

Legal Strategies for Syringe

HARM REDUCTION

Exchange Programs

October 1996

Despite the growing evidence that syringe exchange programs can reduce HIV transmission among intravenous drug users, these programs are hindered by uncertainty in their legal status. In a study published in the *American Journal of Public Health*, the authors reviewed court decisions, published studies, and news stories, and conducted telephone interviews with syringe exchange personnel to identify strategies used by these programs to establish their legality (Scott Burris, JD, David Finucane, JD, Heather Gallagher, JD, and Joseph Grace, JD, "The Legal Strategies Used in Operating Syringe Exchange Programs in the United States," *American Journal of Public Health*, August 1996, p. 1161).

The study found that forty-six states and the District of Columbia have laws restricting the possession or distribution of "drug paraphernalia," which includes hypodermic needles and syringes which can be used to inject controlled substances into the body. Many states also have prescription laws that require a prescription to possess a hypodermic needle or syringe. In addition, syringe exchange programs are subject to federal laws that prohibit the transportation in interstate commerce and the importation of drug paraphernalia. However, all states have laws that empower state and local health officials to take necessary action to prevent the transmission of disease or to respond to public health emergencies.

Fifty-two programs were included in the study. The legal status of three of the programs could not be determined. Nine programs operated without a clear legal basis, subjecting their members, in theory, to prosecution. Twenty-seven have been authorized by amendments to or judicial interpretations of drug laws, have been exempted from those drug laws, or operate in a state without such laws. Thirteen syringe exchanges operate under claims of legality based on local interpretation of state public health and/or drug laws that have not been reviewed by a court. Since the research period began, the number of syringe exchange

programs has increased to more than one hundred, according to David Purchase, Chair of the North American Syringe Exchange Network (NASEN). Programs with no claim to legality are able to operate due to the discretion of local law enforcement authorities. Local officials may be showing tacit support for these programs without openly supporting their legality. Also, many officials are hesitant to divert scarce law enforcement resources from major crimes to more trivial offenses, and prosecutors may doubt their ability to secure convictions. Of eleven prosecutions involving drug paraphernalia or needle prescription identified by the study between 1990 and March 1995, in all but two cases, defendants escaped conviction. Some prosecutions were nullified by the jury, which voted for acquittal even though the elements of the crime appear to have been proven and the defendants did not contest the facts. Other defendants used the necessity defense, arguing that their illegal act was intended to avert a greater harm. These cases, in the opinion of the authors, involved activists who were at least partially motivated by a desire to challenge the law. According to the authors, being arrested and booked, even if charges are dismissed, can deter workers from engaging in syringe exchange, hindering the growth of syringe exchange programs.

Twenty-seven syringe exchange programs have been established with a legal basis through formal action under state law. Syringe exchange has been statutorily authorized in Hawaii, Connecticut, Massachusetts, the District of Columbia, Maryland, and Rhode Island. Oregon and Maine have removed drug law barriers to syringe exchange programs without formally authorizing the programs. In New York, the state Commissioner of Health granted waivers for state-approved syringe exchanges. Administrative agencies in many states have the same authority. Finally, in two states, local officials sought "declaratory judgements" giving them permission to conduct syringe exchange. In Washington, health officials had their authority validated by the state supreme court. A trial court in California denied the health authorities' request for syringe

exchange, saying health officers lacked the authority to override the state's drug paraphernalia laws.

Eleven local governments have operated programs under the authority of public health law, including Philadelphia, Cleveland, Los Angeles, and San Francisco. Nearly all counties and municipalities in the U.S. have the authority under state health codes to respond to health emergencies. Chicago, Illinois, and Hennepin County (Minneapolis), Minnesota operate exchanges in reliance on their attorneys' interpretation of language in state drug laws, namely, exemptions for research or education.

Operating a program with no claim of legality requires some political work in the site community and negotiation with local law enforcement. It is the least expensive option for start-up syringe exchange, entails no lobbying effort, and it gives local authorities the option of showing "politically-deniable" support through inaction. It also allows operation while long-term efforts to change state laws are being made. However, the disadvantages are significant: possible criminal charges, barriers to incorporation or tax exempt status, and more difficult fund raising in many instances.

Programs operating under state law put to rest any questions of legality, but may face other disadvantages. Affecting state legislation can be extremely time and energy consuming. Legislation, once passed or amended, may lead to strict regulations. These may include limits in the number or locations of programs; data maintenance requirements; and limits on the number of needles exchanged. Complying with these restrictions can be difficult and expensive. Other restrictions, such as a limited number of needles or a one-for-one exchange, can undermine the program's effectiveness. It is difficult for health officials to act unilaterally in a state where the legislature or governor is not sympathetic to the idea. One strategy is seeking a "declaratory judgement" on the law in order to operate without risking prosecution, but that may result in a ruling that syringe exchange is illegal, as in California.

Proceeding on the basis of local authorization shifts the burden of legal action to opponents of syringe exchange. It may be easier to build a local consensus, rather than a state-wide consensus, in favor of the program. Armed with a reasonable interpretation of state law, local programs operate under the color of the law, and increase their ability to seek public and grant funding, and incorporate as nonprofits. However, these programs may have to defend their position in court. In one instance, Los Angeles citizens made "citizen's arrests" at a locally authorized syringe exchange, creating a legal test for the authorities. Also, local authorization may not protect exchange consumers from subsequent arrest or prosecution.

According to the authors, despite the widespread reporting that syringe exchange programs violate the law, many have been operating successfully. The long term efficacy of these programs to reduce HIV transmission probably will lead to legislation clarifying their legal status. Until then, the authors conclude, the programs will continue to operate under the legal justification of public health law. For more information, contact NASEN at 535 Dock Street #112, Tacoma, Washington 98402, Tel: (206) 272-4857, Fax: (206) 272-8415 or E-mail: nasen@seanet.com