

2009

Syringe Exchange: An Effective Tool in the Fight Against HIV and Drug Abuse



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I. INTRODUCTION

In light of the recent decision by the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies to remove the language banning federal funding for syringe exchange programs (“SEPs”), comprehensive and current research on the benefits of and need for SEPs is timely.¹ Current political systems and the medical community have failed to adequately respond to the public health crisis of HIV/AIDS in the injection drug user (“IDU”) population, an estimated 350,000 users in the U.S.² While some fear that such programs will increase drug use or contribute to general lawlessness, the overwhelming body of research indicates that the presence of SEPs does not result in increased drug use or crime. On the contrary, SEPs increase the availability of drug treatment for both injection and non-injection drug users, and have been shown to decrease the rate of drug use.³ The current state of federal law must now evolve to reflect the benefits of SEPs, and support communities in implementing SEPs how and where necessary to meet their specific needs.

The implementation of SEPs, needed to confront the HIV/AIDS crisis and climbing drug use rates, has suffered mainly from a lack of sufficient funding. At the present time, the majority of SEPs, cut off from federal funds, function through state and local funding from a variety of non-governmental organizations, public health departments, and state grants. These resources, although important, are grossly insufficient to meet the public need for clean injection equipment and to prevent the spread of HIV/AIDS. The Centers for Disease Control and Prevention (“CDC”), Health Resources and Services Administration, National Institute on Drug Abuse, and Substance Abuse and Mental Health Services Administration (“SAMHSA”) recommend that health care workers counsel IDUs to use a sterile syringe each time they inject drugs.⁴ To achieve this would involve the purchase and distribution of between 920 million and 1.7 billion

¹ The recent bill to lift the ban contains an amendment restricting the use of federal money to assist any program that distributes needles within 1,000 feet of day-care centers, schools, parks, playgrounds, pools and youth centers. Darryl Fears, *House Bill Lifts Ban On Needle Exchanges*, WASHINGTON POST, July 25, 2009, <http://www.washingtonpost.com/wp-dyn/content/story/2009/07/24/ST2009072403831.html>. The bill with this restrictive amendment is unworkable and all but nullifies the many potential benefits of the legislation. *See infra* text accompanying footnotes footnotes 73 to 75.

² *See* Barbara Tempalski et al., *Correlates of Syringe Coverage for Heroin Injection in 35 Large Metropolitan Statistical Areas in the U.S. in Which Heroin is the Dominant Injected Drug*, 19S INT’L J. DRUG POLICY S47, S48 (2008); SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN. (SAMHSA), NAT’L SURVEY ON DRUG USE & HEALTH (2003), <http://www.oas.samhsa.gov/nsduh/reports.htm#2k3>.

³ *See infra* text accompanying footnotes 41-68; *see, e.g.*, PETER LURIE & ARTHUR L. REINGOLD, CTRS. FOR DISEASE CONTROL & PREVENTION, THE PUBLIC HEALTH IMPACT OF NEEDLE EXCHANGE PROGRAMS IN THE UNITED STATES AND ABROAD 9-10 (1993); Joseph Gyuish et al., *Evaluating Needle Exchange: Are there Negative Effects?*, 7 AIDS 871, 874 (1993); Denise Paone et al., *Syringe Exchange in the United States, 1996: A National Profile*, 89(1) AM. J. PUBLIC HEALTH 43, 44 (1999).

⁴ CTRS. FOR DISEASE CONTROL AND PREVENTION, HEALTH RESOURCES AND SERVICES ADMIN., NATIONAL INST. ON DRUG ABUSE, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS, 3-4 (1997).

syringes,⁵ whereas current SEPs distribute less than 45 million⁶ syringes nationwide—a small fraction of the clean syringes required to reduce the spread of HIV and other blood borne pathogens in IDU communities to the extent recommended.⁷

Where national policy has stalled, failing to respond to the current scientific understanding of SEPs and the overwhelming community need, local activism and mobilization have filled that gap. Although federal law currently forbids use of federal funds to support needle exchange, SEPs now operate in 34 of 50 states.⁸ Statistical and anecdotal data illustrate that activism and mobilization at the local level are integral to establishing, maintaining, and expanding aid and resources needed by local communities, such as SEPs in IDU communities.⁹ Such activism, along with other strategies including coalition building, tailoring to a particular population, outreach, and provision of related medical services or counseling, enable SEPs to expand their reach to meet the needs of various IDU communities.

II. CURRENT NEED FOR STERILE SYRINGE COVERAGE

A. Relationship of Injection Drug Use to Spread of Infection

Given the estimated 1,106,400 U.S. residents currently living with HIV/AIDS¹⁰ and the direct link of more than 25% of adolescent and adult AIDS cases to injection drug use,¹¹ SEPs are needed to curb this spread of disease.¹² Thirty six percent of all AIDS cases reported in the

⁵ 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?*, 18S(1) J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES & HUMAN RETROVIROLOGY S45, S46 (1998).

⁶ According to NASEN, 118 SEPs reported exchanging a total of 22,472,168 syringes in 2005. Taking the rate of distribution as constant, we can estimate that the 207 SEPs in operation throughout the country right now distribute somewhere in the area of 43,071,655 syringes.

⁷ See HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS, *supra* note 4.

⁸ Gay Men's Health Crisis (2009) (unpublished database on file with author). When including the District of Columbia and Puerto Rico, the number stands at 36. *Id.*

⁹ See Tempalski, *supra* note 2, at S55.

¹⁰ CTRS. FOR DISEASE CONTROL AND PREVENTION, BASIC STATISTICS (2007), <http://www.cdc.gov/hiv/topics/surveillance/basic.htm>.

¹¹ *Id.* The CDC found that, when taking into consideration mother-to-child transmissions, roughly 36% of all AIDS infections can be related to injection drug use. CTRS. FOR DISEASE CONTROL AND PREVENTION, DRUG ASSOCIATED HIV TRANSMISSION (2002), <http://www.cdc.gov/hiv/resources/Factsheets/idu.htm>.

¹² According to the World Health Org., around 10% of global HIV infection is the result of injection drug use. WORLD HEALTH ORG., ADVOCACY GUIDE: HIV/AIDS PREVENTION AMONG INJECTION DRUG USERS (2004), <http://www.unodc.org/documents/hiv-aids/advocacy%20guide%20on%20on%20prev%20for%20IDU.pdf>.

United States are directly or indirectly associated with injection drug use.¹³ In the U.S., as of 2004, an estimated 250,000 people have died of AIDS due to unsafe injection practices.¹⁴

The provision of sterile syringes is essential to minimizing the risk of transmission of HIV as well as other blood-borne pathogens such as hepatitis B or C, which IDUs have a serious and particular risk of contracting.¹⁵

The reuse and ‘sharing’ of blood-contaminated injection equipment and blood-contaminated dissolved drugs play substantial roles in the transmission of HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), and other blood-borne infections.. These infections cause illness and death among drug users, their sex partners, and, through mother-to-infant transmission, their children.¹⁶

The services of SEPs across the nation are thus critical to addressing this public health crisis at all levels.¹⁷

B. SEPs as a Needed and Cost-Effective Solution

SEPs produce substantial health benefits by reducing the spread of HIV and decreasing rates of infection of other blood-borne pathogens. According to a 2000 report by the former United States Surgeon General David Satcher, “there is conclusive scientific evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective

¹³ HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS, *supra* note 4. Further, over half of HIV infections in children result from injection drug use by a parent. CTRS. FOR DISEASE CONTROL AND PREVENTION, HIV SURVEILLANCE REPORT 2006, <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2006report/pdf/2006SurveillanceReport.pdf>.

¹⁴ CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 10.

¹⁵ See HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS, *supra* note 4. Injection drug users are at serious risk of contracting hepatitis B and hepatitis C—hepatitis B infects from 140,000 to 320,000 people each year and kills between 5,000 and 6,000 people in the U.S.; hepatitis C infects about 36,000 people in the U.S. each year, and kills between 8,000 and 10,000 of those infected. Am. Civ. Liberties Union, Needle Exchange Programs Promote Public Safety, <http://www.aclu.org/drugpolicy/harm/10850res20060531.html>.

¹⁶ HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS, *supra* note 4, at 2.

¹⁷ See Josiah D. Rich et al., *Strategies to Optimize the Impact of Needle Exchange Programs* (published online) (2000), http://www.medscape.com/viewarticle/410302_2. In Tacoma, Washington, participation in such SEP programs was shown by Hagan et al. to be associated with a six-times decreased risk of hepatitis B and a seven-times decreased risk of hepatitis C. Holly Hagan et al., *Reduced Risk of Hepatitis B and Hepatitis C Among Injection Drug Users in The Tacoma Syringe Exchange Program*, 85(11) AM. J. PUB. HEALTH 1531, 1531 (1995).

public health intervention that reduces transmission of HIV.”¹⁸ The World Health Organization (“WHO”) reached the same conclusion after commissioning a review of over 200 studies of SEPs, stating that “[t]here is compelling evidence that increasing the availability and utilization of sterile injecting equipment for both out-of-treatment and in-treatment injecting drug users contributes substantially to reductions in the rate of HIV transmission.”¹⁹ One study cited by the WHO noted an 18.6% annual decrease in the HIV rate in 36 cities with SEPs compared to an 8.1% annual increase in 67 cities that did not contain SEPs.²⁰ Similar results have been found in the U.S. In perhaps the most comprehensive study of the effect of SEPs on HIV transmission, researchers found that over a 12-year period in New York City, the number of new cases of HIV among IDUs decreased while the number of syringes exchanged by SEPs increased from 250,000 to over 3 million.²¹

Additionally, SEPs stem the spread of infection and address the personal and public health risks of injection drug use in a cost-effective, comprehensive fashion. An analysis of a New York State-approved SEP found, over a 12-month period, an estimated 87 HIV infections averted as a direct result of the use of the SEP.²² In order to stem the rate of infection, the U.S. Public Health Service recommends the one-time use of each sterile syringe and other injection equipment.²³ The CDC has stated a public health goal of 100% coverage, with all injections performed with a sterile syringe, noting that the one-time use of sterile syringes remains the most effective way to limit HIV transmission associated with injection drug use.²⁴ Further, research has shown that if IDUs had better access to sterile syringes in the 1980s, a large portion of the

¹⁸ DAVID SATCHER, U.S. DEP’T OF HEALTH AND HUMAN SERVS., EVIDENCE-BASED FINDINGS FOR THE EFFICACY OF SYRINGE EXCHANGE PROGRAMS 5 (2000).

¹⁹ WORLD HEALTH ORG. [WHO], POLICY BRIEF: PROVISION OF STERILE INJECTING EQUIPMENT TO REDUCE HIV TRANSMISSION, at 2, WHO/HIV/2004.03 (2004).

²⁰ HEALTH OUTCOMES INT’L, COMMONWEALTH DEP’T OF HEALTH AND AGEING, RETURN ON INVESTMENT IN NEEDLE AND SYRINGE PROGRAMS IN AUSTRALIA 1 (2002).

²¹ 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(8) AM. J. PUB. HEALTH 1, 3-4 (2005).

²² Franklin N. Laufer, *Cost-Effectiveness of Syringe Exchange as an HIV Prevention Strategy*, 28(3) J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 273, 276-78 (2001).

²³ HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS, *supra* note 4.

²⁴ CTRS. FOR DISEASE CONTROL AND PREVENTION, DRUG-ASSOCIATED HIV TRANSMISSION CONTINUES IN THE U.S. (2002), <http://www.cdc.gov/hiv/resources/Factsheets/PDF/idu.pdf>. The CDC counsels persons who choose to inject drugs to take the following steps to reduce personal and public health risks: “Never reuse or share syringes, water, or drug preparation equipment; use only syringes obtained from a reliable source; use a new, sterile syringe to prepare and inject drugs, if possible, use sterile water to prepare drugs; otherwise use clean water from a reliable source (such as fresh tap water), use a new or disinfected container (cooker) and a new filter (cotton) to prepare drugs; clean the injection site prior to injection with a new alcohol swab; safely dispose of syringes after one use.” HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS, *supra* note 4, at 4.

HIV/AIDS epidemic could have been prevented.²⁵ It is estimated that a national implementation of SEPs in the late 1980s would have saved 20,000 lives and \$1.1 billion in health care costs by the year 2000.²⁶

Unfortunately, sterile syringe coverage in cities across the U.S. is far lower than what is needed to achieve the CDC's 100% coverage public health goal.²⁷ Estimates of coverage in major metropolitan statistical areas range from .03% to as high as 22%, with a mean of 3.2%.²⁸ Past research indicates that around .9 to 2 billion injections occur annually at the national level,²⁹ a number far greater than the approximately 43 million sterile syringes currently distributed by SEPs annually. Throughout the country, only a small percentage of IDUs appear to have contact with SEPs, and whether IDUs have access to sterile syringes depends greatly on the location of the IDU community.³⁰

The philosophy of harm reduction underlying many SEP practices focuses on minimizing the medical and social consequences of drug use for the user, the community, and society at large.³¹ Researchers have developed and proven harm reduction strategies, such as street-based education, to decrease the harmful effects of drug use on the greater community.³² Further, harm reduction methods employed by SEPs are an economically efficient way of preventing illness and driving down health care spending.³³ The cost of preventing an HIV infection in a person

²⁵ Tempalski, *supra* note 2, at S48 (citing David R. Holtgrave et al., *Cost and Cost-effectiveness of Increasing Access to Sterile Syringes and Needles as a HIV Prevention Intervention in the United States*, 18S(1) J. ACQUIRED IMMUNO-DEFICIENCY SYNDROMES AND HUMAN RETROVIROLOGY S133 (1998)).

²⁶ Peter Lurie & Ernest Drucker, *An Opportunity Lost: HIV Infections Associated With Lack of Needle Exchange Programs in the USA*, 349 THE LANCET 604, 606 (1997).

²⁷ See Tempalski, *supra* note 2, at S51.

²⁸ *Id.* at S51. Some of the cities in the sample included Boston, with .32% coverage, Chicago with 6.1%, New York with 1.7%, and San Francisco with 12%. See also, Remis et al., *Enough Sterile Syringes to Prevent HIV Transmission Among Injection Drug Users in Montreal?*, 18S J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES AND HUMAN RETROVIROLOGY S57, S57-S59 (1998), estimating that in Montreal in 1991, about 10 million syringes were needed by 10,000 IDUs over the course of the year, but that only 338,000 syringes were distributed or bought, indicating that less than 3% of the need for unused needles was actually met. *Id.*

²⁹ Lurie et al., *supra* note 5, at S45. The study estimated that in San Francisco, Denver, and New York City, the number of sterile syringes needed per year were 12, 14, and 80 million, respectively. *Id.* at S47.

³⁰ See Tempalski, *supra* note 2, at S48-S51.

³¹ See Harm Reduction Coalition Website, Mission and History, <http://www.harmreduction.org/article.php?list=type&type=63>.

³² John K. Watters et al., *AIDS Prevention for Intravenous Drug Users in the Community: Street-Based Education and Risk Behaviour*, 18 AM. J. COMM. PSYCH. 587, 587-88 (1990).

³³ Laufer, *supra* note 22. Laufer found the average cost of averting an infection to be \$20,947; using \$195,188 as the figure for costs of treatment averted, Laufer estimated a cost savings of \$17,000,000 from 87 infections averted at seven SEPs in New York. *Id.*

that otherwise would have acquired the disease is estimated at \$4,000 to \$12,000, whereas the cost of actually treating a person with HIV is estimated at \$190,000.³⁴ Further, an average city would have to spend only \$131,000 a year to run one SEP (about \$20 per user per year), an amount piling in comparison to the \$120,000 in public health expenditures for a *single* case of infection.³⁵ In addition to the incalculable social benefit of reducing HIV/AIDS and hepatitis prevalence, both establishing and maintaining SEPs can lead to significant economic benefit through cost savings in long-term health care for uninsured or underinsured HIV positive individuals.³⁶

In order for SEPs to be an effective means of addressing this health crisis, sterile syringe coverage needs to reach a sufficient proportion of IDUs to prevent and contain the spread of HIV and other infectious diseases.³⁷ The World Health Organization recommends that SEPs strive to reach at least 60% of IDU populations, while 100% syringe coverage among high-risk populations is the acknowledged public health goal according to the CDC and the U.S. Public Health Service.³⁸ Although this level of access need not be achieved to prevent epidemics,³⁹ current SEPs rarely achieve even adequate syringe coverage in their communities.⁴⁰ To achieve the scope recommended by the CDC, SEP programs must be initiated and expanded on a far wider scale. This expansion and improvement in sterile syringe coverage cannot take place without federal funding, state and local laws amenable to SEP presence, and strategic SEP implementation geared to particular community needs.

³⁴ CTRS. FOR DISEASE CONTROL AND PREVENTION, SYRINGE EXCHANGE PROGRAMS (2005), http://www.cdc.gov/idu/facts/aed_idu_syr.pdf, (citing David R. Holtgrave & Steven D. Pinkerton, *Updates of Cost of Illness and Quality of Life Estimates for Use in Economic Evaluations of HIV Prevention Programs*, 16 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES AND HUMAN RETROVIROLOGY 54 (1997)).

³⁵ U.S. CONF. OF MAYORS, SYRINGE EXCHANGE IN THE UNITED STATES: 1995 UPDATE, HIV CAPSULE REPORT 2 (1996). Note that the \$120,000 is the estimated lifetime cost, from diagnosis to death, of treating one HIV-infected individual.

³⁶ *Id.*

³⁷ See Des Jarlais et al., *Public Health Then and Now: Regulating Controversial Programs for Unpopular People: Methadone Maintenance and Syringe Exchange Programs*, 85(11) AM. J. PUB. HEALTH 1577, 1578 (1995).

³⁸ WORLD HEALTH ORG., UNITED NATIONS OFFICE ON DRUGS AND CRIME, UNITED NATIONS PROGRAM ON HIV/AIDS, TECHNICAL GUIDE FOR COUNTRIES TO SET TARGETS FOR UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT AND CARE FOR INJECTING DRUG USERS (2009), http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf; see HIV PREVENTION BULLETIN: MEDICAL ADVICE FOR PERSONS WHO INJECT ILLICIT DRUGS, *supra* note 4.

³⁹ See R. Heimer, *Community Coverage and HIV Prevention: Assessing Metrics for Estimating HIV Incidence Through Syringe Exchange*, 19S(1) INT. J. DRUG POLICY S65, (2008), available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2367433>. Studies were done of Chicago, Illinois, and New Haven, Connecticut, where the SEP programs reached less than 10% of their estimated IDU populations each month, and had low levels of syringe coverage. However, even with this low amount of need being met, the proportion of AIDS diagnosis attributed to IDUs declined by 21.7% in New Haven and 41.4% in Chicago, suggesting a significant impact on HIV transmission. *Id.*

⁴⁰ See Tempalski, *supra* note 2.

III. POSITIVE IMPACT OF SEPS ON INJECTION DRUG USE

Opposition to the implementation of SEPs centers around the perception that the presence of SEPs leads to increased drug use by increasing access to syringes and by implicitly endorsing illegal drug use.⁴¹ This perception has resonated at both state and local levels, where SEPs are regulated, and the federal level, where funding of SEPs has been banned since 1988.⁴² However, studies indicate that communities that contain SEPs, both in the U.S. and abroad, do not experience increased injection drug use or an increase in crime, and in fact may experience a decrease in the rate of injection drug use.⁴³ Of SEPs nationwide, 97% provide a range of public health services in addition to syringe exchange, such as substance abuse treatment and counseling, prevention education for sexually transmitted diseases, HIV counseling and testing, tuberculosis screening, and primary health care.⁴⁴ Such a comprehensive array of resources creates an approachable environment conducive to decreased drug use, while providing the access to sterile syringes necessary to reduce the spread of HIV and other infectious diseases among IDUs.⁴⁵

Researchers surveying a broad array of SEP locations, including five U.S. and three non-U.S. cities, found that SEPs neither lead to any increase in the amount of drug use by SEP participants nor to any overall change in community levels of drug use, by injection or otherwise.⁴⁶ In an early study on the effect of the presence of SEPs on injection drug use, researchers analyzed data on over 35,000 IDUs admitted for drug treatment in San Francisco County both in the two years preceding implementation of San Francisco's SEPs (1987-88) and the two years following implementation.⁴⁷ The researchers concluded that the presence of the

⁴¹ Scott Burris, *Lethal Injections: The Law, Science and Politics of Syringe Access for Injection Drug Users*, 37 U.S.F. L. REV. 813, 858-59 (2003).

⁴² *Id.* at 818. Note that the U.S. House of Representatives Subcommittee on Labor, Health and Human Services, Education and Related Agencies recently voted in favor of lifting this ban. As of the time of this publication, the decision to lift the ban was before the U.S. House of Representatives Appropriations Committee with an amendment restricting location. See *infra* text accompanying footnotes 73-75.

⁴³ See, e.g., Guydish et al., *supra* note 3, at 874-875; Holly Hagan et al., *Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-Exchange Participation in Seattle Drug Injections*, 19(3) J. OF SUBSTANCE ABUSE TREATMENT 247, 250 (2000). See also *infra* text accompanying footnotes 46 through 57.

⁴⁴ Paone et al., *supra* note 3. According to the Centers for Disease Control and Prevention, 86% of SEPs provide referrals to substance abuse treatment. *Syringe Exchange Programs — United States, 2005*, MORBIDITY & MORTALITY WKLY REP. (Ctr. for Disease Control & Prevention, Atlanta, Ga.), Nov. 7, 2007, at 1165. One may safely assume that the cost-effectiveness of SEPs, shown previously by comparing the \$131,000 per year cost of running an SEP to the \$120,000 *per person* cost of healthcare to a case of syringe-related infection, increases when one accounts for the potential reductions in substance abuse. See *supra* text accompanying footnotes 33 through 35.

⁴⁵ See *infra* text accompanying footnotes 58 through 68.

⁴⁶ LURIE & REINGOLD, *supra* note 3, at 13-14.

⁴⁷ Guydish et al., *supra* note 3, at 871.

SEPs was associated with none of the following: (i) an increase in injection drug use, (ii) an increase in needle-sharing, or (iii) changes in mode of drug use from non-injection to injection.⁴⁸ Neighborhoods with SEPs experienced a lower rate of drug use than analogous neighborhoods with high levels of drug use that did not contain SEPs.⁴⁹ Furthermore, neighborhoods without SEPs experienced greater increases in the proportion of drug treatment admissions allocable to injection drug use and in the frequency of drug injection than neighborhoods with high levels of drug use that did contain SEPs.⁵⁰ Subsequent studies likewise found no relation between the presence of SEPs and increased drug use in Chicago,⁵¹ Anchorage,⁵² Baltimore,⁵³ and Seattle.⁵⁴ International research has yielded similar results. A study of SEP activity and drug treatment admissions in Spain from 1991 to 2004 indicated that while access to sterile syringes increased, the number of new drug injectors decreased sharply.⁵⁵

Former U.S. Surgeon General Satcher, in conjunction with the American Foundation for AIDS Research, prepared a review of all peer-reviewed scientific studies of SEPs conducted from 1998 to 2000, which found that: “the data indicate that the presence of a syringe exchange program does not increase the use of illegal drugs among participants, and in many cases, a decrease in injection frequency has been observed among those attending these programs.”⁵⁶ At least six previous government-funded reports reached the same conclusion, with no such report disputing that conclusion.⁵⁷

⁴⁸ *Id.* at 874-75.

⁴⁹ *Id.* See also John K. Watters, *Syringe and Needle Exchange as HIV/AIDS Prevention for Injection Drug Users*, 271(2) J. AM. MED. ASS'N 115, 119 (1994) (finding that the establishment of San Francisco SEPs did not result in increased drug abuse or recruitment of new and/or younger users).

⁵⁰ Guldish et al., *supra* note 3, at 874.

⁵¹ Dezheng Huo et al., *Cessation of Injection Drug Use and Change in Injection Frequency: The Chicago Needle Exchange Evaluation Study*, 101(11) ADDICTION 1606, 1606 (2006).

⁵² Dennis D. Fisher et al., *Needle Exchange and Injection Drug Use Frequency: a Randomized Clinical Trial*, 33(2) J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 199, 199 (2003).

⁵³ Irene Kuo, *Feasibility of Referring Drug Users from a Needle Exchange Program into an Addiction Treatment Program: Experience with a Mobile Treatment Van and LAAM Maintenance*, 24(1) J. SUBSTANCE ABUSE TREATMENT 67, 69-73 (2003).

⁵⁴ Hagan et al., *supra* note 43, at 250.

⁵⁵ Maria J. Bravo, *More Free Syringes, Fewer Drug Injectors in the Case of Spain*, 65 SOC. SCI. & MED. 1773, 1776 (2007). See also LURIE & REINGOLD, *supra* note 3, at 14 (studying SEPs in five U.S. cities and three non-U.S. cities and concluding that SEPs do not lead to any increase in drug use). Gay Men's Health Crisis, with the assistance of Davis Polk & Wardwell LLP, will be publishing a comprehensive look at international studies of SEPs in the coming months.

⁵⁶ SATCHER, *supra* note 18, at 1.

⁵⁷ JULIE RUIZ-SIERRA, THE LINDESMITH CTR., RESEARCH BRIEF: SYRINGE ACCESS 5 (Updated 2001). The six reports are as follows: NAT'L RESEARCH COUNCIL & INST. OF MED., PROCEEDINGS, WORKSHOP ON NEEDLE EXCHANGE AND BLEACH DISTRIBUTION PROGRAMS (1994); OFFICE OF TECHNOLOGY ASSESSMENT, THE EFFECTIVENESS OF AIDS PREVENTION EFFORTS (1995); DRUG POLICY ALLIANCE, THE CLINTON ADMINISTRATION'S (...continued)

While myriad studies show no increase in drug use as a result of SEPs, those that do show an effect on drug use show across the board a reduction in use. SEP participants have been shown to be more likely than non-participant IDUs to experience substantial reductions in injections, to stop injecting altogether and to remain in drug treatment.⁵⁸ The National Institute of Health (“NIH”) found that SEPs lead to a “reduction in risk behaviors as high as 80 percent in injecting drug users.”⁵⁹ Further, the NIH has noted reductions in HIV transmission rates by 30% or more in SEPs in the U.S.,⁶⁰ with SEPs themselves reporting a removal of nearly 25 million used syringes from U.S. communities.⁶¹

Studies across the country have shown similar results. A Seattle study showed that SEP participants were five times more likely to enter drug treatment than non-participant IDUs.⁶² A three-year study of a Baltimore SEP found that 51% of the participants offered referrals entered drug treatment and that SEP participants succeeded at comparable levels to non-SEP participants in drug treatment despite SEP participants having a greater baseline severity of drug use.⁶³ Several years later, a Baltimore study found the referral success rate had increased to 70%, and that 84% of those entering treatment remained in programs for at least 90 days.⁶⁴

The role of an SEP as a conduit to drug treatment can extend beyond IDUs. A New Haven study revealed that, of the nearly 600 requests for drug treatment received at the New Haven SEP over a two-year period, over 70% were made by individuals not known to exchange needles at that location.⁶⁵ Approximately 45% of the requests were for alcohol and cocaine

(continued...)

INTERNAL REVIEWS OF RESEARCH ON NEEDLE EXCHANGE PROGRAMS (1995); LURIE & REINGOLD, *supra* note 3, at 14; U.S. GEN. ACCOUNTING OFFICE, NEEDLE EXCHANGE PROGRAMS: RESEARCH SUGGESTS PROMISE AS AN AIDS PREVENTION STRATEGY (1993); NAT’L COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME, THE TWIN EPIDEMICS OF SUBSTANCE ABUSE AND HIV (1991).

⁵⁸ Hagan et al., *supra* note 43, at 250.

⁵⁹ *Interventions to Prevent HIV Risk Behaviors*, CONSENSUS STATEMENT (NIH, Bethesda, Md.), Feb. 11-13, 1997, at 4.

⁶⁰ *Id.*

⁶¹ *Update: Syringe Exchange Programs — United States, 2002*, MORBIDITY & MORTALITY WKLY REP. (Ctr. for Disease Control & Prevention, Atlanta, Ga.), July 15, 2005, at 673.

⁶² Hagan et al., *supra* note 43, at 250.

⁶³ Robert Brooner et al., *Drug Abuse Treatment Success Among Needle Exchange Participants*, 113 PUB. HEALTH REPORTS 129, 136 (1998).

⁶⁴ Kuo, *supra* note 53, at 71-72.

⁶⁵ R. Heimer et al., *Needle Exchange Programs as a Conduit to Drug Treatment: The New Haven Experience*, Research presented at the 11th International Conference on AIDS, We.C.3560 (July 10, 1996).

treatment, leading researchers to conclude that the benefits of SEPs extend beyond SEP participants and injection drug users.⁶⁶

Former U.S. Surgeon General Satcher in a 2000 review spoke favorably of the role of SEPs in connecting those with severe drug problems to treatment programs. The Surgeon General concluded that SEPs consistently draw from the demographic with the greatest risk of HIV infection and severe drug use and successfully refer such clients into substance abuse treatment programs.⁶⁷ The report noted that drug treatment programs retain SEP participants at a similar rate as individuals from standard referral services, despite SEP participants generally demonstrating a greater degree of drug use upon entry.⁶⁸ Thus, at the very least, the weight of research indicates that SEPs exemplify the harm reduction approach—they accomplish the primary goal of reducing the spread of HIV and other infectious diseases and create an environment conducive to drug treatment, without exacerbating the underlying problem of injection drug use and its additional social consequences.

IV. EFFECT OF SEPs ON CRIME AND ARREST RATES

The relatively minimal research on the effect (or lack thereof) of SEPs on crime and arrest rates indicates that the presence of SEPs does not lead to increased crime. A study of crime rates in Baltimore over the six-month period prior to the establishment of Baltimore's SEPs and the six-month period following such establishment concluded that the presence of SEPs had no effect on general or drug-related crime rates.⁶⁹ On the contrary, certain categories of crime, such as break-ins, burglaries and violent crimes, saw slight decreases over the course of the study period in areas located near SEPs.⁷⁰ While one study of California SEPs found that participants in legally authorized SEPs were significantly more likely to be arrested for possession of drug paraphernalia than participants in illegal SEPs,⁷¹ the researchers found the difference in arrest rates more likely to be attributable to differences in policing strategies than any purported general lawlessness associated with authorized SEPs.⁷²

⁶⁶ *Id.*

⁶⁷ SATCHER, *supra* note 18, at 3-4.

⁶⁸ *Id.*

⁶⁹ M.A. Marx et al., *Trends in Crime and the Introduction of a Needle Exchange Program*, 90(12) AM. J. PUB. HEALTH 1933, 1934-1935 (2000).

⁷⁰ *Id.* Note that the decreases in SEP areas were contrasted with slight, statistically insignificant increases over the same period in non-SEP areas. *Id.*

⁷¹ Alex N. Martinez et al., *The Impact of Legalizing Syringe Exchange Programs on Arrests Among Injection Drug Users in California*, 84(3) J. URBAN HEALTH 423, 429-33 (2007).

⁷² *Id.*

V. SEP IMPLEMENTATION AND STATISTICS

A. Restrictive Amendment Renders Implementation Unworkable

Although the July 2009 repeal of the funding ban language by the House of Representatives represents a huge shift in policy toward SEPs, the geographic restriction tacked on at the last minute renders the use of such newly available funds almost entirely unworkable. The language of the bill to lift the funding ban, sponsored by Rep. David Obey (D-Wis.) and passed in the House on July 24, 2009, prohibits use of the money to assist any SEP distributing needles within 1,000 feet of day-care centers, schools, parks, playgrounds, pools and youth centers.⁷³ The bill in its current form is only a slight improvement over a complete ban—its restrictions substantially nullify many of the potential benefits that would accompany federal funding for SEPs, 70% of which are located in urban settings.⁷⁴ In many of these urban environments, already-existing SEPs would not be eligible for federal funding. In New York City for instance, an urban community showing dramatic positive success with its SEPs over the last two decades,⁷⁵ all but one of the City's existing SEPs would be prohibited from receiving federal funds. The amendment ignores the need for SEPs in all types of communities, most crucially in urban settings, where IDUs are part of the very populations the amendment seeks to protect.

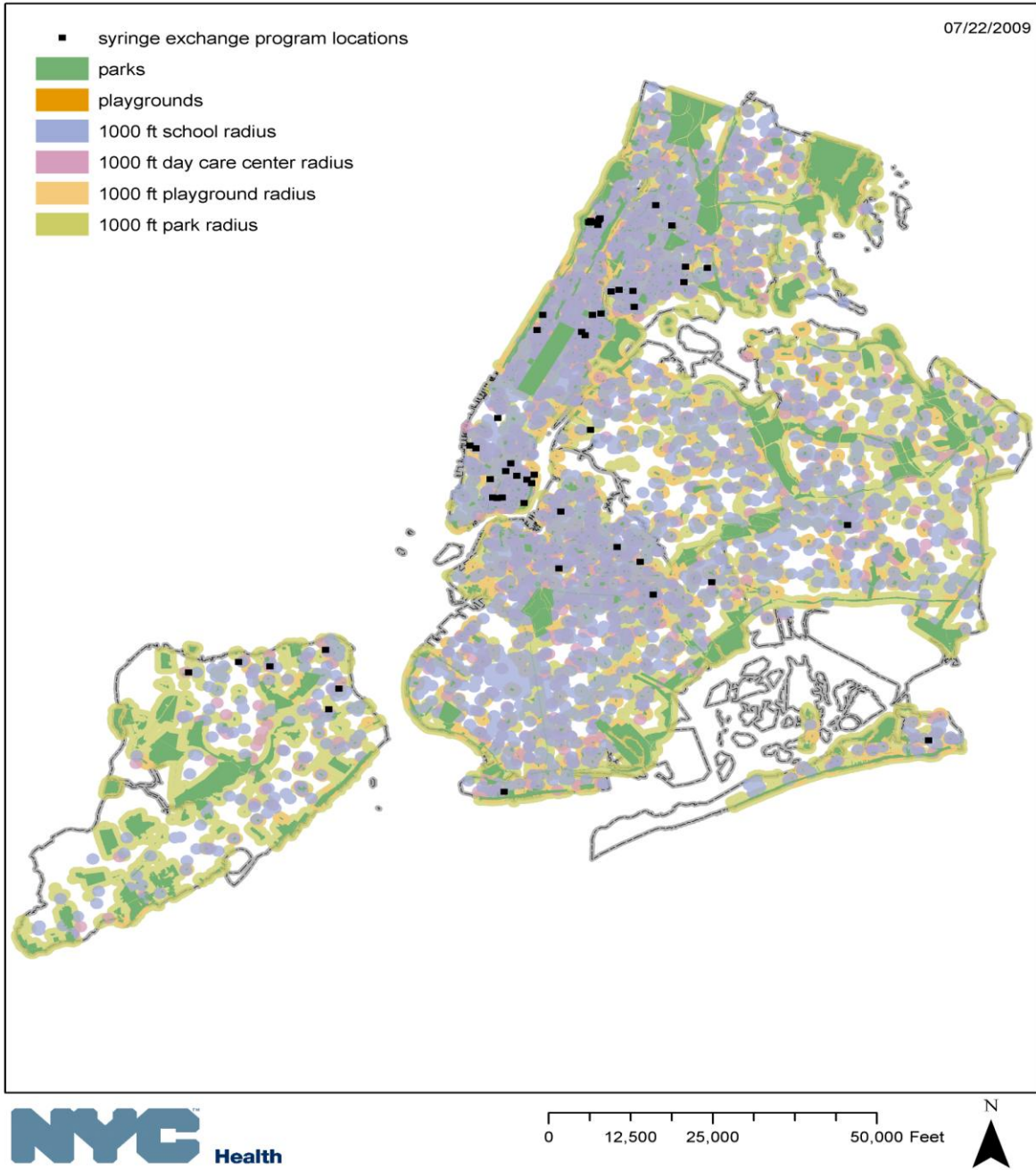
In light of the consensus in the scientific and health communities regarding the benefit of SEPs and the cost-effectiveness of their implementation, the lifting of the federal funding ban without the limitations contained in the current amendment would be a more effective step in the battle against the spread of HIV/AIDS and other blood-borne pathogens. Research has repeatedly shown the heightened success of SEPs that are given government support and funding. For the change in legislation to effect the immense impact on IDU communities and disease transmission for which it has the potential, urban communities must be allowed the opportunity to use the funds as necessary to meet their diverse, particular needs. To restrict funds in the way the 1,000 foot restriction does offers the notion of relief, but allows such relief only on a handful of corners where it may not even be needed. With strong local support now bolstered by the support of the federal government, as well as closely managed relationships with IDU communities and a focus on ease of access, SEPs can exist safely, successfully and peacefully in almost any community, and should be given the chance to do so.

⁷³ Fears, *supra* note 1.

⁷⁴ BETH ISRAEL MEDICAL CTR., SURVEY OF SYRINGE EXCHANGE PROGRAMS (2007) (on file with author).

⁷⁵ See Appendix, regarding the New York Harm Reduction Educators; Des Jarlais et al., *supra* note 21; Laufer, *supra* note 22.

New York City SEPs



B. Current U.S. SEP Figures

The majority of SEPs (70%) are located in urban environments, 21% are rural, and 8% are suburban.⁷⁶ Seventy three percent have 501-C3 status. They stay open on average 26.2 hours per week, have achieved local IDU population coverage rates as high as 22%,⁷⁷ and have been proven effective even with significant financial, staff, and other resource constraints, distributing an estimated 43 million sterile syringes annually.⁷⁸

Studies have shown that IDUs who use SEPs are a diverse group, representing a range of different communities and sub-groups. Thirty five percent of SEPs serve populations the majority of which are people of color;⁷⁹ further, the myriad sub-groups range from immigrant groups to Vietnam War veterans to teenagers.⁸⁰ The majority of IDUs are heroin users, with the second most popular drug being speedball (heroin and cocaine in combination), and third, crystal meth.⁸¹

The existing SEPs in the U.S. offer a range of services in addition to needle exchange, and employ a variety of strategies to address the particular needs of their communities. Forty five percent of SEPs offer mobile exchange, particularly successful because of its accessibility to mobile IDU populations.⁸² Seventy four percent do not enforce a limit on syringes, and 86% allow secondary or satellite exchange.⁸³ A study evaluating the impact of different syringe dispensation policies on achieving adequate syringe coverage (one new syringe for each injection) found that IDUs were most likely to obtain an adequate supply of syringes from programs with the least restrictive policies.⁸⁴

⁷⁶ BETH ISRAEL SURVEY OF SYRINGE EXCHANGE PROGRAMS, *supra* note 74.

⁷⁷ *See id.*; Tempalski et al., *supra* note 2, at S51 (the Tacoma, Washington SEP was shown to have the highest rate of coverage, with coverage defined as the ratio of syringes distributed to the number of syringes needed by heroin injectors per year).

⁷⁸ *See supra* note 6.

⁷⁹ BETH ISRAEL SURVEY OF SYRINGE EXCHANGE PROGRAMS, *supra* note 74.

⁸⁰ *See id.*; Anton Somlai et al., “Lifepoint”: A Case Study in Using Social Science Community Identification Data To Guide The Implementation of a Needle Exchange Program, 11(3) AIDS EDUCATION AND PREVENTION 187, 191-96 (1999).

⁸¹ BETH ISRAEL SURVEY OF SYRINGE EXCHANGE PROGRAMS, *supra* note 74.

⁸² *See* M. Mofizul Islam & Katherine M. Conigrave, *Assessing the Role of Syringe Dispensing Machines and Mobile Van Outlets in Reaching Hard-to-reach and High-risk Groups of Injecting Drug Users (IDUs): A Review*, 4(14) HARM REDUCTION J. (2007), <http://www.harmreductionjournal.com/content/4/1/14>.

⁸³ BETH ISRAEL SURVEY OF SYRINGE EXCHANGE PROGRAMS, *supra* note 74.

⁸⁴ 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(4) ADDICTION 638, 643-44 (2007).

In regard to non-syringe exchange services, 47% of SEPs have peer education programs, and many offer various other services such as referrals to drug treatment (92%), referrals to sexually transmitted disease (STD) screening or for general medical services (80-90%), HIV testing (88%), case management (59%), public benefits assistance (55%), support groups (44%), mental health services (31%), STD treatment (24%), legal services (24%), and dental care (18%).⁸⁵ Many SEPs offer equipment for safe sex and safe injection, such as condoms, alcohol pads, cookers, and bleach, and some programs also offer overdose prevention and maintenance therapy (around 40%).⁸⁶ Around 60-70% of programs also offer food and clothing to program participants. It is clear that these SEPs offer not only sterile syringes to IDUs, but also serve as vital community health centers that cater to many indigent and at-risk community members.⁸⁷

C. Need for Increased Support and Funding

In order to optimize the impact of syringe exchange, SEPs must be established in communities with need, SEPs that already exist must be expanded and improved, and SEPs must be implemented on a larger national scale with the provision of federal funds.⁸⁸ Research has shown that the presence of government funding contributes to a larger number of syringes exchanged, a higher volume of services offered, and a greater likelihood of voluntary HIV testing and counseling.⁸⁹ This is likely due in large part to the benefit from increased financial resources as well as the credibility boost that accompanies government funding.

The U.S. public health response to the spread of blood-borne infections among IDUs has been minimal and geographically uneven,⁹⁰ failing to support the diverse approaches⁹¹ necessary to prevent the spread of HIV/AIDS and other blood-borne pathogens such as hepatitis B and C. The federal funding ban, imposed in 1988, has most drastically hindered the effort to stall the spread of infection by providing clean syringes.⁹² On top of that, many states have legal regimes

⁸⁵ BETH ISRAEL SURVEY OF SYRINGE EXCHANGE PROGRAMS, *supra* note 74.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *See* Rich et al., *supra* note 17.

⁸⁹ Don C. Des Jarlais et al., *Public Funding of U.S. Syringe Exchange Programs*, 81(1) J. URBAN HEALTH 118, 119-20 (2004). About half of all SEP programs receive funding from state or local governments. Des Jarlais et al., *Doing Harm Reduction Better: Syringe Exchange in The United States*, 104(9) ADDICTION 1441, 1444 (2009), <http://www3.interscience.wiley.com/journal/122192013/abstract>.

⁹⁰ *See* Barbara Tempalski, *The Uneven Geography of Syringe Exchange Programs in The United States: Need, Politics, and Place* (2005) (unpublished dissertation, Dept. of Geography, Univ. of Washington) (on file with author).

⁹¹ Such approaches include social services, treatment and detoxification programs, primary health care, outreach, user involvement, and access to sterile injection equipment for IDUs. *See* Rich et al., *supra* note 17; Des Jarlais et al., *supra* note 89, at 1443-44.

⁹² *See* Lurie, *supra* note 26, at 604.

and law enforcement practices that thwart distribution of clean syringes.⁹³ SEPs have managed to address a small fraction of the need for syringe exchange by using various local and private sources of funding, grassroots outreach, and community mobilization. Oftentimes, individuals or local AIDS or gay activist organizations, such as ACT UP, are behind the formation of SEPs, while in other instances SEPs are run through local or state departments of health.

D. Factors Indicative of SEP Success

1. Local Support

Community support and involvement of all stakeholders in policy and direction are crucial factors in establishing and maintaining an SEP. Stakeholders such as health officials, doctors, church leaders, political leaders, law enforcement, school administrators, and community members can provide support and outreach integral to an SEP's success.⁹⁴ In starting or growing SEPs, communities must first identify areas in need. Given the current state of federal law, a large and early obstacle is locating a legal code amenable to the establishment of an SEP, which is difficult given the confused and inconsistent state of current law. In order to achieve success, SEPs must then obtain adequate funding, gain support in the local community, and work strategically to address specific community issues.⁹⁵

Research has shown that at the present time, the most important factor in the successful establishment of an SEP is community support,⁹⁶ which may create a sense of legitimacy, less police opposition, more resources for funding, and greater ease of distribution and IDU travel. In areas that already have SEPs, research has shown that the most important factors in achieving a high level of coverage, or in adequately meeting community need, are community support, government funding, and length of time the SEP has been established.⁹⁷

If an organization already exists that caters in part to the IDU community, it may be worthwhile to integrate SEP services into the existing organization so as to take advantage of the

⁹³ See generally Burris, *supra* note 41, at 818.

⁹⁴ See Moher Downing et al., *What's Community Got to Do With It? Implementation Models of Syringe Exchange Programs*, 17(1) AIDS EDUC. PREV. 68 (2005), available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1510902>; Allan Clear, *Syringe Exchange and the Police: An Alliance in Waiting*, HUFFINGTON POST, http://www.huffingtonpost.com/allan-clear/syringe-exchange-and-the_b_171834.html.

⁹⁵ See Rich et al., *supra* note 17; Somlai et al., *supra* note 80, at 195-201.

⁹⁶ See Tempalski et al., *Social and Political Factors Predicting the Presence of Syringe Exchange Programs in 96 U.S. Metropolitan Areas*, 97(3) AM. J. PUB. HEALTH 437, 444-45 (2007). Significant variables included percentage of the population with a college education, the proportion of men who have sex with men (MSM), and the presence of local ACT UP chapters. *Id.*

⁹⁷ Tempalski et al., *supra* note 2, at S54. Significant variables included government funding, the proportion of men who have sex with men (MSM), and 1993 SEP presence. *Id.*

reputation and tools for outreach already developed.⁹⁸ Partnering with local NGOs or other entities that serve the IDU community has also been shown to be a successful strategy.⁹⁹ Likewise, in expanding the services or geographic reach of an existing SEP, a publicity campaign can be useful to educate, inform, and involve the community during the expansion so as to ensure support for the increased presence in the community.¹⁰⁰

2. Relationship with IDUs

In addition to attaining public funding, SEPs must employ operational strategies that best address the unique needs of their communities.¹⁰¹ This requires extensive research into local area demographics and drug use habits of the various IDU subgroups, establishment of contacts with IDU sub-groups and drug houses, and a liberal exchange policy.¹⁰² Further, outreach workers should reach out to IDUs in the community prior to SEP initiation or expansion, and provide them with program information, including SEP schedules, mobile stop locations, and program features.¹⁰³ Maintaining contact with established drug houses and galleries, and communicating with contacts to learn of new locations of drug houses, may also increase awareness of an SEP in the community.

3. Ease of Access

SEPs should be easily accessible by the target population, as IDUs may be very mobile due to homelessness, avoidance of police, or increased neighborhood dissatisfaction with IDU

⁹⁸ See, e.g., Downing et al., *supra* note 94, where the researchers studied implementation strategies in nine communities and found that although activists played a key role in setting up SEPs, they often had a hard time sustaining them without garnering additional resources or partnering with other organizations that could sustain their programs. *Id.*

⁹⁹ See Laretta Grau et al., *Expanding Harm Reduction Services Through a Wound and Abscess Clinic*, 92(12) AM. J. OF PUB. HEALTH 1915 (2002), available at <http://www.ajph.org/cgi/content/full/92/12/1915>. The Wound and Abscess Clinic at Casa Segura/Safehouse in Oakland, California, held concurrently with a syringe exchange, provided economical treatment and aftercare for injection-associated soft tissue infections. During 20 two-hour clinic sessions, 173 treatment episodes were logged, and the visit cost was estimated at \$5 per patient; increased patient–clinician interactions provided opportunities beyond those afforded by the syringe exchange for patients to obtain resources and referrals to services such as HIV counseling and testing, medical care, and drug treatment. *Id.*

¹⁰⁰ See Downing et al., *supra* note 94, where the authors found that coalitions had to work to reverse negative public opinion and be sensitive to community norms. “Coalition building with a variety of community and church groups, neighborhood associations, political organizations, and other types of health and social service agencies enhanced the acceptance of SEPs by specific constituencies. Developing a process for community input and feedback ensured that community members were included in the siting and development of SEPs in their neighborhoods. Where community norms precluded an open process, community sensibilities were accommodated implicitly by keeping everything out of the public eye.” *Id.*

¹⁰¹ Somlai et al., *supra* note 80, at 187.

¹⁰² *Id.* at 191-201.

¹⁰³ *Id.* at 197-201.

presence at a particular location. In order to better reach IDU communities that are diverse and widely distributed in a particular geographic area, mobile/vehicle exchange has proven to be a very effective strategy across distinct communities with divergent issues.¹⁰⁴ Joey Tranchina of the AIDS Prevention ACTION Network stated that one of the biggest mistakes in expanding access to syringes is “[thinking] that needle exchange services are adequately delivered on a limited time basis that is convenient for the program but not the users. I have repeatedly heard words like: ‘They know when exchange takes place[.] They should be able to arrange their lives to get here.’ Anyone who is serious about this mission knows that is nonsense.”¹⁰⁵ Mobile facilities provide for exchange in a secure environment, remove the stigma, and decrease the chances of police retaliation.¹⁰⁶ Further, such facilities can stay open at any time and afford protection from inclement weather. IDUs inject at all times of the day and in every type of weather, and SEPs must accommodate their needs if they are to be successful.

VI. CONCLUSION

The establishment of SEPs provides a cost-effective, tailored, and proven means to addressing the spread of HIV/AIDS and other blood-borne infections through injection drug use. The success of SEPs at addressing injection drug use and combating related harm to IDUs and communities at large has been proven over the last two decades. SEPs not only provide access to sterile syringes, necessary to meet the CDC’s 100% coverage goal, but also offer resources to IDU communities that extend beyond traditional support programs in both reach and success rate. Furthermore, the miniscule cost of setting up an SEP is a drop in the bucket to the federal government compared to the exorbitant funds it must expend to address the public health problems of injection drug use and the spread of infection. While federal law has been stagnant, the recognition by the House Appropriations Subcommittee of the true benefits of and need for SEPs signals a reflection of current scientific knowledge and a change in national policy and public perception.

Cut off from federal funding since 1988, SEPs have forged their own paths, capitalizing on local, private, and activist support to survive. Given the lack of federal funding and stigma placed upon such programs as a result, the tremendous presence of SEPs in diverse communities across the U.S. is a testament to the great need for such programs and the committed efforts of local communities to obtain the resources they need in any way they can. The biggest barriers to successful implementation of SEPs—identified by SEPs as lack of resources and funding, staff shortages, failure to reach participants, police harassment, lack of outreach, and lack of community and political support¹⁰⁷—can and have been overcome repeatedly by SEPs across the

¹⁰⁴ *Id.* Note that in some instances, mobile exchanges may not be appropriate, particularly if IDUs are well established in other parts of the community.

¹⁰⁵ AIDS Prevention ACTION Network (2009) (on file with author).

¹⁰⁶ Somlai et al., *supra* note 80, at 199, found that a mobile facility faced significantly less community opposition than a fixed site location.

¹⁰⁷ BETH ISRAEL SURVEY OF SYRINGE EXCHANGE PROGRAMS, *supra* note 74.

country. Education and outreach campaigns that involve all local stakeholders—including religious and minority community leaders, police departments, elected officials, and health professionals—can dispel myths leading to discriminatory practices towards IDUs, drum up needed support from community leaders and health service providers, and alter public perception through heightened education. Establishing an efficient and streamlined program, involving mobile-based exchange or partnerships with other organizations, can augment opportunities for referral and increased outreach. Given current federal law, an SEP may need to lobby for increased funding at the state or local level, conducted in conjunction with a public relations campaign directed at various community groups. Ultimately, though, the provision of federal funding for use by SEPs would eliminate obstacles related to resources, access, stigma, and support, allowing communities to address the public health problem of the spread of disease as required by their community’s particular needs.

VII. SUMMARY AND RECOMMENDATIONS

- SEPs are a needed, cost-effective solution to combating the HIV/AIDS public health crisis. The cost of operating an SEP pales in comparison to the cost of supporting a single HIV infected individual.
- SEPs stem the spread of infection by removing millions of used needles each year, and by providing substance abuse services and health resources to IDU communities nationwide.
- Public funding is crucial to the success of SEPs, both because it enables an SEP to function better, and also because government support lends a heightened legitimacy to an SEP.
- The local, state, and NGO funds currently available to meet the need for safe syringe exchange are grossly inadequate to meet public need. The current ban on federal funding must be lifted, without restrictions, for SEPs to more fully address public need.
- The geographically restrictive amendment accepted by the House of Representatives in July 2009 would render the new language unworkable and undercuts the aid House members seek to give communities in need. An IDU community in any area will likely be diverse and multi-factional. SEPs must be able to tailor their services to meet the needs of the particular IDU communities that they serve.
- Community outreach is important in establishing, maintaining, and expanding SEP coverage. All interested community members and groups should be allowed to participate in the establishment and running of the SEP, and should be fully informed on: the need for an SEP, the proven success of SEPs, and common misconceptions regarding the effects of SEPs.
- Research has shown that a liberal exchange policy is associated with higher levels of syringe coverage. SEPs should employ a liberal syringe distribution policy, including mobile exchange, in order to better meet community need.

- IDU communities are very mobile. An important strategy for SEPs is mobile/vehicle distribution, which enables SEPs to 1) better reach IDU communities, 2) provide for more convenient distribution, 3) avoid community opposition to a fixed-location outlet, and 4) rapidly adjust distribution locations or schedules.
- The longer an SEP exists, the more likely it is to be successful in addressing community need. Anecdotal evidence indicates that integrating syringe exchange into pre-existing health services that cater to IDU populations (e.g., HIV/AIDS counseling or condom distribution) can be a successful model for establishment of an SEP. An already existing health program that caters to IDUs will likely have the benefits of 1) an established user base, 2) legitimacy in the community, 3) support from public health officials and local community leaders, and 4) established funding resources.

VIII. ACKNOWLEDGEMENTS

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APPENDICES

SEP Examples

San Francisco

The San Francisco AIDS Foundation, one of the largest syringe exchange programs in the Bay Area, has 11 exchange locations, which an estimated 12,000 clients visited in the 2008-2009 fiscal year.¹⁰⁸ The Foundation's syringe exchange budget was \$825,845, \$668,904 of which was contributed by the city, and all of which was completely depleted a couple of months prior to June 30, when the budget cycle ended. In addition to providing clean syringes, the Foundation provides HIV testing and vaccinations for hepatitis B, and most of its sites have a nurse that deals with wound care and makes referrals for substance abuse treatment.¹⁰⁹ CEO Mark Cloutier has stated that the lifting of the federal funding ban would be progress and that what is promising is "the possibility of opening up a broader conversation about harm reduction as an overall strategy to HIV prevention."¹¹⁰

New York

Members of the The New York Harm Reduction Educators (NYHRE) distribute clean syringes through mobile and fixed site exchange.¹¹¹ With a budget of close to \$2.7 million, NYHRE provides care to 7,218 individuals. During 2006, over 850,000 clean syringes were distributed by NYHRE to IDUs in the South-Central Bronx and East Harlem.¹¹² The program serves adults, primarily from communities of color: approximately 67% of the participants are Latino/a, 25% African-American, and 5% White; two-thirds are male.¹¹³ In addition to needle exchange, the program distributes condoms, antiseptic pads and bleach kits for cleaning the needles; refers individuals to treatment and counseling services offered by the organization; recommends charity organizations where participants can get a hot meal and new clothes; and offers incentives like gift cards for HIV testing.¹¹⁴

¹⁰⁸ Seth Hemmelgarn, *Needle Exchange Ban Could be Lifted*, BAY AREA REPORTER, July 30, 2009, <http://www.ebar.com/news/article.php?sec=news&article=4097>.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ See NYHRE Web site, <http://www.nyhre.org/programsactivities.html>.

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ Stephanie Harnett, *New York Midnight Heroes*, HUFFINGTON POST, July 1, 2009, http://www.huffingtonpost.com/2009/07/01/syringe-exchange-service_n_224049.html.

Of NYHRE's mobile distribution, one of the volunteers stated, "We let them know, if you're going to be out here, be safe, and if you're going to use, use clean."¹¹⁵ In addition to their late night mobile exchange that seeks out IDUs at active drug using locations, NYHRE operates a syringe exchange and testing program six days a week from two converted RVs that park at different spots throughout the city. "A lot of people who are users are not going to travel more than five miles from their neighborhood If they're not going to come over here, we're going to go to them."¹¹⁶ But the program does not just serve IDUs—the RV also serves some diabetics, whose limited mobility means that they cannot travel to get new syringes for daily injections, and who may also be unable to pay for needles; the program provides these patients with up to 100 syringes at a time.¹¹⁷ "These people live in our community and they turn to us for these services People look at syringe exchange and make it [sic] so nasty, because HIV is sexually transmitted or a 'gay disease.' No, it's not that, anyone in the world can use this service."¹¹⁸

Seattle

Seattle's program began operating in 1989 and is described by the Seattle and King County Public Health Department as "an important component of a comprehensive set of programs designed to reduce the spread of HIV and other blood-borne infections among injection drug users, their families and communities," currently serving a community of 18,000 IDUs.¹¹⁹ King County Public Health operates programs in six areas of King County; community-based agencies operate two additional programs.¹²⁰ The programs provide drug treatment and health care, along with other services including testing for HIV, hepatitis, tuberculosis and other infections to which drug users are prone; treatment readiness counseling and case management services; education about harms associated with drug use and how to minimize them; and safe disposal of contaminated equipment.¹²¹

The syringe exchange program in Seattle is funded by disease prevention funds provided by Washington State, King County and the City of Seattle, in addition to private donations and

¹¹⁵ *Id.* (quoting Terrell Jones, a volunteer with the New York Harm Reduction Educators).

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ SEATTLE AND KING COUNTY PUBLIC HEALTH, PUBLIC HEALTH - SEATTLE & KING COUNTY NEEDLE EXCHANGE PROGRAM, <http://www.kingcounty.gov/healthServices/health/communicable/hiv/resources/aboutnx.aspx>

¹²⁰ *Id.*

¹²¹ *Id.*

grants.¹²² King County spends \$1.1 million a year on the needle exchange program. In contrast, the lifetime medical cost to treat one person who has HIV is estimated to be \$385,000.¹²³

By preventing infections in just three people per year, the needle exchange program more than pays for itself. By preventing HIV infections in just 1% of IDUs in King County, the program saves \$70 million in HIV-related medical costs. In this light needle exchange provides both a public health and an economic benefit to the residents of Seattle and King County.¹²⁴

In King County, the rate of HIV injection among injection drug users has remained low and stable for the past 16 years, with only 3% of the local injection drug users infected.¹²⁵ Further, King County's program has also been successful in getting IDUs off the streets and into drug treatment. In the last three years, 691 people were successfully placed in drug treatment and the program provided emergency funding support to keep an additional 307 people in treatment who were facing discharge because of inability to pay.¹²⁶

¹²² See Shaun Knittel, *Bill Seeks to End The Ban on Syringe Exchange Programs*, SEATTLE GAY NEWS, July 17, 2009, http://www.sgn.org/sgnnews37_29/mobile/page14.cfm.

¹²³ SEATTLE AND KING COUNTY PUBLIC HEALTH, *supra* note 119.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.*