NEEDLE EXCHANGE PROGRAMS: Considerations for Criminal Justice

“Needle exchange programs can be an effective part of a comprehensive strategy to reduce the incidence of HIV transmission and do not encourage the use of illegal drugs”

-HHS Secretary Donna Shalala, 1998

“The National Drug Control Strategy focuses on the need for drug treatment to help addicts free themselves of addiction and it’s terrible health and social consequences. Federal treatment funds should not be diverted to short term harm reduction efforts like needle exchange programs.”


Without a doubt, reducing the spread of HIV is a national priority. These statements, however, illustrate the challenges facing public health and public safety regarding the issue of Needle Exchange Programs (NEPs) – one strategy in a mosaic of comprehensive HIV prevention programs designed to address HIV infection among injection drug users. This paper will provide law enforcement and criminal justice professionals with information about:

- Why the controversy between public health and public safety about needle exchange programs?
- The numbers detailing the relationship between HIV/AIDS and intravenous drug use;
- How to enhance community health through collaboration between public health and public safety;
- What is an NEP and how does it operate?
- Historical perspective of needle exchange programs;
- Scientific considerations of needle exchange programs;
- Legal consideration of needle exchange programs
- What’s next in the debate;
- Glossary of Terms
- “Playing By the Numbers”

Why the Controversy?

Striking a balance between “feeding an addiction” and preventing the spread of a fatal disease seems to be the core struggle police officials have with NEPs. The dilemma for law enforcement is the possibility of having to enforce laws restricting an intravenous drug user’s (IDU) access to clean needles, while at the same time acknowledging that these very restrictions contribute to the spread of HIV in their community.

To be caught between a public health crisis and the need to appear that they are not backing away from enforcement of illegal drug use is troubling for police. Contributing to this controversy is conflicting information and data, community standards, the concern about the “message” given to children, and often the absence of a cohesive, coordinated, and comprehensive local policy to address the community’s drug abuse issues.
Some police executives see HIV/AIDS prevention among injection drug users as strictly a public health issue and have left prevention to their public health colleagues, avoiding debate on the more controversial issues. Other police executives have joined with their local public health officials in cooperatively advocating for prevention and treatment options and resources. Still others have become involved, both personally and as an agency, in opposing certain prevention strategies for IDUs, including NEPs. Whatever the path chosen by the law enforcement official in the community’s deliberation over prevention and treatment choices, the leadership role of the police executive is undeniable in this debate.

The Numbers

In the United States between 1.1 and 1.5 million people inject drugs. 1 According to the Centers for Disease Control and Prevention, more than one-third (36%) of all reported AIDS cases are due directly or indirectly to injection drug use as are 31% of recently reported cases. 2 It is estimated that 50% of new HIV infections are among intravenous drug users. 3 In addition, minorities and women have been disproportionately impacted by HIV due directly or indirectly to injection drug use. The costs in health care, lost productivity, accidents and crime? More than $50 billion a year, according to the Center for AIDS Prevention Studies at the University of California, San Francisco. The human toll is incalculable.

One hundred and thirteen NEPs are operating in at least 30 states, some legal, some not. Some receive state funding, others local funding, some operate on public and private contributions. 4 In 1997, NEPs reported that 17.5 million syringes were exchanged. 5 In 1998, the estimated number of syringes exchanged was 19.4 million, an increase of almost 11% from the previous year. 6

Increasing Community Health Through Collaboration Between Public Health and Public Safety

Effectively addressing the “twin epidemics” of injection drug use and HIV/AIDS requires a cohesive and concerted partnership between public health, the community and public safety professionals. These groups acknowledge common goals: reduce injection drug use and reduce the spread of HIV. Additional common objectives include implementation of strategies such as early intervention, outreach to addicts to encourage them to accept treatment, increased availability of on-demand treatment, and access to risk reduction information.

Perhaps the most controversial initiative to address the rule of injection drug use in the spread of HIV has been NEPs. NEPs allow injection drug users to exchange used needles for clean ones. In many communities, there are treatment professionals involved in the NEP who provide referrals to drug treatment, medical care and other resources, some of which are offered at the site of the NEP. NEPs are designed to address the problem of sharing used needles and syringes, which contributes to the spread of HIV and other blood borne infections.

Why do drug abusers continue to inject drugs and share needles? There are several factors including the power of addiction, the lack of treatment beds and services, and the scarcity of clean needles and syringes. At any one time it is estimated that 85% of IDUs are not in drug treatment. 7 There is a large unmet need for drug treatment beds and resources (not including treatment for alcohol abuse). 8 The scarcity of clean, sterile needles means that IDUs use syringes multiple times, share needles with other drug users, or use dirty needles they find in areas of high drug use. Therefore, other harm reduction options, including needle exchange, are needed for those who inject drugs. For a definition of “harm reduction”, see the Glossary.

IDUs may make decisions about seeking sterile needles based on numerous factors including how the local police enforce drug paraphernalia laws and the ease with which needles are available. If the search for a clean needle is time consuming and carries a risk of incarceration, the IDU’s decision may be to forego a clean needle. A female heroin addict was “asked why she did carry sterile syringes to use when she injected drugs” “Because, she answered, I would rather get AIDS than go to jail.” 9
Like Secretary Shalala, many public health and medical organizations endorse NEPs as an effective component of a comprehensive HIV prevention program. The organizations supporting NEPs include:

- American Medical Association
- National Academy of Sciences
- American Public Health Association
- National Institute of Health, Consensus Panel
- Centers for Disease Control and Prevention
- American Bar Association
- United States Conference of Mayors
- American Nurses Association
- American Pharmaceutical Association

Several public safety membership organizations, however, following the lead of Drug Czar Barry McCaffrey, have rejected NEPs maintaining that addicts need treatment, not equipment to further their drug abuse. Opponents of NEPs also believe the presence of NEPs endangers law abiding citizens and potentially damages neighborhoods, and children who see the government’s support of NEPs may view this as acceptance or endorsement of illegal drug use.

**Historical Perspective**

A review of how needle exchange programs became a strategy in HIV/AIDS prevention for IDUs is helpful. NEPs evolved in the U.S. as the role of injection drug use in the spread of HIV became clear.

In 1984, the first NEP was started in Amsterdam, Netherlands, to address the spread of Hepatitis B. Two years later, sterile injection drug equipment was first distributed in the United States. In 1988, the first U.S. NEP was established in Tacoma, Washington.

**What is an NEP and How Does it Operate?**

There is not one way to distribute clean needles to IDUs. Ideally, NEPs offer IDUs a non-threatening, public location to bring a dirty needle and exchange it for a sterile one. At the same time, users can be encouraged and supported in taking advantage of treatment options, medical care and other services. In fact, the United States Conference of Mayors suggests that referral to treatment is perhaps the most overlooked and most vital role NEPs play. Of the 110 NEPs surveyed in 1998, many reported providing a wide range of both medical and social services. Among the medical services provided were HIV counseling and testing (64%), Hepatitis C counseling and testing (24%), Hepatitis B counseling and testing (21%), medical care (19%), Hepatitis B vaccine (16%), TB screening (15%), and STD screening (13%). On-site social services provided included food (36%), assistance in enrolling in welfare and/or Medicaid (25%), transportation (23%), legal assistance (16%), housing services (16%), and nutrition/vitamin therapy (13%).

Three major trends illustrate how NEPs have coming into being:

- Civil disobedience;
- Gradual community acceptance and legitimization; and
- Local community or foundation funding and support.

**Civil disobedience**, designed to challenge existing law and provide IDUs with sterile equipment even when illegal, marked how some NEPs got started. This approach brought NEPs into the news and public
consciousness and began to underscore the connection between injection drug use and the spread of HIV disease. Ultimately, some NEPs were established after much community coalition-building.

Gradual acceptance. Some NEPs that were once illegal have been legitimized and actually receive funding from local governments. In a 1998 survey, 25% of the NEPs responding indicated their status as “illegal-underground”, with another 22% indicated their status as “illegal-tolerated.”

Toward legitimacy – the funded model. Several NEPs now get local, state government and/or foundation funding. Of the 110 NEPs responding to a 1998 survey asking the source of their funding, some from multiple sources, 34 indicated they were receiving state funding, 15 city funding, 12 county funding, 53 were funded by private foundations, 30 funded by individual donations, 3 by corporate donations, and 19 indicated no specific funding source.

Federal funding? The issue of federal funding for NEPs has been a complicated one. There have been five different bans on the use of federal funds for NEPs. In 1998, Health and Human Services Secretary Shalala supported lifting the ban on direct federal funding for NEPs, and Drug Czar Barry McCaffrey, opposed it. Ultimately, the Clinton administration decided to continue the ban reasoning that it was best to have local communities use their own dollars to support NEPs. Although the federal ban remains on funding for NEPs, federal funds are used by researchers to summarize current information and collect new data so that communities can construct the most successful programs possible to reduce the transmission of HIV, while not encouraging illegal drug use.

Scientific Considerations

What does the scientific research tell police executives about the impact of NEPs on illegal drug use, access to treatment, the spread of blood borne diseases, community safety, and the behavior of IDUs?

Scientific research in the last decade suggests several public health benefits of NEPs including: reduction in risk behavior; reduction in the incidence of HIV and other blood borne infections; and greater access to drug treatment and other HIV prevention services. Indeed, after reviewing all of the research, HHS determined “that there is conclusive evidence that needle exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs.

Risk Reduction. Behaviors of IDUs before and after participating in a NEP have been compared. Studies reveal a significant drop in high risk behavior. There is less sharing of drug paraphernalia and ore use of sterile needles. In Baltimore, when comparing behaviors over a two week period following enrollment in the NEP, based on self-reporting the lending of used needles decreased from 34 percent to 15.5 percent. So did the borrowing of syringes (down from 23.2 percent to 11.1 percent). Studies in New York, Portland and San Francisco, where NEPs operate, report level or decreased injection drug use.

In March 1997, the National Institute of Health reported that NEPs “show a reduction in risk behaviors as high as 80% in injecting drug users, with estimates of a 30 % or greater reduction of HIV.”

- Incidence reduction. Recent studies described in the National Research Council’s review of NEPs, have found direct evidence of substantially lower rates of new HIV infection among New York City’s IDUs. Researchers credited the New Haven NEP with a 33 percent reduction in HIV incidence. In Baltimore, after eight years of follow-up, HIV incidence decreased 35 percent. The connection between NEPs and reduced infection is not limited to HIV. In Pierce County, Washington,
research indicates that Hepatitis B and C cases attributable to injection drug use declined by more than 75 percent within two years after a NEP was established. These findings suggest a community-wide effect of the NEP in Baltimore.

- In Hawaii the state department of health funds the NEP. In addition to the needle exchange, the program operates a centralized drug treatment referral system, a methadone clinic and a peer-education program that uses IDUs who use the NEP to reach IDUs who do not. The results of Hawaii’s program? Rates of HIV among IDUs have dropped from 5% in 1989 to 1.1% in 1994 -1996. From 1993 through 1996, 74% OF Hawaii’s NEAP clients reported no sharing of needles. Additionally, only 18% of The AIDS cases reported in Hawaii during 1997 were related to drug injectors, as compared to one-third throughout the rest of the United States.

- The bigger picture. NEPs serve as conduits to drug treatment and other HIV and drug prevention services. They have become a “necessary component of a broader, more comprehensive HIV prevention plan.” In Baltimore, for example, the number of IDUs participating in drug treatment went up from 8 percent to 18.8 percent. In Baltimore, when comparing crime trends in NEP areas to non-NEP neighborhoods, no significant differences were found in any drug-related arrest categories, such as drug possession, economically motivated crimes, resisting arrest or violence. In fact, no differences in the incidence of crime were found at all.

The scientific community’s support for NEPs offers a bright star in the constellation of HIV prevention for injection drug users. The benefits of NEPs, however, are not limited to IDUs and the public at large. Criminal justice has realized some benefits. The benefits are noted by Fred H. Lau, San Francisco Chief of Police, in a letter to HHS Secretary Donna Shalala:

“Of significant importance to our officers is the positive impact that needle exchange has had on public safety. Offices report that needle sticks are less likely to occur during routine “pat-downs” because exchange syringes tend to be capped. This fact, in addition to removing dirty syringes from the streets, thus removing potentially dangerous biomedical waste from the community, and providing participants with referrals to health care and drug treatment programs certainly help prove that the needle exchange program is beneficial to the public health and safety in our community.” March 1, 1998.

Legal Considerations

An overview of the legal issues associated with NEPs provides a perspective for law enforcement executives. This overview may also provide a frame of reference as to how NEPs are becoming acknowledged as a legitimate option for addressing a public health crisis. Having a NEP as part of an HIV prevention strategy is consistent with public health experts’ advice on achieving harm reduction. Yet, following this advice may have legal consequences. In states where NEPs are not legal, program staff and IDUs face arrest and prosecution for possession of drug injection equipment. In addition, arrest with this equipment could lead to charges for possession of drugs if there is enough residue on the syringe or needle.

The most recent survey of NEPs found that, as noted earlier, 25% of the 100 programs responding were “illegal-underground,” meaning that they operate in a state with a prescription law and do not have formal support of local elected officials. Twenty-two percent (22%) of programs reported that they were “illegal-tolerated,” meaning that they operate in a state with a prescription law and received a formal vote of support or approval of a local elected body. Fifty-three percent (53%) of programs considered themselves to be “legal” meaning they operate in a state that has no law requiring a prescription to purchase a hypodermic syringe or has an exception to the law allowing the SEP to operate. The survey further reported that the number of “legal programs” has grown from 33 in 1995 to 59 in 1998.
tolerated” programs have grown from 19 to 24 in the same time period, and the “illegal-underground” programs had increased from 8 to 27 during the four years. 31

Those who advocate for NEPs have used several legal strategies to keep operating: (1) arguing that greater public health interest trumps the drug paraphernalia laws, an argument supported by several courts; (2) using a “necessity” defense in criminal cases; and (3) getting municipal officials to declare a “public health emergency.”

Judicial Declarations. When public health and public safety officials disagree on the use of NEPs; courts have decided which set of laws should take precedence. This helps avoid having two governmental agencies undermine each others’ goals and programs. 32 This was the strategy used in the State of Washington, for example, where courts, including the state Supreme Court found that certain state statutes empowered the health department to prevent the spread of blood borne pathogens. 3

The “Necessity” Defense. In defending against prosecution, some NEPs have argued that they “acted out of necessity . . . [claiming their] actions are legitimate because they were necessary to avert a greater harm . . . the imminent danger of needle-borne transmission of disease.” 34 Elements of this defense are: (1) the action was necessary to avoid imminent danger to a person or the public; (2) the harm causes by the action is not disproportionate to the harm avoided; (3) the defendant acted under a good faith belief that the action was required to prevent a greater harm; and (4) the defendant believed that his/her actions were reasonable at the time. 35 Courts have come to different conclusions in applying this defense. Courts in New York and New Jersey have upheld the defense in the context of NEPs while the Massachusetts Supreme Judicial Court refused to allow the defense to be considered.

Medical Emergency. Several municipalities in California have declared local states of emergency to allow NEPs to operate. The legal viability of this strategy remains unclear: “State law takes precedence over local law, so technically, state drug paraphernalia and syringe prescription laws continue to apply.” 36

What’s Next?

At their core, police and public health officials have the same mission: to ensure and protect the health and safety of the public. Ideally, achieving that goal in the context of injection drug use should reinforce, not undermine, their responsibilities: “The regulation of drug paraphernalia laws must assist police and law enforcement in their attempts to prevent and punish the sale and use of illicit drugs, but should not interfere with public health measures to prevent blood-borne disease.” 37

Until cures are found for blood-borne diseases like HIV and Hepatitis C, prevention is the best way to fight them. NEPs remain an important strategy for doing do.
To be sure, NEPs are not appropriate for every community. A case-by-case analysis should be made by the community, public health officials and police as this option is considered. This analysis could include such things as:

- The role of IDU plays in the spread of HIV and other blood-borne diseases in the community;
- The availability of other strategies for preventing the spread of disease among IDUs;
- How the NEP would fit into the overall picture of public health and drug treatment;
- The legal barriers that may exist, such as the presence of drug paraphernalia laws; and
- The availability of funding for the NEP.

To the extent that a NEP is found to be an appropriate and viable option, it should strive to:

- Expand access to substance abuse treatment, education and counseling;
- Be part of the community’s efforts to discourage illegal drug use;
- Coordinate with local law enforcement to offer training for offices and joint planning activities;
- Encourage and support crime prevention; and
- Rehabilitate IDUs.  

Endnotes

12 Ibid.
13 Ibid.
15 Gostin, page 23.
17 Strathdee, Steffanie, Ph.D., Associate Professor, Johns Hopkins University, School of Public Health and Hygiene, Summary of Research Findings – Needle Exchange Programs in Baltimore.
18 Ibid.
19 Gostin, page 25.
22 Ibid.
23 Strathdee, Steffanie, Ph.D., Associate Professor, Johns Hopkins University, School of Public Health and Hygiene, Summary of Research Findings – Needle Exchange Programs in Baltimore.
24 Ibid.
25 Ibid.
28 Strathdee, Steffanie, Ph.D., Associate Professor, Johns Hopkins University, School of Public Health and Hygiene, Summary of Research Findings – Needle Exchange Programs in Baltimore.
29 Ibid.
30 Ibid.
34 Gostin, page 27.
35 Ibid.
36 Ibid., at 29.
37 Ibid.
38 Ibid., at 28.