

LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

MODEL SYRINGE SERVICES PROGRAM ACT

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SECTION I. SHORT TITLE.

This Act may be referred to as the “Model Syringe Services Program Act,” “the Act,” or “Model Act.”

SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.

(a) Legislative findings.—The [legislature]¹ finds that:

- (1) According to the Centers for Disease Control and Prevention, since 2010, transmission of human immunodeficiency virus (HIV), viral hepatitis, including hepatitis C (HCV), bacterial and fungal infections, and other bloodborne diseases increased as a result of the opioid crisis;²
- (2) Individuals who share needles, syringes, and other drug use supplies are at increased risk of exposure to bloodborne infections including HIV and HCV;³
- (3) In addition, people who inject drugs are at an increased risk of developing skin and heart infections, such as cellulitis, endocarditis, and myocarditis;⁴
- (4) During 2016, the year for which the most recent data is available, the United States experienced \$524 billion in economic losses due to drug misuse, which includes the cost of health care, loss of productivity, criminal justice, research and prevention, and public assistance and social services costs;⁵
- (5) Comprehensive syringe services programs are associated with a decrease in the number of new HIV, HCV, and other bloodborne infectious disease diagnoses;

¹ This Act contains certain bracketed words and phrases (e.g., “[legislature]”). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

² *Persons Who Inject Drugs (PWID)*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed July 19, 2018), <https://www.cdc.gov/pwid/index.html>.

³ *HIV and People Who Inject Drugs*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 6, 2021), <https://www.cdc.gov/hiv/group/hiv-idu.html>.

⁴ *HIV and Injection Drug Use*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed April 21, 2021), https://www.cdc.gov/hiv/basics/hiv-transmission/injection-drug-use.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Frisk%2Fidu.html. See also Rob Moss and Brad Munt, *Injection Drug Use and Right Sided Endocarditis*, 89 HEART 577-581 (2003), <https://heart.bmj.com/content/heartjnl/89/5/577.full.pdf>.

⁵ These figures are based on data from 2016 and are not limited to injection drug users. *Economic Cost of Substance Abuse in the United States, 2016*, RECOVERY CTS. OF AM. (Sept. 2017), <https://recoverycentersofamerica.com/economic-cost-substance-abuse/>.

- (6) Syringe services programs are also associated with a decrease in the number of needlestick injuries to law enforcement, emergency medical services personnel, firefighters, and the general public;⁶
- (7) Accordingly, syringe services programs are not only cost-effective, they are cost-saving, with studies showing that, just by averting new HIV diagnoses, each dollar invested in syringe services programs can provide a return of between \$6.58 to \$7.58 in avoided HIV treatment costs;⁷
- (8) Studies further show that syringe services programs decrease the risk of fatal overdose and provide an opportunity to engage participants in substance use disorder treatment and recovery services;⁸ and
- (9) Studies show that syringe services programs do not increase crime in the communities in which they are located, do not increase hypodermic needle and syringe debris, and do not increase drug use.⁹

(b) Purpose.—The purpose of this Act is to:

- (1) Authorize the establishment of comprehensive syringe services programs within [State];
- (2) Delineate the required components for syringe services programs operating within [State], including that such programs directly provide, or offer referrals to, expanded services including substance use disorder treatment, including medications for addiction treatment, HIV and viral hepatitis testing and treatment services, access to opioid antagonist kits, health care services, and mental health services;

⁶ See *Public Safety, Law Enforcement, and Syringe Exchange*, AMFAR (March 2013), https://www.amfar.org/uploadedFiles/_amfarorg/Articles/On_The_Hill/2013/fact%20sheet%20Syringe%20Exchange%20031413.pdf; Samuel L. Groseclose, et al, *Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting-drug Users and Police Officers—Connecticut 1992-1993*, 10(1) J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES AND HUMAN RETROVIROLOGY 82-89 (Sept. 1, 1995), <https://pubmed.ncbi.nlm.nih.gov/7648290/>; and *Reducing Harms from Injection Drug Use & Opioid Use Disorder with Syringe Services Programs*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 2017), <https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf>.

⁷ Austin Frakt, Ph.D., *Effectiveness and Cost-effectiveness of Syringe Exchange Programs*, ACADEMYHEALTH (Sept. 2, 2016), <https://academyhealth.org/node/2211>.

⁸ *Reducing Harms from Injection Drug Use & Opioid Use Disorder with Syringe Services Programs*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 2017), <https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf>.

⁹ *Syringe Services Programs*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drug-topics/syringe-services-programs>.

- (3) Reduce needlestick injuries to law enforcement, emergency services personnel, sanitation workers, and members of the community;
- (4) Provide data collection and reporting requirements for syringe services programs;
- (5) Provide immunity from criminal arrest, charge, and prosecution for the possession, distribution, or furnishing of hypodermic needles and syringes and other supplies;
- (6) Provide educational and training materials for members of the community, including law enforcement and other first responders, such as emergency medical services; and
- (7) Provide for funding of syringe services programs.

Commentary

A 2018 special report published by the Centers for Disease Control and Prevention (CDC) found that, among people aged 18 to 39 who inject drugs, 39 to 48 percent of those individuals reported sharing syringes, with younger individuals more likely to share syringes than older individuals.¹⁰ Sharing syringes and other injection-related equipment, such as cookers, cotton swabs, filters, and tourniquets, is associated with an increased risk of contracting HIV and viral hepatitis. That same CDC report found that syringe services programs (SSPs) are effective at reducing syringe sharing; unfortunately, only 53 percent of people who inject drugs reported participating in an SSP.¹¹ The lack of SSP usage is likely due to the inability of communities to establish effective SSPs due to “legal and regulatory issues, insufficient funding, and misunderstandings about the effectiveness and safety of SSPs.”¹²

In addition, the CDC reports that, over the last decade, an increased number of people in the United States injected drugs, resulting in a corresponding increase in HIV and viral hepatitis outbreaks.¹³ From 2010 to 2016, reports of hepatitis C virus (HCV) cases rose 3.5-fold, with the majority of such cases attributed to injection drug use.¹⁴ Further, people who inject drugs account for more than 2,500 new HIV cases each year.¹⁵ As of March 26, 2020, the CDC determined that 44 states, the District of Columbia, Puerto Rico, and the Cherokee Nation faced

¹⁰ *HIV and People Who Inject Drugs*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 6, 2021), <https://www.cdc.gov/hiv/group/hiv-idu.html>, citing *HIV Infection Risk, Prevention, and Testing Behaviors Among Persons Who Inject Drugs – National HIV Behavioral Surveillance: Injection Drug Use, 23 U.S. Cities, 2018*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Feb. 2020),

<https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-24.pdf>. Specifically, the percent who reported sharing syringes were 48 percent of persons aged 18-24, 44 percent of persons aged 25-29, and 39 percent of persons aged 30-39.

¹¹ CENTERS FOR DISEASE CONTROL AND PREVENTION, *HIV and People Who Inject Drugs*, *supra* note 3.

¹² *Id.*

¹³ *Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed May 23, 2019), <https://www.cdc.gov/ssp/syringe-services-programs-summary.html>.

¹⁴ *Syringe Services Programs (SSPs) Fact Sheet*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed May 23, 2019), <https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html>.

¹⁵ *Id.*

the risk of “significant increases in hepatitis infection or an HIV outbreak due to injection drug use.”¹⁶ The increase in injection drug use also significantly increases economic costs to the United States. Per the CDC, “[h]ospitalization in the US due to substance-use related infections alone costs over \$700 million annually.”¹⁷

Research shows that SSPs are associated with decreases in the transmission of both HIV and HCV.¹⁸ When program participants also receive medications for addiction treatment, “HIV and HCV transmission is reduced by more than two-thirds.”¹⁹ Further, a 2016 evaluation of an SSP in the District of Columbia showed a 70 percent decrease in new HIV cases among people who inject drugs, “and a total of 120 HIV cases averted in two years.”²⁰ Studies also show that SSPs are associated with improved injection practices with no concomitant increase in injection drug use, are cost-effective, and participants of SSPs are more likely to enter into, and remain in, a substance use disorder treatment program than injection drug users who do not participate in an SSP.²¹

In an article published in the *Journal of Acquired Immune Deficiency Syndromes*, the authors used health surveillance data from Philadelphia for the years 1984 to 2015 and from Baltimore for the years 1985 to 2013 to determine that SSPs in those two cities averted a combined 12,483 new HIV diagnoses among people who inject drugs over a 10-year period.²² Additionally, “considering annual program expenses ... and cost savings [from averted new HIV diagnoses] in each city, and a conservative estimate that 75% of these savings would be experienced in the public sector, the 1-year return on investment in [SSPs] remains in the

¹⁶ *Determination of Need for Syringe Services Programs*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed Feb. 7, 2020), <https://www.cdc.gov/ssp/determination-of-need-for-ssp.html>.

¹⁷ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Summary of Information*, *supra* note 13, citing Matthew V. Ronan & Shoshana J. Herzig, *Hospitalizations Related to Opioid Abuse/Dependence and Associated Serious Infections Increased Sharply, 2002-12*, HEALTH AFFAIRS 35:5, May 2016, at 832-837, [Hospitalizations Related To Opioid Abuse/Dependence And Associated Serious Infections Increased Sharply, 2002-12 | Health Affairs](#).

¹⁸ *Access to Clean Syringes*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 5, 2016), [Access to clean syringes | Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC](#).

¹⁹ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Summary of Information*, *supra* note 13.

²⁰ *Id.*

²¹ See Austin Frakt, Ph.D., *Effectiveness and Cost-effectiveness of Syringe Exchange Programs*, ACADEMYHEALTH (Sept. 2, 2016), <https://academyhealth.org/node/2211>; Holly Hagan et al., *Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-exchange Participation in Seattle Drug Injectors*, 19 J. OF SUBSTANCE ABUSE TREATMENT 247-252 (Oct. 1, 2000); NAT’L INST. OF HEALTH, *INTERVENTIONS TO PREVENT HIV RISK BEHAVIORS* (1997), <https://consensus.nih.gov/1997/1997preventhivrisk104html.htm>; *Syringe Distribution Programs Can Improve Public Health During the Opioid Overdose Crisis*, THE PEW CHARITABLE TRUSTS (March 2021), https://www.pewtrusts.org/-/media/assets/2021/03/syringe_distribution_programs_can_improve_public_health.pdf; and *Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed May 23, 2019), <https://www.cdc.gov/ssp/syringe-services-programs-summary.html>.

²² Monica S. Ruiz et al., *Using Interrupted Time Series Analysis to Measure the Impact of Legalized Syringe Exchange on HIV Diagnoses in Baltimore and Philadelphia*, J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES 82(2), Dec. 1, 2019, at S148-S154, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6820712/>.

hundreds of millions of dollars ...” (\$182.5 million for Philadelphia²³ and \$32 million for Baltimore).²⁴

“Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.”²⁵ Additionally, new participants in SSPs “are five times more likely to enter drug treatment and about three times more likely to stop using drugs than those who don’t use the programs.”²⁶ Use of SSPs is also linked to a self-reported reduction in, or discontinuance of, injection drug use.²⁷ Furthermore, “studies show that SSPs protect first responders and the public by providing safe needle disposal and reducing community presence of needles.”²⁸ A study published in *Drug and Alcohol Dependence* found that syringes were eight times more likely to be improperly discarded in cities without an SSP than in communities with an SSP.²⁹ Additionally, the CDC’s 2015 National HIV Behavioral Surveillance system showed that “the more syringes distributed at SSPs per people who inject drugs in a geographic region, the more likely people who inject drugs in that region were to report safe disposal of used syringes.”³⁰

Further, SSPs are an evidence-based intervention in reducing opioid overdoses by teaching participants overdose prevention, recognition, and response; distributing naloxone to those most likely to use it; and providing real-time information on drug market trends that can drive overdose.³¹ According to a study conducted by the CDC, as of 2019, 94% (247) of responding SSPs in the United States had implemented overdose education and naloxone distribution as part of the services provided to program participants.³² It is undisputed that naloxone saves lives that might otherwise have been lost to overdose, and “[e]nsuring that all SSP participants are provided access to a sufficient and consistent supply of naloxone over time

²³ *Id.*

²⁴ Monica S. Ruiz et al., *Using Interrupted Time Series Analysis to Measure the Impact of Legalized Syringe Exchange on HIV Diagnoses in Baltimore and Philadelphia: Erratum*, J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES 83(2), Feb. 1, 2020, at e12, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7515477/>.

²⁵ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Summary of Information*, *supra* note 13.

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ Hansel E. Tookes et al., *A Comparison of Syringe Disposal Practices Among Injection Drug Users in a City With Versus a City Without Needle and Syringe Programs*, DRUG AND ALCOHOL DEPENDENCE 123(1-3), June 2012, at 255-259, <https://www.sciencedirect.com/science/article/abs/pii/S0376871611005229?via%3Dihub>.

³⁰ *HIV Surveillance Reports*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 5, 2021), <https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>.

³¹ See Jennifer J. Carroll, PhD, MPH, Traci C. Green, PhD, MSc, and Rita K. Noonan, PhD, *Evidence-based Strategies for Preventing Opioid Overdose: What’s Working in the United States*, CENTERS FOR DISEASE CONTROL AND PREVENTION 8 (2018), <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf>; and *Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed May 23, 2019), <https://www.cdc.gov/ssp/syringe-services-programs-summary.html>

³² Barrot H. Lambdin, et al., *Overdose Education and Naloxone Distribution Within Syringe Service Programs – United States, 2019*, MMWR MORBIDITY AND MORTALITY WKLY. REP., CENTERS FOR DISEASE CONTROL AND PREVENTION, Aug. 21, 2020, at 1117.

can optimize efforts to reduce opioid overdose deaths.”³³ SSPs may be the only place for program participants to access such health information and resources.

SECTION III. DEFINITIONS.

[States may already have definitions in place for some or all of the following terms. In such case, states may use the existing definitions in place of those listed below.]

For purposes of this Act, unless the context clearly indicates otherwise, the words and phrases listed below have the meanings given to them in this section:³⁴

- (a) Backpack/outreach unit.—“Backpack/outreach unit” means a system where program staff and volunteers travel through streets and other areas to distribute unused, sterile hypodermic needles, syringes, and other supplies, and collect used hypodermic needles, syringes, and other supplies;³⁵
- (b) Community-based organization.—“Community-based organization” means a public or private organization that is representative of a community, or significant segments of a community, and which is engaged in meeting human, health, educational, environmental, or public safety community needs;
- (c) Contingency management.—“Contingency management” means providing individuals with tangible rewards to reinforce positive behaviors;³⁶
- (d) Delivery.—“Delivery” means the provision of new, unused hypodermic needles, syringes, and other supplies via the use of public or private delivery services including, but not limited to, the United States Postal Service, FedEx, or the United Parcel Service, consistent with state and federal law;
- (e) Department.—“Department” means the [State] Department of [Health/Health and Human Services];
- (f) Emergency opioid antagonist.—“Emergency opioid antagonist” means a drug approved by the United States Food and Drug Administration for the complete or partial reversal of

³³ *Id.* at 1120.

³⁴ Unless otherwise noted via footnote, the drafters adapted these definitions from definitions found in 10-144-252 ME. CODE R. § I (2021), MD. CODE ANN., HEALTH-GEN. § 24-801 (West 2021), MD. CODE REGS. 10.52.01.02 (2021), and N.H. CODE R. He-C 502.02 (2021).

³⁵ *Guide to Starting and Managing Needle and Syringe Programmes*, WORLD HEALTH ORG. 7 (2007), <https://www.unodc.org/documents/hiv-aids/NSP-GUIDE-WHO-UNODC.pdf>.

³⁶ *Principles of Drug Addiction Treatment: A Research-based Guide (Third Edition)*, NAT’L INST. ON DRUG ABUSE 40 (revised Jan. 2018), <https://www.drugabuse.gov/download/675/principles-drug-addiction-treatment-research-based-guide-third-edition.pdf?v=74dad603627bab89b93193918330c223>.

- an opioid overdose, including, but not limited to, naloxone, and includes intramuscular, nasal, and autoinjector formulations;
- (g) Federally qualified health center.—“Federally qualified health center” means a health center as defined in section 1905(l)(2)(B) of the Social Security Act, codified at 42 U.S.C. § 1396d(l)(2)(B);
- (h) Harm reduction organization.—“Harm reduction organization” means an organization that provides a range of services designed to lessen the negative social and/or physical consequences associated with drug use without an expectation that an individual cease using drugs;
- (i) HIV.—“HIV” means the human immunodeficiency virus that causes acquired immune deficiency syndrome (AIDS);
- (j) HIV/AIDS service organization.—“HIV/AIDS service organization” means a community-based organization that provides services related to HIV/AIDS including, but not limited to, testing, prevention, treatment, and counseling services;
- (k) Hypodermic needle.—“Hypodermic needle” means a hollow needle used to inject substances into the body;³⁷
- (l) Medications for addiction treatment.—“Medications for addiction treatment” means drugs approved by the U.S. Food and Drug Administration for the treatment of substance use disorders or the use of such drug, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders and any concomitant conditions associated with it;³⁸
- (m) Mobile unit.—“Mobile unit” means a system of distributing unused, sterile hypodermic needles, syringes, and other supplies from a vehicle or bicycle, usually with a regular route of stops and regular hours;³⁹
- (n) Participant.—“Participant” means an individual engaged in receiving services from a syringe services program;

³⁷ Adapted from the definition of “hypodermic needle” found at dictionary.com, <https://www.dictionary.com/browse/hypodermic-needle>.

³⁸ This definition is taken from the definition of “medication assisted treatment” found at www.samhsa.gov/medication-assisted-treatment.

³⁹ WORLD HEALTH ORG., *supra* note 35.

- (o) Peer support services.—“Peer support services” means the provision of non-clinical, evidence-based support by a person with lived experience of substance use or mental health disorders;
- (p) Post-exposure prophylaxis (PEP).—“Post-exposure prophylaxis (PEP)” means a medication taken to prevent HIV after possible exposure;⁴⁰
- (q) Pre-exposure prophylaxis (PrEP).—“Pre-exposure prophylaxis (PrEP)” means a medication taken by people at risk of exposure to HIV to prevent transmission;⁴¹
- (r) Recovery community organization.—“Recovery community organization” means an independent, non-profit organization led and governed by representatives of local communities of recovery;⁴²
- (s) Residue.—“Residue” means the remains of a controlled substance or other drug attached to or contained within a hypodermic needle or syringe or other supplies;
- (t) Secondary exchange.—“Secondary exchange” means a practice through which program participants distribute unused, sterile hypodermic needles, syringes, and other supplies to peers within their social networks and who may also collect used hypodermic needles, syringes, and other supplies for safe disposal;⁴³
- (u) Supplies.—“Supplies” means hypodermic needles, syringes, drug checking supplies and equipment, including fentanyl test strips, preparation containers, cotton, filters, alcohol wipes, water, saline, tourniquets, disposal containers, wound care items, emergency opioid antagonists, pipes, bubbles, snorting staws, pipe covers, pipes, and other items used in the consumption of drugs;⁴⁴

⁴⁰ *About PEP*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed Apr. 21, 2021), <https://www.cdc.gov/hiv/basics/pep/about-pep.html>.

⁴¹ *PrEP (Pre-exposure Prophylaxis)*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed May 13, 2021), <https://www.cdc.gov/hiv/basics/prep.html>.

⁴² *RCO Best Practices*, FACES & VOICES OF RECOVERY, <https://facesandvoicesofrecovery.org/arco/rco-best-practices/>.

⁴³ Zulqarnain Javed et al., *Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation*, CENTERS FOR DISEASE CONTROL AND PREVENTION 3 (2020), <https://www.cdc.gov/ssp/docs/SSP-Technical-Package.pdf>.

⁴⁴ N.D. CENT. CODE ANN. § 23-01-44 (West 2021).

- (v) Syringe.—“Syringe” means a device used to inject fluids into or withdraw them from the body or its cavities, such as an instrument that consists of a hollow barrel fitted with a plunger and a hypodermic needle;⁴⁵
- (w) Syringe services program.—“Syringe services program” or “program” means a comprehensive program engaged in the distribution or furnishing of hypodermic needles, syringes, or other supplies to participants;
- (x) Viral hepatitis.—“Viral hepatitis” means inflammation of the liver caused by the hepatitis A, B, C, D, and E viruses;
- (y) Wound care.—“Wound care” means treatment of the symptoms of skin and soft tissue infections that may result from injection drug use.

Commentary

This Act uses the term “syringe services program” (SSP) instead of the more common “syringe exchange program” or “needle exchange program” because the intent of an SSP is to provide as many new hypodermic needles and syringes and other supplies as are needed to ensure that the individual can use a new, unused hypodermic needle and syringe for each injection, and “exchange” can be seen to imply a only one-to-one exchange. Additionally, many SSPs offer a broad range of services not limited to the exchange of or access to hypodermic needles and syringes. This range of services includes, among other things, directly providing or referring participants to substance use disorder treatment and recovery services, peer support services, furnishing emergency opioid antagonists in case of overdose and education regarding the use of emergency opioid antagonists, HIV/HCV testing, wound care, education regarding safer use practices and drug checking, as well as distributing or furnishing hypodermic needles and syringes.

This Act also uses the term “medications for addiction treatment (MAT)” rather than “medications for opioid use disorder (MOUD)” as MAT encompasses medications used to treat all types of substance use disorders, including alcohol use disorder, while MOUD is limited to those medications used only to treat opioid use disorder. Further, a study by the National Institutes of Health has shown promise in treating stimulant use disorder with a combination of injectable naltrexone and oral bupropion, so progress is being made toward finding medications for use in treating stimulant use disorder, as well.⁴⁶

The list of items included in the definition of “supplies” is intended to be illustrative, not exclusive. States that require each item to be listed in the body of the statute rather than relying

⁴⁵ Adapted from the definition of “syringe” found at merriam-webster.com, <https://www.merriam-webster.com/dictionary/syringe>.

⁴⁶ *Combination Treatment for Methamphetamine Use Disorder Shows Promise in NIH Study*, NAT’L INST. OF HEALTH (Jan. 13, 2021), <https://www.nih.gov/news-events/news-releases/combination-treatment-methamphetamine-use-disorder-shows-promise-nih-study>.

on this definition may do so; however, legislators should be aware that that might require more frequent updating as terms and usages change.

SECTION IV. AUTHORITY TO IMPLEMENT SYRINGE SERVICES PROGRAMS.

(a) In general.—The following entities, solely or in partnership with another authorized entity, may operate syringe services programs in [State]:

- (1) The Department;
- (2) [City, county, or local] health departments;
- (3) Federally qualified health centers;
- (4) Emergency medical services and other first responder organizations;
- (5) Community-based organizations;
- (6) HIV/AIDS service organizations;
- (7) Substance use disorder treatment providers;
- (8) Recovery community organizations;
- (9) Harm reduction organizations; and
- (10) Any other public or private entity, organization, or individual authorized by the Department.

(b) Program objectives.—The objectives of syringe services programs are to:

- (1) Reduce the transmission of HIV, viral hepatitis, and other bloodborne infectious diseases;
- (2) Reduce the incidence of overdoses among people who use drugs;
- (3) Reduce needlestick injuries to law enforcement officers, other emergency personnel, sanitation workers, and community members;
- (4) Reduce hypodermic needle and syringe litter in the community; and
- (5) Offer program participants connections to ancillary resources, such as treatment, peer support, recovery services, mental health care, and legal services.

(c) Program registration.—Pursuant to a manner prescribed by the Department, entities seeking to establish a syringe services program shall:

- (1) Register with the Department; and
- (2) Regularly confirm that the entity continues to operate a syringe services program;

provided, however, that such registration shall be for the purpose of notification to the Department for data collection purposes or as may be required by a program's funding requirements and for no other purpose.

- (d) Prohibition.—Notwithstanding any other law or regulation to the contrary, no county, city, town, region, or other political subdivision of this state shall be permitted, through the adoption or enactment of an ordinance, rule, or regulation, or via any other method, to:
- (1) Prohibit the establishment or implementation of a syringe services program;
 - (2) Limit the number of hypodermic needles or syringes a program may provide to an individual program participant or require a one-to-one exchange;
 - (3) Limit the number of emergency opioid antagonists or other supplies that may be provided to an individual participant;
 - (4) Place any limitations on the location, hours of operation, or service provision model of a syringe services program; or
 - (5) Place limitations on the hiring practices of a syringe services program, impose restrictions on who can volunteer or act as a consultant, or impose other barriers to the implementation of a syringe services program not otherwise authorized by this Act or other state or federal law.
- (e) Anonymity and confidentiality.—Syringe services programs shall maintain the anonymity of all program participants. Information obtained by a syringe services program that might directly or indirectly identify a program participant, including program records, is confidential, not subject to state or local open records or freedom of information act laws, and not discoverable in any criminal, civil, or administrative proceeding.⁴⁷

Commentary

The bulk of this section comes from N.H. REV. CODE ANN. § 318-B:43, which, rather than requiring that entities eligible to implement an SSP go through an application and approval process, provides that such entities merely register with their state department of health (or similar agency) for notification purposes. This process allows the department of health to maintain certain information regarding entities operating an SSP, such as the name and location

⁴⁷ DEL. CODE ANN. tit. 29, § 7996 (West 2021).

of the entity, without requiring those entities to submit to an onerous and potentially cost prohibitive application procedure.

As of August 2021, 18 states with SSP authorizing laws require that entities submit an application or otherwise register with a specified governmental entity to establish an SSP before they can begin operations.⁴⁸ These application processes range from requirements that applicants include a copy of a policies and procedures manual to, in one extreme case, requiring that the SSP name an administrator who must submit to fingerprinting and a criminal background check.⁴⁹ West Virginia recently enacted legislation that requires SSPs to be licensed by the state, a requirement that is now the subject of a lawsuit.⁵⁰ Some states also require that applicants provide notice to local law enforcement of their intent to operate an SSP or require that the applicant consult with and/or provide a copy of the SSP's proposed security plan to every law enforcement agency with jurisdiction over the area where the SSP will operate.⁵¹ A few states also condition approval of an entity's application on approval of a local governmental authority.⁵² Each of these requirements acts as a barrier to implementation of SSPs and provision of vital health resources. Such requirements can delay the implementation of programs, as entities may be forced to wait up to 60 days to receive a decision on their application and, if the application is denied, potentially go through a lengthy appeals process. Studies agree that SSPs are an important tool in the fight against opioid overdoses, the transmission of HIV and viral

⁴⁸See *Syringe Services Programs: Summary of State Laws*, LEGIS. ANALYSIS & PUB. POL'Y ASS'N (Oct. 2021), <https://legislativeanalysis.org/wp-content/uploads/2021/10/Syringe-Services-Programs-FINAL.pdf> for a complete breakdown of SSP laws in every state; see also, CAL. HEALTH & SAFETY § 121349 (West 2021); CAL. CODE REGS. tit. 17, §§ 7000 and 7002 (2021); GA. COMP. R. & REGS. 511-2-9-.02 (2021); IND. CODE ANN. §§ 16-41-7.5-6 and 16-41-7.5-11 (West 2021); 10-144-252 ME. CODE R. § II (2021); MD. CODE ANN., HEALTH-GEN. § 24-902 (West 2021); MD. CODE REGS. 10.52.01.04 (2021); N.H. REV. STAT. ANN. § 318-B:43 (2021); N.J. STAT. ANN. §§ 26:5C-27 and 26:5C-28 (West 2021); N.J. ADMIN. CODE § 8:63-2.2 (2021); N.M. CODE R. § 7.4.6 (2021); N.Y. PUB. HEALTH LAW § 3381 (McKinney 2021); N.C. GEN. STAT. ANN. § 90-113.27 (West 2021); N.D. CENT. CODE ANN. § 23-01-44 (West 2021); OKLA. STAT. ANN. tit. 63, § 2-1101 (West 2021); R.I. GEN. LAWS ANN. § 23-11-19 (West 2021); TENN. CODE ANN. § 68-1-136 (West 2021); UTAH ADMIN. CODE r. 386-900-4 (2021); VT. STAT. ANN. tit. 18, § 4478 (West 2021); VA. CODE ANN. § 32.1-45.4 (West 2021); W. VA. CODE ANN. § 16-64-2 (West 2021).

⁴⁹ See GA. COMP. R. & REGS. 511-2-9-.03 (2021).

⁵⁰ See S.B. 334, Reg. Sess. (W. Va. 2021) and Milan Puskar Health Right, *et al.*, vs. Bill J. Couch, *et al.*, No. 3:21-cv-00370 (S.D. W. Va. filed June 25, 2021).

⁵¹ See CAL. HEALTH & SAFETY CODE § 121349 (West 2021); COLO. REV. STAT. ANN. § 25-1-520 (West 2021); GA. COMP. R. & REGS. 511-2-9-.03 and 511-2-9-.05 (2021); 10-144-252 ME. CODE R. § I (2021); N.C. GEN. STAT. ANN. § 90-113.27 (West 2021); OHIO REV. CODE ANN. § 3707.57 (West 2021); TENN. CODE ANN. § 68-1-136 (West 2021); UTAH ADMIN. CODE r. 386-900-4 (2021); VA. CODE ANN. § 32.1-45.4 (West 2021).

⁵² See CAL. HEALTH & SAFETY CODE §§ 121349 and 121349.2 (West 2021); COLO. REV. STAT. ANN. § 25-1-520 (West 2021) (does not apply to nonprofit organizations with experience operating an SSP); FLA. STAT. ANN. § 381.0038 (West 2021); IND. CODE ANN. §§ 16-41-7.5-3, 16-41-7.5-4, 16-41-7.5-5, and 16-41-7.5-11 (West 2021); KY. REV. STAT. ANN. § 218A.500 (West 2021); LA. STAT. ANN. § 40:1024 (201); MD. CODE ANN., HEALTH-GEN. 24-902 (West 2021); MD. CODE REGS. 10.52.01.03 and 10.52.01.04 (2021); MASS. GEN. LAWS ANN. ch. 111, § 215 (West 2021); N.J. STAT. ANN. §§ 26:5C-27 and 26:5C-28 (West 2021); N.J. ADMIN. CODE 8:63-2.1 (2021); OHIO REV. CODE ANN. § 3707.57 (West 2021) (notice only); and W. VA. CODE ANN. § 16-64-2 (West 2021). See also *Syringe Distribution Programs Can Improve Public Health During the Opioid Overdose Crisis*, THE PEW CHARITABLE TRUSTS (March 2021), https://www.pewtrusts.org/-/media/assets/2021/03/syringe_distribution_programs_can_improve_public_health.pdf.

hepatitis, and help to navigate people who use drugs to treatment.⁵³ Therefore, the Act’s drafters follow New Hampshire’s and North Carolina’s approach⁵⁴ by eschewing the application process in favor of a less onerous notification process.

The drafters based this decision on multiple factors, including the fact that many of the entities or organizations seeking to implement an SSP will most likely already be licensed, registered, or certified by a state regulatory board and subject to regulation and oversight by that board, thus negating the need to subject the entity to further regulation.⁵⁵ Moreover, as stated by former New Hampshire State Representative Joe Hannon, M.D., “We do not want to limit the organizations that can give [syringes] out because not everyone wants to go to exchanges.”⁵⁶ For example, even where it is legal to obtain syringes for injection drug use from pharmacies, individuals doing so often face stigma and discrimination. In a study of barriers experienced by people who inject drugs in rural Appalachia seeking to obtain hypodermic needles and syringes from pharmacies, many study participants reported: (1) being “hassled” by pharmacy employees (63.3 percent); (2) that needles are too expensive to purchase from the pharmacy for every injection (55.9 percent); (3) embarrassment at buying needles from a pharmacy (47.9 percent); and (4) fear that a family member, friend, or other person known to the individual would see them buying needles from the pharmacy (49.5 percent).⁵⁷ With that in mind, it is imperative that legislation authorizing SSPs be drafted in such a way that barriers be minimized for both the entities and organizations seeking to implement an SSP and the people who will receive services from the SSP, primarily by not including a potentially burdensome application process.

Subsection (d) of this section bars any political subdivision of a state, whether it be a city, county, or town, from adopting any ordinance or rule that would prohibit the operation of an SSP within the locality’s borders. This is an unfortunate practice happening in a few localities across the country. In California, for example, although state law authorizes SSPs, at least one county (Butte) and three municipalities (Paradise, Santa Ana, and Yuba City) prohibit SSP operation

⁵³ See *Syringe Services Programs (SSPs) FAQs*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed May 23, 2019), <https://www.cdc.gov/ssp/syringe-services-programs-faq.html>, *Access to Clean Syringes*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last reviewed Aug. 5, 2016), [Access to clean syringes | Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC](#), and *supra* note 21.

⁵⁴ See N.C. GEN. STAT. ANN. § 90-113.27 (West 2021), which merely requires that organizations report the following information to the North Carolina Department of Health and Human Services, Division of Public Health, prior to commencing operations of a syringe services program: (1) the legal name of the organization or agency operating the program; (2) the areas and populations to be served by the program; and (3) the methods by which the program will meet the requirements for providing services.

⁵⁵ Many syringe services programs are operated by substance use disorder treatment providers, local health departments, health clinics, and hospitals, all of which are already subject to state regulation. However, this should not be taken to mean that only those entities should operate a syringe services program.

⁵⁶ *Relative to Hypodermic Syringes and Needles Containing Residual Amounts of Controlled Drugs and Authorizing the Operation of Syringe Service Programs in New Hampshire: Hearing Before the Health & Human Svcs. Comm.*, 2017 Reg. Sess. (N.H. 2017) (testimony of former State Rep. Joe Hannon, M.D.).

⁵⁷ Stephen M. Davis et al., *Barriers to Using New Needles Encountered by Rural Appalachian People Who Inject Drugs: Implications for Needle Exchange*, HARM REDUCTION J., April 2, 2019, <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-019-0295-5#Tab2>.

within their borders.⁵⁸ In Indiana, Scott County commissioners voted to close the county SSP despite the fact it helped to halt the spread of HIV in the community within months of its opening in 2015 and reduced overdose deaths by 20 percent in 2019.⁵⁹ On the other side of the country, the Atlantic City Council in New Jersey recently voted to eliminate the SSP in that municipality.⁶⁰ Current New Jersey law allows a municipality to “terminate a syringe access program ... operating within that municipality, if its governing body approves such an action by ordinance.”⁶¹ A bill currently making its way through the New Jersey legislature would eliminate this provision.⁶²

Additionally, subsection (d) bars any political subdivision of a state from placing limits on the number of sterile, unused hypodermic needles and syringes or other supplies that an SSP can furnish to participants. There are several reasons for this provision, including the fact that one-to-one exchange programs “are associated with increased syringe sharing and increased risk of infections.”⁶³ Further, one-to-one exchange programs “discourage participants from giving sterile syringes to people who do not attend the program but would benefit from receiving new injection supplies.”⁶⁴ Unlimited, needs-based distribution of hypodermic needles and syringes also provides programs with the flexibility needed to serve participants during emergency situations, such as “during the COVID-19 pandemic when programs had to reduce or discontinue operating hours.”⁶⁵

Subsection (e) provides that programs shall maintain the anonymity of participants. Working group members suggested that programs be prohibited from collecting any identifying information on participants; however, participants that engage in other services offered by a comprehensive SSP, such as receipt of medications for addiction treatment or assistance with enrolling in Medicaid, may need to provide identifying information. Therefore, rather than proscribe programs from collecting identifying information altogether, this Act provides that programs shall maintain the anonymity of participants where possible and keep any identifying information obtained by the program confidential.

⁵⁸ See BUTTE CNTY., CAL., CODE §§ 15-170 to 15-174 (2021); PARADISE, CAL., CODE §§ 17.32.1.100 to 17.32.1.300 (2021); SANTA ANA, CAL., CODE §§ 18-653 to 18-656 (2021); and YUBA CITY, CAL., CODE §§ 5-24-01 to 5-24-04 (2021).

⁵⁹ William Cooke and Gregg Consalves, *Closing an Indiana County’s Syringe Services Program Would be a Public Health Disaster*, STAT (June 1, 2021), <https://www.statnews.com/2021/06/01/syringe-services-program-closure-scott-county-public-health-disaster/>. See also *Indiana Needle Exchange that Helped Contain a Historic HIV Outbreak to be Shut Down*, WKNO 91.1 (June 3, 2021, 11:24 AM), <https://www.npr.org/sections/health-shots/2021/06/01/1001278712/indiana-needle-exchange-that-helped-contain-an-hiv-outbreak-may-be-forced-to-clo> (discussing the misinformation that led the commissioners to close the program).

⁶⁰ See Joe Atmonavage, *Atlantic City Votes to Close State’s Largest Needle Exchange Program, Drawing Outrage*, NJ.COM (July 21, 2021, 10:11 PM), <https://www.nj.com/news/2021/07/atlantic-city-votes-to-close-states-largest-needle-exchange-program-drawing-outrage.html>.

⁶¹ N.J. STAT. ANN. § 26:5C-28 (West 2021).

⁶² S. 3009, 219th Leg. (N.J. 2020) (currently in Senate Budget and Appropriations Comm.).

⁶³ Z. Javed et al., *supra* note 43, at 9.

⁶⁴ *Syringe Distribution Programs Can Improve Public Health During the Opioid Overdose Crisis*, THE PEW CHARITABLE TRUSTS 3 (March 2021), https://www.pewtrusts.org/-/media/assets/2021/03/syringe_distribution_programs_can_improve_public_health.pdf.

⁶⁵ *Id.*

SECTION V. SYRINGE SERVICES PROGRAM COMPONENTS.

- (a) Access.—In order to increase access to hypodermic needles and syringes, syringe services programs may operate from a fixed site (“storefront”), mobile units, backpack/outreach units, through secondary exchange, delivery, or a combination of these methods.
- (b) Participant registration.—Syringe services programs may institute a registration process for program participants for the purpose of records or data collection or as may be required by a program’s funding requirements, as long as such registration is voluntary, non-contingent, and non-coercive, but may not condition receipt of hypodermic needles, syringes, and other supplies on registration with the program.
- (c) Medications for addiction treatment.—Syringe services programs may provide medications for addiction treatment to program participants consistent with state and federal law.
- (d) Contingency management.—Syringe services programs may offer contingency management services to program participants consistent with state and federal law and regulation.
- (e) Community partnerships.—Syringe services programs should coordinate and collaborate with other local agencies, recovery community organizations, community-based organizations, drug-user led organizations, and providers, as appropriate, to maximize services available to program participants and minimize duplication of effort.
- (f) Program input.—Syringe services programs should, when possible, seek the input of people who use drugs, have lived experience, and/or are in recovery in the community where the program will operate when determining the type(s) and size(s) of hypodermic needles and syringes and other supplies to be provided by the program, as well as hours, location, and service provision model or models.
- (g) Required program components.—Syringe services programs shall:
 - (1) Provide hypodermic needles, syringes, and other supplies at no cost and in quantities sufficient to ensure that hypodermic needles, syringes, and other supplies are not shared or reused;

- (2) Provide program participants with education regarding the proper disposal of used hypodermic needles and syringes and other supplies and offer one or more of the following disposal options for used hypodermic needles and syringes:
 - (A) An onsite hypodermic needle and syringe collection and disposal program that meets applicable state and federal standards;
 - (B) Furnish, or make available, mail-back sharps containers authorized by the U.S. Postal Service; or
 - (C) Furnish, or make available, sharps containers for use off-site by program participants that meet applicable state and federal standards;
- (3) Provide program participants with a kit containing at least one emergency opioid antagonist, including instructions and training on how to use such emergency opioid antagonist, or with information regarding where and how to obtain an emergency opioid antagonist;
- (4) Make educational materials available regarding all of the following:
 - (A) Overdose prevention, including materials regarding how to recognize an opioid overdose and how an emergency opioid antagonist can help prevent a fatal overdose;
 - (B) Prevention of HIV, viral hepatitis, and other bloodborne infectious disease transmission, including materials regarding PEP and PrEP;
 - (C) Substance use disorder treatment modalities, including the efficacy of medications for addiction treatment and contingency management;
 - (D) Safe and proper disposal of used hypodermic needles and syringes;
 - (E) Safer drug use practices, including safe injection practices;
 - (F) The benefits of and how to use drug checking supplies; and
 - (G) Information regarding the 988 crisis/suicide prevention call number;
- (5) Include appropriate levels of staff expertise, including for consultants and volunteers, in working with people who use drugs, including ensuring adequate training in safer injection practices, harm reduction, provision of community referrals, preventive education, and cultural sensitivity, as applicable; and
- (6) Provide participants with information regarding program location, hours of operation, program contact information, and services offered.

- (h) Expanded services.—Syringe services programs shall either directly provide or shall provide referrals to the following, where such services are reasonably available in the community:
- (1) Testing options for HIV, viral hepatitis, other bloodborne infectious diseases transmitted through injection drug use, sexually transmitted infections, and COVID-19;
 - (2) Prevention, treatment, and care services for HIV, including PEP and PrEP, viral hepatitis, other bloodborne infectious diseases transmitted through injection drug use, and sexually transmitted infections;
 - (3) Vaccinations for hepatitis A, hepatitis B, human papillomavirus (HPV), influenza, pneumococcal, Tdap (tetanus, diphtheria, pertussis), and COVID-19;
 - (4) Substance use disorder care, treatment, or recovery services, including, but not limited to, medications for addiction treatment, contingency management, and peer support services, as appropriate;
 - (5) Drug checking services, including fentanyl test strips and mass spectrometers, where available;
 - (6) Mental health services, including peer support services, as appropriate;
 - (7) Medical treatment services, including provision of antibiotics, wound care, treatment for viral hepatitis, PEP and PrEP, and pre- and post-natal care;
 - (8) Condom distribution and education regarding safer sex practices;
 - (9) Assistance with obtaining legal services, identification, housing, food, health insurance (Medicaid/Medicare) enrollment, clothing, and transportation services;
 - (10) Family reunification services;
 - (11) Child care; and
 - (12) Any other services deemed appropriate by the Department by rule.

Commentary

The provisions of this section come from a number of state statutes and regulations, including MD. CODE ANN. HEALTH-GEN. §§ 24-803 and 24-903 (West 2021) and MD. CODE REGS. 10.52.01.05 (2021), N.H. REV. STAT. ANN. § 318-B:43 (West 2021), N.J. STAT. ANN. § 26:5C-28 (West 2021), and N.C. GEN. STAT. ANN. § 90-113.27 (West 2021).

The CDC strongly recommends that SSPs “provide low-threshold access to services.”⁶⁶ Thresholds, in the context of services related to substance use disorder, are barriers “that people must cross in order to gain access [to services] and make use of the help offered.”⁶⁷ In their study of thresholds, Edland-Gryt and Skatvedt identify four main thresholds that people seeking services face – (1) the registration threshold; (2) the competence threshold; (3) the threshold of effectiveness; and (4) the threshold of trust.⁶⁸ According to the authors, “[t]he registration threshold is central, because almost all offers of help and assistance ... are based on the clients’ initiative and their willingness to register themselves as a person in need of help.”⁶⁹ The threshold of competence “concerns clients’ capabilities to put forward their needs or requests in a way that the staff can understand and act upon,” while “the efficiency threshold concerns clients who are rejected or receive less help than they need.”⁷⁰ Finally, the threshold of trust is best described as the “quality of relationship with the service provider.”⁷¹ The CDC provides that, “all SSPs should strive to address each of these barriers,” which includes “maximizing access (service location and hours) and ensuring anonymity and no requirements for participation in other services.”⁷² People who use drugs have experienced exclusion from mainstream services, been denied services for which they were presenting, and have a deep familiarity with stigma related to drug use. A syringe services program should be considered a stigma-free alternative to mainstream services.

Bearing in mind that people who use drugs are likely to mistrust people in positions of authority, such as program staff or volunteers, and are also likely to have a co-occurring mental health disorder, be justice involved, or be a member of a higher-risk population (such as individuals who are pregnant, have children, LGBTQ+, or BIPOC), which might make engaging with the program through conventional means difficult, programs should endeavor to make participation as easy as possible. To that end, and where possible in this section, the drafters use the permissive terms “may” or “should” rather than the more prescriptive term “shall” to allow programs the flexibility to implement programs that best fit their communities and the needs of the people they serve.

Subsection (a) is intended to provide as many options to programs as possible for distribution of hypodermic needles, syringes, and other supplies, particularly in rural and other areas where access to public or other means of transportation is not available to convey participants to a fixed program site. Therefore, there is no requirement that programs have a fixed or permanent location. Programs may operate according to any of the listed methods in order to reach as many people who use drugs as possible. However, consistency in route and

⁶⁶ Z. Javed et al., *supra* note 43, at 9.

⁶⁷ Marit Edland-Gryt & Astrid Helene Skatvedt, *Thresholds in a Low-threshold Setting: An Empirical Study of Barriers in a Centre for People with Drug Problems and Mental Health Disorders*, 24 INT’L J. OF DRUG POL’Y 257, 258 (May 2013), [Thresholds in a low-threshold setting: An empirical study of barriers in a centre for people with drug problems and mental health disorders | Elsevier Enhanced Reader](#).

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Z. Javed et al., *supra* note 43, at 19.

⁷² *Id.*

schedule for mobile programs is also very important as people who use drugs need to know that their needs will be met.

Subsection (b) allows programs to implement a registration process for participants for the limited purposes of records or data collection or as may be required by a program’s funding provisions, but prohibits SSPs from otherwise requiring that an individual register with the program in order to receive new, unused hypodermic needles and syringes or other injection drug use supplies. Further, neither this Section nor subsection (b) allow SSPs to require that participants formally enroll in the program itself or in any services offered by the entity or entities managing the SSP (likely to be a local health department, harm reduction organization, local health clinic, or something similar) in order to receive new, unused hypodermic needles, syringes, or other supplies. (The drafters view “registration” as a quick, simple process, akin to a sign-in sheet wherein an individual provides very limited information for record-keeping or data collection purposes, whereas “enrollment” suggests a more involved undertaking wherein a more formal relationship is established between the individual and the SSP.) The limited registration requirements imposed by this subsection are especially useful for programs that operate via mobile or backpack/outreach units as it would allow program staff and volunteers to distribute sterile hypodermic needles and syringes to any person who injects drugs that they encounter without the need of registering or enrolling each person as a participant in the program. However, some state laws in effect as of the date of the drafting of this Model Act require that programs have some sort of registration or enrollment process.⁷³ Some even require that program participants, staff, and volunteers carry identification cards.⁷⁴ Because any kind of registration requirement may lead to hesitation on the part of people who inject drugs to engage with an SSP, this provision is optional for programs. However, SSPs need to be cognizant of how extensive or detailed the registration process will need to be to meet requirements for funding or other purposes. Further, working group members suggested that a more in-depth registration process be implemented for minors participating in the program.

Subsections (e) and (f) are based on the CDC recommendation that programs “begin by centering their work on people who inject drugs ... [who] are the most important part of an SSP and are one of the primary sources of information, guidance, and insight for program design, implementation, and evaluation. Meaningful involvement of people with lived experience ... is key to program success.”⁷⁵ Further, the CDC stresses that “relationships with key community and local, state, and national partners are important for ensuring successful SSP planning, design, and implementation.”⁷⁶ The working group members emphasized that SSPs should strive to seek

⁷³ As of August 2021, six states (Delaware, Maine, Maryland, New Jersey, New Mexico, and New York) require that participants enroll or register with the SSP before he or she can receive new sterile hypodermic needles and syringes. See DEL. CODE ANN. tit. 29, §§ 7992 and 7996 (West 2021); 10-144-252 ME. CODE R. § II (2021); MD. CODE ANN., HEALTH-GEN. §§ 24-803 and 24-901 (West 2021); MD. CODE REGS. 10.52.01.05 (2021); N.J. STAT. ANN. § 26:5C-28 (West 2021); N.M. CODE R. § 7.4.6 (2021); and N.Y. COMP. CODES R. & REGS. tit. 10, § 801.35 (2021).

⁷⁴ See DEL. CODE ANN. tit. 29, §§ 7992 and 7996 (West 2021); 10-144-252 ME. CODE R. § II (2021); MD. CODE ANN., HEALTH-GEN. §§ 24-803, 24-807, 24-903, and 24-906 (West 2021); MD. CODE REGS. 10.52.01.05 (2021); N.J. STAT. ANN. §§ 26:5C-27 and 26:5C-28 (West 2021); N.J. ADMIN. CODE § 8:63-3.1 (2021); N.M. CODE R. § 7.4.6 (2021); N.Y. COMP. CODES R. & REGS. tit. 10, § 801.35 (2021); OHIO REV. CODE ANN. § 3707.57 (West 2021).

⁷⁵ Z. Javed et al., *supra* note 43, at 5.

⁷⁶ *Id.*, at 11.

input from people who use drugs who are black and brown, indigenous, people of color, as well as from members of the LGBTQ+ community to ensure that they are included in the process and that individuals who provide such information, guidance, and insight should be compensated for their participation at the same rate and for the same services as provided by other consultants.

As set forth in the commentary to Section IV, studies show that “needs-based distribution is the most effective syringe distribution model, both in terms of syringe coverage ... and disease prevention.”⁷⁷ Additionally, needs-based distribution promotes greater secondary syringe exchange, that is, having program participants distribute unused hypodermic needles and syringes to people who inject drugs and are currently not participating in an SSP, “which broadens program reach and improves overall effectiveness.”⁷⁸ According to a report from the PEW Charitable Trusts (PEW), “[l]imits on syringe distribution, such as one-to-one or ‘exact exchange’ programs, discourage participants from giving sterile syringes to people who do not attend the program but would benefit from receiving new injection supplies.”⁷⁹ Further, one-to-one exchanges “are associated with increased syringe sharing and increased risk of infections among [people who inject drugs] and are therefore *not* recommended.”⁸⁰ Therefore, subsection (e)(1) of this section does not provide limitations on the number of hypodermic needles and syringes that can be distributed or furnished to program participants. It should be emphasized that no participant is or should be required to engage in any of the ancillary services offered by an SSP in order to receive new, unused hypodermic needles and syringes or other supplies.

Subsection (g)(2) is based on CAL. BUS. & PROF. CODE § 4145.5 (West 2021) and provides programs with multiple options regarding disposal of used hypodermic needles and syringes. Working group members noted that SSPs are often the target of community complaints regarding hypodermic needle and syringe litter. However, there is evidence that the presence of SSPs in a community is associated with a reduction in improperly disposed of hypodermic needles and syringes.⁸¹

Subsection (g)(3) requires programs to provide program participants with at least one emergency opioid antagonist kit or, where the program is unable to obtain such kits due to funding constraints, shortages, or other barriers, information on how to obtain such a kit. Working group members stressed that providing multiple kits is advised as it sometimes takes more than one application to reverse an overdose. Members also emphasized that programs should not be limited to one type of emergency opioid antagonist, but should be permitted to provide any and all formulations available to them, including intramuscular, nasal, or autoinjector.

Subsection (g)(5) requires that programs include appropriate levels of staff expertise. While at least two states require that programs have a physician or registered nurse oversee the program,⁸² programs should be free to take advantage of any and all expertise available in their

⁷⁷ *Id.*, at 9.

⁷⁸ *Id.*

⁷⁹ THE PEW CHARITABLE TRUSTS, *supra* note 64.

⁸⁰ Z. Javed et al., *supra* note 43 (emphasis in original).

⁸¹ NAT’L INST. ON DRUG ABUSE, *Syringe Services Programs*, *supra* note 9.

⁸² See IND. CODE ANN. § 16-41-7.5-6 (West 2021) and N.D. CENT. CODE § 23-01-44 (West 2021).

area, and operation of programs should not be dependent upon having a physician or registered nurse willing to provide oversight of the program, particularly in rural areas where staffing options are already limited.

When writing this section, the drafters kept CDC and U.S. Department of Health and Human Services guidance in mind regarding what components comprise successful and effective SSPs.⁸³ In addition, the drafters paid particular attention to the recommendations contained in the PEW report, *Syringe Distribution Programs Can Improve Public Health During the Opioid Overdose Crisis*.⁸⁴ According to all three sources, SSPs should ideally be part of a comprehensive program that includes:

- Provision of hypodermic needles and syringes, other injection-related supplies, and disposal services;
- Provision of naloxone and training related to proper administration;
- Education on safer injection techniques and to reduce “sexual, injection and overdose risks”;⁸⁵
- Distribution of condoms;
- Screening for HIV, viral hepatitis, sexually transmitted infections (STIs), and tuberculosis;
- Either directly providing or providing referral and linkage to:
 - HIV, viral hepatitis, STI, and tuberculosis prevention, treatment, and care services;
 - Vaccinations for hepatitis A and B, HPV, influenza, pneumococcal, and Tdap;
 - Substance use disorder treatment, including medication for addiction treatment; and
 - Medical care, mental health services, and other support services.⁸⁶

Therefore, subsections (c), (g), and (h) promote these recommendations.

⁸³ See Zulqarnain Javed et al., *Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation*, CENTERS FOR DISEASE CONTROL AND PREVENTION (2020), <https://www.cdc.gov/ssp/docs/SSP-Technical-Package.pdf> and *Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*, DEP’T OF HEALTH & HUM. SERV. (March 29, 2016), <https://www.cdc.gov/hiv/pdf/risk/hhs-ssp-guidance.pdf>.

⁸⁴ THE PEW CHARITABLE TRUSTS, *supra* note 64.

⁸⁵ *Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*, DEP’T OF HEALTH & HUM. SERV. 2 (March 29, 2016), <https://www.cdc.gov/hiv/pdf/risk/hhs-ssp-guidance.pdf>.

⁸⁶ *Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*, DEP’T OF HEALTH & HUM. SERV. (March 29, 2016), <https://www.cdc.gov/hiv/pdf/risk/hhs-ssp-guidance.pdf>; Zulqarnain Javed et al., *Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation*, CENTERS FOR DISEASE CONTROL AND PREVENTION 15-16 (2020), <https://www.cdc.gov/ssp/docs/SSP-Technical-Package.pdf>; and *Syringe Distribution Programs Can Improve Public Health During the Opioid Overdose Crisis*, THE PEW CHARITABLE TRUSTS 3 (March 2021), https://www.pewtrusts.org/-/media/assets/2021/03/syringe_distribution_programs_can_improve_public_health.pdf.

SECTION VI. DATA COLLECTION.

- (a) Required information.—Syringe services programs shall collect the following data and provide the aggregate totals to the Department quarterly:
- (1) The number of participant encounters;
 - (2) The number of hypodermic needles and syringes distributed;
 - (3) The estimated number of used hypodermic needles and syringes collected by or given to program staff, employees, or volunteers for disposal; and
 - (4) The number of emergency opioid antagonist kits distributed, or the number of participants referred to programs providing emergency opioid antagonists.
- (b) Voluntary reporting.—If available to the syringe services program, the program may, but shall not be required to, provide the following additional information to the Department:
- (1) Demographic information regarding participants including, but not limited to, age, gender, race, ethnicity, area of residence, types of drugs used, length of drug use, and frequency of injection;
 - (2) The number of participants engaged in, or referred to, substance use disorder treatment services, including contingency management services, either through referral or directly provided by the program;
 - (3) The number of participants who received, or who were referred to entities that provide, medication for addiction treatment;
 - (4) The number of participants who received tests for, or who were referred to services that provide testing for, HIV, viral hepatitis, or other bloodborne infectious diseases;
 - (5) The number of participants who received, or who were referred to entities that provide, mental health treatment services;
 - (6) The number of participants who received, or who were referred to entities that provide, social services, entitlements, and instrumental supports;
 - (7) The number of participants who received, or who were referred to entities that provide, health care services, including reproductive health care, treatment for viral hepatitis, PEP, PrEP, and wound care services;
 - (8) The number of participants who received, or who were referred to entities that provide, recovery support services, including peer support services; and
 - (9) Any other information identified by the Department by rule.

- (c) Confidentiality of data.—All data collected by a syringe services program and provided to the Department pursuant to this section shall be de-identified and shall not be subject to subpoena in any civil, criminal, or administrative proceeding.
- (d) Annual report.—The Department shall submit an annual report to the governor and the [appropriate Senate and House committees] the encompasses aggregate data received from all programs.

Commentary

The provisions of this section are taken from *Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation*, DEL. CODE ANN. tit. 29, § 7995 (West 2021), FLA. STAT. ANN. § 381.0038 (West 2021), and N.H. REV. STAT. ANN. § 318-B:43 (2021).

The data elements required to be submitted under subsection (a) are fairly minimal. In its technical package, the CDC states that, “[d]ata collection is a critical aspect of program planning and evaluation.”⁸⁷ However, the CDC further states that, “data collection should neither distract from the primary mission of syringe distribution for participants nor act as a barrier to . . . participation” and “[d]ata collection should be minimal to reduce participant and administrative burden and should never be a barrier to care.”⁸⁸ PEW recommendations align with the CDC and provide that SSPs should be permitted to operate in such a manner that “[m]inimize administrative burdens (e.g., data collection) that hinder program operation and jeopardize participant anonymity.”⁸⁹ Additionally, in a 2018 survey of SSPs, 60 percent of programs reported that data collection acted as a barrier to providing services to people who use drugs “due to service user fears about loss of anonymity and/or law enforcement.”⁹⁰ Both the CDC and PEW also agree that data collection elements could be limited to: the number of syringes distributed, the number of syringes received, the number of naloxone kits distributed, and the number of referrals made.⁹¹

Subsection (b) incorporates voluntary reporting elements that includes information regarding expanded services provided to participants.

⁸⁷ Z. Javed et al., *supra* note 43, at 18.

⁸⁸ *Id.*

⁸⁹ THE PEW CHARITABLE TRUSTS, *supra* note 64, at 2.

⁹⁰ Peter Davidson, Priya Chakrabarti, and Michael Marquesen, *Impacts of Mandated Data Collection on Syringe Distribution Programs in the United States*, 79 INT’L J. ON DRUG POL’Y (Apr. 4, 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7308185/>.

⁹¹ Z. Javed et al., *supra* note 43, at 18 and THE PEW CHARITABLE TRUSTS, *supra* note 64, at 4.

SECTION VII. IMMUNITY.

- (a) In general.—No program employee, staff member, consultant, volunteer, or participant of a syringe services program shall be detained, arrested, charged, or prosecuted for possessing, distributing, or furnishing hypodermic needles, syringes, or other supplies; nor have their property subject to forfeiture; nor be subject to any civil or administrative penalty including, but not limited to, disciplinary action by a professional licensing board, credentialing restrictions, contractual or civil liability, or medical staff or other employment action; nor be denied any right or privilege for actions, conduct, or omissions relating to the approval or operation of a syringe services program in compliance with the provisions of this Act.
- (b) Residue.—No program employee, staff member, consultant, volunteer, or participant of a syringe services program shall be arrested, charged, or prosecuted for possession of a controlled substance or other illicit drug due to the presence of residue in a hypodermic needle or syringe or other supplies.
- (c) Law enforcement.—A law enforcement officer who, acting in good faith and without malice, arrests or charges a person who is thereafter determined to be entitled to immunity under this section shall not be subject to civil liability for the arrest or filing of charges.⁹²
- (d) No stop or seizure.—A law enforcement officer may not stop, search, or seize an individual or any hypodermic needles, syringes, or other supplies in the individual's possession based on the fact that the individual is a program employee, staff member, consultant, volunteer, or participant of a syringe services program.
- (e) No probable cause.—The fact that an individual has attended a syringe services program may not be the basis, in whole or in part, for a determination of probable cause or reasonable suspicion by a law enforcement officer and may not be used as evidence in a criminal case against a participant.⁹³
- (f) Probation, parole, and pre-trial release.—Notwithstanding any other law, regulation, or court order to the contrary, an individual who is a participant of a syringe services

⁹² TENN. CODE ANN. § 68-1-136 (West 2021).

⁹³ IND. CODE ANN. § 16-41-7.5-9 (West 2021).

program may not be held in violation of the terms of their probation, parole, or pre-trial release for possessing or obtaining hypodermic needles and syringes or other supplies from a syringe services program.

Commentary

In 36 states, the District of Columbia, and the U.S. Virgin Islands, hypodermic needles or syringes are included in the legal definition of “drug paraphernalia.”^{94, 95} Twenty-three states, the District of Columbia, and Puerto Rico⁹⁶ provide exceptions to criminal penalties for possession of hypodermic needles and syringes, while 17 states and the District of Columbia provide exceptions to criminal penalties for furnishing or distributing hypodermic needles and syringes.⁹⁷

⁹⁴ See ALA. CODE § 13A-12-260 (2021); ARIZ. REV. STAT. ANN. § 13-3415 (2021); ARK. CODE ANN. § 5-64-101 (West 2021); CAL. HEALTH & SAFETY § 11014.5 (West 2021); DEL. CODE ANN. tit. 16, § 4704 (West 2021); D.C. CODE ANN. § 48-1101 (West 2021); FLA. STAT. ANN. § 893.145 (West 2021); GA. CODE ANN. § 16-13-1 (West 2021); HAW. REV. STAT. ANN. § 329-1 (West 2021); IDAHO CODE ANN. § 37-2701 (West 2021); KAN. STAT. ANN. § 21-5701 (West 2021); KY. REV. STAT. ANN. § 218A.500 (West 2021); LA. STAT. ANN. § 40:1021 (2021); MD. CODE ANN. CRIM. LAW § 5-101 (West 2021); MICH. COMP. LAWS ANN. § 333.7451 (West 2021); MINN. STAT. ANN. § 152.01 (West 2021); MISS. CODE ANN. § 41-29-105 (West 2021); MO. ANN. STAT. § 195.010 (West 2021); NEB. REV. STAT. ANN. § 28-439 (West 2021); N.M. STAT. ANN. § 30-31-2 (West 2021); N.Y. GEN. BUS. LAW § 850 (McKinney 2021); N.C. GEN. STAT. ANN. § 90-113.21 (West 2021); N.D. CENT. CODE ANN. § 19-03.4-01 (West 2021); OHIO REV. CODE ANN. § 2925.14 (West 2021); OKLA. STAT. ANN. tit. 63, § 2-101 (West 2021); 35 PA. STAT. AND CONS. STAT. ANN. § 780-102 (West 2021); S.D. CODIFIED LAWS § 22-42A-1 (2021); TEX. HEALTH & SAFETY CODE ANN. § 481.002 (West 2021); UTAH CODE ANN. § 58-37a-3 (West 2021); V.I. CODE ANN. tit. 19, § 593 (2021); VA. CODE ANN. §§ 18.2-265.1 and 54.1-3466 (West 2021); WASH. REV. CODE ANN. § 69.50.102 (West 2021); W. VA. CODE ANN. § 47-19-3 (West 2021); WYO. STAT. ANN. § 35-7-1056 (West 2021).

⁹⁵ Colorado, Illinois, Montana, and Tennessee do not include hypodermic needles or syringes in the list of drug paraphernalia examples in the state law, but it is unlawful in each state to possess, distribute, or furnish any item used to inject a controlled substance into a human body. In Indiana, there is no definition of “drug paraphernalia,” but the criminal code makes it unlawful to possess an instrument used to introduce a controlled substance into the human body. See COLO. REV. STAT. ANN. § 18-18-426 (West 2021); 720 ILL. COMP. STAT. ANN. 600/2 (West 2021); MONT. CODE ANN. § 45-10-101 (West 2021); and TENN. CODE ANN. § 39-17-402 (West 2021).

⁹⁶ See CAL. HEALTH & SAFETY CODE §§ 121349.1 and 11364 (West 2021); COLO. REV. STAT. ANN. §§ 18-18-428 and -430.5 (West 2021); DEL. CODE ANN. tit. 29, § 7993 (West 2021); D.C. CODE ANN. § 48-1103 (West 2021); FLA. STAT. ANN. § 381.0038 (West 2021); GA. CODE ANN. § 16-13-32 (West 2021); HAW. REV. STAT. ANN. § 325-114 (West 2021); 720 ILL. COMP. STAT. ANN. 600/3.5, 600/4, and 635/1 (West 2021); 410 ILL. COMP. STAT. ANN. 710/5 (West 2021); KY. REV. STAT. ANN. § 218A.500 (West 2021); ME. REV. STAT. ANN. tit. 17-A, § 1111 (West 2021); MD. CODE ANN. HEALTH-GEN. §§ 24-808 and 24-908 (West 2021); Michigan (no criminal penalties in code for possession of drug paraphernalia); MONT. CODE ANN. § 45-10-107 (West 2021); N.H. REV. STAT. ANN. § 318-B:44 (West 2021); N.J. STAT. ANN. § 2C:36-6a (West 2021); N.M. STAT. ANN. § 30-31-25.1 (West 2021); N.Y. PUB. HEALTH LAW § 3381 (McKinney 2021); N.Y. PENAL LAW § 220.45 (McKinney 2021); N.C. GEN. STAT. ANN. §§ 90-113.22 and 90-113.27 (West 2021); N.D. CENT. CODE ANN. § 23-01-44 (West 2021); OHIO REV. CODE ANN. § 3707.57 (West 2021); OKLA. STAT. ANN. tit. 63, § 2-101.1 (West 2021); P.R. LAWS ANN. tit. 24, § 2608 (2021); TENN. CODE ANN. §§ 40-7-124 and 68-1-136 (West 2021); UTAH CODE ANN. § 58-37a-5 (West 2021); VA. CODE ANN. § 54.1-3466 (West 2021); WASH. REV. CODE ANN. § 69.50.412 (West 2021).

⁹⁷ See CAL. HEALTH & SAFETY CODE §§ 121349.1 and 11364.7 (West 2021); COLO. REV. STAT. ANN. § 18-18-430.5 (West 2021); DEL. CODE ANN. tit. 29, § 7993 (West 2021); D.C. CODE ANN. § 48-1103 (West 2021); FLA. STAT. ANN. § 381.0038 (West 2021); GA. CODE ANN. § 16-13-32 (West 2021); HAW. REV. STAT. ANN. § 325-114 (West 2021); 720 ILL. COMP. STAT. ANN. 600/4 (West 2021); IND. CODE ANN. § 35-48-4-8.5 (West 2021); KY. REV. STAT. ANN. § 218A.500 (West 2021); ME. REV. STAT. ANN. tit. 17-A, § 1110 (West 2021); MD. CODE ANN. HEALTH-GEN.

Finally, 13 states provide exceptions to criminal penalties for possession of a controlled substance for any residue contained in a hypodermic needle or syringe.⁹⁸

In a study published in the *Harm Reduction Journal* in 2019, 72 percent of program participants surveyed identified fear of arrest as the barrier most likely to prevent them from engaging with an SSP.⁹⁹ That finding is “congruent with” studies conducted in Denver, Baltimore, Oakland, Los Angeles, and San Francisco, where fear of arrest is the “most frequently cited barrier.”¹⁰⁰ With that in mind, the drafters included subsections (a) and (b) of this section in order to ensure that program staff, employees, volunteers, and participants are exempt from any state criminal penalties for possessing, furnishing, or distributing hypodermic needles, syringes, or other supplies and any residue present in a hypodermic needle or syringe. A working group member suggested that the immunity for employees, consultants, and volunteers under subsection (b) be limited to those employees, consultants, and volunteers acting pursuant to the scope of their employment or duties with the SSP.

It is highly recommended that states that enact this Model Act also enact legislation that either deletes hypodermic needles, syringes, tourniquets, cookers, drug checking supplies, and other supplies from the state definition of “drug paraphernalia” or, alternatively, specifically exempts (*i.e.*, decriminalizes) such materials from the state criminal code. While the provisions of subsections (a) and (b) apply only to program staff, employees, volunteers, and participants, as those individuals come within the purview of this Model Law, any changes a state chooses to make to its drug paraphernalia laws would not be so limited.

Subsection (c) provides immunity from civil action to police officers who, in the performance of their duties, arrests an individual for possession, distribution, or furnishing of a hypodermic needle, syringe, or other supplies who turns out to be immune from arrest pursuant to this Act. Working group members expressed reservations regarding this provision as providing immunity to law enforcement officers for wrongfully arresting an individual who is immune pursuant to the provisions of this Act may encourage officers to arrest first and verify later. A 2007 study found that 17 percent of participants in legal SSPs in California had been arrested or cited for possession of drug paraphernalia in the six months prior to being interviewed while only 10 percent of individuals participating in an illegal SSP had been subject to arrest or citation for possession of drug paraphernalia, and fear of arrest is one of the main

§§ 24-808 and 24-908 (West 2021); Michigan (no criminal penalties for distribution); MONT. CODE ANN. § 45-10-107 (West 2021); N.J. STAT. ANN. § 2C:36-6a (West 2021); N.M. STAT. ANN. § 30-31-25.1 (West 2021); UTAH CODE ANN. § 58-37a-5 (West 2021); VA. CODE ANN. § 54.1-3466 (West 2021); WASH. REV. CODE ANN. § 69.50.4121 (West 2021).

⁹⁸ See ARIZ. REV. STAT. ANN. § 36-798.52 (2021); COLO. REV. STAT. ANN. §§ 18-18-403.5 and 18-18-428 (West 2021); 420 ILL. COMP. STAT. ANN. 710/5 (West 2021); KY. REV. STAT. ANN. § 218A.500; ME. REV. STAT. ANN. tit. 17-A, §§ 1106 and 1107-A (West 2021); MD. CODE ANN. HEALTH-GEN. §§ 24-809 and 24-909 (West 2021); NEV. REV. STAT. ANN. § 453.336 (West 2021); N.H. REV. STAT. ANN. § 318-B:26 (West 2021); N.J. STAT. ANN. § 2C:36-6a (West 2021); N.Y. PENAL LAW § 220.03 (West 2021); N.C. GEN. STAT. ANN. §§ 90-113.22 and 90-113.27 (West 2021); TENN. CODE ANN. § 68-1-136 (West 2021); VA. CODE ANN. § 32.1-45.4 (West 2021); W. VA. CODE ANN. § 16-64-8 (West 2021).

⁹⁹ Stephen M. Davis et al., *supra* note 57.

¹⁰⁰ *Id.*

reasons why individuals do not participate in SSPs.¹⁰¹ Further, questions were raised regarding how law enforcement would be able to identify participants, employees, consultants, or volunteers with the program without some sort of identification card or identifying marker on the hypodermic needles, syringes, or other supplies provided by the program. The best solution to all of these issues is for legislators to decriminalize generally the possession, distribution, or furnishing of items classified as drug paraphernalia.

Finally, subsections (d) and (e) stem from Indiana law that prohibits law enforcement from using a person's association with an SSP, either as an employee, volunteer, or participant, as the basis for either a stop and frisk or probable cause for the issuance of a warrant.¹⁰² The purpose of including these provisions is to ensure that all individuals involved with an SSP, whether an employee or a participant, feel comfortable and safe in using and providing the services offered and are able to do so without fear that participation in the program might lead to arrest or prosecution.

In addition to these immunity provisions, reviewers noted that, oftentimes, participation in an SSP can have a detrimental effect on participants' ability to retain custody of their minor children or get housing. With that in mind, states may want to include a provision that participation in an SSP cannot be the sole reason for removal of custody or denial of housing.

SECTION VIII. EDUCATION AND TRAINING.

- (a) In general.—Within [*n*] months of the enactment of this Act, the Department shall develop education and training materials with the purpose of educating state and local governmental entities, law enforcement personnel, emergency medical services, health care workers, elected officials, and members of the public regarding:
- (1) The effectiveness of syringe services programs;
 - (2) State laws governing syringe services programs;
 - (3) Evidence regarding the public health and safety benefits of syringe services programs;
 - (4) Evidence regarding how proper disposal of used hypodermic needles and syringes through syringe services programs results in a decrease in needlestick injuries to law enforcement and other emergency personnel;
 - (5) The legal status of hypodermic needles, syringes, and other supplies; and

¹⁰¹ Alexis N. Martinez, et al, *The Impact of Legalizing Syringe Exchange Programs on Arrests Among Injection Drug Users in California*, 84(3) J. OF URBAN HEALTH 423-435 (May 2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2231826/>.

¹⁰² See IND. CODE ANN. § 16-41-7.5-9 (West 2021).

(6) Evidence that the existence of a syringe services program in a community does not result in an increase in crime or hypodermic needle or syringe debris.

(b) Availability.—The Department shall, at a minimum, make such education and training materials available via print materials and on its website.

Commentary

Syringe services programs face numerous objections to being established and operated in communities primarily due to misinformation surrounding these programs, such as that SSPs increase injection drug use, lead to an increase in hypodermic needle and syringe debris in public areas, lead to an increase in needlestick injuries among first responders, and lead to an increase in crime in communities where SSPs are present. As discussed throughout this Model Act, none of the above concerns are legitimate. The intent of this section is to increase knowledge among several core groups – state and local governmental entities, law enforcement personnel, health care workers, elected officials, and members of the public – to help prevent the spread of misinformation and increase buy-in from those groups.

This section also implements the PEW recommendation that “state government entities and civil society groups should work with local law enforcement to develop and deliver training on the value of SSPs, the state laws that govern them, and drug paraphernalia.”¹⁰³ Per the PEW report, “training should cover public health benefits of SSPs, how proper disposal of syringes through the programs can reduce the risk of needle stick injuries to police, the legality of syringes and other drug paraphernalia, and the efficacy of medication treatment for [opioid use disorder].”¹⁰⁴

SECTION IX. GRANT PROGRAM AND FUNDING.

(a) Grant program.—The Department may establish a grant program for registered syringe services programs for the purpose of funding, in whole or in part, the operations of such programs, including the purchase of hypodermic needles and syringes and other supplies.

(b) Budget allocation.—The legislature may appropriate [\$_____] for fiscal years [*n*] to the Department for the purpose of funding, in whole or in part, the ongoing activities required as part of this Act, including any syringe services grant program established by the Department.

(c) Pursuit of funding.—The Department may pursue all federal funding, matching funds, and foundation or other charitable funding for the initial start-up and ongoing activities required under this Act.

¹⁰³ THE PEW CHARITABLE TRUSTS, *supra* note 64, at 4-5.

¹⁰⁴ *Id.*, at 5.

- (d) Receipt of funding.—The Department may receive such gifts, grants, and endowments from public or private sources as may be made from time to time, in trust or otherwise, for the use and benefit of the purposes of this Act and expend the same or any income derived from it according to the term of the gifts, grants, or endowments.

Commentary

Funding is a constant struggle for SSPs. A study conducted by Eyasu H. Teshale, *et al.*, estimated that the cost of operating a small, rural SSP could be as low as \$400,000 a year, while the cost of operating a large, urban SSP could be as much as \$1.9 million per year.¹⁰⁵ The CDC recommends that programs diversify funding, stating that, “diversifying funding sources is beneficial for program sustainability”;¹⁰⁶ however, PEW takes a seemingly opposing view, stating that, “[w]ithout public finding, programs have to rely on a patchwork of temporary private grants that can each have their own requirements and restrictions, limiting the sustainability and scope of SSP operations.”¹⁰⁷ Although federal funding is available to SSPs, programs cannot use certain federal funds to purchase sterile needles or syringes.¹⁰⁸ However, eligible programs can use federal funds for personnel, HIV and HCV testing kits, syringe disposal services, provision of emergency opioid antagonists, development of educational materials, condoms, and other activities to support the SSP.¹⁰⁹ Programs are only eligible for federal funding if they are in an area that is determined by the CDC to be experiencing, or at risk of, a significant increase in viral hepatitis or HIV due to injection drug use.¹¹⁰

In light of those restrictions and due to the struggles SSPs have in obtaining funding, this section allows the state department of health to establish a grant program for registered SSPs for the purpose of funding, in whole or in part, the services offered by those programs. While some may be opposed to state funding for hypodermic needles, syringes, and other supplies because they believe, erroneously, that it equates to state funding of drug misuse, the opposite is true. As stated throughout the commentary in this Act, individuals who participate in an SSP are five times more likely to enter a treatment program and three times more likely to decrease or stop injecting drugs than those who do not participate in such programs.¹¹¹ Given that drug misuse costs at least \$524 billion annually in the United States in terms of lost productivity, health care, and criminal justice costs, investing in SSPs simply makes more fiscal sense.¹¹²

¹⁰⁵ Eyasu H. Teshale *et al.*, *Estimated Cost of Comprehensive Syringe Service Program in the United States*, PLOS ONE (April 26, 2019), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0216205>.

¹⁰⁶ Z. Javed *et al.*, *supra* note 43, at 21.

¹⁰⁷ THE PEW CHARITABLE TRUSTS, *supra* note 64, at 5.

¹⁰⁸ DEP’T OF HEALTH & HUM. SERV., *supra* note 85, at 1.

¹⁰⁹ *Id.*, at 3.

¹¹⁰ *Id.*, at 1.

¹¹¹ CENTERS FOR DISEASE CONTROL AND PREVENTION, *Summary of Information*, *supra* note 13.

¹¹² RECOVERY CTS. OF AM., *supra* note 5.

SECTION X. RULES AND REGULATIONS.

The Department shall promulgate such rules and regulations as are necessary to effectuate this Act.

SECTION XI. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provisions or applications, and to this end, the provisions of this Act are severable.

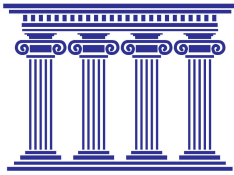
SECTION XII. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of determination of the effective date].

ABOUT THE LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

Based in Washington D.C., and led by and comprised of experienced attorneys, the Legislative Analysis and Public Policy Association is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

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