

Center for Law and the Public's Health  
at Johns Hopkins and Georgetown Universities

Johns Hopkins Bloomberg School of Public Health

Hampton House, Room 580

624 N. Broadway

Baltimore, MD 21205

(410) 955-7624

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**Syringe Access Law in the United  
States**

*A State of the Art Assessment of Law  
and Policy*

As of November 30, 2002

**Scott Burris  
Steffanie A. Strathdee and  
Jon S. Vernick**

Syringe Access Law in the United States:  
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By  
Scott Burris, Steffanie A. Strathdee and Jon S. Vernick

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**I. Introduction**

Ensuring that injection drug users who cannot or will not stop injecting have access to sterile syringes is an important part of a comprehensive approach to reducing the transmission of viral and bacterial infections associated with injection drug use.<sup>1</sup> Seen purely in terms of public health science and prevention practice, ensuring syringe access for IDUs is clearly an appropriate strategy: both evaluation research and experience in the field show that adequate syringe access produces positive health effects without creating negative societal ones. Access to sterile syringes through syringe exchange programs (SEPs) has been associated with decreased rates of needle sharing, decreased prevalence and incidence of blood borne infections such as HIV and hepatitis B and C, and increased rates of entry into drug treatment among injection drug users (IDUs). There is no evidence that such programs increase crime, drug use or the number of discarded needles on the street. Pharmacies, syringe vending machines and deregulating syringe access can further expand sterile syringe coverage to IDUs, thereby increasing the potential to achieve these positive public health outcomes.

Despite its public health value, however, syringe access has been politically controversial in the United States. In our political culture driven by symbols and perceptions, improved syringe access has been painted as “soft on drugs,” a retreat from zero tolerance that will be seen as an endorsement of drug use. Polls continue to show that only a little more than half of respondents support enhanced

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<sup>1</sup> Academy for Educational Development, *New Attitudes and Strategies: A Comprehensive Approach to Preventing Blood-Borne Infections among IDUs*. 2000, at <http://www.cdc.gov/HIV/projects/IDU-ta/brochure.htm>.

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syringes access – a majority, but evidently one that is too narrow or uncommitted to counterbalance the intense symbolic force of the syringe access issue in policy-making. Syringe access, then, is quite a familiar public health policy issue: science and professional judgment point to an intervention that is unsettling if not absolutely unacceptable to a significant part of the U.S. public and its political leaders.

Syringe access is regulated by state law. The legal regulation of syringe access varies from state to state but takes one or more of three forms: *syringe prescription laws* and regulations; other *pharmacy regulations* or miscellaneous statutes imposing a variety of restrictions on the sale of syringes by pharmacists or others; and *drug paraphernalia laws* prohibiting the sale or possession of items intended to be used to consume illegal drugs.<sup>2</sup> Laws on *drug possession* also may be applied in a manner that in practical terms regulates the possession of syringes, and so must also be considered for their possible effects on syringe access.<sup>3</sup>

The primary policy questions have been the legality of over-the-counter sales of syringes to IDUs, the legality of syringe possession by IDUs, and the authority of public health officials or private sector providers to initiate access interventions. Where clearly legal modes of syringe access are absent, proponents of health interventions like syringe exchange have had to seek the support of legislators, governors, mayors and law enforcement officials. Money, too, has been an issue: at the

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<sup>2</sup> L. O. Gostin, and Z. Lazzarini, *Prevention of HIV/AIDS among Injection Drug Users: The Theory and Science of Public Health and Criminal Justice Approaches to Disease Prevention*, 46 Emory Law Journal 587 (1997).

<sup>3</sup> Scott Burris, Joseph Welsh, Mitzi Ng, Mei Li, and Alyssa Ditzler, *State Syringe and Drug Possession Laws Potentially Influencing Safe Syringe Disposal by Injection Drug Users*, Journal of the American Pharmaceutical Association (2002).

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federal level, there has been an ongoing debate for many years over what, if any, syringe access research or program activities could be conducted with federal funding. Meanwhile, syringe access programs have depended on state or local funding, philanthropy, and the work of volunteers to operate.

This review assesses the current state of syringe access *policy* in the United States. Although it will also discuss the *science* behind the syringe access issue, its main purpose is to set out where the United States stands on syringe access law, practice and public attitudes, and to suggest ways in which policy-oriented research can contribute to loosening the political knot that now binds public health efforts to reduce the harms of drug use. In order to fulfill this goal, we report on the status of policies that both facilitate and impede access to clean needles for IDUs and others. Because syringe access is a matter of political dispute, we acknowledge our perspective on the issue: as public health researchers and scholars, we believe that an assessment of the best available research in this area suggests that policies easing access to clean needles can reduce disease transmission without producing substantial countervailing harms.

## **II. Scope**

The main focus of this paper is the body of law that regulates syringe sale, purchase, possession and disposal in the context of injection drug use in the United States, the District of Columbia, the Virgin Islands and Puerto Rico. This body of law includes

- drug paraphernalia laws
- syringe prescription laws and regulations
- pharmacy regulations and miscellaneous syringe laws

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- needle exchange laws and regulations, and
- drug possession laws.

We identified and reviewed prior studies on syringe access law and its enforcement in the legal and public health literature. We updated and re-analyzed laws collected for earlier studies by one of the authors (Burris). We also systematically searched for bioethical commentary and public opinion data on syringe access issues.

To place these findings in context, this review includes a description of the emergence of syringe access as a public health practice and object of policy debate. The review also summarizes and critically assesses the public health research on the health effects of syringe access rules and the collateral effects of policies enhancing syringe access for IDUs. The discussion in these areas does not, however, constitute a systematic literature review.

### **III. Background**

Access to injection equipment has been regulated at the state level for many years. The hypodermic syringe was popularized in the latter half of the nineteenth century, often as a means for injecting opiates such as morphine and heroin. As rates of opiate addiction began to increase, states responded with legislation making it more difficult for drug users to obtain syringes.<sup>4</sup> New York State enacted the first such law in 1911. Among other provisions, New York's law required a written order from a physician before a syringe could be obtained. Just three years later, the federal Harrison Act

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<sup>4</sup> Gostin, and Lazzarini, *supra* note 2.

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was passed, marking the start of a major federal role in the control of the narcotics trade. Beginning in 1915, several other states, mostly in the East, followed New York's lead and enacted their own laws limiting the availability of syringes.<sup>5</sup>

Legislative efforts to restrict access to injection equipment were not limited to the early part of the past century, however. Another important flurry of activity occurred in the 1970s with the rapid adoption of state laws criminalizing the possession of certain devices, including syringes, used to inject illegal drugs. These so-called "drug paraphernalia" laws were often patterned after a Model Drug Paraphernalia Act (MDPA) written by the Drug Enforcement Agency in 1979 at the request of President Carter.<sup>6</sup> They were originally intended to provide a means of prosecuting operators of "head shops"-- stores specializing in equipment for drug users. By 1976, it was estimated that between fifteen and thirty thousand of these stores were doing an annual three billion dollar business in such items as cigarette rolling papers, bongs and freebasing kits. Syringes were not generally mentioned in the legislative debates or court challenges to these laws, nor is it even clear that syringes were being sold in head shops. Debate about the laws usually focused on their breadth, and the danger that innocent sellers of items with both legal and illegal uses (such as rolling papers or scales) might be prosecuted.<sup>7</sup>

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<sup>5</sup> M. Parts, *Disease Prevention as Drug Policy: A Historical Perspective on the Case for Legal Access to Sterile Syringes as a Means of Reducing Drug-Related Harm*, 24 Fordham Urban Law Journal 475 (1997).

<sup>6</sup> Gostin, and Lazzarini, *supra* note 2.

<sup>7</sup> L. Ferguson, M. Perez, and S. Burris, *Syringe Exchange in Pennsylvania: A Legal Analysis*, 8 Temple Political and Civil Rights Law Review 41 (1998).

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In a few states, the model law was amended to explicitly exclude pharmacists, but in most states the possibility that pharmacists would be covered through the laws' reference to needles was apparently not considered. Until the emergence of HIV, these laws were seen exclusively in the context of the control of drug abuse.

HIV changed that, as transmission through drug injection was recognized as a serious threat to public health. The first syringe exchange program (SEP) was introduced in Amsterdam, the Netherlands, in 1984.<sup>8</sup> The program, initiated by a drug user organization whose name may loosely be translated as the Junkies' Union, was soon adopted by the Municipal Health Department of Amsterdam, where it became a fundamental component of HIV prevention activities among IDUs. In the late 1980's, SEPs were introduced in the United Kingdom, Australia, Canada and several other European countries. Global expansion of SEPs has occurred in both developed and developing countries, including China, Russia, the Ukraine, Kyrgyzstan, Nepal, Bangladesh, India, Pakistan and Colombia. As of December 2000, there were at least 46 regions, countries and territories that reported having at least one SEP.<sup>9</sup>

In the USA, the first SEP was introduced in 1988, in Tacoma, Washington, and spread from there with the help of NGOs such as the National AIDS Brigade, the North American Syringe

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<sup>8</sup> J. A. van den Hoek, H. J. van Haastrecht, and R. A. Coutinho, *Risk Reduction among Intravenous Drug Users in Amsterdam under the Influence of AIDS*, 79 American Journal of Public Health 1355 (1989).

<sup>9</sup> S. A. Strathdee, and David Vlahov, *The Effectiveness of Needle Exchange Programs: A Review of the Science and Policy*, 1 AIDScience 1 (2001).

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Exchange Network and Act-Up. Expert reviews of the science supported syringe exchange,<sup>10</sup> but early commentators generally assumed that syringe exchange was illegal in the United States unless explicitly authorized by state law.<sup>11</sup> By 1995, there were at least 55 SEPs operating in 46 cities in 21 states.<sup>12</sup> A review of the legal strategies used to implement these SEPs found that 27 programs in ten jurisdictions had been authorized by law or court decision, or were in a state without a syringe-related law. Thirteen programs were operating without any change in law, backed by local governments exercising their legal authority to protect public health. At least nine SEPs were operating without any claim to legal authorization.<sup>13</sup>

Although syringe exchange was developing rapidly at the state level, and finding support in several key states, a controversy over funding SEPs began to dominate the debate at the federal level.

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<sup>10</sup> P. Lurie, A.L. Reingold, and Bowser. B. (eds.), *The Public Health Impact of Needle Exchange Programs in the United States and Abroad: Summary, Conclusions and Recommendations* (1993); J. Normand, D. Vlahov, and L.E. Moses, *Preventing HIV Transmission: The Role of Sterile Syringes and Bleach* (1995); National Commission on AIDS, *the Twin Epidemics of Substance Abuse and HIV* (1991); Office of the Surgeon General, *Evidence-based Findings on the Efficacy of Syringe Exchange Programs: an Analysis from the Assistant Secretary for Health and Surgeon General of the Scientific Research Completed since April 1998* (2000) (available at <http://www.harmreduction.org/surgreview.html>).

<sup>11</sup> Lurie et al., *supra* note 10; L. O. Gostin, *The Interconnected Epidemics of Drug Dependency and AIDS*, 26 *Harvard Civil Rights-Civil Liberties Law Review* 113 (1991); Centers for Disease Control and Prevention, *Syringe Exchange Programs--United States, 1994-1995*, 44 *MMWR - Morbidity & Mortality Weekly Report* 684 (1995).

<sup>12</sup> Centers for Disease Control and Prevention, *supra* note 11.

<sup>13</sup> S. Burris, D. Finucane, H. Gallagher, and J. Grace, *The Legal Strategies Used in Operating Syringe Exchange Programs in the United States*, 86 *American Journal of Public Health* 1161 (1996).

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In November 1988, a federal ban on U.S. funding for SEPs was enacted.<sup>14</sup> Provisions stated that the ban on federal funding could be lifted only if the President of the United States or the US Surgeon General determined that SEPs reduced the transmission of HIV infection and did not increase drug abuse. More restrictive language was inserted into the Comprehensive Alcohol Abuse, Drug Abuse, and Mental Health Amendments Act of 1988, specifying that no funding could be spent “to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection.”<sup>15</sup> The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 included similar provisions. Later Department of Health and Human Services appropriations acts prohibited funding for NEPs “unless the President of the United States certifies that such programs are effective in stopping the spread of HIV and do not encourage the use of illegal drugs.”<sup>16</sup> The legislative restrictions included a proviso that would allow funding if it were certified that syringe exchange reduced HIV incidence without increasing drug abuse. Because there was also an administrative ban on research to evaluate NEPs from 1988 to 1991,<sup>17</sup> this was the quintessential Catch-22.

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<sup>14</sup> Health Omnibus Programs Extension of 1988.

<sup>15</sup> Comprehensive Alcohol Abuse, Drug Abuse, and Mental Health Amendments Act of 1988.

<sup>16</sup> Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1990; Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1991.

<sup>17</sup> D. Vlahov, D.C. Des Jarlais, E. Goosby, P.C. Hollinger, P.G. Lurie, M.D. Shriver, S.A. Strathdee. *Case study: Needle Exchange Programs for the Prevention of HIV Infection* (forthcoming 2002).

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In 1998, Secretary of the Department of Health and Human Services, Donna Shalala issued the required findings, but the Clinton administration, in the face of continuing opposition in Congress and from its own Office of National Drug Control Policy, declined to seek funding for syringe exchange programs or research. The Surgeon General reiterated the Secretary's findings in 2000.<sup>18</sup> Nevertheless, since 1999 the annual Labor/Health and Human Services appropriations bills have contained a ban on federal funding of syringe exchange.<sup>19</sup>

For many years there has also been an annual battle over the Congressional budget appropriation for the District of Columbia. Riders to the fiscal year 2001 not only prohibited the District from funding syringe exchange, and but also barred the privately funded SEP from operating close to public housing and within 1000 feet of a school.<sup>20</sup> After vigorous lobbying from proponents of SEPs, the fiscal year 2002 appropriation removed the restrictions on the operation of the private SEP, but maintained the ban on federal funding.<sup>21</sup>

Despite the lack of federal funding, by 1999 there were over 160 SEPs in operation in 39 U.S. states, the District of Columbia and Puerto Rico.<sup>22</sup> Yet the lack of federal and state support for SEPs

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<sup>18</sup> Office of the Surgeon General, *supra* note 10.

<sup>19</sup> Departments of Labor, Health And Human Services, And Education, And Related Agencies Appropriations Act, 2002.

<sup>20</sup> Personal communication, Ms. Paola Barahona, 2001.

<sup>21</sup> District of Columbia Appropriations Act, 2002.

<sup>22</sup> P. O. Coffin, B. P. Linas, S. H. Factor, and D. Vlahov, *New York City Pharmacists' Attitudes toward Sale of Needles/Syringes to Injection Drug Users before Implementation of*

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has clearly taken its toll. In a survey of 81 SEPs across the U.S., Paone and colleagues reported that SEPs that operated illegally were significantly less likely to offer crucial ancillary services, such as on-site HIV testing and counseling and formal arrangements for referrals to drug abuse treatment services.<sup>23</sup> In 1993, an evaluation of sixteen North American SEPs reported that these programs seldom reached more than 30% of the IDUs in their communities.<sup>24</sup> Although U.S. SEPs distribute some 15-20 million syringes each year,<sup>25</sup> it is estimated that America's 1.5 million IDUs annual perform 1.3 billion injections.<sup>26</sup> In countries like the UK and Australia, where SEPs are supported both federally and locally, the number of sterile syringes provided per IDU per year is much higher.<sup>27</sup>

The continuing federal funding controversy coincided with and may even have contributed to a stall in the authorization of new syringe exchange programs at the state and local levels. In part, however, the decline in legislation dealing with SEPs has reflected the increasing awareness of syringe

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*Law Expanding Syringe Access*, 77 *Journal of Urban Health* 781 (2000).

<sup>23</sup> D. Paone, J. Clark, Q. Shi, D. Purchase, and D. C. Des Jarlais, *Syringe Exchange in the United States, 1996: A National Profile*, 89 *American Journal of Public Health* 43 (1999).

<sup>24</sup> Lurie et al., *supra* note 10.

<sup>25</sup> See, e.g., Paone, Clark, Shi, Purchase, and Des Jarlais, *supra* note 23; Centers for Disease Control and Prevention, *Update: Syringe Exchange Programs--United States, 1998.*, 50 *MMWR - Morbidity & Mortality Weekly Report* 384 (2001).

<sup>26</sup> P. Lurie, T. S. Jones, and J. Foley, *A Sterile Syringe for Every Drug User Injection: How Many Injections Take Place Annually, and How Might Pharmacists Contribute to Syringe Distribution?*, 18 *Suppl 1 Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology* S45 (1998).

<sup>27</sup> Strathdee, and Vlahov, *supra* note 9.

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access proponents of the limitations of SEPs and the need for other, complementary strategies. In recent years, advocates in several states have successfully sought “syringe deregulation” – the removal of legal barriers to over-the-counter sales and free distribution of syringes. Deregulation in its purest form eliminates all significant legal restrictions on the sale or possession of hypodermic needles and syringes. It allows the broadest range of syringe access options for IDUs, including SEPs, retail sales, physician prescription and distribution, vending machine sales and free distribution through community organizations and public health agencies. It decriminalizes needle possession, with the purpose of eliminating criminal law as a deterrent to sterile injection. Less sweeping forms of deregulation allow the sale and possession of a specified number of syringes, or lift restrictions on sale in pharmacies.

Since the beginning of the HIV epidemic, eleven states (Connecticut, Hawaii, Maine, Minnesota, New Hampshire, New Mexico, New York, Oregon, Rhode Island, Washington and Wisconsin) have deregulated the sale or possession of at least some number of syringes. In others, notably California and Illinois, efforts at deregulation have been unsuccessful. To date, no state that has liberalized syringe access in response to HIV has rescinded the change, but change continues to be a matter of controversy in states that maintain restrictive access policies.

Public health authorities recommend that injection drug users use a new, sterile syringe for every injection.<sup>28</sup> Despite the continued growth of syringe exchange, and the deregulation of syringes in one-fifth of the United States, the US has consistently fallen far short of this public health goal. In the third

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<sup>28</sup> U.S. Public Health Service, HIV Prevention Bulletin: Medical Advice for Persons Who Inject Illicit Drugs (1997).

decade of its HIV epidemic, the U.S. continues to debate whether and how to make syringes available to injection drug users.

#### **IV. Syringe Access Policy in the United States: A Summary of the Law and the Legal Literature**

Selling, buying, possessing and disposing of syringes are heavily regulated activities. With a few exceptions, the prior literature on syringe access legality, summarized in the first section of this part, has focused on the presence or absence of the various forms of syringe access regulation in the several United States. This is an important topic, and Section B below summarizes the latest data on which states have what laws. But syringe access law is much more complicated than a simple list of laws can show. Although many of these laws are generally similar from state to state, there is in fact a great deal of state-to-state variation in legal syringe access for IDUs. Moreover, legal researchers have increasingly recognized that the legality of different means of syringe access depends upon the form of access (syringe exchange or pharmacy, e.g.), the legal status of the person providing the access (e.g., a physician), the particular combination of laws and case decisions in the state and the attitudes of people who enforce the laws where the access provider wants to operate. This review therefore adds a new analytic step to the existing literature on syringe access law, by analyzing state-by-state the legality of three basic modes of syringe access: retail sale without a prescription, sale with a prescription, and syringe exchange or other forms of free distribution.

##### *A. The Legal Literature*

The legality of syringe access for IDUs in the United States has been previously explored in the

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legal literature. Parts' review of the history of syringe access laws provided an excellent overview of current and past legislation, as well as a thorough review of a largely forgotten medical literature describing outbreaks of malaria, tetanus and other needle-borne disease among IDUs in the early and mid-twentieth century.<sup>29</sup> Several articles and reports in the first decade of the epidemic identified syringe prescription and drug paraphernalia laws as possible barriers to preventing HIV among IDUs.<sup>30</sup> Some early surveys of SEPs based their assessment of legality on the presence or absence of a syringe prescription law, ignoring paraphernalia or pharmacy practice laws.<sup>31</sup> When discussed, paraphernalia laws were assumed to prohibit SEPs and retail sale of syringes.<sup>32</sup> Gostin and Lazzarini<sup>33</sup> undertook a study of the laws and regulations applicable to syringe access, including the prescription, drug paraphernalia and pharmacy practice rules of all U.S. states and territories. Although comprehensive in

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<sup>29</sup> Parts, *supra* note 5.

<sup>30</sup> L. O. Gostin, *The Interconnected Epidemics of Drug Dependency and AIDS*, 26 Harvard Civil Rights-Civil Liberties Law Review 113 (1991); Jeff Stryker, *IV Drug Use and AIDS: Public Policy and Dirty Needles*, 14 Journal of Health Politics, Policy and Law 719 (1989); L.O. Gostin, *Drug-Dependent Populations: Legal and Policy Options*, in *AIDS and IV Drug Abusers* (R. Galea, B. Lewis & L. Baker eds 1988); C. Pascal, *Intravenous Drug Abuse and AIDS Transmission: Federal and State Laws Regulating Needle Availability*, in *Needle Sharing Among Intravenous Drug Abusers: National and International Perspectives* (R. Batjes and R. Pickens eds 1988). For a description of early reports and recommendations, see Catherine O'Neill, *Intravenous Drug Abusers*, in *AIDS and the Law: A Guide for the Public* 253, 278-80 (H. Dalton, S Burris & the Yale AIDS Law Project eds 1987).

<sup>31</sup> Centers for Disease Control and Prevention, *supra* note 11; Paone, Clark, Shi, Purchase, and Des Jarlais, *supra* note 23.

<sup>32</sup> Gostin, *supra* note 11.

<sup>33</sup> Gostin and Lazzarini, *supra* note 2.

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its scope, the study did not analyze the law on a state-by-state basis, so meaningful differences in the wording of paraphernalia, prescription and pharmacy regulations, and important legal issues of their interaction in a given state, were noted but not examined.

Burris and colleagues<sup>34</sup> used legal research and survey techniques to identify the legal strategies used by SEPs to operate in the US. Their analysis identified considerable uncertainty in the legal status of syringe exchange, uncertainty that reflected not only the complexity of the relevant statutes but also the interplay of multiple statutes and the practices of law enforcement and public health officials. Uncertainty about the legal status of syringe exchange was considerably different than clear illegality. SEPs, the study found, could successfully operate without explicit authorization in a climate of uncertainty; likewise, absent a clear legal prohibition in state law, local governments often had the authority under public health laws to operate or authorize SEPs. The legal and practical effects of this uncertainty were illustrated by Ferguson and colleagues,<sup>35</sup> who analyzed in detail the law of one state to show that syringe exchange could reasonably be considered legal in a conventional legal analysis even though the state had both a drug paraphernalia law and a syringe prescription regulation.

The importance of dealing with intra-state legal complexity and the inherent uncertainty of much legal analysis was the starting point for Burris and colleagues,<sup>36</sup> who investigated the legality of physician

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<sup>34</sup> Burris, Finucane, Gallagher, and Grace, *supra* note 13.

<sup>35</sup> Ferguson, Perez, and Burris, *supra* note 7.

<sup>36</sup> S. Burris, P. Lurie, D. Abrahamson, and J. D. Rich, *Physician Prescribing of Sterile Injection Equipment to Prevent HIV Infection: Time for Action*, 133 *Annals of Internal Medicine* 218 (2000); S. Burris, P. Lurie, and M. Ng, *Harm Reduction in the Health Care System: The*

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prescription and pharmacy sale of syringes to IDUs, a mode of access first suggested by Gostin and Lazzarini.<sup>37</sup> This study used a different methodology than Gostin and Lazzarini, taking the collected data and, for each state and territory covered, creating a memorandum analyzing the statutes and case law according to standard legal practices. (These memoranda are available at <http://www.temple.edu/lawschool/AIDSpolicy>.) These memoranda were also the basis of an analysis of syringe deregulation prepared by Burris and Ng for the AIDS Coordinating Committee of the American Bar Association.<sup>38</sup>

Related legal issues have also received study. Mehlman assessed the tort issues associated with syringe access by physician prescription and pharmacy sale, finding that the risk of civil liability for providing syringes was remote.<sup>39</sup> Abrahamson reviewed the effect of federal law on syringe access, and concluded it was minimal.<sup>40</sup>

### *B. Syringe Access Law Today*

This section updates Gostin and Lazzarini's<sup>41</sup> survey of syringe access law, accounting for the

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*Legality of Prescribing and Dispensing Syringes to Drug Users*, 11 Health Matrix 5 (2001).

<sup>37</sup> Gostin and Lazzarini, *supra* note 2.

<sup>38</sup> Scott Burris, and Mitzi Ng, *Deregulation of Hypodermic Needles and Syringes as a Public Health Measure: A Report on Emerging Policy and Law in the United States* (2001).

<sup>39</sup> M. Mehlman, *Liability for Prescribing Intravenous Injection Equipment to IV Drug Users*, 11 Health Matrix 73 (2001).

<sup>40</sup> D. Abrahamson, *Federal Law and Syringe Prescription and Dispensing*, 11 Health Matrix 65 (2001).

<sup>41</sup> Gostin and Lazzarini, *supra* note 2.

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many changes to law that have occurred in the past five years. This section also summarizes state laws setting the minimum amount of drugs whose possession is a crime.

### 1. Prescription Laws

Thirteen states and the Virgin Islands impose some form of syringe prescription requirement by statute. Pennsylvania requires a prescription by regulation. The requirement stands as a substantial barrier to syringe access in only seven of these jurisdictions: California, Delaware, Illinois, Massachusetts, New Jersey, Pennsylvania and the Virgin Islands. In Florida and Virginia, a prescription is required only for minors.<sup>42</sup> In Nevada, a prescription is not required for syringes to be used for asthma, diabetes or other medical conditions;<sup>43</sup> these exceptions, in combination with a favorable view of syringe sales from the pharmacy board, has reportedly led to reasonably liberal syringe access in the state. The remaining four prescription-law states – Connecticut, New Hampshire, New York, and Maine – have partially deregulated syringes and now allow non-prescription sale and possession of syringes in limited numbers. These statutes, and any requirements they may impose in addition to a prescription, are summarized in Table I.

// Insert Table I about here//

### 2. Other Pharmacy Regulations and Miscellaneous Statutes

Four other types of restriction on the sale of syringes appear in state law, usually but not always within the Pharmacy Code. Twenty-two states allow only pharmacies to sell syringes. Nine require the

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<sup>42</sup> Fla. Stat. Ann. §893.147(2); Va. Code Ann. § 54.1-3468.

<sup>43</sup> Nev. Rev. Stat. Ann. §454.48.

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seller to determine, or the buyer to produce information about, the use to which the syringe will be put. Fifteen require records of some type to be kept. Eleven require the buyer to show identification. Finally, eleven states specify limits on the display of syringes in retail establishments, normally requiring that they be kept behind the counter. These sub-prescription limits on syringe sales are most often (but not always) found in state pharmacy laws and regulations, and are therefore usually referred to as “pharmacy regulations.” Pharmacy regulations were collected and presented in tabular form by Gostin and Lazzarini in 1997, and we were provided with access to some of their data.<sup>44</sup> Pharmacy regulations are also annually reported in tabular form by National Association of Boards of Pharmacy. To update and verify the information from these sources, we compared pharmacy regulations collected by Gostin and Lazzarini with the results of our own collection of pharmacy regulations from Lexis, Westlaw and printed copies of regulations compiled in 1999-2000, and with the 2001 NABP pharmacy law survey.<sup>45</sup> Where there were discrepancies, we rechecked the regulations on Westlaw or Lexis, and/or contacted regulatory agencies. Results are included in Table I.

### 3. Drug Paraphernalia Laws

The District of Columbia and every jurisdiction studied except Alaska and Puerto Rico have drug paraphernalia laws. Most of these laws were passed in the 1970s and 1980s to regulate an

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<sup>44</sup> Gostin and Lazzarini, *supra* note 2.

<sup>45</sup> National Association of Boards of Pharmacy, *2001-2002 Survey of Pharmacy Law* (2002).

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increasing retail trade in drug-use equipment, and closely followed a model paraphernalia law drafted by the United States Department of Justice.<sup>46</sup> The typical statute defines drug paraphernalia to include all equipment, products and materials of any kind which are used, intended for use, or designed for use to “manufacture, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance” in violation of law.<sup>47</sup> It then provides an exemplary list of items that could be considered drug paraphernalia in some intended uses. In the majority of states, this list includes “[h]ypodermic syringes, needles, and other objects used, intended for use, and designed for use in parenterally injecting controlled substances into the human body.”<sup>48</sup> Under this definition, the status of any item as paraphernalia depends not just on the characteristics of the item itself but also the intention or acts of the defendant. To commit a crime, the seller must not only transfer possession of the syringe, but must do so knowing of the intended drug-related use.<sup>49</sup> Paraphernalia laws usually create two basic offenses: manufacturing or distributing and possessing paraphernalia. Not every state has created both offenses. The crime is typically a misdemeanor.

Nearly all state paraphernalia laws follow the same pattern, though there are small but important differences in many states that influence the applicability of paraphernalia laws to syringes. In addition to the states, discussed below, that have fully or partially deregulated syringes as a public health

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<sup>46</sup> Gostin & Lazzarini, *supra* note 2.

<sup>47</sup> Neb. Rev. Stat. §28-441.

<sup>48</sup> Neb. Rev. Stat. §28-439.

<sup>49</sup> Commonwealth v. Lacey, 496 A.2d 1256 (Pa. Super. 576, 1985).

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measure, a significant minority of states have provisions that, at least on paper, make it legal under some circumstances for a seller knowingly to dispense a syringe to an IDU. These exemptions, set out in Table II, take several forms. Nine state paraphernalia laws explicitly or implicitly exclude syringes in at least some quantity. Indiana's statute, for example, exempts items "historically and customarily used in connection with the...injecting...of...lawful substance[s]," thus at least in theory legalizing over-the-counter pharmacy sales of syringes.<sup>50</sup> In nine states, pharmacists and in some instances other health care providers are exempt from the law. In four states with laws based on the Justice Department's model act, the drafters of the paraphernalia law chose to depart from model and did not refer to injection or syringes in the text of the law. Although the broad definition of paraphernalia reasonably could be deemed to include syringes even without explicit reference, the decision to omit the references while otherwise adopting the Justice Department model could be read by a judge as evidence of a legislative decision not to prohibit syringe sale and possession. In a fifth state, South Carolina, the statute was not based on the model act: it does not allude to injection or syringes, and more importantly does not apply to items to be used in the consumption of heroin.<sup>51</sup> In states that have both paraphernalia and prescription laws, the interaction of the two must be individually assessed.

// Insert Table II about here//

Paraphernalia laws were broadly written to criminalize sale or possession of any item intended to be used to facilitate illegal drug use. In theory, items that are used in drug injection -- like cotton and

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<sup>50</sup> Indiana Code §35-48-4-8.5.

<sup>51</sup> S.C. Code Ann. §44-53-391(a).

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small vessels used to dissolve drugs (“cookers”), and even bleach kits -- are legally indistinguishable from syringes. Because items used in drug preparation have also been implicated in the spread of bloodborne diseases, especially hepatitis C virus, public health agencies and syringe exchange programs have routinely distributed them along with syringes. In areas where syringe exchange has not been authorized, some agencies distribute bleach kits as an alternative harm reduction measure. With the political focus on syringe access, the potential legal ambiguity of these other activities was largely ignored. In recent years, however, there have been anecdotal reports of SEPs being deterred from offering, and IDUs being arrested for possessing, sterile cookers and cotton. Efforts to import specially designed sterile cookers that have been used in other countries’ public health efforts have been affected by concern about the potential application of paraphernalia laws. The problem does not appear to be widespread, but does illustrate the potential sweep of drug paraphernalia laws.

### 4. Deregulation

A number of states have substantially changed their regulation of syringe access in response to the public health threat of injection-related diseases. What is often referred to as “deregulation” is the removal of the state as a barrier to syringe access. It has taken a variety of forms, which are summarized in Table III.

Oregon was the first state to squarely face the question of syringe access as a public health measure. Prior to 1987, syringe sales were not regulated. In that year, the state legislature passed a paraphernalia law based on the model statute but heeded the advice of state health officials to explicitly

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exclude syringes from the definition of paraphernalia.<sup>52</sup> In Oregon, it is therefore legal to sell needles not only in pharmacies but also in other retail outlets, possibly even vending machines, and to distribute them free through SEPS or other mechanisms. This approach can be described as “complete deregulation” and minimizes the legal barriers to syringe access.

Wisconsin followed Oregon’s approach in 1989, but the next state to act adopted a rather different model. Connecticut, which had been the first state to legislatively authorize an SEP, took on the issue of wider retail access in 1992. The legislature elected to allow retail sale of syringes without a prescription, but only in pharmacies and only in an amount of ten or fewer.<sup>53</sup> At the same time, the paraphernalia law was amended to exclude hypodermic syringes and needles sold or possessed in an amount of ten or fewer. In 1999, the possession, but not the purchase, limit was raised to thirty.<sup>54</sup> The numbers, and indeed the entire approach, were born of politics rather than health concerns.<sup>55</sup> The “ten-and-under” approach, in which sale and/or possession is legalized only in a specified number of syringes, has been followed by Maine, Minnesota, New Hampshire and New York.<sup>56</sup>

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<sup>52</sup> Or. Rev. Stat. §§ 475.525; L. N. Wright, and K. M. Gebbie, *Oregon's Exclusion of Syringes from Its 1987 Drug Paraphernalia Law Was an HIV Prevention Measure*, 18 Suppl 1 Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology S144 (1998).

<sup>53</sup> Conn. Gen. Stat. Ann. §21a-65.

<sup>54</sup> Conn. Gen. Stat. Ann. §21a-240(20).

<sup>55</sup> S. Bray, J. Lawson, R. Heimer. *Doffing the Cap: Increasing Syringe Availability by Law but not in Practice, Connecticut 1999* (forthcoming, 2001).

<sup>56</sup> Me. Rev. Stat. Ann. tit. 17-A, §1110; Minn. Stat. § 151.40(2), 325F.785, 145.924; N.H. Rev. Stat. Ann. §§ 318:52-c(I); N.H. Rev. Stat. Ann. § 318-B:26; N.Y. Public Health Law § 3381;

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The ten-and-under approach appears to cause some confusion or conflict over the legality of particular syringes. Because the legality of a syringe depends, in a partial deregulation system, on factors including where it was obtained and how many others are in the possessor's control, some police officers continue to regard a syringe as illegal unless proven otherwise. In Connecticut, the ambiguous legal status of needles led to continuing reports from SEPs, IDUs and public health officials that police officers were continuing to stop drug users and arrest them for needle possession. The problem eventually came to federal court. In *Doe v. Bridgeport Police Dept.*,<sup>57</sup> a federal judge prohibited the Bridgeport Police Department from stopping, searching, arresting, or threatening any person in possession of less than thirty-one sterile or previously-used needles.

Unrestricted pharmacy sales -- a third variation on deregulation -- emerged in 2000-2002 in Rhode Island, New Mexico, Hawaii and Washington. The Rhode Island legislature repealed its prescription law and eliminated all criminal penalties for syringe possession. The legislature also amended its paraphernalia law to make clear that syringes were not covered by removing its reference to "[h]ypodermic syringes, needles, and other objects intended for use or designed for use in parenterally injecting controlled substances into the human body."<sup>58</sup> The deregulation act requires pharmacists to provide information on drug treatment, HIV prevention and safe disposal practices to purchasers.

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N.Y. Gen. Bus. Law § 853.

<sup>57</sup> *Doe v. Bridgeport Police Department*, 198 F.R.D. 325 (D. Conn., 2001).

<sup>58</sup> 2000 RI H 7949 Substitute A.

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By regulating only *sales*, Rhode Island provides more options for public health distribution of needles at no charge. Thus the Rhode Island law effectively legalizes syringe exchange altogether and could allow other, less formal modes of distribution. (In Rhode Island, syringe exchange programs were previously allowed under a separate provision, R.I. Gen. Laws § 23-11-19,<sup>59</sup> which places the department of health in charge of operating or supervising the program(s).) It should be noted that a deregulation law that confined all *delivery* of syringes to pharmacies would not liberalize free distribution as Rhode Island's law has done, because that term usually embraces all transfers, not just sales. Because it eliminates all criminal penalties for syringe access, Rhode Island's model, like Oregon's, substantially reduces the role of law enforcement as a deterrent to sterile injection.

New Mexico's new policy was less sweeping. It exempted from the paraphernalia law only "the sale or distribution of hypodermic syringes and needles by pharmacists licensed pursuant to the Pharmacy Act."<sup>60</sup> Because it mentioned both sale and distribution, the statute could not reasonably be read to follow Rhode Island in deregulating free distribution. Passed in haste at the end of the legislative session, the law did not as clearly as possible decriminalize the possession of syringes by IDUs, though this appears to have been the intent.

In 2001, the Hawaii legislature passed a temporary act (set to repeal in 2003) that allows a physician, pharmacist or institutional health care employee acting under the supervision of a physician or pharmacist to sell "sterile hypodermic syringes in a pharmacy, physician's office, or health care

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<sup>59</sup> R.I. Gen. Laws § 23-11-19.

<sup>60</sup> N.M. Stat. Ann. § 30-31-25.1(B).

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institution for the purpose of preventing the transmission of dangerous blood-borne diseases.”<sup>61</sup> The law also legalizes possession by the IDU. In contrast to Rhode Island, its language seems by implication to forbid free distribution.

Most recently, Washington’s legislature passed, in 2002, an amendment to the state paraphernalia law exempting syringes distributed through pharmacies (free or for a price) from the paraphernalia law, and stating that “[i]t is lawful for any person over the age of eighteen to possess sterile hypodermic syringes and needles for the purpose of reducing bloodborne diseases.” The law also specified, however, that no pharmacist is required to sell syringes.<sup>62</sup> A section of the bill mandating the provision of materials about drug treatment and proper syringe disposal, and setting other limits on pharmacy sales, was vetoed by the Governor.<sup>63</sup>

//insert Table III about here//

### 5. Drug Possession Laws

Although they are not directed explicitly at syringes, drug possession statutes are also relevant to syringe access. In all but six jurisdictions, controlled substance possession laws embrace or could be interpreted to embrace any measurable amount of drug.<sup>64</sup> See Table IV. This means that the

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<sup>61</sup> 2001 Haw. Sess. Laws, Act 292, § 1.

<sup>62</sup> Wash. Sen. Doc. 1759, 57th Leg., 2002 Reg. Sess. (March 28, 2002).

<sup>63</sup> Wash. Sen. Doc. 1759, 57th Leg., 2002 Reg. Sess. (March 28, 2002).

<sup>64</sup> Danny R. Veilleux, *Minimum Quantity of Drug Required to Support Claim That Defendant Is Guilty of Criminal Possession of Drug under State Law*, 4 American Law Reports 5th 1 (1992); Burris et al., *supra* note 64.

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amount of drug left in the barrel of a syringe after use could be sufficient to ground a conviction for drug possession. This in turn means that a used syringe possessed under circumstances indicative of drug use can legally justify arrest and “search” for drugs both in the syringe and on the person of the possessor. There are reports that IDUs have been prosecuted under these circumstances, and that fear of such prosecutions acts in practical terms to regulate the possession of the syringe itself.<sup>65</sup>

//insert Table IV about here//

The prosecution of IDUs for possession of controlled substances based on the residue of drugs left in a used syringe was challenged in lawsuits in Connecticut and New York. The plaintiffs, who were clients of legal SEPs and (in Connecticut) legal pharmacy purchasers, successfully argued that such prosecutions were illegal under the state laws that had liberalized syringe access.<sup>66</sup> In Connecticut, the federal court held that Connecticut’s syringe exchange and pharmacy-sale laws had not only eliminated criminal penalties for possessing fewer than 31 needles, but also necessarily decriminalized possession of any trace amounts of drug in the used syringe. The court reasoned that

[c]riminalizing the possession of trace amounts of narcotics within decriminalized, previously-used hypodermic syringes and needles would lead to absurd results which would thwart the public health purpose behind the 1992 legislation: discouraging needles and syringe exchange program participants from transporting previously-used

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<sup>65</sup> Doe v. Bridgeport Police Department, 198 F.R.D. 325 (D.Conn., 2001); Roe v. City of New York, 2002 WL 31599522 (S.D. N.Y., 2002).

<sup>66</sup> *Id.*

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injection equipment to the Exchange, and encouraging all drug injecting drug users to hastily and likely improperly abandon now-easily-obtainable injection equipment after one use in order to avoid arrest.<sup>67</sup>

We found no data on the number of people prosecuted and imprisoned for possession of trace amounts of heroin or other injectable drugs. One could reasonably assume that the number is small: there is little glory for prosecutors or police in trying or arresting users, and one can imagine jurors and judges, particularly in big cities, disfavoring efforts to treat small-time use as big time crime. If those assumptions are true, raising the minimum amount of drug possessed necessary to ground a crime to a specified or “usable” amount would not have a real impact on the ability of the state to prosecute and jail people who possessed drugs. Without minimizing the value of data on these points, however, it is likely that the real value to law enforcement of these low possession thresholds is in their facilitation of “street policing.”

It has long been recognized that the strategies and legal interpretations of law enforcement officers on the streets can differ from the law on the books. Police officers have considerable discretion within the rules to use law to control street situations. Dealing with IDUs, they can stop and frisk, question, confiscate syringes, warn or arrest. Arrest does not necessarily have to be aimed at prosecution and conviction upon a major charge, such as drug possession. An officer may simply use the arrest to get a person off the street for a few hours. A charge of possession based on residue possession may be plea-bargained to a lesser charge, still occasioning a period of pre-trial

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<sup>67</sup> *Doe*, 198 F.R.D. 325.

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imprisonment and an addition to the user's criminal record. Many drug users are on probation or parole, so that a drug related arrest or conviction, however minor the charge, may lead to re-incarceration on the original charge.

### *C. Syringe Access By Jurisdiction and Mode*

Identifying what laws a state has relevant to syringe access is only the first step in the analysis of syringe access legality. Leaving aside syringe exchange or deregulation laws, the statutes and regulations discussed above were not written with disease prevention in mind, and frequently leave some room for uncertainty as to their applicability to syringe access initiatives. Even laws that unambiguously prohibit some forms of syringe access may authorize others: syringe prescription laws generally prohibit sales without a prescription, but may not prohibit physicians from prescribing syringes to IDUs. In the absence of an explicit statute or judicial decision on the precise issue, the determination of the legality of a mode of syringe access in a particular state is a matter of professional legal judgement taking into consideration statutory language, legislative intent, case decisions, and social factors. Such legal analysis is constrained to some extent by norms of interpretation within the legal profession, but these constitute outer bounds of plausible reasoning, leaving considerable room for reasonable disagreement. The conclusions below should thus be understood as professionally defensible predictions about how a judge -- the legal official ultimately empowered to say what the law is -- would interpret the law in a state. This is reflected by our use of three categories of legality: "clearly legal" and "clearly illegal" -- both indicating that the plain text of laws or case decisions would

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be deemed by most lawyers to authorize or bar the activity -- and “reasonable claim to legality,” indicating that an attorney could ethically advise a client that the law, while unclear, could be interpreted to allow the conduct at issue. This legal uncertainty is a characteristic and important aspect of syringe access policy and practice.

### 1. Retail Syringe Sale Without a Prescription

In states without a prescription requirement, the main legal influences on the retail sale of syringes are drug paraphernalia laws, and statutes or regulations requiring the buyer to demonstrate a legitimate medical purpose for the purchase. Assessing legality of over-the-counter sales in these states is not always a clear-cut matter. As discussed above, drug paraphernalia laws at most only prohibit the knowing sale of syringes to an IDU; a seller who does not know of the intended use, and is not being willfully blind to clear indications of the user’s intention, does not violate the law. Table V therefore addresses the harder question of whether a knowing sale is legal.

Paraphernalia laws in some states contain exemptions that would cover at least some knowing retail sales. Moreover, nearly all state paraphernalia laws were passed before the HIV epidemic, and were aimed at the sale of non-medical equipment in stores catering to recreational drug users. In many of these states, it is reasonable to conclude that paraphernalia laws were not intended to prohibit sales of a medical device like a syringe in retail establishments not catering primarily to drug users, as part of an effort to reduce HIV transmission. The argument that paraphernalia laws do not apply is particularly strong in the case of pharmacy sales, because pharmacists enjoy special legal status as licensed sellers

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of a wide variety of regulated drugs and devices. This argument is generally *not* reasonable where legislatures have subsequently amended paraphernalia laws to allow SEPs. Amending a paraphernalia law to allow SEPs would not be necessary unless the legislature believed that syringe sales were generally limited by the paraphernalia law. Courts' interpretive custom of interpreting statutes that make a limited exception to continue to bar activity that has not been exempted would lead to the same conclusion.

Retail sales may be restricted to pharmacies by explicit provision of law or regulation, or because the generally applicable law prohibiting sales exempts only pharmacists. Other regulations or syringe laws may also influence sales.

//Insert Table V about here//

## 2. Sale with Prescription

Physicians generally have broad discretion to prescribe drugs and devices they believe will be medically beneficial for patients.<sup>68</sup> A prescription is proper if it is written (1) in good faith, (2) in the course of normal professional practice, and (3) for a legitimate medical purpose in accordance with treatment principles accepted by a responsible segment of the medical profession.<sup>69</sup> For their part,

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<sup>68</sup> B.F. Furrow, T.L. Greaney, S.H. Johnson, T. Jost, and R.L. Schwartz, *Health Law* (1995); California Business & Professional Code Ann. § 2051 (West, 1998); Board of Medical Quality Assurance v. Andrews, 260 Cal.Rptr. 113 (Cal.App., 1989).

<sup>69</sup> L. O. Gostin, *The Legal Environment Impeding Access to Sterile Syringes and Needles: The Conflict between Law Enforcement and Public Health*, 18 Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology S60 (Suppl 1 1998); 21 United States Code § 802(21); 35 Pennsylvania States § 780-111(d); United States v. Rosenberg, 515 F.2d 190, 193 (9<sup>th</sup> Cir. 1975) ; People v. Schade, 32 Cal.Rptr. 2d 59, 69 (1994); C. Vaeth. *Annotation: State Law*

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pharmacists are authorized to dispense medications ordered by a valid prescription and are ordinarily expected to do so in the absence of good reason to refuse.

Burris et al.<sup>70</sup> examined the legality of physician prescription of injection equipment to patients as a means of preventing disease transmission as a consequence of injection drug use. (We have updated their results to take into consideration subsequent changes in state law.) The practice was clearly legal in 49 of the 53 jurisdictions, while dispensing syringes in pharmacies was clearly legal in 28. State law was considered to provide a reasonable claim to legality in two states with respect to prescribing and 21 with respect to dispensing. Prescribing injection equipment was clearly prohibited by law in only two jurisdictions; dispensing was clearly illegal in only three. The legalities of needle distribution through the health care system are thus quite different from those associated with lay distribution through syringe exchanges or pharmacy sale without prescription. See Table VI.

//insert Table VI about here//

### 3. Syringe Exchange

Syringe exchange continues to grow as a mechanism of sterile syringe access. Programs reportedly operating in the United States are summarized in Table VII. In legal terms, syringe exchange programs may be placed into four categories (See Table VIII.). Twelve states and the District of

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*Criminal Liability of Licensed Physician for Prescribing or Dispensing Drug or Similar Controlled Substance*, 13 American Law Reports 5<sup>th</sup> 1 (1994) F.M. McClellan, *Medical Malpractice: Law, Tactics and Ethics* (1994).

<sup>70</sup> Burris, Lurie, Abrahamson, and Rich, *supra* note 36; Burris, Lurie, and Ng, *supra* note 36.

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Columbia have affirmatively authorized syringe exchange programs. Eight states -- Connecticut, Hawaii, Maine, Maryland, New Mexico, Rhode Island and Vermont – and the District have done so by passing laws establishing programs. (In Maryland, SEPs are authorized in Baltimore only. In Vermont and New Hampshire, no SEP has actually been approved to operate by the health department). Two states -- California and Massachusetts – have delegated the decision to allow SEPs by passing legislation authorizing local governments to approve them. In New York, syringe exchange programs are authorized by the Commissioner of Health exercising power granted in the paraphernalia law to waive its application.<sup>71</sup> In Washington state, local health officials secured a declaratory judgement from the state Supreme Court holding that the paraphernalia law did not prohibit them from authorizing syringe exchange programs, a ruling that was later codified by the legislature.

// insert Table VII and Table VIII about here//

Syringe exchanges in three states are presently operating by authority of local government, without explicit authorization from state authorities. In Philadelphia, Allegheny County (PA) and Cleveland, local officials determined that their public health authority extended to authorizing syringe exchange, despite the existence of state laws otherwise limiting syringe access to IDUs. In Chicago, local law enforcement and health officials have interpreted a “research” exemption from the paraphernalia law to encompass syringe exchange programs. While these interpretations are legally debatable, they are also legally reasonable and have proven a politically expedient way to operate SEPs in states unlikely to change their law. In five states, the law does not regulate the free distribution

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<sup>71</sup> N.Y. Public Health Law § 3381.

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of syringes, and therefore does not prohibit syringe exchange.

Syringe exchange programs operate in at least nineteen states without a specific claim to legality. The law in these states may or may not clearly forbid SEPs, but these SEPs nevertheless are able to operate through more or less tacit arrangements with law enforcement authorities. In some of these states, such as Massachusetts, illegal exchanges operate along with legally authorized ones, usually in areas where legal exchange does not operate or is regarded as insufficient by the non-sanctioned exchange providers. Where there is no explicit authorization for SEPs, the legality of syringe exchange or other modes of free distribution depends upon the specific language and case law under any applicable syringe prescription, drug paraphernalia and pharmacy practice laws. Based on a review of reported cases, New Jersey is the only state without any legal needle access in which lay exchangers have actually been convicted of a syringe law violation. The fact that an exchange operates without a clear legal basis does not necessarily mean that such a basis could not be identified. In Colorado, for example, local governments have substantial authority to deal with local health threats, and so a city would have a reasonable basis for authorizing an SEP under its own authority. Research has not been performed on the legal authority of most cities to authorize syringe exchange.

Syringe exchanges explicitly authorized by statute are subject to a variety of rules concerning the way they may distribute syringes and the services they must offer. Strict one-for-one exchange policies are often required by policy makers to placate concerns that SEP could lead to an increase in improperly discarded syringes or encourage initiation of injection among youth.<sup>72</sup> These rules, which

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<sup>72</sup> Lurie et al., *supra* note 10.

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like the “ten and under” cap reflect political rather than public health imperatives, may have in some instances a significant impact on the effectiveness of official SEPs, and may explain why illegal or unofficial SEPs may continue to operate in states that have authorized legal programs. These limits are summarized in Table IX. SEP operating policies not explicitly required by applicable law may also influence syringe access. For example, some SEPs follow a “high access” model that focuses on direct contact with each IDU, rather than a “high volume” model that aims for maximum dissemination of syringes. Some high-access -SEPs have actively discouraged secondary exchange -- giving large numbers of syringes to exchange clients with the expectation that they will be given or sold to others -- despite some evidence that secondary exchange could enhance the effectiveness of syringe exchange.<sup>73</sup>

//insert Table IX about here//

### *D. Syringe Disposal*

Syringe disposal has emerged as another important facet of syringe access policy. The prospect of providing syringes to IDUs sometimes triggers concerns that needles contaminated with HIV will be carelessly discarded in schoolyards or other inappropriate places. In Windham, Connecticut, the SEP was closed in significant part because of allegations that users were discarding

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<sup>73</sup> C. A. Latkin, and V.L. Forman, *Patterns of Needle Acquisition and Sociobehavioral Correlates of Needle Exchange Program Attendance in Baltimore, Maryland, U.S.A*, 27 *Journal of Acquired Immune Deficiency Syndromes* 398 (2001); T. W. Valente, R. K. Foreman, B. Junge, and D. Vlahov, *Satellite Exchange in the Baltimore Needle Exchange Program*, 113 *Suppl 1 Public Health Reports* 90 (1998).

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needles in the surrounding community.<sup>74</sup> Generally, however, an effective mechanism for safe syringe disposal is inherent in the SEP intervention. Disposal is an explicit part of SEP regulation in only four states, but SEPs typically provide one new syringe for every used syringe turned in, or in some other way tie the number of needles given out to the number brought back. Thus syringe exchange programs do not increase the time that potentially contaminated syringes circulating in the community and, indeed, reduce the number of inappropriately discarded ones.<sup>75</sup> Empirical studies of discarded syringes in the vicinity of syringe exchange programs have documented the absence of increases in unsafely discarded syringes.<sup>76</sup>

The disposal issue has loomed even larger in the development of deregulation policies, because deregulation laws may expand syringe availability without necessarily providing new means of safe disposal. Recent deregulation laws, including Minnesota's and New York's, have dealt with the disposal question by mandating information on disposal for buyers and encouraging voluntary disposal programs or referral efforts by sellers. A pre- and post-deregulation study by the Minnesota

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<sup>74</sup> R. S. Broadhead, *The Impact of a Needle Exchange's Closure*, 114 *Public Health Reports* 439 (1999).

<sup>75</sup> K. J. Oliver, S. R. Friedman, H. Maynard, L. Magnuson, and D. C. Des Jarlais, *Impact of a Needle Exchange Program on Potentially Infectious Syringes in Public Places*, 5 *Journal of Acquired Immune Deficiency Syndromes* 534 (1992); M. C. Doherty, R. S. Garfein, D. Vlahov, B. Junge, P. J. Rathouz, N. Galai, J. C. Anthony, and P. Beilenson, *Discarded Needles Do Not Increase Soon after the Opening of a Needle Exchange Program*, 145 *American Journal of Epidemiology* 730 (1997).

<sup>76</sup> Doherty, Garfein, Vlahov, Junge, Rathouz, Galai, Anthony, and Beilenson, *supra* note 75; Oliver, Friedman, Maynard, Magnuson, and Des Jarlais, *supra* note 75.

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Department of Health found that the proportion of IDUs using officially approved means of syringe disposal did not change after pharmacy sales were legalized (remaining at about 20%). “Although most disposal methods used by IDUs were classified as being unsafe, most of these methods did not pose a serious threat to the general public .... Over 94% of these unsafe methods included some variation of the following: placing a capped syringe in a soda can or other container that is then crushed and thrown in the trash.”<sup>77</sup> But if the early evidence is that pharmacy availability does not make the disposal problem worse --- i.e. does not lead to disposal in parks and so on -- it also points to the overall lack of safe disposal options for needles used outside the health care system.

Over 3 billion syringes are used each year in community settings (i.e., outside health care facilities), and are deposited in the general waste stream in the United States.<sup>78</sup> Discarded needles are a source of injury and anxiety to workers in trash disposal, recycling, and related activities. Most of these syringes come from people administering medications for conditions such as diabetes, but many are attributable to injection drug users IDUs.<sup>79</sup> The American Medical Association’s Council on Scientific Affairs, summarizing the results of a national conference on disposal, reported that “there are no defined

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<sup>77</sup> N. U. Cotten-Oldenburg, P. Carr, J.M. DeBoer, et. al., *Impact of Pharmacy-Based Syringe Access on Injection Practices among Injecting Drug Users in Minnesota, 1998 to 1999*, 27 *Journal of Acquired Immune Deficiency Syndromes* 183 (2001).

<sup>78</sup> "Disposing of Hypodermics: Stuck with a Needle Problem." *American Medical News* (07.30.01).

<sup>79</sup> G. E. Macalino, K. W. Springer, Z. S. Rahman, D. Vlahov, and T. S. Jones, *Community-Based Programs for Safe Disposal of Used Needles and Syringes*, 18 Suppl 1 *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology* S111 (1998).

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regulations or laws that guide the disposal of sharps in the community.’<sup>80</sup> While states may have their own system for handling the community disposal of used sharps, “many are not successful and guidelines that do exist are conflicting and often inappropriate. This has led to confusion among stakeholders regarding the proper disposal of used sharps in the community”.<sup>81</sup> Only a few communities have locally-administered programs for syringe disposal.<sup>82</sup>

The problem is not just a lack of regulation, but also the effects of substantial regulation that pertains to but does not fully address community syringe disposal. Dealing with sharps puts any policy reformer at the intersection of several complex, overlapping regulatory systems. Discarded syringes may be subject to regulation under general state solid waste management statutes, or under specific statutes dealing with medical waste.<sup>83</sup> These, however, often exempt syringes generated in individual, community use. The Occupational Safety and Health Administration’s Bloodborne Pathogen standard applies to workers who may reasonably anticipate coming into contact with used syringes.<sup>84</sup> The

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<sup>80</sup> American medical Association, Council on Scientific Affairs, Safe Disposal of Syringes, Needles, and Other Sharps in the Community (Report A-01, 2001). Available at <http://www.ama-assn.org/ama/pub/article/2036-4965.html>.

<sup>81</sup> *Id.*

<sup>82</sup> Macalino, Springer, Rahman, Vlahov, and Jones, *supra* note 79; E. Riley, P. Beilenson, D. Vlahov, L. Smith, M. Koenig, T. S. Jones, and M. Doherty, *Operation Red Box: A Pilot Project of Needle and Syringe Drop Boxes for Injection Drug Users in East Baltimore*, 18 Suppl 1 Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology S120 (1998).

<sup>83</sup> Ala. Code § 22-27-1 to -7; Alabama Department of Environmental Management Admin Code R. 335-13-7.01 – .10.

<sup>84</sup> 29 CFR Part 1910.1030.

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standard requires employers to write an Exposure Control Plan setting out tangible steps for reducing worker risk as set out in the rule. Some states have created voluntary guidelines for community disposal, advising syringe users, for example, to dispose of syringes in coffee cans or plastic milk containers. Use of the mail as a means of returning community syringes for proper disposal is governed by U.S. Postal Service Regulations and some states' solid waste law.<sup>85</sup> Finally, the array of laws governing syringe and drug possession may also influence disposal, to the extent that fear of arrest may make IDUs unwilling to follow through on safe disposal of their used, blood-contaminated syringes.<sup>86</sup>

Many of these regulations may raise the cost or limit the options for any agency, business or community group willing to undertake responsibility for disposal. At the same time, the overlapping of jurisdiction leaves unclear who is ultimately responsible for syringes disposed in the community. Of course, a system of syringe disposal is not free, adding the difficult question of who should bear the cost to the policy dilemma. Although the data are only now being systematically collected, there are reports of agencies at the state and local level developing community syringe disposal models, and waste management providers have experimented with mail-back disposal systems in at least one state. Developing a coordinated approach and appropriate funding mechanism for collecting community-generated syringes is an important policy priority that may require legislative action at the state or federal level.

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<sup>85</sup> 39 CFR Part 111.1.

<sup>86</sup> K. W. Springer, C. E. Sterk, T. S. Jones, and L. Friedman, *Syringe Disposal Options for Injection Drug Users: A Community-Based Perspective*, 34 *Substance Use & Misuse* 1917 (1999); Cotten-Oldenburg, Carr, DeBoer, et al., *supra* note 77.

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To the extent that safe systems of community sharps disposal are implemented, the syringe access laws set out earlier may act as barriers to participation by IDUs. Community disposal programs usually require the participant to dispose of syringes in specially designed or labeled containers placed in regular trash, or to take the needles to a designated community disposal site.<sup>87</sup> In either case, an IDU would have to accumulate used needles, many of which would contain drug residues, and dispose of them in a way or in a place that makes concealment difficult. To the extent that possession or use of syringes for drug use, or possession of trace amounts of illegal drug, are crimes, participating in safe disposal creates a legal risk for IDUs. As one IDU put it, “They’d [the police] catch you with a dirty syringe and you’d go to jail for possession, so people ain’t hardly gonna keep ‘em laying around, keep ‘em in a container or whatever.”<sup>88</sup>

Burris and colleagues reviewed syringe access and drug possession laws to determine whether they could be interpreted to criminalize the possession of a used syringe by an IDU.<sup>89</sup> Drug possession laws could be applied to trace amounts in 47 jurisdictions. Taking into account the two jurisdictions without a paraphernalia law, the fourteen states that have authorized at least some possession of syringes (through deregulation, syringe exchange legislation or otherwise), and six other jurisdictions whose paraphernalia laws regulate only sale (MA, MI, VT, VA, WV, WY), the study found 31 jurisdictions whose paraphernalia laws make it a crime for an IDU to possess a used syringe. In three

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<sup>87</sup> Macalino, Springer, Rahman, Vlahov, and Jones, *supra* note 79.

<sup>88</sup> Springer, Sterk, Jones, and Friedman, *supra* note 86.

<sup>89</sup> Burris, Welsh et al., *supra* note 64.

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of these (AZ, DE, ND), the crime is a felony. Prescription laws in seven jurisdictions (CA, DE, IL, NV, NJ, VA, VI) also prohibit possession of syringes without a prescription. Together, these provisions operate to create at least potential criminal liability for IDUs participating in safe disposal activities in all but two states. See Table X.

//insert Table X about here//

From a policy perspective, the most significant finding of the study is that these barriers exist even in most of the states that have deliberately adopted policies affording IDUs legal access to syringes (and indeed even in states that have mandated that syringe purchasers be given information about safe disposal). In these states, the specific barrier is usually a drug possession provision, which may not have been addressed because of a lack of awareness of the way that drug possession laws are tied to disposal, or because of political reluctance to “weaken” drug possession laws by excluding the possession of residue. In some states, the failure to remove barriers to disposal may also reflect the legal complexity of syringe access and drug possession law: in New Mexico, for example, legislation to ease syringe access removed legal barriers to the sale of syringes to IDUs, but apparently inadvertently did not legalize their possession once purchased.<sup>90</sup> Nevertheless, some policy makers have recognized and addressed the problem in part: in DC and MD, syringe exchange legislation explicitly immunized SEP clients (though not other IDUs) from prosecution for the possession of residues.

## **V. Research Regarding The Effects of Syringe Access Policies**

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<sup>90</sup> Controlled Substances Act, New Mexico Statutes Annotated § 30-31-25.1(2002).

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Both sides in the debate over enhancing syringe access frequently rely on health research data to support their positions. There exists a large body of literature on injection drug use, law and health, although several questions that have been crucial in policy debate have not been clearly answered. In this section, we will highlight research addressing the most salient factual issues for policy. These issues are whether restrictive syringe access laws do indeed influence the ability of IDUs to purchase syringes, whether removing some or all legal barriers to syringe access is effective in enhancing syringe access and reducing needle sharing, and whether changes in syringe law have adverse health or societal consequences, such as increasing drug use or crime. Although the research generally is of high quality – it has, as we observed at the outset, convinced us of the value of syringe access to public health -- there are methodological limitations associated with studying syringe access. There is also a paucity of research in specific areas such as the effects of deregulation of syringe laws or pharmacy access. Because sound policy depends upon sound data, and because policy debates are often framed in terms of empirical evidence, we conclude by discussing the limits of data and the implications of those limits for policy development.

### *A. The Effects of Syringe Access Laws on the Ability of IDUs to Purchase Syringes*

Syringe access laws were intended to prevent IDUs from obtaining syringes. Research shows that syringe laws do not prevent IDUs from obtaining the syringes they need for injecting drugs, but they generally do make it more difficult for IDUs to obtain syringes and keep *sterile* syringes in their possession.

The effect of these laws varies with their specific type and stringency. Prescription laws appear

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to have the most consistently negative impact on syringe access. They are unambiguous, leaving the pharmacist virtually no discretion. They generally entail the maintenance of records that can be reviewed by pharmacy or drug-control authorities, heightening their deterrent effect. Possession of a syringe without a prescription is also a crime under these laws, which have been found to be regularly enforced in states where research has been done.<sup>91</sup> An immediate effect is seen in the price of “street” syringes: a survey of SEP personnel in eighteen states found that street prices rose steadily and substantially according to whether there was no syringe possession law, an unenforced law or an enforced law. These results were significant at the .01 level.<sup>92</sup> Friedman and colleagues found that prescription laws in the United States were associated with a higher incidence and prevalence of HIV infection.<sup>93</sup>

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<sup>91</sup> J. Lopez-Zetina, P. Kerndt, W. Ford, T. Woerhle, and M. Weber, *Prevalence of HIV and Hepatitis B and Self-Reported Injection Risk Behavior During Detention among Street-Recruited Injection Drug Users in Los Angeles County, 1994-1996*, 96 *Addiction* 589 (2001); P. Case, *Arrests and Incarceration of Injection Drug Users for Syringe Possession in Massachusetts: Implications for HIV Prevention*, 18 *Suppl 1 Journal of Acquired Immune Deficiency Syndromes* S71 (1998); J. D. Rich, and C.K. Foisie, *High Street Prices of Syringes Correlate with Strict Syringe Possession Laws*, 26 *American Journal of Drug & Alcohol Abuse* 481 (2000); J. D. Rich, Brian P. Dickenson, Kai-Lih Lie, and Patricia Case, *Strict Syringe Laws in Rhode Island Are Associated with High Rates of Reusing Syringes and HIV Risks among Injection Drug Users (Letter)*, 18 *Journal of Acquired Immune Deficiency Syndromes* S140 (1998).

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<sup>92</sup> Rich and Foisie, *supra* note 91.

<sup>93</sup> S. R. Friedman, T. Perlis, and D. C. Des Jarlais, *Laws Prohibiting over-the-Counter Syringe Sales to Injection Drug Users: Relations to Population Density, HIV Prevalence, and HIV Incidence*, 91 *American Journal of Public Health* 791 (2001); *see also* Rich, Dickenson, Lie, and Case, *supra* note 91.

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Prescription laws indirectly prohibit SEP operation and have been used to prosecute syringe exchange personnel.<sup>94</sup> In 1996, nearly a quarter of SEPs operating in the United States were illegal underground programs.<sup>95</sup> The same year, over half of all SEPs in the USA reported police harassment of clients, and one quarter reported police harassment of SEP staff or volunteers.<sup>96</sup> At least three dozen SEP volunteers have been arrested in 21 cities and 8 states since 1986.<sup>97</sup> Although few studies have assessed the impact of police pressure on SEP activities, some studies have reported that such arrests have reduced SEP attendance, limited their expansion, and may have increased the length of time contaminated needles circulated on the streets.<sup>98</sup> Heimer and colleagues concluded that “among the many structural impediments SEPs face, none may be more important than their legal status.”<sup>99</sup>

Because syringes are normally sold in pharmacies, pharmacy regulations, which are directed

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<sup>94</sup> Burris, Finucane, Gallagher, and Grace, *supra* note 13.

<sup>95</sup> D. Paone, J. Clark, Q. Shi, D. Purchase, and D. C. Des Jarlais, *supra* note 23.

<sup>96</sup> R. N. Bluthenthal, A. H. Kral, E. A. Erringer, and B. R. Edlin, *Use of an Illegal Syringe Exchange and Injection-Related Risk Behaviors among Street-Recruited Injection Drug Users in Oakland, California, 1992 to 1995*, 18 *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology* 505 (1998).

<sup>97</sup> R. N. Bluthenthal, *Syringe Exchange as a Social Movement: A Case Study of Harm Reduction in Oakland, California*, 33 *Substance Use & Misuse* 1147 (1998); Lurie et al., *supra* note 10.

<sup>98</sup> R. N. Bluthenthal, *Impact of Law Enforcement on Syringe Exchange Programs: A Look at Oakland and San Francisco*, 18 *Medical Anthropology* 61 (1997); R Heimer, R.N. Bluthenthal, M Singer, and K Khoshnood, *Structural Impediments to Operational Syringe-Exchange Programs*, 11 *AIDS and Public Policy Journal* 169 (1996).

<sup>99</sup> Heimer, Bluthenthal, Singer, and Khoshnood, *supra* note 98.

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primarily at pharmacists, are probably almost as significant a barrier to syringe access as prescription requirements.<sup>100</sup> Being required to show ID, or to prove medical need (e.g., diabetes), may deter many IDUs from even trying to purchase syringes. Research indicates that pharmacists are generally aware of, and are intent on complying with, pharmacy regulations.<sup>101</sup> Unlike prescription laws, these pharmacy regulations allow pharmacists a fair amount of discretion. For example, a South Carolina pharmacist may decide that preventing bloodborne disease is a “legitimate medical purpose” justifying sale, or accept without further inquiry into the buyer’s claim to be a diabetic. In recent years, pharmacy boards in Washington, Maine, Maryland and Nevada have taken formal or informal action to encourage pharmacists to exercise their discretion to sell syringes to IDUs.

Paraphernalia laws appear to be enforced against IDUs who possess syringes. Seven of 147 IDUs in a 1995 Connecticut study reported recent paraphernalia arrests, as did plaintiffs and witnesses in a recent Connecticut law suit.<sup>102</sup> Ethnographic and survey research among IDUs has repeatedly

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<sup>100</sup> J. A. Taussig, B. Weinstein, S. Burris, and T. S. Jones, *Syringe Laws and Pharmacy Regulations Are Structural Constraints on HIV Prevention in the US*, 14 Suppl 1 AIDS S47 (2000).

<sup>101</sup> A. A. Gleghorn, G. Gee, and D. Vlahov, *Pharmacists' Attitudes About Pharmacy Sale of Needles/Syringes and Needle Exchange Programs in a City without Needle/Syringe Prescription Laws*, 18 J Acquir Immune Defic Syndr S89 (1998); P. Case, T. Meehan, and T.S. Jones, *Access to Sterile Syringes in Maine: Pharmacy Practice after the 1993 Repeal of the Syringe Prescription Law*, 18 Suppl 1 Journal of Acquired Immune Deficiency Syndromes S94 (1998).

<sup>102</sup> J-P C Grund, D D Heckathorn, R S Broadhead, and D Anthony, *In Eastern Connecticut, IDUs Purchase Syringes from Pharmacies but Don't Carry Syringes (Letter)*, 10 Journal of Acquired Immune Deficiency Syndromes 104 (1995); Doe v. Bridgeport Police Department, 198 F.R.D. 325 (D. Conn., 2001); Doe v. Bridgeport Police Department, 198 F.R.D. 325 (D. Conn., 2001); accord Rich and Foise, *supra* note 42, at 484.

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found that fear of arrest is a factor in whether or not IDUs carry their own syringes with them when they are purchasing and using drugs.<sup>103</sup> Arrests, or fear of arrest, can lead to circumstances where needle sharing is inevitable.<sup>104</sup>

The effect of paraphernalia laws on IDU's ability to *purchase* syringes is uncertain, in large part because the applicability of paraphernalia laws to pharmacy sales is unclear.<sup>105</sup> Although the language of the typical paraphernalia law would embrace the knowing sale of a syringe to an IDU for drug consumption, paraphernalia laws do not require pharmacists to question a syringe purchaser about the intended use. A search of reported cases by Burris and colleagues found no instance in which a pharmacist had been prosecuted under a paraphernalia law or pharmacy regulation for improperly selling a syringe.<sup>106</sup> Research among pharmacists indicates that most are either not specifically aware of

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<sup>103</sup> S. Koester, *Copping, Running, and Paraphernalia Laws: Contextual and Needle Risk Behavior among Injection Drug Users in Denver*, 53 *Human Organization* 287 (1994); P. Bourgois, *The Moral Economies of Homeless Heroin Addicts: Confronting Ethnography, HIV Risk, and Everyday Violence in San Francisco Shooting Encampments*, 33 *Substance Use & Misuse* 2323 (1998); M.C. Clatts, J. L. Sotheran, P. A. Luciano, T. M. Gallo, and L. M. Kochems, *The Impact of Drug Paraphernalia Laws on HIV Risk among Persons Who Inject Illegal Drugs: Implications for Public Policy*, in *How to Legalize Drugs* 80 (J.M. Fish ed., 1998); J. P. Grund, L. S. Stern, C. D. Kaplan, N. F. Adriaans, and E. Drucker, *Drug Use Contexts and HIV-Consequences: The Effect of Drug Policy on Patterns of Everyday Drug Use in Rotterdam and the Bronx*, 87 *British Journal of Addiction* 381 (1992); D. Metzger, G. Woody, D. De Philippis, A. T. McLellan, C. P. O'Brien, and J. J. Platt, *Risk Factors for Needle Sharing among Methadone-Treated Patients*, 148 *American Journal of Psychiatry* 636 (1991).

<sup>104</sup> Koester, *supra* note 103.

<sup>105</sup> Burris, Lurie, Abrahamson, and Rich, *supra* note 36.

<sup>106</sup> *Id.*

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paraphernalia laws or that these laws do not figure heavily into their decisions to sell syringes.<sup>107</sup>

Paraphernalia laws have been a barrier to SEPs, though in several states they have been interpreted by courts or local officials not to bar exchange programs.<sup>108</sup>

Studies examining deregulation also suggest that the legal rules governing syringe access and possession influence drug users' behaviors, although changes in law may not immediately have their intended effects. Despite a 1992 change in Connecticut state laws that allowed the purchase of up to ten syringes without a prescription, only 30% of IDUs surveyed after the new law took effect reported that they regularly carried their own syringes. The majority (65%) cited fear of arrest as their main reason for not carrying syringes in public.<sup>109</sup> (Nevertheless, over a three year period in Connecticut (1992-1995), the proportion of IDUs who shared syringes decreased from 71% to 29%).<sup>110</sup> A

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<sup>107</sup> S.K. Koester, B.A. White, T.W. Bush, and C.E. Christiansen, Role of Pharmacists in Increasing Sterile Syringe Accessibility: A Formative Study (Paper presented at the National HIV Prevention Conference, Atlanta, 1999); C. E. Sterk, J. A. Taussig, and B. Junge, Pharmacists' Syringe Sale Practices with Injection Drug Users in Atlanta, Georgia (Paper presented at the National HIV Prevention Conference, Atlanta, 1999); M. Singer, *Pharmacy Access to Syringes among Injecting Drug Users: Follow-up Findings from Hartford, Connecticut*, 113 Suppl 1 Public Health Reports 81 (1998); Case, Meehan, and Jones, *supra* note 101 ; Singer, *supra* note 107; Gleghorn, Gee, and Vlahov, *supra* note 101; J. A. Taussig, B. Junge, S. Burris, T. S. Jones, and C. E. Sterk, *Individual and Structural Influences Shaping Pharmacists' Decisions to Sell Syringes to Injection Drug Users in Atlanta, Georgia* (forthcoming 2002).

<sup>108</sup> Burris, Finucane, Gallagher, and Grace, *supra* note 13.

<sup>109</sup> Grund, Heckathorn, Broadhead, and Anthony, *supra* note 102.

<sup>110</sup> T. Diaz, S.Y. Chu, B. Weinstein, E. Mokotoff, and T.S. Jones, *Injection and Syringe Sharing among HIV-Infected Injection Drug Users: Implications for Prevention of HIV Transmission*, 18 Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology S76 (1998).

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Minnesota study comparing IDUs' behaviors before and after the state legislation repealed syringe prescription laws found that IDUs were more likely to purchase syringes and were less likely to share needles, but there were no changes in the proportions who carried or re-used syringes, or safely disposed of syringes.<sup>111</sup> In their report of needle use practices in Seattle, Washington, where needle purchase is legal, Calsyn and colleagues (1991)<sup>112</sup> observed lower rates of needle sharing compared to regions where needle purchase and possession was illegal. Furthermore, a recent analysis suggests that such restrictions on syringe access have in fact influenced HIV acquisition. In an analysis of 96 metropolitan areas in the US, Friedman et al.<sup>113</sup> found that metropolitan areas with anti-over-the-counter syringe laws had a significantly higher mean HIV prevalence (13.8% vs 6.7%) than other metropolitan areas. These authors concluded that laws restricting syringe access are associated with HIV transmission and should be repealed. However, the impact of a repeal in syringe prescription laws may be limited in settings where paraphernalia and possession laws persist.

In the majority of U.S. states, which have only a paraphernalia law and perhaps some pharmacy regulations, the sale of syringes to IDUs is largely at the discretion of the individual pharmacist. Pharmacists vary considerably in their willingness to sell syringes, as well as in the prices

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<sup>111</sup> Cotten-Oldenburg, Carr, DeBoer, et al., *supra* note 77.

<sup>112</sup> D. A. Calsyn, A. J. Saxon, G. Freeman, and S. Whittaker, *Needle-Use Practices among Intravenous Drug Users in an Area Where Needle Purchase Is Legal*, 5 AIDS 187 (1991).

<sup>113</sup> Friedman, Perlis, and Des Jarlais, *supra* note 93.

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they charge.<sup>114</sup> Race, gender and over-all appearance were related to the ability to purchase syringes in some but not all experimental syringe buying studies.<sup>115</sup> Store or chain policies were identified as important factors in some studies.<sup>116</sup> Pharmacists also report restrictive sales practices not required by law. These include requiring the buyer to provide photo identification, a prescription, a diabetes ID, or the name and address of a doctor.<sup>117</sup> Law, particularly pharmacy law, appears to play into pharmacists' decisions to sell syringes to IDUs, but other factors, such as store or chain policies, attitudes towards IDUs and harm reduction, or fear that selling syringes to IDUs will attract an unsavory clientele are also important.<sup>118</sup> Studies of pharmacist syringe sale practices suggest that attitudes

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<sup>114</sup> Koester, *supra* note 103; Broadhead, *supra* note 74; Cottler L Compton W, Decker S, Mager D, Stringfellow R, *Legal Needle Buying in St. Louis*, 82 American Journal of Public Health 595 (1992); Case, Meehan, and Jones, *supra* note 101; C. R. Harbke, D. G. Fisher, H. H. Cagle, B. N. Trubatch, A. M. Fenaughty, and M. E. Johnson, *Telephone Survey of Alaskan Pharmacists' Nonprescription Needle-Selling Practices*, 77 Journal of Urban Health 113 (2000). B. N. Trubatch, D. G. Fisher, H. H. Cagle, A. M. Fenaughty, and M. E. Johnson, *Nonprescription Pharmacy Sales of Needles and Syringes*, 90 American Journal of Public Health 1639 (2000); F.S. Bridges, J.P. Ramsey, and J.C. Santana, *Sale of Nonprescription Syringes to Men and Women-Florida, 1994-1995*, 1 Florida Journal of Pharmacy 12 (1998).

<sup>115</sup> J.P. Ramsey, and F.S. Bridges, *Purchase Denials of Legal Injection Equipment to Women in South Florida* (paper presented at the HIV Infected Women Conference, 1995); Trubatch, Fisher, Cagle, Fenaughty, and Johnson, Compton W, *supra* note 114; Koester, *supra* note 103; Bridges, Ramsey, and Santana, *supra* note 114.

<sup>116</sup> Harbke, Fisher, Cagle, Trubatch, Fenaughty, and Johnson, *supra* note 114.

<sup>117</sup> Case, Meehan, and Jones, *supra* note 101; Gleghorn, Gee, and Vlahov, *supra* note 101; Taussig, et al., *supra* note 107.

<sup>118</sup> T. Myers, R. Cockerill, C. Worthington, M. Millson, and J. Rankin, *Community Pharmacist Perspectives on HIV/AIDS and Interventions for Injection Drug Users in Canada*, 10 AIDS Care 689 (1998); Harbke, Fisher, Cagle, Trubatch, Fenaughty, and Johnson, *supra* note 114.

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towards the activity are more important to pharmacist behavior than law, at least in states not requiring a prescription.

While laws clearly have a serious impact on access to equipment and its use, law is not the only factor. Individual-level factors, gender dynamics, social norms and the need to relieve symptoms of withdrawal are also important determinants of needle sharing behaviors.<sup>119</sup> Even in settings where there are no legal limits to sterile syringe acquisition by IDUs (e.g., Holland)<sup>120</sup> needle sharing has not been entirely eliminated. However, it is clear that this is not a necessary requirement since cities such as New York and Amsterdam have essentially reversed their HIV epidemic among IDUs without eliminating needle sharing altogether.<sup>121</sup> Nevertheless, the evidence supports the view that changing policy can have the desired effect of decreasing needle sharing levels in a community, and in turn, decreasing the likelihood of an HIV epidemic. An important goal is to determine the optimal levels of sterile syringe coverage that are required to prevent or reverse an epidemic of HIV or other blood borne infections.

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<sup>119</sup> C. Latkin, W. Mandell, D. Vlahov, M. Oziemkowska, and D. Celentano, *People and Places: Behavioral Settings and Personal Network Characteristics as Correlates of Needle Sharing*, 13 *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology* 273 (1996); S. A. Strathdee, D. M. Patrick, C. P. Archibald, M. Ofner, P. G. Cornelisse, M. Rekart, M. T. Schechter, and M. V. O'Shaughnessy, *Social Determinants Predict Needle-Sharing Behaviour among Injection Drug Users in Vancouver, Canada*, 92 *Addiction* 1339 (1997).

<sup>120</sup> van den Hoek, van Haastrecht, and Coutinho,

<sup>121</sup> E. J. van Ameijden, and R. A. Coutinho, *Maximum Impact of HIV Prevention Measures Targeted at Injecting Drug Users*, 12 *AIDS* 625 (1998); D. Des Jarlais, T. Perlis, S. R. Friedman, T. Chapman, J. Kwok, R. Rockwell, D. Paone, J. Milliken, and E. Monterroso, *Behavioral Risk Reduction in a Declining HIV Epidemic: Injection Drug Users in New York City, 1990-1997*, 90 *American Journal of Public Health* 1112 (2000).

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*Summary:* Available data indicate that syringe access laws make it harder for IDUs to obtain new syringes, and create disincentives to carry them. While these laws do interfere with access to and use of new, sterile syringes, they do not prevent IDUs from getting some sort of syringe and injecting drugs. In most places in the United States, pharmacists make the decision about whether or not an IDU will be able to purchase a sterile syringe. Law has some influence on this decision, but a number of surveys of pharmacists attitudes and practices indicate that other considerations, including views on health and drug use, play a stronger role. Thus although syringe access law is clearly an important factor in determining whether IDUs will have and use sterile syringes, it is only one of many.

### *B. Evidence of the Health Effects of Syringe Access Initiatives*

Data on the effectiveness of syringe access has been reviewed extensively elsewhere.<sup>122</sup> In this section, we briefly recount the main findings.

Almost all of the international literature investigating syringe access and health effects has focused on the relationship between SEPs and blood borne infections. SEPs have been associated with a number of positive health outcomes. As early as 1986, Buning and colleagues from Amsterdam

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<sup>122</sup> Normand, Vlahov, and Moses, *supra* note 10; Lurie et al., *supra* note 10; D. R. Gibson, N. M. Flynn, and D. Perales, *Effectiveness of Syringe Exchange Programs in Reducing HIV Risk Behavior and HIV Seroconversion among Injecting Drug Users*, 15 AIDS 1329 (2001); Strathdee, and Vlahov, *supra* note 9 ; F. I. Bastos, and S. A. Strathdee, *Evaluating Effectiveness of Syringe Exchange Programmes: Current Issues and Future Prospects*, 51 Social Science & Medicine 1771 (2000).

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reported declines in needle sharing and injection frequency associated with SEP participation.<sup>123</sup> Other studies subsequently reported reductions in incidence of HIV, HBV and HCV infections, decreased needle sharing among HIV-negative and HIV-positive persons, decreases in syringe re-use and increased rates of entry into drug treatment programs.<sup>124</sup>

In the United Kingdom and Australia, where SEPs were introduced early and vigorously within the context of a comprehensive prevention program including expanded methadone maintenance programs, HIV epidemics among IDUs have been essentially averted.<sup>125</sup> Despite variations between programs, a recent international comparison showed that in 29 cities with established SEPs, HIV prevalence decreased on average by 5.8% per year, but increased on average by 5.9% per year in 51 cities without SEPs.<sup>126</sup> In New York City, SEPs have been associated with a dramatic decline in HIV

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<sup>123</sup> E. C. Buning, R. A. Coutinho, G. H. van Brussel, G. W. van Santen, and A. W. van Zadelhoff, *Preventing AIDS in Drug Addicts in Amsterdam*, 1 *Lancet* 1435 (1986).

<sup>124</sup> Strathdee, and Vlahov, *supra* note 9.

<sup>125</sup> A. Wodak, and P. Lurie, *A Tale of Two Countries: Attempts to Control HIV in Australia and the United States*, *Journal of Drug Issues* 117 (1997); G. V. Stimson, *AIDS and Injecting Drug Use in the United Kingdom, 1987-1993: The Policy Response and the Prevention of the Epidemic*, 41 *Social Science & Medicine* 699 (1995); G. V. Stimson, *Has the United Kingdom Averted an Epidemic of HIV-1 Infection among Drug Injectors?* 91 *Addiction* 1085 (1996); D. C. Des Jarlais, H. Hagan, S. R. Friedman, P. Friedmann, D. Goldberg, M. Frischer, S. Green, K. Tunving, B. Ljungberg, and A. Wodak, *Maintaining Low HIV Seroprevalence in Populations of Injecting Drug Users*, 274 *JAMA* 1226 (1995).

<sup>126</sup> S. F. Hurley, D. J. Jolley, and J. M. Kaldor, *Effectiveness of Needle-Exchange Programmes for Prevention of HIV Infection*, 349 *Lancet* 1797 (1997).

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incidence, indicating an HIV epidemic among IDUs that has essentially been reversed.<sup>127</sup> To date, this study represents some of the most compelling evidence in favor of SEPs, prompting New York City health officials to launch an expanded syringe access initiative involving pharmacists and registered physicians who are actively prescribing syringes to IDUs.

In contrast to the above findings, two studies have not found SEPs to have a protective effect on the risk of acquiring HIV infection. In 1997, an outbreak of HIV infection was described among IDUs in Vancouver, Canada despite the existence of a high volume SEP that had been introduced early.<sup>128</sup> In Montreal, Canada, SEP attenders were reported to have higher HIV incidence rates than non-attenders.<sup>129</sup> Both studies fanned the flames of controversy surrounding NEP effectiveness in the United States. However, in Canada these data were interpreted as an indication that SEPs alone may be insufficient for meeting the need for sterile syringes among an IDU community, especially in settings where frequent cocaine injection predominates.<sup>130</sup> In fact, it was estimated that both Vancouver and

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<sup>127</sup> Des Jarlais, Perlis, Friedman, Chapman, Kwok, Rockwell, Paone, Milliken, and Monterroso, *supra* note 121.

<sup>128</sup> Strathdee, Patrick, Archibald, Ofner, Cornelisse, Rekart, Schechter, and O'Shaughnessy, *supra* note 119.

<sup>129</sup> J. Bruneau, F. Lamothe, E. Franco, N. Lachance, M. Desy, J. Soto, and J. Vincelette, *High Rates of HIV Infection among Injection Drug Users Participating in Needle Exchange Programs in Montreal: Results of a Cohort Study*, 146 *American Journal of Epidemiology* 994 (1997).

<sup>130</sup> M. T. Schechter, S. A. Strathdee, P. G. Cornelisse, S. Currie, D. M. Patrick, M. L. Rekart, and M. V. O'Shaughnessy, *Do Needle Exchange Programmes Increase the Spread of HIV among Injection Drug Users?: An Investigation of the Vancouver Outbreak*, 13 *AIDS* F45 (1999); Strathdee, Patrick, Archibald, Ofner, Cornelisse, Rekart, Schechter, and O'Shaughnessy, *supra* note 119; E. Wood, M. W. Tyndall, P. M. Spittal, K. Li, R. S. Hogg, J. S. Montaner, M. V.

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Montreal would need to more than triple the number of syringes being exchanged to meet the public health goal of a sterile syringe for every injection.<sup>131</sup> Another study that failed to find a protective effect of SEP on HBV and HCV infection was reported by Hagan et al. in Seattle.<sup>132</sup> This study again prompted concerns from policy makers and scientists that the science surrounding SEP effectiveness suffered from methodologic shortcomings.<sup>133</sup>

To some extent, methodological concerns are valid, since evaluations of SEPs typically rely on observational study designs, which are inherently prone to bias. For example, recent analyses have shown that in many cities, SEPs attract high risk IDUs.<sup>134</sup> Such self-selection is not unexpected, nor

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O'Shaughnessy, and M. T. Schechter, *Factors Associated with Persistent High-Risk Syringe Sharing in the Presence of an Established Needle Exchange Programme*, 16 AIDS 941 (2002).

<sup>131</sup> R. S. Remis, J. Bruneau, and C. A. Hankins, *Enough Sterile Syringes to Prevent HIV Transmission among Injection Drug Users in Montreal?*, 18 Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology S57 (Supp. 1 1998); Strathdee, Patrick, Archibald, Ofner, Cornelisse, Rekart, Schechter, and O'Shaughnessy, *supra* note 119.

<sup>132</sup> H. Hagan, J. P. McGough, H. Thiede, N. S. Weiss, S. Hopkins, and E. R. Alexander, *Syringe Exchange and Risk of Infection with Hepatitis B and C Viruses*, 149 American Journal of Epidemiology 203 (1999). *But see* H. Hagan, D. C. Jarlais, S. R. Friedman, D. Purchase, and M. J. Alter, *Reduced Risk of Hepatitis B and Hepatitis C among Injection Drug Users in the Tacoma Syringe Exchange Program*, 85 American Journal of Public Health 1531 (1995).

<sup>133</sup> R. A. Coutinho, *Needle Exchange, Pragmatism, and Moralism*, 90 American Journal of Public Health 1387 (2000); A. R. Moss, *Epidemiology and the Politics of Needle Exchange*, 90 American Journal of Public Health 1385 (2000).

<sup>134</sup> J. A. Hahn, K. M. Vranizan, and A. R. Moss, *Who Uses Needle Exchange? A Study of Injection Drug Users in Treatment in San Francisco, 1989-1990*, 15 Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology 157 (1997); Bruneau, Lamothe, Franco, Lachance, Desy, Soto, and Vincelette, *supra* note 129; D. Vlahov, B. Junge, R. Brookmeyer, S. Cohn, E. Riley, H. Armenian, and P. Beilenson, *Reductions in High-Risk Drug Use Behaviors among Participants*

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even undesirable, given that most SEP function as low threshold interventions.<sup>135</sup> These selection factors may explain why cities such as Montreal and Vancouver have observed higher HIV seroconversion rates among SEP attenders compared to non-attenders.<sup>136</sup> In such settings, IDUs who subsequently begin attending SEP may have a higher risk of HIV seroconversion before ever attending the program.<sup>137</sup> This has been clearly shown in San Francisco, where IDUs who later began attending SEPs had higher HIV incidence rates than those who never attended.<sup>138</sup> More recently in Vancouver, the number of HIV seroconversions observed among frequent versus infrequent SEP attenders could be predicted solely on the basis of their higher baseline risk profile.<sup>139</sup> These findings suggest that

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*in the Baltimore Needle Exchange Program*, 16 *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology* 400 (1997); C. P. Archibald, M. Ofner, S. A. Strathdee, D. M. Patrick, D. Sutherland, M. L. Rekart, M. T. Schechter, and M. V. O'Shaughnessy, *Factors Associated with Frequent Needle Exchange Program Attendance in Injection Drug Users in Vancouver, Canada*, 17 *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology* 160 (1998); Schechter, Strathdee, Cornelisse, Currie, Patrick, Rekart, and O'Shaughnessy, *supra* note 119.

<sup>135</sup> E. Drucker, P. Lurie, A. Wodak, and P. Alcabes, *Measuring Harm Reduction: The Effects of Needle and Syringe Exchange Programs and Methadone Maintenance on the Ecology of HIV*, 12 *Suppl A AIDS* S217 (1998).

<sup>136</sup> C. M. Lowndes, and M. Alary, *Re: "High Rates of HIV Infection among Injection Drug Users Participating in Needle Exchange Programs in Montreal: Results of a Cohort Study"*, 148 *American Journal of Epidemiology* 713 (1998); Schechter, Strathdee, Cornelisse, Currie, Patrick, Rekart, and O'Shaughnessy, *supra* note 119.

<sup>137</sup> P. Lurie, *Invited Commentary: Le Mystere De Montreal*, 146 *American Journal of Epidemiology* 1003 (1997); Lowndes and Alary, *supra* note 136; Hahn, Vranizan, and Moss, *supra* note 134.

<sup>138</sup> Hahn, Vranizan, and Moss, *supra* note 134.

<sup>139</sup> Schechter, Strathdee, Cornelisse, Currie, Patrick, Rekart, and O'Shaughnessy, *supra* note 119.

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selection factors could entirely explain observed disparities in HIV incidence rates based on SEP attendance. Despite these limitations, the majority of observational studies have consistently shown a protective effect of SEPs on rates of needle sharing and HIV incidence. These data lend strong support to the contention that SEPs can effectively reduce the risk of blood borne diseases, especially when they operate within the context of a comprehensive program including other forms of syringe access.<sup>140</sup>

Cost-effectiveness studies of various syringe access programs have also been conducted. A recent study of seven New York State approved SEPs reported a cost-effectiveness ratio of \$20,947 per HIV infection averted, suggesting that SEPs are both cost effective and cost saving.<sup>141</sup> A national policy of funding SEPs, pharmacy sales and syringe disposal in the U.S. was estimated to cost \$34,278 per HIV infection averted, which is well below the lifetime costs of treating an individual's HIV infection.<sup>142</sup> Lurie and colleagues estimated the cost per syringe distributed for five syringe distribution

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<sup>140</sup> E. J. van Ameijden, J. A. van den Hoek, C. Hartgers, and R. A. Coutinho, *Risk Factors for the Transition from Noninjection to Injection Drug Use and Accompanying AIDS Risk Behavior in a Cohort of Drug Users*, 139 *American Journal of Epidemiology* 1153 (1994); Hagan, Jarlais, Friedman, Purchase, and Alter, *supra* note 132; D.C. Des Jarlais, Michael Marmon, and D. et al. Paone, *HIV Incidence among Injecting Drug Users in New York City Syringe Exchange Programmes*, *Lancet* 987 (1996); Vlahov, Junge, Brookmeyer, Cohn, Riley, Armenian, and Beilenson, *supra* note 134.

<sup>141</sup> F. N. Laufer, *Cost-Effectiveness of Syringe Exchange as an HIV Prevention Strategy*, 28 *Journal of Acquired Immune Deficiency Syndromes* 273 (2001).

<sup>142</sup> D. R. Holtgrave, S. D. Pinkerton, T. S. Jones, P. Lurie, and D. Vlahov, *Cost and Cost-Effectiveness of Increasing Access to Sterile Syringes and Needles as an HIV Prevention Intervention in the United States*, 18 *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology* S133 (Supp. 1 1998).

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strategies: SEP, a pharmacy-based SEP, free pharmacy distribution of pharmacy kits, sale of such pharmacy kits to IDUs, and sale of syringes in pharmacies.<sup>143</sup> In this study, the cost per syringe was \$0.97 for the SEP, \$0.37 for the pharmacy-based SEP, \$0.64 for pharmacy kit distribution, \$0.43 for pharmacy kit sale, and \$0.15 for syringe sale. The total annual cost of providing 50% of the syringes needed for a single syringe for every injection ranged from \$6 to \$40 million for New York City, from \$1 to \$6 million for San Francisco, and from \$30,000 to \$200,000 for Dayton, Ohio. The annual HIV seroincidence for the program to be cost-neutral compared with the cost of medical treatment for HIV injections was 2.1% for the SEP, 0.8% for the pharmacy SEP, 1.4% for pharmacy kit distribution, 0.9% for pharmacy kit sale, and 0.3% for syringe sales. This study suggests that all five strategies could distribute syringes at relatively low unit costs; however, SEPs would be the most expensive and syringe sales would be the cheapest. At annual seroincidence exceeding 2.1%, all strategies are likely to be cost-saving to society. This point is borne out in a report issued in 2002 by the Australian Department of Health and Ageing. The report concluded that Australia's \$83 million investment in needle-exchange programs from 1990 to 2000 returned between \$1.3 billion and \$4.2 billion in avoided costs.<sup>144</sup>

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<sup>143</sup> P. Lurie, R. Gorsky, T. S. Jones, and L. Shomphe, *An Economic Analysis of Needle Exchange and Pharmacy-Based Programs to Increase Sterile Syringe Availability for Injection Drug Users*, 18 *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology* S126 (Supp. 1 1998).

<sup>144</sup> Commonwealth Department of Health and Ageing, *Return on Investment on Needle and Syringe Programs in Australia (2002)* (available at <http://www.health.gov.au/pubhlth/publicat/document/roireport.pdf>).

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U.S. policies restricting syringe access at the federal and state levels have therefore placed serious limits on the ability to provide a sterile syringe for every injection. Legislation governing SEP funding and operation clearly undermine their effectiveness, and could even contribute to a lack of measurable benefit. Yet even in cities where SEPs are legal, there are fiscal and legislative restrictions on their hours of operation, staffing, and number of syringes exchanged per visit; few SEPs offer true 24 hour coverage. Beyond SEPs, state deregulation laws can persist in limiting the purchase of more than 10 syringes without a prescription (e.g., Connecticut), and pharmacy regulations can deter drug users from successfully purchasing syringes over the counter.

Achieving and sustaining adequate syringe coverage in a community will certainly require that restrictive policies do not limit access; however, to achieve the goal of a sterile syringe for every injection, the international literature indicates that diversification of syringe sources and other interventions will be needed.<sup>145</sup>

*Summary.* Evaluations of syringe access policies elsewhere in the world have generally found them to be effective in reducing HIV transmission without causing increases in drug use or other negative effects. Studies in Vancouver and Montreal found that SEPs had no protective effect; although these studies have been widely invoked by SEP opponents, the consensus among SEP researchers (including the authors of the studies) is that SEP alone may not be sufficient to reverse the health effects of frequent, high risk injection. Cost-effectiveness analyses have generally found that syringe access interventions do produce a net benefit for society.

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<sup>145</sup> Strathdee, and Vlahov, *supra* note 9.

*C. Evidence of Negative Effects of Policies to Improve Syringe Access*

From a policy perspective, attention has focused on whether or not increased syringe access is associated with increases in drug use, crime, or the number of discarded needles on the street. Once again, the available research to date has focused almost entirely on these issues in relation to SEPs.

Studies have consistently shown that SEPs are not associated with increases in drug use. In Amsterdam, van Ameijden and colleagues found that the introduction of SEP was not associated with a decrease in the median age of initiation of injection.<sup>146</sup> The frequency of injection drug use among IDUs attending SEP in Baltimore did not increase after a SEP was introduced.<sup>147</sup>

The possibility that SEPs send adolescents a "mixed message" that contradicts anti-drug messages and condones illicit drug use has been cited as an important reason for maintaining a Congressional ban on federal funding of NEP in the United States.<sup>148</sup> Yet in a survey of high school adolescents in Baltimore, the majority of adolescents did not perceive that seeing drug users utilize SEP

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<sup>146</sup> van Ameijden, van den Hoek, Hartgers, and Coutinho, *supra* note 140; see also E. C. Buning, *Effects of Amsterdam Needle and Syringe Exchange*, 26 *International Journal of the Addictions* 1303 (1991) (no increase in drug use observed in Amsterdam associated with needle exchange).

<sup>147</sup> Vlahov, Junge, Brookmeyer, Cohn, Riley, Armenian, and Beilenson, *supra* note 134.

<sup>148</sup> R. Goodlatte, R. Arney and T. Tiaht, *Send the Right Message to Our Children: Just Say NO to Free Needles for Drug Addicts!* (Letter to the Congress of the United States of America, 1999); D.E. Rogers, and J.E. Osborn, *AIDS Policy: Two Divisive Issues*, 270 *Journal of the American Medical Association* 494 (1993).

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promotes illicit drug use.<sup>149</sup> In fact, almost half perceived seeing drug users utilize SEP as actually deterring illicit drug use. To our knowledge, the only other study to examine the effect of NEP on attitudes of youth toward drug use was conducted by Friedman et al. in Bushwick, New York.<sup>150</sup> In this study, only 7% of adolescents and young adults surveyed were aware that a SEP was operating in their vicinity. The authors concluded that a SEP was unlikely to have had any effect on drug use decision-making among the youth in the area, given the low level of awareness of the existence of the program. Taken together, these findings do not support the concerns that SEPs promote acceptance of drug use among youth.

One of the most enduring community concerns is that SEPs could attract IDUs to congregate in their neighborhoods, thereby increasing crime rates. In a review of 16 SEPs, Lurie and colleagues<sup>151</sup> reported no evidence that SEPs were associated with increased crime. This report, however, accounted only for specific crimes that were likely to be drug-related and did not compare crime rates in terms of proximity to the SEPs. More recently, Marx et al.<sup>152</sup> compared arrest rates in SEP areas

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<sup>149</sup> M.A. Marx, H. Brahmhatt, P. Beilenson, R.S. Brookmeyer, S. A. Strathdee, C. Alexander, and D. Vlahov, *Impact of Needle Exchange Programs on Adolescent Perceptions About Illicit Drug Use, AIDS and Behavior* (In press).

<sup>150</sup> S. R. Friedman, R. Curtis, B. Jose, P. L. Flom, A. Neaigus, and D. C. Des Jarlais, *The Message Not Heard: Myth and Reality in Discussions About Syringe Exchange*, 13 AIDS 738 (1999).

<sup>151</sup> Lurie et al., *supra* note 10.

<sup>152</sup> M. A. Marx, B. Crape, R. S. Brookmeyer, B. Junge, C. Latkin, D. Vlahov, and S. A. Strathdee, *Trends in Crime and the Introduction of a Needle Exchange Program*, 90 American Journal of Public Health 1933 (2000).

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vs. non-SEP areas in Baltimore, before and after the program was introduced over a 15 month period.<sup>153</sup> Four types of arrest categories were studied (drug possession, economically motivated offenses, resistance to police and violent offenses). In all cases, there was no significant increase in arrest rates in SEP areas compared to other regions in the city, suggesting that at least in this setting, SEP had no influence on crime rates. The extent to which SEP is associated with an increase in violent crime has also been examined in Harlem, New York.<sup>154</sup> Here, a detailed analysis found no relationship between reports of robberies or assaults and the proximity to local SEPs, suggesting that NEPs do not adversely affect rates of violence in their vicinity.

Researchers have also examined whether SEPs are associated with an increased number of discarded needles on the street. An early study by Oliver (1992) suggested no such increase.<sup>155</sup> A more detailed study that estimated the quantity and geographic distribution of discarded needles on the streets of Baltimore, Maryland two years after the SEP opened, found a significant decline in the overall quantity of discarded needles relative to drug vials and bottles.<sup>156</sup> The mean number of needles per 100

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<sup>153</sup> *Id.*

<sup>154</sup> Sandro Galea, Jennifer Ahern, Crystal Fuller, Nicholas Freudenberg, and David Vlahov, *Needle Exchange Programs and Experience of Violence in an Inner City Neighborhood*, 28 *Journal of Acquired Immune Deficiency Syndromes* 282 (2001).

<sup>155</sup> K. J. Oliver, S. R. Friedman, H. Maynard, L. Magnuson, and D. C. Des Jarlais, *Impact of a Needle Exchange Program on Potentially Infectious Syringes in Public Places*, 5 *Journal of Acquired Immune Deficiency Syndromes* 534 (1992).

<sup>156</sup> M. C. Doherty, B. Junge, P. Rathouz, R. S. Garfein, E. Riley, and D. Vlahov, *The Effect of a Needle Exchange Program on Numbers of Discarded Needles: A 2-Year Follow-Up*, 90 *American Journal of Public Health* 936 (2000).

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trash items per block was 2.42 before the NEP opened and 1.30 two years later. These data suggest that this SEP did not increase the number or distribution of discarded needles, and in fact was likely to have reduced the number of discarded needles that could lead to community needle stick injuries.

Although the above data are largely restricted to Baltimore, to date there appears to be no published evidence or even a body of anecdotal reports that enhanced syringe access causes negative societal effects.

*Summary.* The research consistently supports the conclusion that increased syringe access does not promote drug use, or increase crime or the volume of improperly discarded needles in the community.

### *D. Limitations of Existing Research on Syringe Access Policies*

The majority of the published studies focus on evaluations of SEPs; there is a paucity of data investigating outcomes related to other forms of syringe access, such as pharmacies, physician prescription, and syringe vending machines. The small amount of published research in this area may reflect the fact that the importance of alternate syringe sources in achieving sterile syringe coverage among IDUs has only recently been recognized. Similarly, studies examining behavioral, societal and health effects of deregulation of prescription, paraphernalia or possession laws and pharmacy sales are sparse. The latter studies are rare because they require a change in legislation or pharmacy regulations in order to create the conditions for a “natural experiment.”

Even among studies of SEP effectiveness, an overriding problem has been the lack of a formal

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evaluation component that includes biologic outcomes, such as HIV incidence. Longitudinal studies are ideal for conducting such investigations, but these studies are costly and time consuming. In most cities, HIV incidence rates are approximately 2% per year, limiting the ability to make inferences based on HIV incidence rates in the absence of a very large sample size. As a consequence, much of the existing data relies on behavioral surrogates, such as reports of needle sharing behavior and syringe exchange attendance, which are prone to socially desirable responding (i.e., giving the response that the respondent believes that others would approve of). However, there is evidence to suggest that self-reports of IDUs' behaviors are reasonably valid.<sup>157</sup> In fact, a recent report suggests that socially desirable responding may lead to an underestimation of the protective effect of SEPs by as much as 20%.<sup>158</sup>

The ideal study design to examine whether or not providing sterile syringes to IDUs reduces the risk of blood borne disease without promoting negative societal effects would be a randomized clinical trial of individuals in communities that have access or no access to sterile syringes. However, a reasonable argument can be made that such a design is unethical, since the majority of the international literature supports a protective effect of sterile syringe access on rates of blood borne disease. To deny

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<sup>157</sup> J.C. Anthony, D. Vlahov, D.D. Celentano, A.S. Menon, J.B. Margolick, S. Cohn, K.E. Nelson, and B.F. Polk, *Self-Reported Interview Data for a Study of HIV-1 Infection among Intravenous Drug Users: Description of Methods and Preliminary Evidence on Validity*, 21 *Journal of Drug Issues* 739 (1991).

<sup>158</sup> M. Safaeian, R. Brookmeyer, D. Vlahov, C. Latkin, and S. A. Strathdee, *The Validity of Self-Reported Needle Exchange Attendance among Injection Drug Users: Implications for Program Evaluation*, *American Journal of Epidemiology* (In press).

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some members of a community access to an intervention that is known to save their lives would certainly be accused of violating prevailing ethical standards. Randomization of different communities rather than individuals with access to different syringe sources may circumvent these ethical concerns. This approach is not generally feasible in most settings, though, since local drug scenes are highly variable. However, data from a community-based randomized trial of SEP versus pharmacy access to syringes in Alaska are pending.<sup>159</sup>

Given the lack of data on syringe access outcomes from intervention trials, there is likely to be a continued reliance on observational studies (i.e. non-experimental study designs) to examine the effectiveness of SEP, pharmacy access and deregulation. As a consequence, a major methodological hurdle is the lack of an appropriate comparison group through which valid inferences about risk reduction reasonably can be made. In deregulation studies, one approach has been to compare risk behaviors and health outcomes in the period prior to the regulation change, compared to the period afterward. This approach is limited by the possibility that other secular changes may have occurred during this period which may bias results. National studies using multiple data sets over time may help to uncover trends, but this type of ecological approach cannot be used to make inferences at the individual level.

Even in cases where virtually all IDUs in a given setting have utilized a given syringe source, it is still possible to undertake process evaluation to determine which combination of services or components of SEPs are most or least effective. This is especially needed since SEPs vary enormously

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<sup>159</sup> Personal communication, Dr. Dennis Fisher 2001.

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in the range of services they provide, hours of operation and local regulations, including factors governed by their legal status. The lack of comparability across programs has hampered evaluation studies and limited to the generalizability of specific findings.

Unfortunately, very few studies have evaluated programmatic characteristics of SEPs. This research can help to determine which kinds of services will maximize sterile syringe coverage in a community.<sup>160</sup> One such example is the finding that mobile SEPs are likely to attract higher risk IDUs than fixed site programs.<sup>161</sup> Without taking into account the various components of SEPs and their direct and the indirect effects, observational studies attempting to evaluate SEP will likely continue to produce conflicting findings.

In light of the selection factors that are inherent in observational studies, there is a need for more sophisticated analyses that take into account these biases, lest they underestimate or mask a protective effect of the intervention, or create spurious associations. In evaluations of SEPs, for example, most studies have merely employed dichotomous categorizations (e.g., SEP attenders versus non-attenders, frequent vs. infrequent attenders). This simplistic approach overlooks the fact that non-attenders may have entirely met their need for sterile syringes through other means. A recent analysis of SEP attenders in Amsterdam -- a city where sterile syringes are readily available through pharmacies -- found that irregular SEP attenders had a higher risk of HIV seroconversion than non- or frequent

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<sup>160</sup> Bastos and Strathdee, *supra* note 122.

<sup>161</sup> E. D. Riley, M. Safaeian, S. A. Strathdee, M. A. Marx, S. Huettner, P. Beilenson, and D. Vlahov, *Comparing New Participants of a Mobile Versus a Pharmacy-Based Needle Exchange Program*, 24 *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology* 57 (2000).

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attenders.<sup>162</sup> These authors concluded that irregular SEP attenders had the least exposure to sterile injection equipment and consistent prevention messages, which placed them at higher risk of infection. Some authors have suggested that propensity scores or hierarchical modeling may offer viable solutions to “adjust” for the selection bias that can compromise the validity of research findings.

Beyond factors relating to frequency of utilization of a specific syringe source and the volume of syringes obtained, program effectiveness can vary depending on the circulation time of contaminated syringes in the community<sup>163</sup> and whether syringes are obtained directly or indirectly through intermediaries. In the case of SEPs, this phenomenon is referred to as secondary exchange. While secondary exchange provides extended coverage of SEPs to IDU in the broader community, its recipients typically do not receive HIV/AIDS education, counseling or referrals to drug treatment that could have been received had they attended the SEP themselves.<sup>164</sup> To date, research is lacking on these indirect effects of SEPs, which could prove to be just as important as the direct effect on SEP attenders. Furthermore, pharmacies may serve as an excellent venue for providing health education to IDUs; however, thus far they appear to have been grossly under-utilized in this regard.

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<sup>162</sup> van Ameijden, and Coutinho, *supra* note 121.

<sup>163</sup> Edward H. Kaplan, *Probability Models of Needle Exchange*, 43 *Operations Research* 43 558 (1995); E. H. Kaplan, *A Method for Evaluating Needle Exchange Programmes*, 13 *Statistics in Medicine* 2179 (1994).

<sup>164</sup> Valente, Foreman, Junge, and Vlahov, *supra* note 73.

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No matter what method is used to study syringe access, it is crucial to devote more attention to the social context of risk. This context includes elements ranging from IDUs sexual relationships,<sup>165</sup> to the socioeconomic characteristics of the communities where they live.<sup>166</sup> Of particular importance, as our review of the data has illustrated, is the role of law and law enforcement practices on IDU behavior and the risk of disease. Ethnographic research clearly shows that IDUs' ability to obtain sterile injection equipment, to carry it, and to inject in a sterile fashion is strongly influenced by the extent to which they fear police interference.<sup>167</sup> Research that fails to address this key determinant of IDU health will not provide an adequate understanding of necessary changes in policy and law enforcement practices, or of effective means for individual IDUs to reduce their risk.

*Summary.* The available data is sufficient to justify a public policy of greater syringe access for IDUs, but the literature has limitations, at least some of which can be addressed in future research. One correctable deficiency is the lack of data on measures other than SEP, which will be remedied as

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<sup>165</sup> Tim Rhodes, *The 'Risk Environment': A Framework for Understanding and Reducing Drug-Related Harm*, 13 *International Journal of Drug Policy* 85 (2002); T. Rhodes, G. V. Stimson, and A. Quirk, *Sex, Drugs, Intervention, and Research: From the Individual to the Social*, 31 *Substance Use & Misuse* 375 (1996).

<sup>166</sup> Robert Sampson, and Jeffrey Morenoff, *Public Health and Safety in Context: Lessons from Community-Level Theory on Social Capital*, in *Promoting Health: Intervention Strategies from Social and Behavioral Research* 366 (B. Smedley, and S.L. Syme ed., 2000).

<sup>167</sup> See, e.g., Koester, *supra* note 103; Bourgois, *supra* note 103; Kim Blankenship, and Stephen Koester, *Criminal Law, Policing Policy, and HIV Risk in Female Street Sex Workers and Injection Drug Users*, *Journal of Law, Medicine & Ethics* (forthcoming 2002).

current studies on the implementation of recent interventions are completed.<sup>168</sup> Enhancing the use of biologic outcome measures can reduce the distortions of self-reported behavior. Because randomized controlled studies, often referred to as the gold-standard in other areas of biomedical research, are difficult and arguably unethical to use in the syringe access context, observational studies will continue to be the main method of studying syringe access. These may be improved by, among other steps, incorporating more scrutiny of program factors (such as hours of operation, location, etc.) and by the development of more sophisticated analytic approaches.

## **VI. Analysis of Public Opinion, Ethics, and Politics**

Lawfulness and effectiveness are only part of the syringe access policy problem. It remains critically important to address at least three additional, and inter-related, questions: 1) does enhanced syringe access have an adequate level of public support, 2) is the policy ethically appropriate, and 3) is the policy politically feasible.

### *A. Public Support*

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<sup>168</sup> G.S. Birkhead, S.J. Klein, A.R. Candelas, H.A. Plavin, and M. Narcisse-Pean. (2002). New York State's Expanded Syringe Access Demonstration Program (ESAP): A Statewide Intervention to Prevent HIV/AIDS (Paper presented at *XIV International AIDS Conference* in Barcelona, Spain, 2002); S. J. Klein, K. Harris-Valente, A. R. Candelas, M. Radigan, M. Narcisse-Pean, J. M. Tesoriero, and G. S. Birkhead, *What Do Pharmacists Think About New York State's New Nonprescription Syringe Sale Program? Results of a Survey*, 78 *Journal of Urban Health* 679 (2001).

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Public policy is influenced by public opinion. Public support for a given policy, however, does not always produce immediate action by policy-makers. This disconnect between public opinion and public policy may be more likely to occur where, as with syringe access policies, public opinion is relatively malleable. Also, opponents of a given public health policy sometimes feel more strongly about the issue than do supporters. There are many other examples of this phenomenon. For example, solid majorities of the American public have long supported making it more difficult to obtain and carry handguns.<sup>169</sup> Yet progress in enacting gun violence prevention laws has been relatively slow.<sup>170</sup>

To assess the possible role of public opinion in shaping present and future syringe access policies, we undertook a systematic search for all reported national surveys. Several different methods were employed. The Roper Center for Public Opinion Research at the University of Connecticut acts as a repository for public opinion polls on all topics. We performed a search of its database for any survey question with the words “needle,” “syringe,” or “drug paraphernalia.” We reviewed each question and eliminated those that: 1) were unrelated to syringe access programs, 2) were from polls that were not national in scope, or 3) were tangential to basic support or opposition to these policies. A total of 21 different questions from 11 different polls conducted from 1987 to 1999 were identified in

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<sup>169</sup> S. P. Teret, D. W. Webster, J. S. Vernick, T. W. Smith, D. Leff, G. J. Wintemute, P. J. Cook, D. F. Hawkins, A. L. Kellermann, S. B. Sorenson, and S. DeFrancesco, *Support for New Policies to Regulate Firearms. Results of Two National Surveys*, 339 *New England Journal of Medicine* 813 (1998).

<sup>170</sup> J. S. Vernick, and S. P. Teret, *A Public Health Approach to Regulating Firearms as Consumer Products*, 148 *University of Pennsylvania Law Review* 1193 (2000).

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this manner. These are summarized in Table XI.<sup>171</sup> To allow the reader to better assess how question wording can influence poll results, we have included the full text of each question in Table XI.

In addition, we conducted a Lexis/Nexis search of newspaper articles for references to national polls since 1995. This search yielded one additional poll, conducted by the Kaiser Family Foundation in late 2000, and released to the public in June 2001.<sup>172</sup> As the most recent poll we identified, its findings are summarized here.

That poll included 4 questions relevant to syringe access by IDUs. Fifty-eight percent of respondents reported that “to help stop the spread of HIV” they would favor “needle exchange programs which offer clean needles to IV drug users in exchange for used needles.” Nearly identical proportions also supported: changing federal law to permit “state and local governments [to] decide for themselves whether to use their federal funds for needle exchange programs”(60%); “allowing IV drug users to purchase clean needles from a licensed pharmacist” (61%); and “allowing doctors and physicians to provide IV drug users with a prescription for clean needles” (60%).<sup>173</sup> For each of these questions, there were only modest, if any, differences in support or opposition among various gender, race, or age groups.

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<sup>171</sup> Roper Center for Public Opinion Research. On-line Database of Poll Questions; searched June 2001.

<sup>172</sup> Henry J. Kaiser Family Foundation website, <http://www.kff.org/docs/about> visited December 14, 2001.

<sup>173</sup> *Id.*

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As Table XI demonstrates, there is no clear national consensus on the desirability of syringe access programs. Over time, support has ranged from 29% to 73%. We were able to identify just two additional questions querying public support for other syringe access policies, both in a 1994 poll sponsored by an organization called Drug Strategies. In that poll, just 37% of respondents favored “allowing drug users to buy clean needles without prescriptions from pharmacies; 40% favored “removing criminal penalties for the simple possession of needles and syringes.”

As is often the case with public opinion polls, however, precise question wording can strongly affect observed public support or opposition. For example, in both 1998 and 1999, the Family Research Council asked questions about support for syringe exchange programs. In the 1998 question, users of SEPs were referred to as “those addicted to illegal drugs.” In 1999, the question was identical, except that users of SEPs were now described as “drug addicts.” Support in 1998 was 43%; in 1999, it had fallen to 34%. In an earlier 1997 poll sponsored by the Kaiser Family Foundation, the phrase “IV (intravenous) drug users” is employed, and 64% of respondents favored SEPs.

Other differences in question design can also be important. For example, in the same Kaiser poll (above), a separate question using what are called “permissive statements” was asked of a different subset of respondents. Respondents were told that “some people favor offering clean needles ... to reduce the spread of HIV; others oppose exchange programs because they ... send the message that it’s OK to use illegal drugs.” With these permissive statements, support was substantially lower, just 48%. However, even from this lower baseline of support, when respondents are then told that

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scientific evidence suggests that SEPs are effective, support again increases to a total of 60%. Clearly, levels of national support for SEPs are not very stable.

The biases of the organizations sponsoring the polls may also affect the outcomes of interest. For example, the Family Research Council describes itself as “champion[ing] marriage and family as the foundation of civilization, the seedbed of virtue, and the wellspring of society.”<sup>174</sup> By comparison, the Kaiser Family Foundation is an “independent philanthropy focusing on the major health care issues facing the nation.”<sup>175</sup> The Family Research Council, therefore is likely to view syringe access interventions through the lens of its “family values” mission, while Kaiser will pose the question as one primarily of health policy. These differences may be perceived (perhaps subtly) by respondents. They are also likely to affect the context in which questions about syringe access policies are asked within the larger survey instrument.

It can very difficult to interpret the policy-impact of survey research findings on topics that most respondents have probably not carefully considered. Weak levels of support may simply mean that many respondents do not fully understand the issue (or its scientific basis), which cannot be explained effectively in a brief telephone interview. Even if levels of national support are malleable, this may be less relevant for some aspects of syringe access policy than for others. Most SEPs are locally designed and implemented. In that sense, local levels of support are probably far more important than national

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<sup>174</sup> Family Research Council website, <http://www.frc.org/aboutfrc.cfm?CFID=275366&CFTOKEN=4333757> visited December 14, 2001.

<sup>175</sup> Henry J. Kaiser Family Foundation, *The AIDS Epidemic at 20 Years: The View from America*. Menlo Park, CA: The Kaiser Family Foundation; 2001.

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levels. In addition, to the extent that many of these programs are privately funded, governmental or public support may simply not be needed in some places. However, national public opinion can obviously affect willingness to provide state or federal funds for SEPs. Currently, federal funds may not be used to support SEPs.

Our results also suggest possible ways to increase public support for syringe access interventions. It appears that linking syringe access with broader drug policy is associated with lower levels of support. To the extent that the “war on drugs” is seen as a moral crusade by some, and a misguided failure by others, uncoupling syringe access from drug policy has the potential to de-polarize the syringe access debate. Similarly, describing syringe access interventions as health policy, rather than drug control policy, may also increase support. Finally, a public discourse that avoids the use of loaded terms, like “drug addicts” or “junkies,” may contribute to a more rational, less stigma-driven assessment of syringe access by the public.

### *B. Bioethics Literature Regarding Syringe Access Policies*

Despite the controversy surrounding syringe access policies, especially SEPs, there has been little scholarly effort devoted to analyzing their bioethical implications. A comprehensive literature review, with the invaluable assistance of the National Reference Center for Bioethics literature at Georgetown University’s Kennedy School of Ethics, yielded just two journal articles whose primary focus was on the ethics of SEPs. Many other articles include brief discussions of the societal or moral appropriateness of SEPs, often in the discussion section of a more general article, but do not develop an explicit ethical basis for that conclusion. These are generally excluded from this section.

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The most comprehensive published effort to analyze the bioethics of SEPs was by Loue, Lurie, and Lloyd in 1995.<sup>176</sup> That article employs a traditional bioethics framework, popularized by Beauchamp and Childress.<sup>177</sup> That framework typically includes an analysis of the following basic components: 1) nonmaleficence; 2) beneficence; 3) respect for persons; and 4) justice.

Nonmaleficence refers to the obligation to avoid intentionally harming others, while beneficence includes affirmative actions designed to help others. Respect for persons incorporates concepts of autonomy and informed consent. Justice in this context implies fairness in treatment, and an appropriate distribution of benefits and burdens. Loue et al. also add a discussion of utilitarianism. Utilitarianism focuses on the consequences of actions in order to assess their rightness. Right actions or policies will attempt to maximize good outcomes and minimize bad ones.<sup>178</sup>

For Loue et al., the principle of beneficence is easily satisfied by SEPs. SEPs reduce the risk of infection for individuals. For communities, the number of syringes discarded in public places is decreased. Nonmaleficence is also satisfied where the SEP insulates users from targeting by the police. Other potential harms to IDUs participating in SEPs, such as the risk that drug use will be encouraged, can be mitigated by referrals for drug treatment or counseling. SEPs exhibit respect for persons when they encourage healthy decisions, lack any form of compulsion to participate, and ensure confidentiality

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<sup>176</sup> S. Loue, P. Lurie, and L. S. Lloyd, *Ethical Issues Raised by Needle Exchange Programs*, 23 *Journal of Law, Medicine & Ethics* 382 (1995).

<sup>177</sup> T.L. Beauchamp, and J.F. Childress, *Principles of Biomedical Ethics* (1994).

<sup>178</sup> *Id.*

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of the users. Finally, the principle of justice requires that society accept the costs of SEPs, and not discriminate against IDUs. This is especially important where society has chosen not to provide adequate drug treatment resources in most communities.<sup>179</sup> For Loue et al., SEPs are also justified on utilitarian grounds. If properly designed and implemented, they minimize harms to IDUs and the community.

The only other effort to systematically assess the ethical implications of SEPs was authored by Maura O'Brien in 1989, just one year after the first SEP in the U.S. was instituted.<sup>180</sup> Employing a different framework, O'Brien also concludes that SEPs are ethically justified. The strength of her conclusion was limited, however, by the absence of substantial effectiveness data at that early date.

Loue et al. also briefly discuss the ethics of physician prescription and pharmacy sale of syringes, topics that Lazzarini addresses in substantially more detail.<sup>181</sup> Lazzarini employs a variety of ethical principles and theories, but also focuses on the 4 traditional principles. Regarding physician prescription of syringes, she notes that principles of beneficence and respect for persons might seem to conflict. The notion of autonomy inherent in respect for persons argues for physician prescription of syringes where that is the informed choice of an IDU. But a "beneficent" physician might be concerned about facilitating an IDUs drug habit. Lazzarini concludes, however, that physician prescription of

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<sup>179</sup> Loue, Lurie, and Lloyd, *supra* note 176.

<sup>180</sup> M. O'Brien, *Needle Exchange Programs: Ethical and Policy Issues*, 4 AIDS & Public Policy Journal 75 (1989).

<sup>181</sup> Z. Lazzarini, *An Analysis of Ethical Issues in Prescribing and Dispensing Syringes to Injection Drug Users*, 11 Health Matrix 85 (2001).

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syringes is ethically appropriate. She argues that the principle of beneficence warrants both efforts to convince IDUs to cease their drug use or enter treatment, and efforts to provide sterile syringes for those IDUs who cannot or will not stop injecting drugs.

The few ethical analyses that have been done support the use of SEPs and physician prescribing of syringes. However, based on the relatively scant volume of literature, we wonder if the bioethics community has devoted adequate attention to this issue. This is especially surprising given the high levels of media and policy-maker attention that syringe access policies have received. In particular, it does not appear that bioethicists have devoted nearly as much attention to the ethics of syringe access policy as they have to other aspects of the AIDS epidemic, such as issues of patient screening or contact tracing. From a policy perspective, greater participation by bioethicists and other opinion leaders could affect both public opinion and the political feasibility of some syringe access policies.

Another interesting feature of the SEP literature concerns research ethics. A randomized, controlled trial of IDUs assigned to SEP participation or non-participation has been deemed by many to be ethically problematic. The concern is that, given the magnitude of research suggesting that SEPs are beneficial, the research community no longer has the necessary equipoise that would allow randomly excluding some IDUs from SEP participation. However, if one were persuaded by recent research suggesting that, at least in some circumstances SEPs may not reduce seroconversion rates, this could alter the bioethics landscape. Under those circumstances, randomized, controlled trials might be ethically permissible provided that the control group had some other form of access to clean syringes.

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Whether additional research, even some “gold-standard” clinical trial, would affect the positions of opponents is a separate question (see next section).

### *C. Politics Issues Regarding Syringe Access*

We have previously described the history of SEPs in the United States. This history has also been presented in greater detail by others.<sup>182</sup> But there have been only limited efforts in the political science or public health literature to systematically explore the politics of syringe access policy.<sup>183</sup> Nevertheless, in our view, some features of the structure of the political debate are apparent. We identify three major themes in that debate: 1) disagreements about science, 2) concerns about symbolism and, 3) differences in how the problem is framed.

The available research is interpreted differently by syringe access proponents and opponents. For example, SEP opponent Robert Maginnis writes: “Two compelling studies, published in 1997, found that NEP participants were more likely to contract HIV than addicts who don’t use NEPs.”<sup>184</sup> SEP proponents argue that these same studies may have been influenced by selection bias. Proponents are also more likely to consider the totality of the scientific evidence supportive of the benefits of SEPs. Disagreements about SEP science may also reflect different views about the appropriate course of

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<sup>182</sup> Vlahov *et al*, *supra* note 17.

<sup>183</sup> *See, e.g.*, Moss, *supra* note 133; Coutinho, *supra* note 133.

<sup>184</sup> Maginnis RL. Injecting Drug Use: A 2000 Overview. The Family Research Council. Available on website at <http://www.frc.org/get/is00d3.cfm> visited December 14, 2001.

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action if there is *any* scientific uncertainty. Some opponents of SEPs may believe that SEPs should not be implemented if there is any doubt that they may promote drug use. In addition, because SEPs have not been instituted in all communities, opponents may be uncertain about the overall effect SEPs would have if more widely implemented. Unfortunately, the absence of federal funding for both SEPs and SEP research creates a feedback mechanism. The absence of federal funding makes large-scale, well-designed studies much more difficult to conduct. And the lack of the kind of effectiveness data that such studies might produce helps to perpetuate and even reinforce the funding ban.

Other arguments are based not on disputes over science, but over the symbolism of SEPs or other syringe access policies. Opponents argue that SEPs send a message that drug use is condoned, and undermine other anti-drug messages. Proponents generally respond with some variation on the theme of harm reduction -- that some IDUs will not stop injecting illegal drugs, despite anti-drug messages, and that therefore SEPs are an appropriate response. Interestingly, at least one public opinion poll has sought to indirectly assess the persuasiveness of this argument. In a 1998 poll sponsored by the SEP opponents, The Family Research Council, a plurality of respondents (46%) thought that “government funded needle exchange programs” did not “represent an official endorsement of drug use by the government.” Forty-one percent thought that SEPs would represent such an endorsement.

Perhaps most important to understanding the politics of SEPs, however, are differences in how opponents and proponents define and frame the problem. Consistent with their concern about science and symbolism, opponents view SEPs primarily through the lens of drug policy, while proponents of

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SEPs generally define the problem as one of disease prevention. Interestingly, this latter view may be gaining currency with the public. In a 2001 poll sponsored by the Pew Research Center, 1500 U.S. adults were asked a series of questions about drug policy. When asked: “All in all, should drug use be treated more like a crime or more like a disease?”, 35% said “crime” and 52% “disease.” Attitudes were similarly divided in an analysis of community responses to a 2000 California law making it easier for localities to sponsor SEPs. Among key stakeholders, police were most likely to be opposed to SEPs, often describing them as likely to increase crime by “facilitating drug use.” By comparison, local public health officials provided epidemiological data to policy-makers and SEP advocates, suggesting an understandable health perspective on the issue. Changing police attitudes proved important to the ultimate success of SEPs in some communities.<sup>185</sup>

Resolving this problem-framing disjunction may be the most significant challenge for SEP proponents. One possible strategy, already employed by scientists and some policy-makers, uses research to demonstrate that SEPs do not harm drug control efforts. Another strategy may be to argue that, in general, health issues should outweigh or trump possible drug control issues. The persuasiveness of both arguments might be bolstered by reference to the experience of European countries that have instituted SEPs without an increase in drug use.

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<sup>185</sup> C. Collins, T. Summers, Aragon R., and Johnson S.B., Syringe Exchange and AB 136: The Dynamics of Local Consideration in 6 California Communities (2002).

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Of course, for some opponents, the decision is probably a simple political one. They represent, or are influenced by, a constituent group that has a particular cluster of positions, including opposition to SEPs.<sup>186</sup> For those whose position is based on realpolitik, it is unlikely that polling or other data will change minds.

### **VII. Recommendations for Policy**

Were public health policy dictated purely by behavioral research and cost-benefit analysis, unfettered syringe access would be part of the response to prevent the spread of bloodborne disease throughout the United States and elsewhere. While the existing research base has its limitations, the strong preponderance of the data and the experience of other countries leave little doubt that making sure IDUs can obtain, carry and use a sterile syringe for as many injections as possible can make a valuable contribution to controlling HIV among IDUs.

In considering this “ideal” policy, it is not particularly problematic that the research supporting syringe access has limitations of both methodology and scope. Nor is it significant that the goal of having every IDU use a new sterile syringe for every injection is not likely to be achieved anytime soon even with completely unfettered syringe access. Policy frequently proceeds faster than prevention science, and necessarily so: perfect information is a luxury policy makers cannot afford. Throughout

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<sup>186</sup> L. Rosenstock, and L. J. Lee, *Attacks on Science: The Risks to Evidence-Based Policy*, 92 *American Journal of Public Health* 14 (2002).

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public health and governance generally, policy-makers must make reasoned judgments in response to problems before all questions can be answered.

Syringe access is important, probably even necessary, but it is not a panacea for the prevention of bloodborne disease among IDUs and their surrounding communities. In the ideal policy, formed and continuously updated based on new data, syringe access would be part of a comprehensive set of medical and social interventions aimed at increasing the uptake and success of drug treatment while reducing the harmful health consequences of continuing drug use. For syringe access to work for public health, it need not be 100 percent successful; it just needs to increase the marginal use sufficiently to either cost effectively reduce cases or create a sufficient level of safe use to reverse the trend of the epidemic. In the ideal world, the effects and best practices of unfettered syringe access would continue to be studied, and policy would be adapted accordingly.

In our distinctly non-Platonic world, health policy is not made purely on the basis of science and expert reflection. Syringe access is a contentious political issue and the public reaction to enhanced access is mixed, even if not deeply felt. In this real world, the essential challenge for policy makers who credit the information public health professionals provide is to decide where to draw the line between effectiveness and political feasibility. Experience shows that the location of this line can vary from state to state and even city to city. Our review suggests the following conclusions.

### *1. Syringe access should be deregulated.*

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Complete deregulation is the most desirable model to maximize access to sterile syringes. Syringes are standard medical devices used by millions of people on a daily basis. Apart from quality control, they have been regulated only in so far as they are susceptible for use with illegal drugs. Compared with other syringe access options, deregulation allows distribution by the widest variety of means and outlets. With restrictions repealed, syringes could be sold not only in pharmacies, but also convenience stores, groceries and other accessible locations,<sup>187</sup> or could be handed out without cost by public health and community organizations. By removing all restrictions on syringe sales, deregulation also eliminates legal barriers to syringe exchange. Deregulation takes possession almost entirely out of the purview of law enforcement, making it legally safe for IDUs to have sterile syringes at hand when they need them, and removing an important legal barrier to safe syringe disposal. It is a “market-driven” solution that leaves sellers and buyers free to make their own choices. From the political point of view, it eliminates syringes access as a debating issue and gives public health agencies a free hand in crafting distribution programs that best serve the goal of disease prevention. There is no evidence that unfettered access to sterile injection equipment causes people to begin or increase drug use, or an increase in the improper disposal of used syringes.

***2. IDUs should not be subject to arrest or prosecution for possession of the residue of drugs left in the barrel of used syringe.***

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<sup>187</sup> Y. Obadia, I. Feroni, V. Perrin, D. Vlahov, and J. P. Moatti, *Syringe Vending Machines for Injection Drug Users: An Experiment in Marseille, France*, 89 *Id.*1852 (1999).

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The ability to *obtain* a syringe is not sufficient to minimize unsafe syringe use among IDUs. IDUs must also be comfortable carrying the syringe. Although not optimal, re-use of one's own syringe is preferable to sharing, and it is necessary to retain a used syringe for proper disposal at a syringe exchange or elsewhere. As the federal judge concluded in *Doe v. Bridgeport Police Department*,<sup>188</sup> arresting drug users for possessing a residual, trace amount of an illegal drug in the barrel of a syringe is antithetical to a public policy favoring sterile injection and proper disposal of used syringes. It is unlikely that state drug possession laws would be rendered ineffective by raising the minimum quantity of drugs necessary to ground a conviction. Although the ability to make a stop or arrest based on probable cause to believe that a used syringe contains drugs may be a tool of street law enforcement, a health perspective suggests society pays a high price for its use. States should revisit this issue. Regardless of the need for de minimis thresholds for general drug control, it is possible to exempt such amounts within syringes, or for law enforcement authorities to develop standard operating procedures that avoid stops, arrests or prosecutions based on drug residues in syringes.

### ***3. Laws governing SEPs should place a minimum of restrictions on their manner of operation.***

Deregulation does not eliminate the need for the SEP as a public health program. SEPs can provide a range of health and social services that pharmacies and other retail outlets ordinarily cannot. With or without deregulation, however, the best laws authorizing SEPs will be those that set a minimum

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<sup>188</sup> *Doe v. Bridgeport Police Department*, 198 F.R.D. 325 (D.Conn., 2001).

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number of restrictions on the manner in which the intervention is conducted. Syringe exchange is a work in progress for public health. Assessment data and day-to-day experience should continue to be collected and digested into best practices, which SEPs should be free to adopt as they become known. Rigid one-for-one exchange requirements or caps on the number of syringes to be exchanged are not consistent with research evidence even today, and restrictions generally are not consistent with the development of optimal practices. In fact, limitations on SEP operations may inadvertently “stack the deck” against the ability of these programs to prevent blood-borne disease transmission among IDUs.

***4. The US should develop a national policy on the disposal of household sharps.***

Although there is no compelling reason to continue to regulate distribution and possession of syringes, there is an unmistakable need for a national policy for the disposal of medical sharps used outside the health care system. An effective system could be developed and funded within the private sector, or conducted by government, but leadership and probably a legal mandate and some funding will be required from government. In 2002, a Coalition for Safe Community Needle Disposal was founded to spearhead development of disposal solutions at the local, state and national levels. See <http://www.safeneedledisposal.org/>.

***5. Syringe access should be integrated into a comprehensive approach to reducing drug use and its health consequences.***

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Improved access to sterile syringes can substantially reduce IDUs' risks of acquiring and transmitting blood-borne viral infections. It should not, however, be seen as a free-standing intervention or strategy. This review has focused on the role of syringe access in the behavior of IDUs and the spread of bloodborne disease, but syringe access is only one factor in this complex social equation. Taking a broader view of the spread of disease among IDUs, and the resources for preventing it, the Centers for Disease Control and Prevention (CDC) and other leaders in HIV prevention recommend a comprehensive approach to prevention of blood-borne infections among IDUs, their sex partners and children.<sup>189</sup> Syringe access is an important component of a comprehensive approach, but should be supported by other interventions including substance abuse treatment, effective community outreach to IDUs, drug and health services in correctional facilities, strategies to prevent sexual transmission of disease, HIV counseling, testing and referral, services for IDUs living with HIV, and primary drug prevention.<sup>190</sup> CDC's recommendation is consistent with the data we have reviewed on syringe access policies, both from a public health and a policy point of view. In health terms, it is clear that many factors influence IDU risk behavior, and that better syringe access can significantly reduce but not alone prevent the continued spread of HIV. In political terms, an approach that places syringe access in a larger effort to get people off drugs and to prevent them from starting drug use in the first place emphasizes that harm reduction measures are not aimed at promoting drug use.

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<sup>189</sup> Academy for Educational Development, *supra* note 1.

<sup>190</sup> *Id.*

**6. *The critical importance of properly implementing syringe access policies should be recognized and addressed.***

There is frequently a gap between the way policies are intended to work and the way they actually operate in practice.<sup>191</sup> This implementation gap typically reflects a variety of factors, including unanticipated barriers, confusion about the policy's details, and often most important, resistance to the policy among those who are intended to be influenced by it or who must carry it out. In the case of syringe access, the ultimate goal is to facilitate safe behavior among IDUs, but a necessary precondition is participation in syringe exchange, pharmacy access, physician prescription or safe disposal schemes. Likewise, as the *Doe v. Bridgeport* and *Roe v. City of New York* cases dramatically illustrate, the understanding and support of police and prosecutors can be indispensable to the actual implementation of policies that enhance syringe access on paper. It is therefore not sufficient to merely pass a syringe access law. Policy-makers should require and fund an implementation support and evaluation process that includes education directed at consumers, pharmacists or other sellers, and law enforcement, so that all the key players understand the value of syringe access and their role in disease prevention. Research on the impact of the new policy on attitudes and behaviors among all the stakeholders is also crucial.

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<sup>191</sup> See, e.g., Jeffrey L. Pressman & Aaron B. Wildavsky, *Implementation* (1973); J.T. Murphy, *State Educational Agencies and Discretionary Funds* (1974); Jeffrey Pressman, *Federal Programs and City Politics* (1975); D.S. Van Meter & C.E. Van Horn, *The Policy Implementation Process: a Conceptual Framework*, 6 *Admin. & Soc'y* 445 (1985); Christopher C. Hood, *The Limits of Administration* (1976); Eugene Bardach, *The Implementation Game: What Happens After a Bill Becomes Law* (1977); *Effective Policy Implementation* (Daniel Mazmanian & Peter A. Sabatier, Eds., 1981)

### VIII. A Research Agenda for Better Policy

A review of this kind rests on the premise that policy matters to health. The data we have discussed here plainly support the view that syringe access and drug possession laws and law enforcement practices influence how drug users inject, whether they do so with a new syringe or not, and how they dispose of used syringes. These laws, and the police practices flowing from them, may be understood to be structural factors influencing the health of IDUs.<sup>192</sup> There is a growing recognition in public health that such structural factors are important targets for public health intervention;<sup>193</sup> the challenge for research is to uncover how substance abuse policies create health effects, and to suggest how policies and practices may be changed to improve public health. Recognizing substance abuse policy and its implementation as significant factors in health has at least three implications for research.

First: if substance abuse policy is a structural factor in health, then it is a topic that merits more study from *all* researchers working on HIV/AIDS and other diseases linked to drug use. For epidemiologists, for example, policies and practices at the state and local levels should be more thoroughly investigated along with the usual individual demographic and risk factors.<sup>194</sup> Behavioral

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<sup>192</sup> K. M. Blankenship, S. Bray and M. Merson, *Structural Interventions in Public Health*, 14 Suppl 1 AIDS S11 (2000); E. Sumartojo, *Structural Factors in HIV Prevention: Concepts, Examples, and Implications for Research*, 14 Suppl 1 AIDS S3 (2000); Blankenship and Koester, *supra* note 167; Zita Lazzarini, and Robert Klitzman, 30 *Journal of Law, Medicine & Ethics* XX (forthcoming 2002); Scott Burris, Ichiro Kawachi, and Austin Sarat, *Integrating Law and Social Epidemiology*, 30 *Journal of Law, Medicine & Ethics* XX (2002).

<sup>193</sup> Blankenship, Bray and Merson, *supra* note ?.

<sup>194</sup> See, e.g., Friedman, Perlis, and Des Jarlais, *supra* note 93.

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research among IDUs should pay more attention to the effects of policy and policy implementation on IDUs behavioral options and choices. Analyses of syringe sharing, for example, that ignore the role of laws and police behavior are certainly incomplete. The same may be said of health services research and program evaluation; police attitudes and practices should be considered as important factors in SEP utilization, for example. The point is not to ignore non-policy factors, or to make such factors secondary, but to include policy as one of many important factors.

Second: Policy data of the sort primarily summarized here – specifying the kinds of laws that exist on the books across the country – is important, but incomplete. Law as actually implemented can and often does differ significantly from law as written by legislatures or interpreted by judges. For most people outside the legal system, and particularly for people like IDUs who are subject to legal intervention, it is the law on the streets – the law as applied by police officers and prosecutors – that has the greatest effect on their behavior and daily lives.<sup>195</sup> Important ethnographic studies of IDUs have begun to document and explain these effects,<sup>196</sup> but much more needs to be done to properly delineate the important role of policy in IDU health and behavior. Ethnography has and can continue to make an

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<sup>195</sup> On law in everyday life, see generally Patricia Ewick and Susan Silbey, *The Common Place of Law: Stories from Everyday Life* (1998); Austin Sarat, '... *The Law Is All over*': Power, Resistance and the Legal Consciousness of the Welfare Poor, 2 *Yale Journal of Law and the Humanities* 343 (1990).

<sup>196</sup> Blankenship, and Koester, *supra* note 167; Bourgois, *supra* note 103; Koester, *supra* note 103.

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important contribution.<sup>197</sup> As suggested above, however, the implementation of policy on the streets is a matter for researchers of all kinds.

Third: It follows from the first two points that research on substance abuse policy and health will often best be conducted in an interdisciplinary fashion. It will be particularly useful for researchers in policing and criminology to collaborate with substance abuse policy and health researchers. More specifically, there is a need for further research on a number of cross-cutting and important questions:

- How are syringe access policies actually implemented by pharmacists, police officers, prosecutors and others who put law into practice?
- What are the knowledge, attitudes and beliefs of police officers towards syringe access, harm reduction and public health interventions among IDUs?
- What is the impact of legislative changes relating to deregulation in terms of IDUs' behaviors, health and societal effects?
- What social, economic, political or other factors are associated with adoption (or rejection) of laws facilitating access to clean needles for IDUs?
- What factors make laws facilitating access to clean needles for IDUs more (or less) politically acceptable to groups that generally oppose such laws?
- What level of sterile syringe coverage is needed to prevent, arrest and reverse epidemics of blood borne infections?

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<sup>197</sup> S. K. Koester, *The Context of Risk: Ethnographic Contributions to the Study of Drug Use and HIV*, 143 NIDA Research Monograph 202 (1994).

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- To what extent does the optimal level of syringe coverage vary by types of drugs used (e.g., cocaine vs. heroin), the stage of an epidemic and the geographic concentration of IDUs in a given region?
- Which components and combinations of syringe access programs will optimize sterile syringe coverage under various circumstances?
- What types of syringe disposal services will be most amenable to over-the-counter syringe outlets?

### **VIII. Conclusion**

Preventing the continued spread of HIV and other bloodborne diseases among IDUs presents significant challenges to policy makers. The scientific evidence, as interpreted by most public health professionals, dictates the elimination of drug policy barriers to safe injection, especially laws and regulations limiting syringe access. This conclusion is not incontrovertible, however, and in any event decisions about drug policy are rarely made based on data alone. Thus eleven states have deregulated syringe access to some extent, and four more have authorized SEPs, but most states have not acted. The national polling data suggest that public attitudes are malleable on this issue, but the decisions are made at the state level.

Changing drug possession law, or even instituting law enforcement policies discouraging stops or arrests based on the possession of a possibly tainted, used syringe, could be more politically problematic. The very suggestion by syringe access proponents of a change in possession laws may be

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perceived as ratifying the charge that syringe access generally is merely a political stalking horse for drug legalization. Despite these considerations, however, lawmakers in Maryland and the District of Columbia exempted SEP clients from prosecution for possessing trace amounts of drug in used syringes, and federal courts in *Doe v. Bridgeport*<sup>198</sup> and *Roe v. City of New York*<sup>199</sup> ruled that state legislatures had intended to do so when deregulating syringes and authorizing syringe exchange.

The issue of disposal is certainly complex, given the number of existing regulatory systems it touches and the wide range of social actors (from individual consumers to waste processors) involved. Unlike syringe access, there is a real price tag: someone has to pay for the creation and permanent operation of a disposal system. If the lack of a community disposal system is creating significant costs in injuries, however, developing a system may be a net benefit. We have succeeded in developing disposal systems for other commonly used items, such as batteries and motor oil. Disposal of household sharps can, with leadership, be rationalized.

Given the challenges, does the research indicate any ways to improve the political fortunes of sterile syringe access and the comprehensive approach to drug abuse? There is little written on the political dynamics of syringe access, and much of that takes the view that drug and syringe access policy reflect deep structural inequalities of a sort not likely to be overcome by politics as usual.<sup>200</sup> From our experience in drug policy and health, we can suggest some small steps.

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<sup>198</sup> *Doe v. Bridgeport Police Department*, 198 F.R.D. 325 (D. Conn., 2001).

<sup>199</sup> *Roe V. City of New York*, 2002 WL 31599522 (S.D. N.Y., 2002).

<sup>200</sup> Friedman, Perlis, and Des Jarlais, *supra* note 93.

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Observation of the syringe access debate over time suggests that syringe access is not in fact the divide across which opponents and proponents face each other. The debate, that is, is not about the “answer” but the “problem.” The problem syringe access proponents seek to solve is HIV and other bloodborne diseases. The problem opponents are concerned about is drug use and its implications for the moral state of society. Syringe access proponents are prepared to take the risk of compromising drug control in order to prevent disease (and are reasonably confident that the risk of needle access harming drug control is very low). People concerned primarily about drug control are far more averse to any risk that syringe access poses to their goals. This is reminiscent of the politics that obtained for most of the first half of the last century in syphilis control. As described by Allen Brandt, a bitter, decades-long battle over syphilis control policy pitted those who saw the “problem” as venereal disease (and who therefore proposed condoms, medical prophylaxis and education to reduce disease transmission) against those who saw the “problem” as immoral sexuality (and who therefore advocated abstinence and even sometimes opposed health measures that would reduce the negative consequences of negative behavior). In this quite analogous context, advances in STD control depended upon strong leadership from a charismatic Surgeon General, and coalitions between public health agencies and private voluntary associations.<sup>201</sup>

Strong and public leadership must articulate the high health costs of drug abuse and how a comprehensive approach including syringe access can and does reduce them. It must explicitly address

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<sup>201</sup> Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1980* (1987).

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the fear that a health approach encourages drug use. But it must do more. When Franklin Roosevelt's Surgeon General, Thomas Paran, first wrote candidly about syphilis in *Reader's Digest*, and spoke openly about it on national radio, he was attacking a stigma that was making it practically impossible to undertake widespread public education, screening and treatment for STDs. When Surgeon General Koop began to speak out openly about HIV/AIDS, he was bringing powerful support to an effort to reduce the stigma of HIV which has made remarkable progress in the past twenty years. Success in addressing drug abuse and its health consequences requires the same sort of anti-stigma campaign. Until drug users are seen as valuable human beings, and drug abuse as a complex but treatable disorder, stigma will continue to complicate prevention and act as a brooding omnipresence in legislative deliberation.<sup>202</sup>

Given the challenges, it is important to highlight the many "second best" policies that can be helpful intermediate steps towards a policy of best practices. Retail sales restricted to pharmacies, or to a limited number of syringes, have been authorized in states where the votes were not there for complete deregulation. Research suggests that these measures do improve access. Likewise, SEPs with distribution caps or other requirements, while not optimal, are valuable. In states where state-wide support for SEP has been absent, local governments have successfully used their inherent health powers to authorize exchange.

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<sup>202</sup> On stigma and the law, see generally S. Burris, *Disease Stigma in Public Health Law and Research*, 30 J. L., Med. & Ethics 179 (2002).

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There are also important steps to be taken that do not involve legislative change. Our review identified forty-two jurisdictions where it is clearly or arguably legal for pharmacists to sell syringes to IDUs without a prescription, and research shows that many pharmacists are willing to do so.

Pharmacists, the gatekeepers for syringe access in the US and health professionals with the training to play an important health promotion role, are a key audience for educational interventions. A study in Canada concluded:

From a policy perspective, we have found that support from the federal government, regulatory bodies, and professional associations may be an important catalyst to pharmacists' participation in programs [to address substance abuse and its health risks].

Further, it does not appear to be possible to implement such policies without professional development and continuing education, and collaboration with the community. ... Movement forward with expanded preventive and harm-reduction strategies by pharmacies will require careful planning. These should include not only education about the law and the public health value of sterile syringe access, but also efforts to deal with pharmacists concerns about disposal, security and increased work loads.<sup>203</sup>

The same may be said of police and prosecutors. Mutual mistrust between health advocates and law enforcement officials is bad for both sides and the public in the middle. Education on health

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<sup>203</sup> T. Myers, R. Cockerill, M. Millson, J. Rankin, and C. Worthington, *The Role of Policy in Community Pharmacies' Response to Injection-Drug Use: Results of a Nationwide Canadian Survey*, 11 AIDS & Public Policy Journal 78 (1996).

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issues and the impact of drug abuse health interventions on drug control can be informative to health and law enforcement professionals alike. Certainly, the day-to-day success of interventions with drug users can be enhanced by support and collaboration with law enforcement. Support from law enforcement is also very helpful, if not indispensable, to political success.