Doffing the cap: increasing syringe availability by law but not in practice, Connecticut, 1999

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Abstract

Syringe exchange programs (SEP) have been established and their numbers have increased in the United States over the decade of the 1990s. Among the states leading in the development of exchanges has been Connecticut, which established its first legal exchange in 1990. But this has occurred in tandem with state regulations that have reduced program effectiveness. One such regulation is the existence of a cap on the number of syringes that can be exchanged. Originally set at five syringes per visit, the cap was increased to 10 in 1992 and to 30 in 1999. We have explored the history of the cap on exchanges, focusing on the 1999 change in the statutes governing syringe exchange and syringe availability. We describe the research demonstrating the effects of the cap and the structural reasons why increasing the cap, although necessary, has not been sufficient to improve syringe exchange program effectiveness. © 2001 Elsevier Science B.V. All rights reserved.

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Introduction

Injection drug use is a major risk factor for HIV infection and AIDS, accounting for approximately one quarter of AIDS cases in the United States and one-tenth of AIDS cases worldwide. Although HIV is transmitted among drug injectors primarily by shared syringes, injection-related risk is largely a consequence of the structural context of drug use. When injectors obtain health promoting information and when access to clean syringes is increased, the combination has proved effective in keeping HIV transmission low (Des Jarlais et al., 1995a,b; Drucker et
Interventions, that have proven successful in preventing the spread of HIV among injectors have focused on decreasing injection through substance abuse treatment, on decreasing syringe sharing through education and behavior change, and on increasing the availability of clean syringes through legalizing syringe purchase and possession and by establishing syringe exchange programs (SEPs) (NIH Consensus Development Program, 1997; Needle et al., 1998). The last of these interventions remains exceedingly controversial in the United States. Public health officials and AIDS activists have supported SEPs, calling for their expansion and for increases in public funding. They have been opposed by drug control officials and conservative politicians and community groups, who have tarred SEPs as promoting drug use and have prevented the expenditure of federal funds for their operations.

Even in locations within the United States where SEPs have been established, the creation of the local context necessary to optimize program operations has been hampered by political opposition. The opposition to SEPs has led to compromises that have undermined SEP effectiveness. One such compromise was the institution of a cap on the number of syringes that could be exchanged at SEPs in the state of Connecticut. The cap served both symbolic and functional purposes, symbolically appearing to give the SEP control over syringes, while functionally restricting syringe supply. The limitations on the syringe supply have troubled public health professionals and AIDS activists, who have urged that caps be lifted. However, raising the cap has been construed by SEP opponents as a concession to drug users and a threat to communities, who fear uncontrolled distribution of syringes. Attempts to lift caps have made clear the limitations to challenging the social and political factors underlying restrictions on SEPs. The political realities in the United States are such that the struggles to lift the cap on the number of syringes that an SEP can exchange are as symbolic as their initial imposition.

In this paper, we will detail the legislation regarding the cap in the state of Connecticut. This necessitates that we first outline the history of the legislation in Connecticut, detailing both the successes and failures of the state’s policies regarding increased access to clean syringes. Then we will detail the activism that led, during the state legislature’s 1999 session, to changes in syringe exchange laws, including an increase in the cap. Finally, we will describe how the intent of the legislature was subverted, and the stipulated changes delayed or not implemented. Throughout, the focus will be on, but not limited to, the cap. As we come to understand how the cap became part of the legislation permitting SEPs, what consequences it has had for injection-related risk behaviors, how it has been increased to permit increased access to clean syringes, and why the recent amending of the statute regarding the cap, by itself, might be insufficient, we can come to some more general conclusions regarding structural impediments to increasing syringe availability.

**Syringe regulation, 1990–1998**

The New England State of Connecticut was among the first US jurisdictions in which local political organizing was instrumental in gaining legal acceptance of and the allocation of state and municipal funds for SEPs (Fig. 1). The history of Connecticut’s experiments with increasing syringe availability began in 1987 with 3 years of lobbying on the part of New Haven’s AIDS activist community (O’Keefe, 1991). The lobbying effort was
originally designed to repeal the state law banning the purchase or possession of syringes without a prescription, as a prerequisite to starting an SEP. However, the long process of lobbying necessitated coalition building and legislative compromise. When legislation finally passed in 1990, it was accomplished as a modification of the existing statute prohibiting syringe possession and sales without a prescription. The compromise permitted a demonstration SEP as an exception to the syringe prohibition legislation, which remained otherwise in force, and gave some state financial support for program operations. In return, the demonstration SEP was required to keep records of all exchanges, to follow a strict one-for-one exchange policy with a cap of five syringes per exchange, and to have a written evaluation of the program completed within 1 year of the program’s start. The cap of five and strict exchange policy were included to allay fears that the demonstration SEP would become a syringe distribution rather than exchange program and that discarded syringes would inundate the streets of New Haven.

The first legal SEP in New England began operating in New Haven, CT in November 1990. Because outreach teams had already generated interest among potential SEP customers, more than 200 different customers visited the SEP within its first 30 working days. By the end of its first year of operations, this number had increased to more than a thousand (Heimer et al., 1993; Khoshnood et al., 1995). Furthermore, by the time
the SEP started, an evaluation system based on syringe tracking and testing was ready to be implemented by a team of researchers at Yale University (Kaplan, 1991; Heimer et al., 1992). As mandated by the state, the results of an evaluation covering the first 6 months of data collection were released in July, 1991 (O’Keefe et al., 1991). The report, including demographic, drug use, HIV risk behavior data from 720 SEP customers and 1370 syringe tests, concluded that the SEP was likely to have reduced HIV transmission by one-third (Kaplan and O’Keefe, 1993). The data also indicated that one out of four customers requested and one out of seven customers entered substance abuse programs as a result of referrals through the SEP (O’Keefe et al., 1991; Heimer and Lopes, 1994). The report was front-page news (Navarro, 1991).

The striking results and conclusions drawn from the New Haven SEP evaluation had significant political consequences in the Connecticut state legislature the following year. Three pieces of legislative reform were enacted in 1992 that greatly expanded the availability of clean syringes. First, the state legislature increased the number of sanctioned and funded SEPs, adding programs in Bridgeport, Danbury, Stamford, Windham, and Hartford, the state capital (Fig. 1). Second, the state repealed legislation making it a crime to purchase or possess ten or fewer syringes without a prescription. Finally, because the decriminalization legislation called for a cap of ten syringes, the SEP legislation was amended to raise the cap on the number of syringes which could be exchanged per visit to ten as well.

The new SEPs began their operations in early 1993, several months after many pharmacies began to sell syringes to drug injectors (Singer et al., 1995). As a result of decriminalization, injectors reported engaging in less HIV risk behavior (Groseclose et al., 1995). However, the liberalized policy and increased syringe availability did not remove all the obstacles to safe syringe acquisition. The cap, doffed but not removed, was only one of at least five limitations, which functioned to slow the progress of expanding syringe availability implicit in the legislation. These limitations have continued to hamper public health efforts to reduce the spread of syringe-borne infectious diseases among Connecticut’s injectors.

First, newfound legislative support for SEPs did not extend so far as to revoke all statutes restricting syringe possession. There remained an additional legal hurdle to promoting syringe hygiene in the form of an anti-paraphernalia law, a type of legislation common in many states (Gostin et al., 1997). Prior to 1992, possession of syringes without a prescription violated this law, and syringes confiscated from injectors, as well as the contents of those syringes, could be used as evidence against them. Although the anti-paraphernalia law was amended so that possession of ten or fewer syringes no longer qualified as paraphernalia, police routinely behaved as though the previous restriction remained in force, claiming that possession of even one syringe was illegal. Moreover, possession of a used syringe with ‘an unweighable quantity of narcotics’ was not explicitly made legal (Connecticut Law Revision Commission, 1997). As a result, injectors transporting used syringes to SEPs for exchange placed themselves at risk for arrest and prosecution. The consequences of this became apparent during the course of research project on a peer-driven intervention to promote HIV prevention among injectors conducted in eastern Connecticut (Broadhead et al., 1995). Injectors in two Connecticut communities (including one with an SEP) were interviewed in evaluating this project. The data from the structured questionnaire used dur-
ing these interviews revealed that fear of arrest or harassment was cited by the majority of injectors as the reason why they chose not to carry syringes with them when they left home (Grund et al., 1995). The authors concluded that, by failing to carry syringes with them, these injectors were placing themselves at risk for having to share syringes with other injectors and that this risk was as a direct consequence of perceived police practice.

Second, SEPs did not receive adequate financial or operational attention. This led to low attendance at some SEPs, and led local activists and health professionals to discount their community’s need for their SEP. The inadequate support resulted, in turn, in the inability of these SEPs to actively work to increase their customer base. This chain of events has doomed SEPs in Stamford and Danbury to marginal status, serving less than 10% of injectors estimated to reside in those cities (Rawji, 2000).

Third, the state’s model program, the New Haven SEP, stagnated following its heyday prior to the 1992 legislative changes, in part as a consequence of the legalization of non-prescription pharmacy syringe sales. Syringe availability through pharmacies drew injectors away from SEPs. The number of customers at the New Haven SEP was reduced by half (Heimer et al., 1996a,b), and the SEP went from serving injectors from 26 different cities and towns, prior to decriminalization, to serving injectors from only five. While pharmacy access to syringes has much to commend it, SEPs do more than exchange syringes (Heimer, 1998a). The benefits of SEPs, including dissemination of health promoting information and materials, referrals to medical and social services, and facilitated entry into substance abuse treatment (Heimer, 1998b), were harder to access by injectors who chose to get their syringes from pharmacies. As participation decreased, the New Haven SEP failed to develop strategies that retained old customers or brought in new ones. Part of their inability to recruit new clients can be attributed to the syringe cap, which gave the SEP no competitive edge over a pharmacy as a source of syringes. As the number of the customers decreased, real funding levels also decreased. In effect, many of the New Haven neighborhoods served by the SEP at its zenith were neglected after the passage of the 1992 legislation.

Fourth, the cities with new SEPs had not undertaken the political lobbying that preceded the establishment of the demonstration SEP in New Haven. The newly established SEPs were not necessarily viewed with sympathy by the municipal health departments that were called on to operate them. This problem has been documented in the analysis of the growing pains of the SEP in Hartford (Heimer et al., 1996a,b). Lack of administrative support led to a curtailment of SEP activities and services. Within 3 years of its establishment in the spring of 1993, the Hartford SEP was moribund. It was resuscitated only by transferring program operations from the city health department to a non-profit AIDS service organization.

Fifth, negative publicity surrounding an incident in Windham in which a young girl was stuck by a needle discarded in her front yard brought community opposition to SEPs to a crescendo (Broadhead et al., 1999a). The SEP did not respond effectively. It neither challenged their perceived responsibility for the incident nor lobbied for support. With neither local nor state health department support, the SEP closed in March 1997. In addition, the negative publicity caused five of seven local pharma-
cies to stop selling syringes to individuals who did not have prescriptions, despite the legality of such activity. It has been clearly demonstrated that the loss of easy access to syringes placed injectors in the northeastern Connecticut city at elevated risk for syringe-borne infectious disease in the months following the closure (Broadhead et al., 1999b).

Thus, by the middle of 1997, the number of legal SEPs in Connecticut had shrunk from six to five and only the Bridgeport SEP was operating anywhere near maximum effectiveness. The problem was exacerbated by the reluctance on the part of the state Department of Public Health to ask for increased state funding for the fledgling SEPs. State officials expressed concern that merely raising the issue with the legislature might result in decreased funding or even a resumption of prohibition. This reluctance to publicly discuss the needs of SEPs precluded any criticism or reevaluation of the strict one-for-one exchange and syringe cap policies. It should be kept in mind that this was occurring at the same time that panel after panel of experts looking into American SEPs were concluding that SEPs were effective HIV prevention measures and that the evaluation of the New Haven SEP made the strongest case for SEPs’ effectiveness (Lurie et al., 1993; Nadel, 1993; Normand et al., 1995; NIH Consensus Development Program, 1997). Therefore, the failure of the state Department of Public Health to fully support syringe exchange was based on political and not on public health considerations. During this period, whenever the AIDS activist or harm reduction communities would urge the health department or its executive personnel to promote SEP expansion or increased funding, the specter of the SEP closing in Windham would be raised by the Department of Public Health.

Research on Connecticut’s SEPs: focus on lifting the cap

While there was little progressive activity in the political arena between 1992 and 1999, there was considerable research into the operations and efficacy of the state’s SEPs. Three different research groups, studying different Connecticut SEPs, have provided as comprehensive a picture of SEP operations and effects as has been assembled anywhere. As the data continued to accumulate, epidemiological evaluations of program operations made clear that the SEPs were not living up to their potential. An evaluation of the New Haven SEP was conducted from 1990 to 1995, while other teams of researchers received funding to undertake evaluations of the Hartford and Windham SEPs. The evaluation in New Haven was conducted from the inception of the program in 1990 and continued into the era of syringe decriminalization, and the evaluation in Hartford ran from April 1993 to March 1997 (Heimer et al., 1996a,b; Singer et al., 1997). Both relied on the syringe tracking system that allowed researchers to know whether syringes returned to the SEP originated with the SEP (Kaplan, 1991). By determining the percentage of program syringes returned, the degree to which the SEPs met their customers needs could be measured. In New Haven, return percentages started very low (less than 25%) and increased to more than 60% (Fig. 2A). In Hartford, return percentages in the range of 50–65% were observed throughout the 4 years of study (Fig. 2B). If the SEPs were completely meeting the needs of the customers, then all returned syringes would be replaced by program syringes and eventually all returned syringes would have originated from the exchange. Instead, it is clear that the gap between an ideal 100% return rate and that achieved by the SEPs demonstra-
Fig. 2. Return of program syringes to Connecticut syringe Exchange Programs (SEPs). Syringe tracking permitted the determination of the percentage of syringes returned to SEP, which originated therefrom. This percentage is an estimate of the extent to which the SEP meet the syringe needs of its customers. (A) Return percentages for the New Haven SEP were calculated monthly for the first 38 months of SEP operations. (B) Return percentages for the Hartford SEP were calculated periodically during syringe collection periods from the start of SEP operations through July 2000.

Fig. 3. Reuse of syringes by SEP customers. Syringe tracking data were used to estimate the number of times syringes were used by New Haven SEP participants before the syringes were returned to the exchange. The mathematics of the estimates and data for the first twenty months have been described previously (Heimer et al., 1998).
program increased its reach during its initial months of operation, the average number of injections per syringe fell to four. By 1993, the number dropped to an average of three injections per syringe. The bad news was that the number did not approach one. In Hartford, data collected in 1998 present a less sanguine picture of the benefits from SEP participation. Regular customers still reused their syringes an average of nearly seven times, non-customers reused their syringes eight times, and only one in eight injectors reported using their syringe once and once only. Thus, injectors, even those who were regular SEP customers, failed to obtain enough syringes to inject safely.

It is worthwhile contrasting the Connecticut data with those from the Chicago Recovery Alliance SEP (Heimer et al., 1998). During the period of study, the Chicago SEP operated with no cap on the number of syringes per visit and an exchange policy that resulted in the distribution of approximately 10% more syringes than were returned. Chicago SEP customers reported that prior to the start of the exchange they reused their syringes an average of nine times, a number similar to that found in New Haven prior to the start of its SEP. However, once the Chicago SEP was operating, customers reported using their syringes an average of 1.5 times. Furthermore, the median and modal number of injections per syringe were one, approximating the ideal. The political climates in Connecticut and in Chicago were generally similar; the SEPs were not the central focus of either state’s AIDS prevention efforts and the programs in both places had experienced repeated manpower shortages and financial constraints. However, the Chicago SEP had never been encumbered by a cap. This suggested that lifting the syringe cap and one-for-one exchange restrictions might assist Connecticut SEPs in better serving their customers.

The campaign to lift the cap, 1999

Based upon the research record, lifting the cap was identified as a priority when a coalition of Connecticut AIDS activist groups met before the beginning of the 1999 state legislative session to set their legislative agenda. The coalition consisted of a few of the original activists who had helped bring needle exchange to Connecticut in 1990, advocacy organizations supporting harm reduction, representatives of municipalities currently operating SEPs, and researchers whose data had identified programmatic successes and weaknesses. The coalition developed policy proposals in conjunction with a professional lobbyist, setting as its goals an increase in the cap on the number of syringes that could be exchanged to 30, an increase in state funding for SEPs, the establishment of a pilot syringe disposal project with a university based evaluation, and a change in the law to allow SEPs to give a first time customer an Early Intervention Package that included up to 30 syringes and HIV prevention and substance abuse treatment information. The packages, it was felt, would be a boon in recruiting and retaining new customers who often arrived at the SEP without any syringes to exchange and were often turned away empty-handed never to return. While the coalition would have preferred abolishment of the cap, it recognized the incremental nature of public policy change, and decided that a request to completely remove the limit on the number of syringes that could be exchanged was not feasible in the existing political climate.

Preparation for the legislative session began with recruitment of individuals from municipal, academic, legal, and advocacy organizations to support a year-long campaign to improve the state’s SEPs. The coalition also courted key legislators, especially those who headed relevant legislative committees, and
individuals at the State Department of Public Health. Meetings with these individuals revealed that while they wholeheartedly supported the coalition’s efforts, they unanimously felt that organizing around the proposed changes should be done cautiously and quietly. This caution was based on the concern that despite a decade of existence in Connecticut, SEPs remained controversial. The closure of the Windham SEP served as a constant reminder of the vulnerability of the state’s SEPs.

On March, 24, the Senate Public Health Committee quietly introduced Senate Bill 1378, An Act Concerning Needle Exchange Programs. When a public hearing was held the following week, the coalition took advantage of the opportunity to present the rationale for the desired changes intended to promote increased syringe hygiene. The Connecticut Association of Directors of Public Health supplied written endorsement of the legislative changes. Testimony offered by SEP staff and one of the New Haven evaluators focused on the cap. They contended that the ten-syringe cap and the one-for-one exchange mandate impeded progress toward reducing the spread of HIV among injectors and prevented SEPs from serving new customers effectively. They argued that these restrictions prevented hundreds of individuals from establishing contact with the program, and called for statutory allowance of the Early Intervention Packages. They also called for a demonstration syringe disposal program modeled after one in Baltimore, MD (Riley et al., 1998). All those testifying at the hearing called for increased funding for the state’s SEPs and for expansion of programs to new cities. No one testified against the bill at the public hearing.

Two weeks later the joint Senate and House Public Health Committee issued a unanimous favorable recommendation for a substitute bill, which kept the original language of Senate Bill 1378, and added a section which changed Connecticut’s anti-paraphernalia law to allow for possession of 30 syringes. The approved Bill contained language that reflected the full range of the coalition’s demands.

The bill was then referred to the Appropriations Committee, which holds authority over all State expenditures. Although the Appropriations Committee leadership was supportive of the changes and had been involved in the original struggle, in 1990, to bring syringe exchange to Connecticut, they raised concerns that a contentious debate might occur if the bill were discussed in the Appropriations Committee. They worried that such a debate might even jeopardize the existing programs. The coalition was informed that their desired changes would be included in a bill to be later submitted to the legislature, but would not be debated in the Appropriations Committee. At this point, coalition members could only wait and see if, as promised verbally, their desired changes would be implemented by the end of the session.

On the final day of the legislative session, a bill for the budget of the Department of Public Health, which did indeed include the desired changes, was introduced. However, the session ran very long and the bill not called until 23:30 h. A constitutional requirement that the legislative session end at midnight meant that although the bill was called, it could not be acted upon before the session officially ended. Therefore, the 1999 regular session of the Connecticut General Assembly ended without the approval of the coalition’s desired changes.

Because bills for several departmental budgets had not been approved, the governor called a special legislative session to convene 1 week after the end of the regular legislative
session. Now that the proposed legislative changes were in the open, there was time for opposition to organize against the new provisions. Indeed, opposition did arise from several legislators who had routinely opposed SEPs. They announced their intention to submit an amendment to strike the changes in the legislation. Although in the end these legislators never did propose their amendment, some of the language in the original bill was weakened to placate them. The proposals to expand SEPs to new communities and to establish a demonstration syringe disposal scheme were dropped. The final approved language in the amended statute governing SEPs read in part.

The programs shall...(A) provide that program participants receive an equal number of needles and syringes for those returned, up to a cap of 30 needles and syringes per exchange; (B) provide that first-time applicants to the program receive an initial packet of 30 needles and syringes, educational material and a list of drug counseling services; and (C) assure, through program-developed and (Connecticut Department of Public Health) commissioner-approved protocols, that a person receive only one such initial packet over the life of the program...

In addition, a change in the drug paraphernalia statute specifically exempting the carriage of 30 or fewer syringes was approved. The cap was legally increased to 30 syringes per visit and the syringe paraphernalia law was greatly relaxed beginning October 1, 1999.

Implementing the new legislation

But like a cap, which is politely doffed and replaced, the cap of ten syringes per exchange did not disappear on October 1. In Hartford, the cap policy was changed 2 weeks after the law took effect. However, the tracking of syringes as part of an ongoing research study has detected no increase in the number of syringes exchanged and no increase in the number of syringes exchanged per visit to the SEP. This study was designed to investigate the relationships among neighborhood availability of legal syringes either through SEPs or pharmacies and individuals’ level of HIV and hepatitis risk from their practices in syringe access, use, and discard (Singer et al., 2000). Recent interviews with SEP customers enrolled in this study revealed that individuals rarely exchanged more than five syringes per visit and less than 1% of exchanges described by customers reached the cap. In addition, the percentages of returned syringes originating from the exchange has not changed, suggesting that the Hartford SEP continues to fail to meet the needs of its customers (Fig. 2B). In New Haven and Bridgeport, the increased cap did not become official policy until November, 1999 and January, 2000, respectively.

Progress regarding the Early Intervention Packages has been even slower. Extra syringes for first-time customers began to be distributed in December, 1999 by the New Haven SEP and in April, 2000 by the Bridgeport SEP. However, such distributions have occurred only on occasion, on an ad hoc basis. Neither SEP has prepared comprehensive Early Intervention Packages to be kept on their van for new customers as they arrive. The Hartford SEP has been so concerned about the negative publicity that might occur were a non-injector to receive a free package of syringes that packages have not been made available in Hartford at all. Furthermore, the state requirement that SEPs document that an injector receive one and only one Early Intervention Package has discouraged the SEPs in New Haven and Bridgeport from using the packages as outreach tools as originally intended.
Several non-programmatic factors impeded implementation of the new law. One factor was bureaucratic difficulties between the Connecticut Department of Public Health, charged with approving protocols to lift the cap, and the five extant SEPs, which were given the responsibility for crafting the protocols to implement the increase and for the distribution of the Early Intervention Packages. The primary bureaucratic obstacle was that state officials failed to inform the SEPs what was expected of them and informed them instead that the Department of Public Health was 'looking into the matter'. This information was repeated at quarterly meetings of state officials and local SEP personnel held after the amended law was passed and again after it was to take effect. The poor communications were worsened by a contemporaneous but unrelated evaluation of SEP operations by the Department of Public Health. Such an evaluation had been long overdue, but because the impetus for the evaluation was top-down from the state to the local agencies running the SEPs, it was viewed with suspicion by the SEPs. Suspicion was not alleviated by the way the evaluation was conducted. Department of Public Health leadership of the evaluation changed mid-project, confusing the local SEPs. Making matters worse, the Department of Public Health chose not to disclose the report, either to public or to the SEPs. Part of this was due to the unflattering nature of the report, which identified many of the SEPs' limitations. Most of these shortcomings had been recognized by the SEP staff themselves, and had contributed to the formation of legislative lobbying to amend the SEP statutes, the Department of Public Health was reluctant to air the SEP shortcomings. It did not want to give mixed signals by urging the state legislature to increase SEP liberties and funding while at the same time reporting that the SEPs were not functioning smoothly. The failures to elicit full SEP cooperation in the evaluation and to release the report to the SEPs worsened communication between the SEPs and the Department of Public Health.

Another important bureaucratic obstacle was a lack of funding to act on the legislative change. The state initially informed the SEPs that no new funds would be available to cover the anticipated increase in syringe demand, to prepare and distribute the Early Intervention Packages, or to increase their community outreach. When the Department of Public Health announced, months later, that some additional funding for the SEPs was to be made available, it was stipulated that this money was to be used to establish a uniform computer-based data collection and reporting system. This increased the friction between the state and the municipal programs because program staff had hoped to use the funding to increase the street presence of the SEPs. They felt that using the funds for system-wide changes was a misallocation of funds intended to strengthen their programs.

A second type of factor compromising the impact of the new legislation was police actions. The police had routinely harassed and arrested those carrying syringes, ignoring the amended 1992 paraphernalia statute. The practice continued after the 1999 change took effect, despite the clear intention of the law to exempt possession of 30 or fewer syringes from legal sanction. In Bridgeport and Hartford, SEP customers have continued to report routine police harassment based on syringe possession. As a result, SEP customers have tended to keep their contact time at the SEP short, to keep their identity concealed from the police. Even in New Haven, where general tolerance of the local SEP has extended over a
decade, individual policemen have, on occasion since October 1, stopped individuals whom they suspected to be injectors and frisked them for syringe possession. These incidents have been widely spread by word of mouth in the drug injector community and have effectively hamstrung HIV prevention efforts. The retention of this status quo has made the SEPs reluctant to expand their activities and SEP customers reluctant to carry large numbers of syringes for exchange. The SEPs have only recently undertaken a comprehensive campaign to educate their customers about the protections they are entitled to under the amended syringe paraphernalia statute, a year after its passage.

Conclusion

In summary, SEPs in Connecticut may now legally distribute more syringes than they could a year ago, but the political, economic, and administrative support that would enable SEPs to actually do so has been absent. Attempts to develop a coherent and comprehensive program for increasing syringe availability have been hobbled by opponents of harm reduction approaches to injection drug use and by the political doubts of the supporters of such measures. Any activities that carry the risk of incurring negative publicity are discouraged. Funding is insufficient, and program operations and communications between the state Department of Public Health and the municipal agencies that run the SEPs need improvement. Police harassment continues.

The syringe cap remains an important issue, in and of itself, because of its potential impact on syringe exchange and thereby on HIV risk, but also because it brings into focus larger questions of policy changes and their implementation. The history of SEPs in Connecticut demonstrates that if the activities of SEPs are to be expanded and improved, lifting legislative restrictions that limit their functions is necessary but not sufficient. It is also necessary to address the social and political factors that led to the creation of these restrictions in the first place, and to address other, related manifestations of these factors, such as police harassment of drug users, insufficient financial support for SEPs, and ultimately, program inertia.

The data on the gap between injectors' needs for syringes and the ability of SEPs working under an exchange cap to meet those needs suggest that SEPs in other regions with syringe exchange caps could enhance the impact of their programs' operations by following Connecticut's example in raising the syringe cap, or, better yet, eliminating the cap altogether. However, to avoid the obstacles to the implementation of new policies suffered in Connecticut, SEP workers and lobbyists elsewhere should develop a strategy that recognizes the bureaucratic, social, and political factors that are likely to accompany restrictive legislation. Such a strategy will require efforts to obtain sufficient funding to supply larger quantities of syringes and to conduct outreach. It will be important to maintain efforts to educate and work with legislators, the police, community representatives, and local organizations in an effort to develop support for SEPs, rather than trusting that legal legitimacy will protect SEPs. Attempts must be made to ensure that programs receive administrative support and are kept well-informed of pertinent decisions made within government departments. Interventions to reduce police harassment are needed. This may be accomplished through legal action, as has recently occurred in Bridgeport, CT (Doe v. Bridgeport Police
Department, 2001), or through police training. Finally, attempts must be made to ensure that lifting the syringe cap does not mean imposing other restrictions in its place (such as the requirement that all distribution be documented). In short, SEP advocates should continue to develop a broad agenda for reform, even in the face of scarce funding and abundant political opposition. We hope that our example in Connecticut will prove useful in assisting such efforts elsewhere.

Understanding these factors, especially in the context of legislative and operational history, also has implications for the assessment of the efficacy of SEPs. Although some researchers have argued that SEPs are poor methods of controlling HIV transmission (Moss, 2000), analyses of the efficacy of SEPs cannot rely solely on epidemiological evaluations. Thorough evaluation must also consider the question of whether the inadequacies of SEPs are due to the social and political context within which they struggle to operate and to the difficulties SEPs, especially those in the United States, face when they attempt to expand their reach. While it may be too soon to quantify how effective SEPs are at reducing the harm attendant upon injection drug use, it is not too soon to argue that comprehensive evaluations must take into account both operational and structural concerns in answering the fundamental question: ‘are syringe exchanges effective?’

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