The Legal Strategies Used in Operating Syringe Exchange Programs in the United States

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ABSTRACT

Objectives. This study sought to identify the strategies used by syringe exchange programs to establish their legality.

Methods. Statutes, court decisions, published studies of exchange programs, and news stories were reviewed, and telephone interviews were conducted with syringe exchange personnel.

Results. Twenty-seven exchanges have been authorized by amendments to or judicial interpretations of state drug laws or by administrative action under such laws, or operate in a state that has no laws regulating needles. At least 13 programs operate under claims of legality based on local interpretations of state law, principally public health law. The remaining syringe exchanges operate without a claim of legality.

Conclusions. The deployment of syringe exchanges has been hindered by concerns about their legal status. This study shows that the applicability of drug laws to syringe exchange is open to dispute, and that local public health authorities may under some circumstances rely on their own legal authority to fund or operate syringe exchange programs. (*Am J Public Health.* 1996;86:1161–1166)

Introduction

The evidence that syringe exchange can reduce the rate of human immunodeficiency virus (HIV) transmission among intravenous drug users continues to grow.[1–5] However, the effective use of this strategy has been hindered by uncertainty about its legal status under laws that prohibit the distribution of drug paraphernalia or that require a prescription for the sale of a needle.[6] Such uncertainty may deter government health agencies and private parties from conducting syringe exchange, can deter government agencies and foundations from funding syringe exchange, and can prevent publicly funded syringe exchanges from getting liability insurance, charitable tax status, and other items necessary for effective operation. Consequently, developing a workable legal foundation for a syringe exchange is an important step in establishing an effective program.

We investigated the legal basis for syringe exchange programs operating in the United States. Our data consisted of statutes, court decisions, published studies of such programs, news stories, and interviews with program personnel.

The Legal Environment

Forty-six states and the District of Columbia have laws restricting the possession or delivery of drug paraphernalia.[5] Only four states—Alaska, Iowa, North Dakota, and South Carolina—are without a form of paraphernalia law.[5] Most of these laws are based on the Model Drug Paraphernalia Act, which was promulgated by the US Drug Enforcement Administration in 1979.[7,8] The laws criminalize the manufacture, possession, or distribution of drug paraphernalia. The phrase *drug paraphernalia* is broadly defined in the statutes to cover any equipment, product, or material of any sort, including hypodermic needles and syringes, intended to be used to introduce illicit or controlled substances into the body.[5] As a consequence of this broad definition, even items such as bleach and cotton swabs could be deemed drug paraphernalia, depending entirely on the intent of the user or distributor. As one judge put it, "Criminal intent is what distinguishes the paper clip which holds the pages of this memorandum of opinion from an identical clip which is used to hold a marijuana cigarette."[9]

A parallel federal statute prohibits the importation of drug paraphernalia or their transportation in interstate commerce.[10] Many syringe exchange programs purchase syringes and bleach kits by mail order and so could, at least in theory, be subject to prosecution by federal authorities.[11] Although this act has not been used to prosecute anyone involved with syringe exchange and is not likely to be, it exemplifies the potential of broadly written drug laws to chill the expansion of syringe exchange.[12]

In several of the highest areas of HIV prevalence, syringe exchange programs are also subject to state prescription laws. A prescription is required for the purchase or possession of a hypodermic needle or syringe in the District of Columbia, California, Delaware, Illinois, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, and

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Editor's Note. See related annotation by Glantz and Mariner (p 1077) in this issue.

TABLE 1—Legal Bases for Operating Syringe Exchange Programs

No Clear Legal Basis	Formal Legal Authorization under State Drug Law	Authorization under Local Interpretation of State Drug or Public Health Law
9 syringe exchange programs	Fairbanks, Alaska	Alameda Co, Calif (2)
	Bridgeport, Conn	Los Angeles, Calif
	Hartford, Conn	Marin Co, Calif
	New Haven, Conn	Salinas, Calif
	Storrs, Conn	San Francisco, Calif
	Willimantic, Conn	Santa Clara Co, Calif
	District of Columbia	West Hollywood, Calif
	Honolulu, Hawaii (3)	Boulder, Colo
	Baltimore, Md	Chicago, Ill
	Boston, Mass	Hennepin Co, Minn
	Cambridge, Mass	Cleveland, Ohio
	Buffalo, NY (2)	Philadelphia, Pa
	New York, NY (6)	
	Portland, Ore	
	Rhode Island	
	Seattle-King Co., Wash	
	Spokane, Wash	
	Tacoma, Wash	
	Yakima, Wash	

TABLE 2—Completed Prosecutions of Syringe Exchange Workers

Acquittals	Convictions
Commonwealth v Parker, Mass (1990)	*Commonwealth v Parker,* Mass (1990)
People v Tranchina, Calif (1991)	*Commonwealth v Leno,* Mass (1991)
People v Bordowitz, NY (1991)	
People v Cezar, NY (1991)	
State v Sorge, NJ (1991)	
Commonwealth v Luger, Mass (1991)	
People v Halem, Calif (1993)	
People v Stuen-Parker, Ill (1994)	
People v Halem, Calif (1995)	

Rhode Island.[5] Connecticut's law forbids the distribution or sale of more than 10 needles and syringes without a prescription.[13] Prescription laws do not require proof of criminal intent; mere possession of a hypodermic needle or syringe without a prescription is enough for a conviction. Furthermore, the prescription usually must be written by a physician for a "legitimate medical purpose."[6] In a few other states, more general laws limit the possession or dispensing of needles without requiring prescriptions.[14–16]

All states have laws, framed in more or less broad terms, empowering health officials at the state and local level to take necessary action to prevent the transmission of disease; such authority includes extraordinary powers to respond to emergencies.[17] For example, California state law empowers municipalities to declare a public health emergency and "promulgate orders and regulations necessary to provide for the protection of life and property."[18] The exercise of these powers has traditionally been reviewed with considerable deference by courts, and health measures aimed at controlling communicable disease are rarely overturned.[19] In contrast to the limitations imposed by paraphernalia laws, public health statutes are a reservoir of broad authority to develop programs, including syringe exchange, to control HIV.

Findings

We collected all legislation, regulations, and court decisions concerning syringe exchange programs. These programs were identified from published lists,[5,12] newspaper stories, legal materials, and references from other such programs. Programs whose claim to legality was not discernible from the legal materials or other published sources were surveyed by telephone and, if unavailable, by letter. Fifty-two programs were included in the study. The legal status of three could not be determined.

Proponents of syringe exchange have followed three principal avenues in relation to the law (Table 1). Nine programs in our study operate without a clear legal basis, their members being subject, in theory, to prosecution under paraphernalia or prescription laws. Twenty-seven syringe exchanges have been directly or indirectly authorized by amendments to or judicial interpretations of drug laws, have been exempted from those laws by state administrative action, or operate in one of the states that does not have such drug laws. Thirteen programs operate under claims of legality based on local interpretations of state public health and/or drug law that have not been reviewed by a court. In all cases, these different approaches have evolved in response to local political, regulatory, and community dynamics.

No Claim to Legality

The question of "legality" of syringe exchange is complicated, not least in the case of syringe exchanges operating without a clear legal basis. Programs with no claim to legality are able to operate because local law enforcement officials exercise their discretion not to arrest or prosecute program personnel. While the motivations of these officials are beyond the scope of our study, several factors alone or in combination may provide some explanation. First, law enforcement officials or political leaders with control over law enforcement activities may tacitly support syringe exchange despite an unwillingness to act openly to develop a legal basis. Several programs in our survey provided anecdotal support for this view. Second, law enforcement officials may not regard syringe exchange as a sufficiently important activity to justify the diversion of resources required for prosecution. Finally, prosecutors may doubt their ability to secure convictions. We identified 11 cases in which exchangers were tried for drug paraphernalia or needle prescription violations between 1990 and March 1995 (Table 2). In all but two cases, defendants escaped conviction through either jury

nullification or the successful use of the necessity defense. "Jury nullification" refers to the ability of a jury to vote for acquittal even though the formal elements of the crime would appear to have been proven and no recognized defense was offered. The necessity defense allows a judge or jury to acquit a syringe exchanger who shows that his or her illegal act was reasonably intended to avert a greater harm—in this instance, the transmission of HIV through contaminated injection equipment.[12,20-22]

The cases that have gone to trial involved activists who were at least partially motivated by a desire to challenge the law. We did not attempt to document every instance in which syringe exchangers were arrested. Other studies suggest that the number of such cases is not substantially greater than the number of completed prosecutions and that many of the same defendants are involved, notably Jon Parker.[12] Being arrested and booked can deter program workers from engaging in syringe exchange even if no charges are filed, or if charges are dismissed prior to trial or disposed of with a plea bargain. Nevertheless, to the extent that program workers are not actually subject to arrest in a community or, even if arrested, cannot be convicted, the "illegality" of their behavior is largely a formality, although one with certain negative consequences for the growth of syringe exchange programs.

State Legislative, Judicial, or Administrative Action

Twenty-seven syringe exchange programs have established a legal basis through formal action to clarify their status under state drug law. Syringe exchange has been statutorily authorized in Hawaii,[23] Connecticut,[24] Massachusetts,[25] the District of Columbia,[26] Maryland,[27] and Rhode Island.[28] Two other states have removed drug law barriers to syringe exchange without formally authorizing exchange programs: Oregon amended its drug law to exempt needles and syringes, thereby eliminating the barriers to exchange without specifically mentioning syringe exchange programs,[29] and Maine repealed its needle prescription law.[30] Legislation is currently pending in 6 additional states (Table 3).

TABLE 3—Active Pending Legislation Regarding Syringe Exchange Programs (SEPs), May 1996

Citation	Subject Matter	Status
California Senate Bill 1976	Authorizes one or more local pilot SEPs	In committee April 24, 1996
Hawaii House Bill 2924	Abolishes SEP	In committee January 29, 1996
Illinois Senate Bill 1366	Requires health dept to establish demonstration SEPs in 3 counties with highest total AIDS cases among intravenous drug users	In committee February 6, 1996
Illinois Senate Bill 1368	Amends prescription law to allow sale and possession of ≤10 syringes without a prescription	In committee February 6, 1996
Illinois House Bill 2873	Requires SEPs in counties with a rate of AIDS greater than 32/100 000 and provides immunity from paraphernalia laws for participants and staff	In committee February 6, 1996
Illinois House Bill 3266	Same as Senate Bill 1368	In committee February 8, 1996
New Jersey Senate Bill 92	Amends prescription law to allow sale of syringes at pharmacies in quantities of ≤10 and paraphernalia law to allow possession of ≤10 syringes not contaminated with illegal drugs	Introduced January 11, 1996
New Jersey Senate Bill 417	Requires Dept of Motor Vehicles be notified of licensed drivers participating in any SEP	In committee January 18, 1996
New Jersey Senate Bill 463	Establishes 3-year demonstration SEP, with immunity from paraphernalia laws for staff and participants	In committee January 18, 1996
New Mexico Senate Bill 214	Appropriates $168 000 to fund an SEP	Reported favorably with amendments from committee February 16, 1996
New York Senate Bill 1998	Decriminalizes sale, possession, and use of syringes in SEPs, health care facilities, and pharmacies	In committee January 3, 1996
New York Assembly Bill 2810	Same as Senate Bill 1998	In committee January 3, 1996

In New York, drug statutes authorize the state commissioner of health to waive needle prescription laws.[31] Using this power, the commissioner has promulgated regulations granting a waiver for state-approved syringe exchanges.[32] Administrative agencies in many states have similar authority.[33-35]

Finally, in two instances, local officials went to court seeking "declaratory judgments" that they had the authority to conduct syringe exchange. Through this device, a party seeking a clarification of law for a specific purpose may obtain a ruling without waiting to be prosecuted for a violation. In Washington State, Spokane County health officials, disputing an opinion of the state attorney general challenging their authority,[36] had their interpretation validated by the state supreme court.[37] In Sacramento, Calif, however, a trial court held in early 1995 that syringe exchange was prohibited by the state's drug paraphernalia law and

that the county supervisors lacked the authority to override the law.[38]

Local Authority

Our study found that 11 local governments had rejected the common assumption that drug laws govern the legal analysis of syringe exchange programs, choosing instead to analyze these programs under the rubric of public health law. Philadelphia,[39] Cleveland,[40] Los Angeles,[41] San Francisco,[42] and six other counties or cities in California conduct syringe exchange based on their public health powers under state and local law.[43–46] Government officials and their attorneys in these municipalities have taken the position that drug laws were not intended to apply to bona fide disease control measures and so do not prohibit syringe exchange programs established pursuant to emergency health powers.

The procedure for authorizing needle exchange in these localities has been similar. Nearly all counties and major municipalities in the United States have been given the authority under state health codes, local government law, or home rule charters to respond to health emergencies. The power may be vested in a city or county council or board of health.[18,47,48] The local authorization of a syringe exchange program begins with a formal resolution declaring a health emergency, describing the local spread of HIV through drug use, and providing evidence in support of syringe exchange as an effective preventive measure. The declaration of emergency vests the local health department, mayor, or other executive authority with extraordinary power to respond as the necessity requires. This power is used to approve, operate, and/or fund a syringe exchange program. The emergency is periodically redeclared, as health statutes ordinarily limit the emergency to a period of weeks.[49] (In Colorado, the Boulder County health department has proceeded on its own authority without a declaration of emergency or other special step.)

In two cities, local authorities have operated syringe exchanges in reliance on their attorneys' interpretation of general language in state drug laws that arguably creates an exception for syringe exchange programs. The Chicago syringe exchange relies on an exemption in state needle prescription law for "chemical, clinical, pharmaceutical or other scientific research,"[50] a term the local states' attorney has opined includes syringe exchanges. Similarly, Hennepin County, Minnesota, funds a syringe exchange program under an interpretation of an exemption in the state's needle possession law for "persons engaged in bona fide research or education."[16,51] Under the county's interpretation, the exemption also applies to the state's drug paraphernalia law because conduct that is legal under a more specific rule cannot be illegal under a general one.

The data presented here are subject to an important limitation. The number of syringe exchange programs increased rapidly during the research period; the North American Syringe Exchange Network now has at least 68 member programs.[52] For this reason, the number of programs operating without a legal basis is certainly larger than that reported here. Our findings on programs operating under local authorization, which are based on media reports as well as on survey data, are less subject to this limitation. Our findings on state-level legal authorization are current as of October 1995. Table 3 was compiled in May 1996 and includes only bills active in 1996.

Discussion

The literature on syringe exchange has generally assumed that programs not explicitly approved under prescription or paraphernalia laws, or located in jurisdictions where no such laws apply, are illegal.[5,52,53] Yet apart from those states that have enacted new legislation addressing syringe exchange, most places have no statutory or decisional law explicitly discussing the legality of the practice. While most states have drug paraphernalia or prescription laws that may reasonably be interpreted to prohibit syringe exchange, these laws have rarely been enforced, and most people charged under them have escaped conviction. Moreover, evidence of the efficacy of syringe exchange has continued to grow. Under these circumstances, local officials and their legal advisors in 13 cities and counties have found it equally reasonable to conclude that syringe exchange, conducted under public health auspices, is authorized under public health law and not prohibited by drug law.

It is appropriate, indeed inevitable, for elected officials and their legal counsel to act on reasonable interpretations of unsettled law. Competing claims of the law governing syringe exchange programs can ultimately be resolved only by judicial or legislative action. On two occasions identified in our study, local officials sought immediate judicial review of their legal claims. In most cases, however, local officials have simply proceeded in the absence of a ruling contrary to their position. No arrests have been made, suits filed, or legislation enacted to challenge their legal position. The experience of locally authorized syringe exchanges thus shows that amending drug paraphernalia and prescription laws is not the only viable option for program proponents and may in some cases be a poorer approach than either of the alternatives, each of which has its own advantages and disadvantages.

Simply operating an exchange certainly requires at least some political work in the site community to gain acquiescence, if not support, from neighbors. To avoid police intrusion, it also requires some negotiation with local law enforcement officials. Yet it remains the cheapest alternative for the start-up syringe exchange. It entails no effort to lobby an indifferent or hostile legislator in an often remote state capital; it requires no statewide consensus but only an immediate and local one; and it affords local authorities the option of providing tacit, but politically deniable, support for syringe exchange. It may also allow a program to operate while long-term efforts to change state law proceed.

The disadvantages of operating without a clear legal basis are significant. Arrest and conviction on criminal charges cannot be ruled out. The defense of necessity is not always accepted. For example, a Massachusetts court reasoned that defendants charged with violating statutes that restrict possession and distribution of hypodermic needles were not entitled to a necessity defense because the prevention of possible future harm did not excuse a current systematic violation of the law in anticipation of an eventual overall benefit to the public.[22] Similarly, the claim of urgent necessity may be less convincing when raised by repeat players.[54] In addition to legal jeopardy, programs without a claim of legality may not be allowed to incorporate or claim tax exempt status, both of which advantages are theoretically unavailable to criminal enterprises. Finally, although the American Foundation for AIDS Research and other philanthropies have funded syringe exchanges that lack a clear legal basis, concerns about the issue presumably may make fundraising over the long term more difficult in many instances.

The advantages of explicit authorization under state drug laws are plain. It utterly puts to rest any questions about the legality of syringe exchange and

constitutes an endorsement of the intervention. The negative aspects, however, are also significant. Getting a bill passed by the state legislature is difficult, requiring what may be the considerable energy and determination of a cohesive group of legislators, state health administrators, and others in the executive branch, as well as of advocates.[55] Even a small band of determined opponents may have the power to frustrate the legislation.

Even if legislation passes, its form may create problems for exchanges. All of the exchange programs approved in this manner have been subject to more or less strict regulations. Several have been denominated as experimental[25,27,28] and have been limited in the number or location of exchange sites.[26,27] Connecticut, the District of Columbia, Hawaii, Maryland, and Massachusetts require the programs to maintain data on the number of needles exchanged as well as on the program's success in reducing HIV transmission among intravenous drug users. These requirements, while generally consistent with the proper running of an exchange program, may not be appropriate in every case and may significantly raise the cost of operating an exchange. Certainly, inflexible restrictions such as a limited number of needles[24] or a one-for-one exchange[27] can undermine the effective operation of a particular exchange. Thus, in several places where some legal exchange is authorized, such as Baltimore and Washington State, we found that other syringe exchanges continued to operate without claims of legal basis.

The alternative of relying on an executive agency to amend regulations under drug laws, assuming it has the authority to do so, may not be more viable. It is difficult for a state health commissioner to act unilaterally in a state where the legislature or governor does not support syringe exchange, and, in fact, this route has been followed only in New York. Seeking court approval of syringe exchange through a declaratory judgment action is legally conservative in that the agency can get a formal ruling on the law without risking a criminal prosecution. It is also time-consuming and may, as in Sacramento, precipitate a ruling that syringe exchange is illegal. Once an agency has been party to a case deciding that needle exchange violates drug law, it will no longer be able to reasonably argue a contrary interpretation of the law.

Proceeding on the basis of a local authorization, without prior judicial or legislative approval, has a number of distinct advantages. It has often proven easier to get a local consensus in favor of an exchange program than to convince legislators from throughout a state. On the tactical level, this approach has the substantial benefit of shifting the burden of legal action to opponents of syringe exchange. The experience of programs to date suggests that not every public official who would refuse to support syringe exchange would undertake to act affirmatively against it, particularly given the distinct possibility that local health authorities would have their legal position upheld. Armed with a reasonable interpretation of state public health law, locally authorized programs can operate under color of law, with the ability to receive public funding, incorporate as nonprofits, seek grant funding, and so on. The terms and services can be tailored to meet local needs with less pressure to require specific services or validation. This is a strategy whose chief advantage is its sensitivity to and reliance on local political conditions. Like proceeding without any claim of legal right, it depends on establishing, by discussion and negotiation, a modus vivendi between exchangers and law enforcement authorities.

Local authorization under public health law, however, does have its drawbacks. Local officials may have to defend their position in court if opponents secure an arrest, file a suit, or cut off funding. Even if local law enforcement authorities have agreed not to make arrests, the existence of drug laws remains a weapon for other opponents. In one instance, for example, individuals who opposed the location of a Los Angeles syringe exchange forced the police's hand by making "citizen's arrests" at a locally authorized syringe exchange.[56] Local authorization for the program may not effectively protect syringe exchange consumers from subsequent arrest or prosecution for possessing drug paraphernalia.

Conclusion

Syringe exchange demonstrates the importance of a complex understanding of the law as it applies to public health work. The law, as Wing observes, is not just a set of rules but a process and a culture in which rules are developed, interpreted, and enforced.[57] Despite the widespread assumption in the legal and public health literature that syringe exchange generally violates drug laws, this study shows that many syringe exchange programs are successfully operating on a contrary view. In the long term, the efficacy of syringe exchange in reducing HIV transmission will probably lead to legislation throughout the nation clarifying its legal status. In the meantime, however, public officials and syringe exchange advocates who are able to develop a local consensus may consider using public health law to legally justify the public operation or funding of a syringe exchange program. □

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