RACIAL DISPARITIES IN INJECTION-RELATED HIV: A CASE STUDY OF TOXIC LAW

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I. INTRODUCTION

Racial minorities suffer disproportionately high rates of almost all major diseases including heart disease, diabetes, cancer, obesity, and HIV/AIDS.[1] As a

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result, African Americans and other nonwhite populations in the United States live shorter and less healthy lives than their white counterparts.[2] It is not race itself, however, that accounts for the elevated incidence of these diseases or their role in reduced life expectancy. Health disparities are ultimately caused by social inequality.[3] In the United States, the distribution of income, education, access to health care, and other resources crucial to health[4] correlate highly to race, with people of color tending to have less of each than whites.[5] These social and economic inequalities create and perpetuate differential exposure to health risks through the entire course of life.[6] Few diseases reflect this process as clearly as HIV/AIDS. Since its emergence in the early 1980s, the incidence of HIV has been higher for African Americans than any other racial or ethnic group in the United States.[7] Although African Americans comprise only about thirteen percent of the U.S. population, they account for almost half of the people who contract HIV each year.[8] Latinos contract HIV at nearly three times the rate of whites.[9] The disparity

1. HEALTHREFORM.GOV, HEALTH DISPARITIES: A CASE FOR CLOSING THE GAP 1 (rev. 2009), http://www.healthreform.gov/reports/healthdisparities/disparities_final.pdf (collecting studies).

2. Life expectancy at birth for white men (75.7 years) and women (80.8 years) is years longer than for black men (69.5 years) and women (76.3 years). CTRS. FOR DISEASE CONTROL & PREVENTION & NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2008, at 124 (2009), http://www.cdc.gov/nchs/data/hus/hus08.pdf.

3. COMM'N ON SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 1 (2008); *see* Stephen L. Buka, *Disparities in Health Status and Substance Use: Ethnicity and Socioeconomic Factors*, 117 Pub. Health Rep. S118, S118 (2002) (observing that in most societies people of higher social position live longer and are healthier than people of lower social position).

4. *See* Bruce Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80, 85–88 (1995) (discussing how social resources increase ability to avoid health risks).

5. The average income for white households ($50,740) is substantially higher than the average household income for African Americans ($34,001). ALEMAYEHU BISHAW & JESSICA SEMEGA, U.S. CENSUS BUREAU, INCOME, EARNINGS, AND POVERTY: DATA FROM THE 2007 AMERICAN COMMUNITY SURVEY 3 tbl.1 (2008), *available at* www.census.gov/prod/2008pubs/acs-09.pdf. In March 2010, the unemployment rate for African Americans was 16.6%, almost twice the unemployment rate for white Americans. U.S. Bureau of Labor Statistics, U.S. Dep't of Labor, Economic News Release, http://www.bls.gov/news.release/empsit.t02.htm (last visited Mar. 1, 2011). This earnings gap reflects and is reflected by a huge educational gap. Other, more insidious social disadvantages also persist. *See, e.g.*, Marianne Bertrand & Sendhil Mullainathan, *Are Emily and Greg More Employable than Lakisha and Jamal? A Field Experiment on Labor Market Discrimination*, 94 AM. ECON. REV. 991, 997–98 (2004) (finding that between applicants with identical resumes, applicants with "black-sounding" names received fifty percent fewer callbacks than those with "white-sounding" names).

6. COMM'N ON SOC. DETERMINANTS OF HEALTH, *supra* note 3, at 7.

7. CTRS. FOR DISEASE CONTROL & PREVENTION, ESTIMATES OF NEW HIV INFECTIONS IN THE U.S. 4 fig.5 (2008), *available at* http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/incidence.pdf.

8. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV/AIDS AND AFRICAN AMERICANS (2007), *available at* http://www.cdc.gov/hiv/topics/aa/index.htm.

in HIV infection rates between African American injection drug users and white injection drug users is among the most shocking in the country: African Americans who inject drugs are ten times more likely to be diagnosed with HIV/AIDS than white injectors.[10] At a time when the Obama administration is developing a new HIV prevention strategy for the United States, and Congress has finally lifted its notorious ban on federal funding for syringe exchange programs,[11] this Article considers the disparity in HIV among injecting drug users and the ways in which law and policy help create and perpetuate that disparity.

The analysis of how social conditions shape the level and distribution of health in a population is inevitably complex. While the relationship between social inequality and health disparities is empirically well-established, research cannot claim to have exhaustively catalogued the mechanisms through which social status influences health over a life course.[12] The complexity is evident in the case of the HIV disparity among injection drug users ("IDUs"). Blacks and whites inject heroin and other illicit substances at a very similar rate, yet black IDUs are much more likely to contract HIV.[13] From a social determinants perspective, we would expect some difference simply because, on average, blacks are poorer than whites.[14] Poorer HIV outcomes are just one way in which their lower position in

9. Ctrs. for Disease Control & Prevention, Estimated Rate of New HIV Infections by Race/Ethnicity—United States, 2006, http://www.cdc.gov/hiv/topics/surveillance/resources/slides/incidence/slides/HIV-Incidence_5.pdf (last visited Mar. 1, 2011).

10. Ctrs. for Disease Control & Prevention, *HIV Infection Among Injection-Drug Users—34 States, 2004–2007*, 58 MMWR 1291, tbl.1, *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5846a2.htm?s_cid=mm5846a2_e#tab1 (showing the annual rate of HIV infection per 100,000 by black IDUs as 11.0 and the annual rate of HIV infection by white IDUs as 0.9).

11. See *infra* notes 152–53 and accompanying text for a discussion noting that the federal funding ban, which has been in place since 1988, was removed by Congress in 2009.

12. *See, e.g.*, Michael Marmot, *Multilevel Approaches to Understanding Social Determinants*, *in* SOCIAL EPIDEMIOLOGY 349, 365–66 (Lisa F. Berkman & Ichiro Kawachi eds., 2000) (recognizing complexity in study of social determinants and advocating multi-disciplinary approach); Christopher J. L. Murray et al., *Eight Americas: Investigating Mortality Disparities Across Races, Counties, and Race-Counties in the United States*, 3 PLOS MED. e260 (2006). *See generally* SOCIAL EPIDEMIOLOGY, *supra* (describing theory, methods, and data on social determinants of health).

13. *See* Don C. Des Jarlais et al., *Persistence and Change in Disparities in HIV Infection Among Injection Drug Users in New York City After Large-Scale Syringe Exchange Programs*, 99 AM. J. PUB. HEALTH S445, S445 (Supp. 2 2009) (discussing higher rate of HIV contraction among minority IDU users). See *infra* note 17 for a comparison of drug use rates by race.

14. BISHAW & SEMEGA, *supra* note 5. The impact of socioeconomics on the incidence of HIV/AIDS can be viewed from multiple directions. For example, the intricate network of laws that control public program eligibility for housing subsidies has been shown to correlate with HIV risk. Poor housing is positively correlated with numerous HIV risk factors including risky sexual practices and injection drug use. Daniel P. Kidder et al., *Housing Status and HIV Risk Behaviors Among Homeless and Housed Persons with HIV*, 49 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 451, 452–54 (2008). Whether housing is driving these behaviors or reflecting low social capital is difficult to determine, but the relationship is a strong

the social gradient expresses itself.[15] Some of the difference comes from the feedback effects of higher prevalence over time: as the proportion of IDUs with HIV in a distinct subpopulation rises, so does the risk of infection for others in that sub-population. Differential access to treatment, which reduces infectivity, can work the same way, as can disparities in *other* diseases, like herpes simplex, that can mediate infection with HIV.[16] These and other drivers of the HIV disparity are important, but our focus is narrower: our claim is that law has contributed significantly to creating and perpetuating this disparity, both by increasing the risks of drug use for black IDUs compared to white IDUs, and by hindering the scale-up of proven prevention measures which, properly funded and located, could substantially reduce disparate outcomes regardless of their cause. Thus we point in this Article to unhealthy policies and practices that can be changed now.

This Article begins in Part II by summarizing the evidence on two key points: that criminal laws and law enforcement practices have fueled disparities in HIV among IDUs and that syringe access initiatives like syringe exchange programs (SEPs) and unhindered pharmacy sales can prevent HIV among drug users without increasing drug use or other social problems. In Part III, we turn to the heart of our legal story. The racial and ethnic dimensions of the "War on Drugs" are well known and will only briefly be discussed. The adoption of a public health approach to drug control, focusing on prevention and treatment rather than arrest and punishment, could, if properly implemented, have a powerful effect on disparities. Most of our discussion, however, will focus on an area where

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one. *See* Susan Saegert & Gary W. Evans, *Poverty, Housing Niches, and Health in the United States*, 59 J. SOC. ISSUES 569, 570 (2003) (developing "conceptual model" of housing niches to shed light on societal health inequalities and consequences of implementing programs to eradicate such inequalities). Laws can shape this intermediate factor which impacts HIV risk by creating standards for housing eligibility that might exclude persons who live in substandard housing, or with others, who are newcomers to a jurisdiction, or who have drug use or criminal records. Zita Lazzarini & Robert Klitzman, *HIV and the Law: Integrating Law, Policy, and Social Epidemiology*, 30 J.L. MED. & ETHICS 533, 538 (2002). Proper housing can impact health by making access to proper health care and to services that require a stable mailing address more likely, and by eliminating the need for fearful, furtive, and unhygienic drug use. Neighborhood disorder has also been associated with sexual risk behaviors and drug use. Carl A. Latkin et al., *Direct and Indirect Associations of Neighborhood Disorder with Drug Use and High-Risk Sexual Partners*, 32 AM. J. PREVENTIVE MED. S234, S237–38 (Supp. 2007).

15. HIV/AIDS has historically been associated with minority status, low social capital, and poverty. Leigh E. Krueger et al., *Poverty and HIV Seropositivity: The Poor Are More Likely to be Infected*, 4 AIDS 811, 812–13 (1990). Communal social capital and collective efficacy are also important. Worldwide, HIV transmission is disproportionately higher in groups that are discriminated against and who suffer human rights abuses. Peter Piot et al., *Squaring the Circle: AIDS, Poverty, and Human Development*, 4 PLOS MED. e314 (2007).

16. *See generally* Esther E. Freeman et al., *Herpes Simplex Virus 2 Infection Increases HIV Acquisition in Men and Women: Systematic Review and Meta-Analysis of Longitudinal Studies*, 20 AIDS 73 (2006) (reviewing studies and concluding that herpes simplex infection is associated with a three-fold increase in HIV infection).

immediate and dramatic change could and should happen within the national HIV prevention strategy and in the legislative agendas of state legislatures. In spite of the evidence and nearly two decades of experience, access to sterile syringes through SEPs and pharmacies remains the undernourished stepchild of HIV prevention. Politics, ideology, and the overall scarcity of prevention funding explain part of this lamentable situation, but as an immediate barrier to syringe access the law stands out both for its force and as an example of how disparities happen. We explain the various federal, state, and local restrictions on the implementation of SEPs. Our legal analysis is particularly attuned to how laws, regulations, and policies at each of the three levels of government end up influencing retail access to syringes and the local operation of SEPs.

The Conclusion follows: HIV can be prevented, but virtually everywhere proven HIV prevention strategies have been hindered or prohibited by law, poor funding, and weak political will. If we are serious about reducing racial disparities in HIV, there is one proven intervention that can and must be immediately adopted: make syringes available at pharmacies and syringe exchanges at a level and in the places necessary to reach minority IDUs, which means removing legal barriers, scaling up programs and services, and eliminating harassment and other police practices that discourage IDUs from carrying syringes and depress the effectiveness of SEPs.

II. LAW HURTS; SYRINGE ACCESS HELPS

HIV/AIDS remains a major public health problem in the United States, the burden of which falls disproportionately on African Americans and Latinos. Rates of injection drug use[17] (and risky sexual behavior[18]) are similar between racial and ethnic groups, and yet the average annual rate of new HIV infections is over ten times higher for black IDUs (11.0 per 100,000) and five times higher for Latino

17. The reported prevalence of injection drug use is actually higher among white Americans than African Americans. According to the most recent evidence, 0.18% of white Americans and 0.14% of African Americans reported injection drug use in the past year between 2006 and 2008. OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH & HUM. SERVS., INJECTION DRUG USE AND RELATED RISK BEHAVIORS (2009), http://www.oas.samhsa.gov/2k9/139/139IDU_HTML.pdf.

18. If rates of risky sexual behavior were higher among African Americans, one plausible explanation would be that higher prevalence rates among African American IDUs reflect riskier sex practices by African Americans in the same racially homogenous networks. However, as with injection drug use, the evidence seems to suggest that whites engage in more risky sexual practices than their black counterparts. Kim M. Blankenship et al., *Black-White Disparities in HIV/AIDS: The Role of Drug Policy and the Corrections System*, 16 J. HEALTH CARE FOR POOR & UNDERSERVED 140, 141–42 (2005) ("Examination of sexual risk reveals that, as a group, African Americans also do not appear to be engaging in riskier sexual behavior than their White counterparts. Though African American youth do report more sexual behavior earlier than White youth, consistent use of a reliable means of contraception has been more strongly associated with African American than White youth; reported condom use is higher among Blacks than among other racial and ethnic groups." (footnotes omitted)).

IDUs (4.9 per 100,000) than white IDUs (0.9 per 100,000).[19] In this section, we look at this epidemiological difference from a legal point of view. We first describe the evidence suggesting that drug control laws and law enforcement practices increase HIV risk among IDUs and may be doing so differentially for minority IDUs. Regardless of the causes of disparities, there is substantial evidence that we can prevent HIV in IDUs by promoting access to sterile injection equipment. We summarize this evidence and recount what we know about the state of syringe access in the United States.

A. How Laws and Law Enforcement Practices Influence HIV Risks and Disparities Among IDUs

It is helpful to view the IDU as operating within a "risk environment" in which individual behavioral decisions are shaped, and their consequences largely determined, by environmental circumstances, ranging from how many other drug users in the area have HIV to whether there is a safe place to obtain syringes and inject drugs to the availability of quality addiction treatment.[20] As the environment improves, the IDU has more healthy options and faces fewer consequences for making risky choices. Law and law enforcement practices shape this risk environment in a number of ways.[21] Prescription laws and pharmacy regulations that limit the purchase of syringes make it harder for IDUs to access clean syringes.[22] Drug paraphernalia laws that prohibit the distribution or possession of the tools for drug use influence access to some degree, but more powerfully deter IDUs from carrying sterile syringes for fear of arrest or other negative interactions with police.[23] Even drug possession laws can deter IDUs from carrying syringes, because in many places IDUs are subject to arrest for

19. Ctrs. for Disease Control & Prevention, *HIV Infection Among Injection-Drug Users—34 States, 2004–2007*, 58 MORBIDITY & MORTALITY WKLY. REP. 1291, 1293 tbl.1 (2009); *see also* CTRS. FOR DISEASE CONTROL & PREVENTION, STATE OF THE HIV/AIDS EPIDEMIC, HIV INCIDENCE IN THE UNITED STATES, http://www.cdc.gov/hiv/surveillance/incidence/sote/idu-race-sex.htm (last visited Mar. 1, 2011) (reporting that, of the IDUs who contracted HIV in 2006, 63% were African Americans, 17% were Hispanic/Latino, and only 20% were white).

20. Tim Rhodes, *The 'Risk Environment': A Framework for Understanding and Reducing Drug-Related Harm*, 13 INT'L J. DRUG POL'Y 85, 86–88 (2002).

21. Scott Burris et al., *Addressing the "Risk Environment" for Injection Drug Users: The Mysterious Case of the Missing Cop*, 82 MILBANK Q. 125, 131 (2004).

22. *See, e.g.*, N.Y. PUB. HEALTH LAW § 3381(1)(c)(ii) (McKinney 2009) (limiting retail purchase to ten syringes at a time); Josiah D. Rich et al., *Strict Syringe Laws in Rhode Island Are Associated with High Rates of Reusing Syringes and HIV Risks Among Injection Drug Users*, 18 JAIDS & HUMAN RETROVIROLOGY S140–01(Supp. 1998) (discussing how prescription requirements impede access to syringes).

23. Ricky N. Bluthenthal et al., *Collateral Damage in the War on Drugs: HIV Risk Behaviors Among Injection Drug Users*, 10 INT'L. J. DRUG POL'Y 25, 27–28 (1999); Burris et al., *supra* note 21, at 131; Stephen K. Koester, *Copping, Running, and Paraphernalia Laws: Contextual Variables and Needle Risk Behavior Among Injection Drug Users in Denver*, 53 HUMAN ORG. 287, 292–93 (1994).

possessing the residue of a controlled substance in a used syringe.[24] Legal impediments to syringe access have also been found to increase the price of syringes sold on the street, creating another negative pressure for injection practices.[25] These laws are environmental factors that increase the sharing and reuse of syringes.[26]

The problem is not just laws "on the books" restricting access to syringes, particularly when we are considering health disparities. The law, as written, applies to everyone, regardless of race or class.[27] How laws are actually put into practice thus becomes a key factor, both because enforcement may vary by race or class or neighborhood, and for the more generic reason that the rules on the streets may differ in important ways from the formal rules on the books. Police dealing with IDUs on the street wield a range of laws, including those concerning drug possession and distribution, public order, and possession of drug paraphernalia or syringes. To enforce drug laws, police rely upon extensive and often unrelenting surveillance campaigns as well as periodic "crackdowns."[28] These practices have been found to significantly alter the injection behavior of IDUs.[29] Fearing arrest and harassment, IDUs often respond to aggressive police

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24. Scott Burris et al., *State Syringe and Drug Possession Laws Potentially Influencing Safe Syringe Disposal by Injection Drug Users*, 42 J. AM. PHARMACEUTICAL ASS'N S94, S94–S95 (Supp. 2002). IDUs will carry used syringes to exchange or otherwise properly dispose of them, or for reuse. *Id.* Though reuse is not ideal because of the heightened risk of bacterial infections, reusing one's own needle is safer as far as HIV is concerned than sharing syringes with others.

25. Josiah D. Rich et al., *High Street Prices of Syringes Correlate with Strict Syringe Possession Laws*, 26 AM. J. DRUG & ALCOHOL ABUSE 481, 484 (2000).

26. *See, e.g.*, Bluthenthal et al., *supra* note 23, at 31–32 (finding that IDUs concerned about being arrested while carrying needles were more than one and a half times more likely to report sharing); Donald A. Calsyn et al., *Needle-Use Practices Among Intravenous Drug Users in an Area Where Needle Purchase Is Legal*, 5 AIDS 187, 189–90 (1991) (observing lower rates of needle sharing in Seattle where syringes are legal compared with regions where purchase and possession of needles are illegal); David G. Metzger et al., *Risk Factors for Needle Sharing Among Methadone-Treated Patients*, 148 AM. J. PSYCHIATRY 636, 638 (1991) (finding that New Jersey and Pennsylvania respondents who shared needles also reported more arrests and legal difficulties).

27. "[T]he majestic equality of the laws . . . forbid[s] rich and poor alike to sleep under the bridges, to beg in the streets, and to steal . . . bread." JACQUES ANATOLE FRANÇOIS THIBAULT [ANATOLE FRANCE], THE RED LILY 95 (Frederic Chapman ed., Winfred Stephens trans., John Lane Co. 1910) (1894).

28. *See, e.g.*, Evan Wood et al., *Displacement of Canada's Largest Public Illicit Drug Market in Response to a Police Crackdown*, 170 CANADIAN MED. ASS'N J. 1551,1553–54 (2004) (describing effects of massive crackdown in Vancouver, one of North America's largest areas of concentrated illicit drug activity).

29. Campbell Aitken et al., *The Impact of a Police Crackdown on a Street Drug Scene: Evidence from the Street*, 13 INT'L J. DRUG POL'Y 193, 196–201 (2002); Don C. Des Jarlais & Samuel R. Friedman, Editorial, *Shooting Galleries and AIDS: Infection Probabilities and 'Tough' Policies*, 80 AM. J. PUB. HEALTH 142, 142–43 (1990).

activities by retreating to more remote areas or injecting more hurriedly.[30] Rapid, furtive injections are particularly harmful because of the challenge of hygienically reaching a vein while in fear and under stress.[31] Studies have suggested that when IDUs are preoccupied by stress about arrest, they tend to worry less about or have fewer means to avoid syringe sharing.[32] Even in areas where laws do not restrict access "on the books," IDUs often fear—sometimes with justification—that carrying a syringe will lead to trouble with police. In New York, Rhode Island, and Connecticut, for example, police continued to arrest drug users with syringes even after the law was changed to allow it; they simply changed the charge from possession of the syringe to possession of the residue of drugs inside the syringe.[33] The relationship between the intensity of policing practices and riskier injection practices explains reported correlations between measures of law enforcement intensity (drug arrests, police employees per capita, and corrections expenditures per capita) and higher rates of HIV prevalence among injectors.[34]

The impact of law on IDUs extends beyond the risk environment for injection drug use. Law also profoundly impacts the availability and accessibility of services for IDUs. As IDUs are driven from one area to the next, they may be displaced from known entry points for services like SEPs and forced to inject in areas where even the most rudimentary hygienic practices are impossible.[35] Laws that criminalize

30. Philippe Bourgois, *The Moral Economies of Homeless Heroin Addicts: Confronting Ethnography, HIV Risk, and Everyday Violence in San Francisco Shooting Encampments*, 33 SUBSTANCE USE & MISUSE 2323, 2336 (1998); M. Clatts et al., *The Impact of Drug Paraphernalia Laws on HIV Risk Among Persons Who Inject Illegal Drugs: Implications for Public Policy*, *in* HOW TO LEGALIZE DRUGS 80, 88–89 (J.M. Fish ed., 1998); Jean-Paul C. Grund et al., *Drug Use Contexts and HIV-Consequences: The Effect of Drug Policy on Patterns of Everyday Drug Use in Rotterdam and the Bronx*, 87 BRIT. J. ADDICTION 381, 386 (1992).

31. Will Small et al., *Impacts of Intensified Police Activity on Injection Drug Users: Evidence from an Ethnographic Investigation*, 17 INT'L J. DRUG POL'Y 85, 89 (2006) (discussing negative impacts of hurried injection under police pressure).

32. *Id.* at 88–89. *See generally* Thomas Kerr et al., *The Public Health and Social Impacts of Drug Market Enforcement: A Review of the Evidence*, 16 INT'L J. DRUG POL'Y 210 (2005) (reviewing studies).

33. Doe v. Bridgeport Police Dep't, 198 F.R.D. 325, 328 (D. Conn. 2001); Roe v. City of New York, 232 F. Supp. 2d 240, 246–47 (S.D.N.Y. 2002); *see also* Leo Beletsky et al., *Attitudes of Police Officers Towards Syringe Access, Occupational Needle-Sticks, and Drug Use: A Qualitative Study of One City Police Department in the United States*, 16 INT'L J. DRUG POL'Y 267, 269–72 (2005) (describing police knowledge of and response to change in law).

34. Samuel R. Friedman et al., *Relationships of Deterrence and Law Enforcement to Drug-Related Harms Among Drug Injectors in US Metropolitan Areas*, 20 AIDS 93, 97 (2006). There are, of course, ways to use police energy and resources more positively for health. In some places, police are working cooperatively with health authorities to promote safer behavior and access to services. Kora DeBeck et al., *Police and Public Health Partnerships: Evidence from the Evaluation of Vancouver's Supervised Injection Facility*, 3 SUBSTANCE ABUSE TREATMENT, PREVENTION & POL'Y 11, 12 (2008) (reporting that 182 (16.7%) of participants at Safe Injection Facility were referred to facility by police, and that 22 (2.0%) participants reported that they first learned of the SIF via communication with local police).

35. Small et al., *supra* note 31, at 88–89 (noting experiences of displaced IDUs who inject under bridges and behind grated gutters).

possession of injection equipment and the focus of enforcement efforts on high-drug areas can result in high levels of arrest in areas where SEPs are located, which may considerably reduce the use of SEPs.[36] Even where SEPs are operating legally, the threat of arrest may continue to steer clients away.[37]

There is good reason to be concerned that disparities in the enforcement of drug laws are helping drive disparities in HIV.[38] Even though they have rates of drug use and criminal behavior that are similar to those of whites, African Americans and Hispanics are more subject to arrest,[39] detention,[40] conviction,[41] and incarceration.[42] The arrest rate for African Americans in 2000 was 29.1 per

36. Corey S. Davis et al., *Effects of an Intensive Street-Level Police Intervention on Syringe Exchange Program Use in Philadelphia, Pa.*, 95 AM J. PUB. HEALTH 233, 233–34 (2005) (finding that SEP use declined after introduction of police anti-drug operation, with greater declines among black participants than among whites).

37. Philippe Bourgois et al., *Social Misery and the Sanctions of Substance Abuse: Confronting HIV Risk Among Homeless Heroin Addicts in San Francisco*, 44 SOC. PROBS. 155, 160 (1997); Alexis N. Martinez et al., *The Impact of Legalizing Syringe Exchange Programs on Arrests Among Injection Drug Users in California*, 84 J. URB. HEALTH 423, 428–33 (2007) (finding that odds of being arrested or cited for drug paraphernalia in six-month period were significantly higher for clients of legal SEPs when compared to clients of illegal SEPs despite similarity in neighborhoods in which they operated, perhaps because of higher visibility to law enforcement of legal NEPs).

38. Sandro Galea & David Vlahov, *Social Determinants and the Health of Drug Users: Socioeconomic Status, Homelessness, and Incarceration*, 117 PUB. HEALTH REP. S135, S139–40 (Suppl. 1 2002); *see also* Davis et al., *supra* note 36, at 234 (finding that during police crackdown both black and male participation fell disproportionately).

39. FED. BUREAU OF INVESTIGATION, CRIME IN THE UNITED STATES, 2006, at tbl.43 (2007), http://www2.fbi.gov/ucr/cius2009/data/table_43.html (finding that African Americans represented 33.6% of those arrested in 2009 for drug offenses).

40. James F. Nelson, N.Y. STATE DIV. OF CRIMINAL JUSTICE SERVS., DISPARITIES IN PROCESSING FELONY ARRESTS IN NEW YORK STATE: 1990–1992, at i (1995) (finding that minorities charged with felonies were more likely to be detained than whites and concluding that ten percent of minorities detained in New York City and thirty-three percent detained elsewhere in New York State would have been released prior to arraignment if minorities were detained at same rate as comparably situated whites).

41. WILLIAM J. SABOL ET AL., BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2006, at 8 (2007) (finding that fifty-three percent of persons receiving drug convictions are black, yet only twelve percent of overall population is black).

42. HUMAN RIGHTS WATCH, TARGETING BLACKS: DRUG LAW ENFORCEMENT AND RACE IN THE UNITED STATES (2008), *available at* http://www.hrw.org/en/node/62236/section/1 (finding that blacks and whites engage in drug offenses—possession and sales—at roughly comparable rates); HUMAN RIGHTS WATCH, DECADES OF DISPARITY: DRUG ARRESTS AND RACE IN THE UNITED STATES (2009), http://www.hrw.org/sites/default/files/reports/us0309web_1.pdf (using FBI data to find that "[i]n every year from 1980 to 2007, blacks were arrested nationwide on drug charges at rates relative to population that were 2.8 to 5.5 times higher than white arrest rates; In every year between 1980 and 2007, arrests for drug possession have constituted 64% or more of all drug arrests. From 1999 through 2007, 80 percent or more of all drug arrests were for possession.").

1,000 persons; it was 4.6 per 1,000 persons for whites.[43] Studies have suggested that 28.5% of African American males will enter prison at least once if current first-incarceration rates do not change, compared to 16% of Hispanic men and less than 5% of white males.[44] Put another way, an African American male can expect to spend on average 3.09 years in prison or jail over his lifetime, compared to 1.06 years for a Hispanic man and 6 months for a white man.[45] This suggests—on the one hand—that the deleterious impact of law and policing is even more acute for minority IDUs than the general population; more police pressure leads to more risky behavior and more HIV/AIDS.[46] On the other hand, incarceration is itself a risk factor for HIV.[47] Fear of arrest, which is greater for minorities,[48] may disproportionately deter black IDUs from accessing SEPs even in the areas where they are operating.[49] These dynamics reduce syringe access for all IDUs, but may have an unequal effect on racial minorities if policing is more concentrated in areas where African Americans live and seek services.[50]

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43. Katherine Beckett et al., *Race, Drugs, and Policing: Understanding Disparities in Drug Delivery Arrests*, 44 CRIMINOLOGY 105, 106 (2006) (citing DONZINGER, BUREAU OF JUSTICE STATISTICS, TOTAL ESTIMATED DRUG LAW VIOLATION ARRESTS IN THE UNITED STATES, 1980–2003 (2005)).

44. THOMAS B. BONCZAR & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, LIFETIME LIKELIHOOD OF GOING TO STATE OR FEDERAL PRISON 1 (1997).

45. Robert S. Hogg et al., *Years of Life Lost to Prison: Racial and Gender Gradients in the United States of America*, 5 HARM REDUCTION J. 4 (2008), http://www.harmreductionjournal.com/content/pdf/1477-7517-5-4.pdf.

46. *See, e.g.*, Blankenship et al., *supra* note 18, 143–46 (noting role of incarceration in driving HIV rates up among African Americans because HIV rates high among prisoners so risky behaviors of sexual activity and drug use become more risky in prison setting).

47. *See* Daniel Werb et al., *HIV Risks Associated with Incarceration Among Injection Drug Users: Implications for Prison-Based Public Health Strategies*, 30 J. PUB. HEALTH 126, 129 (2008) (finding that incarceration was independently associated with HIV transmission and acquisition behaviors).

48. *See, e.g.*, Sandra Lee Browning et al., *Race and Getting Hassled by the Police: A Research Note*, 17 POLICE STUD. 1, 6 (1994) (reporting based on qualitative study of degree to which blacks are hassled that there is significant association between being African American and being hassled by police; 46.6% of blacks reported being hassled versus only 9.6% of whites); Rod K. Brunson & Jody Miller, *Young Black Men and Urban Policing in the United States*, 46 BRIT. J. CRIMINOLOGY 613, 634 (2006) (finding that African American adults and juveniles have more distrust of police than other groups and that blacks disproportionately report 'getting hassled' by police); Michelle Fine et al., "*Anything Can Happen with Police Around": Urban Youth Evaluate Strategies of Surveillance in Public Places*, 59 J. SOC. ISSUES 141, 144 (2003) (finding that "non-delinquent" African American young men also report high rates of police contact suggesting that race and not different behavior accounts for significant portion of difference in police treatment).

49. Rachel Anderson et al., *Delivering Syringe Exchange Services Through "Satellite Exchangers": The Sacramento Area Needle Exchange, USA*, 14 INT'L J. DRUG POL'Y 461, 462 (2003).

50. *See* Curtis J. VanderWaal et al., *African-American Injection Drug Users: Tensions and Barriers in HIV/AIDS Prevention*, 36 SUBSTANCE USE & MISUSE 735, 743 (2001) (finding that African Americans face unique circumstances in accessing services targeted at IDUs).

Disparities in HIV infection rates among injection drug users are probably both influencing and influenced by differential risks of sexual transmission of HIV. Researchers estimate that up to 13% of people whose HIV is associated with injection drug use are sex partners of IDUs and 1% are children of IDUs or their sex partners.[51] There is at least some evidence that high incarceration rates have contributed to HIV transmission and disparities by disrupting sexual networks, leading people whose partnerships are disrupted by incarceration to change partners when they otherwise would not have done so.[52] In this way, drug use and law enforcement interact with other environmental and behavioral factors to influence the level and distribution of HIV infections in America.

B. Syringe Access Works—Where It's Available

Many complex and entrenched social factors carry the black injector to the point of getting HIV through an infected needle. These factors can be addressed,[53] but even if they are not, transmission through drug injection can be prevented.[54] Interventions that provide robust access to clean syringes reduce the likelihood of syringe sharing and reuse.[55] A comprehensive approach to limiting the spread of HIV via unsterile needles includes SEPs, sale of syringes in pharmacies and other retail outlets without prescription or other limitations, and elimination of laws and law enforcement practices that deter IDUs from possessing syringes. SEPs have the added benefit of facilitating entry into drug treatment, which is independently protective against HIV.[56]

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51. CTRS. FOR DISEASE CONTROL & PREVENTION, DRUG-ASSOCIATED HIV TRANSMISSION CONTINUES IN THE UNITED STATES 1 (2002), http://www.cdc.gov/hiv/resources/Factsheets/PDF/idu.pdf.

52. *See, e.g.*, Galea & Vlahov, *supra* note 38, at 139–40 (noting risky sexual behavior is more prevalent among incarcerated IDUs than general population); Werb et al., *supra* note 47, at 129 (finding that incarceration was independently associated with HIV transmission and acquisition behaviors).

53. *See* K.M. Blankenship et al., *Structural Interventions: Concepts, Challenges and Opportunities for Research*, 83 J. URB. HEALTH 59, 59–68 (2006) (discussing how structural interventions can provide strong approaches to HIV prevention and result in broader health outcomes, and how they can be extremely sustainable when based in laws and policies or when incorporated as part of other essential services).

54. The U.S. Public Health Service deems "once only use of sterile needles and syringes" to be essential to reducing rates of transmission among injection drug users. CTRS. FOR DISEASE CONTROL & PREVENTION ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS 3 (1997), http://www.cdcnpin.org/Reports/MedAdv.pdf.

55. *See generally* Ricky N. Bluthenthal et al., *Drug Paraphernalia Laws and Injection-Related Infectious Disease Risk Among Drug Injectors*, 29 J. DRUG ISSUES 1, 12 (1999) (stating consistent access to clean syringes lowers HIV rates).

56. *See* James L. Sorensen & Amy L. Copeland, *Drug Abuse Treatment as an HIV Prevention Strategy: A Review*, 59 DRUG ALCOHOL DEPENDENCE 17, 22 (2000) (finding clear evidence that Methadone Maintenance Treatment (MMT) reduces HIV risk behaviors, particularly needle use, and strong evidence that it prevents HIV infection).

Syringe exchange programs provide IDUs an opportunity to safely dispose of used syringes and to receive free, sterile ones.[57] Many of these programs also offer an array of other services to support the health of IDUs including HIV/AIDS education and counseling, condom distribution, referrals to treatment for substance abuse, screening for communicable diseases, and primary medical services.[58] A considerable body of research evidence indicates that SEPs help reduce HIV risk behavior and transmission. In the majority of studies, SEP participation has been associated with a reduction in HIV risk behaviors and HIV seroprevalence, which is a measure of the rate of HIV-positive people in a given population.[59] Behavioral benefits include reductions in needle sharing,[60] syringe reuse,[61] and the sharing of other injection equipment.[62] Better coverage—that is, provision of enough syringes to use a new, sterile syringe each time—is associated with safer injection.[63] Studies have consistently shown that SEPs contribute to a

57. CTR. FOR DISEASE CONTROL & PREVENTION, SYRINGE EXCHANGE PROGRAMS 1 (2005), http://www.cdc.gov/idu/facts/aed_idu_syr.pdf.

58. *Id.* at 1–2.

59. David R. Gibson et al., Editorial Review, *Effectiveness of Syringe Exchange Programs in Reducing HIV Risk Behavior and HIV Seroconversion Among Injecting Drug Users*, 15 AIDS 1329, 1338 (2001); Steffanie A. Strathdee & David Vlahov, *The Effectiveness of Needle Exchange Programs: A Review of the Science and Policy*, 1 AIDSCIENCE 16, 3–4 (2001), http://aidscience.org/Articles/aidscience013.pdf; Alex Wodak & Annie Cooney, *Do Needle Syringe Programs Reduce HIV Infection Among Injecting Drug Users: A Comprehensive Review of the International Evidence*, 41 SUBSTANCE USE & MISUSE 777, 779–80 (2006).

60. Ricky N. Bluthenthal et al., *The Effect of Syringe Exchange Use on High-Risk Injection Drug Users: A Cohort Study,* 14 AIDS 605, 607–09 (2000) [hereinafter Bluthenthal et al., *Effect of Syringe Exchange Use*]; Ricky N. Bluthenthal et al., *Use of an Illegal Syringe Exchange and Injection-Related Risk Behaviors Among Street-Recruited Injection Drug Users in Oakland, California, 1992 to 1995*, 18 JAIDS & HUM. RETROVIROLOGY 505, 505 (1998); John K. Watters et al., *Syringe and Needle Exchange as HIV/AIDS Prevention for Injection Drug Users*, 271 JAMA 115, 118–20 (1994).

61. Robert Heimer et al., *Syringe Use and Reuse: Effects of Syringe Exchange Programs in Four Cities,* 18 JAIDS & HUM. RETROVIROLOGY S37, S40–43 (Supp. 1 1998); David Vlahov et al., *Reductions in High-Risk Drug Use Behaviors Among Participants in the Baltimore Needle Exchange Program*, 16 JAIDS & HUM. RETROVIROLOGY 400–06 (1997).

62. Dezheng Huo et al., *Drug Use and HIV Risk Practices of Secondary and Primary Needle Exchange Users,* 17 AIDS EDUC. & PREVENTION 170, 179 (2005); Dezheng Huo & Lawrence J. Ouellet, *Needle Exchange and Injection-Related Risk Behaviors in Chicago: A Longitudinal Study*, 45 JAIDS 108, 113 (2007).

63. *See* Ricky N. Bluthenthal et al., *Approval of Syringe Exchange Programs in California: Results From a Local Approach to HIV Prevention*, 98 AM. J. PUB. HEALTH 278, 279 (2007) [hereinafter Bluthenthal et al., *Approval of SEPs in California*] (noting that clients of programs with unlimited distribution or unlimited exchange of syringes were less likely to reuse syringes); Ricky N. Bluthenthal et al., *Examination of the Association Between Syringe Exchange Program (SEP) Dispensation Policy and SEP Client-Level Syringe Coverage Among Injection Drug Users*, 102 ADDICTION 638, 644 (2007) [hereinafter Bluthenthal et al., *SEP Dispensation Policy*] (encouraging policies that "adhere to the 'one shot for one syringe' public health recommendation").

reduction or stabilization of injection frequency.[64] Researchers have also consistently found that the ancillary services provided by SEPs improve IDU health by promoting access to drug treatment[65] (including medication-assisted therapy using medicines like methadone),[66] HIV testing,[67] and general health care. The behavior change associated with SEP attendance is durable over time.[68]

Reduction in HIV seroprevalence has been demonstrated in some, though not all, studies of SEP participants,[69] but a significant protective effect has consistently been seen in population-level studies exploring links between SEPs and seroprevalence.[70] In the United Kingdom and Australia, where SEPs were introduced early and vigorously, HIV epidemics among IDUs were averted.[71] An international comparison showed that in twenty-nine cities with established SEPs, HIV prevalence *decreased* on average by 5.8% per year, while it *increased* on average by 5.9% per year in fifty-one cities without SEPs.[72] In New York City, SEPs have been associated with a dramatic decline in HIV infection among IDUs, with the level of infection falling as the number of syringes exchanged increased.[73]

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64. Holly Hagan et al., *Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-Exchange Participation in Seattle Drug Injectors*, 19 J. SUBSTANCE ABUSE TREATMENT 247, 248–51 (2000).

65. Dezheng Huo et al., *supra* note 62, at 171; Carl A. Latkin et al., *Needle Exchange Program Utilization and Entry into Drug User Treatment: Is There a Long-Term Connection in Baltimore, Maryland?* 41 SUBSTANCE USE & MISUSE 1991, 1992 (2006); Nina G. Shah et al., *Correlates of Enrollment in Methadone Maintenance Treatment Programs Differ by HIV-Serostatus*, 14 AIDS 2035, 2039–41 (2000); Strathdee & Vlahov, *supra* note 59, at 2.

66. R. Douglas Bruce, *Methadone as HIV Prevention: High Volume Methadone Sites to Decrease HIV Incidence Rates in Resource Limited Settings*, 21 INT'L J. DRUG POL'Y 122, 122–23 (2010).

67. *See* Robert Heimer et al., *Assessment of HIV Testing of Urban Injection Drug Users: Implications for Expansion of HIV Testing and Prevention Efforts*, 97 AM. J. PUB. HEALTH 110, 111, 114 (2007) (noting high rates of HIV testing for IDU's that attend SEP's).

68. Naomi Braine et al., *Long-Term Effects of Syringe Exchange on Risk Behavior and HIV Prevention*, 16 AIDS EDUC. & PREVENTION 264, 273 (2004).

69. *See, e.g.*, Gibson et al., *supra* note 59, at 1338; Robert Heimer et al., *Needle Exchange Decreases the Prevalence of HIV-1 Proviral DNA in Returned Syringes in New Haven, Connecticut*, 95 AM. J. MED. 214, 218 (1993); Wodak & Cooney, *supra* note 59, at 790.

70. Gibson et al., *supra* note 59, at 1338.

71. Don C. Des Jarlais et al., *Maintaining Low HIV Seroprevalence in Populations of Injecting Drug Users*, 274 JAMA 1226, 1228–30 (1995).

72. Susan F. Hurley et al., *Effectiveness of Needle-Exchange Programmes for Prevention of HIV Infection*, 349 LANCET 1797, 1799 (1997).

73. Don C. Des Jarlais et al., *HIV Incidence Among Injection Drug Users in New York City, 1990 to 2002: Use of Serologic Test Algorithm to Assess Expansion of HIV Prevention Services*, 95 AM. J. PUB. HEALTH 1439, 1441–42 (2005) (finding that over 12-year period in New York City, number of new cases of HIV among IDUs decreased while number of syringes exchanged by SEPs increased from 250,000 to over 3 million).

Although other factors, such as mortality among HIV-infected IDUs,[74] can also lead to reduced seroprevalence, the most recent estimates suggest that there has been a significant reduction in HIV incidence among IDUs in the United States.[75] Evidence that SEPs can significantly reduce epidemics of hepatitis B and C is mixed.[76]

Studies in this field have known methodological limitations, including reliance on self-reported behavior change and inability to control for important ecological factors (such as the availability of syringes from sources other than SEPs, differing law enforcement practices or other local social characteristics).[77] Thus, expert reviews of the accumulated evidence have been important in developing both scientific and political consensus. As early as 1993, a systematic review conducted under the auspices of the Centers for Disease Control and Prevention ("CDC") concluded that evidence supported the effectiveness of SEPs in reducing risk behavior,[78] a conclusion subsequently confirmed by a panel convened by the U.S. Institute of Medicine.[79] In 1997, a National Institutes of Health ("NIH") consensus panel concluded, based on the weight of the evidence, that "[t]here is no longer doubt that these programs work."[80] The Surgeon General

74. Barbara Tempalski et al., *HIV Prevalence Rates Among Injection Drug Users in 96 Large US Metropolitan Areas, 1992–2002*, 86 J. URB. HEALTH 132, 149 (2009).

75. Irene H. Hall et al., *Estimation of HIV Incidence in the United States*, 300 JAMA 520, 526 (2008).

76. *See* Holly Hagan et al., *Syringe Exchange and Risk of Infection with Hepatitis B and C Viruses*, 149 AM. J. EPIDEMIOLOGY 203, 212 (1999) [hereinafter Hagan et al., *Syringe Exchange*] (concluding that SEPs did not protect against hepatitis B or hepatitis C infection); Holly Hagan et al., *Reduced Risk of Hepatitis B and Hepatitis C Among Injection Drug Users Participating in the Tacoma Syringe Exchange Program*, 85 AM. J. PUB. HEALTH 1531, 1536 (1995) (estimating SEP's led to 60% Reduction in hepatitis B and 65% reduction in hepatitis C); Judith A. Hahn et al., *Hepatitis C Virus Infection and Needle Exchange Use Among Young Injection Drug Users in San Francisco*, 34 HEPATOLOGY 180, 186 (2001) (stating that SEPs are not as effective in reducing hepatitis C infection as they are in reducing HIV infection).

77. *See* Bluthenthal et al., *Effect of Syringe Exchange Use*, *supra* note 60, at 610 (stating that differing community factors, such as law enforcement practices, socio-demographic, and economic differences, and availability of illicit substances create problems in comparing different communities); Hagan et al., *Syringe Exchange*, *supra* note 76, at 209 (stating that measurement error may be problem in studies that rely on self-reporting of risk behavior); Hahn et al., *supra* note 76, at 186 (stating that study was limited by self-reporting).

78. PETER LURIE ET AL., SCH. OF PUB. HEALTH, UNIV. OF CAL. BERKELEY, THE PUBLIC HEALTH IMPACT OF NEEDLE EXCHANGE PROGRAMS IN THE UNITED STATES AND ABROAD: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 15–17 (1993) (finding decreased number of discarded syringes and decreased rates of HIV drug risk behavior); Nat'l Insts. of Health, *Interventions to Prevent HIV Risk Behaviors*, NIH Consensus Statement, Feb. 11–13, 1997, at 1, *available at* http://consensus.nih.gov/1997/1997PreventHIVRisk 104PDF.pdf (finding that "[s]tudies show reduction in risk behavior as high as eighty percent in injection drug users).

79. PANEL ON NEEDLE EXCHANGE AND BLEACH DISTRIBUTION PROGRAMS, NAT'L RESEARCH COUNCIL AND INST. OF MED., PREVENTING HIV TRANSMISSION: THE ROLE OF STERILE SYRINGES AND BLEACH (Jacques Normand et al. eds., 1995).

80. Nat'l Insts. of Health, *supra* note 78, at 10.

reached the same conclusion in a 2000 review of the evidence.[81] Most recently, a Cochrane evidence assessment in 2004 concluded that "[e]vidence strongly supports the effectiveness of needle exchange programs in reducing HIV incidence amongst IDUs."[82] SEPs also appear to be cost effective.[83]

The study data on negative consequences of SEPs are limited but consistent. Studies in Baltimore and Harlem found no association between operation of an SEP and increases in neighborhood crimes including assault, robbery, and drug possession.[84] Assessing the effect of SEP operation on drug use behavior, and particularly the initiation of injection, has been as difficult as it has been relevant to the policy debate. Studies have consistently shown that SEPs are not associated with increases in drug use[85] or the creation of pathological networks of high-risk injectors.[86] SEP client populations tend to be stable in their age and history of injection drug use, indicating that opening SEPs does not attract new, young injectors.[87] As discussed above, SEP users generally decrease or stabilize their injection rates, and may decrease the number of injections in public places.[88] The only randomized controlled study of SEPs found no difference in positive drug tests or injection frequency over time comparing SEP clients and IDUs obtaining

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81. DAVID SATCHER, U.S. DEP'T OF HEALTH & HUMAN SERVS., EVIDENCE-BASED FINDINGS ON THE EFFICACY OF SYRINGE EXCHANGE PROGRAMS: AN ANALYSIS OF THE SCIENTIFIC RESEARCH COMPLETED SINCE APRIL 1998, at 1 (2000).

82. COCHRANE COLLABORATIVE REVIEW GROUP ON HIV INFECTION & AIDS, COCHRANE COLLABORATION, EVIDENCE ASSESSMENT: STRATEGIES FOR HIV/AIDS PREVENTION, TREATMENT AND CARE 8 (2004). A 2010 "review of reviews" took a conservative approach and reached more guarded conclusions. There is only "tentative evidence" that SEPs reduce HIV incidence, a finding that the authors of the review suggest may be a result of a shortage of sufficiently robust studies on syringe access. *See* Norah Palmateer et al., *Evidence for the Effectiveness of Sterile Injecting Equipment Provision in Preventing Hepatitis C and Human Immunodeficiency Virus Transmission Among Injecting Drug Users: A Review of Reviews*, 105 ADDICTION 844 (2010).

83. 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 JAIDS & HUMAN RETROVIROLOGY S133, S137 (Supp. 1 1998); Franklin N. Laufer, N.Y. State Dep't of Health, *Cost-Effectiveness of Syringe Exchange as an HIV Prevention Strategy*, 28 JAIDS 273, 277–78 (2001).

84. Sandro Galea et al., *Needle Exchange Programs and Experience of Violence in an Inner City Neighborhood*, 28 JAIDS 282, 286–87 (2001); Melissa A. Marx et al., *Trends in Crime and the Introduction of a Needle Exchange Program*, 90 AM. J. PUB. HEALTH 1933, 1934–35 (2000).

85. Joseph Guydish et al., *Evaluating Needle Exchange: Are there Negative Effects?*, 7 AIDS 871, 874 (1993).

86. Martin T. Schechter et al., *Do Needle Exchange Programmes Increase the Spread of HIV Among Injection Drug Users?: An Investigation of the Vancouver Outbreak*, 13 AIDS F45, F49–51 (1999); Thomas W. Valente et al., *Satellite Exchange in the Baltimore Needle Exchange Program*, 113 PUB. HEALTH REP. 90, 94–95 (Supp. I 1998).

87. Bluthenthal et al., *Effect of Syringe Exchange Use*, *supra* note 60, at 607; Robert Heimer et al., *supra* note 69, at 219; Watters et al., *supra* note 60, at 119.

88. Vlahov et al., *supra* note 61.

syringes at pharmacies.[89] Concern that SEPs might influence young people to adopt injection has not been borne out by research. The majority of adolescents in a Baltimore survey did not perceive SEPs as promoting illicit drug use; indeed, most saw it as a deterrent.[90] Only seven percent of adolescents and young adults surveyed in the neighborhood of a New York City SEP were even aware that it existed.[91]

SEPs are a mode of safe syringe disposal, but typically distribute more syringes than they collect.[92] Despite this, research indicates that SEPs do not add to and may decrease the community burden of improperly discarded syringes. An early study suggested no increase in the number of discarded needles on the street.[93] A repeated census of trash in the area around a new Baltimore SEP found no immediate increase and, over two years, a significant decrease in discarded syringes relative to other trash items.[94] Conversely, closure of an exchange in Connecticut did not lead to a decrease in improperly discarded syringes.[95] An evaluation of the effects of syringe deregulation in Connecticut found that reported needle-stick injuries among police declined substantially in the six-month period following the relaxation of rules on syringe purchase and possession.[96]

Expert reviews have consistently concluded that SEPs neither increase drug use nor reduce local quality of life.[97] Perhaps more tellingly, the absence of serious

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89. Dennis G. Fisher et al., *Needle Exchange and Injection Drug Use Frequency: A Randomized Clinical Trial*, 33 JAIDS 199, 203 (2003).

90. Melissa A. Marx et al., *Impact of Needle Exchange Programs on Adolescent Perceptions About Illicit Drug Use*, 5 AIDS & BEHAV. 379, 383 (2001).

91. Samuel R. Friedman et al., *The Message Not Heard: Myth And Reality In Discussions About Syringe Exchange*, 13 AIDS 738, 739 (1999).

92. *See* Kate Ksobiech, *Return Rates for Needle Exchange Programs: A Common Criticism Answered,* 1 HARM REDUCTION J. (2004), http://www.harmreductionjournal.com/content/pdf/1477-7517-1-2.pdf (finding that about 90% of needles were returned).

93. Kathy J. Oliver et al., Letter to the Editor, *Impact of a Needle Exchange Program on Potentially Infectious Syringes in Public Places*, 5 JAIDS 534, 534 (1992).

94. Meg C. Doherty et al., *Discarded Needles Do Not Increase Soon After the Opening of a Needle Exchange Program*, 145 AM. J. EPIDEMIOLOGY 730, 736 (1997); Meg C. Doherty et al., *The Effect of a Needle Exchange Program on Numbers of Discarded Needles: A 2-Year Follow-Up*, 90 AM. J. PUB. HEALTH 936, 938–39 (2000).

95. *See* Robert S. Broadhead et al., *The Impact of a Needle Exchange's Closure*, 114 PUB. HEALTH REP. 439, 446–47 (1999) (concluding that "problem of discarded syringes in Windham was not reduced after the closure of the exchange").

96. Samuel L. Groseclose et al., *Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting-Drug Users and Police Officers—Connecticut, 1992–1993*, 10 JAIDS & HUMAN RETROVIROLOGY 82, 87 (1995).

97. *See* PANEL ON NEEDLE EXCHANGE AND BLEACH DISTRIBUTION PROGRAMS, *supra* note 79, at 251–52 (stating that SEPs did not increase the number of dirty needles in public places, and that there is "no credible evidence" that SEPs increase drug use); Nat'l Insts. of Health, *supra* note 78 (stating that studies

negative effects is borne out by the stability of SEPs once in operation. With one or two exceptions,[98] SEPs once initiated have continued to operate without the sort of community opposition or legislative action that would be expected to follow serious signs of negative results.

While the evidence base is smaller, changing laws and regulations restricting pharmacy syringe sales leads to increased syringe purchases and reduced risk behaviors among IDUs without negative community effects. The sale of sterile syringes at community pharmacies can be limited by several factors including state and local laws, state pharmacy regulations, and the attitudes and beliefs of pharmacists.[99] Easing legal restrictions on syringe sales increased the willingness of pharmacists to sell syringes to IDUs,[100] and the volume of syringe purchases by IDUs.[101] The provision of new sterile syringes through pharmacies or other retail

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neither show that SEPs increase drug use nor increase discarded needles in communities); SATCHER, *supra* note 81, at 1 (stating that SEPs do not increase the use of illegal drugs); Wodak & Cooney, *supra* note 59, at 797–98 (surveying other studies of SEPs and finding "no convincing evidence" of increased drug use).

98. *See* Broadhead et al., *supra* note 95, at 439–41 (discussing SEP in Wyndham, Connecticut, which closed in 1997 after public controversy).

99. Patricia Case et al., *Access to Syringes in Maine: Pharmacy Practice after the 1993 Repeal of the Syringe Prescription Law*, 18 JAIDS & HUMAN RETROVIROLOGY S94–101 (1998); Beth A. Lewis et al., *Pharmacists' Attitudes and Concerns Regarding Syringe Sales to Injection Drug Users in Denver, Colorado*, 42 J. AM. PHARMACEUTICAL ASS'N S46, S46 (2002); Wendy Reich et al., *Injection Drug Users Report Good Access to Pharmacy Sale of Syringes*, 42 J. AM. PHARMACEUTICAL ASS'N S68, S68 (2002); Jennifer Taussig et al., *Individual and Structural Influences Shaping Pharmacists' Decisions to Sell Syringes to Injection Drug Users in Atlanta, Georgia*, 42 J. AM. PHARMACEUTICAL ASS'N S40, S40 (2002).

100. See Ryan J. Deibert et al., *Increased Access to Unrestricted Pharmacy Sales of Syringes in Seattle-King County, Washington: Structural and Individual-Level Changes, 1996 Versus 2003*, 96 AM. J. PUB. HEALTH 1347, 1351 (2006) (noting that regulatory changes prompted "changes in pharmacist attitudes" toward syringe sales); Thomas J. Stopka et al., *Increasing Syringe Access and HIV Prevention in California: Findings from a Survey of Local Health Jurisdiction Key Personnel*, 84 J. URB. HEALTH 116, 117 (2007) (noting that "large percentage of pharmacists" agreed to sell syringes where state legislation permitted them to do so); Linda A. Valleroy et al., *Impact of Increased Legal Access to Needles and Syringes on Community Pharmacies' Needle and Syringe Sales—Connecticut, 1992–1993*, 10 JAIDS & HUMAN RETROVIROLOGY 73, 78(1995) (noting that most Connecticut pharmacies sold non-prescription syringes when permitted by law to do so).

101. *See* Niki U. Cotten-Oldenburg et al., *Impact of Pharmacy-Based Syringe Access on Injection Practices Among Injecting Drug Users in Minnesota, 1998 to 1999*, 27 JAIDS 183, 189 (2001) (stating that proportion of IDUs using pharmacies as source of syringes almost doubled after legal restrictions on sales of syringes were eased in Minnesota); Don Des Jarlais et al., *Legal Syringe Purchases by Injection Drug Users, Brooklyn and Queens, New York City, 2000–2001*, 42 J. AM. PHARMACEUTICAL ASS'N S73, S73 (2002) (stating that IDUs increasingly used pharmacies as source of syringes when New York began allowing syringe purchases without prescriptions); Stopka et al., *supra* note 100, at 117 (stating that after pharmacy regulations regarding syringe sales are relaxed, IDUs increasingly rely on pharmacies as source of syringes).

outlets is associated in most (though not all)[102] studies with safer injection practices among IDUs.[103] A study comparing New York City, which has both SEPs and pharmacy sales, with nearby Newark, New Jersey, which had neither, found that Newark participants were three times as likely to test positive for HIV, more than twice as likely to reuse someone else's syringe, and more than 100 times as likely to report obtaining their new syringes from illegal sources.[104]

In jurisdictions where a prescription is not required to purchase syringes, the decision to sell syringes to a customer lies within the discretion of a pharmacist;[105] studies indicate that IDUs are able to purchase syringes but face a significant rate of refusal (on average 35%).[106] A number of states, including New York, California, Connecticut, and Minnesota, have launched and evaluated pharmacy syringe access interventions that have increased sales to IDUs.[107] As with SEPs, most studies found reduced risk behaviors without negative side effects, such as an increase in improperly discarded syringes, increased drug use, crime, or negative experiences among pharmacists.[108] A study of the New York

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102. *See* Ricky N. Bluthenthal et al., *Sterile Syringe Access Conditions and Variations in HIV Risk Among Drug Injectors in Three Cities*, 99 ADDICTION 1136, 1136 (2004) (finding similar rates of syringe sharing in SEP and non-SEP areas).

103. Cotten-Oldenburg et al., *supra* note 101, at 189; Enrique R. Pouget et al., *Receptive Syringe Sharing Among Injection Drug Users in Harlem and the Bronx During the New York State Expanded Syringe Access Demonstration Program*, 39 JAIDS 471, 474 (2005); Reich et al., *supra* note 99, at 568–71; Alan J. Richard et al., *New Syringe Acquisition and Multi-Person Use of Syringes Among Illegal Drug Users*, 23 J. PUB. HEALTH POL'Y 324, 324–25 (2002); Merrill Singer et al., *Changing the Environment of AIDS Risk: Findings on Syringe Exchange and Pharmacy Sales of Syringes in Hartford, CT*, 18 MED. ANTHROPOLOGY 107, 127 (1997).

104. Alan Neaigus et al., *Greater Drug Injecting Risk for HIV, HBV, and HCV Infection in a City Where Syringe Exchange and Pharmacy Syringe Distribution Are Illegal*, 85 J. URB. HEALTH 309, 314–15 (2008).

105. Deibert et al., *supra* note 100, at 1352.

106. Wilson M. Compton et al., *A Multistate Trial of Pharmacy Syringe Purchase*, 81 J. URB. HEALTH 661, 664 (2004); *see* Ruth Finkelstein et al., *Pharmacy Syringe Sale Practices During the First Year of Expanded Syringe Availability in New York City (2001–2002)*, 42 J. AM. PHARMACEUTICAL ASS'N S83, S85 (2002) (stating that only sixty-nine percent of testers were able to purchase syringes).

107. *See* Deibert et al., *supra* note 100, at 1351–52 (examining pharmacists' attitudes and practices regarding syringe exchange programs in Washington State); Crystal M. Fuller et al., *Impact of Increased Syringe Access: Preliminary Findings on Injection Drug User Syringe Source, Disposal, and Pharmacy Sales in Harlem, New York*, 42 J. AM. PHARMACEUTICAL ASS'N S77, S78 (2002) (describing Expanded Syringe Access Demonstration Program in New York City); Gary A. Novotny et al., *The Minnesota Pharmacy Syringe Access Initiative: A Successful Statewide Program to Increase Injection Drug User Access to Sterile Syringes*, 42 J. AM. PHARMACEUTICAL ASS'N S21, S22 (2002) (evaluating success of Minnesota syringe access program); Stopka et al., *supra* note 100, at 121–23 (surveying health personnel regarding over-the-counter syringe purchase program in California).

108. Cotten-Oldenburg et al., *supra* note 101, at 185–89; Ctrs. for Disease Control & Prevention, *Impact of New Legislation on Needle and Syringe Purchase and Possession—Connecticut, 1992*, 42 MORBIDITY & MORTALITY WKLY. REP. 145, 145 (1993); Fuller et al., *supra* note 107, at S79–80; Bruce D. Johnson et al., *The Nonimpact of the Expanded Syringe Access Program upon Heroin Use, Injection*

pharmacy sales program found that a shift away from SEPs as the source of one's last syringe was associated with a significant shift towards less safe means of disposal, suggesting that to the extent pharmacies complement SEPs as a source of syringes, it is important to provide a means of disposal that is as safe and accessible as returning syringes to SEPs.[109] A cost-effectiveness analysis found that providing access to sterile syringes through pharmacies would be cost-effective even at a relatively low prevalence of HIV.[110]

Notwithstanding all the evidence that access to clean syringes is essential to slowing the spread of HIV, syringes are still far too difficult to obtain at pharmacies and SEPs are still far too few in number.[111] The World Health Organization recommends that SEPs reach at least sixty percent of IDU populations to effectively control HIV.[112] Today, the United States is not close to reaching this level of coverage in *any* major city.[113] Over ten years ago, the annual

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Behaviours, and Crime Indicators in New York City and State, 8 JUST. RES. & POL'Y 27, 35–43 (2006); Groseclose et al., *supra* note 96, at 86–87; Kaveh Khoshnood et al., *Syringe Source, Use, and Discard Among Injection-Drug Users in New Haven, Connecticut*, 15 AIDS & PUB. POL'Y J. 88, 90–93 (2000).

109. Charles M. Cleland et al., *Syringe Disposal Among Injection Drug Users in Harlem and the Bronx During the New York State Expanded Syringe Access Demonstration Program*, 34 HEALTH EDUC. & BEHAV. 390, 395–98 (2007) (suggesting that less IDUs returning to SEPs might explain increase in less safe disposal methods).

110. *Id.* at 395–96.

111. To measure the importance of SEP coverage, or SEP dose, on IDU HIV risk factors, Bluthenthal et al. tested the dose responses of coverage at less than 50%, from 50% to 99%, from 100% to 149%, and at more than 150%; they predictably found a significant positive relationship between coverage and HIV risk. Ricky N. Bluthenthal et al., *Higher Syringe Coverage Is Associated With Lower Odds of HIV Risk and Does Not Increase Unsafe Syringe Disposal Among Syringe Exchange Program Clients*, 89 DRUG & ALCOHOL DEPENDENCE 214, 215–18 (2007). The study employed a definition of individual syringe coverage calculated as the proportion of syringes retained from SEP visits to total number of injections in the last thirty days. *Id.* at 215. Among the 1577 IDUs surveyed in the study, those with individual coverage less than 50% were twice as likely to share syringes as those with individual coverage between 100% and 150%. *Id.* at 219. Studies that model the relationship between syringe coverage and HIV transmission have found the same inverse correlation as well as a threshold effect; syringe access helps but only when coverage reaches a minimum level. *See* Peter Vickerman et al., *Model Projections on the Required Coverage of Syringe Distribution to Prevent HIV Epidemics Among Injecting Drug Users*, 42 JAIDS 355, 357 (2006) (finding "a steplike relationship between syringe distribution coverage and the endemic HIV prevalence in each setting. That is, assuming that other factors remain equal, increasing syringe distribution coverage from a low level will have little effect on HIV prevalence until a threshold coverage is reached [(of fifteen percent to twenty percent)]").

112. WORLD HEALTH ORG. ET AL., TECHNICAL GUIDE FOR COUNTRIES TO SET TARGETS FOR UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT AND CARE FOR INJECTING DRUG USERS 18 (2009), http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf.

113. Quantifying syringe coverage can be a tricky exercise, *see, e.g.*, Dave Burrows, *Rethinking Coverage of Needle Exchange Programs*, 41 SUBSTANCE USE & MISUSE 1045, 1046 (2006) (discussing use of modeling to ensure proper coverage and evaluation processed in SEPs internationally), but the evidence is clear: syringes are still far too inaccessible. In a recent study in four major cities, SEP programs were found to cover only ten percent of the estimated IDU population. Robert Heimer, *Community Coverage*

number of injections by IDUs in the United States was estimated to be between 920 million and 1.7 billion.[114] At the time, SEPs were distributing about twenty million syringes a year.[115] Despite the continued accumulation of evidence supporting their effectiveness and the addition of new SEPs each year, SEPs operating now are only able to provide about thirty million syringes a year, enough syringes for just over three percent of all injections.[116] Between 1996 and 2007, state and local government funding increased from $3.9 million to $14.4 million per year, and total spending, including private donations, reached nearly $20 million.[117] Growth to be sure, yet in 2007 the President's budget for HIV prevention was nearly $1 billion,[118] and SEPs still operate in only thirty-six states.[119] In many of these states, there are only a few exchanges.[120] In

and HIV Prevention: Assessing Metrics for Estimating HIV Incidence Through Syringe Exchange, 19 INT'L J. DRUG POL'Y S65, S71–72 (Supp. 2008). Another study found that coverage in major urban areas is at most 22% with a mean of 3.2%. Barbara Tempalski et al., *Correlates of Syringe Coverage for Heroin Injection in 35 Large Metropolitan Areas in the US in Which Heroin is the Dominant Injected Drug*, 19 INT'L J. DRUG POL'Y S47, S51 (Supp. 2008); *see also* Daliah I. Heller et al., *The Syringe Gap: An Assessment of Sterile Syringe Need and Acquisition Among Syringe Exchange Program Participants in New York City*, 6 HARM REDUCTION J. 1, 3 (2009), http://www.harmreductionjournal.com/content/pdf/1477-7517-6-1.pdf (finding that fifty-four percent of study participants surveyed from ten large SEPs in New York City lacked adequate syringe coverage).

114. Peter Lurie et al., *A Sterile Syringe for Every Drug User Injection: How Many Injections Take Place Annually, and How Might Pharmacists Contribute to Syringe Distribution?*, 18 JAIDS & HUMAN RETROVIROLOGY S45, S45 (1998).

115. Don C. Des Jarlais et al., *Doing Harm Reduction Better: Syringe Exchange in the United States*, 104 ADDICTION 1441, 1442 tbl.1 (2009) (finding that number of syringes provided through SEPs has climbed consistently since 1994 with yearly amounts (in millions) as follows: 8 (1994–1995), 13.9 (1996), 17.5 (1997), 19.4 (1998), 22.6 (2000), 24.9 (2002), 24 (2004), 22.5 (2005), 27.6 (2006), and 29.5 (2007)).

116. *Id.* at 1445. According to a survey by the National Association of Syringe Exchange Programs, 29.5 million syringes were provided in 2007, the most recent year for which data is available.

117. *Id.*

118. HENRY J. KAISER FAMILY FOUND., HIV/AIDS POLICY FACT SHEET: U.S. FEDERAL FUNDING FOR HIV/AIDS: THE FY 2007 BUDGET REQUEST (2006), http://www.kff.org/hivaids/upload/7029-03.pdf.

119. Ctrs for Disease Control & Prevention, *Syringe Exchange Programs—United States, 2005*, 56 MORBIDITY & MORTALITY WKLY. REP. 1157, 1164–67 (2007).

120. For SEPs—where they exist—any number of factors can make them less accessible or attractive to specific groups of IDUs. For example, operating hours have been found to impact the racial distribution of SEP customers. In a study in Chicago, the use of SEPs during daytime hours was much higher proportionally for African Americans; whites were much more likely to attend SEPs during nighttime hours. *See* Heena Brahmbhatt et al., *Characteristics and Utilization Patterns of Needle-Exchange Attendees in Chicago: 1994–1998*, 77 J. URB. HEALTH 346, 353 (2000) (finding different racial patterns of utilization based on operating hours of numerous SEPs and that "evening NEP venues were accessed by a higher proportion of Caucasian and Puerto Rican IDUs, whereas daytime sites predominantly attracted African-American users"); *see also* Evan Wood et al., *Needle Exchange and Difficulty with Needle Access During an Ongoing HIV Epidemic*, 13 INT'L J. DRUG POL'Y 95, 101 (2002) (noting that limited operating hours is major impediment to access for some IDUs).

Pennsylvania, for example, SEPs only operate in Pittsburgh and Philadelphia.[121] In other states, like California and Massachusetts, SEPs are authorized by the state but their actual implementation is subject to local approval, which prevents their operation in many areas where need is great.[122] Tellingly, the location of SEPs has been found to be more closely correlated with political conditions than with the need for the service.[123] The mania of budget cutting that struck after the 2010 election may well lead to SEPs cutting services or closing down.

We could locate no studies documenting the additional syringe coverage afforded by pharmacy sales. There is evidence that programs promoting access to syringes at pharmacies and the removal of laws impeding pharmacy access have increased access to syringes.[124] As we discuss further in Part III, many states have removed prescription requirements, so that only two states (New Jersey and Delaware) still require prescriptions for all adult syringe purchases.[125] Programs that include activities beyond legalization to encourage pharmacies to dispense syringes have been found to expand access,[126] but these have been implemented in only a few states.[127] The decision to sell usually lies with the pharmacist;

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121. Don Sapatkin, *Changes May Ease Way for Needle Exchanges,* PHILA. INQUIRER, Dec. 23, 2009, at A01.

122. See *infra* notes 172–94 and accompanying text for a discussion of local approval provisions.

123. *See* Tempalski et al., *supra* note 113, at S48 (listing political factors that reduce likelihood of attaining safe, one-time syringe use). Tempalski and co-authors attempted to identify predictors of SEP operation in cities. *Id.* at S48. They found that cities with SEPs were likely to have a higher representation of males who have sex with males (MSM), higher levels of community activism, and higher levels of education. *Id*. at S55. Neither resource availability nor institutional opposition predicted the presence of an SEP. *Id.* at S53. They found no correlation between need and services aimed at IDUs. *Id.* at S48 They interpreted their findings as showing the decisive importance of organized HIV activism in building support for and launching SEPs. *Id.* at S55.

124. *See* Des Jarlais et al., *supra* note 101, at S74 (finding that "large majorities" of those seeking syringes could access them).

125. SCOTT BURRIS, NON-PRESCRIPTION ACCESS tbl.IV (2008), http://www.temple.edu/lawschool/phrhcs/otc.htm. Prescriptions are required for minors in Florida, Illinois, New Hampshire, and Virginia. Prescriptions are required for purchases of more than a certain number of syringes (usually ten) in California, Connecticut, Illinois, Minnesota, New Hampshire, and New York. *Id.* In California, purchase without a prescription is actually subject to local authorization, so in some areas a prescription is still required. Nevada has a prescription law, but exempts syringes for use in treating diabetes, asthma and other medical conditions. *Id.*

126. For example, since the inauguration of the New York "Expanded Syringe Access Demonstration Program" (ESAP), which authorizes pharmacies to dispense syringes, the median spatial access value—or the average density of pharmacies within a populated area—across New York City's forty-two health districts was increased from 8.00 participating pharmacies per square mile to 11.76 participating pharmacies per square mile. Hannah L.F. Cooper et al., *Temporal Trends in Spatial Access to Pharmacies that Sell Over-the-Counter Syringes in New York City Health Districts: Relationship to Local Racial/Ethnic Composition and Need*, 86 J. URB. HEALTH 929, 934 (2009).

127. *See, e.g.*, Barbara Ginley et al., *Maine Board of Pharmacy Strongly Supports Unrestricted Sale of Sterile Syringes*, 42 J. AM. PHARMACEUTICAL ASS'N S24, S24–25 (2002) (reporting that programs and

surveys of pharmacists and buying experiments both show that some pharmacists remain unwilling to sell syringes to suspected IDUs even where there are no legal barriers.[128] Even if no prescription is required and the pharmacist is willing to sell, IDUs may fear that buying or carrying syringes will lead to arrest under drug paraphernalia laws or other negative interactions with police.

IDUs of all races lack sufficient access to sterile syringes to get close to the public health goal of a new, sterile syringe for every injection. Disparities can arise from this generalized lack of syringe access in at least two ways: if minorities have poorer access to SEPs or pharmacies than whites, or if comparable levels of access are insufficient to reduce the higher baseline risks in black IDU populations. The latter mechanism—that high prevalence African American communities simply need more services than they are getting—may explain why disparities continue despite the fact that SEPs are often sited in high-need communities.[129] The evidence strongly suggests that syringe access reduces infections and that it has made a big difference in many places even at the rather low level at which it has been implemented. Moreover, the reduction in infections has been similar for whites and non-whites.[130] The problem here, as with many other health

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reforms aimed at promoting pharmacy sales as HIV prevention measure were successful in Maine); Stopka et al., *supra* note 100, at 121–23 (finding expanded pharmacy sales effective generally but noting that they may not reach some more vulnerable groups

128. Compton et al., *supra* note 106, at 664 (finding that among 1,600 attempted syringe purchases in three cities, thirty-five percent resulted in refusal across all races and genders); Wilson M. Compton III et al., *Legal Needle Buying in St. Louis*, 82 AM. J. PUB. HEALTH 595, 596 (1992) (reporting on study of availability of syringes to IDUs in large midwestern city where no laws restricted sale of syringes and finding that almost half of pharmacies (42%) either refused to sell syringes or sold them only in costly quantities); Beth A. Lewis et al., *Pharmacists' Attitudes and Concerns Regarding Syringe Sales to Injection Drug Users in Denver, Colorado*, 42 J. AM. PHARMACEUTICAL ASS'N S46, S46 (2002) (reporting that even though no state law prohibited sale of syringes, staff at thirteen out of twenty-two Colorado pharmacies refused to sell to researchers posing as IDUs); Reich et al., *supra* note 99, at S55–56 (reporting findings that pharmacists in some areas decide to sell syringes conditionally based on their own criteria such as whether customer acted "reasonably" and had "plausible" reasons for purchasing syringes, or not at all even when law allows such sales).

129. This dynamic was observed in a study of a Montreal SEP in the 1990s. The study, which showed that SEP users were more likely than non-users to get HIV, was held out by SEP opponents as proof that SEPs are dangerous. 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, 999 (1997). In fact, the authors' conclusion, shared by most experts, was that the SEP "appears to have attracted subpopulations of IDUs with a higher baseline rate of HIV" and that insufficient coverage and continued barrier to accessing the SEPs services were failing to reduce high transmission rates. *Id.* at 999–1001; *see also* Peter Lurie, Invited Commentary, *Le Mystère de Montréal*, 146 AM. J. EPIDEMIOLOGY 1003, 1003–04 (1997) ("Do these results demonstrate that NEPs, far from preventing HIV transmission, actually cause an increase in transmission as some NEP opponents have claimed? . . . The simple answer . . . is 'no.'").

130. Ctrs. for Disease Control & Prevention, HIV Surveillance in Injection Drug Users, slide 15, *available at* http://www.cdc.gov/hiv/idu/resources/slides/slides/idu.pdf (graphically illustrating the

disparities, is that equal reductions in populations with disparate starting rates do not eliminate the gap—everyone is better off but the disparity remains. This problem is a major challenge across public health and health care.[131]

Pharmacy sales may, at least in some places, illustrate the first mechanism: minority IDUs may have a harder time than whites buying syringes in drug stores. There are several possible causes. One is that the spatial distribution of pharmacies in relation to IDU populations is skewed along racial and ethnic lines.[132] In New York City, high-need white areas were far more likely to have outlets for retail sale of syringes than areas with higher concentrations of minorities.[133] Studies in New York have also found that minority IDUs are less likely to use pharmacies to access syringes.[134] Some researchers have suggested that disparate utilization of pharmacy access results from the location of pharmacies in areas that tend to be less racially diverse.[135] Even when non-prescription sales of syringes are authorized, and retail outlets are accessible, in at least some places minorities may still be refused syringe purchase at significantly higher rates than whites.[136]

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approximately parallel reduction in AIDS diagnoses among African American and White injection drug users over the last two decades).

131. *See, e.g.*, Nicole Lurie, Editorial, *Health Disparities—Less Talk, More Action*, 353 NEW ENG. J. MED. 727, 727–28 (2005) (discussing parallel progression of health for whites and racial minorities); David Satcher et al., *What If We Were Equal? A Comparison of the Black-White Mortality Gap in 1960 and 2000*, 24 HEALTH AFF. 459, 460–61 (2005) (finding that gap between black-white standardized mortality ratios changed very little between 1960 and 2000 and actually worsened for infants and for African American men age thirty-five and older).

132. Cooper et al., *supra* note 126, at 939 ("ESAP [Expanded Syringe Access Program] access is a racialized feature of the risk environment in NYC health districts; that is, it appears to be a protective feature that is distributed across geographic areas according to local racial/ethnic composition. This distribution may . . . . help explain the lower rates of ESAP pharmacy utilization among black injectors in NYC if the racial/ethnic composition of injectors across districts follows that of the general population.").

133. *Id.* at 938 ("Among high-need districts, 'whiter' districts had about twice the spatial access to ESAP pharmacies at baseline than districts with a low proportion of non-Hispanic white residents (39.02 vs. 18.82 pharmacies per square mile). This inequality increased over time . . . .").

134. *See* Sherry Deren et al., *Impact of Expanding Syringe Access in New York on Sources of Syringes for Injection Drug Users in Harlem and the Bronx, NYC, USA*, 14 INT'L J. DRUG POL'Y 373, 378 (2003) (observing minority underutilization of pharmacy needle programs); Fuller et al., *supra* note 107, at S81–82 (finding slower uptake in use of ESAP by blacks and Latinos as compared to whites). Other studies have found differences in refusal associated with whether the pharmacy is located in a local or urban area. *See, e.g.*, Compton et al., *supra* note 106, at 665 (finding higher rates of refusal in urban rather than rural areas).

135. *See* Cooper et al., *supra* note 126, at 939 (finding racial composition to be more powerful predictor of ESAP use than actual local need).

136. Haven B. Battles et al., *Who Purchases Nonprescription Syringes? Characterizing Customers of the Expanded Syringe Access Program (ESAP)*, 86 J. URB. HEALTH 946, 947 (2009) (studying New York pharmacies participating in ESAP and finding that whites were less likely than blacks or Hispanics to

III. GRUDGING REFORM, BUT CONTINUED BARRIERS TO ACCESS

Drug prohibition is surely among the most durable and least successful policy initiatives in American history. Drug control efforts in the United States over the last century have been based on the premise that drug use is inherently dangerous (not to mention immoral) and that criminal law is the best tool for reducing illicit drug consumption.[137] The key features of this approach have been surveillance, arrest, and incarceration of drug users.[138] While drugs (both legal and illegal) do carry significant health risks, there is little evidence that the criminal justice approach to drug control in any of its various forms has succeeded in reducing drug use, let alone producing better health overall.[139] If anything, the evidence of the pathological effects of this approach has only grown.[140]

There have been some efforts to fashion truces of sorts in the war. In recent years, approaches oriented more towards treatment and variations of therapeutic jurisprudence—for example, drug courts—have become more common.[141] If nothing else, economic pressures and the high cost of incarceration have instigated some efforts to reduce the jailing of nonviolent drug offenders.[142] Between 2000 and 2006, states reduced the population of African American

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have been refused syringe sale (36% vs. 63% and 68% respectively); Compton et al., *supra* note 128, at 595–96 (finding high rates of refusal or hassles—for example, requiring large purchases of syringes—and possible racial disparities in access via pharmacies); Elizabeth C. Costenbader et al., *Racial Differences in Acquisition of Syringes from Pharmacies Under Conditions of Legal but Restricted Sales*, 21 INTL. J. DRUG POL'Y 425–28 (2010) (finding that African American IDUs were one-fifth as likely as white IDUs to report pharmacies as their primary source of syringes in Raleigh-Durham, NC).

137. *See generally* Scott Burris et al., *supra* note 21 (examining and critiquing traditional modes of law enforcement concerning injection drug users).

138. *See id.* at 133 (observing troubling impact of arrests and incarceration on injection drug users).

139. For a thorough assessment, see ROBERT J. MACCOUN & PETER REUTER, DRUG WAR HERESIES: LEARNING FROM OTHER VICES, TIMES, AND PLACES (2001).

140. In addition to the disparities evidence we have discussed in this Article, consider for example the striking finding that individuals released from prison are at significantly elevated risk of death in the ensuing months, Ingrid A. Binswanger et al., *Release from Prison—A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 158–61 (2007), or the evidence that fear of police can deter people from seeking help during a drug overdose, Catherine T. Baca & Kenneth J. Grant, *What Heroin Users Tell Us About Overdose*, 26 J. ADDICTIVE DISEASES 63, 64–67 (2007). If one accepts the plausible proposition that there are better ways to reduce drug addiction than police intervention through criminal law, then our current level of addiction represents a prevention and treatment failure, not a sign that we just need to arrest more dealers or users.

141. *See, e.g.*, John S. Goldkamp, *The Drug Court Response: Issues and Implications for Justice Change*, 63 ALB. L. REV. 923, 923 (2000) (observing proliferation of drug courts since first establishment in Florida in 1989).

142. *See, e.g.*. New Jersey Office of the Public Defender, http://www.state.nj.us/defender/drugcrt.shtml (last visited Mar. 1, 2011) (detailing merits of New Jersey's drug courts for nonviolent drug offenders).

prisoners by 55,300;[143] fifty-six percent of this decline was attributed to fewer blacks being imprisoned for drug offenses.[144] Examples like Portugal's apparently happy experiment with depenalization of drug possession,[145] and the widespread adoption of harm reduction approaches by many European countries, Australia, and Canada,[146] show that there are better ways to address the health and social harms of drug abuse. Nonetheless, though the Obama Administration's Drug Czar Gil Kerlikowske has promised a national drug strategy based on a public health approach,[147] substantial change in drug control law and law enforcement will be slow in coming.

Syringe access offers a somewhat easier area for substantial progress. Whatever may develop in drug policy reform in the coming years, it is imperative—and possible—to scale up the single most effective prevention tool at our disposal. In the remainder of this Part, we describe the current state of the law governing syringe exchange programs and pharmacy sales of syringes, updating previous reports,[148] and for the first time covering local regulations in key cities with SEPs.

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143. WILLIAM J. SABOL ET AL., U.S. DEP'T OF JUSTICE, BJS BULLETIN NCJ 228417, PRISONERS IN 2008, at 4–6 (2009).

144. *Id*. at 6.

145. *See generally* GLENN GREENWALD, CATO INSTITUTE, DRUG DECRIMINALIZATION IN PORTUGAL: LESSONS FOR CREATING FAIR AND SUCCESSFUL DRUG POLICIES (2009); Caitlin Elizabeth Hughes & Alex Stevens, *What Can We Learn from the Portuguese Decriminalization of Illicit Drugs?*, 50 BRITISH J. CRIMINOLOGY 999 (2010).

146. The International Harm Reduction Association gives all three high marks for the inclusion of harm-reduction practices in national policies. *See* INT'L HARM REDUCTION ASS'N, OCEANIA—REGIONAL OVERVIEW (2006), http://www.ihra.net/Oceania#RegionalOverview [hereinafter IHRA, OCEANIA]; INT'L HARM REDUCTION ASS'N, EURASIA—REGIONAL OVERVIEW (2006), http://www.ihra.net/Eurasia#RegionalOverview [hereinafter IHRA, EURASIA]; INT'L HARM REDUCTION ASS'N, NORTH AMERICA—REGIONAL OVERVIEW (2006), http://www.ihra.net/north-america [hereinafter IHRA, NORTH AMERICA]. Australia has national harm-reductions programs and has pioneered the roll out of innovative harm reduction interventions. IHRA, OCEANIA, *supra.* Almost all of the twenty-nine countries in Eurasia have explicit references to harm reduction in official documents and law and "[k]ey harm reduction interventions (including needle and syringe exchange and opioid substitution therapy) are available in almost all countries in this region. . . ." IHRA, EURASIA, *supra*. Canada has many harm-reduction services. IHRA, NORTH AMERICA, *supra*.

147. Gary Fields, *White House Czar Calls for End to "War on Drugs*," WALL ST. J., May 14, 2009, at A3 (reporting Drug Czar Gil Kerlikowske's announcement that nation's drug policy would shift toward favoring treatment rather than incarceration).

148. *See* AM. BAR ASS'N, AIDS COORDINATING COMM., DEREGULATION OF HYPODERMIC NEEDLES AND SYRINGES AS A PUBLIC HEALTH MEASURE: A REPORT ON EMERGING POLICY AND LAW IN THE UNITED STATES (Scott Burris ed., 2001), *available at* http://www.abanet.org/AIDS/publications/deregulation.pdf (examining medical facts and legal developments surrounding deregulation of syringes); Scott Burris et al., *Harm Reduction in the Health Care System: The Legality of Prescribing and Dispensing Syringes to Drug Users*, 11 HEALTH MATRIX 5, 39–62 (2001) (examining results of study surveying state laws concerning physician prescription and pharmacy sales of syringes to drug users); Scott Burris et al., *Lethal Injections: The Law,*

The law governing syringe access is primarily state. The federal government has minimal direct regulatory power over SEPs. Although syringes are classified as Class II devices under the Federal Food, Drug and Cosmetic Act (FDCA) and are therefore subject to modest controls regarding quality and product safety,[149] the FDCA only regulates the design, manufacturing, labeling, and marketing in interstate commerce of medical devices; it does not regulate medical practice, including the use of medical devices.[150] The potential application of the Federal Mail Order Drug Paraphernalia Control Act and the Controlled Substances Act have been theoretical concerns of SEP operators in the past, but have generally not presented significant impediments to syringe exchange.[151] In contrast to the case of medical marijuana, federal agents have never intervened to shut down an SEP. The federal government's primary tool for regulating SEPs has been through its use of the conditional spending power. Beginning in 1988, Congress included provisions in budget legislation that barred the use of federal funds for purchasing

Science, and Politics of Syringe Access for Injection Drug Users, 37 U.S.F. L. REV. 813 (2003) [hereinafter Burris et al., *Lethal Injections*] (examining effectiveness of SEPs in context of public controversy surrounding them); Scott Burris et al., *Physician Prescribing of Sterile Injection Equipment to Prevent HIV Infection: Time for Action*, 133 ANNALS INTERNAL MED. 218, 220–22 (2000) (surveying local laws regarding legality of physicians prescribing sterile injection equipment); Scott Burris et al., *The Legal Strategies Used in Operating Syringe Exchange Programs in the United States*, 86 AM. J. PUB. HEALTH 1161, 1161–62 (1996) [hereinafter Burris et al., *Legal Strategies*] (examining applicability of drug laws to SEPs); Scott Burris et al., *The Legality of Selling or Giving Syringes to Injection Drug Users*, 42 J. AM. PHARMACEUTICAL ASS'N S13, S14–17 (Supp. 2002) (examining state laws regarding legality of physicians and pharmacies dispensing syringes to injection drug users); Scott Burris et al., *State Syringe and Drug Possession Laws Potentially Influencing Safe Syringe Disposal by Injection Drug Users*, 42 J. AM. PHARMACEUTICAL ASS'N S94, S95–97 (Supp. 2002) (reviewing state laws and judicial decisions for potential barriers to proper syringe disposal by injection drug users).

149. 21 U.S.C. § 360c(a)(1)(B) (2006).

150. *See* 21 U.S.C. § 331 (listing prohibited acts); 21 U.S.C. § 351 (regulating devices from manufacture to marketing).

151. Syringes could fall within the definition of paraphernalia set forth in the Paraphernalia Act, which would thereby subject them to federal regulation. *See* Federal Mail Order Drug Paraphernalia Control Act, Pub. L. No. 99-570, 100 Stat. 2307, (codified as amended at 21 U.S.C. § 863 (2006)) (regulating and defining "drug paraphernalia"). However, the Act is plainly limited to the regulation of materials that are sold or offered for sale or are transported in "the mails or any other facility of interstate commerce." 21 U.S.C. § 863(a). SEPs are local institutions and do not exchange syringes across state lines. The Act also contrasts paraphernalia with objects used by "legitimate supplier[s]" that have "legitimate uses . . . in the community." 21 U.S.C. §863(e). Finally, any SEPS operating with local or state authority would be excluded from the scope of the Paraphernalia Act. 21 U.S.C. § 863(f) ("This section shall not apply to . . . any person authorized by local, State, or Federal law to manufacture, possess, or distribute such items."). While sweeping in scope, the Controlled Substances Act, Pub. L. No. 90-513, 84 Stat. 1236, amended by Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 2307 (codified as amended by 21 U.S.C. §§ 801–977 (2006)) does not apply to medical devices. *See* 21 U.S.C. § 802(6) (defining controlled substance as scheduled drugs or other substances).

or distributing syringes to drug users.[152] The funding ban has been a significant impediment to efforts to scale up SEPs and has helped perpetuate the idea that SEPs are dangerous or ineffective. In the fall of 2009, Congress removed the ban from fiscal year 2010's budget legislation.[153] New language allows federal funding for SEPs except in locations "that local public health or law enforcement agencies determine to be inappropriate."[154] However, federal laws including the Ryan White Care Act,[155] the Health Omnibus Programs Extension Act of 1988[156] (HOPE Act), and the Runaway, Homeless and Missing Children Act of 2003[157] contain independent language barring the use of federal money for syringe exchange activities. Similar language is contained in acts governing block grants for drug addiction prevention and treatment.[158] To effectuate Congress's intent in removing the funding ban language from the budget legislation, these must be amended as well.[159]

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152. Health Omnibus Programs Extension of 1988, Pub. L. No. 100-607, § 256, 102 Stat. 3048, 3110 (codified at 42 U.S.C. § 300ee-5 (2006)).

153. H.R. REP. NO. 111-366, at 1080 (2009) (Conf. Rep.).

154. *Id.*

155. 42 U.S.C. § 300ff-1 (2006) ("None of the funds made available under this Act, or an amendment made by this Act, shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs."). This prohibition is also noted in HEALTH RES. & SERVS. ADMIN., HIV/AIDS BUREAU & DIV. OF SERV. SYS., THE RYAN WHITE CARE ACT TITLE II MANUAL, sec. IV, ch. 1, 8 (2003), *available at* ftp://ftp.hrsa.gov/hab/t2SecIVChap1.pdf ("In accordance with Sec. 2678 and Sec. 422 of the CARE Act, as amended, funds may not be used for syringe exchange programs.").

156. 42 U.S.C. § 300ee-5 ("None of the funds provided under this Act or an amendment made by this Act shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome.").

157. 42 U.S.C. § 5752 ("None of the funds contained in this subchapter may be used for any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.").

158. *See, e.g.*, 45 C.F.R. § 96.135(a)(6) ("The State shall not expend the Block Grant on the following activities: To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS."); 42 U.S.C. § 300x-31(a)(1)(f) ("A funding agreement for a grant under section 300x-21 of this title is that the State involved will not expend the grant … to carry out any program prohibited by section 300ee-5 of this title.").

159. The legal maneuvering necessary to get federal funding to SEPs was exemplified in a February 2011 notice in the federal register. The notice reported a finding by the Surgeon General that "that a demonstration syringe services program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome." This, in turn, enabled the "expenditure of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds" on SEPs. *See* Determination That a Demonstration Needle Exchange Program Would be Effective in Reducing Drug Abuse and the Risk of Acquired Immune Deficiency Syndrome Infection Among Intravenous Drug Users, 76 Fed. Reg. 10038 (Feb. 23, 2011). Even as the Obama administration

A. State and Local Syringe Exchange Laws

As the HIV epidemic began to unfold in the early 1980s, selling, buying, possessing, and disposing of syringes were heavily regulated activities in most states. The principal categories of regulation were three: rules that required a prescription for the purchase of syringes, drug paraphernalia laws that prohibited the sale or possession of any item for the purpose of illegal drug use, and pharmacy board regulations setting out various requirements regarding the display or sale of syringes.[160] There were, of course, no laws that explicitly addressed syringe exchange programs.[161] Efforts to increase access to sterile syringes thus unfolded in an environment less of prohibition than of legal uncertainty, as prevention advocates developed ways to increase access and lawyers tried to figure out whether or not they were legal.

At first, attention focused on SEPs. Most states where the epidemic was most severe—on the East Coast and in California—had both prescription and paraphernalia laws to deal with.[162] Virtually all the rest of the states had paraphernalia laws.[163] To make a long story short, proponents of SEP pursued three different legal strategies.[164] In some states, advocates—a category that often included public health and local government officials—sought clear legislative authorization for SEPs.[165] Alternatively, some localities determined that they could authorize SEPs to operate under local law without any change in state law.[166] Most SEPs, however, were founded, as Burris and colleagues put it, "without a claim of legality."[167] This perhaps pedantic phrasing was chosen

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was looking for means of getting federal dollars to SEPs, Republicans in the House were moving to restore the federal ban in their budget legislation. Full-Year Continuing Appropriations Act, H.R. 1, 112th Cong §§ 1591, 1847 (2011).

160. *See* Burris et al., *Lethal Injections*, *supra* note 148, at 814 (setting forth three main forms of syringe access regulation).

161. We are not aware of any studies that have documented the state of the relevant law at the beginning of the HIV epidemic, but some of the early legal papers give a sense of the starting point. *See* Burris et al., *Legal Strategies*, *supra* note 148, at 1161–62 (identifying strategies used by syringe exchange programs to establish their legality); Larry Gostin, *The Interconnected Epidemics of Drug Dependency and AIDS*, 26 HARV. C.R.-C.L. L. REV. 113, 119 (1991) (recommending governmental drug policy that employs therapeutic goals in order to curb AIDS epidemic); Lawrence O. Gostin & Zita 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, 684–89 (1997) (examining arguments that syringe exchange programs are lawful based on broad powers conferred on governments by HIV/AIDS statutes).

162. Burris et al., *Legal Strategies*, *supra* note 148, at 1161.

163. *Id.* at 1162.

164. *Id.*

165. *Id.* at 1165.

166. *Id.* at 1164.

167. *Id.* at 1164.

deliberately to help vitiate the prevailing belief that SEPs that were not positively authorized were illegal. Because no laws explicitly prohibited SEPs, and there was a reasonable argument that drug paraphernalia laws were not intended to prohibit bona fide public health interventions, the legality of SEPs in states with paraphernalia laws could and has continued to be reasonably asserted by proponents of the intervention.[168] This interpretive approach has allowed SEPs with community support to go into operation even if the state legislature would not pass a law positively authorizing them.[169] Not surprisingly, however, the limited evidence on the topic supports the common-sense assumption that clear legal support enhances the capacity of SEPs to deliver syringes and other services.[170] Table I summarizes the current state of SEP legality, covering all states with SEPs reported to the CDC. There may be unreported SEPs operating in other states, as well as SEPs operating without authority within states with authorized programs.[171]

Table I: Legal Status of Syringe Exchange Programs in the United States[172]

168. The argument that SEPs are not prohibited by paraphernalia laws, under at least some circumstances, has had a mixed record. It was accepted in the case of a publicly authorized SEP in Washington. *See* Spokane County Health Dist. v. Brockett, 839 P.2d 324, 329–32 (Wash. 1992) (holding that SEPs are not prohibited by paraphernalia laws). More recently, the Texas Attorney General issued an opinion asserting that the paraphernalia law barred syringe exchange even where it had been authorized by the state legislature! *See* Jordan Smith, *Needle-Exchange Pilot Stung by Prick*, AUSTIN CHRONICLE, May 23, 2008, *available at* http://www.austinchronicle.com/gyrobase/Issue/column?oid=627449 (explaining that Texas Attorney General expressed opinion that participants in SEPs not immune from prosecution). In 2007, the Texas legislature authorized a pilot program in Bexar County, but the local district attorney threatened to prosecute anyone who actually distributed syringes under the state paraphernalia law. *Id.* In an advisory opinion, the state Attorney General concluded that in passing the provision, the legislature did not intend to excuse individuals implementing exchanges, or their clients, from paraphernalia law liability. Tex. Atty. Gen. Op. GA-0622 (2008), 2008 WL 1972703.Exchanges operating in Texas, including an unauthorized exchange in Bexar County, several of whose operators were arrested in 2007, are classified as operating without claim to legal authority. *Id.*

169. Press Release, Harm Reduction Coalition, Lake County Authorizes Syringe Exchange; Programs Still Unauthorized in Two-Thirds of State of California (Feb. 27, 2008), http://www.harmreduction.org/ article.php?id=731 (describing unauthorized SEP program in Fresno County California).

170. *See* Bluthenthal et al., *Approval of SEPs in California*, *supra* note 63, at 278 (2008) (indicating that SEP availability and success affected by "various state-level approaches to [their] implementation").

171. For an example, see Press Release, Harm Reduction Coalition, *supra* note 169.

172. The list of states where SEPs operate is taken from Centers for Disease Control and Prevention, *Syringe Exchange Programs United States, 2005*, 56 MORBIDITY & MORTALITY WKLY. REP. 1164, 1164 (2007).

SEP authorized by state law (15)	**SEP authorized by local government based on its interpretation of state law (3)**	**Free distribution of syringes not restricted by state law (5)**	**SEP(s) operating without specific claim to legality – 2008 (14)**
CA†, CO†, CT, DE, DC, HI, ME, MA†, MD, NH, NJ, NM, RI*, VT, WA	IL, OH, PA	AK, LA, OR, RI, WI	AZ, GA, IN, KS, MI, MN, MT, NY, NC, OK, PR, TN, TX, UT

†Requires authorization by local government
*State law no longer restricts free distribution

Although explicit legal authorization appears to be a positive factor, even laws that purport to authorize SEPs may come with stipulations that can lessen their reach or effectiveness. For example, some states still limit syringe exchange to one-for-one, where clients can only receive clean syringes if they have a used one to trade,[173] or set age limits that exclude high-risk populations from SEP coverage.[174] Some research has found that restrictions like one-for-one exchange or numerical limits on how many syringes can be exchanged reduce the effectiveness of the intervention.[175] As noted on Table I, in three states that authorize SEPs the state legislature merely passed on the decision to actually allow SEPs to local governments.[176] Thus, in California, SEPs are "legal" but many

173. *See, e.g.*, DEL. CODE. ANN. tit. 29, § 7992 (2008) (providing for one-for-one exchange of needles for prevention of blood-borne diseases and referral of IDUs to treatment and other health and social services programs).

174. *See, e.g.*, WASH REV. CODE ANN. § 69.50.412 (LexisNexis 2009) (stating that "[i]t is lawful for any person over age of eighteen to possess sterile hypodermic syringes and needles for purpose of reducing blood-borne diseases").

175. *See* Bluthenthal et al., *SEP Dispensation Policy*, *supra* note 63, at 643 (finding that adequate syringe coverage correlates with dispensation policy).

176. CAL. HEALTH & SAFETY CODE § 121349(b) (West 2006) ("In order to attempt to reduce the spread of HIV infection and blood-borne hepatitis among the intravenous drug user population within California, the Legislature hereby authorizes a clean needle and syringe exchange project pursuant to this chapter in any city and county, county, or city upon the action of a county board of supervisors and the local health officer or health commission of that county, or upon the action of the city council, the

cities are not served or are served by "underground" exchanges.[177] In Massachusetts, the local approval requirement has prevented SEPs in areas of high need.[178] In Springfield, for example, the public health authority authorized SEPs and used emergency powers to promote implementation only to be overruled when a city attorney found that a vote of the city council was required by the "local approval" provision in the state statute.[179] The city council voted the SEP down despite support for the SEP among the health authorities and law enforcement in the community.[180]

It is also the case, unfortunately, that legal authorization of SEPs (or pharmacy sales, for that matter) may not be enough to insulate clients from trouble with the police. In both New York and Connecticut, drug users had to go to federal court to stop police from arresting them or confiscating syringes even after the law was changed to make syringe possession legal.[181] Numerous academic studies and other reports have documented police officers stopping SEP clients at

mayor, and the local health officer of a city with a health department, or upon the action of the city council and the mayor of a city without a health department."); MASS. GEN. LAWS ANN. ch. 111, § 215 (West 2006) ("The department of public health is hereby authorized to promulgate rules and regulations for the implementation of not more than ten pilot programs for the exchange of needles in cities and towns within the commonwealth upon nomination by the department. Local approval shall be obtained prior to implementation of each pilot program in any city or town."); COLO. REV. STAT. § 25-1-508 ("In addition to all other powers and duties conferred and imposed upon a county board of health or district boards a district board of health by the provisions of this subpart 3, a county board of health or district boards . . . shall have and exercise the following specific powers and duties: . . .To approve, as provided for in section 25-1-520, a clean syringe exchange program proposed by an agency. A county board of health or district board of health shall not be required to approve a proposed program.").

177. Rachel Anderson et al*., Delivering Syringe Exchange Services Through "Satellite Exchanges": The Sacramento Area Needle Exchange, USA*, 14 Int'l Drug Pol'y 461, 461–62 (2003) (noting that SEP may be legal but their clients may be charged for paraphernalia law violations).

178. David Buchanan et al., *Empirical Science Meets Moral Panic: An Analysis of the Politics of Needle Exchange*, 24 J. PUB. HEALTH POL'Y 427, 429 (2003) (describing history of syringe exchange in Massachusetts and noting that "[t]here have been a number of popular referenda seeking 'local approval' over the ensuing years, in Worcester, Springfield, Holyoke, and New Bedford, but whenever needle exchange has been put to a popular vote in Massachusetts, it has been defeated"); *see also* Bluthenthal et al., *Approval of SEPs in California*, *supra* note 63, at 278 (noting that "[i]n Massachusetts, no local referendum on opening a program has been approved since 1997, and the few local governments that had approved new programs reversed themselves in response to negative public reactions.").

179. Buchanan et al., *supra* note 178, at 429.

180. *Id.*

181. *See* Doe v. Bridgeport Police Dep't, 198 F.R.D. 325, 329–30 (D. Conn. 2001) (describing plaintiffs' application for restraining order against police who continued to arrest injecting drug users because they possessed hypodermic needles notwithstanding law making possession legal); *see also* Roe v. City of N.Y., 232 F. Supp. 2d 240, 246–47 (S.D.N.Y. 2002) (describing plaintiff's arrest for possessing needle even though she carried needle exchange card permitting possession).

or near the exchange, confiscating syringes or disregarding program identification cards.[182]

State and local governments may impose further restrictions by law or practice. In the summer of 2009, researchers at Temple's Center for Health Law, Policy and Practice undertook a closer look at how law restricts where and how SEPs may be implemented at the local level.[183] The impetus for the research was an amendment to the bill lifting the federal funding ban. The amendment, added to the House version of the bill, would have prohibited the use of federal funds for SEPs operating "within "1,000 feet" of day care centers, schools, universities, public pools, parks, playgrounds, video arcades or youth centers or an event sponsored by these organizations."[184] The proposal offers an excellent illustration of how seemingly minor stipulations can have a powerful negative effect on SEP operations. Maps prepared for major cities showed that a 1,000-foot limitation would bar SEPs almost everywhere, pushing them to undeveloped or industrial areas inaccessible to clients. Our research was intended to find out how localities currently regulate the operation of SEPs and to assess the local impediments to the effective operation of SEPs.

In seven of the cities (Cleveland, Los Angeles, New York, Newark, Pittsburgh, Washington, and Wilmington), SEPs may not operate within a certain distance of schools or other places where children congregate.[185] Spatial restrictions vary

182. *See, e.g.*, Alexis N. Martinez et al., *The Impact of Legalizing Syringe Exchange Programs on Arrests Among Injection Drug Users in California*, 84 J. URB. HEALTH 423, 428–29 (2007) (noting rates of arrest and confiscation by program participants).

183. We analyzed state and local laws, regulations, and written policies dealing with the operation and siting of needle exchange programs in nineteen U.S. cities to determine how the siting of NEPs is restricted by law. Our research team searched through LexisNexis; Westlaw; local government websites; and other publicly available, internet-accessible sources for state statutes, state regulations, local ordinances, and written standards for syringe exchange programs in each city. We verified the results of the legal research and obtained substantiation of locally accepted rules through telephone consultation with former and current SEP operators and workers who had first-hand knowledge of the local law. The cities studied were Baltimore, Boston, Chicago, Cleveland, Detroit, Los Angeles, Milwaukee, Minneapolis, New Haven, New York, Newark, Philadelphia, Pittsburgh, Portland, Providence, San Francisco, Seattle, Washington, D.C., and Wilmington.

184. H.R. REP. NO. 111-366, at 1080 (2009) (Conf. Rep.).

185. *E.g.*, LOS ANGELES COUNTY, CAL., MUNICIPAL CODE § 12.21(D); D.C. CODE § 48-1121 (2009); N.J. ADMIN. CODE § 8:63 App. (2007); ALLEGHENY COUNTY, PA., CODE § 851-5 (2009); AIDS INSTITUTE, NEW YORK STATE DEPARTMENT OF HEALTH, POLICIES AND PROCEDURES: SYRINGE EXCHANGE PROGRAMS 22 (2009) *available at* http://www.health.state.ny.us/diseases/aids/harm_reduction/needles_syringes/syringe_exchange/docs/policies_and_procedures.pdf [hereinafter NY AIDS INSTITUTE]; DEP'T OF PUB. HEALTH, CITY OF CLEVELAND, EMERGENCY ORDER PERMITTING AND ENCOURAGING NEEDLE EXCHANGE PROGRAMS IN THE CITY OF CLEVELAND (1998) (on file with authors) [hereinafter CLEVELAND DEP'T OF PUB. HEALTH].

from "near" to 1,500 feet.[186] This variation in spatial restrictions reflects the fact that cities have different needs. In New York City, for example, the location restriction is flexible: New York City SEPs cannot operate "near schools, playgrounds, daycare facilities or other settings which would be inappropriate and which would potentially generate community opposition."[187] This provision gives health authorities and SEP operators discretion to offer SEP services in appropriate locations in this densely populated city. Likewise, Cleveland's law gives the Director of Public Health the discretion to waive its 1,000-foot restriction whenever necessary and appropriate.[188] Our research did not investigate whether these restrictions impair SEP services or harm communities in need of SEP services.

In eight of the cities (Baltimore, Boston, Los Angeles, New York, Newark, San Francisco, Washington, and Wilmington), laws or policies require *community consultation* that provides some forum for community input and public discussion or approval of SEP sites or general SEP operation.[189] These provisions take a number of forms, from Baltimore's rule that SEP staff meet with and secure the approval of local residents and businesses[190] to California's requirement of an annual opportunity for community comment and input.[191]

In ten cities, we found no written laws or policies specifically related to where SEPs could operate. In most cases, however, we were told about "unwritten rules" that required community consultation or approval by mayors or other city officials. In Philadelphia, for example, sites must be approved by the city Office of Addiction Services, one of the SEPs' main funders.[192] In Chicago, the Chicago Recovery Alliance and others work informally with government and community

186. In Newark, SEPs are subject to a state law that prohibits the operation of SEPs "near" schools. N.J. ADMIN. CODE § 8:63 App. An Allegheny County ordinance requires SEPs within Pittsburgh to operate at least 1,500 feet from a school. ALLEGHENY COUNTY, PA, CODE § 851-5 (2009).

187. NY AIDS INSTITUTE, *supra* note 185, at 22.

188. CLEVELAND DEP'T OF PUB. HEALTH, *supra* note 185.

189. Washington D.C. is the only locality in which community consultation is required by a local law. D.C. CODE § 48-1121. In Boston, Los Angeles, San Francisco, and Newark, the requirement comes from state statutes, CAL. HEALTH & SAFETY CODE § 121349(b) (2006); MASS. GEN. LAWS ANN. ch. 111, § 215 (2003), or a state regulation, N.J. ADMIN. CODE. § 8.63. In Baltimore, a local policy requires community consultation. BALTIMORE CITY HEALTH DEP'T, NEEDLE EXCHANGE PROGRAM PROTOCOL & PROCEDURES § A, p. 5 (on file with authors) [hereinafter BALTIMORE PROTOCOLS & PROCEDURES]. In New York and Wilmington, state policies require community consultation. NY AIDS INSTITUTE, *supra* note 185, at 22; DEL. DIV. OF PUB. HEALTH, NEEDLE EXCHANGE PILOT PROGRAM: STANDARD OPERATING PROCEDURES 6 (2006) (on file with authors).

190. BALTIMORE PROTOCOLS & PROCEDURES, *supra* note 189, at 5.

191. CAL. HEALTH & SAFETY CODE § 121349.2.

192. Personal Communication from Yaya Liem, SEP Coordinator, to Corey S. Davis (August 25, 2009).

leaders to find suitable locations.[193] There is a formalized process in Baltimore that requires meetings with neighborhood and business associations; the meetings are geared towards promoting empowerment and community buy-in.[194] Indeed, in every city, the usual political processes that govern the location and operation of services can be expected to influence where and how SEPs do their work.

From the policy perspective, syringe exchange continues to make progress. The lifting of the federal funding ban, and the rejection of the 1,000-foot restriction, were considerable victories not only in what was explicitly achieved, but also in the implicit message that undergirds them: SEPs are an essential public health tool whose implementation is best managed by communities and their public health officials.[195] Unfortunately, progress is coming far too slowly. There are still far too many places with no SEPs, and no place that has them has reached the level of service recommended by public health experts.

B. Pharmacy Sale and Syringe Possession: The "Deregulation Model"

As evidence and thinking evolved, public health and harm reduction workers began to ask why there should be any regulation of syringe sale and purchase at all. After all, many countries, and an increasing number of U.S. states, were functioning just fine without such regulations, and seeing positive effects on HIV prevalence among IDUs.[196] The policy debate broadened from the legality of SEPs to the removal or easing of prescription requirements and paraphernalia law restrictions on obtaining or carrying syringes. The history of syringe deregulation from 1987 to 2002 has been told in full elsewhere,[197] and is summarized in Table II. Since then the trend has continued, with three additional states liberalizing their paraphernalia or prescription laws to facilitate access to clean syringes. In 2003, the Illinois paraphernalia and prescription laws were amended to permit pharmacies to sell and individuals to possess up to twenty hypodermic syringes or needles without a prescription.[198] In 2004, California modified its prescription law

193. Personal Communication from Dan Bigg, Executive Director of Chicago Recovery Alliance, to Corey S. Davis (August 25, 2009).

194. BALTIMORE PROTOCOLS & PROCEDURES, *supra* note 189, at 5.

195. The new language allows federal funding for SEPs except in locations "that local public health or law enforcement agencies determine to be inappropriate." H.R. REP. NO. 111-366, at 1080 (2009) (Conf. Rep.) This is not a requirement that local authorities affirmatively approve or go back and review each site in order to get federal funds. Rather, this language is intended to avoid federal interference and to empower locally appropriate operational decisions regarding the siting and location of SEPs.

196. *See* Burris et al., *Lethal Injections*, *supra* note 148, at 815–21 (describing evolvement of syringe regulations and syringe exchange programs).

197. *See id.* (describing history of syringe deregulation).

198. The Hypodermic Syringes and Needles Act, 720 ILL. COMP. STAT. ANN. 635/0.01-6 (West 2003 & Supp. 2009), was passed in 1955, and amended in 2003. The operative provision is 720 ILL. COMP. STAT.

to authorize local governments to allow the sale of up to ten hypodermic needles or syringes without a prescription.[199] The paraphernalia law was amended to exempt "possession solely for personal use of ten or fewer hypodermic needles or syringes if acquired from an authorized source."[200] In 2006, the Massachusetts legislature passed an amendment to its Controlled Substances Act, allowing pharmacies to sell non-prescription "[h]ypodermic syringes or hypodermic needles for the administration of controlled substances by injection . . . to persons who have attained the age of 18 years. . . ."[201] The amendment also struck from the definition of paraphernalia "hypodermic syringes, needles and other objects used, primarily intended for use or designed for use in parenterally injected controlled substances into the human body," and, for good measure, added the clause "[t]his section shall not apply to the sale of hypodermic syringes or hypodermic needles to persons over the age of 18 pursuant to [the previous section]."[202]

These developments have certainly been positive, but they are not without defect. The main problem is the specification of a limited number of syringes for purchase and possession. Ten, twenty, or even thirty syringes will not last very long for a person injecting with a new syringe two or three times a day; the convenience and possible price advantage of buying in bulk are not available to regular syringe users, whether they are using heroin, cocaine, or legal medications like insulin. On the street, numerical restrictions create dangerous ambiguities in the legal status of syringes. Because the legality of a syringe depends, under such a law, on factors including where it was obtained and how many others are in the

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ANN. 635/1(b), which states "A person who is at least 18 years of age may purchase from a pharmacy and have in his or her possession up to 20 hypodermic syringes or needles." *See also* 720 ILL. COMP. STAT. ANN. § 600/3.5(a) (excluding individuals covered under § 635/1(b) from misdemeanor liability for possessing hypodermic syringes or needles).

199. Section 4145(a) of the California Business and Professions Code states:

> [A] pharmacist or physician may, without a prescription or a permit, furnish . . . syringes for human use . . . if one of the following requirements is met:
>
> . . . .
>
> (2) Pursuant to authorization by a county, with respect to all of the territory within the county, or a city, with respect to the territory within the city, for the period commencing January 1, 2005, and ending December 31, 2010, a pharmacist may furnish or sell 10 or fewer hypodermic needles or syringes at any one time to a person 18 years of age or older if the pharmacist works for a pharmacy that is registered for the Disease Prevention Demonstration Project pursuant to Chapter 13.5 (commencing with Section 121285) of Part 4 of Division 105 of the Health and Safety Code and the pharmacy complies with the provisions of that chapter.

CAL. BUS. & PROF. CODE § 4145(a) (West Supp. 2010).

200. CAL. HEALTH & SAFETY CODE § 11364(c) (West 2007).

201. MASS. GEN. LAWS ANN. ch. 94C, §27 (West Supp. 2009).

202. MASS. GEN. LAWS ANN. ch. 94C, §32I(d).

possessor's control, some police officers continue to regard a syringe as illegal unless proven otherwise.[203]

Table II: Syringe Deregulation in the United States

State	Year	Prior Law(s)	Change
OR	1987	Paraphernalia law	Syringes explicitly excluded from paraphernalia law
WI	1989	Paraphernalia law	Syringes explicitly excluded from paraphernalia law
CT	1992	Prescription law	Allowed purchase of ten or fewer syringes without prescription
CT	1992	Paraphernalia law	Allowed possession of ten or fewer syringes without a prescription (raised to thirty or fewer in 1999 amendment)
CT	1992	Paraphernalia law	Redefined paraphernalia law to exclude syringes
ME	1993	Prescription law	Allowed the sale of ten or fewer syringes without a prescription
ME	1997	Paraphernalia law	Allowed possession of ten or fewer syringes
MN	1997	Paraphernalia law	Allowed pharmacy sale of up to ten syringes without a prescription and the possession of up to ten unused syringes at a time
NY	2000	Prescription law	Allowed the sale of ten or fewer syringes without a prescription
NY	2000	Paraphernalia law	Allowed the possession of legally obtained syringes
NH	2000	Prescription law	Allowed the purchase of ten or fewer needles in a pharmacy without a prescription
NH	2000	Paraphernalia	Syringes excluded from paraphernalia

203. *See* Burris et al., *Lethal Injections*, *supra* note 148, at 848–49 (explaining that one quarter of SEPs in country were illegal in 1996 but one half of SEPs reported police harassment or arrest of individuals going to or volunteering at SEPs); NEW YORK CITY AIDS HOUSING NETWORK ET AL., STUCK IN THE SYSTEM: EXPANDING SYRINGE ACCESS BY RECONCILING THE PENAL CODE WITH THE PUBLIC HEALTH LAW 8–12 (2010), *available at* http://www.urbanjustice.org/pdf/publications/Stuck_in_the_System.pdf (describing that SEP participants were harassed and arrested by New York City Police).

		law	law
RI	2000	Prescription law	Repealed
RI	2000	Paraphernalia law	Syringes excluded from paraphernalia law
NM	2001	Paraphernalia law	Allowed the sale of syringes by licensed pharmacists
HI	2001	Paraphernalia law	Exempts sale by medical professionals to IDU for disease control purposes; exempts possession by IDU
WA	2002	Paraphernalia law	Allows pharmacy sale and IDU possession "for the purpose of reducing the transmission of bloodborne diseases"
IL	2003	Prescription law	Allowed pharmacy purchase and subsequent possession of up to twenty syringes without a prescription
IL	2003	Paraphernalia law	Allowed the possession of legally obtained syringes
CA	2004	Prescription law	Authorized local governments to permit pharmacy sales
CA	2004	Paraphernalia law	Allowed the possession of legally obtained syringes
MA	2006	Prescription law	Allowed non-prescription pharmacy purchase by purchasers older than eighteen years old
MA	2006	Paraphernalia law	Syringe sales explicitly excluded from the paraphernalia law
PA	2009	Prescription regulation	Repealed pharmacy regulation requiring prescription for syringe purchase
NY	2010	Penal law	Eliminates misdemeanor crimes for syringe possession or possession of drug residue in a syringe for authorized syringe possessors

In some states, pharmacy code regulations also limit access to syringes. These regulations restrict access in diverse ways, including limiting the sale of syringes to pharmacies,[204] requiring identification of customers,[205] or prohibiting

204. *See, e.g.*, GA. COMP. R. & REGS 480-10-.13 (2003) ("No person other than a licensed pharmacist or a pharmacy intern/extern, acting under the direct supervision of a licensed pharmacist, shall sell,

sales when the retailer suspects that the customer may use the syringe for unlawful purposes.[206] Many of these regulations still exist and continue to impede access. As with paraphernalia and prescription laws, there has been some deregulation among the states in this area of the law as well over the last few years. For example, Pennsylvania recently adopted a regulatory rule change that allows pharmacists to dispense an unlimited number of syringes without a prescription.[207]

As is the case with syringe exchange, we have seen steady progress in the deregulation of syringes. The public health case is strong, and experience shows that regulating syringe sales through prescription or other limits does not serve any apparent public purpose. As with SEP law, however, the progress in policy reform has been painfully slow. As attention moves to the drug user—to her willingness not just to obtain but to carry sterile syringes—the focus of policy reform will turn more to paraphernalia and drug possession laws, where ideological arguments over drug control policy once again threaten to obscure the evidence for change.

C. Paraphernalia Laws

Paraphernalia laws are of importance not just to whether SEPs are legal or pharmacists can sell syringes, but also whether IDUs can freely carry them for

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distribute, exchange, or give, to any person a hypodermic syringe or needle designed or marketed primarily for human use"). *See generally* NAT'L ASS'N OF BDS. OF PHARMACY, SURVEY OF PHARMACY LAW 65–69 (Nat'l Ass'n of Bds. of Pharmacy CD-ROM, 2009) (reporting that forty states allow the sale of syringes/needles without a prescription or additional requirements, one allows for non-prescription sales to non-minors, one allows non-prescription sales of ten or less needles or syringes, one restricts non-prescription sales to pharmacies, one state requires a purchaser to be eighteen years or older and provide positive identification; in addition, twelve states restrict the sale of needles / syringes to pharmacies).

205. See, for example, title 856, rule 2-6-18 of the Indiana Administrative Code, which provides:

> (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). . . .

IND. ADMIN. CODE 2-6-19 (2009). *See also generally* NAT'L ASS'N OF BDS. OF PHARMACY, *supra* note 204, at 65–69 (listing prescription requirements for syringes and needles applicable to each state).

206. *See, e.g.*, GA. COMP. R. & REGS. 480-10-.13 ("No hypodermic needle or syringe shall be sold by a pharmacist . . . if such person has reasonable cause to believe that it will be used for an unlawful purpose.").

207. For a discussion of the rule change and access to the final rule, see Independent Regulatory Review Commission, Regulation Details: 16A-5418, http://www.irrc.state.pa.us/Regulations/RegInfo.cfm?IRRCNo =2625 (last visited Mar. 1, 2011). The final rule revises 49 PA. CODE § 27.18 (2010).

future use or proper disposal. Every state except Alaska[208] currently has some form of paraphernalia law.[209] Some of these laws effectively prohibit SEPs. For example, in Florida, the paraphernalia law continues to make the exchange of syringes illegal and exposes persons making the exchange to potential criminal prosecution.[210] The application of paraphernalia laws to syringes has been discussed elsewhere.[211] While some deregulation efforts have included amendments to paraphernalia laws or the provision of statutory carve-outs, these laws continue to impede access to varying degrees.[212] In some cases, states have authorized SEP distribution or pharmacy sales but have not explicitly decriminalized syringe possession or the possession of drug residue in used syringes, producing the spectacle of one agency of government distributing syringes and another taking them away again.[213]

Although virtually all state paraphernalia laws are based on the same Justice Department Model Act, there are important variations in terms that often create more space for pharmacy sales or SEPs. These are set out in Table III below. For example, where paraphernalia laws clearly do not apply to syringes, they raise no question as to the legality of distributing syringes via SEPs. Where they exempt pharmacists, they raise no doubts about the legality of pharmacy sales. Now that prescription requirements have become so rare, and given the increasing evidence that enforcement of paraphernalia laws can deter IDUs from obtaining or carrying new syringes, amending paraphernalia laws to clearly exclude syringes should be a high policy priority in HIV prevention.

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208. There are, however, municipal ordinances proscribing the possession of syringes in a number of localities, including Anchorage. *See* ANCHORAGE, ALASKA MUN. CODE § 8.35.010 (2009) ("Drug paraphernalia includes but is not limited to: . . . Hypodermic syringes, needles. . . ."); ANCHORAGE, ALASKA MUN. CODE § 8.35.025 ("It is unlawful for a person to intentionally or knowingly possess *drug paraphernalia* in public regardless of whether the item of paraphernalia is publicly displayed.").

209. Burris et al., *Lethal Injections*, *supra* note 148, at 828.

210. Pressure has been growing in Florida to repeal or amend the state paraphernalia law to allow SEPs, but political opposition has been fierce. Robin Williams Adams, *Proven Effective, Needle Exchange Banned in Fla.*, LEDGER, Jan. 17, 2010, at A12 (detailing conflicting views among Florida officials regarding syringe exchange programs and describing "the only syringe exchange in Florida listed with North American Syringe Exchange Network" as "a semi-undercover operation").

211. *See generally* Burris et al., *Lethal Injections*, *supra* note 148.

212. *See id.* at 828–33 for a discussion of the deregulation of drug paraphernalia laws.

213. *See, e.g.*, NEW YORK CITY AIDS HOUSING NETWORK ET AL., *supra* note 203, at 2–3 (describing conflict between state public health law authorizing syringe possession and state penal law criminalizing it). *See generally* Burris et al., *Lethal Injections*, *supra* note 148, at 828–33 (summarizing legal provisions).

Table III: Syringe-Related Exemptions in State Drug Paraphernalia Laws (excludes SEP provisions)

Exempts some or all syringes (13)	**Exempts some types of sellers (8)**	**Omits reference to syringes or injection (4)**	**Other significant exemption (8)**
CA (<10)	GA (pharmacists)	CO	IA (syringes sold for "lawful purpose")
CT	HI (MDs, pharmacists & health care institutions)	MI	LA (items for medical use)
IN (items customarily used to inject lawful substances)	MT (MDs & pharmacists)	SC	NJ (with prescription for authorized use)
IL (<21)	NM (pharmacists)	WY	NM (those directly engaged in SEPs)
ME (<10)	OH (MDs & pharmacists)		MA (does not criminalize simple possession of paraphernalia)
MN (<10)	TN (MDs & pharmacists)		MI (does not criminalize simple possession of paraphernalia)
NH (<10)	VA (MDs & pharmacists)		SC (does not cover items used with heroin)
NV (with prescription)	WV (licensees such as pharmacists)		VA (does not criminalize paraphernalia possession)
NY (syringes legally obtained from pharmacy or SEP)			
OR			
RI			
WA (to reduce bloodborne disease)			
WI			

IV. CONCLUSION: FOLLOWING THE EVIDENCE TO POLICY CHANGE

The HIV epidemic among IDUs has not just been caused by a virus. Law has also played a part, both in increasing the risk for IDUs and quite possibly in creating a durable racial and ethnic disparity in IDU HIV infection rates. Law has played and continues to play a role in retarding the adequate scaling up of syringe access. The law's role in aiding and abetting the HIV epidemic was, initially, accidental and unfortunate. Now, after more than two decades, it is obvious and indefensible. The causes and cures of health disparities are complex; the path to a drug policy that effectively controls the harms of drug abuse without imperiling public health is difficult. But this much is clear: SEPs and expanded pharmacy sales of syringes are proven ways of reducing the transmission of HIV, and should be used to the fullest. In particular, the glaring racial and ethnic disparity in HIV/AIDS among IDUs calls for urgent expansion of syringe access (not to mention drug treatment, overdose prevention, and other harm reduction services) for high prevalence populations.

The end of the federal funding ban was an important step in the right direction.[214] It is essential to realize, however, that lack of federal funds has never been the most significant barrier to wider syringe access. Legal barriers and lack of commitment to the health of a marginalized, stigmatized population have and will continue to play a far more powerful role. Federal leadership in a public health approach to drug abuse will help with the stigma; federal funding can create incentives for states and cities to introduce syringe access programs, but sustained legal and political work will be required in the majority of states where syringe access is still in legal doubt, or clearly illegal.

As Part III of this Article has shown, states have plenty to do in reforming their syringe-related laws to eliminate barriers to access. New Jersey and Delaware, the last hold-outs, should press forward to remove their prescription requirements. States whose paraphernalia laws include syringes can amend the law to exclude syringes, and complete the deregulatory process by repealing pharmacy regulations that unnecessarily impede those in need from buying syringes. The many states where SEPs operate without claim to legal authority can eliminate any doubt by positively authorizing the intervention. Drug possession laws should be amended to preclude arrest or conviction based on drug residues detected in used syringes. As legal barriers are removed, states can positively promote pharmacy syringe sales through interventions like New York's Expanded Syringe Access Program.[215] None of these steps will be very expensive in the context of HIV prevention budgets, and experience shows that syringe access

214. But see *supra* note 159 which notes the potential reinstatement of the ban.

215. See *supra* notes 99–110 and accompanying text for a discussion of pharmacy syringe access.

reform virtually never engenders lingering political controversy or negative consequences for legislators.

The federal government can certainly help. Federal funding is a logical place to start. Lifting the ban on funding is not the same thing as providing new monies earmarked for syringe access. In fact, all Congress has done so far is to make it possible for states, local governments, and NGOs to tap existing federal funding streams to pay for syringes. More is needed, and more is justified purely from the cost point of view. Syringe access prevents HIV and other infections and thus saves money as well as lives. The $20 million this country invests annually in SEPs is ludicrously small.[216] Given that SEPs are now closing down because of local budget deficits, federal money is essential to keep the current level of service, let alone for any significant expansion.[217]

The administration and Congress can use the federal spending power not only to offer new money for syringe access programs, but also to dramatically accelerate the removal of legal barriers to syringe access programs. Congress could and, if it is attending to evidence should, require that states, as a condition of receiving federal HIV prevention funding, remove legal barriers to the operation of SEPs and the sale of syringes in pharmacies. Such stipulations are, of course, a common way for Congress to influence state policy, and not unprecedented in the area of HIV; the Ryan White Comprehensive AIDS Resources Emergency Care Act of 1990 required states to ensure that a person who intentionally infected another with HIV could be criminally prosecuted under state law.[218]

While positive federal action would be a boon to HIV prevention, there is a risk that federal involvement will make things worse. In July of 2010, the department of health and human resources released a guidance document that seemed to suggest that federal funds can only be used for SEPs that have been

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216. See *supra* notes 111–23 and accompanying text for a discussion of funds allocated to SEP programs in the United States.

217. *See, e.g.*, Medical News Today, *Only Drop-In Needle Exchange Center in Minnesota Closes Due to Lack of Funding*, Aug. 5, 2009, http://www.medicalnewstoday.com/articles/159854.php ("Minnesota's only storefront needle exchange drop-in center, called Access Works!, 'fell victim to economic hard times and federal anti-drug policies' and ended its program last week after 13 years, the Minnesota Independent reports. The program 'traded used needles for clean ones, conducted HIV and Hepatitis C testing, taught overdose prevention, held support groups and connected users with chemical dependency treatment experts,' according to the Independent. Federal funding cannot be used to administer needles for such programs, Lauri Wollner, executive director of the program said. She added, 'The federal ban has had a long-term impact. We spend almost $40,000 a year on needles and about $5,000 a year on disposal (of used needles).' Private donations also have been down, she said." (citations omitted)).

218. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, § 2647, 104 Stat. 576, 603 (codified as amended at 42 U.S.C. § 30ff-47 (2008)). The provision required states to "certify" either that existing law provided for such prosecution or that a new law would be enacted. *Id.*

officially recognized as appropriate by local law enforcement agencies.[219] Collaboration between local public health and law enforcement agencies is important to the delivery of services to IDUs. In instances in which local law enforcement has opposed even explicitly legal SEPs, service has been heavily compromised and opportunities at disease prevention therefore lost.[220] Having the buy-in or at least acquiescence of law enforcement is necessary to the effective operation of a local SEP. The guidance of HHS is unfortunate, however, because of its implication that local law enforcement must officially approve SEPs. This not only implies a veto power for local law enforcement, which is entirely inappropriate for a proven public health intervention, but it once again paints syringe exchange as an intervention of dubious legality. CDC guidelines are not regulations and are not required to go through a formal notice and comment period, yet they are treated as influential if not as binding by funding recipients, and may be made binding in contracts.

A reasonable fidelity to the statutory language should lead to this additional requirement being removed. The steps we recommend are, or ought to be, easy. The benefits of syringe access are demonstrably real, and the feared side effects have never materialized. Substantial reform of our approach to the control of illicit drug use is, obviously, a far more difficult matter. Here, too, evidence shows we have a problem, but possible solutions are more elusive—and controversial. We close with three thoughts about the way forward.

First, it is possible to make the enforcement of current drug laws healthier even in the absence of changes in the laws themselves. Police can be trained to understand the goals and methods of harm reduction.[221] Standard operating procedures and enforcement policies can be changed to make clear that drug users should not be arrested or hassled for possessing syringes or the residue of drugs in used syringes.[222] This is happening now in the United States and abroad, and we have good examples of the effort paying off in the form of police officers who support and help implement harm reduction approaches.[223] Police agencies can adopt official harm reduction policies and use management tools to ensure

219. DEP'T OF HEALTH & HUMAN SERVS., IMPLEMENTATION GUIDANCE FOR SYRINGE SERVICE PROGRAMS, *available at* http://www.cdc.gov/Hiv/Resources/Guidelines/Pdf/Ssp-Guidanceacc.Pdf.

220. See *supra* notes 33, 181–82, 218–19 and accompanying text.

221. Corey S. Davis & Leo Beletsky, Bundling Occupational Safety with Harm Reduction Information as a Feasible Method for Improving Police Receptiveness to Syringe Access Programs: Evidence from Three U.S. Cities, 6 HARM REDUCTION J. (2009), http://www.harmreductionjournal.com/content/pdf/1477-7517-6-16.pdf.

222. *See, e.g.*, NEW YORK CITY AIDS HOUSING NETWORK ET AL., *supra* note 203, at 6 (describing New York City police policies).

223. *See, e.g.*, Law Enforcement Against Prohibition, http://www.leap.cc/cms/index.php (last visited Mar. 1, 2011) (describing organizations efforts in supporting harm reduction policies).

they are put into practice on the streets. Police and health agencies can work together to more effectively address the challenges posed by substance abuse.

Second, we can allow states and localities the space for exploring policy initiatives that could move us beyond the impasse of prohibitionist policies. The President himself is on record affirming the role of states and cities as policy labs.[224] In Canada, safe injection facilities for chronic drug users have proven to be productive not only in reducing the health and social costs of drug use, but also in bridging the gap between health and law enforcement agencies.[225] Trying that in the United States will require not only state or local authorization but federal acquiescence.[226] The growing phenomenon of medical marijuana provides another occasion for cities and states to find non-prohibitionist ways to regulate illicit drug use. Of course, drug courts, alternative sentencing and diversion regimes, and other projects to reduce incarceration of non-violent drug offenders and increase access to treatment also fall into this category of action. From a public health point of view, the imperative is less to scale up these kinds of approaches as it is to measure and then, if necessary, improve the health outcomes they produce. As law enforcement agencies and prisons take on a greater role as treatment providers, and as courts adopt a therapeutic approach to jurisprudence, it is only sensible that they begin to take responsibility for health as well as law enforcement outcomes.[227]

Finally, we can continue in all possible fora to ask for serious debate on the alternatives to simple drug prohibition. Other countries are exploring alternatives to prohibition and penalization, and we can learn from these initiatives. We can also look to the extensive knowledge base on the regulation of legal substances. Abandoning drug prohibition, for at least some currently illegal drugs, is not abandoning drug control. Alcohol and cigarettes kill far more Americans than illicit drugs,[228] and are the objects of heavy regulation. Our experience with these substances demonstrates that regulation of dangerous drugs in transparent legal markets can be as difficult as it is necessary. Yet the data tell us that we do not have to achieve abstinence to meaningfully reduce the health and social harms of

224. Memorandum from President Barack Obama to the Heads of Executive Departments and Agencies, (May 20, 2009), *available at* http://www.whitehouse.gov/the_press_office/presidential-memorandum-regarding-preemption/.

225. *See, e.g.*, DeBeck et al., *supra* note 34 (discussing success of safe injection facilities program).

226. Scott Burris et al., *Federalism, Policy Learning, and Local Innovation in Public Health: The Case of the Supervised Injection Facility*, 53 ST. LOUIS U. L.J. 1089, 1093–94 (2009).

227. *See, e.g.*, Scott Burris & Dave Burrows, *Drug Policing, Harm Reduction and Health: Directions for Advocacy*, 20 INT'L J. DRUG POL'Y 293, 293–94 (2009) (advocating increased law enforcement and judicial responsibility for public health issues).

228. American Cancer Society, Cigarette Smoking, http://www.cancer.org/docroot/PED/content/PED_10_2X_Cigarette_Smoking.asp (last visited Mar. 1, 2011) ("Smoking cigarettes kills more Americans than alcohol, car accidents, suicide, AIDS, homicide, and illegal drugs combined.")

legal drugs. The data also leave no doubt that strategies like taxation, zoning, spatial limits on use, and specific bans on dangerous behaviors (like driving while intoxicated) do not come with the enormous social costs associated with criminalization and incarceration.

In the end, rational policy should be guided by a simple equation: how do we reduce the total harm caused by illegal drugs and the methods we use to regulate them? This Article has demonstrated the significant negative impact of syringe access and drug control law on the overall incidence and distribution of HIV/AIDS in this country. It is time for our political leaders to do the math.