval of a qualified entity:

(1) The legislative body of the municipality, the executive body of the county, or the local health department that approved the qualified entity.

(2) The state health commissioner, if the state health commissioner determines that the qualified entity has failed to comply with section 6 [IC 16-41-7.5-6] of this chapter.

(b) If a person described in subsection (a)(1) or (a)(2) terminates the approval of a qualified entity, the person shall notify the other

\(^{87}\) Id.


\(^{89}\) See id.

\(^{90}\) Id.

\(^{91}\) Id.

\(^{92}\) Id.

\(^{93}\) IND. CODE § 16-41-7.5-6(6) (2021).
person with authority to terminate that is described in subsection (a) of the termination.\textsuperscript{94}

In fewer than 100 words, section seven brings the conversation full circle, and, again, brings to mind the uphill battle for a SSP in Scott County. Even if a program follows all measures listed in Indian Code section 16-41-7.5-6, Indiana Code section 16-41-7.5-7(a)(1) allows the approving qualified entity to terminate the approval by vote.

As we saw in Lawarence County, Commissioner, Rodney Fish voted to end the local SSP clinic, he cited to 2 Chronicles 7:13–14, which provides, “[I]f my people, which are called by my name, shall humble themselves, and pray, and seek my face, and turn from their wicked ways; then will I hear from heaven, and will forgive their sin, and will heal their land.”\textsuperscript{95} In a follow up comment Fish said, “My conclusion was that I could not support this program and be true to my principles and my beliefs.”\textsuperscript{96} Fish, against support from the Lawrence County health board members and local hospital officials, cited his personal faith-based moral dilemma as justification for ending the SSP.\textsuperscript{97}

Indiana Attorney General Curtis Hill offered his support by citing to false information: “handing out sterile needles encourages substance abusers to shoot up, and, in many cases, shoot up more often.”\textsuperscript{98} Contrary to these misguided statements, almost two decades of extensive research shows there is no merit to the claim that SSPs increase the “initiation, duration, or frequency of illicit drug use or drug injecting.”\textsuperscript{99} Evidence tends to show the opposite. Individuals who inject drugs and participate in an SSP are more likely to seek drug treatment and stop the use of injection drugs.\textsuperscript{100} Those currently injecting drugs and participating in an SSP regularly are almost three times as likely to report a reduction in drug use frequency than those who have never attended.\textsuperscript{101} As Leo Beletsky, Professor of Law and Health Sciences at Northeastern University points out, in Austin, Indiana, “We’re still letting moral panics guide policy, to everyone’s detriment.”\textsuperscript{102}

\begin{footnotes}
\item \textsuperscript{94} \textit{IND. CODE} § 16-41-7.5-7 (2021).
\item \textsuperscript{96} Id.
\item \textsuperscript{97} Id.
\item \textsuperscript{98} Id.
\item \textsuperscript{99} Id.
\item \textsuperscript{100} Wodak & Cooney, \textit{supra} note 22, at 802.
\item \textsuperscript{101} \textit{Syringe Services Programs (SSPs) FAQs, CTR. FOR DISEASE CONTROL AND PREVENTION}, https://www.cdc.gov/ssp/syringe-services-programs-faq.html#:~:text=Studies%20show%20that%20SSPs%20protect,of%20needles%20in%20the%20community.&text=11%2C12%2C13-Do%20SSPs%20lead%20to%20more%20crime%20and%20increase%20illegal%20drug%20use [https://perma.cc/6HYQ-UB7T] (last visited Mar. 15, 2022).
\item \textsuperscript{102} Norcia, \textit{supra} note 54, at 3.
\end{footnotes}
C. Illusory Criminal Immunity: Indiana Code Sections 16-41-7-8 and 16-41-7-9

Indiana Code section 16-41-7-8 is one of the rare instances in which federal and state laws are identical.\(^{103}\) Section 16-41-7-8 provides that a state agency may not provide funds to a qualified entity “to purchase or otherwise acquire hypodermic syringes or needles for a program under this chapter.”\(^{104}\) While section 16-41-7-8 is an important aspect of legislative reform needed for SSPs, it relates to the larger issue of criminal drug paraphernalia possession and the associated legal ramifications of possession of needles and syringes. The cost of supplying sterile needles can vary from $1 to $3.50 per needle depending on geographical proximity to a major urban area.\(^{105}\) While this can add up to over $2,008 for a singular patient in a rural area, the price of distribution is not the most significant hurdle for legislative reform to allow for government funding to purchase sterile needles.\(^{106}\) Federal and state law will remain silent on this issue until larger hypodermic needle and syringe possession are decriminalized or legalized.

Indiana Code section 16-41-7-9 offers some protection for the search and seizure of needles and syringes acquired through an SSP.\(^{107}\) A law enforcement officer “may not stop, search, or seize an individual based on the fact the individual has attended”\(^{108}\) a legally qualified SSP. Furthermore, an individual’s participation in an SSP “may not be the basis, in whole or in part, for a determination or probable cause or reasonable suspicion.”\(^{109}\) However, both sections fail to offer any practical immunity for the possession of drug paraphernalia, thus limiting the effectiveness of SSPs across the state.\(^{110}\) Recall as well, the criminal charge was elevated from a misdemeanor to a felony charge in 2015 during the same legislative session that created SSP law in Indiana.\(^{111}\)

In line with the zero-tolerance influence of drug enforcement in the United States, the legislature likely elevated this charge in order to deter intravenous drug use. Unfortunately, this heightened criminal charge led to the opposite result. Intravenous drug users who are afraid of arrest and criminal charges while possessing drug paraphernalia are 1.74 times more likely to engage in risky needle

\(^{103}\) Chapman, supra note 39.

\(^{104}\) IND. CODE § 16-41-7.5-8 (2021); see also 42 U.S.C. § 300ee-5 (2021) (Federal law is included here simply to show that change, in this instance, must occur at the Federal and State level).


\(^{106}\) Id. at 6.

\(^{107}\) IND. CODE § 16-41-7.5-9 (2021).

\(^{108}\) IND. CODE § 16-41-7.5-9(a) (2021).

\(^{109}\) IND. CODE § 16-41-7.5-9(b) (2021).


sharing and are 2.08 times more likely to share other drug supplies such as sponges and spoons.\footnote{ACLU, supra note 9.}

In a 2018 Indiana Court of Appeals case, the court reasoned,

> It is apparent that Section 16-41-7.5-9 protects the means by which individuals in counties with certain disease epidemics obtain hypodermic syringes. It does so by prohibiting mere possession of a needle obtained through the program or attendance at the program as bases for arrest or prosecution. Nothing in the language of the statute purports to condone unlawful conduct that transpires after an individual has obtained a needle from the exchange program. Thus, while Leatherman could not be prosecuted for obtaining hypodermic needles from a needle exchange or participating in a needle exchange program, he could be found guilty of possession of paraphernalia if there was evidence that he intended to use those syringes for unlawful ends.\footnote{Id.}

Despite the protections granted by SSP legislation in Indiana, the defendant Leatherman was found guilty of drug paraphernalia possession from needles and syringes acquired through an SSP. The court upheld Leatherman’s possession of paraphernalia charge on the grounds that he “knowingly or intentionally possessed an instrument, device, or other object that he intended to use for introducing into his body a controlled substance.”\footnote{Id. at 885.}

Because Leatherman was in simultaneous possession of two syringes and liquid meth, he was found to have the sufficient intent to use the needles to “introduce” into his body a controlled substance.\footnote{Id. at 885.} Although the State did not prove the liquid in the syringe was a controlled substance, “evidence of possession of even a small amount of a controlled substance—such as the bag of methamphetamine—together with possession of paraphernalia . . . provide[d] sufficient circumstantial evidence of the intent to use the paraphernalia.”\footnote{Id. at 886.} The court went on to say that Leatherman “could be found guilty of possession of paraphernalia if there was evidence that he intended to use those syringes for unlawful ends.”\footnote{Id.} Through some legal gymnastics, the court reasoned that SSP legislation does not “condone unlawful conduct that transpires after an individual has obtained a needle from the exchange program.”\footnote{Id.}

The court recognized the legality of the statute but narrowed its application.\footnote{See id.} It is not a leap to interpret the court’s reasoning as ending any perceived immunity once you leave the SSP facility. SSPs distribute needles and
syringes to reduce the risky behavior of intravenous drug use, but participants are held criminally liable if used in this way. Indiana is one of twenty-five states that does not offer criminal immunity for the possession of drug paraphernalia provided by SSPs for the prevention of bloodborne illnesses such as HIV and hepatitis C.\footnote{Hoss, supra note 35, at 835.}

After the holding in \textit{Leatherman}, the defense of criminal immunity for possession of a needle obtained from an SSP was effectively nullified.\footnote{See Hoss \textit{et al.}, supra note 110.} Without meaningful protection of criminal immunity, SSP legislation has increased the criminal liability for possession of a needle regardless of how it was obtained. Illegal use of drugs is inherently linked with SSPs and that practical reality must be reflected in the laws governing drug paraphernalia possession. While it remains legal to possess a needle obtained at an SSP, participants will inevitably use them for their intended purpose: the safe injection of illegal, harmful substances.

The \textit{Leatherman} opinion’s statutory analysis represents the issues that come from a law in need of clarification. The judicial system has no recourse to alter or affect the changes necessary. SSPs are a harm reduction tool designed to prevent the risky use of sharing needles among intravenous drug users of controlled substances. Judges and advocates cannot reshape this understanding through zealous advocacy. At a minimum, it requires a change in law that allows needles obtained from SSPs to fall outside the scope of a drug paraphernalia possession charge. Even this solution presents problems for law enforcement. If no identification is needed to obtain a sterile needle, then everyone arrested for possession of a needle will claim it came from an SSP. If criminal immunity was meant to incentivize or promote participation, this is not a feasible solution.

\subsection*{D. General Reflection on Indiana SSP Code and Legislative Change}

For SSPs to operate without undue burden and legal limitations hindering their effectiveness, changes must be made to current legislation. The first, and most pressing, of the changes must be an end to the emergency designation required in Indiana Code section 14-41-7.5-5. SSPs are an effective tool in mitigating high transmission rates of bloodborne illnesses within communities, but their use as such limits the reach of these harm reduction efforts. In an authoritative study on the effectiveness of SSPs by Wodak and Cooney, evidence clearly indicates that “areas threatened by or experiencing an epidemic of HIV infection among [intravenous drug users] should urgently adopt measures to increase the availability, access, and utilization of sterile injecting equipment and expand implementation to scale as soon as possible.”\footnote{Wodak \& Cooney, supra note 22, at 802.} The 2015 outbreak of HIV in Scott County could have been almost entirely avoided if Indiana Governor Pence allowed for the use of SSP as a preventative public health measure.

Furthermore, Indiana must remove all barriers created by the burdensome process of renewal found in Indiana Code section 14-41-7.5-11. The emergency
designation along with the year limits on SSPs reflect Indiana’s narrow legislative approach to harm reduction. If Indiana is to realize the whole potential of SSPs, it must turn to the human rights model. SSPs, supported by legislation, must operate for a minimum of five years with uninterrupted service to the community. The CDC has recognized SSPs as one of its HI-5 initiatives, a set of public health measures that offer communities cost-effective programs with a proven track record for positive health outcomes in five years or less. The CDC underscores the value of making the healthy choice, the easy choice. The short, but important, motto reiterates the need for legislation that supports SSP approval with minimal administrative hurdles such as the reapproval or rejection of approval for moral or scientifically unfounded reasons.

Along those same lines, SSP approval should not be left to chance. Approval by a local qualified entity, in this case, amounts to little more than political or moral approval. Indiana should adopt a more relaxed approval process that allows for SSP implementation as a preventative measure, a legal change that could have prevented hundreds of HIV infections in the state and saved millions of dollars. Instead of leaving the choice to local government, SSP approval should be presumed if the petitioning organization submits an application that clearly demonstrates a commitment in good faith to help injection drug users regardless of community transmission levels of bloodborne illnesses. If approval is presumed, this will allow SSPs to meaningfully engage the community and prove their value over time. It will also draw resources away from political and legal battles and give SSPs more time to meet the health demands of their communities.

Additionally, parts of Indiana Code section 16-41-7.5-6 could act as a list of basic guidelines rather than a bar to admission. Legislatures and public health officials should all agree that consistency and basic level of services should be offered from all SSPs. The appropriate guidelines drawn from the existing law include: (1) annually registering the program in a manner prescribed by the state department with the state department and local health department in the county or municipality where services will be provided by the qualified entity if the qualified entity is not the local health department; (2) storing and disposing of all syringes and needles collected in a safe and legal manner; (3) providing education and training on drug overdose response and treatment, including the administration of an overdose intervention drug; (4) providing drug misuse treatment information and referrals to drug treatment programs, including programs in the local area and programs that offer medication assisted treatment that includes a federal Food and Drug Administration approved long acting, nonaddictive medication for the treatment of opioid or alcohol dependence; (5) providing syringe and needle

124 Id.
126 See Hoss, supra note 35, at 834.
distribution and collection without collecting or recording personally identifiable
information; (6) operating in a manner consistent with public health and safety; (7)
keeping sufficient quantities of an overdose intervention drug in stock and to
administer in accordance with section 16-42-27; (8) providing testing for
communicable diseases, and if an individual tests positive for a communicable
disease, providing health care services or a referral to a health care provider for the
services; and (9) establishing a referral process for program participants in need of
information or education concerning communicable diseases or health care. 127

Instead of risking disapproval based on moral concerns, a checklist of
guidelines, rather than requirements, will hold SSPs responsible for implementing
harm reduction efforts aimed at increasing recruitment for drug misuse and mental
health treatment to address the root cause of the HIV and opioid overdose
epidemics. The guidelines mentioned above give SSPs a basic shape but allow for
flexibility to meet the needs of their community without jeopardizing their
existence. For example, some SSPs may find that a local testing site is willing to
anonymously test for communicable disease at a lower cost and more quickly. The
law should encourage programs to seek the best care at the lowest cost rather than
force burdensome procedures to be conducted on site. As Wodak and Cooney state in
their study, “[h]owever worthwhile it may be to increase the availability and use of
sterile injecting equipment with the aim of controlling HIV infection among
[intravenous drug users], this appears to be a necessary rather than a sufficient
intervention.” 128 Providing sterile needles and syringes is but one item on the listed
guidelines, and SSPs need the flexibility to fill in those healthcare options based on
the needs revealed through continued interaction with their community, not legal
mandates.

In place of approval by local government, Indiana Code section 16-41-7.5-6
will serve as guardrails monitored by the Indiana Department of Health. If the SSP
site fails to carry out any of these expectations, they will be given a reasonable
amount of time to remedy these deficiencies or offer a reasonable explanation for
why it is unnecessary or untenable for their program. Notably, this section will still
leave some discretion to the health department in that the SSP must operate in a
“manner consistent with public health and safety.” 129 This will offer the health
department a safety mechanism for the most extreme of cases in which SSPs are
not political or socially viable.

Advocates for broader access to SSPs might push against this
recommendation, as they should. But, health care reform, particularly when paired
with the stigmatized topic of drug misuse treatment, is slow moving. If SSPs are
forced on communities and cause a breakdown of communication between
policymakers and local citizens, they will not thrive. As community acceptance of
SSPs grows, the hope is this discretion will be invoked rarely, if ever. To this point,
it should be reiterated that the case for SSP effectiveness is “so compelling” that

127 IND. CODE § 16-41-7.5-6 (2021).
128 Wodak & Cooney, supra note 22, at 803.
129 IND. CODE § 16-41-7.5-6 (2021).
there is no longer good reason for pilot programs.\textsuperscript{130} Pilot programs may delay the expansion and access to sterile needles and syringes by freezing these SSPs in the pilot phase making it more difficult to secure adequate funding and maintain high enough levels of community engagement.\textsuperscript{131}

The intersection of SSP law and the criminal justice system is a close second to the removal of an emergency designation for legislative reform in Indiana. Without moving far outside of the scope of SSP law reform, this Article offers one straightforward solution: legalize the possession of hypodermic needles and syringes. California is one of the few examples where it is legal to possess a hypodermic needle and syringe without a prescription that was acquired from a physician or pharmacist if you are above the age of eighteen.\textsuperscript{132} Indiana could adopt this legal approach and allow legislatures to include all SSP staff as approved providers of sterile needles and syringes.

Legalization would serve the Indiana community in significant ways. First, it would eliminate the felony drug paraphernalia charges associated with possession of a needle and syringe making access to sterile needles and syringes the easier choice. Sterile needles and syringes acquired from qualified entities would reduce risky behaviors, encourage healthier habits (i.e., only off-market or used needles would qualify as criminal drug paraphernalia possession), and allow the government to more accurately access problematic intravenous drug use based on location and population. Additionally, studies have shown that opening additional legal avenues for acquiring sterile injecting equipment is an effective supplement to traditional SSPs. Access to sterile injecting equipment at pharmacies, and in some countries, vending machines, provides access to a “somewhat different population of [intravenous drug users].”\textsuperscript{133}

Legalizing the possession of needles and syringes would also reduce the number of non-violent drug offenses burdening criminal justice courts and lessen the stigma associated with criminal drug convictions. This points back to the Leatherman case discussed above. By legalizing the possession of a needle and syringe, Indiana law will no longer be bogged down in confusing statutory interpretation. For instance, Leatherman would still have been subject to the punitive aims of discouraging the use of a controlled substance but would not be penalized for efforts to reduce community spread of bloodborne infections. Although individuals will still be criminally liable for possession of a controlled substance, the legalization of needle and syringe possession will reflect a network of laws designed to discourage drug abuse but promote harm reducing behavior.

Another appeal for the legalization of needle and syringe possession relates to the safety of law enforcement officers in Indiana. One in three officers will

\begin{enumerate}
\item \textsuperscript{130} Wodak & Cooney, \textit{supra} note 22, at 802–03.
\item \textsuperscript{131} \textit{Id.}
\item \textsuperscript{132} \textsc{Cal. Bus. \\ \\ Prof. Code} § 4145.5 (West 2022).
\item \textsuperscript{133} Wodak & Cooney, \textit{supra} note 22, at 803.
\end{enumerate}
accidentally be stuck by a needle over their career. These needle sticks expose law enforcement officers to bloodborne illnesses, and post-exposure treatment is costly. These potentially fatal sticks occur mostly during searches in which the individual lies about the presence of a needle out of fear of criminal liability. The presence of SSPs in a community has been found to reduce these types of needle stick injuries. Removing the fear of a drug paraphernalia charge can help to decrease these potentially life-altering injuries to law enforcement agents. Intravenous drug users will be more likely to communicate the presence of potential hazardous materials to law enforcement for their protection and avoid the cascading effect a criminal drug charge has on their future interests.

Legalization of needle and syringe possession is no small request considering California is the only state to implement a clear exception for needles from its drug paraphernalia criminal charge. Without standing down from the greater goal of legalization, Marion County would be a good place to begin the discourse. Practically speaking, the political landscape of Marion County, and Indianapolis, presents a viable opportunity to begin the conversation in the state. This Article suggests that one path forward might be first decriminalizing the possession of a needle and syringe. Marion County, through local government, has the flexibility to implement these measures.

Legalization is not taking a back seat to decriminalization. It offers communities in Indianapolis the chance to take full advantage of an unequivocally effective form of harm reduction: SSPs. Indiana will be best served by gradually presenting the idea to the Indiana General Assembly and showing its positive effects in real time. Additionally, by increasing access to sterile injection equipment, moral concerns will eventually cede to the clear and convincing evidence: access to sterile needles and syringes decrease drug use, promotes healthier lifestyles, and reduces the communal transmission of bloodborne infections. Decriminalization will amplify the incontrovertible evidence of effectiveness; legalization will make it sustainable.

The legalization of hypodermic needles would remove legal barriers limiting the effectiveness of SSPs. It promotes wider use of SSPs and creates additional avenues to procure sterile needles and syringes for individuals fearful of being recognized at their local facility. Legalization also eliminates any potential criminal liability for procession of paraphernalia thus reducing the stigma associated with participation. By expanding access, it would also improve the points of contact with each participant, increasing the opportunity to share educational materials on drug treatment and primary care as well as other supplementary information. Not only

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135 Id.
136 Id.
137 TERRY, ET. AL., supra note 24, at 29.
138 See generally CAL. BUS. & PROF. CODE § 4145.5 (West 2022).
would SSPs be more accessible, but law enforcement officers would be safer and less overworked.

**CONCLUSION**

SSPs are a proven mechanism for fighting against epidemics of bloodborne illnesses. But SSPs should not be limited to this role by legislation. Indiana law, and state law across the country, should embrace SSPs as a multifaceted public health response aimed at preventing both the HIV and opioid overdose epidemics and offering persons who use drugs an opportunity to realize their health care as a human right. Through a concerted effort to reform SSP legislation, Indiana could become the legal model for the implementation of SSPs at the state level. It could also stand as a leader in the Midwest on drug policies focused on a holistic approach to treating problematic opioid use and fighting against the dual opioid overdose and HIV epidemics.

By eliminating the emergency declaration requirement, modifying the approval process, and legalizing the possession of hypodermic needles and syringes, SSPs in Indiana will thrive. Removing the current legal obstacles in Indiana law will extinguish the roots of the current legislative approach aimed at the reduction of bloodborne infection born out of the mishandled response in Scott County. It will resituate SSPs within a legal framework that promotes extended interaction with communities suffering from drug misuse treatment gaps, a reality everywhere in the United States.

This Article hopes to encourage a continued dialogue between Indiana lawmakers, SSP advocates, and the larger Indiana community. The path towards greater access to SSPs belongs to all these actors and we must continue our civil discourse for the health, safety, and welfare of our fellow Hoosiers. The recommendations and observations presented in this Article are not the only answers. None of these proposals are meant to limit the creativity and commitment necessary to effectuate positive change in Indiana law.

At a minimum, we can agree that the prolonged presence of SSP access will encourage sustainable models of medical care for drug misuse treatment that extends well beyond just drug use and overdose prevention. SSPs start the process of making communities healthier by offering sterile needles, drug testing kits, and HIV testing, but won’t stop there if allowed. SSPs, through harm reduction efforts, end up connecting people to larger health care systems thought to be out of reach.

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139 See Wodak & Cooney, *supra* note 22.