RESOLVED, That in order to further scientifically based public health objectives to reduce HIV infection and other blood-borne diseases, and in support of our long-standing opposition to substance abuse, the American Bar Association supports the removal of legal barriers to the establishment and operation of approved needle exchange programs that include a component of drug counseling and drug treatment referrals.
Neural exchange programs, by increasing the availability of sterile syringes, are an important technique for reducing HIV infection and other blood-borne diseases, such as hepatitis B and C, among the most rapidly expanding source of HIV infection, injection drug users (IDUs) and their often unknowing sexual partners and their children. Extensive studies by the nation’s leading public health and scientific agencies have shown that needle exchange programs do not increase the frequency of drug use and do not increase the number of new drug injectors. Moreover, needle exchange programs involving drug counseling and drug treatment program referrals do hold the promise of actually reducing drug abuse.

Drug treatment referrals should be a component of any needle exchange program because drug treatment programs provide the most effective means of reducing drug dependency. Unfortunately, treatment on demand is not always available, but needle exchange programs can keep IDUs uninfected until they enter treatment programs. Needle exchange programs also reduce the incidence of infected needles from playgrounds, streets and trash receptacles; protecting children, sanitation workers and others from needle sticks.

The policy of the American Medical Association is that the AMA “encourages needle exchange programs.” The resolution that supported this policy statement recognized that syringe exchange programs reduce incidents of HIV infection and that negative consequences of these exchange programs have not been detected.

However, the AMA is only one of two bookends. The implementation of the medical science is presently hamstrung by legal barriers that were erected before the era of HIV/AIDS. Therefore, this recommendation supports removal of legal barriers to needle exchange programs.

1American Medical Association, Policy Compendium, House of Delegates Policy 95.958.
In so doing, the ABA also recognizes that the determination of which barriers should be removed will turn on the laws, policies, customs and attitudes of each jurisdiction.

**DIMENSIONS OF THE PUBLIC HEALTH CRISIS**

The HIV epidemic as we know it is almost a decade and a half old. Although pharmacological interventions recently have shown progress in arresting the disease, a cure is as elusive as ever; in many communities, the epidemic advances unchecked.

Primarily because of transmission through shared needles, HIV infection has become a major public health problem among IDUs. Although there are a number of prevention techniques known to be effective — abstinence from drug use, disinfection of injection equipment between uses, and reduction in needle sharing —, the evidence is overwhelming that providing IDUs with sterile needles is an essential component of any effective harm reduction strategy aimed at reducing HIV transmission and IV drug abuse. One proven method of making sterile syringes available to IDUs is the establishment of needle exchange programs. Properly designed, such programs will:

- provide sterile injection equipment to injection drug users; used needles and syringes are returned for new ones, and the supply of free and legal sterile injection equipment is constant. Moreover, as program staffers' contact with injection drug users increases, the goal is to establish trust and rapport and to facilitate not only “safer” injection practices but entry into treatment for drug abuse.

Contrary to widespread concerns, respected studies have demonstrated that needle exchange programs do _not_ increase drug use and may decrease it, and do _not_ cause more widespread drug use. Furthermore, needle exchange programs stabilize and reduce HIV rates in the populations they serve. Needle exchange programs, even if exempted from criminal and public health laws restricting the sale, distribution, and possession of drug paraphernalia, will not be able to serve all IDUs. Therefore, we recommend: the repeal of laws restricting the non-prescription sale of needles and syringes and the modification of drug paraphernalia laws so as to remove needles and syringes from the scope of such laws.

In addition to the substantial medical savings that will result from the reduction of risky behaviors and the consequential reductions in HIV infection rates, the social benefits of needle exchange programs are immense. The reduction in human suffering of drug injectors, their partners, and their children can hardly be underestimated. Equally important are reductions in the social costs of time lost at work by infected persons and caregivers and the social services costs of assisting families in need and minor children left without parents.

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*Editorial: The Evaluation of Needle Exchange Programs. 84 Am. J. Public Health 1899, at 1890 (1994).*
HIV TRANSMISSION: THE ROLE OF INJECTION DRUG USERS

(a) Background Data. As of June 30, 1996, AIDS had claimed over 342,982 lives in the United States, and 548,102 cases of AIDS had been reported to the Centers for Disease Control and Prevention (CDC). In 1992, HIV infection became the leading cause of death among men ages 25 to 44 and the fourth leading cause of death among women in the same age group. The same is true today.

(b) Injection Drug Use is Driving the Spread of AIDS. The spread of HIV among IDUs, their sexual partners, and their offspring accounts for a major portion of new HIV infections in the United States and the continuing expansion of the HIV epidemic. According to a recent National Research Council report, "The epidemiological data indicate that the HIV epidemic in this country is now clearly driven by infection occurring in the population of injection drug users, their sexual partners and their offspring." The CDC's data indicate that the overall proportion of HIV cases attributable to injection drug use has steadily increased from 12 percent in 1981 to 28 percent in 1993. By 1994 other respected experts put the percentage attributable to injection drug use at one-third.

(c) Effects on Women and Children. In the United States, more than 80% of HIV positive women inject drugs or are the partners of people who do. AIDS is now among the ten most common causes of death in American children under five; in New York, it is the second leading cause of death in African American children and the leading cause of death in Hispanic children of that age. As of June 30, 1996, there were 7,296 pediatric AIDS cases reported to the CDC. In 37% of the cases, the mother was an IDU, and in an additional 17% of the cases, she had sex with an IDU. Thus, over half of all pediatric AIDS cases are associated with the HIV epidemic among injection drug users.

Surveillance Report, supra Note 3, at 31.}

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"Id.


"Id. at 9.

"Don C. Des Jarlais and Samuel R. Friedman, AIDS and the Use of Injected Drugs, Scientific American, at 82 (February 1994)."

"Id. at 84.


"Id."
Among women of child-bearing age infected sexually (primarily by addicts), the rate of HIV infection is rising rapidly. In 1992, 2,442 women were diagnosed with AIDS contracted sexually, a 17% jump over 1991 and the highest increase for any group. That trend has continued.

INFECTION RATES AND NON-STERILE NEEDLES

(a) Explosive Increase of HIV Rates in Injection Drug Use Communities. Once HIV has been introduced into a community of drug users via travel or men having sex with men, the infection can explode rapidly. Cities as disparate as Edinburgh, Scotland (increase from 5% infection rate among IDU's to 57% in 2 years) and Bangkok, Thailand (1 to 43% in one year) experienced this phenomenon. Furthermore, after rapidly rising, seroprevalence rates stabilize at high levels (69% in Milan, Italy, by 1985 and 55-60% in New York City in 1984 through 1987).

(b) Dangerous Practice Causes Transmission. Needles and syringes are very efficient transmitters of HIV. The main factor associated with HIV infection among injection drug users, however, is the practice of sharing "injection equipment." This multiperson use of syringes is particularly dangerous because residual blood retained in the syringe from one person can be unintentionally and, even with rinsing, inconspicuously passed along to the next person using the syringe. Recent studies have shown that while disinfection is helpful, it is not consistently effective in other than laboratory conditions. According to a leading substance abuse/HIV medical scientist, "The injection devices are often shared by dozens of drug users who do not have any social relationship with one another and therefore do not know one another's HIV status or about any risky behavior they may engage in."

(c) Reasons Behind Use of Dirty Needles. Sharing drug injection equipment is not

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\[^{10}\text{Id.}\]
\[^{11}\text{Id.}\]
\[^{12}\text{Surveillance Report, supra note 3, table 5 at 10.}\]
\[^{13}\text{National Research Council Report, supra note 5 at 10.}\]
\[^{14}\text{Id.}\]
\[^{15}\text{Id. at 2.}\]
\[^{16}\text{Id.}\]
\[^{17}\text{Editorial, supra note 2, at 1850.}\]
\[^{18}\text{Des Jarlais, supra note 7, at 84.}\]
merely a learned response or a function of the culture of the drug world. Sharing is also the direct result of a limited supply of sterile needles and syringes, which can deny drug users any realistic opportunity to engage in safer behavior. IDUs are compelled to use dirty syringes because of the scarcity and higher prices of unused needles, and the fear of arrest for possession of syringes and needles.

(d) Public Health Consequences. The National Research Council Report found that, aside from the obvious deadly consequences for IDUs, the use of non-sterile injection equipment has far-reaching consequences for the health of the broader community. The National Research Council has concluded that, "Communities of injection drug users with high levels of both HIV infection and risk behaviors (i.e., involving drugs and sex) can serve as a bridge across distinct populations and efficiently impact the infection rate of other groups for which the HIV prevalence rates are currently relatively low." 3

COMMUNITY CONCERNS, PUBLIC POLICY AND HARM REDUCTION

According to a recent survey undertaken by the Kaiser Family Foundation, 66% of American adults favor providing clean needles to IDUs. Nevertheless, a significant segment of the public and government policy makers have continued to express reservations about needle exchange programs, objecting that (i) society, and certainly government sponsored entities, should not provide the means to participate in harmful, illegal activity; (ii) monies for needle exchange programs would be better spent on supporting presently underfunded drug treatment and prevention programs; and (iii) needle exchange programs will encourage more drug activity by present users and will attract new users.

(a) "Contradictory" Message. At first blush, it appears contradictory to provide needles to IDUs at the same time society urges IDUs not to use drugs. Given the current state of treatment availability in the United States, as well as the clear direction of the HIV epidemic, however, this conclusion is not as simple as it first appears. There is a legitimate medical and public health objective in providing clean needles to IDUs who cannot or will not stop injecting drugs.

Currently there is not sufficient funding in virtually every jurisdiction to bring all IDUs

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4Id. at 131-132.
into treatment immediately. On any given day in the United States, only 10-15% of IDUs are in treatment and only one half of IDUs have any history of drug abuse treatment. As the CDC has pointed out, from a public health perspective, needle exchange programs cannot be a meaningful bridge to treatment if all they can do is refer their clients to waiting lists or assist them in jumping over others waiting for admission to treatment programs. If there were adequate treatment slots available, needle exchange programs would be particularly valuable because, given their “user-friendly” approach, they attract IDUs who traditionally have had no interest in drug treatment. Moreover, many IDUs are not suitable for treatment under criteria established for admission to treatment programs. Therefore, while in some senses it is an interim measure, needle exchange programs can assist in keeping an IDU free of blood-borne diseases such as HIV or hepatitis until treatment programs are available and appropriate.

Additionally, by providing clean needles, needle exchange programs protect the sexual partners and children of IDUs who may not be engaged in any drug abuse but are the unknowing recipients of HIV transmission.

Needle exchange programs are not a unique attempt to resolve a seemingly contradictory message. During World War I, the official policy for our expeditionary forces required sexual abstinence and punishment for sexual disease infection. However, in the last 18 months of World War I, almost 400,000 soldiers were diagnosed with venereal diseases. Recognizing the failure of the World War I policy, the armed forces distributed 50 million condoms each month during World War II.

Needle exchange programs, when coupled with drug counseling and referrals to treatment, do not send a contradictory message. It is clear that they work together toward getting IDUs off drugs and keeping them healthy until treatment can begin. The CDC sees needle exchange programs as “one part of a comprehensive approach to the prevention of HIV in IDUs, an approach that would also emphasize the expansion of drug treatment and school and community-based interventions to prevent the initiation of drug use.”

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20Centers for Disease Control and Prevention, The Public Health Impact of Needle Exchange Programs in the United States, School of Public Health, University of California, Berkeley and Institute for Health Policy Studies, University of California, San Francisco (October 1983). Vol 1 at 10. (hereinafter “CDC” Report).

21CDC Report, supra note 25, at 12.

22For example, immigration status can make one ineligible for treatment.


24Id.

(b) Funding Needle Exchange Programs and Drug Treatment Should Not Be an Either/Or Proposition. Critics of needle exchange programs, particularly those in minority communities, find it ironic that government would fund the supplying of needles to addicts to continue their habits, while not adequately funding treatment for all who need or desire it. These concerns have not been taken lightly by researchers. However, given the harm reduction benefits of needle exchange programs, it is important to support relatively inexpensive needle exchange programs, while continuing to build the political support necessary to provide for drug treatment for all who seek it.

It is significant that public opinion in minority communities on the issue of needle exchange programs is hardly monolithic. Public opinion polls indicate black Americans' support for needle exchange programs is the same as that of the general population. In New Haven, Connecticut, Mayor John Daniels, an African-American, had opposed needle exchange programs as a state legislator, but as mayor had become convinced of their efficacy after studying the compelling data. In another instance, within two years of canceling New York City's needle exchange program experiment, Mayor David Dinkins, another African-American political leader, re-established needle exchange programs after studying the success of New Haven's program.

The CDC researchers recognized that needle exchange programs initially seemed at odds with the abstinence ethic of drug programs and were the subject of legitimate community concerns, particularly in Latino and African-American areas. However, their report concludes that attitudes could change and needle exchange programs could operate successfully where proponents consulted with and worked with local leaders to develop a comprehensive approach to preventing HIV "which should include needle exchange programs and the expansion of drug treatment services."

(c) No Increased Drug Activity From Needle Exchange Programs. In 1992, the U.S. Secretary of Health and Human Services asked the prestigious National Academy of Sciences to conduct a study on the impact of needle exchange and bleach distribution programs on drug use behavior and the spread of HIV. The study was conducted by National Academy of Sciences' principal operating agency, the 80 year-old preeminent National Research Council.

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29CDC Report, supra note 25, at 14.
31CDC Report, supra note 25, at 23.
After an exhaustive review of five major studies, a distinguished panel of experts commissioned by the National Research Council concluded in their 1995 report that:

- Needle exchange programs do not increase the frequency of injection among program participants;
- Needle exchange programs do not increase the number of initiates to injection drug use; and,
- There is no general increase in drug use in the communities in which needle exchange programs are located.26

The previously discussed 1993 CDC-sponsored review of the research concerning HIV and the impact of needle exchange programs came to similar conclusions:

- Needle exchange programs are not associated with a change in injection frequency among needle exchange program clients;
- There is no evidence of any increase in the level of community drug use in needle exchange program areas.27

Even more recently, a consensus panel convened by the National Institutes of Health reviewed the same questions. The panel's report concludes:

An impressive body of evidence suggests powerful effects from needle exchange programs. Data are available to address three central concerns.

Does needle exchange promote drug use?
A preponderance of evidence shows either no change or decreased drug use. Additionally, individuals in areas with needle exchange programs have increased likelihood of entering drug treatment programs.

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26 NRC Report, supra note 4, at 198. The NRC relied upon (1) a 1991 review carried out by congressional request of the effectiveness of Needle Exchange Programs (U.S. General Accounting Office, 1993); (2) a comprehensive evaluation carried out by University of California researchers for the Centers of Disease Control and Prevention (Lurie et al., 1993); (3) selected studies published since two 1993 literature reviews; (4) detailed examination of a set of recent studies in New Haven, Connecticut; and (5) detailed examination of a set of recent studies in Tacoma, Washington.

27 NRC Report, supra note 5, at 252.


29 NIH Consensus Statement on Intervention to Prevent HIV Risk Behaviors (February 13, 1997). The conclusions are supported by a report from HHS Secretary Shalala to the Senate Committee on Appropriations dated February 18, 1997.
Do programs encourage non-drug users, particularly youth, to use drugs? On the basis of measures such as hospitalizations for drug overdoses, there is no evidence that community norms change in favor of drug use or that more people begin using drugs.

Do programs increase discarded needles in the community? In the majority of studies there was no increase in used needles discarded in public places.

RESEARCH STUDIES DEMONSTRATE ADDITIONAL BENEFITS OF NEEDLE EXCHANGE PROGRAMS

Properly designed needle exchange programs typically include HIV prevention and drug counseling, and an array of other social and medical services, including referral to drug treatment, and can assist injection drug users in remaining in treatment. Thus, there is promise that needle exchange programs will meet the additional congressional requirement of actually reducing drug abuse.

Federal research has examined whether needle exchange programs reduce HIV transmission rates. As noted above, needles and syringes are efficient transmitters of HIV, and the IDU practice of sharing needles can infect all of the multiple users. Increasing the availability of sterile syringes while at the same time removing contaminated needles from circulation should contribute greatly to the reduction of HIV transmission among IDUs. Research has shown that needle exchange programs accomplish that goal without increasing or spreading drug abuse. For example, a study of the New Haven needle exchange program population revealed a 30% decrease of HIV prevalence in returned needles. Also the sharing of syringes by drug injectors decreased by more than 40%. And, it should be noted that the CDC found evidence suggesting a potential connection between HIV infection rates and laws that restrict the possession, distribution and sale of injecting equipment:

HIV seroprevalence among IDUs entering drug treatment tends to be higher in states that have prescription laws (median = 15.0%) than in states that do not have these laws (median = 2.7%), although this relationship may not be causal. In Connecticut, where the paraphernalia and prescription laws were modified to permit the purchase of up to 10 syringes without a prescription, sales of syringes to IDUs appear to have increased.

NIH Consensus Statement on Intervention to Prevent HIV Risk Behaviors (February 13, 1997).


NRC Report, supra note 5 at, 228.

Although Connecticut IDUs responding to a questionnaire reported no change in the proportion who had shared at least one, those in four focus groups reported fewer sharing episodes. Finally, researchers in Baltimore, Maryland, a state without a prescription law, found a 2.5-fold higher HIV seroprevalence among non-diabetic compared to diabetic IDUs, a finding they attributed to diabetics having better access to sterile syringes.40

A second area of inquiry is to look at foreign jurisdictions that have had experience with needle exchange programs. Many industrialized countries including France, Germany, Italy, Sweden, Switzerland, the Netherlands, Great Britain, Australia, and Canada use needle exchange programs as part of their public health efforts to reduce the spread of HIV and other blood-borne infections among drug users and their sexual partners. An analysis of the foreign experience with HIV risk reductions among IDUs revealed three provocative findings: (i) significant majorities of drug users will seek to reduce their HIV risk, but the success of drug injectors' efforts depends on their ability to obtain clean needles; (ii) the success rate depends on when the programs were instituted -- i.e., when the HIV infection rate was minimal or after HIV became entrenched in the community; and, (iii) where infection rates are high, modest reductions are nevertheless possible but only where the efforts are extensive.41

Closer to home, some 60 needle exchange programs operating in the United States responded to the United States Conference of Mayor's April 1995 survey.42 Programs are operating in at least 46 cities in at least 21 states. In nine cities, more than one program is providing services. A total of eight million new, sterile syringes were given out to injection drug users in exchange for used syringes in 1994, as compared to 2.4 million in 1993.

A recent study by the Chemical Dependency Institute at Beth Israel Medical Center in New York found that providing sterile syringes and appropriate prevention counseling to IDUs in communities where the HIV infection rate among IDUs is below 5% can have a significant impact in preventing the spread of the virus. For example, in Tacoma, a city of 177,000 with about 500 intravenous drug users, prevention efforts cost $20 per user annually, and held the infection rate to less than 5%. The estimated lifetime cost of treating one HIV infected individual is $120,000.43 The cost-benefits of needle exchange programs are particularly important in times of budgetary restraint.

There have also been highly promising results where needle exchange programs have been instituted in communities with a high incidence of HIV infection. As described above,
New Haven, Connecticut implemented an experimental legal needle exchange program beginning in November 1990, after several years of study.46

As a result of the preliminary success in New Haven, the state of Connecticut expanded the programs to Bridgeport and Hartford. In July of 1992 the state decriminalized the possession of injection equipment without a prescription and as a consequence, there was an almost 50% reduction in the monthly volume of exchanges in New Haven.

The NRC Report found the importance of the evidence from the New Haven studies to be twofold. "They provide: (i) direct evidence of lower levels of HIV infection among needles in use ['the prevalence of HIV in needles decreased by one-third'] and (ii) indirect, model-based estimates of changes in the incidence of new HIV infections among needle exchange program participants."47

In addition to the significant and substantial reductions in the infectivity of the syringes exchanged through the New Haven needle exchange program, the data also reveal increases in referral to drug treatment and no change in the number of injection drug users.48

The ideal study for the empirical evaluation of a needle exchange program would involve a large number of injection drug users enrolled in a needle exchange program who were compared with a suitable control group and followed for HIV seroincidence.49 However, in addition to other methodological problems, there is usually no suitable control group. Recently, where one had been identified, a lawsuit was instituted on behalf of the group that would not receive the sterile needles.50 Because of these problems with empirical studies, Kaplan and his colleagues began with the basic idea that needle exchange causes a reduction in needle circulation times, which in turn reduces the probability that different injection drug users will use the same needle and thus reduces the probability of HIV transmission.51

47NRC Report, supra note 5, at 227.
48Id.
49Editorial, supra note 2, at 1890.
NEEDLE EXCHANGE PROGRAMS REDUCE CONTAMINATED NEEDLES

Discarded needles are a major public health and safety problem in the United States. Approximately one million dirty needles are left in public spaces each year in a medium-sized city like Baltimore. The collection of needles and syringes is an important function of needle exchange programs, for they significantly reduce this hazardous biomedical waste. Needle exchange programs usually distribute limited numbers of needles and syringes (10-20) per visit and require the participant to return the needles thereafter on a 1 for 1 exchange. The consequences for public health and safety are obvious, for potentially contaminated needles are not discarded in playgrounds, alleyways, and trash receptacles but are returned for proper disposal.

A study of needle returns at a San Francisco needle exchange program found that, overall, 60% of the needles distributed were returned within the required time periods. The San Francisco program had two stationary sites and two recovery outreach teams. Significantly, 87% of the needles returned were returned to the site of original distribution (88-94% to stationary sites and 74% to recovery teams). A further indication of stability in the user population was the finding that nearly 50% of the distributed needles were returned within two weeks.

Significantly, there was no reported increase in discarded needles and syringes in Connecticut after limited pharmacy sales without prescription were authorized in 1992.

One of the strongest arguments for properly designed and funded needle exchange programs is that the safe disposal of used syringes is not a simple or inexpensive proposition, even for health departments or conventional health facilities. For needle exchange programs with limited resources, proper disposal is a great burden; thus, legalizing and funding needle exchange programs will assure this important task is done properly.

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4Diane K. Sugg, Syringe disposal a sticky problem: City to test bureaucracy drop boxes for dirty needles, Baltimore Sun, June 8, 1996, at 1A.


7Capsule Report, supra note 42, at 3.
LEGAL BARRIERS TO NEEDLE EXCHANGE PROGRAMS

There are a number of legal barriers that prevent programs providing syringes to IDUs from operating effectively. These barriers include drug paraphernalia laws, laws requiring a prescription to purchase and/or possess needles and syringes, and regulations governing pharmacies. Federal restrictions on use of the mails in interstate commerce also have a significant effect on the ability of these programs to exist and function. These restrictions have been extensively described elsewhere in the National Research Council Report and in recent articles in peer reviewed public health journals and medical journals. The description of legal barriers below is drawn from these sources and will only be briefly described.

Forty-seven states, the District of Columbia and the Virgin Islands have drug paraphernalia laws. Of the remaining states, Alaska and Iowa have local provisions which regulate drug paraphernalia in local areas. The large majority of state laws are based on the Model Drug Paraphernalia Act of 1979, which was drafted by the U.S. Drug Enforcement Administration as a reaction to the use of drugs by younger people and the use of the mails to sell paraphernalia. The Act has been broadly interpreted to include any product which is intended to be used to introduce illicit or controlled substances into the body, including needles and syringes. Other federal legislation bars the importation, use of the mails, or other interstate transport for drug paraphernalia. It was clear that these statutes were designed to meet a particular threat and that their effect on facilitating transmission of blood-borne diseases through needles and syringes was not considered.

A far smaller number of jurisdictions, currently eight states and one territory, mandate medical prescriptions for most syringes sales. Ten other states limit prescription sales of...
needles or syringes through law or local ordinance." For example, restrictions by number (Connecticut permits the sale of 10 or fewer syringes without a prescription), by age (Virginia requires a prescription for anyone under 16, and Florida, anyone under 18 years of age), only from an authorized seller or only to persons with a legitimate medical need.

Further barriers are pharmacy regulations established by state pharmacy boards or other government agencies. Twenty-three states restrict access to syringes, limiting sales to persons who need sterile syringes for medical conditions. Some of these states go further and require identification and proof of medical need.

Each of these barriers limits the ability of state or local agencies or organizations to develop and implement HIV reduction strategies, including needle exchange programs. Further, the fear of arrest and incarceration can have a chilling effect on possession of clean needles and syringes even in jurisdictions that have legally authorized or sanctioned needle exchange programs. Thus, both removing legal barriers and providing statutory authorization for these programs will assist in program success.

THE NEED FOR ABA ACTION ON NEEDLE EXCHANGE PROGRAMS

As this report has demonstrated the medical and public health data support the needle exchange program approach to harm reduction for IDUs, their sexual partners, and their children. The Kaiser survey indicates a majority of the public also endorses these measures. Despite this important public support, many national and state public officials remain wary of these initiatives. For example, the President's 1997 National AIDS Strategy contains only one paragraph devoted to the subject of "preventing HIV transmission from the use of contaminated injection equipment," recognizing that the CDC recommends using sterile needles and that removal of restrictions on over-the-counter sale of syringes has resulted in decreased reported needle sharing. On the state level, the Governor of New Jersey rejected the recommendation of the Governor's Council on AIDS, which proposed decriminalizing the sale and distribution of hypodermic syringes and needles without prescriptions and which also encouraged the establishment of community-based needle exchange programs.

Needle exchange programs need support from both the medical and the legal communities. The medical community, through the AMA, already has spoken out on this
issue. The ABA, as a body of lawyers and judges, is uniquely situated to do the same in a dispassionate, deliberative manner. Needle exchange programs, as part of an effective strategy for reducing the rate of HIV infection, are inhibited by legal barriers. The uncertainty generated by such laws and how they will be applied 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."  

The precise legal changes that must be made in a particular jurisdiction to allow needle exchange programs to operate effectively and legitimately are best left to the states and municipalities where the programs are needed. This approach is consistent with the research that demonstrates that needle exchange programs will best succeed where the community is consulted prior to establishment of needle exchange programs and during their continued operation.

CONCLUSION

Given the overwhelming evidence, it is incumbent upon the nation's lawyers, through the American Bar Association, to further legitimate public health, law enforcement, and drug reduction strategies by addressing the legal barriers to needle exchange programs and recommending their removal. The Supreme Court, in the context of considering a risk-benefit balancing involving findings of fact based on reasonable medical judgments given the state of medical knowledge, concluded that "in making these findings, courts normally should defer to the reasonable medical judgments of public health officials." School Board of Nassau County v. Arline, 107 S. Ct. 1123, 1131 (1987). The public health evidence compiled and weighed by the Centers for Disease Control, the National Research Council, and the National Institutes of Health is overwhelming that needle exchange programs reduce HIV infections, will not increase drug activity, will help eliminate contaminated needles, and will increase drug referrals. The overwhelming scientific evidence supports the establishment of needle exchange programs as a considered response to the growing public health epidemic of AIDS. Properly designed programs will enhance public safety and law officer safety by eliminating contaminated needles and by encouraging drug counseling and drug treatment referrals in non-coercive settings.

Leslie A. Harris
Chair, Section of Individual Rights and Responsibilities
August 1997

18Burris, supra note 35, at 1161.
19CDC Report, supra note 25, at 23.
106B

GENERAL INFORMATION FORM
To Be Appended to Reports with Recommendations
(Please refer to instructions for completing this form.)

Submitting Entity: Section of Individual Rights and Responsibilities
Submitted By: Leslie A. Harris, Chair

1. Summary of Recommendation(s).
   This recommendation supports the removal of legal barriers to the establishment and operation of approved needle exchange programs. The recommendation is based on the overwhelming scientific and public health evidence, from more than 100 programs in the U.S. and abroad, that these programs do not increase either the frequency of drug use or the number of drug users, but do reduce transmission of HIV and other blood-borne diseases by injection drug users (IDUs).

   The recommendation specifically requires a component of drug counseling and referrals to drug treatment as part of all approved programs. Among the legal reforms implicated by the recommendation are: (i) exempting needle exchange programs from drug paraphernalia laws; (ii) repeal of pharmacy laws and regulations limiting the sale of syringes without a prescription; and, (iii) modification of drug paraphernalia laws to remove syringes from the scope of those laws. This recommendation will also reduce the number of needles, some of which may be infected with HIV, from streets and playgrounds.

   The recommendation leaves the determination of which legal barriers to remove, in order to facilitate needle exchange programs, to individual jurisdictions; understanding that such determination will turn on the laws, policies, customs and attitudes of each.

2. Approval by Submitting Entity.
   The Council of the Section of Individual Rights and Responsibilities unanimously approved the Recommendation at its fall meeting on November 8, 1996, and agreed to serve as sponsor. The Council of the Criminal Justice Section unanimously approved the recommendation at its spring meeting on April 26, 1997, and agreed to serve as co-sponsor. The Commission on Mental and Physical Disability Law unanimously approved the Recommendation at its spring meeting on April 12, 1997, and agreed to serve as co-sponsor. The National Lesbian and Gay Law Association approved the Recommendation and agreed to serve as co-sponsor on April 12, 1997.

3. Has this or a similar recommendation been submitted to the House or Board previously?
   No.

4. What existing Association policies are relevant to this recommendation and how would they be affected by its adoption?
The ABA has policies supporting voluntary counseling and testing for HIV and mandating the protection of privacy with regard to counseling and testing (1988); prohibiting HIV/AIDS discrimination (1988); and endorsing the global strategy of the World Health Organization for the worldwide prevention and control of AIDS (1989).

An important element apparent in each of these ABA policies is the Association's determination to assist in stopping the spread of HIV/AIDS. The proposed policy will not effect any change in the above policies, but, like them, would further the ABA goal of having the legal field assist, wherever appropriate, in stopping the spread of the virus.

The ABA also has policies calling on the appropriate authorities to provide drug treatment for drug-dependent persons processed through the criminal justice system who desire treatment and for whom treatment is available and urging that the therapeutic process be utilized, in lieu of criminal prosecution, for drug-dependent persons apprehended for simple possession or other consumption-related offenses (1974); and supporting development of a comprehensive, systemic approach to addressing the needs of defendants with drug problems through multidisciplinary strategies that include coordination among the criminal justice, health, social service, and education systems and the community (1994).

The proposed resolution, though only tangentially related to the first policy cited above, is in accord with it in that needle exchange programs can act as a bridge to treatment. While focusing on the legal barriers to stopping the spread of HIV/AIDS rather than focusing on specific drug treatment issues of defendants within the criminal justice system, the proposed resolution also completely supports the second ABA policy cited above.

5. What urgency exists which requires action at this meeting of the House?

Injection drug users, their sexual partners, and their children are the fastest growing risk group for infection with HIV but legal barriers to needle exchange programs and curbs on federal funding have severely limited the availability of these programs. Recent studies in a number of communities have shown that if needle exchange programs had been available, a significant number of lives could have been saved. For example, in the District of Columbia, between 294 and 646 HIV infections could have been prevented and between $16 million and $34 million in medical care costs associated with these HIV infections could have been avoided. It is important to address the legal barriers to needle exchange programs as quickly as possible so that states and local jurisdictions can determine the most appropriate form of program to meet the needs of their particular populations, and begin programs that will help produce the spread of HIV/AIDS.

6. Status of Legislation. (If applicable.)

There is no federal legislation pending that addresses the topic of the proposed resolution. At the state level, New Mexico, in April 1997, became the sixth state (joining Hawaii, Connecticut, Massachusetts, Maryland and Rhode Island) to authorize needle exchange programs as a means of reducing new HIV infections. In addition, without formally authorizing needle exchange programs, Oregon amended its drug law to exempt needles and syringes, and Maine repealed its needle-prescription law. It should be noted, however, that the United States Code Annotated Title 42 (the Public Health and Welfare), Chapter 6A (Public Health Service), Subchapter XXIII (Prevention of Acquired Immune Deficiency Syndrome) disallows federal funding of needle exchange programs until demonstration needle exchange
programs show that they are effective in reducing the risk of HIV infection. The Secretary of Health and Human Services (HHS), in February 1997, transmitted to Congress the results of such studies, which do show the reduction in risk of HIV infection. However, the Code provisions also include the further requirement that such studies demonstrate reduced drug abuse, and although all of the studies indicated that there is no increase in drug abuse, only some were able to show a decrease in drug abuse. Congress has not yet acted on this new information.

Besides the states mentioned above, numerous other states and cities are struggling with responding to the HIV/AIDS health crisis, which is being driven by IDU's, in the face of restrictive legal barriers to needle exchange programs. A few (New York state and the cities of Philadelphia, Cleveland, Los Angeles, and San Francisco) have invoked emergency powers to protect the public health as a means of bypassing state laws which effectively bar the operation of needle exchange programs. This resolution seeks to give relief to those states and cities which are struggling with the legal barriers, and recognizes that the determination of which legal barriers to remove should turn on the laws, policies, customs and attitudes of each jurisdiction.

7. Cost to the Association. (Both direct and indirect costs.)

Adoption of this Recommendation would result in only minor indirect costs associated with Governmental Affairs and AIDS Coordination Project staff time devoted to the policy subject matter as part of the staff member's overall responsibilities.

8. Disclosure of Interest. (If applicable.)

N/A

9. Referrals

The proposed resolution was sent to the following entities prior to submission:
- Criminal Justice Section
- Family Law Section
- General Practice, Solo and Small Firm Section
- Health Law Section
- Litigation Section
- Section of Administrative Law and Regulatory Practice
- Section of International Law and Practice
- Judicial Division
- Young Lawyers Division
- Commission on Homelessness and Poverty
- Commission on Mental and Physical Disability Law
- Coordinating Group on Bioethics and the Law
- Standing Committee on Substance Abuse
- Appellate Judges Conference
- National Conference of Federal Trial Judges
- National Conference of State Trial Judges
- National Lesbian and Gay Law Association
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The Criminal Justice Section, the Commission on Mental and Physical Disability Law, and the National Lesbian and Gay Law Association are already co-sponsors. The Section of International Law and Practice agreed to support the resolution. It is anticipated that several other entities will endorse the resolution prior to its consideration by the House of Delegates.

10. Contact Person. (Prior to the meeting.)

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11. Contact Person. (Who will present the report to the House.)

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12. Contact Person Regarding Amendments to This Recommendation. (Are there any known proposed amendments at this time? If so, please provide the name, address, telephone, fax and ABA/net number of the person to contact below.)

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There are no known amendments at this time.