

Deregulation of Hypodermic Needles and Syringes as a Public Health Measure: A Report on Emerging Policy and Law in the United States

Scott Burris, Editor

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Preface

When a public health imperative is seen to clash with a widely shared norm, it can be difficult to reconcile policy objectives. Certainly, the need to reduce transmission of HIV, the virus that causes AIDS, is an agreed-on public health objective. It is also the case that a significant percentage of cases of transmission of HIV in the United States are directly or indirectly linked to injection drug use. The laws and policies against drug use is seen by many as necessary to prevent illegal drug use. Yet there may be legitimate reasons to permit the sale and distribution of sterile injection equipment to reduce the public health epidemic that is caused by HIV transmission.

In 1997, acting on a report with recommendation of the American Bar Association (ABA) AIDS Coordinating Committee, the ABA adopted policy supporting the removal of legal barriers to the establishment and operation of approved needle exchange programs that include a component of drug counseling and drug treatment referral. Needle exchanges continue to be used in cities and counties. However, there are other approaches to making sterile syringes available. Therefore, consistent with ABA policy and in keeping with the Committee's mission to provide the most current HIV/AIDS-related information to the legal profession and the public, this report is the Committee's effort to illuminate the policy and legal questions surrounding this vital public health issue. Because we believe it will be an important contribution to the debate, we intend to make the report widely accessible, including use of the ABA Web site, www.abanet.org, which is accessed more than one million times per month.

We are grateful that Committee member Scott Burris, liaison from the Section of Individual Rights and Responsibilities, has taken the time and effort to draft much of this report. We also appreciate the collaborative efforts of Dr. T. Stephen Jones and Jennifer Taussig

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Sidney D. Watson
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March 2001

Summary

HIV, hepatitis, and other infections spread through the use of unsterile injection equipment pose a major health threat in the United States, causing thousands of deaths and millions of dollars in preventable health care expenditures every year. The victims include not only drug users themselves, but also indirectly their sex partners and their children, whose infections at birth can be attributed to drug use.

Scarcity of clean needles for injection drug users (IDUs) is one of the main causes of the problem. Scarcity of needles is, in turn, almost entirely the result of public policy. Drug paraphernalia, needle prescription, and pharmacy practice laws and regulations were intended to make it difficult for IDUs to purchase syringes, and they have done so. These rules, and the steps police take to enforce them, often make IDUs who have needles reluctant to carry them for fear of arrest. Public health dictates reducing or eliminating legal barriers to syringe access.

Over the past decade, the main intervention to increase IDU access to sterile syringes was needle exchange. Needle exchange programs distribute new syringes to people who bring back used ones, and normally provide an array of health and social services, including access to drug treatment. Although by 1997, more than 130 needle exchanges were distributing over 17 million needles, needle exchange was growing increasingly controversial. Critics questioned the effectiveness of needle exchange and contended that giving needles to IDUs, especially with government money, sent a message that drug use was acceptable. Research has established that needle exchange programs can help control HIV and do not encourage drug use, but it also has become clear that needle exchange is not a panacea for the problem of syringe access: other ways for IDUs to obtain syringes, particularly non-prescription pharmacy sales, are also needed to make it possible for IDUs to inject only with sterile syringes.

The year 2000 saw the crystallization of a new trend in needle policy: deregulation. Both New York and New Hampshire passed legislation allowing the unrestricted sale of ten or fewer syringes in pharmacies, and Rhode Island deregulated syringe sales altogether. This action brought to nine the number of states that have changed their laws to allow IDUs to buy and possess sterile syringes. Deregulation avoids some of the political and public health problems of needle exchange: it vastly increases the sources for syringes, but eliminates the “endorsement” that may be perceived when government pays the bill. Deregulation, however, brings to a head the ultimate conflict between disease prevention and traditional policies aimed at restricting access to the tools of illegal drug use.

Legislators across the nation are now facing this conflict. This report lays out the medical facts and legal developments behind the deregulation of syringes. It describes three approaches states have taken to syringe deregulation:

- complete deregulation (lifting all significant restrictions on sale and possession of syringes);
- unrestricted pharmacy sales (lifting restrictions on possession but confining sales to pharmacies); and
- “ten and under” (unrestricted sale and possession of a specified number of syringes).

With this report, the AIDS Coordinating Committee of the American Bar Association aims to provide policymakers and the public with the basic legal and medical information necessary for thoughtful consideration of the issues underlying deregulation and related approaches to reducing the spread of HIV/AIDS.

I. Introduction

The sharing of syringes is a significant threat to public health in the United States. Syringe sharing is directly linked to the spread of HIV and other infectious diseases among injection drug users (IDUs), their sex partners, and their children. In fact, researchers estimate that as many as half of new HIV infections are caused by the sharing of needles and syringes contaminated with HIV—directly due to injection drug use, through sexual contact with drug injectors, or birth to a mother who acquired HIV infection through these means.¹ The sharing of syringes by IDUs is the leading source of HIV infection among women and children² and a primary cause of transmission of the hepatitis viruses.³ Although in the past it was widely believed that drug users shared syringes by choice, as a social ritual, it is now known that syringe sharing is largely a result of a scarcity of syringes.⁴ The epidemics of HIV and other blood-borne diseases, and increasing evidence of the role of syringe regulations in the spread of disease, have confronted policymakers with a hard choice between new public health measures and traditional law enforcement strategies.

Syringes are scarce because of public policies designed to make it harder for injection drug users to obtain and carry them. Most states have drug paraphernalia laws that make it a crime for any person to possess or sell items intended to facilitate drug use. Many states have pharmacy regulations that set limits on the sale of syringes. A significant minority of states require a prescription to buy a syringe. These laws, passed over the last hundred years as part of the effort to control drug abuse, embody a long-standing policy of limiting IDUs' ability to obtain the equipment they need to prepare and consume illicit drugs. Although there is no evidence that these laws actually reduce drug abuse, some policymakers believe they send a clear message of disapproval. There is no doubt that they have been effective in reducing the availability of syringes.

Medical research shows that providing safe injection equipment to IDUs prevents HIV and other blood-borne infections without increasing drug abuse.⁵ There is a strong consensus among public health and medical authorities that IDUs should use sterile syringes for every injection.⁶ Providing sterile injection equipment to IDUs through needle exchange programs and pharmacies appears to be cost-effective for society.⁷ The public health imperative is clear: every injection drug user who continues to inject should be able to obtain and use a new, sterile needle every time he or she injects drugs.

The policy questions have become more complicated as knowledge of the behavioral, medical, and legal issues has grown. Early in the epidemic, both lawmakers and public health advocates focused on the question of authorizing needle exchange programs. Needle exchange has become increasingly controversial, however. Experience has shown, too, that needle exchange programs alone cannot provide the syringes necessary to prevent sharing and reuse. Even where needle exchange is authorized, continued criminalization of syringe possession can lead to conflict between public health and law enforcement practices.⁸ Other means of providing syringes—including pharmacy sales, physician prescription, and even vending machine sales—have been tried or proposed, and to some extent all are likewise in conflict with syringe access laws. States are now squarely facing the question of the general deregulation of syringes.

The ABA supports the elimination of barriers to syringe exchange programs that offer drug abuse counseling and treatment referral services to IDUs. The AIDS Coordinating Committee has urged state bar leaders to become actively involved with law reform efforts. This report, however, is meant to be a fair-minded summary of medical and legal developments in a highly contentious area of public policy. It summarizes the legal developments across the nation relating to syringe access and the basic scientific evidence behind these current trends. Part II reviews the accumulated scientific data linking unsafe injection practices to the transmission of diseases like HIV and hepatitis. Part III describes the laws pertaining to syringe regulation and the research findings on how implementation of these laws by

police and prosecutors influences the injecting behavior of IDUs. Part IV examines the merit of modifying and repealing laws restricting syringe access and describes the models of deregulation that various states have adopted. Finally, in Part V, physician prescription of syringes and needle exchange are discussed as important additional approaches to increasing syringe availability.

II. Public Health Needs

A. Injection Drug Users Are at High Risk of Infection with HIV, Hepatitis, and Bacterial Infections

Injection drug users (IDUs) engage in multiple behaviors that place them at high risk of acquiring HIV, viral hepatitis, and bacterial infections. Through direct and indirect sharing of blood-contaminated injection equipment, IDUs risk infection with HIV, hepatitis A virus (HAV), hepatitis B virus (HBV) and hepatitis C virus (HCV).⁹ Direct sharing is multiperson use of the same syringe. Indirect sharing involves multiperson use of the same drug preparation equipment such as cookers, cotton and water, and is typical during the processes of preparing and injecting drugs.¹⁰ IDUs and their sexual partners are also at increased risk of acquiring these blood-borne infections through their involvement in high-risk sexual behaviors, which are often linked to high-risk drug using behaviors.¹¹

Surveillance data from the Centers for Disease Control and Prevention (CDC) reflect that injection drug use is directly or indirectly associated with approximately a third of all reported AIDS cases in the United States.¹² Up to one-half of new HIV cases are believed to be IDU-associated.¹³ In 1999, 14,000 of the 46,400 reported AIDS cases were IDU-associated, with more than half of these cases occurring among heterosexual male IDUs. Twenty-one percent of the cases were among female IDUs, 13% were among men who have sex with men and inject drugs, 13% were among heterosexual partners of IDUs, and less than 1% were children whose mothers were IDUs or who were sex partners of IDUs. The surveillance figures reflecting the IDU-associated AIDS cases are, most likely, an underestimate of the

true number of IDU-associated cases because some AIDS cases initially classified as “other risk not reported or identified” are classified later as IDU-related.

Injection drug use has largely driven the transmission of HIV and AIDS among ethnic and racial minorities. In 1998, close to 40% of all reported AIDS cases among African Americans were IDU-associated and, among Hispanics, 43% of reported cases were IDU-associated.¹⁴ The IDU-associated AIDS rate was ten times higher for African Americans than for whites in 1998 and five times higher for Hispanics than for whites.¹⁵

Injection drug use and its associated high-risk behaviors also contribute substantially to the transmission of HAV, HBV, and HCV. It is estimated that injection drug use accounts for 60% of HCV transmission, with studies consistently finding injection drug use to be the most important risk factor for HCV infection.¹⁶ Prevalence rates of HCV among IDUs in the United States and abroad range from 65% to 80%.¹⁷ Recent studies of young IDUs have found significant rates of HCV among persons injecting for relatively short periods of time (less than two years), suggesting that new initiates of injection drug use are becoming infected with HCV very early in their injection careers. In a study of young IDUs in Baltimore, researchers found an incidence rate of 16.0/100 person years for IDUs who had been injecting for less than two years.¹⁸

Injection drug use is also a primary risk behavior for the transmission of HBV. Studies in the United States and abroad have found HBV prevalence rates among IDUs ranging from 65% to 90%.¹⁹ While the hepatitis B vaccination has helped to decrease the overall incidence of HBV in the general population, IDUs remain a group in which new infections continue to occur at high rates. Studies suggest that HBV infection can occur very quickly after initiation to injection drug use, with one study finding that close to 50% of IDUs who had been injecting drugs for one year or less were seropositive for HBV.²⁰

Since 1982, IDUs have been recognized as a group at increased risk for infection with HAV. Investigations of outbreaks of HAV

among IDUs have shown that the most likely route of transmission was percutaneous, through the sharing of injection paraphernalia.²¹

HIV, as well as chronic infections with HBV and HCV, can lead to significant morbidity and mortality for IDUs. While medications for HIV positive persons have helped to improve their health and immune status, there are numerous medical complications of living with HIV, and not everyone has access to the costly medications that help to ward off deadly complications of HIV. Chronic HBV and HCV infections can lead to liver failure, cirrhosis and liver cancer. Antiviral treatments for both HBV and HCV infections are moderately effective and have considerable side effects. Routine vaccinations of IDUs for both HAV and HBV are strongly recommended.

B. Access to Sterile Injection Equipment Is Crucial to Prevent Disease

Providing IDUs with access to sterile syringes would seem to be a logical public health strategy for averting further transmission of HIV and other blood-borne infections among IDUs and their sexual partners and children. In 1997, the U.S. Public Health Service advocated in an HIV Prevention Bulletin that IDUs who continue to inject drugs should use a new, sterile syringe for every injection, and that syringes should be obtained from reliable sources such as pharmacies.²² These public health recommendations were echoed in an Institute of Medicine report that concluded that “[f]or injection drug users who cannot or will not stop injecting drugs, the once-only use of sterile needles and syringes remains the safest, most effective approach for limiting HIV transmission.”²³

While there are no perfect studies on the impact of programs to increase access to sterile syringes, there is remarkable agreement on the benefits of these programs. For example, a novel but widely accepted model based on HIV testing of syringes returned to the New Haven syringe exchange program estimated a one-third reduction in HIV incidence among IDUs participating in the program.²⁴ An eco-

logical study found that HIV seroprevalence decreased in cities with syringe exchange programs and increased in cities without them.²⁵ A consensus conference of the National Institutes of Health (NIH) concluded that syringe exchange programs should be widely supported.²⁶ Among IDUs in Australia, prevalence and incidence of HIV infection has remained very low because of a combined policy of widespread access to syringes (both syringe exchange programs and extensive pharmacy sale of syringes) and expansion of substance abuse treatment.²⁷ Evaluation of the impact of the 1992 changes in Connecticut syringe laws found that pharmacies sold increasing numbers of non-prescription syringes, and that IDUs shifted their syringe purchases from “street” to pharmacy purchases.²⁸ A review of international efforts to prevent HIV among drug injectors concluded that syringe access was an important element.²⁹ Former NIH director Harold Varmus offered the following opinion on syringe exchange programs:

An exhaustive review of the science in this area indicates that needle exchange programs can be an effective component of the global effort to end the epidemic of HIV disease. . . . recent findings have strengthened the scientific evidence that needle exchange programs do not encourage the use of illegal drugs.³⁰

Improved access to sterile syringes can substantially reduce IDUs’ risks of acquiring and transmitting blood-borne viral infections, but should be seen as a component of a comprehensive approach to preventing blood-borne infections and not as a free-standing intervention or strategy. The Centers for Disease Control and Prevention (CDC) and other leaders in HIV prevention recommend that efforts to prevent HIV transmission among IDUs, their sex partners, and children should be comprehensive.³¹ The CDC-recommended comprehensive approach includes eight strategies and four principles. The eight strategies are:

- substance abuse treatment;
- community outreach;
- access to sterile syringes;
- services in the criminal justice system;

- strategies to prevent sexual transmission;
- counseling and testing services, partner counseling and referral services, and prevention case management;
- services for IDUs living with HIV/AIDS; and
- primary drug prevention.

The four principles are:

- ensure coordination and collaboration;
- ensure coverage, access, and quality;
- recognize and overcome stigma; and
- tailor services and programs.

C. Providing Syringes Helps and Does Not Hurt Efforts to Reduce Drug Use and Related Social Problems

Because preventing disease is just one of many public health concerns arising from drug use, public health professionals, policy-makers, and the public have all been concerned about understanding the effect of syringe access programs on the overall drug epidemic. Particular concern has been voiced that liberalizing syringe access could encourage non-drug users to begin drug use or reduce the willingness of current users to enter treatment. There have also been concerns that better syringe access could lead to more needles being improperly—and dangerously—discarded in the community, and that syringe access programs could increase neighborhood crime. This section reviews the data on these concerns.

1. Better Syringe Access Does Not Hurt Efforts to Reduce Drug Use

Because of the legal penalties for and the profound stigma of drug use, it is technically extremely difficult to obtain scientifically valid data on the use of drugs in a community, state, or nation. This limitation has made it essentially impossible to evaluate the impact of HIV preven-

tion interventions on overall patterns of drug use in the community. However, there are extensive studies of the impact of syringe access interventions on IDUs participating in the programs. Almost all studies of the drug use behavior of IDUs participating in syringe exchange programs show decreases in drug use behaviors that can transmit blood-borne infections.³² Studies of changes in syringe laws in Connecticut and Minnesota have documented that IDUs decrease sharing of syringes and other risks for blood-borne infection transmission.³³ Opponents of interventions to improve access to sterile syringes have expressed concern that such interventions would “send the wrong message” about drug abuse to children, suggesting that such use was socially acceptable. However, the one study of this fear, a survey of Baltimore high school students’ attitudes, found no relationship between knowledge of syringe exchange programs and inclination to use drugs.³⁴

2. Syringe Access Programs Can Be Gateways to Substance Abuse Treatment Programs

Syringe access programs attract IDUs who want to obtain syringes. Such programs, therefore, offer the opportunity to contact and interact with IDUs, including offering opportunities to promote entry into substance abuse treatment programs that can reduce or eliminate drug use and drug injection. Studies of syringe exchange programs have found them to be effective in recruiting IDUs and linking them to substance abuse treatment programs.³⁵ In addition, programs that increase the interaction between IDUs and pharmacists offer opportunities for the pharmacists to provide IDUs with information about and referrals to substance abuse treatment. These interactions have been documented in Connecticut³⁶ and Minnesota.³⁷

3. Better Syringe Access Does Not Result in More Improperly Discarded Syringes

Fear that IDUs will discard used needles improperly has played a significant role in policy debates about improving syringe access.

Improperly discarded syringes in communities come from IDUs, but also from persons administering medications for conditions such as diabetes.³⁸ Perhaps the most obvious cause of the problem is the lack of options in the community for safe disposal of syringes used by all needle users.³⁹

Safe disposal of used syringes is an important part of the mission of syringe exchange programs. Syringe exchange programs provide one new syringe for every used one turned in, or in some other way tie the number of needles given out to the number brought back. Thus syringe exchange programs generally do not increase the overall number of syringes circulating in the community and, indeed, reduce the number of used ones. Empirical studies of discarded syringes in the vicinity of syringe exchange programs have documented the absence of increases in unsafely discarded syringes.⁴⁰ Drug paraphernalia laws have a powerful, chilling effect on IDUs' willingness to dispose of used syringes safely by taking them to syringe exchange programs and/or safe disposal sites. The risk of arrest for possession of syringes makes many IDUs unwilling to follow through on safe disposal of their used, blood-contaminated syringes.⁴¹

Programs to increase the availability of sterile syringes through pharmacies have been linked to efforts to improve used syringe disposal in Minnesota and New York. The 1997 "Minnesota Syringe Access Initiative" required participating pharmacies to register and indicate how they would assist customers in properly disposing of used syringes. About one half of Minnesota pharmacies registered.⁴² Similar required activities related to syringe disposal are included in the new laws in New York State allowing sale and possession of up to ten syringes.⁴³

4. Syringe Access Programs Do Not Appear to Increase Local Crime

Some commentators have expressed concern that the introduction of syringe access programs in neighborhoods might lead to increases in property or violent crime,⁴⁴ although no such increases have been reported. A recently published study assessed trends in crime in a

Baltimore neighborhood before and after the introduction of a needle exchange program, and compared these trends with crime in other areas of the city.⁴⁵ Economically motivated crimes, violent crimes and resisting arrest all increased more rapidly outside the needle exchange neighborhood than within it, while drug possession increased more in the needle exchange neighborhood than outside it. None of these differences were statistically significant, however, leading to the conclusion that needle exchange did not have a serious influence on crime.

D. Optimum Prevention: A Variety of Syringe Access Opportunities

The goal of programs to increase IDU access to sterile syringes is to provide enough sterile syringes so that a new sterile syringe can be used for every drug injection.⁴⁶ Given that each IDU is estimated to account for about 1,000 drug injections per year,⁴⁷ large numbers of syringes will be required to achieve this goal. Syringe exchange programs are popular, but many of them exchange relatively few syringes each year.⁴⁸ Because pharmacies are conveniently located, open for extended hours and offer relatively easy access to health professionals, they are excellent facilities to sell sterile syringes.⁴⁹ In addition, IDUs prefer different types of services to obtain/purchase sterile syringes.⁵⁰ For example, some IDUs prefer not to use syringe exchange programs because such use identifies them as IDUs.⁵¹ Young IDUs in France were more likely to use a syringe vending machine than syringe exchange programs and pharmacies.⁵² In a city with both syringe exchange and pharmacy sources for syringes, IDUs use different sources and differing combinations of sources.⁵³ Achieving public-health-scale increases in the availability of sterile syringes for IDUs will require multiple sources of sterile syringes (including both syringe exchange programs and pharmacies).

It must be stressed that efforts to prevent HIV and other blood-borne infections among IDUs, their sex partners, and children cannot be based solely on increased access to sterile syringes.⁵⁴

A comprehensive approach that includes substance abuse treatment, programs in correctional settings, high-quality medical and social services for HIV-infected IDUs and other programs will achieve the greatest impact on both the spread of infectious diseases and the substance abuse itself.

III. Legal Barriers to Syringe Access

This section examines more closely the laws and law enforcement practices that influence syringe access.

A. Paraphernalia, Syringe Prescription, and Pharmacy Practice Rules

Generally speaking, three categories of laws directly limit access to sterile injection equipment: specific syringe prescription laws, general drug paraphernalia laws, and miscellaneous pharmacy practice regulations.⁵⁵

1. Syringe Prescription Laws

Syringe prescription laws were enacted to remedy the abuse of opiates such as morphine during the late 19th and early 20th centuries.⁵⁶ Thirteen states currently have a law or regulation that requires a prescription to purchase a syringe under at least some circumstances. These laws may be divided for present purposes into two groups: those that pervasively regulate the sale and possession of needles and constitute a major barrier to IDU access, and those that pose few or no barriers. The latter group includes three states whose laws apply in only limited circumstances (Florida,⁵⁷ Nevada,⁵⁸ and Virginia⁵⁹) and four states that have “deregulated” sales of ten syringes and fewer (these states—Connecticut, New Hampshire, New York, and Maine—are discussed below.) This leaves six states whose syringe prescription rules remain an impediment to syringe access: California, Delaware, Illinois, Massachusetts, New Jersey, and Pennsylvania.

Most of the general prescription laws on the books today limit who may legally possess a syringe, require a prescription for sale to

non-medical or other unauthorized personnel and set out more or less onerous record-keeping requirements. Delaware's law provides:

(a) No person shall deliver at retail or furnish to any person other than a practitioner an instrument commonly known as a hypodermic syringe or an instrument commonly known as a hypodermic needle or any instrument adapted for the use of narcotic drugs by parenteral injection without a written order of a practitioner or oral order of a practitioner immediately reduced to writing by such person.

...

(c) No person except a practitioner or regular dealer in medical or surgical supplies or their authorized agents or employees shall possess an instrument described in subsection (a) of this section, without having in the person's possession a certificate from a physician certifying that the possession of such instrument is necessary for the treatment of an injury, deformity or disease then suffered by the person possessing the same. Any person convicted of unlawfully possessing an instrument described in subsection (a) of this section shall be guilty of an unclassified misdemeanor, and upon conviction shall be fined not more than \$100, be imprisoned not more than 30 days, or both. Every person who lawfully possesses an instrument described in subsection (a) of this section shall, before disposal, destroy such instrument in such a manner as to render it unfit for reuse in any manner.

(d) Any person who delivers, disposes of or gives away any instrument commonly known as a hypodermic syringe or an instrument commonly known as a hypodermic needle or any instrument adapted for the use of narcotic drugs by parenteral injection except in the manner prescribed in this section, shall be guilty of a class G felony.⁶⁰

2. Drug Paraphernalia Laws

Drug paraphernalia laws are found in the District of Columbia and every state except Alaska. Most paraphernalia laws in effect today were enacted in the 1970s and 1980s to regulate the growth of the “head-shop” industry, which had grown to between 15,000 and 30,000 outlets by 1976 doing an annual \$3 billion business in such items as cigarette rolling papers, bongos (used for smoking marijuana and hashish), and freebasing kits (for cocaine).⁶¹ “The impetus behind the [laws] was the belief that the possession, sale, manufacture, delivery, and advertisement of drug paraphernalia encourage and glamorize the illegal use of controlled substances, as well as increase the public’s acceptance of such use.”⁶² Most of these statutes are based on, and are often virtually identical to, a model drug paraphernalia act drafted by the U.S. Department of Justice in the late 1970s.⁶³

The typical statute defines drug paraphernalia generally as all equipment, products and materials of any kind that 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” the state’s controlled substances laws.⁶⁴ It then provides a list, by way of example, of a dozen or more particular 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.”⁶⁵ It is important to note that by this definition, however, the status of any item as paraphernalia depends not just on the characteristics of the item itself but also on the intention or acts of the defendant. A small glass vial used to store saffron in a spice store is not drug paraphernalia. The same vial, sold with knowledge to a crack dealer to be used in packaging his product, would be paraphernalia. These laws do not impose any obligation on the retail seller to investigate the purposes of a purchaser of an item, like a syringe, that has both legitimate and illegitimate uses. To commit a crime, the seller must have knowledge of, or be willfully ignoring, the intended drug-related use.⁶⁶

The model paraphernalia law was written in broad terms to encompass almost any type of item that might be used for drug abuse. Because of this, both legislators and courts were concerned that the laws could be construed to apply to innocent transactions, people, or equipment.⁶⁷ To guide the finder of fact, paraphernalia statutes often include a list of factors to be taken into consideration in determining whether an item is drug paraphernalia. The list typically includes consideration of legitimate uses for the item, which could well embrace disease control.⁶⁸

Paraphernalia laws usually create two basic offenses: manufacturing or distributing and possessing. Not every state has created both offenses. The offense of manufacturing and distributing is phrased in terms that tend to repeat the scienter (knowledge) element built into the definition and make it a crime to

deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used to . . . inject . . . or otherwise introduce into the human body a controlled substance or marijuana in violation of [state controlled substances laws].⁶⁹

It is typically unlawful, in the words of the model statute, “[t]o use, or to possess with intent to use, drug paraphernalia to . . . introduce into the human body a controlled substance in violation” of controlled substances laws.⁷⁰ Although it has received less attention than laws regulating the sale of syringes, restriction of paraphernalia possession has also been identified as an important contributing cause of unsterile injection.⁷¹

The severity of this offense varies. In most states, a paraphernalia law violation is a misdemeanor,⁷² but in a few it is a felony.⁷³ Anecdotal evidence and research suggests that these laws are often enforced, at least in some states.⁷⁴

Paraphernalia laws are ubiquitous, but they can differ in small ways that have a significant impact on the analysis of syringe access. Nine states’ paraphernalia laws exclude syringes categorically⁷⁵ or

when sold in amounts of ten and under.⁷⁶ South Carolina's paraphernalia law omits any reference to syringes or injection and does not apply to items used in the consumption of opiates. Six more states provide some kind of immunity to pharmacists that would cover the knowing sale of syringes to IDUs under at least some circumstances.⁷⁷

3. Pharmacy Regulations

Pharmacy regulations complete the legal quilt and differ depending on state and territory. Leaving aside syringe prescription laws, which often appear in the Pharmacy Code, pharmacy law includes three basic types of controls over syringe sales: "sub-prescription" controls on purchase, such as requiring the buyer to demonstrate a legitimate medical or legal purpose for the syringe purpose; record-keeping and display rules; and, finally, a variety of informational and disposal rules that are found primarily in states that have liberalized or deregulated syringe purchase limits (and which are discussed below). Twenty-three states have some sort of pharmacy regulation pertaining to syringe sales.⁷⁸ Pharmacy regulations can often have a significant impact on syringe availability. Pharmacists are often unaware of paraphernalia laws, or are unsure of their effect, but tend to be well-educated about the rules directly governing their profession.

Sub-prescription requirements put the pharmacist in the position of deciding who should be allowed to purchase a syringe. Georgia's pharmacy laws provide an example of legality hinging on the pharmacist's perceptions of the buyer's purpose:

Pharmacies shall keep injectable syringes behind the counter in their prescription departments and in no other place. No person other than a Registered Pharmacist or a Registered Intern acting under the immediate and direct personal supervision of a Registered Pharmacist shall sell injectable syringes. No injectable syringe shall be sold by a person having reasonable cause to believe that it will be used for an unlawful purpose.⁷⁹

Record-keeping requirements can be a deterrent to purchase even when the pharmacist is willing to sell. Indiana's regulations offer an example of the sort of record-keeping requirements present in pharmacy regulations, requirements that apply even though no prescription is required for purchase:

(a) A . . . device known as a hypodermic syringe and/or needle for human use may be dispensed by a pharmacist without a prescription to a purchaser at retail, provided that:

. . .

(4) the pharmacist requires every purchaser of a . . . device . . . not known to the pharmacist to furnish suitable identification (including proof of age where appropriate); and

(5) separate bound record books for dispensing of . . . devices under this section . . .

are maintained by the pharmacist. These books shall contain the name and address of the purchaser, the name and quantity of . . . devices purchased, the date of each purchase, and the name or initials of the pharmacist who dispensed the substance or devices to the purchaser and these books shall be maintained in accordance with the record keeping requirements of 856 IAC 2-4-1.⁸⁰

Although most states do not have explicit rules about syringes in their pharmacy codes, all states regulate the practice of pharmacy and can punish what is deemed to be "unprofessional conduct." Some pharmacists may believe it is improper or unprofessional to sell syringes to IDUs.

Given the important role of pharmacy sales of syringes, any public policy aimed at promoting such sales must address the attitudes of pharmacists. In addition to legal concerns, pharmacists' willingness to sell syringes depends on their beliefs about the public health importance of syringe access, their attitudes about drug use, and their per-

ceptions of the risk of increased crime, bad customer reaction, and discarded syringes.⁸¹

4. Summary

Syringe prescription laws, pharmacy rules, and prohibitions on drug paraphernalia in effect make pharmacists the gate-keepers of syringe access. In practice, the IDUs who can pass themselves off as having other reasons for buying a syringe, or whose appearance does not raise any suspicion in the pharmacist, are able to buy sterile syringes.

A summary of the syringe prescription and paraphernalia laws by state is presented in Table 1. Important pharmacy board regulations are also noted.

Table 1. Syringe access law in fifty states & the District of Columbia

STATE	PRES. LAW	PARA. LAW	COMMENT
AL		X	
AK		X	Local drug paraphernalia ordinances in several cities
AR		X	
AZ		X	
CA	X	X	
CO		X	Paraphernalia law does not mention syringes
CT	X	X	Paraphernalia law excludes <31 syringes; prescription law excludes < 11
DE	X	X	
DC		X	
FL	X	X	Prescription required for sales to minors only
GA		X	Pharmacy regulations require legitimate medical purpose for syringe sale
HI		X	
ID		X	
IL	X	X	

Table 1. *continued*

STATE	PRES. LAW	PARA. LAW	COMMENT
IN		X	Paraphernalia law exempts sellers of items “historically and customarily used in connection with the . . . injecting . . . of . . . lawful substance[s].”
IA		X	Paraphernalia law excludes syringes distributed for a “lawful purpose”
KS		X	
KY		X	Syringe sale law places detailed restrictions on sales
LA		X	Paraphernalia law explicitly excludes items distributed for medical use
ME	X	X	Sale of <11 syringes unrestricted
MD		X	Board of Pharmacy has implied that pharmacist discretion to dispense syringes to prevent disease
MA	X	X	
MI		X	Dispensing legal if authorized for disease prevention purposes by any state or local agency
MN		X	Sale of <11 syringes unrestricted
MO		X	
MT		X	Paraphernalia law exempts physicians & pharmacists
MS		X	
NE		X	
NV	X	X	Prescription required except for insulin, asthma and other specified uses
NH	X	X	Prescription law excludes <11 syringes for adults; paraphernalia law no longer applies to injection equipment
NJ	X	X	
NM		X	Paraphernalia law exempts pharmacy sale or distribution of syringes

Table 1. *continued*

STATE	PRES. LAW	PARA. LAW	COMMENT
NY	X	X	Prescription law excludes <11 syringes and paraphernalia law exempts syringes obtained pursuant to the prescription law
NC		X	
ND		X	
OH		X	Physicians and pharmacists exempt from paraphernalia law
OK		X	
OR		X	Paraphernalia law excludes syringes
PA	X	X	Prescription required for sale by pharmacy regulation
RI		X	Paraphernalia law excludes injection equipment
SC		X	Syringes separately regulated; paraphernalia law does not include “injection” or syringes and does not apply to heroin use
SD		X	
TN		X	Paraphernalia law exempts physicians and pharmacists; buyer must show “medical need” per pharmacy regulations
TX		X	
UT		X	
VT		X	
VA	X	X	
WA		X	Pharmacy regulation to clarify legality of unrestricted sales pending
WV		X	Paraphernalia law allows sale by licensees such as pharmacists
WI		X	Paraphernalia law excludes syringes
WY		X	
Total	13	50	

B. Law Enforcement Practices

Legal restrictions on the sale of syringes make them scarce for drug users. Police enforcement of syringe possession, paraphernalia, and even drug possession laws can make users who have syringes unwilling to carry them, which can lead to an IDU injecting with a borrowed or second-hand syringe.⁸² Enforcing syringe possession laws also gives rise to dramatic expenditures for syringe-related arrests and incarceration.

Ethnographic evidence and widespread anecdotal reports suggest that general street policing to enforce syringe laws may create an environment in which drug abuse is furtive and hidden.⁸³ Under drug paraphernalia and needle prescription law, possession of a syringe can be the basis for a stop and frisk and informal confiscation.⁸⁴ In fact, police may think they are acting leniently by confiscating needles, rather than taking action to formally arrest injection drug users. Arrest and prosecution are also common in some places. Although in most states syringe possession is a misdemeanor, many IDUs are on parole or probation from earlier criminal convictions, so they are subject to return to prison on arrest or conviction of a drug-related crime of any level. Street-based drug injectors are particularly susceptible to the enforcement of syringe laws because they are so noticeable.⁸⁵ In one ethnographic survey, 23 of 24 IDUs stated that they did not carry syringes because they feared arrest.⁸⁶ The underground quality of drug use leads some users to shooting galleries or other concealed venues where clean water and other hygienic amenities are lacking, which can contribute to the transmission of infections.⁸⁷

Published studies of linking syringe-based arrest and incarceration found significant levels of prosecution. In Rhode Island, needle and syringe arrests accounted for 10% of all drug possession arrests and 7% of all drug-possession-related convictions prior to deregulation.⁸⁸ The state expended considerable state funds to enforce syringe laws, spending nearly a million dollars in incarceration costs alone. Incidentally, the state also had one of the highest proportion of AIDS cases linked to injection drug use and the highest reported rate of syringe re-use among IDUs.⁸⁹

Strict syringe possession laws may also correlate with high street prices for syringes. In a recent study surveying needle exchange program (NEP) workers throughout the United States about local street prices of syringes, results indicated that there was a strong correlation between syringe possession laws and higher street prices.⁹⁰ Street prices of syringes are an easily quantifiable method of assessing the availability of syringes and may reflect syringe availability and sharing.

These findings suggest that criminalizing the distribution and possession of syringes is likely to create shortages of injection equipment, lead to greater reuse of syringes among IDUs⁹¹ and result in large expenditures for the arrest, conviction and incarceration of IDUs prosecuted for syringe possession.

Paraphernalia laws also contribute to the improper and often hazardous disposal of used syringes by IDUs because of their fear of arrest for syringe possession. Numerous studies have found that, while IDUs report trying to dispose of their used syringes in ways intended to minimize potential injury to other individuals, their efforts are often impeded by their fear of arrest for possession of syringes and fear that possession of used syringes will identify them as IDUs to the police.⁹² The fear of arrest for paraphernalia possession translates into increased risk-taking among IDUs because they are less likely to carry a syringe on them and, thus, are more likely to share a syringe with another drug user when they are ready to inject.

IV. Deregulation

There appears to be little doubt among public health experts that restricting access to sterile syringes is a significant contributor to the spread of blood-borne disease among drug users and their sex partners and children. The first major intervention widely proposed to address the problem was needle exchange, but that has proven to be both politically controversial and subject to important limitations. Between the political barriers and some of the built-in limits of exchange (such as limited hours of service and limited appeal to certain IDUs), NEPs have not been able to meet the need for sterile syringes on their own.⁹³ At the same time, data from states like Connecticut,⁹⁴ that have liberalized the rules for pharmacy sales, have shown the value of using existing retail distribution systems to distribute what are, after all, inexpensive consumer items. Increasing the availability of syringes now requires more than just needle exchange programs. In the past year, the agenda in state legislatures has shifted from establishment of NEPs, to considering whether and to what extent to deregulate the market for syringes. This section examines what states have done and discusses in detail the three basic approaches that legislatures have chosen: complete deregulation, unrestricted pharmacy sales and pharmacy sale of some limited number of syringes.

A. Deregulation Developments

“Deregulation” is the removal of the state as a barrier to syringe access. 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 NEPs, 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 injec-

tion. Politically, deregulation potentially eliminates or significantly reduces the concern about government “endorsement” of drug use, often raised in debates about NEPs, because the state is neither paying for nor distributing needles. With deregulation, funds may also be shifted from incarceration to other state-related uses.

Since the beginning of the HIV epidemic, nine states⁹⁵ may be said to have deregulated the sale or possession of at least some number of syringes.⁹⁶ In addition, Alaska has stuck to its long-standing policy of not restricting access to syringes. States have taken a variety of approaches, discussed below.

Oregon was the first state to face the question of syringe access squarely as a public health measure. Before 1987, syringe sales were not regulated. In that year, the state legislature passed a paraphernalia law based on the model statute but chose to explicitly exclude syringes from the definition of paraphernalia.⁹⁷ In 1989, after the connection between HIV and dirty needles had become clear, Wisconsin also excluded hypodermic syringes from its roster of drug paraphernalia.⁹⁸

Connecticut had both a general drug paraphernalia and a specific syringe prescription law. In 1992, the Connecticut General Assembly modified its syringe prescription laws to allow any person to buy ten or fewer needles at a pharmacy without a prescription.⁹⁹ At the same time, the paraphernalia law was amended to exclude hypodermic syringes and needles sold or possessed in amounts of ten or fewer. In 1999 the possession (but not the purchase) limit was raised to 30.¹⁰⁰

Maine also had a syringe prescription and drug paraphernalia law. In 1993 the Maine legislature passed Public Law 393, which removed the prescription requirement for syringe sales. Four years later, in 1997, a second bill was enacted to remove the criminal penalties for possession of ten or fewer syringes.¹⁰¹

Minnesota had state syringe and drug paraphernalia statutes that regulated the sale and possession of syringes. In 1997 it amended these laws to allow the pharmacy sale of up to ten syringes without a prescription and the possession of up to ten unused syringes at any time.¹⁰²

New York had both a syringe prescription and drug paraphernalia law. In 2000, however, it modified its syringe prescription law to allow the sale of ten or fewer syringes without a prescription.¹⁰³ The

paraphernalia law was amended so that the paraphernalia provisions did not apply to the sale and possession of ten or fewer syringes authorized under its prescription law.¹⁰⁴ The new law also required pharmacies selling syringes to provide information to users about syringe disposal and drug treatment options. The deregulation program was authorized as a two-year experiment. The department of health will evaluate the impact of deregulation and report back to the legislature.

New Hampshire also amended its syringe prescription and drug paraphernalia laws in 2000. New Hampshire's syringe prescription law now allows a patient to buy ten or fewer needles in a pharmacy without a prescription.¹⁰⁵ The 2000 needle deregulation legislation also removed syringes from inclusion in the drug paraphernalia act by deleting the act's references to "injecting."¹⁰⁶ As in New York, the amendment requires pharmacists to provide purchasers with information on the safe disposal of syringes and needles.

Rhode Island had both prescription and paraphernalia laws. In 2000 the Rhode Island legislature repealed its prescription law and amended its paraphernalia law to exclude syringes as a disease prevention measure. The legislature repealed the prescription requirement and eliminated all criminal penalties for syringe possession. It also made clear that syringes were not covered by the paraphernalia act by cutting 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."¹⁰⁷ The deregulation act requires pharmacists to provide information on drug treatment, HIV prevention and safe disposal practices to purchasers.

Iowa moved against the trend, although apparently not deliberately, when, in April 2000, it enacted a paraphernalia law.¹⁰⁸ The bill was a last-minute amendment to another bill dealing with methamphetamine, which was passed with limited debate on the last day of the legislative session, without discussion or consideration of the public health issues.

As this report went to press, the New Mexico legislature amended the State's paraphernalia law to allow unrestricted pharmacy distribution of syringes. 2001 NM S.B. 320 (enacted April 3, 2001).

B. Deregulation Choices

Although there appears to be a trend toward making syringes more available to IDUs in states with substantial injection drug use, there is no consistent legal approach to such change. To illustrate the options available to policy-makers, this report examines how three states have approached deregulation. The key differences have to do with whether syringe sales should be limited to pharmacies, whether there should be some limit on the number of syringes that can be purchased at one time and the degree to which sellers should be responsible for providing information and/or disposal opportunities to purchasers.

1. Complete Deregulation: The Oregon Model

Oregon excludes syringes from its drug paraphernalia law and has no other restrictions on their sale or possession. Therefore it is legal in that state to sell needles in pharmacies and in other retail outlets, possibly even vending machines, and to distribute them through needle exchanges or any other convenient medium. This approach can be described as complete deregulation and minimizes the legal barriers to syringe access. Two public health professionals who played leadership roles in the development of this approach have described the policy deliberations:

In the mid-1980s, when discussion of a state drug paraphernalia law was occurring in Oregon, there were few AIDS cases and low HIV seroprevalence in the state. This gave Oregon the luxury of time to consider aggressive prevention measures. The state had an active director of substance abuse treatment policy who was interested in seeing that Oregon had effective substance abuse prevention and treatment policies that were consistent with policies being discussed nationally.

In Oregon, unlike situations in some other states at the time, syringes and needles could be purchased in pharmacies without a prescription. There was little or no evidence that over-

the-counter sale of syringes and needles was a significant contributor to drug use in Oregon. Pharmacies, however, testified to advisory groups on HIV policy that they made it difficult for persons without medical indications (e.g. diabetes) to purchase syringes and needles. There was mounting evidence from other states that the prevalence of HIV infection was rapidly increasing among intravenous drug users. As a means of what is now known as “harm reduction,” the Oregon Health Division worked with pharmacists and the Board of Pharmacy beginning in 1985 to make over-the-counter sales of syringes and needles less burdensome for persons without medical indications.

When the new drug paraphernalia law was proposed in 1986, the original drafts were developed with little Health Division input. The Health Division made a strong case for exclusion of syringes and needles as a means of preventing HIV infection. The related issues of hepatitis B and hepatitis C infection were not as widely discussed at the time. There was active debate within the Department of Human Resources (DHR) because of conflicting priorities between the Health Division and the office that dealt with drug and alcohol policy. The debate that developed within the DHR was extensive enough that the DHR did not make a recommendation on the proposed legislation, effectively stopping consideration of the proposed drug paraphernalia law for the 1985 biannual session of the legislature.

During the interim before the 1987 biannual session, Oregon public health, drug treatment, and law enforcement agencies agreed that HIV prevention was significant enough to warrant exclusion of syringe and needles from the drug paraphernalia law. Revised legislation excluding syringes and needles from the definition of drug paraphernalia was approved during the 1987 legislative session.¹⁰⁹

Oregon allows for the exclusion of syringes by an explicit clause in its paraphernalia law. The statute continues to include injection in the roster of drug-use practices that contribute to defining paraphernalia under the first part of the definition but specifically states that “[D]rug paraphernalia does not include hypodermic syringes or needles.”¹¹⁰ This may be contrasted with the recent legislation in New Hampshire, which simply removes the paraphernalia law’s references to “injecting.” This was sufficient in New Hampshire, which did not explicitly mention syringes in its paraphernalia law, because the simultaneous changes in the prescription law clearly manifested the legislature’s intent to deregulate syringes. Given the broad definition of “paraphernalia” in most statutes, however, such a minimalist approach could leave some doubts about whether syringes were still covered under paraphernalia laws.¹¹¹ The Oregon approach also has the advantage of maintaining regulation over other possible (if somewhat unlikely) means of drug injection that are not desirable from either a drug control or public health point of view.

Complete deregulation is the most desirable model to maximize access to sterile syringes. It allows distribution by the widest variety of means and outlets. With restrictions repealed, syringes could be sold not only in pharmacies, but also in convenience stores, groceries and other accessible locations, or could be handed out free of charge by public health and community organizations. By removing all restrictions on syringe sales, deregulation also eliminates legal barriers to needle exchange. Deregulation takes possession almost entirely out of the purview of law enforcement. It is a “market-driven” solution, insofar as it leaves sellers and buyers free to make their own choices. From a political point of view, it closes needle 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.

Even complete deregulation may leave a loophole through which needle possession may still be the basis of prosecution. After drug injection, a syringe barrel will often contain a minute residual amount of the controlled substance that is nevertheless sufficient to constitute the crime of illegal drug possession. In some jurisdictions, law enforcement authorities have been reported to be confiscating syringes or even

arresting IDUs on this ground. Although the one court decision addressing this issue concluded that a deregulation law by implication immunized drug users from this sort of prosecution,¹¹² it may be necessary for syringe deregulation legislation to address this issue explicitly.

2. Unrestricted Pharmacy Sales: The Rhode Island Model

Rhode Island recently substantially eliminated the restrictions on sales of syringes but has continued to confine their sale to pharmacies:

Deregulation syringe act for diabetes and health promotion.—
 (1)(a) Hypodermic syringes, needles or any instrument adapted for the administration of drugs by injection shall not be sold except in licensed pharmacies. Every sale shall be made subject to the rules and regulations of the director of the department of health.

(b) The following conditions shall apply to all purchases of hypodermic syringes or needles:

...

(iv) At all licensed pharmacies where hypodermic needles and syringes are kept for retail sale pursuant to this section, the needles and syringes shall be stored in a manner that makes them available only to authorized personnel and not openly available to customers; . . .¹¹³

Pharmacies are ubiquitous in urban areas and often are open 16 to 24 hours a day. But restricting access to pharmacies, particularly if sale is accompanied by restrictions on display, continues to make the pharmacist the decision-maker and may pose the same sort of psychological barrier that used to interfere with condom sales when condoms were commonly kept behind drug store counters. Some rural and inner city areas may not have a convenient pharmacy. On the potentially beneficial side of the ledger, restricting sales to pharmacies allows the state to impose more requirements for education and assistance in disposal, discussed below, though it is not yet clear whether these restrictions are beneficial in practice.¹¹⁴

By regulating only *sales*, Rhode Island and other states following this model provide more options for public health distribution of needles at no charge. Thus the Rhode Island law effectively legalizes needle exchange altogether and could allow other, less formal modes of distribution along the lines of how condoms are provided at no cost.¹¹³ Because it eliminates all criminal penalties for syringe access, Rhode Island's model, like Oregon's, substantially reduces law enforcement as a deterrent to sterile injection.

3. "Ten and Under Deregulation": The Connecticut Model

Connecticut has adopted a model that deregulates the sale and purchase of needles, but only in limited quantities. Today, it is legal to buy up to ten and possess up to 30 needles at any one time:

Hypodermic needles and syringes in a quantity of ten or less without a prescription may be provided or sold at retail only by the following: (1) By a pharmacy licensed in accordance with section 20-594 and in such pharmacy only by a licensed pharmacist or under his direct supervision; (2) by a needle exchange program established pursuant to section 19a-124; and (3) by a health care facility or a licensed health care practitioner for use by their own patients.¹¹⁶

Under this system, retail sales are limited to ten per transaction, but needle exchange programs can give up to 30 at a time.

On initial examination, the "ten and under model" offers similar drawbacks and benefits to the Rhode Island approach. By restricting sales to pharmacies, the state may impose requirements on the pharmacist to provide education of HIV prevention, drug treatment, and safe syringe disposal to purchasers. The ten and under model also has value as a political compromise between liberalizing syringe regulation while still limiting IDU access to syringes. This approach has been followed by Maine, Minnesota, New Hampshire and New York.

Precisely because the arbitrary cap on possession and sale is a product of politics rather than public health science, the ten and under

model is potentially problematic from a public health perspective. Three Connecticut advocates of syringe access recently lamented the

compromises that have undermined syringe exchange program (SEP) effectiveness. One such compromise was the institution of a cap on the number of syringes that could be exchanged at SEPs in the state of Connecticut. The cap served both a symbolic and a functional purpose. Symbolically, it helped to dispel suspicions that SEPs encourage drug use by making syringes readily available, appeared to increase SEP control over distributed syringes, and added a veneer of political acceptability to SEPs. Functionally, the cap restricted the supply of syringes for SEP customers.¹¹⁷

IDUs vary in the frequency of injection, and some injectors may often inject ten or more times in a day, as is the case with cocaine users. For these IDUs, a ten and under restriction may make it difficult to comply with the advice to use a clean needle for every injection. Raising the cap to 30 addresses this problem to some degree but still ultimately lacks a clear public health justification.

A second problem is that the ten and under model continues to restrict the non-commercial or free distribution of needles. This retains state regulation of needle exchange programs, which require a specific exemption to operate. It also prevents other, more novel or less service-intensive modes of needle distribution, such as vending machines. Finally, ten and under models do not take syringes out of the realm of law enforcement. Possession beyond the designated number remains a crime, so any syringe remains potential evidence of a crime and, potentially, probable cause for a stop and frisk or search. With syringes maintaining ambiguous legal status, it may be more difficult to convince police officers to avoid behavior that discourages IDUs from carrying sterile syringes.

In Connecticut, the ambiguous legal status of needles led to continuing reports from needle exchanges, IDUs and public health officials that police officers were continuing to stop drug users and arrest them for needle possession. Some law enforcement officials were

also prosecuting users for possession of controlled substances based on the residue of drugs left in a used syringe. The problem eventually came to federal court. In *Doe v. Bridgeport Police Dept.*,¹¹⁸ a federal judge prohibited the Bridgeport Police Department stopping, searching, arresting, or threatening any person in possession of less than thirty-one sterile or previously-used needles. The court held that the deregulation law 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.

Criminalizing 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 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.¹¹⁹

The decision may help clarify matters in Connecticut, but the problem of continuing uncertainty about the legality of syringes is virtually inherent in the “ten and under” model.

C. Disposal and Information Requirements

Two ancillary questions have come up consistently in needle deregulation debates: disposal of used needles and balancing drug abuse reduction with the greater availability of needles. Several states that have chosen the Rhode Island or Connecticut model have addressed these concerns by requiring pharmacists to provide information about disposal and drug treatment to IDUs purchasing needles. Rhode Island, for example, mandates that:

(b) The following conditions shall apply to all purchases of hypodermic syringes or needles:

(i) Pharmacists shall make available to each purchaser at the time of purchase information regarding the safe disposal of

hypodermic syringes or needles, including local disposal locations or a telephone number to call for such information;

(ii) Pharmacists may also provide purchasers with information on drug addiction treatment, including a local telephone number to get assistance;

(iii) The director of the department of health shall adopt rules and regulations relative to the content, format, and distribution of any materials required under this section and any other matter necessary to effectuate the purposes of this section;

...

(v) A registered pharmacy or licensed pharmacist that sells hypodermic needles or syringes must certify to the director of the department of health participation in an activity that supports proper disposal of used hypodermic needles or syringes.¹²⁰

These requirements address very important community concerns. Literally billions of needles are used by Americans every year for uses unrelated to drug abuse, and little has been done in many communities to ensure that needle users are aware of and have access to proper means of disposal.

Used syringes discarded in community settings such as parks, beaches, and trash receptacles have provoked a negative reaction to unsafe needle disposal practices.¹²¹ Although needle exchange programs and drug users are often blamed for improperly disposed needles, the evidence so far suggests that NEPs do not cause the problem,¹²² which is actually the result of too few disposal options for all syringe users. A broad range of laws and regulations have been implemented to address the disposal of medical waste, and a variety of strategies have been implemented to provide safe disposal for everyone who uses needles in the community. Some communities have encouraged placing used syringes in puncture-resistant containers such as plastic soda cans, which are then labeled as “biohazard” and discarded in the trash. Community drop boxes may be used as disposal sites.

Other communities offer systematic collection of syringe containers, which are then treated as biohazardous waste.

Guidelines for safe disposal practices have been readily available to people with diabetes for some time. Needle exchange programs are just as important for the needles they reclaim for proper disposal as for the sterile needles they distribute. Among injection drug users, however, targeted efforts to save and dispose of used syringes safely are constrained by fear that possession will label them as law breakers or single them out for arrest.¹²³

Disposal takes time and entails marginal expenses for retailers, which explains in large part the tendency to require pharmacists to provide information but not disposal services. In Minnesota, which pioneered the idea of requiring pharmacists to provide disposal information, the state pharmacy organizations made clear that they would not support a law that mandated pharmacists to collect and arrange disposal of used syringes. Even handing out a brochure may be perceived by some pharmacists as a pointless burden. In the past decade, Congress and the states have substantially increased the obligations of pharmacists to provide counseling and other information services to customers,¹²⁴ even as competition in the industry has increased the pace of pharmacy practice. In real life, many pharmacists often have difficulty providing services beyond preparing prescriptions and making minimal checks for contraindications.

Disposal of syringes is ultimately a community problem that is best addressed by integrating syringes into the general waste stream in a sensible and safe way, or through community-wide syringe disposal schemes.¹²⁵ Sellers can certainly play an informational role, and just as certainly cannot be expected to accept primary responsibility. Information requirements represent a political compromise, whose effect should be monitored and evaluated. Other considerations include making it legal for IDUs to carry syringes to locations for safe disposal and avoiding the stigma attached to being identified as an IDU by providing anonymous disposal options.

Providing education about drug abuse treatment also addresses a key health issue. Substance abuse treatment works and reduces the risks of disease transmission. Nevertheless, merely providing infor-

mation at the time of syringe sale seems more symbolic than of practical value. The main barrier to IDUs interested in drug treatment is not information but access: getting into a program involves finding an available slot, working out eligibility issues and maintaining the commitment to treatment during the often long period spent looking for and getting into a program. Information requirements are easy to impose. While cheap, they are not free. The more time, money, and effort needle retailers are required to expend in providing information and documenting regulatory compliance, the less likely they are to be willing to sell needles to anyone.

D. Summary of Syringe Access Approaches

The differences between deregulation and other syringe access options are summarized in Table 2.

Table 2. Syringe access models

INTERVENTION	ALLOWS NEPS	ALLOWS PHARMACY SALE	ALLOWS GENERAL RETAIL SALE	ALLOWS GENERAL FREE DISTRIBUTION	ELIMINATES POSSESSION PROSECUTION
STATUTES AUTHORIZING NEPS	YES	NO	NO	NO	NO
"TEN AND UNDER" CT, ME, MN, NH, NY	NO	YES	NO	SOME	NO
UNRESTRICTED PHARMACY SALES - RI	YES	YES	NO	YES	YES
DEREGULATION - AK, OR, WI	YES	YES	YES	YES	YES

E. The Role of Pharmacy Boards

Pharmacy boards are the most visible and important regulators of pharmacists, so their advice and information can carry special weight among pharmacists. In 1992 a nationwide survey of state pharmacy association executives and leaders of state pharmacy boards found moderate support for the repeal of prescription and paraphernalia laws and only limited support for pharmacist participation in the sale and distribution of syringes.¹²⁶ However, support for pharmacy action is now more widespread because of evidence indicating the public health benefits of increasing syringe access to IDUs. In 1999, the American Pharmaceutical Association urged “boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes . . . to decrease the transmission of blood-borne diseases.”¹²⁷

A recent resolution by the Washington Board of Pharmacy demonstrates how a regulatory agency can intervene to reassure professionals uncertain about the law. Washington law requires that

[o]n the sale at retail of any hypodermic syringe, hypodermic needle, or any device adapted for the use of drugs by injection, the retailer shall satisfy himself or herself that the device will be used for the legal use intended.¹²⁸

The Washington Board of Pharmacy became concerned that some pharmacists might interpret this law as prohibiting the sale of syringes to injection drug users, in spite of the legitimate medical and public health purposes that such a sale would serve. The board therefore adopted an interpretation of the term “legal use” that includes preventing disease.¹²⁹ In a similar move, in 1999 the Maryland Board of Pharmacy advised pharmacists in a newsletter that it was appropriate to take many factors into consideration when determining what constitutes the need for syringes and needles before dispensing them. Such factors include chronic illness, prevention of disease transmission and self-administration of intravenous medication.

F. Support for Deregulation

Restricted access to sterile syringes from pharmacies, coupled with the fear of arrest for syringe possession, translate into high-risk injection-related practices among IDUs that place them at increased risk of infection with HIV and viral hepatitis. Recognizing this tremendous public health problem and the legitimate medical purpose sterile syringes serve in preventing transmission of these blood-borne pathogens, a number of national organizations have adopted policies supporting the removal of legal and regulatory barriers to syringe sales.

In 1997, the American Medical Association (AMA) House of Delegates approved a series of new AMA policies including “that the AMA strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription.”¹³⁰ The AMA policy recognizes the importance of removing barriers to both the sale and possession of syringes.

In 1999, the American Pharmaceutical Association (APhA) adopted a policy stating that the “APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.”¹³¹ The National Association of Boards of Pharmacy (NABP) adopted a similar resolution in May 2000. Both these statements recognize the important public health role pharmacists can play by selling syringes to IDUs.

In 1999, the AMA, APhA, the National Alliance of State and Territorial AIDS Directors, the Association of State and Territorial Health Officials, and the National Association of Boards of Pharmacy issued a joint letter to their respective state affiliate groups encouraging them to coordinate their state-level efforts to improve access to sterile syringes. A copy of this letter is in Appendix III.

The American Bar Association adopted policy in 1997 favoring legalization of needle exchange programs that include a drug-treat-

ment referral component. (The ABA has not adopted policy regarding the deregulation of hypodermic needles or syringes.) In 2000, the AIDS Coordinating Committee sent a letter to state bar associations encouraging them to collaborate with other groups to improve sterile syringe access. A copy of this letter is in Appendix II.

V. Other Approaches to Increasing Syringe Access

Deregulation is the most direct route to maximum syringe access. Not all states may be willing to pursue this path, so other avenues to better syringe access continue to be important to the public's health. This section examines two. Physician prescription of injection equipment to IDUs is a new intervention aimed at affording greater access to syringes and improving health care for IDUs. Needle exchange is a proven health intervention that continues to play a role in reducing blood-borne disease among IDUs, their sex partners, and their children.

A. Physician Prescription

Prescription distribution of syringes is a new clinical intervention used to increase IDU access to sterile syringes. The complex web of prescription, drug paraphernalia, and pharmacy practice rules discussed above makes physicians and pharmacists the primary gatekeepers to syringe access. Even where prescriptions are not required by law, having a prescription may help an IDU convince a pharmacist to sell syringes.

Physicians generally have broad discretion to prescribe drugs and devices they believe will be medically beneficial for patients.¹³² 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.¹³³ For their part, pharmacists are authorized to dispense medications ordered by a valid prescription and ordinarily are expected to do so in the absence of good reason to refuse.¹³⁴

The relevant statutes, regulations, and court decisions in the 50 states, the District of Columbia, and Puerto Rico were collected

and analyzed in a recent study by Burris et al.¹³⁵ (see Table 3). Physician prescription of injection equipment to patients as a means of preventing disease transmission during drug use is clearly legal in 48 of the 52 jurisdictions, while dispensing syringes in pharmacies is clearly legal in 27. State law is considered to provide a reasonable claim to legality if it neither explicitly allows nor forbids prescribing or dispensing, such that an attorney acting ethically and in good faith could argue that the practices are legal. Two states are classified in this category with respect to prescribing and 22 with respect to dispensing. Prescribing injection equipment is clearly prohibited by law in only two jurisdictions; dispensing is clearly illegal in only four. The legalities of needle distribution through the health care system are thus quite different from those associated with lay distribution through needle exchanges¹³⁶ or pharmacy sale without prescription.¹³⁷

Table 3. The legality of prescribing and dispensing sterile injection equipment to injection drug users to prevent disease transmission

Physician prescription of sterile injection equipment			Pharmacy sale of prescribed syringes		
Clearly legal	Reasonable claim to legality	Clearly illegal	Clearly legal	Reasonable claim to legality	Clearly illegal
AL, AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OR, PA, PR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY	OH, OK	DE, KS	AK, CA, CO, CT, IL, IN, LA, ME, MA, MI, MN, MT, NV, NH, NJ, NM, NY, OR, PA, PR, RI, SC, TN, VA, WA, WV, WI	AL, AR, AZ, DC, FL, ID, IA, KY, MD, MS, MO, NE, NM, NC, ND, OH, OK, SD, TX, UT, VT, WY	DE, GA, HI, KS

B. Syringe Exchange

Because of extensive evidence demonstrating the effectiveness of syringe exchange programs, there has been substantial support by leading medical authorities,¹³⁸ professional organizations,¹³⁹ and the President's HIV Advisory Council for such programs. Research studies of syringe exchange programs indicate that such programs provide health benefits among IDUs, including reduction in needle sharing and high-risk behavior,¹⁴⁰ decrease in the incidence of HIV¹⁴¹ and other blood-borne diseases,¹⁴² and greater access to HIV and drug use prevention programs.¹⁴³ Most recently, the Surgeon General reviewed the research data since 1998 and concluded that "there is conclusive scientific evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs."¹⁴⁴ Numerous medical and scientific organizations also validate the public health effects of syringe exchange.¹⁴⁵

Currently, 31 jurisdictions have syringe exchange programs,¹⁴⁶ including ten with statutes explicitly authorizing such programs.¹⁴⁷ These programs typically offer an array of services for IDUs. Of 87 programs surveyed in 1996, 97% referred to substance abuse treatment, 80% provided education to reduce the risk of STDs, and many others provided primary health care, tuberculosis screening, and HIV counseling and testing.¹⁴⁸ Although lowering HIV rates is the primary goal of needle exchange, other outcomes have been found, including reduced drug use, lower rates of criminal activity for profit and greater entry and retention in drug treatment programs.¹⁴⁹

Syringe exchange programs are not a complete solution to the problem of unsterile injection. Research has shown that if the availability of clean syringes fails to meet the needs of the IDU population in a given community, re-use of syringes is likely to occur and subsequently affect HIV incidence.¹⁵⁰ Unfortunately, the existing network of some 134 NEPs cannot satisfy the needs of IDUs in the United States on its own. Estimates of the annual number of syringes required to meet the Department of Health and Human Services' sin-

gle-use standard run in the range of one billion.¹⁵¹ However, in 1997, the most recent estimate of the number of syringes distributed by NEPs in the United States was only 17.5 million.¹⁵²

VI. Conclusion: Building Consensus

Many policies, including those governing access to drug treatment, the sale of needles by pharmacies, and the arrest of IDUs for possessing needles influence the spread of HIV and other blood-borne diseases.¹⁵³ From a public health point of view, only a comprehensive effort to address the twin epidemics of communicable disease and drug abuse has the potential to significantly reduce the toll society is paying in lost lives and lost human potential. There is considerable evidence that liberalizing syringe access laws will make a major contribution to public health efforts. This report has documented the evidence and the legal responses of states.

Increasing access to syringes for IDUs can be a politically charged issue and raises deep worries for many people about a possible negative impact on efforts to reduce drug abuse. The experience of the states that have deregulated syringes since the beginning of the HIV epidemic provides some assurance that these downside risks are small, but syringe access remains an issue in which symbolism and emotion are as important as scientific evidence. Most states that have faced the issue effectively have reached a decision after a period of education, rational debate, and sincere efforts to build consensus among all interested constituencies. Drug users are not an alien force in the population: they are fathers, mothers, brothers, sisters, children. The challenge for policymakers is to craft policies that effectively address the problems of drug abuse without endangering the very people we seek to protect.

Appendix I:

The American Bar Association AIDS Coordinating Committee

The American Bar Association (ABA) AIDS Coordinating Committee was established in 1987 and charged with developing the ABA's AIDS-related activities, generating policy recommendations and encouraging new ABA-sponsored AIDS programs. The Committee is composed of a chair appointed by the ABA President, a vice-chair and representatives of more than fifteen other ABA entities and several ABA-affiliated organizations

ABA Policy

Through the AIDS Coordinating Committee, the ABA adopted policy, beginning in 1988, to address a number of HIV/AIDS-related concerns. Early ABA policies related to HIV/AIDS addressed issues such as voluntary counseling and testing; disclosure of identifying information; discrimination based on real or perceived HIV serostatus against otherwise qualified individuals in employment, housing, public accommodations, and government services; and procedures for dealing with HIV/AIDS in courtrooms and correctional facilities.

In 1989 the ABA adopted an omnibus package of HIV/AIDS-related policies that address access to the legal system and administration of justice, confidentiality, public health law, access to health care, HIV testing and counseling, insurance, drug abuse, immigration, education of the public, and partner notification.

Subsequent policies have addressed a number of additional issues, including long-term planning through legal mechanisms such

as stand-by guardianship, advance medical directives, viatical settlements, and appropriate consumer safeguards; compassionate release of nonviolent prisoners dying of AIDS or other terminal illnesses; and removal of legal barriers to implementation of needle exchange programs that include drug counseling and treatment.

Status/Activities

In addition to formulating ABA policies on HIV/AIDS, the AIDS Coordinating Committee and AIDS Coordination Project assist practitioners and others working with HIV/AIDS legal issues through their publications and programs. In addition to this publication, the project currently has available its *Directory of Legal Resources for People with HIV/AIDS* (3rd ed., 2001).

In January 1999, the Committee held a first-of-its-kind, national, invitational symposium to address newly emerging issues in HIV/AIDS law. Titled, *HIV/AIDS and the Law: An Agenda for Beyond the Millennium*, the program assembled experts from a variety of backgrounds to focus on four primary aspects of the future of HIV/AIDS law: prevention, access to medical and legal care, international issues and discrimination in the workplace and beyond. The symposium identified a number of issues on which the Committee will base its future policy resolutions, publications and other projects.

The ABA has testified before Congress and the National Commission on AIDS, speaking on behalf of the Ryan White Act reauthorization and other AIDS-related issues. Most recently, the ABA has advocated federal funding for approved needle exchange programs, as defined in the ABA needle exchange policy. And, in spring 2000, the Committee published *Perspectives on Returning to Work: Changing Legal Issues and the HIV/AIDS Epidemic* (Mark E. Rust, editor). The Committee continues to follow these and other HIV/AIDS-related issues closely.

Appendix II:

ABA AIDS Coordinating Committee Letter on Syringe Deregulation

January 28, 2000

Presidents and Executive Directors
State and Local Bar Associations
(Letters sent individually by name)

Dear _____:

I am writing to ask your help in an urgent matter of public health—the transmission of HIV and other deadly blood-borne diseases through the use of contaminated drug injection equipment. Two years ago, the American Bar Association (ABA) adopted policy supporting the removal of legal barriers to the establishment of needle exchange programs. It states:

Resolved, that in order to further scientifically based public health objectives to reduce HIV infection and other blood-borne diseases, and in support of our long-standing opposition to substance abuse, the American Bar Association supports the removal of legal barriers to the establishment and operation of approved needle exchange programs that include a component of drug counseling and drug treatment referrals.

This policy reflects the Association's long-standing concern with substance abuse and the HIV/AIDS epidemic and is predicated on two substantiated facts: first, laws that prevent injection drug users (IDUs) from using clean injection equipment have facilitated the spread of blood-borne diseases (including HIV and Hepatitis B and C) to their sex partners, their children, and other IDUs; and second, the availability of clean needles and syringes to IDUs has not increased drug use. Today, the Centers for Disease Control and Prevention estimate that one-third of HIV cases and serious epidemics of needle-borne Hepatitis B and C are attributable to contaminated needles.

Recently, five leading medical, pharmacy and public health organizations came together to encourage their state affiliates to take action to eliminate barriers to syringe access. They all agree that syringe access programs have proven to be an effective strategy in reducing the spread of blood-borne disease. The American Medical Association, the American Pharmaceutical Association, the Association of State and Territorial Health Officials, the National Association of Boards of Pharmacy, and the National Association of State AIDS Directors encouraged their professional colleagues "and other state leaders in these fields to meet, assess the situation in [their respective] states and decide on appropriate approaches to these important public health issues."

This initiative by leading health organizations provides an opportunity for the organized bar and medical communities to work jointly to resolve a difficult social issue. Lawyers can help bring reasoned and dispassionate analysis to the debate over the value of syringe access programs and can help remove the legal obstacles to the establishment of such programs in jurisdictions that wish to implement or expand them. Those jurisdictions that have adopted such programs have demonstrated that removal of legal obstacles may include these ABA-supported interventions:

- amending the drug paraphernalia laws to clarify that they do not prohibit needle exchange programs or other public

- health strategies that increase access to and use of sterile injection equipment;
- eliminating syringe prescription laws or regulations;
 - issuing regulatory opinions, or amending statutes and health regulations, to clarify that selling or prescribing syringes to prevent disease is a “legitimate medical purpose;”
 - eliminating impediments to syringe sales found in pharmacy regulations; and
 - developing better mechanisms for the safe disposal of used syringes.

In addition, lawyers and appropriate health professionals can work jointly to enhance the availability of substance abuse counseling and treatment. Over two decades of research have proven beyond a reasonable doubt that drug abuse treatment is effective and can reduce drug use in America. Unfortunately, some IDUs may not be receptive to the idea of treatment; even if they are, treatment is not always available when needed. One benefit of syringe access programs is that repeated personal contact with an IDU can provide opportunities to build trust and encourage voluntary participation in drug treatment programs.

We urge you to take a leadership role and offer to work jointly with health organizations in your state to eliminate barriers to syringe access. A list of contacts is attached for your reference. The ABA is ready to support and assist your efforts and to work for necessary reforms at the national level. Please contact Steven Powell, Director, ABA AIDS Coordination Project, at 202/662-1025 (e-mail: powells@staff.abanet.org) if you would like additional information about the issue or the type of assistance the ABA may be able to provide.

Sincerely,

Robert E. Stein, Chair
ABA AIDS Coordinating Committee

Appendix III:

Joint Public Health Letter on Syringe Regulation

American Medical Association
Physicians dedicated to the health of America



NASTAD
NATIONAL ALLIANCE
OF STATE AND TERRITORIAL
AIDS DIRECTORS



October 1999

HIV Prevention & Access To Sterile Syringes

Dear Colleague:

Approximately one third of all AIDS cases and one half of hepatitis C cases are directly or indirectly linked to injection drug use. Limited access to sterile syringes contributes to the transmission of these blood-borne infections among injection drug users (IDUs), their sex partners, and their children.

The United States Public Health Service recommends that drug users who continue to inject use a new, sterile syringe for each injection to prevent the transmission of blood-borne pathogens and that they obtain syringes from reliable sources such as pharmacies.

In many states, there are legal and regulatory barriers to the pharmacy sale of sterile syringes to IDUs, including prescription and drug paraphernalia laws and pharmacy regulations on syringe sales. The American Medical Association (AMA), the American Pharmaceutical Association (APhA), the Association of State and Territorial Health Officials (ASTHO), and the National Alliance of State and Territorial AIDS Directors (NASTAD) have suggested that the removal or modification of legal barriers is an important step in increasing the availability of sterile syringes through pharmacies. Connecticut, Minnesota, and Maine have made such changes.

AMA, APhA, ASTHO, and NASTAD have adopted the following policies related to pharmacy sale of syringes.

- | | |
|---------------|---|
| AMA (1997) | That the AMA strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription. |
| APhA (1999) | APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases. |
| ASTHO (1995) | ASTHO policy states that as a possible public health strategy to reduce the transmission of injection-related blood-borne infections, states should explore the removal of legal barriers such as drug paraphernalia and prescription laws, which criminalize the distribution and/or possession of needles and syringes. |
| NASTAD (1997) | NASTAD calls on state and local legislative bodies to increase access to sterile needles and syringes through needle exchange programs; to deregulate possession of needles, syringes and associated injection equipment as drug |

paraphernalia; to increase access to sterile syringes via sale by pharmacies; and to increase access to drug treatment for those individuals ready for such treatment.

NASTAD encourages each state health department to work with pharmacy boards and local law enforcement agencies to change local laws which would increase access to sterile injection equipment.

AMA, APhA, ASTHO, NASTAD, and the National Association of Boards of Pharmacy (NABP) believe that coordinated efforts of state leaders in pharmacy, public health, and medicine are needed to address access to sterile syringes as a means of preventing further transmission of blood-borne diseases.

We encourage you and other state leaders in these fields to meet, assess the situation in your state, and decide on appropriate approaches to these important public health issues. Other issues that may be important to consider are the availability of substance abuse treatment and options for safe disposal of syringes.

For more information, you can contact the following staff members of the organizations issuing this letter:

AMA	LJ Tan at (312) 464-4147, litjen_tan@ama-assn.org
APhA	Jann Skelton at (800) 237-2742 ext 7198, jbs@mail.aphanet.org
ASTHO	Helen Fox Fields at (202) 371-9090, hffields@astho.org
NABP	Jan Teplitz at (847) 698-6227, jteplitz@nabp.net
NASTAD	Julie Scofield at (202) 434-8090, Jscofield@NASTAD.org

We look forward to working with you to address these significant public health problems.

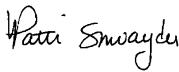
Sincerely,



E. Ratcliffe Anderson, Jr., MD
Executive Vice President
American Medical Association



John A. Gans, PharmD
Executive Vice President
American Pharmaceutical Association



Patti Shwayder
Interim Executive Vice President
Association of State and Territorial
Health Officials



Julie M. Scofield
Executive Director
National Alliance of State
and Territorial AIDS Directors



Carmen Catizone, MS, RPh
Executive Director / Secretary
National Association of Boards of Pharmacy

Appendix IV:

A Representative Syringe Prescription Statute

Del. Code Ann. tit. 16, §4757.

(a) No person shall deliver at retail or furnish to any person other than a practitioner an instrument commonly known as a hypodermic syringe or an instrument commonly known as a hypodermic needle or any instrument adapted for the use of narcotic drugs by parenteral injection without a written order of a practitioner or oral order of a practitioner immediately reduced to writing by such person.

(b) Every person who disposes of or delivers at retail, or gives away to any person the instruments described in subsection (a) of this section, upon the written order of a practitioner or oral order of a practitioner immediately reduced to writing by such person, shall, before delivering the same:

(1) Enter into a book kept for that purpose the day of the delivery, the name, age and address of the purchaser and a description of the instrument sold, disposed of, furnished or given away; or

(2) Retain on file the original written order or oral order reduced to writing, noting on such orders any refills.

(c) No person except a practitioner or regular dealer in medical or surgical supplies or their authorized agents or employees shall possess an instrument described in subsection (a) of this section, without having in the person's possession a certificate from a physician certifying that the possession of such instrument is necessary for the treatment of an injury, deformity or disease then suffered by the person possessing the same. Any person convicted of unlawfully possessing an instrument described in subsection (a) of this section shall be guilty of an unclassified misdemeanor, and upon conviction shall be fined not more than \$100, be imprisoned not more than 30 days, or both. Every person who lawfully possesses an instrument described in subsection (a) of this section shall, before disposal, destroy such instrument in such a manner as to render it unfit for reuse in any manner.

(d) Any person who delivers, disposes of or gives away any instrument commonly known as a hypodermic syringe or an instrument commonly known as a hypodermic needle or any instrument adapted for the use of narcotic drugs by parenteral injection except in the manner prescribed in this section, shall be guilty of a class G felony.

(e) Nothing in this section shall prohibit the delivery, furnishing, sale, purchase or possession of an instrument commonly known as a hypodermic syringe or an instrument commonly known as a hypodermic needle used or to be used solely and exclusively for treating poultry or livestock and such delivery, furnishing, sale, purchase, possession or use shall be governed by rules and regulations to be prescribed by the Department of Agriculture.

(f) This section does not apply to:

(1) The sale at wholesale by pharmacies, drug jobbers, drug wholesalers and drug manufacturers or manufacturers and dealers in surgical instruments to practitioners; and

(2) The furnishing or obtaining of hypodermic syringes or hypodermic needles for uses which the Secretary determines are industrial. Notwithstanding the other provisions of this section, a person may obtain such instruments, without a written order or oral order reduced to writing, for such industrial uses.

Appendix V:

The Model Drug Paraphernalia Act

Article I *(Definitions)*

The term “drug paraphernalia” means all equipment, products and materials of any kind which are used, intended for use, or designed for use, in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this Act (meaning the Controlled Substances Act of this State). It includes, but is not limited to: (1) Kits used, intended for use, or designed for use in planting, propagating, cultivating, growing or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived; (2) Kits used, intended for use, or designed for use in manufacturing, compounding, converting, producing, processing, or preparing controlled substances; (3) Isomerization devices used, intended for use, or designed for use in increasing the potency of any species of plant which is a controlled substance; (4) Testing equipment used, intended for use, or designed for use in identifying or in analyzing the strength, effectiveness or purity of controlled substances; (5) Scales and balances used, intended for use, or designed for use in weighing or measuring controlled substances; (6) Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose, used, intended for use,

or designed for use in cutting controlled substances; (7) Separation gins and sifters used, intended for use, or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining marihuana; (8) Blenders, bowls, containers, spoons and mixing devices used, intended for use, or designed for use in compounding controlled substances; (9) Capsules, balloons, envelopes and other containers used, intended for use, or designed for use in packaging small quantities of controlled substances; (10) Containers and other objects used, intended for use, or designed for use in storing or concealing controlled substances; (11) Hypodermic syringes, needles and other objects used, intended for use, or designed for use in parenterally injected controlled substances into the human body; (12) Objects used, intended for use, or designed for use in ingesting, inhaling, or otherwise introducing marihuana, cocaine, hashish, or hashish oil into the human body, such as:

- (a) Metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens, permanent screens, hashish heads, or punctured metal bowls;
- (b) Water pipes;
- (c) Carburetion tubes and devices;
- (d) Smoking and carburetion masks;
- (e) Roach clips; meaning objects used to hold burning material, such as a marihuana cigarette, that has become too small or too short to be held in the hand;
- (f) Miniature cocaine spoons and cocaine vials;
- (g) Chamber pipes;
- (h) Carburetor pipes;
- (i) Electric pipes;
- (j) Air-driven pipes;
- (k) Chillums;
- (l) Bongs;
- (m) Ice pipes or chillers.

In determining whether an object is drug paraphernalia, a court or other authority should consider, in addition to all other logically relevant factors, the following:

- (1) Statements by an owner or by anyone in control of the object concerning its use;
- (2) Prior convictions, if any, of an owner, or of anyone in control of the object, under any State or Federal law relating to any controlled substance;
- (3) The proximity of the object, in time and space, to a direct violation

of this Act; (4) The proximity of the object to controlled substances; (5) The existence of any residue of controlled substances on the object; (6) Direct or circumstantial evidence of the intent of an owner, or of anyone in control of the object, to deliver it to persons who he knows, or should reasonably know, intend to use the object to facilitate a violation of this Act; the innocence of an owner, or of anyone in control of the object, as to a direct violation of this Act should not prevent a finding that the object is intended for use, or designed for use as drug paraphernalia; (7) Instructions, oral or written, provided with the object concerning its use; (8) Descriptive materials accompanying the object which explain or depict its use; (9) National and local advertising concerning its use; (10) The manner in which the object is displayed for sale; (11) Whether the owner, or anyone in control of the object, is a legitimate supplier of like or related items to the community, such as a licensed distributor or dealer of tobacco products; (12) Direct or circumstantial evidence of the ratio of sales of the object(s) to the total sales of the business enterprise; (13) The existence and scope of legitimate uses for the object in the community; (14) Expert testimony concerning its use.

Article II

(Offenses and Penalties)

SECTION (A) (Possession of Drug Paraphernalia)

It is unlawful for any person to use, or to possess with intent to use, drug paraphernalia to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale or otherwise introduce into the human body a controlled substance in violation of this Act. Any person who violates this section is guilty of a crime and upon conviction may be imprisoned for not more than (), fined not more than (), or both.

SECTION (B) (Manufacture or Delivery of Drug Paraphernalia)

It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this Act. Any person who violates this section is guilty of a crime and upon conviction may be imprisoned for not more than (), fined not more than (), or both.

SECTION (C) (Delivery of Drug Paraphernalia to a Minor)

Any person 18 years of age or over who violates Section (B) by delivering drug paraphernalia to a person under 18 years of age who is at least 3 years his junior is guilty of a special offense and upon conviction may be imprisoned for not more than (), fined not more than (), or both.

SECTION (D) (Advertisement of Drug Paraphernalia)

It is unlawful for any person to place in any newspaper, magazine, handbill, or other publication any advertisement, knowing, or under circumstances where one reasonably should know, that the purpose of the advertisement, in whole or in part, is to promote the sale of objects designed or intended for use as drug paraphernalia. Any person who violates this section is guilty of a crime and upon conviction may be imprisoned for not more than (), fined not more than (), or both.

Article III
(Civil Forfeiture)

SECTION (insert designation of civil forfeiture section) of the Controlled Substances Act of this State is amended to provide for the

civil seizure and forfeiture of drug paraphernalia by adding the following after paragraph (insert designation of last category of forfeitable property): () all drug paraphernalia as defined by Section () of this Act.

Article IV ***(Severability)***

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

Endnotes

1. See Scott D. Holmberg, *The Estimated Prevalence and Incidence of HIV in 96 Large U.S. Metropolitan Areas*, 86 AM. J. PUB. HEALTH 642 (1996); see also 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 (collected at <http://www.harmreduction.org/shalalaltr.html>).
2. See P.M. Wortley, P.L. Fleming, *AIDS in Women in the United States: Recent Trends*, 278 JAMA 911 (1997); see also J. Normand, D. Vlahov, and L. Moses, Preventing HIV Transmission: the Role of Sterile Needles and Bleach (1995) (available at <http://www.nap.edu/catalog/4975.html>).
3. See M.J. Alter and L.A. Moyer, *The Importance of Preventing Hepatitis C Virus Infection among Injection Drug Users in the United States*, 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL S6 (Supp. 1, 1998); see also R.S. Garfein, M.C. Doherty, E.R. Monterroso et al., *Prevalence and Incidence of Hepatitis C Virus Infection among Young Adult Injection Drug Users*, 18 ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL S11 (1998).
4. See Stephen K. Koester, *Copping, Running, and Paraphernalia Laws: Contextual and Needle Risk Behavior among Injection Drug Users in Denver*, 53 HUMAN ORGANIZATION 287 (1994); see also Don C. Des Jarlais and Samuel R. Friedman, *The Psychology of Preventing AIDS among Intravenous Drug Users*, 43 AM. PSYCHOL. 865 (1988); R. Broadhead, Y. Van Hulst, and D. Heckathorn, *Risk Associated with Closing a Needle Exchange Program*, 46 SOCIAL PROBLEMS 48 (1999); P. Bourgois, *The Moral Economics of Homeless Heroin Addicts: Confronting Ethnography, HIV Risk, and Everyday Violence in San Francisco Shooting Encampments*, 33 SUBSTANCE ABUSE & MISUSE 2323 (1998).
5. The Public Health Impact of Needle Exchange Programs in the United States and Abroad (P. Lurie and A.L. Reingold, eds.) (October 1993); J. Normand, D. Vlahov, L. Moses, *supra* note 2; Evidence-Based Findings, *supra* note 1.
6. The leading federal public health agencies addressing drug use prepared a set of consensus guidelines for physicians caring for drug users that explicitly recommended that drug users be counseled to “use a new, sterile syringe to prepare and inject drugs.” See U.S. Public Health Service. HIV Prevention Bulletin: Medical Advice for Persons Who Inject Illicit Drugs.

- Atlanta, GA and Rockville, MD: U.S. Public Health Service, May 8, 1997; U.S. Preventive Services Task Force. Guide to clinical preventive services, 2nd ed. (Williams & Wilkins eds., 1996); *see also* Statements/ Resolutions/ Policies on Increased Access to Clean Needles and Syringes (collected at <http://www.sfaf.org/hpp/statmnts.html>).
7. A recent cost-benefit analysis indicates that a policy of funding syringe exchange programs, pharmacy sales, and syringe disposal to cover all illicit drug injections would cost an estimated \$34,278 per HIV infection averted. This figure is well below the estimated lifetime cost of medical care for a person with HIV infection. *See* David R. Holtgrave et al., *Cost and Cost-Effectiveness of Increasing Access to Sterile Syringes and Needles as an HIV Prevention Intervention in the United States*, 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL S133 (Supp. 1, 1998).
 8. *See* Doe v. Bridgeport Police Department, 2001 WL 50350, __ F.Supp.2d __ (D. Conn. 2001) (finding that police continued to arrest exchange clients and/or confiscate their needles).
 9. M. Marmor, D.C. Des Jarlais, H. Cohen et al., *Risk Factors for Infection with Human Immunodeficiency Virus among Intravenous Drug Abusers in New York City*, 1 AIDS 39 (1987); R.E. Chaisson, A.R. Moss, R. Onishi et al., *Human Immunodeficiency Virus Infection in Heterosexual Intravenous Drug Users in San Francisco*, 77 AM. J. PUB. HEALTH 169 (1987); E.E. Schoenbaum, D. Hartel, P.A. Selwyn et al., *Risk Factors for HIV-1 Infection in Intravenous Drug Abusers*, 321 NEW ENG. J. MED. 874 (1989); D. Vlahov, A. Munoz, J.C. Anthony et al., *Association of Drug Injection Patterns with Antibody to Human Immunodeficiency Virus Type 1 among Intravenous Drug Users in Baltimore*, 132 AM. J. EPIDEMIOL 847 (1990); C.B. McCoy, L.R. Metsch et al., *Parenteral Transmission of HIV among Injection Drug Users: Assessing the Frequency of Multi Person Use of Needles, Syringes, Cookers, Cotton, and Water*, 18 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME S25 (Supp. 1 1998); S. Koester, *Following the Blood: Syringe Reuse Leads to Blood-borne Virus Transmission among Injection Drug Users [Letter]*, 18 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME S139 (Supp. 1 1998).
 10. S. Koester and L. Hoffer, *Indirect Sharing: Additional HIV Risks Associated with Drug Injection*, 9 AIDS AND PUBLIC POLICY JOURNAL 100 (1994).
 11. A. Chu, A. Torbert et al., *Overlapping AIDS Epidemic among Injecting Drug Use (IDU) and Heterosexual Exposure (HT) in New York City (NYC) AIDS Cases*, 1998; 5th Conference on Retrovirology and Opportunistic Infections, February 1-5, 1998 (Abstract No. 129, p. 103).
 12. Centers for Disease Control and Prevention (CDC). 11(2) HIV/AIDS Surveillance Report 1 (1999a).

13. See Holmberg, *supra* note 1.
14. Centers for Disease Control and Prevention (CDC), *Trends in the HIV/AIDS Epidemic—1999* (collected at <http://www.cdc.gov/hiv/graphics/surveill.htm>).
15. Centers for Disease Control and Prevention (CDC), HIV/AIDS surveillance—general epidemiology slide set (collected at <http://www.cdc.gov/hiv/graphics/surveill.htm>).
16. See Alter, *supra* note 3; D.L. Thomas et al., *Correlates of Hepatitis C Virus Infections among Injection Drug Users*, 74 *Medicine* (Baltimore) 212 (1995).
17. F. Bortolotti et al., *Epidemiological Aspects of Acute Viral Hepatitis in Drug Abusers*, 5 *Infection* 277 (1982); E. Chamot et al., *Incidence of Hepatitis C, Hepatitis B, and HIV Infections among Drug Users in a Methadone-Maintenance Programme*. 6 *AIDS* 431 (1992); J.A.R. van den Hoek et al., *Prevalence, Incidence and Risk Factors for Hepatitis C Virus Infection among Drug Users in Amsterdam*. 162 *J. INFECT DIS.* 823 (1990); J.B. Zeldis et al., *Seroepidemiology of Viral Infections among Intravenous Drug Users in Northern California*, 156 *WEST J. MED.* 30 (1992); E. van Ameijden et al., *A Longitudinal Study on the Incidence and Transmission Patterns of HIV, HBV, and HCV Infection among Drug Users in Amsterdam*, 9 *EUR. J. EPIDEMIOL.* 255 (1993); I. van Beek et al., *Risk Factors for Hepatitis C Virus Infection among Injecting Drug Users in Sydney*, 70 *GENITOURIN MED.* 321 (1994).
18. See Garfein, *supra* note 3.
19. A. Ponzetto et al., *Hepatitis B Markers in United States Drug Addicts with Special Emphasis on the Delta Hepatitis Virus*, 4 *HEPATOLOGY* 1111 (1984); L. Rosenblum et al., *Sexual Practices in the Transmission of Hepatitis B Virus and Prevalence of Hepatitis Delta Virus Infection in Female Prostitutes in the United States*, 267 *JAMA* 2477 (1992); P. Piot, C. Goilav and E. Kegels, *Hepatitis B: Transmission by Sexual Contact and Needle Sharing*, 8 *VACCINE* S37 (1990); sources cited *supra* note 17.
20. See R.S. Garfein, D. Vlahov et al., *Viral Infections in Short-term Injection Drug Users—the Prevalence of the Hepatitis C, Hepatitis B, Human Immunodeficiency, and Human T-lymphotropic Viruses*, 86 *AM. J. PUBLIC HEALTH* 655 (1996).
21. Y.F. Hutin et al., *Identifying Target Groups for a Potential Vaccination Program during a Hepatitis A Communitywide Outbreak*, 89 *AM. J. PUB. HEALTH* 918 (1999); S.A. Villano et al., *Hepatitis A among Homosexual Men and Injection Drug Users: More Evidence for Vaccination*, 25 *CLINICAL INFECTIOUS DISEASES* 726 (1997); A. Widel et al., *Increased Occurrence of Hepatitis A with Cyclic Outbreaks among Drug Addicts in a Swedish Community*, 11 *INFECTION* 198 (1983).

22. See U.S. Public Health Service, *supra* note 6.
23. See Normand & Vlahov, *supra* note 2.
24. See Edward H. Kaplan and Robert Heimer, *HIV Incidence among New Haven Needle Exchange Participants: Updated Estimates from Syringe Tracking and Testing Data*, 10 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. 175 (1995).
25. Susan F. Hurley et al., *Effectiveness of Needle Exchange Programs for Prevention of HIV Infection*, 349 LANCET 1797 (1997).
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28. L.A. Valleroy, B. Weinstein, T.S. Jones et al., *Impact of Increased Legal Access to Needles and Syringes on Community Pharmacies' Needle and Syringe Sales—Connecticut, 1992-1993*, 10 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. 73 (1995); see also S.L. Groseclose, B. Weinstein B, T.S. Jones et al., *Impact of Increased Legal Access to Needles and Syringes on the Practices of Injecting-Drug Users and Police Officers—Connecticut, 1992-93*, 10 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. 82 (1995).
29. S.A. Strathdee, E.J.C. van Ameijden et al., *Can HIV Epidemics among Injection Drug Users Be Prevented?* 12 AIDS S71 (Supp. A, 1998).
30. See <http://www.hhs.gov/news/press/1998pres/980420a.html>.
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33. S.L. Groseclose, B. Weinstein B, T.S. Jones et al., *Impact of Increased Legal Access to Needles and Syringes on the Practices of Injecting-drug Users and Police Officers—Connecticut*, 1992-93, 10 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. 82 (1995); M. Singer et al., *The Social Geography of AIDS and Hepatitis Risk: Qualitative Approaches for Assessing Local Differences In Sterile Syringe Access among Injection Drug Users*, 90 AM J. PUBLIC HEALTH 1049 (2000); personal communication Niki Oldenburg and Gary Novotny (Minnesota Health Department).
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39. *Id.*; see also K. Berkowitz et al., *Syringe Disposal Practices among Insulin Users*, 45 DIABETES 68A (1996).
40. K.J. Oliver et al., *Impact of a Needle Exchange Program on Potentially Infectious Syringes in Public Places* [letter], 5 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. 534 (1992); M.C. Doherty et al., *The Effect of a Needle Exchange Program on Numbers of Discarded Needles: a 2-year Follow-up*, 90 AM J. PUBLIC HEALTH 936 (2000). *Accord Doe v. Bridgeport Police Department*, 2001 WL 50350, __F.Supp.2d__(D. Conn. 2001).
41. K.W. Springer et al., *Syringe Disposal Options for Injection Drug Users: A Community-based Perspective*, 34 SUBSTANCE USE & MISUSE 1917 (1999); Patricia Case, Thera Meehan & T. Stephen Jones, *Arrests and Incarceration*

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 44. C. Fay, *Needle "Exchanges" Often Aren't*, WASHINGTON POST, April 26, 1999, at A18.
 45. Melissa A. Marx et al., *Trends in Crime and the Introduction of a Needle Exchange Program*, 90 AM. J. PUB. HEALTH 1933 (2000).
 46. T. Stephen Jones & David Vlahov, *Use of Sterile Syringes and Aseptic Drug Preparation Are Important Components of HIV Prevention among Injection Drug Users*, 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. S1 (1998).
 47. See P. Lurie, T.S. Jones, 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 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. S45 (1998).
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 51. See K.W. Springer et al., *supra* note 41.
 52. Y. Obadia et al., *Syringe Vending Machines for Injection Drug Users: An Experiment in Marseilles, France*, 89 AM. J. PUBLIC HEALTH 1852 (1999).
 53. Kaveh Khoshnood et al., *Syringe Source, Re-use and Discard among IDUs in a City with a Legal Needle Exchange Program (NEP) and Non-prescription Syringe Availability*, 12 INT CONF AIDS 381 (1998) (abstract no. 23200).

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54. S.A. Strathdee et al., *Needle Exchange Is Not Enough: Lessons from the Vancouver Injecting Drug Use Study*, 11 AIDS F59 (1997).
55. See generally 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 L. J. 587 (1997) (presenting results of a national survey of syringe access laws).
56. *Id.*
57. Fla. Stat. Ann. §893.147(2) (requiring prescription only for buyers under 18 years of age).
58. Nevada's prescription law allows syringes to be sold without prescription:
(a) For the use in the treatment of persons having asthma or diabetes; and
(b) For use in injecting intramuscular or subcutaneous medications prescribed by practitioner for the treatment of human beings.
Nev. Rev. Stat. Ann. §454.480. The effect of these exceptions has been to allow routine pharmacy sales to all customers.
59. Va. Code Ann. §54.1-3468 (requiring prescription only for people 16 and younger).
60. Del. Code Ann. tit. 16, §4757. See generally *Dayton v. State*, 250 A.2d 383 (1969). The complete provision, including record-keeping requirements and exemptions, is in Appendix IV.
61. Gostin & Lazzarini, *supra* note 55, at 611-12 (reviewing congressional investigation of paraphernalia problem).
62. *High Gear and Toke Shop v. Beacom*, 689 P.2d 624, 627 (Co. 1984)
63. *Reprinted in Annotation, Validity, under Federal Constitution, of So-called "Head Shop" Ordinances or Statutes, Prohibiting Manufacture and Sale of Drug Use Related Paraphernalia*, 69 A.L.R. FED. 15 (1984 & Supp. 1998). The Model Act may also be found in Appendix V of this report.
64. Neb. Rev. Stat. §28-441; see also Ariz. Rev. Stat. § 13-3415 (F)(2)(k); Colo. Rev. Stat. Ann. §18-18-425 et seq.; D.C. Code Ann. §33-601 (3); Ga. Code Ann. § 16-13-32.1(a); Ohio Rev. Code Ann. § 2925.14(A). But see Ind. Code §35-48-4-8.5 (exempting from the paraphernalia law sellers of items "historically and customarily used in connection with the . . . injecting . . . of . . . lawful substance[s]"); S.C. Code Ann. §44-53-391(a) (making it unlawful to "possess, sell or deliver, or possess with the intent to deliver, or sell paraphernalia." The paraphernalia law does not include "injection" or syringes, and does not apply to heroin use.).
65. Neb. Rev. Stat. §28-439.
66. See, e.g., *Commonwealth v. Lacey*, 344 Pa. Super 576, 496 A.2d 1256 (1985)

67. See Laura Ferguson, Marisol Perez, Scott Burris, *Syringe Exchange in Pennsylvania: A Legal Analysis*, 8 *TEMPLE POL. & CIV. RIGHTS L. REV.* 41 (1998).
68. See, e.g., Kan. Stat. Ann. §65-4151; Cal. Health & Safety Code §11014.5; Fla. Stat. Ann. §893.146; 720 Ill. Comp. Stat. Ann. 600/4; Mont. Code Ann. §45-10-102; Vt. Stat. Ann. tit. 18 §4475(b).
69. S.D. Codified Laws §22-42A. *Accord* Ky. Rev. Stat. Ann. §218A.500(3); Mass. Gen. Laws ch. 94C §32I; N.C. Gen. Stat. §90-113.23; N.M. Stat. Ann. §30-31-25.1(C); Wyo. Stat. Ann. §35-7-1056.
70. See Annotation, *supra* note 63.
71. See Lawrence O. Gostin, Zita Lazzarinia, T. Stephen Jones, and Kathleen Flaherty, *Prevention of HIV/AIDS and Other Blood Borne Disease among Injection Drug Users: A National Survey on the Regulation of Syringes and Needles*, 277 *JAMA* 53 (1997); see also Gostin & Lazzarini, *supra* note 55, at 648.
72. See, e.g., Ala. Code §13A-5-12(1); Cal. Health & Safety Code §11374; Ind. Code §35-50-3-2; Kan. Stat. Ann. §65-4162; Neb. Rev. Stat. §28-442.
73. Ariz. Rev. Stat. §13-701; Haw. Rev. Stat. Ann. § 329-43.5; Idaho Code §37- 2734B; Mo. Ann. Stat. §195.235(1); Nev. Rev. Stat. Ann. §453.560; S.D. Codified Laws §22-42A-4; 22-6-1; Tenn. Code Ann. §39-17-425(b)(2).
74. See, e.g., Josiah Rich, Laura Dokson and Brian P. Dickinson, *The Economic Cost of Strict Syringe Control*, 81 *MED. & HEALTH/RHODE ISLAND* 207 (1998) (hereafter Rich, *Economic Cost*) (finding 731 arrests in Rhode Island between 1994 and 1996, leading to \$4.1 million dollars in incarceration costs); Patricia Case et al., *supra* note 41 (finding 824 arrests in ten Massachusetts cities in 1994, leading to 417 convictions and 171 incarcerations); see also J.D. Rich, C.K. Foisie et al., *High Street Prices of Syringes Correlate with Strict Syringe Possession Laws*, 26(3) *AM. J. OF DRUG & ALCOHOL ABUSE* 481-487 (2000) (hereafter Rich, *High Street Prices*) (evaluating economic effects of syringe law enforcement); Springer et al., *supra* note 41 (reporting that IDUs often fear paraphernalia arrests).
- . The direct costs of paraphernalia law enforcement can be substantial. Case and her colleagues estimated that Massachusetts spent as much as \$1.7 million incarcerating 171 convicted paraphernalia law violators in 1994, not including costs of arrest, pre-trial detention, prosecution and other administrative activities. By way of comparison, the authors estimated that the same amount would have paid for detoxification therapy for 1,629 drug users. See Case et al., *supra* note 41.
75. Georgia, Oregon, Rhode Island, Wisconsin. Ga. Code Ann. § 16-13-32 (excluding syringes for legitimate medical purposes); Or. Rev. Stat. §

- 475.525 (3) (“drug paraphernalia does not include hypodermic syringes or needles”); R.I. Gen. Laws §§21-28.5-1 et seq. (excluding “hypodermic syringes, needles, and other objects intended for use or designed for use in parenterally injecting controlled substances into the human body”); Wis. Stat. Ann. §961.571(1) (“[d]rug paraphernalia” excludes: hypodermic syringes, needles and other objects used or intended for use in parenterally injecting substances into the human body”).
76. Connecticut, Maine, Minnesota, New Hampshire, New York. Conn. Gen. Stat. Ann. §21a-240(20); Me. Rev. Stat. Ann. tit. 17-A, §1110; Minn. Stat. Ann. §151.40; N.H. Rev. Stat. Ann. §§318:52-c et seq.; N.Y. Public Health Law §3381 (effective January 2001).
77. Colorado, Indiana, Louisiana, Montana, Ohio, Tennessee. Colo. Rev. Stat. Ann. §18-18-308; Ind. Code §25-26-13-16; La. Rev. Stat. Ann. §40:1034; Mont. Code Ann. §45-10-107; Ohio Rev. Code Ann. §2925.14(D); Tenn. Code Ann. §39-17-425(a)(1).
78. See Gostin & Lazzarini, *supra* note 55.
79. Ga. Comp. R. & Regs. r. 480-10-13.
80. Ind. Admin. Code tit. 856, r. 2-6-18.
81. See Jennifer Taussig, Beth Weinstein, Scott Burris, and T. Stephen Jones, *Pharmacy Sales of Sterile Syringes: An Important Component of HIV Prevention Programs for Injection Drug Users*, 14 AIDS S47 (Supp. 1 2000).
82. Don C. Des Jarlais, *Structural Interventions to Reduce HIV Transmission among Injecting Drug Users*, 14 AIDS S41, S45 (Supp. 1 2000).
83. Ricky N. Bluthenthal et al., *Drug Paraphernalia Laws and Injection-Related Infectious Disease Risk among Drug Injectors*, 29 JOURNAL OF DRUG ISSUES 1 (1999).
84. See *Doe v. Bridgeport Police Department*, 2001 WL 50350, __F.Supp.2d__ (D. Conn. 2001); Case et al, *supra* note 41.
85. See Koester, *supra* note 4.
86. *Id.*; see also Springer et al., *supra* note 41 (describing influence of paraphernalia laws on willingness of IDUs to accumulate syringes at home for disposal).
87. *Id.*; see also Bourgois, *supra* note 4; M. Marmor et al., *supra* note 9; D.C. Des Jarlais, H. Cohen et al., *Risk Factors for Infection with Human Immunodeficiency Virus among Intravenous Drug Abusers in New York City*, 1 AIDS 39 (1987).
88. See Rich, *Economic Cost*, *supra* note 74. This estimate does not include expenses related to court procedures, law enforcement, or public health and medical costs. Case and colleagues found similar costs in Massachusetts. See Case et al., *supra* note 41.

89. Centers for Disease Control and Prevention, *AIDS Associated with Injecting-Drug Use—United States*, 45 MMWR 392 (1996); *see also* Josiah Rich, B.P. Dickinson, P. Case et al., *Strict Syringe Laws in Rhode Island are Associated with High Rates of Re-Using Syringes and HIV Risks* [letter], 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIR. S140 (Supp. 1 1998).
90. Rich, *High Street Prices*, *supra* note 74. The study reports that, on average, syringes were sold for \$2.87 in areas with syringe possession laws, and \$1.14 in other areas without such laws.
91. Repeal of syringe laws in other states suggests that allowing the legal purchase and possession of syringes without a prescription decreases syringe sharing and incident HIV and secondary infections among IDU populations. For example, Connecticut repealed syringe laws in 1992. Since then, syringe sharing among IDUs has decreased from 71% to 29%. *See* T. Diaz, S.Y. Chu, B. Weinstein et al., *Injection and Syringe Sharing among HIV-infected Injection Drug Users: Implications for Prevention of HIV Transmission*, 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. S76 (Supp. 1 1998).
92. *See* Springer, *supra* note 41; *see also* Koester, *supra* note 4; J. Grund et al., *In Eastern Connecticut, IDUs Purchase Syringes from Pharmacies But Don't Carry Syringes* [letter], 10 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. 104 (1995).
93. *See, e.g.*, Roel A. Coutinho, *Needle Exchange, Pragmatism, and Moralism*, 90 AM. J. PUB. HEALTH 1387, 1388 (2000).
94. *See* Taussig et al., *supra* note 81.
95. Connecticut, Maine, Minnesota, New Hampshire, New Mexico, New York, Oregon, Rhode Island, and Wisconsin.
96. This does not include the six states that have authorized needle exchange programs without deregulating other avenues of syringe access.
97. Or. Rev. Stat. §§475.525 .
98. Wis. Stat. Ann. §961.571(1).
99. Conn. Gen. Stat. §21a-65.
100. Conn. Gen. Stat. Ann. §21a-240(20).
101. Me. Rev. Stat. Ann. tit. 17-A, §1110.
102. Minn. Stat. §151.40(2), 325F.785, 145.924.
103. N.Y. Public Health Law §3381(effective January 1, 2001).
104. N.Y. Gen. Bus. Law §853.
105. N.H. Rev. Stat. Ann. §§318:52-c(I).

106. N.H. Rev. Stat. Ann. §318-B:26.
107. 2000 RI H 7949 Substitutue A.
108. 2000 Ia. HF 2421.
109. See Lester N. Wright and Kristine M. Gebbie, *Oregon's Exclusion of Syringes from Its 1987 Drug Paraphernalia Law Was an HIV Prevention Measure*, 18 J ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. S144 (Supp. 1 1998).
110. Or. Rev. Stat. §475.525 (3).
111. Recall that under statutes based on the model law, there is a catchall clause, ("or otherwise introduce into the human body" that would, by its plain terms, cover injection even if injection were not explicitly mentioned. S.D. Codified Laws §22-42A. *Accord* Ky. Rev. Stat. Ann. §218A.500(3); Mass. Gen. Laws ch. 94C §32I; N.C. Gen. Stat. §90-113.23; N.M. Stat. Ann. §30-31-25.1(C); Wyo. Stat. Ann. §35-7-1056.
112. See *Doe v. Bridgeport Police Department*, 2001 WL 50350, __F.Supp.2d__ (D. Conn. 2001), discussed in Part IV. B. 3. below.
113. R.I. Gen. Laws §21-28-4.04 (*as amended* 2000).
114. Like New Hampshire, Rhode Island did not explicitly exclude syringes from its paraphernalia law, but instead removed the law's references to injecting and excised needles from the list of examples of paraphernalia. As in New Hampshire, the paraphernalia law remains written broadly enough to be deemed to cover syringes, though the overall purpose of the deregulation law is so clear as to make this concern purely theoretical. Oregon's explicit exclusion nevertheless remains the clearest approach to eliminating paraphernalia law controls on syringes.
115. In Rhode Island, needle exchange programs were previously allowed under a separate provision, R.I. Gen. Laws §23-11-19, 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.
116. Conn. Gen. Stat. Ann. §21a-65. Additionally, under Conn. Gen. Stat. Ann. §21a-65(c), there are some storage, security, and product destruction guidelines for all locations where hypodermic needles and syringes are kept.
117. Sarah Bray, Jelani Lawson & Robert Heimer, *Doffing the Cap: Increasing Syringe Availability by Law But Not in Practice, Connecticut 1999* __INT'L J. DRUG POL'Y__ (forthcoming, 2001).
118. 2001 WL 50350, __F.Supp.2d__(D. Conn. 2001).
119. *Id.*

120. R.I. Gen. Laws §21-28-4.04 (*as amended* 2000).
121. See Macalino, *supra* note 38.
122. See Doherty et al., *supra* note 40.
123. *Id.*
124. The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) expanded pharmacists' duties. OBRA-90 requires pharmacists to screen prescriptions, keep a history of patient records, and offer to discuss proper drug use with Medicaid patients. Following the mandate of OBRA, many states applied those duties to all pharmacist-patient encounters. See 42 U.S.C. § 1396r-8(g) (1994). For a discussion of the pharmacist's duty under OBRA-90 standards, see Steven W. Huang, *The Omnibus Reconciliation Act of 1990: Redefining Pharmacists' Legal Responsibilities*, AM J.L. & MED. 417 (1998); David B. Brushwood, *The Pharmacist's Duty under OBRA-90 Standards*, 18 J. LEGAL MED. 475 (1997).
125. *Id.*
126. W.A. Zellmer, *Pharmacist Involvement in Needle Exchange Programs*, NS34 AMERICAN PHARMACY 48 (1994), cited in The United States Conference of Mayors, *The Role of Pharmacies in Preventing HIV among Injection Drug Users*, AIDS INFORMATION EXCHANGE, Dec. 1999, at 7.
127. American Pharmaceutical Association, *Report of the 1999 Session of the APhA House of Delegates*. San Antonio, TX: American Pharmaceutical Association (March 1999).
128. Wash. Rev. Code Ann. §70.115.050.
129. The board's draft resolution, which has been approved in principle by the medical board, states:

Whereas: Recent studies by the Centers for Disease Control and Prevention (CDC) and by various states have found that a large number of new cases of HIV/AIDS, hepatitis and other sexually transmitted diseases are found in persons who either are injection drug users (IDU's) or who have had sexual relationships with IDU's. A recent meeting cosponsored by CDC, National Association of Board of Pharmacy, and the American Pharmaceutical Association demonstrated that revisions in state laws and rules to permit the unrestricted sale or distribution of sterile needles and syringes would reduce the transmission of blood-borne diseases.

Now Therefore be it Resolved: that the Washington State Board of Pharmacy has determined that the term, "legal use" as used in 70.115.050 RCW—Hypodermic Syringes includes, the distribution of sterile hypodermic syringes and needles for the purpose of reducing the transmission of blood-borne diseases. Such distribution shall be performed through public health and community based HIV prevention programs.

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130. G.D. Lundberg, *New Winds Blowing for American Drug Policies* [editorial], 278 JAMA 946 (1997).
 131. American Pharmaceutical Association, *Report of the 1999 Session of the APhA House of Delegates*. San Antonio, TX: American Pharmaceutical Association, March 1999.
 132. B.F. Furrow, T.L. Greaney, S.H. Johnson, T. Jost, and R.L. Schwartz, HEALTH LAW 139 (West 1995); California Business & Professional Code Ann. § 2051 (West, 1998); Board of Medical Quality Assurance v. Andrews, 211 Cal.App.3d 1346, 1353 n.2, 260 Cal.Rptr. 113, 118 n.2 (Cal. App. 1989).
 133. L. Gostin, *The Legal Environment Impeding Access to Sterile Syringes and Needles: the Conflict Between Law Enforcement and Public Health*, 18 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. S60 (Supp. 1 1998); 21 United States Code § 802(21) (Supp. II 1996); 21 Code of Federal Regulations § 1306.04(a)(1998); 35 Pennsylvania States § 780-111(d) (West 1993); United States v. Rosenberg, 515 F.2d 190, 193 (9th Cir. 1975); People v. Schade, 25 Cal.Ct.App.4th 1605, 30 Cal.Ct.App.4th 1515 32 Cal.Rptr. 2d 59, 69 (1994); C. Vaeth., *Annotation: State Law Criminal Liability of Licensed Physician for Prescribing or Dispensing Drug or Similar Controlled Substance*, 13 AMERICAN LAW REPORTS 5th 1-52 (1994); F.M. McClellan, *Medical Malpractice: Law, Tactics and Ethics* (1994).
 134. S. Strauss. THE PHARMACIST AND THE LAW (1980).
 135. S. Burris, P. Lurie, D. Abrahamson, and J. Rich, *Physician Prescribing of Sterile Injection Equipment to Prevent HIV Infection: Time for Action*, 133 ANN. INTERNAL MED. 218 (2000).
 136. S. Burris, H. Gallagher, J. Grace, and D. Finucane, *The Legal Strategies Used in Operating Syringe Exchange in the United States*, 86 AM. J. PUBLIC HEALTH 1161 (1996).
 137. See Gostin & Lazzarini, *supra* note 55.
 138. These include the Centers for Disease Control and the National Commission on AIDS.
 139. These include the American Medical Association, the American Public Health Association, the American Bar Association, and the U.S. Conference of Mayors.
 140. See U.S. General Accounting Office, *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy* (1993); Hagan et al., *supra* note 32; Denise Paone et al., *New York City Syringe Exchange: An Overview*, in National Research Council & Inst. of Med., *Proceedings, Workshop on Needle Exchange and Bleach Distribution Programs* 47 (1994) (hereinafter NRC/IOM, *Proceedings*); K. Oliver et al., *Behavioral and Community Impact of the Portland Exchange Program*, in NRC/IOM,

- Proceedings at 35; Watters et al., *supra* note 32; Don C. Des Jarlais & Samuel R. Friedman, *AIDS and the Use of Injected Drugs*, 270 SCI. AM. 82 (1994); Merrill Singer et al., *Letter, Sale, and Exchange of Syringes*, 10 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. 104 (1995); David Vlahov et al., *Reduction in High Risk Drug Use Behaviors among Participants in the Baltimore Needle Exchange Program*, 16 J. ACQUIR. IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. 400 (1997). See generally Ernest Drucker et al., *Measuring Harm Reduction: the Effects of Needle and Syringe Exchange Programs and Methadone Maintenance on the Ecology of HIV*, 12 AIDS S217 (Supp. A 1998) (reviewing research studies); see also Heimer et al., *supra* note 32; Heimer & Kaplan, *supra* note 24; Ricky N. Bluthenthal, A.H. Kral, E.A. Erringer et al., *Use of An Illegal Syringe Exchange and Injection-Related Risk Behaviors among Street-Recruited Injection Drug Users in Oakland, California, 1992-1995*, 18 J. ACQUIR IMMUNE DEFIC. SYNDR. HUM. RETROVIROL. 505 (1998); Holly Hagan et al., *Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle Exchange Participation in Seattle Drug Injectors*, __ J. SUBSTANCE ABUSE TREATMENT__ (forthcoming).
141. See Kaplan & Heimer, *supra* note 24; Don C. Des Jarlais et al., *HIV Incidence among Injecting Drug Users in New York City Syringe Exchange Programs*, 348 LANCET 987(1996); See Hurley et al., *supra* note 25; R. Robles, H. Colon, T. Matos et al., *Syringe and Needle Exchange as HIV/AIDS Prevention for Injection Drug Users in Puerto Rico*, 45 HEALTH POLICY 209 (1998).
142. Holly Hagan et al., *Reduced Risk of Hepatitis B and Hepatitis C among Injection Drug Users in the Tacoma Syringe Exchange Program*, 85 AM. J. PUBLIC HEALTH 1531 (1995). A second study conducted in Seattle reported that participation in the syringe exchange program did not appear to be protective against new HCV and HBV infections. These findings suggest that syringe sharing is still practiced by a substantial proportion of IDUs in the sample. Further, maximal prevention of hepatitis transmission among this population would require distribution of a sufficient volume of sterile equipment to eliminate reuse. See Holly Hagan et al., *Syringe Exchange and Risk of Infection with Hepatitis B and C Viruses*, 149 AM. J. EPIDEMIOLOG. 203 (1999).
143. See Gostin & Lazzarini, *supra* note 55, at 676.
144. See Evidence-based Findings, *supra* note 1.
145. Organizations supporting access to sterile syringes include the American Medical Association, American Public Health Association, Centers for Disease Control and Prevention, Pennsylvania Medical Society, National Academy of Sciences, National Institutes of Health Consensus Panel,

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- Office of Technology Assessment of the U.S. Congress, President Bush's and President Clinton's AIDS Advisory Commissions.
146. Updated via Project Sero & Temple University Project on Harm Reduction in the Health Care System. See <http://www.projectsero.org>.
147. These states include California, Connecticut, Hawaii, Maine, Massachusetts, Maryland, New Mexico, Rhode Island, Vermont, and Washington, D.C.
148. Denise Paone et al., *Syringe Exchange in the United States, 1996: A National Profile*, 89 AM. J. PUBLIC HEALTH 43 (1999).
149. See Brooner et al., *supra* note 35; see also Hagan et al., *supra* note 140.
150. Julie Bruneau et al., *High Rates of HIV Infection among Injection Drug Users Participating in Needle Exchange Programs in Montreal: Results of a Cohort Study*, 146 AM. J. EPIDEMIOLOGY 994 (1997); J. Bruneau et al., *Assessing Harm Reduction Strategies: The Dilemma of Observational Studies*, 146 AM. J. EPIDEMIOLOGY 1007, 1010 (1997). Although the Montreal study is sometime cited as evidence that syringe exchange programs do not work, the authors of the study themselves took the unusual step of disclaiming that interpretation of their data. Julie Bruneau & Martin T. Schecter, *The Politics of Needles and AIDS*, N.Y. TIMES, Apr. 9, 1998 at 27. Subsequent data from the Montreal cohort indicate that there was no correlation between HIV seroconversion and NEP use. See J. Bruneau, N. Lachance et al., *Changes in HIV Seroconversion Rates of IDUs Attending Needle Exchange Programs in Montreal: The Saint-Luc Cohort*, CANADIAN J. INFECTIOUS DISEASES (Supp., 1999) cited in Evidence-based Findings, *supra* note 1.
151. See Lurie et al., *supra* note 47.
152. See CDC, *supra* note 48.
153. Robert Heimer et al., *Structural Impediments to Operational Syringe Exchange Programs*, 11 AIDS & PUB. POL'Y J. 169 (1996).