Bill as Introduced

1999 SESSION

99-0606
01/09

HOUSE BILL ***427***

AN ACT relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

SPONSORS: Rep. Splaine, Rock 34; Rep. C. Kane, Rock 32; Rep. O'Keefe, Rock 21; Rep. Copenhaver, Graf 10; Rep. DeChane, Straf 6

COMMITTEE: Criminal Justice and Public Safety

ANALYSIS

This bill revises the laws that require a prescription to purchase a hypodermic needle to allow persons, except for persons under 18 years of age, to acquire such needles without a prescription. However, such needles are still to be sold only in registered pharmacies, except for public and nonpublic schools in certain cases. The bill also imposes certain informational requirements and other conditions before such needles can be sold.

This bill also modifies the drug paraphernalia laws applying to syringes.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

99-0606
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord One Thousand Nine Hundred and Ninety-Nine

AN ACT relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Prescription Not Required for Persons Over 18; Other Requirements. Amend RSA 318:52-c to read as follows:

318:52-c Sale of Hypodermic Syringe.

I.*(a)* Hypodermic syringes, needles or any instrument adapted for the administration of drugs by injection shall not be sold except in registered pharmacies. No person shall sell, furnish, or give to any person [~~or persons other than a duly licensed physician, dentist, veterinarian, nurse, podiatrist, pharmacist, or embalmer, or a hospital, sanitarium, clinical laboratory or any other medical institution or a state or governmental agency, or a regular dealer in medical, dental or surgical supplies, or a resident physician or intern or advanced registered nurse practitioner of a hospital, sanitarium or other medical institution~~], ***under 18 years of age,*** an instrument commonly known as a hypodermic syringe, hypodermic needle or any instrument adapted for the administration of drugs by injection without the written or oral prescription of a duly licensed physician, dentist, veterinarian, or advanced registered nurse practitioner. Such prescription shall contain the name and address of the patient, the date of the prescription, the description of the instrument prescribed, and the number of instruments prescribed.

(b) The following conditions shall apply to all purchases of hypodermic syringes or needles:

(1) Pharmacists shall provide to each purchaser at the time of purchase information regarding the safe disposal of hypodermic syringes or needles, including local disposal locations or a telephone number to call for such information, if appropriate.

(2) Pharmacists shall also provide purchasers with information on drug addiction treatment, including a local telephone number to get assistance, if appropriate.

(c) A purchaser shall not be sold more than 10 syringes or needles at any single purchase unless such purchaser has a prescription for a bulk purchase.

(d) The commissioner of health and human services shall adopt rules, under RSA 541-A, relative to:

(1) The content, format, and distribution of any materials required under this paragraph.

(2) Any other matter necessary to administer this paragraph.

II. Public and nonpublic schools, including institutions of higher learning, shall be exempt from the [~~provisions of~~] ***requirement under*** paragraph I ***that such needles be sold only in registered pharmacies*** when the school is purchasing the syringes and needles for use in school science laboratory activities and assignments.

2 Reference Added. Amend RSA 318:52-d to read as follows:

318:52-d Recording and Filing of Prescription. Every person who dispenses, sells, furnishes, or gives away a hypodermic syringe or hypodermic needle or an instrument adapted for the administration of drugs by injection, upon the written or oral prescription of a duly licensed practitioner ***under RSA 318:52-c***, shall record over [~~his~~] ***such person's*** signature the date of sale or furnishing of the instrument and the number of instruments sold. This prescription shall be retained on file for a period of 4 years and shall be open to inspection by any public officer or employee engaged in the enforcement of RSA 318 or 318-B. A prescription filled in accordance with this section shall be sufficient authority, without the necessity of a renewal or reissuance, to permit subsequent sales or the furnishing of hypodermic syringes or hypodermic needles or instruments adapted for the administration of drugs by injection to the person to whom the prescription was issued for a period of one year from the date of its original issuance.

3 Prescription Required For Minors. Amend RSA 318:52-e to read as follows:

318:52-e Control or Possession of Hypodermic or Like Instruments Without Prescription Prohibited ***for Minors***. No person ***under 18 years of age*** shall have under [~~his~~] ***such person's*** control or possess a hypodermic syringe, hypodermic needle, or any instrument adapted for the administration of drugs by injection, [~~except a duly licensed physician, dentist, nurse, pharmacist, podiatrist, veterinarian, embalmer, a manufacturer or dealer in embalming supplies, registered wholesale druggist, manufacturing pharmacist, manufacturer of surgical instruments, official of any government having possession of the articles covered by this section by reason of his official duties, paramedical personnel acting under the direction of a physician, dentist, or advanced registered nurse practitioner, employees of a hospital, sanitarium or other licensed medical institution acting under the direction of its superintendent or officer in immediate charge, a carrier or messenger engaged in the transportation of such articles during the official performance of his duties, or a~~] ***unless the*** person [~~who~~] has received a written or oral prescription issued under RSA 318:52-c. For the purpose of this subdivision, no such prescription shall be valid which has been outstanding for more than one year. [~~Provided, however, that the industrial use of hypodermic syringes, needles or instruments in any manufacturing process not utilizing drugs shall not be prohibited, so long as such use is under the proper supervision of a designated person or persons; and such hypodermic syringes, needles or instruments may be purchased for such use from a registered drug store without a written or oral prescription issued under RSA 318:52-c.~~]

4 Injecting Deleted. Amend the introductory paragraph of RSA 318-B:1, X-a to read as follows:

X-a. "Drug paraphernalia" means all equipment, products and materials of any kind which are used or intended for use or customarily intended for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, [~~injecting,~~] ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this chapter. It includes, but is not limited to:

5 Inject Deleted. Amend RSA 318-B:2, II to read as follows:

II. It shall be unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia, knowing that it will be used or is customarily intended to be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, [~~inject,~~] ingest, inhale, or otherwise introduce into the human body a controlled substance.

6 Effective Date. This act shall take effect January 1, 2000.

Committee Minutes

Date: April 11, 2000
Time: 2:00 PM
Room: LOB 102

The Senate Committee on Public Institutions/Health Human Services held a hearing on the following:

HB 427 relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

Members of Committee present: Senator Squires
Senator Wheeler
Senator Pignatelli

Senator Katherine W. Wheeler, D. 21: In the absence of Senator Squires who's over testifying in Representative's Hall on the safe storage of firearms around children and he will be here shortly but in his absence, I will open the hearing on House Bill 427, *relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes* and call on the Prime Sponsor, Representative Splaine.

Representative James Splaine, Rock. D. 34: Thank you Madame Chair and member of the Committee (laughter). We're all prime sponsors on this bill by the way. I want to just address three things and be very brief because a couple of people here must attend to other things and I'll be here until the end of the public hearing if you have any other questions that I might be able to answer, but this is really a bill that addresses a very obvious and specific problem. That is the continued spread of AIDS and a couple of testifiers will point out how prevalent that is in the state of New Hampshire. Continuing the spread of AIDS and Hepatitis and other blood-borne diseases in our state by allowing, essentially, for the availability of hypodermic needles without prescription and there are some regulations and guidelines for that, some education that would be provided by the pharmacies which would be making these available to their customers on a voluntary basis. Pharmacies are not required to do this.

Sometime ago, Cecelia Kane and I had a discussion, this was several years ago, about the need for being able to find a way to reduce the spread of AIDS.

I was Chair – President – of the AIDS Response Seacoast, a couple of members who are going to be here today will be testifying, and she will explain to you her personal story about why she's so concerned about this but she has introduced legislation time and time again. She's really a hero and she won't say that on her part but I will, a hero in this regard because I think she's saved many lived just discussing it up to this point through the years. She's been a hero in trying to stop the spread of AIDS through a pilot needle exchange program. The problem with that legislation has continually been, and it has been passed. I co-sponsored it with her at one time. She sponsored many times and her perseverance finally sought her successful but the problem has been that it has been difficult to identify a community that has been willing to say "Yes. Let's give it a try." So, last winter we were talking about how do we succeed on this issue because this might be Cecelia's final time on legislature, although some of us are trying to get her to run again, and the thought was – well I suggested let's go for what the legislature has said yes to several times but the Governor has vetoed it in the past and that is allowing for the availability of needles without prescription.

The House Committee that heard this bill last year, as Trisha O'Keefe will explain because she was on that committee and served on the sub-committee, worked very hard and thoroughly on it. There were probably only two, three, four supporters the first time we had a public hearing. This is over a year ago. But after a summer of interim study, the Committee decided to support it and it was reported out of the House this past January by voice vote with a lot of work by Representative O'Keefe and others.

I urge you to consider supporting this legislation. There may, indeed, be a lot of other reasons why we say yes to this but the bottom line is that at least some minds are going to be changed by having availability of cleaner needles in the system among those people who tend to use intravenous drugs and use needles for their habit. It's nothing that's being endorsed by this legislation. None of us want to encourage that kind of cultural lifestyle and in fact this legislation, through it's education components, could contribute to it reducing that lifestyle but at the very least Cecelia Kane's cause and message of the past decade – that she wants to see lives saved – will have been at least consciously achieved. Thank you very much.

Senator Katherine W. Wheeler, D. 21: Thank you Representative Splaine. Would you just – before you leave the chair – Senator Pignatelli had asked me about the legislative history and I've been around during all of this and I've always supported it but I can't remember – it actually passed both bodies and was vetoed?

Representative Splaine: I'd like to....

Senator Katherine W. Wheeler, D. 21: Representative O'Keefe is going to give us that.

Representative Splaine: Exactly. They were here at that time and I was in for two years but not for all of that legislative history.

Senator Katherine W. Wheeler, D. 21: Fine. People that are testifying later will explain that to us. Representative O'Keefe.

Representative Patricia O'Keefe, Rock. D. 21: Written testimony handed in and read. **See Attachment A.**

Senator Katherine W. Wheeler, D. 21: Thank you. Representative O'Keefe, I don't have a question but could you leave a copy of that with the secretary. Especially if we wind up having to report it out on Thursday. It would be useful.

Senator Debora B. Pignatelli, D. 13: Thank you Mr. Chairman. I have some questions, I don't know whether you're proper person to ask them but I'm going to ask them and if you're not then someone who comes after you would be able to answer. What's the incentive for drug users to properly dispose of used hypodermic needles? From my understanding, these people are not the most responsible people in our society.

Representative O'Keefe: I would think – you would be surprised. If you heard the testimony on the methadone bill...

Senator Debora B. Pignatelli, D. 13: I did.

Representative O'Keefe: ...this morning – well, there are a lot of middle class injected drug users too and that people would be responsible if they were given the chance. I think one of the reasons, and there are people that can address it probably better than I am, if they don't have the fear of being arrested for having it on their person, they would take the time to dispose of it properly but when they're afraid and they see somebody coming, they might toss it off to the side so they won't be caught with it on their person and risk arrest. But, there are people behind me that ....

Senator Debora B. Pignatelli, D. 13: Thank you.

Senator James W. Squires, D. 12: Representative Kane.

Representative Cecelia Kane, Rock. D. 32: I am Representative Cecelia Kane and I'm serving my sixth Session in the Legislature. My first Session was in 1988 and I came into the Legislature because my son died of AIDS. My only son. Thirty-four years old. To do anything for AIDS was to come into the Legislature and I can truthfully say that I have met some wonderful people and I have enjoyed being in the Legislature. The one thing that I wanted to do was something to stop the spread of AIDS and slow the spread of AIDS. We did pass the prescription bill and it was vetoed by Governor Gregg and Governor Merrill and we passed it in the House and the Senate.

I have, I believe you're going to have a lot of information but I want to pass this around. **See Attachment B.** This is how AIDS has been a very complacency lately. People think that it's gone away and it hasn't and by passing this bill here, New Hampshire will be with the rest of the New England states in program. Maine also has this prescription program. You could go into Vermont at anytime and they have no – you didn't need any prescription in Vermont. Connecticut, Massachusetts and Rhode Island all have this program in so I do hope that you will pass this program.

I must say that I'm a little bit nervous but my tenth year in working for this – it would be so wonderful if we could pass these two bills for the people of New Hampshire.

Senator James W. Squires, D. 12: Any questions?

Senator Katherine W. Wheeler, D. 21: Thank you Senator Squires. Would you believe, Representative Kane, that I've been with you and watched your work for all of those twelve years and so impressed with what you've done? Would you further believe that I certainly hope that we can finally it passed and signed into law?

Representative Kane: Thank you very much.

Senator James W. Squires, D. 12: Senator Pignatelli.

Senator Debora B. Pignatelli, D. 13: Representative Kane, I'm going to struggle with this. As you know I haven't supported these bills in the past but I have supported other measures to try to stop the spread of AIDS such as exchanging a used needle for a clean needle. Why isn't that program in this bill? Bring a used needle back and get a new needle. Bring two ....

Representative Kane: That's in the pilot needle exchange program. I also know that you've had a lot of difficulty with the disposal of the needles and recently I had a server made of the 27 hospitals and just how they dispose of

the needles. It proved to be very, very interesting. There are a few hospitals that do have a definite program on the disposal of needles but with these two programs, those will be taken care of.

Another most important thing, I feel on these programs, is that there is going to be treatment and counseling that you're going to be with these people and it's a disease. We're dealing with an incurable – in research, they have found no vaccines or anything. It is fatal. It's a disease that's fatal, that's taken a whole generation of people. Just think of the lives that we could have changed if Governor Gregg hadn't vetoed those bills.

Senator Debora B. Pignatelli, D. 13: Just a follow-up. Representative Kane, it doesn't concern you that if people – drug users – are able to go in and buy prescriptions at will – buy hypodermic devices at will – in the drugstores that we could find used hypodermic needles around in the parks, outside of houses where people are injecting? That our kids could find these needles around. It's always been my feeling that if a drug user chooses to inject drugs that they hold on to that needles because they don't know where the next needle is going to come from and so they hold onto it. They may share which is awful as we know but they hold onto it, whereas if you could buy hypodermic needles without prescription, it seems to me that there's not much of an incentive to hold onto it. It's easy to toss in the street, in the park, wherever. Is that of concern to you?

Representative Kane: The thing is, is that you're going to find these but you're going to find them with clean needles. You're not going to be having the dirty needles and I think it's very important on the disposal also. They're going to have to bring in the dirty needles in order to get clean needles because of the program.

Senator Debora B. Pignatelli, D. 13: Just a final question. So under this bill, if you bring in 5 used hypodermic needles, you can buy 5 without?

Representative Kane: No. You're going to need the two programs. You're going to need this but not needing a prescription and then the pilot needle exchange program takes care of the dirty needles and the exchange of needles.

Senator Debora B. Pignatelli, D. 13: Thank you.

Senator James W. Squires, D. 12: Thank you very much Representative Kane. Janet Monahan.

Janet Monahan, NH Medical Society: Written testimony handed in. **See Attachment C.**

Senator James W. Squires, D. 12: Any questions? Thank you Janet. Dr. Kassler.

Dr. William Kassler, Department of Health and Human Services: Written testimony handed in. **See Attachment D and E.** (turn over tape)

Senator Katherine W. Wheeler, D. 21: Thank you very much Mr. Chair. Dr. Kassler, I have two questions. One is for diabetics who have insurance coverage for their needles, does the deregulation affect the reimbursement?

Dr. Kassler: No.

Senator Katherine W. Wheeler, D. 21: So the prescription would still be honored and still...

Dr. Kassler: The prescription would be honored and for those, for example, managed care plans that use the prescription to track utilization and whatnot, that would still be in effect.

Senator Katherine W. Wheeler, D. 21: Further question. You came to use form CDC, didn't you?

Dr. Kassler: Yes.

Senator Katherine W. Wheeler, D. 21: So you've have, it's my understanding that CDC has for a long time had a policy saying that this was a good way of reducing the spread of HIV/AIDS. I know you have access to a lot of their information. The 42 states that don't regulate the sale of needles, have they had problems with – any more problems than other states with the disposal of used needles?

Dr. Kassler: No. I can point to the prospective evaluation of states who were in the process of enacting, Maine and Connecticut, and we looked before and after. It's very difficult to bring a lot scientific evidence to bear on trash and disposal but the tremendous amount of anecdotal evidence exists, that injection drug users shoot up in shooting galleries and in other places where they share and that the baseline is that there is a lot of trash from this.

What we found in Connecticut is that drug users recognized very quickly that this was an opportunity for them to be able to get clean needles, to not be at risk of diseases and also that they didn't want to do anything to blow it. And

that there were a handful of incidents that were well publicized after the law went into effect. A pharmacist found a used syringe in among their shelves of their goods. Another pharmacist found something in the parking lot and the community got together and said "listen guys. You're going to blow it." Pharmacist who will voluntarily choose to sell to drug users and pass out the educational material are going to say, "not in my store you don't", after these incidences. So what happened was the AIDS service organization in the community got together and did some self policing and these few, very publicized initial incidences were not repeated.

Senator Katherine W. Wheeler, D. 21: Thank you.

Senator Debora B. Pignatelli, D. 13: Thank you Mr. Chairman. Dr. Kassler, thank you for your testimony. How long does the HIV virus and the Hepatitis C, Hepatitis B virus live in the used needles?

Dr. Kassler: The general thinking is that following the complete desiccation or drying of the blood, very shortly thereafter the virus will no longer be viable. Studies have been done with HIV that have indicated that depending upon the conditions, the exposure to air and how much blood is left in the syringe, if there is a huge amount of blood, for example there's a cc worth of blood in the syringe that it could take several weeks for the blood to completely dry. On the other hand, if there are trace amounts from an empty needle, it could be several hours. So it really depends on a lot of environmental factors.

Senator Debora B. Pignatelli, D. 13: So once the blood is dried, there is only a trace amount of blood and it took only 3 or 4 hours for it to dry then somebody else who finds the needle could use that needle again without fear of getting the Hepatitis or AIDS virus?

Dr. Kassler: Theoretically, that is possible. The reason why an injection drug user would not do that, find something on the street, is that injection drug users prize more than anything else access to their veins and that means that using a dull or rusty needle would be likely to lacerate the vein, cause scarring and so in addition to being incredibly uncomfortable, would blow that opportunity to have access to that vein. So injection drug users are very, very careful about trying to use the sharpest, the cleanest needles for continued preservation of their intravenous access. As well, we know that drug users do not want to use dirty needles because they do not want to get into exposure to all of these blood-borne pathogens and given the choice, they will exercise self-preservation and choose to use clean syringes.

Senator Debora B. Pignatelli, D. 13: So why wouldn't a program where drug users would bring their used syringes back to a certain place where they could exchange them for clean syringes? Why isn't that program instead of this program?

Dr. Kassler: I believe they're two important, parallel and very complimentary public health interventions. First of all, by allowing the network of pharmacies out there to provide education and to provide access points an individual drug user would have the option of going to any pharmacy as opposed to going into an injecting drug neighborhood where there's a large enough community to have a needle exchange program. So, they would get that access. So in many respects, the greatest impact on the greatest number of injection drug users is through a law that is permissive rather than setting up a special program.

I believe that the program that you speak about, the syringe exchange program, are good for hard-core neighborhoods as part of outreach where outreach workers go find the hard-core drug users, provide education, referral to other services and counseling and that does help a hard-core commune but it's not going to be widely diffused and finally, while we've seen that enabling law for needle exchange being passed, we see a lot of redolence on the part of communities to permit that to go forward whereas this being permissive rather than the setting up of a program where it allows pharmacists to sell would get around that barrier.

Senator Debora B. Pignatelli, D. 13: Just one final question. In your testimony you said on page 4, *"in high drug using neighborhoods, the number of non-prescription syringes rose dramatically."* So, in high drug use neighborhoods, it sounds like the people took advantage of going to the pharmacies in getting – what do you think they did with the used needles since this is a high drug using neighborhood?

Dr. Kassler: Part of the information the pharmacists would give back to a purchaser would be how to safely dispose. It is the same information that the medical community gives to, for example, diabetics and that would be to take a used plastic milk bottle or some other devise, put them in and cap that and either return that to a collection area or put it into the waste stream when it's capped and protected from accidental exposure into a transfer station or incinerator. So, that the same advice that is currently given to diabetics would hold true for that. That was the advice given in Connecticut, for example, and it did not result anecdotally in any increase in needle stick injuries or any trash problems aside from, again, for a few key incidents that were quickly resolved with education.

Senator Debora B. Pignatelli, D. 13: That's a recommendation, not a mandate?

Dr. Kassler: That would be part of any administrative rules that the Department of Health and Human Services will write up governing this program, that would be an essential component. To me that goes hand in hand. We want to prevent problems and we don't want to create new problems. I believe that we can prevent problems without creating new problems through education and administrative rules.

Senator Debora B. Pignatelli, D. 13: Just one final question. It says in your testimony on page 1 that there are 6,000 injection drug users in New Hampshire. Those are not diabetics?

Dr. Kassler: No. Those are people who are injecting illegal drugs. That number is our best estimate.

Senator Debora B. Pignatelli, D. 13: Tell me about these 6,000 people. Someone referenced that many of them might be just like you and I, that they might hold jobs. Do you know something about these 6,000 people?

Dr. Kassler: I could tell you in a previous practice in Rhode Island I had a case of a gentleman who is an executive of a high-tech company who was an injection drug user and who had AIDS. He was able to hold down a white-collar job as a manager in a fortune 500 company. We tend, in our society because of the media, to focus on the hard-core street addict committing crimes, hanging out on the street corner but in fact injection drug use, as we learned about from the papers and from the principal who in Southern New Hampshire who had the problem, this is an addiction that cuts across socioeconomic class, race, age and so it is probably more widely distributed in society than we would believe or expect.

Senator Debora B. Pignatelli, D. 13: So you don't have any specific information about these 6,000 drug users in New Hampshire? Do you have demographic information about where they're located?

Dr. Kassler: No. As you might expect, we – this is a stigmatized and illegal behavior with criminal behavior and so it's not very easy to go out and count folks. We can look at who comes in for treatment. We could look at arrests. It's hard to get unduplicated data. So this is a very – it's our best estimate based on some federal guidelines about how to count cases but we can't tell you who they are and what they look like in any sort of epidemiological or really demographic way that I would have confidence in sharing with you.

Senator Debora B. Pignatelli, D. 13: Thank you very much.

Senator James W. Squires, D. 12: Senator Wheeler.

Senator Katherine W. Wheeler, D. 21: Thank you. In answer to Senator Pignatelli's question, in the methadone hearing s this morning we learned about heroin addicts in New Hampshire and one of the things the Attorney General said was the New Hampshire addicts live on both sides of the tracks. There's not class of people that are addicted to drugs that they used hypodermics for that's different from any other class.

My question was since the research has been in linking the sharing of needles with the spread of HIV/AIDS, had any of the states that had not, therefore, regulated the sale of needles become upset enough about needles being left around that could infect people that they regulated needles? Have any states gone to regulation?

Dr. Kassler: In the ten years that I personally have been tracking this, there has been no instance of the reverse where states that have not had needles and syringe laws created prescription requirements or criminalization of possession.

Senator Katherine W. Wheeler, D. 21: Thank you.

Senator James W. Squires, D. 12: Dr. Kassler, just a brief question. In Connecticut following the bill, does the pharmacist, pharmacy post a sign of indication they are participating – how does someone know going into a CVS or something that they're a member of the program?

Dr. Kassler: They didn't advertise. What happened very quickly is that the AIDS service organization, the social organizations, the word of mouth became that type of informal network. The other thing is that frequently pharmacists wanted the right to be able to choose who they sold to and who they didn't so that, for example, if a person dressed like me came in and did that, they wouldn't ask any questions. If someone came in that was perhaps causing trouble, they might ask more questions. So it became a very informal type of system and it seems to have worked well and by looking at the data in terms of the sales and lack of problems, I would say it did work well.

Senator James W. Squires, D. 12: So, the bill says that – do they indicate to anybody to the Department, to anybody so you have some idea where the needles are being purchased?

Dr. Kassler: What we would likely do as part of our public health program is develop education material for the pharmacists, materials on how to dispose for the drug users. We would probably do some sort of a survey perhaps engaging pharmacists in sort of key areas, educating pharmacists ourselves and tracking that as part of an evaluating of this program.

Senator James W. Squires, D. 12: So you won't be able to start activating any organized manner where these sales are being done? Wouldn't you be a little interested to know that?

Dr. Kassler: With some assistance from CDC, for example, we could very easily institute a very similar sort of an evaluation as we did in Connecticut, for example, and do surveys of providers. We can look at sales records. Yes, I think we have the ability to institute of the evaluation of the impact of this. It would be my recommendation that we do.

Senator James W. Squires, D. 12: Thank you. Any other questions? Seeing none, Mr. Sandquist.

Dan Sandquist, Portland, Maine Public Health: Good afternoon. My name is Dan Sandquist. I'm here as a New Hampshire resident. I'm also here as a representative of the Department of Health and Human Services, Division of the Public Health for the City of Portland, Maine where I work as a Health Promotion Specialist for that Department doing syringe exchange and working with injection drug users in an HIV prevention capacity.

I came primarily to shed some light on Maine's experience with their legislation addressing this issue but it seems to have been covered already but I've been making some notes around some of the questions that have come up and I'd like to address those if I could, particularly some of your questions around disposal issues and whatnot. I also want to congratulate the sponsors of this legislation for taking the access of sterile syringes and injection equipment as well as the drug paraphernalia laws in one bill and addressing both of those issues at the same time because that was a big stumbling point that we had in Maine. You could buy syringes legally but you couldn't possess them once you stepped out onto the street. People weren't used to taking advantage of the sales.

I'm also here as concerned around Hepatitis infections, Hepatitis B and C, as I am HIV because Hepatitis, particularly Hepatitis C, is much more infectious and more easily transmittable than HIV and what we know around injectors at this point is that the majority of them are already infected with Hepatitis C, over 90%. In some areas, close to 100%. There is some data, although I don't have it front of me, that studies that were done that if people

in the first two or three years of their injection history have access to sterile equipment they can put off that potentially fatal disease.

Around the disposal issue, I've been involved with the syringe exchange for about five years in southern New Hampshire, northern Massachusetts, in Maine and in Arizona. One of the questions that I routinely ask people when beginning a working relationship is what are you doing now? How are you disposing of the syringes now? And over 95% of the people that I've talked to do whatever they can to disable the syringe before they discard it. There's a major fear factor around arrest. People that are known in the street get pulled over. They get padded down. If they see a cop coming, they're going to get rid of the any incriminating evidence that they might have that would cause arrest, particularly heroin addicts who know that if they go into jail they're going to start getting sick in a few hours and it's a very, very uncomfortable process, I'm told from opioids. What they do, as a routine, is they break off the point or the needle piece of it and often times they'll put it inside the barrel of the syringe and run the plunger up behind it, stick it in a coke can, in a bottle, in some other kind of a container that would keep it from being easily recognized in trash and protecting people. Drug users are not callous people. They are irresponsible, perhaps, around making appointments. A lot of other aspects of their life is chaotic because of the drug life but they're not callous people that really don't care about what happens to other people. They do the best they can to try to eliminate the possibility of infections to other people. They also don't want to have discarded syringes around their property to cause any kind of attention to be brought to any activity that's going on in their house. So, more often than not, people are discarding on the street is because of the stress related to potential arrest. I always encourage people to use laundry detergent bottles with the screw-on caps because it's a much harder plastic container. I've to find out what the requirements are for diabetics in the state and try to follow along that path and there really isn't a lot of direction.

In terms of collection, I think that if we were able to – if outreach workers were able to carry syringes, not necessarily as part of the syringe exchange but carry (cough) containers so when they're engaging a drug user and talking about opportunities for treatment of for testing or for other health measurers that might be available, they can pick up and collect used equipment and safely dispose of it in a local fashion without the fear of arrest and without being in violation of many laws for carrying a syringe.

The other thing that keeps syringe exchange programs from going – we did pass the syringe exchange program a couple of years ago and I maybe stepping on toes but there's a blue wall that comes to bear around the police departments feeling that syringe exchange violates their fight on the war of

drugs and they can't condone it. I know in Nashua, the City Public Health Department was prepared to write a proposal for an exchange program in that city and they (door closing) to the chief of police in that town and he said no and that was the end of it. I think that same thing happens in other towns that they kind of act in an uniform – they act in an uniform position around this that it goes against what they're trying to do and they really have difficulty looking at the public health aspect of it.

The other thing it goes in line with folks that don't want to participate in syringe exchange program, it has to do with the stigma associated with being a drug user. A lot of folks just don't want to be known and they don't want to be seen going into a van or into a syringe exchange site or into any place that has a reputation (change tapes).....they have other options available to them, other resources available to them. People that are living on the street level or in a chaotic life, they don't have those options and they end up going into clinics or using vans or what have you. They don't really care too much about what people think but there are a lot of people that do and they have the means. It's the same as going for an HIV test. Folks from Manchester will drive to Keene to take an HIV test because they don't want to be seen going into that clinic where they can get an anonymous test. So, there's a lot of stigma that plays into that.

The CDC and the Public Health Services made a recommendation, given the fact that bleaching is not as effective as was thought because drug users traditionally don't bleach in the manner that's prescribed, for the amount of time and for the duration and the process. So, it's not as effective. So, both of these health bodies have come up with and they've recommended a clean syringe for every injection. This injection equipment is only made for single use. It's made for hospital settings, medical settings. You use it once and you throw it away. After it's used once it starts to degrade. The point starts to degrade because any responsible manufacturing company is going to take every cost they can out of the product that they're going to sell and only what they're liable for is first single injection, after that if it's used more often than that, they're not liable anyway. I know people that are walking around with broken off needles – the points of the needles – in their arms because of reuse and having this happen. So, on one hand we encourage people, if their going to use, to use a single syringe every time but we live in a state where you don't have that kind of access and not only do you put yourself at risk for having the points break off but as the point from the needles degrades, you're actually tearing the skin, tearing the tissue, tearing the vein rather than slicing into the vein. You're causing more opportunity for infections, more opportunities for abscesses, more medical costs, more emergency room visits and traditionally, these folks that deal with these medical conditions, they put them off for as long as possible because of the abusive approach that they

get in emergency rooms by a lot of the staff at the hospitals that look at the drug user as creating his own problem and they don't have any sympathy for them. So the last thing a drug user is going to do is subject himself to that situation.

That's all I have to say.

Senator James W. Squires, D. 12: I have a question. I'm curious, in your experience, what is the size of the needle that is most commonly used? Insulin?

Ms. Sandquist: They're usually 28 gage, ½ cc.

Senator James W. Squires, D. 12: Any questions? Thank you. That completes the ones that checked off....Yes.

Cynthia Bowman, AIDS Response Seacoast: Written testimony handed in. **See Attachment F.**

Senator Debora B. Pignatelli, D. 13: Thank you. You're over on the seacoast, is that correct?

Ms. Bowman: We're on the seacoast and we serve all of Rockingham and Strafford County doing our work, yes.

Senator Debora B. Pignatelli, D. 13: Do you recommend that your clients go Maine to get the clean syringes that they need?

Ms. Bowman: Have I ever done that? Yes I have done that. I don't feel great about having done that but I have done that because the person I was talking to at that time did not have clean needles available and was doing everything she could do not to share equipment.

Senator Debora B. Pignatelli, D. 13: Can I just ask one follow-up question? Do we know how many clean syringes have been sold in Maine since the bill came in to – since the bill passed there, over and above?

Ms. Bowman: I don't know what it was before and I don't know what it was after.

Senator Debora B. Pignatelli, D. 13: Thank you.

Senator Patricia Krueger, D. 16: I just have a kind question. I thought I heard you say and please correct me if I'm wrong because I may have

misheard you, when you were talking about users and I thought you mentioned the fact the they did not want to pass on their illness to someone else. Is that what I heard you say?

Ms. Bowman: I said that and I was speaking of if they have HIV infection or Hepatitis.

Senator Patricia Krueger, D. 16: Right. But what I thought I also heard you say, if I might Mr. Chairman, that these people really did have this concern but yet I don't find in their characteristic of someone who would be in the predicament they're already in as an intravenous drug user as someone who would normally care because obviously they don't even care about their own health. And that's the dilemma I'm having with what you say. I really need you to resolve that with me because philosophically I can understand this.

Ms. Bowman: As an educator as AIDS Response, we work in all of the substance abuse treatment programs in our two county service area. What I can tell you, and I've been doing this work in Maine since 1985 and in New Hampshire since 1991. What I can tell you is the people I meet who are in treatment centers talk to me about their life and they're people like you and me. They're people who worked in our communities, white-collar, blue-collar, whatever, have families, have children. They're not always the people that we see pictured in the media. Do some of them get to that place? Yes they do and it's because of their addiction and it's because there hasn't always been help for them when they've wanted it. We've had so few beds available for people. Women who have children, feared giving up their children to go into treatment. People sometimes get to that point and yet they're people who care about others. They can be loyal to their friends, the people who are good to them. I don't know if I'm helping you.

Senator Patricia Krueger, D. 16: Yes you did. Thank you.

Senator Debora B. Pignatelli, D. 13: Cindy, how much do needles cost from a pharmacist?

Ms. Bowman: Possibly $5.00. Maybe less.

Senator Debora B. Pignatelli, D. 13: Or $12.00?

Ms. Bowman: Depends on how they're packaged. They could be $5.00 for 5 or 6. They could be $3.00 for 5 or 6. It depends on where they're being sold. It's been a while since I've done that. Checked it out. Depends on how they're packaged. Whether they're sold individually, in packages of 5 or

packages of 10. They're not all that expensive. For some people they'll be too much money but for the majority of people, they will access them.

Senator Patricia Krueger, D. 16: One last question, thank you Mr. Chairman. That puts forth another question being that if somebody was addicted to a certain drug, wouldn't they prefer to use a dirty needle on the worst of days and spend the money on more drug?

Ms. Bowman: I don't know how to answer that. I think the majority of people who are users understand about these deadly diseases out there. They don't want to die. They don't want to die from HIV, they don't want to die from their addiction. They want to live so I can't answer you. If it came down to that choice what they do, I don't know. I think most of them aren't going to be at that moment of choice most of the time and that's where we can have an impact.

Senator Patricia Krueger, D. 16: I appreciate your honesty.

Senator James W. Squires, D. 12: In your testimony, you elude also to this number we heard about 6,000. How, from your perspective, where does that come from? I'm assuming it's fed form a variety of sources as was referenced. How accurate is it? There must be a range, some estimate. How do you approach that problem?

Ms. Bowman: When I read that number it was in Fosters Paper on February 1, 1998, which means that's now old. Which means that number is probably considerably higher. That would be my bet. When I talked to the people in the substance abuse treatment program they know how many people have accessed services there. Again, when I check, if I'm writing grants I need some information, when I check with police departments and find out how many people were involved in either police arrest with needles or illegal behavior around this? How many people show up at emergency rooms? I think there are ways to estimate. I don't how else those numbers get arrived at. They are estimates, I know that.

Senator James W. Squires, D. 12: You obviously have a very long and impressive experience in this field, thus in your judgement, do you think that's a reasonable number? Is it one that strikes you, given your experience base, as consistent with New Hampshire's population?

Ms. Bowman: I think it's higher.

Senator James W. Squires, D. 12: You think the number is low.

Ms. Bowman: I think the number is low. I do think the number is low. I think because it's an old number, I do think it's low. I think in the last couple of years we've seen a resurgence of heroin use. It's cheaper. There's more of it. We've also seen other drugs. We've seen people trying to avoid needle use by using some substances in different ways. Some of those ways still put them at risk for HIV and Hepatitis. I think it's a bigger problem. I think it's been a problem but I think it's a bigger problem than it was a few years ago.

Senator James W. Squires, D. 12: Thank you. Would anyone else like to speak to this bill? House Bill 427? Yes.

Representative Alphonse Haettenschwiller, Hills. D. 29: Mr. Chairman, I don't really need to speak but I would like to go on record as strongly favoring this bill. I'm Alphonse Haettenschwiller. I'm a Representative from Hillsborough 29.

Senator James W. Squires, D. 12: Anybody else? Seeing none, I will close the public hearing on House Bill 427.

Hearing closed at 3:20 pm.

Respectfully submitted,

Merideth A. Chandler,
Committee Secretary

Attachment A

Rep. Patricia M O'Keefe - Rockingham 21
Testimony on HB 427
April 11, 2000

Thank you ~~Madam~~ Mr. Chair; members of the committee

I am here to comment on HB 427...which removes the prescription requirement to purchase hypodermic needles and syringes and modifies the drug paraphernalia laws applying to them.

This is the sixth time a bill of dealing with this issue has come before the NH Legislature...in 1992 and 1993 bills passed both the House and Senate before being vetoed by the Governor. In 94, 95, and 1997 bills passed the House, but were found Inexpedient by the Senate.

At this time approximately one third of all AIDS cases and one half of hepatitis C cases are directly or indirectly linked to injection drug use in the US. Limited access to sterile syringes contributes to the transmission of these blood-borne infections among injection drug users, their sex partners and their children. Here in New Hampshire, for the years 1993-98, 21% of all AIDS cases and 24% of HIV infection reports are **directly** linked to injecting drug use.

Opponents of this legislation are of the opinion that this type of intervention condones illegal drug use. **Less than 10 states** require a prescription for purchase of needle/syringes...and of these states that do... some have a much higher percentage of these blood-borne infections attributed to injecting drug use.

In NH these laws have been on the books for about 30 years....they were enacted during the first big push in the war on drugs...I feel the sponsors put forth this legislation with the best of intentions...whether or not it was effective is difficult to gauge...what I do know is that the sponsors and the legislature that enacted the laws did NOT know that a dozen years down the road there would appear deadly blood-borne organisms that would spread to epidemic levels...and that the most efficient way of spreading theses diseases was simply to inject with an infected needle.

There are injecting drug users in the state and treatment program slots are at a premium...

In 1998 The Bureau of Substance Abuse services estimated that on any given day there are 120 people waiting to get into residential tx And **these beds are for both alcohol and drug tx**

What we can do is provide access to clean needles for those who are struggling with a debilitating addiction.

By doing this we can reduce the potential for the spread of infection for those at risk...the IDU, their sex partners and children.

1992	HB 1350	Passed H&S	Vetoed by Gov.	sustained
1993	HB 493	Passed H&S	"	"
1994	HB 1483	Passed H	ITL Senate	
1995	HB 282	Passed H	"	
1997	HB 470	Passed H	"	

Boston Globe – 4-21-99

Attachment B

A new foe in fight against HIV

LARRY KESSLER



MARGARET SCOTT ILLUSTRATION

In 16 years of fighting AIDS, I've seen how tricky HIV can be. It seeks out and exploits our weaknesses as a society.

In the beginning, the virus focused on ignorance. In response, AIDS groups rallied to educate ourselves, the general public, politicians, and health-care providers. Then the virus used poverty, racism, and homophobia, concentrating its destructive power on the people in society who have historically been neglected. We're still working on that.

Now, as we look into the next century, we see the virus hooking onto complacency. People are tired of hearing about AIDS, tired of being careful, tired of giving. New treatments have persuaded some that AIDS is no longer deadly. Consequently, many have let down their guard. Rising sexually transmitted disease rates show evidence of dramatically increased risky behavior, particularly on the part of some young people and gay men.

One consequence of this complacency was the recent announcement that due to declining donations, the AIDS Action Committee has laid off 19 staff members and trimmed our budget by $1 million. Ironically, this comes as we are serving 2,000 clients, the most ever. It comes at a time when an estimated 33,000 Massachusetts residents will be living with HIV by year's end, when four people in the Commonwealth are infected every day, and 40,000 Americans were infected in the past 12 months.

It's troubling to wonder if the loss of interest in AIDS is related to the fact that people with AIDS are increasingly disenfranchised. Complacency has come at a time when the people who walk through the doors looking for help are likely to be poor, women, and people of color. It's faulty, of course, to think that we can stop AIDS at the borders of a particular community and let it flourish in others.

Though new drugs extend and improve the lives of some people living with HIV, there is still no cure for AIDS, nor is there a vaccine. By some estimates, as many as 50 percent of people with HIV cannot even use these expensive treatments because of life-threatening side effects, the dauntingly complex regimen, or simply because the drugs don't work for them.

In spite of all this – indeed, because of all this – we cannot allow complacency to diminish our resolve. We are more determined than ever to keep the promise AIDS Action made when we formed in 1983: to end the AIDS epidemic. That now means redoubling our efforts in two areas: preventing the spread of HIV and keeping the people with HIV healthy.

Complacency about AIDS comes at a bad time for those who seek help.

Two decades into the epidemic, we cannot assume that people – particularly young people – know how to protect themselves from AIDS. They don't, evidenced by the fact that young adults in their 20s represent nearly one in five AIDS cases in the Commonwealth. Most were probably infected as teenagers. Every year, 4 million American children become teenagers and need to know about AIDS. AIDS Action has filed legislation to introduce comprehensive HIV education programs into schools.

However, we will never end the spread of HIV without addressing the issue of clean needles, either through needle exchange programs or by allowing the over-the-counter sale of syringes. (The latter approach is embodied in a bill before the state Legislature.) Injection drug use is the leading cause of new infections in the state. No amount of talk about ending the epidemic can substitute for clean needles and substance abuse treatment.

There is good news in Massachusetts, which has always been a leader in progressive, effective AIDS policies. The AIDS death rate has dropped significantly due to efforts to ensure access to care. Fewer people with HIV are progressing to full-blown AIDS in Massachusetts – new AIDS cases also declined in 1997, down 34 percent, more than twice the national average. By expanding Medicaid to include poor people with HIV infection, the Massachusetts Legislature can continue to make a difference in life expectancy.

AIDS Action will remain vigilant until there is a vaccine and a cure. But everyone must be involved. By keeping our eyes on the goal, we can all win the fight against AIDS.

Larry Kessler is executive director of the AIDS Action Committee in Boston.

Attachment C

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April 11, 2000
HB 427
An act relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

The NH Medical Society is supporting HB 427 to allow persons 18 years or older to purchase hypodermic needles without a prescription. The Medical Society has historically supported such legislative efforts based upon the recommendations of NH infectious disease specialists and because the containment of HIV and hepatitis depends upon the public and private sectors working together to reduce risk factors.

In the past, opponents of this legislation have expressed fear that enactment would increase the incidence of IV drug abuse. This is a total misconception. In fact, just the opposite has occurred. When IV drug abusers obtain needles either from pharmacies or from needle exchange programs and are provided with educational materials about needle safety and drug rehabilitation programs, IV drug use has actually decreased. In addition, the educational materials have increased the number of IV drug users who voluntarily enter drug rehabilitation programs.

Intravenous drug use is the second leading cause of HIV transmission and this represents a difficult group of people to reach. HB 427 would provide a positive step towards preventing the transmission of HIV within this population. Enactment of HB 427 will **not provide free needles to drug abusers.** It will allow IV drug abusers to purchase sterile needles along with information about the safe disposal of needles and more importantly, information on treatment options for drug addiction. The opportunity for a positive contact with IV drug abusers will discourage drug abuse, not encourage illegal drug use.

Every available means must be used to combat the spread of AIDS and hepatitis. Infected IV drug abusers are the ones who are rapidly infecting the heterosexual community, including spouses and children. Six years ago, HIV infection became the number one cause of death among Americans 25 to 44 years old. If we can reduce the number of people sharing needles, we can reduce the spread of HIV and the number of cases of AIDS. The Medical Society urges you to support this important public policy change. Thank you.

H-95.958 Syringe and Needle Exchange Programs

The AMA: (1) encourages needle exchange programs; (2) will initiate and support legislation revoking the 1988 federal ban on funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription. (Res. 231, I-94; Reaffirmed Ref. Cmt. D, I-96; Modified by CSA Rep. 8, A-97)

AMA Policy

Summary : In October 1993, the Maine legislature repealed the law requiring a prescription to purchase syringes. The new law allowed but did not require licensed pharmacists to dispense syringes without a prescription to anyone 18 years of age or older. Between November, 1995 and January 1996, we conducted a telephone survey of 208 Maine pharmacists to evaluate (1) the willingness of Maine pharmacists to sell syringes without a prescription (2) pharmacy practices and policies with regard to the sales of syringes without a prescription. Our data show that 95% of pharmacists report they are willing, either in either in "all cases" or at the "discretion of the pharmacist," to sell syringes without a prescription. However, when asked specifically about willingness to sell syringes without a prescription to "suspected injection drug users (IDUs) over 18 years of age": 48% were willing, 40% were not willing, and 12% did not know or declined to answer. In addition, other requirements for the purchase of syringes without a prescription were reported, such as the requirement for the customer to provide a "reasonable justification." A total of 28 (15.4%) pharmacists in the state were willing to sell syringes in all cases to suspected IDUs without a prescription as permitted by law, with no additional requirements. Seventeen pharmacists (8.4%) reported negative incidents reported involving IDUs and the sale of syringes without a prescription since the amendment in the law. An estimated 16,533 syringes without a prescription were reported sold in the month previous to interview, but the estimated numbers sold fell short of estimated syringes required for IDUs in Maine to use a new syringe for every injection. The data suggest that while the repeal of the prescription law increased access to sterile syringes for injection drug users, barriers such as the drug paraphernalia laws and pharmacy policies and practice may prevent injection drug users from obtaining sterile syringes to protect their health.

Study Finds AIDS Risk to Addicts Drops if Sale of Syringes Is Legal

By GEORGE JUDSON

STAMFORD, Conn., Aug. 29 — Offering fresh hope in the battle to control AIDS, new studies have found that needle sharing among drug users fell 40 percent after Connecticut passed a 1992 law permitting pharmacies to sell syringes without a prescription.

With 75 percent of AIDS cases in Connecticut, and a majority nationally, occurring among intravenous drug users and their sex partners and children, the increased availability of clean needles should slow the spread of the virus by shared needles, the studies, published in the Journal of Acquired Immune Deficiency Syndromes, concluded.

"This is something that made a dramatic change in behavior at no cost to the public," said Beth Weinstein, director of the AIDS division of the Connecticut Department of Health, which conducted the studies with the Federal Centers for Disease Control and Prevention.

"This is not a big outreach program," she said. "It's not a needle exchange that costs the government money. It's a change in the law."

Connecticut is one of only five states — the others are North Dakota, Alaska, Iowa and South Carolina — that both allows nonprescription sales of syringes and has no drug paraphernalia law against their possession. Nine states and the District of Columbia require prescriptions both to buy syringes and to possess them, and they include those with the largest numbers of drug users and highest incidence of AIDS among them: California, New York, New Jersey, Illinois, Pennsylvania, and Massachusetts.

In 1992 Connecticut, a pioneer in needle-exchange programs, decided to go beyond the limited sites and hours of exchanges by making syringes available over the counter in pharmacies across the state and by legalizing the possession of syringes that are not contaminated with illegal drugs.

Continued on Page B5, Column 1

It imposed one restriction: Each nonprescription purchase was limited to 10 syringes, about $5 at today's prices. The main buyers of prescription syringes, diabetics, typically buy packs of 100.

Less than a year after the Connecticut needle laws took effect in 1992, the studies report, 83 percent of the state's pharmacies were selling needles over the counter, and drug users had turned to them as their main source of needles.

So far only Maine has followed Connecticut's lead, although legislation to permit over-the-counter sales in New York has been introduced for several years by Assemblyman Richard N. Gottfried of Manhattan.

"There's no evidence that I've heard of that the prescription requirement for needle sale or possession has had any effect in reducing drug addiction or reducing needle use," Mr. Gottfried said. "It has simply forced drug addicts to share needles. The main argument against the legislation is that somehow it would appear to condone or encourage illegal drug use."

That concern has been paramount as needle-exchange programs have slowly spread. In New York City, where Mayor David N. Dinkins opposed needle exchanges during his term, five programs are now operating, and experts in H.I.V. and drug treatment are increasingly supportive, but some residents of neighborhoods where the needle exchanges operate remain unhappy about open drug use.

In Connecticut, health officials had to convince pharmacists of the importance of clean syringes in fighting AIDS and hepatitis to win their support for nonprescription sales.

As Connecticut users buy needles easily, they stop sharing.

"Pharmacists are educated about the use of drugs to treat disease, so to ask them to support legislation that would essentially help people abuse drugs was something we had to look at," said Daniel C. Leone, executive vice president of the Connecticut Pharmacists Association.

INSIDE

Maritime Future in Question

A new report suggests that New York, after spending millions to subsidize its shipping industry, might be better off letting it die. Page B1.

Evelyn Wood Dies

The woman whose students could read full pages while others are still reading this sentence died on Saturday in Arizona at 86. Page D17.

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NY TIMES

Study Finds Addicts' AIDS Risk Falls if Syringe Sale Is Legal

Continued From Page A1

(2)

Eventually the association did support the law, which permits, rather than requires, pharmacists to sell nonprescription syringes. According to a survey reported in the Journal of Acquired Immune Deficiency Syndromes, an estimated 83 percent of the state's pharmacies were taking part in 1993, selling about 56,000 syringes over the counter each month.

About 10 percent of pharmacies reported problems with syringe buyers or finding used syringes in or around their stores, and many of those stopped sales. But since the survey, Ms. Weinstein said, the number of pharmacies participating appears to have stabilized.

The study also found that sales in city neighborhoods with large numbers of drug users quickly soared, while sales in smaller towns with fewer drug users remained low, evidence that the syringes were going to their intended users, addicts who had previously acquired needles on the street.

In a second study, researchers surveyed drug users at H.I.V. counseling programs, prisons and drug-treatment centers and found that less than a year after the laws took effect, 78 percent had bought syringes from a pharmacy in the previous month, while only 28 percent had bought needles on the street.

Most important, their use of syringes was changing. Of those who said they bought syringes only from pharmacies, 30 percent said they had shared a needle at least once in the previous month, a sharp drop from the 52 percent in a survey right after the laws took effect.

Researchers said lower rates of sharing syringes had also been found among drug users in Washington state who bought needles mainly from pharmacies, in a 1991 survey. That state allows nonprescription sales but has laws against the possession of drug paraphernalia. In addition, sharing rates fell in France after that country eliminated restrictions on syringes.

In an accompanying editorial, the journal called on other states to eliminate prescription requirements and drug paraphernalia laws, based on Connecticut's experience.

The president of the American Public Health Association, Dr. Caswell A. Evans, also said the studies should encourage other states to act. "Any program that is getting more clean syringes into the H.I.V. community should be having a beneficial effect," he said.

But one area that needs more attention, Dr. Evans added in a telephone interview, is collecting used syringes. While needle-exchange programs require drug users to return needles they have used, the pharmacy sales in Connecticut do not.

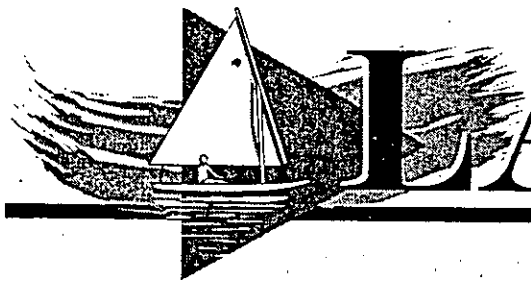
Researchers said the studies further suggest that sharing needles as a ritual is less important to drug users than sharing from necessity.

"There's always been this talk about the ritual of sharing," Ms. Weinstein said. "But now a number of drug users say, 'I carry three syringes with me, so that way if my buddy wants to share, I give him a clean one.' "



George Rube for The New York Times

In Connecticut, syringes can be bought without a prescription. A new study shows that their availability reduces needle sharing by drug users.



LAKES R

Hospital collects used— medical needle tomorrow

Also: Free Jazz

Tomorrow from 3 to 7 p.m., Lakes Region General Hospital in Laconia will be holding a "drop-off" for needles used in medical treatment therapies.

Used needles should be brought to the front lobby of the hospital in a closed container like a bleach bottle, or in a hospital-provided "sharps container." The needles will be collected in a clearly marked red receptacle. New sharps' containers will be provided to replace old ones or doled out to anyone making a first-time visit to the drop-off.

The drop-off program began about a year ago.

"The Infection Control Department realized there was a need to provide more safe disposal of used needles in the region," said hospital spokeswoman Bridget Fontaine. "The danger is in the needles not being incinerated properly and the public gaining access to them somehow."

Diabetics and people with hepatitis B make up the majority of needle-users, according to Fontaine. Many have already embraced the program.

"In the last year the hospital received 20 'sharp boxes,' and there's about 30 needles in a box," Fontaine said.

The hospital has needle drop-offs four times a year – in March, June, September and December.

Attachment D

Department of Health and Human Services
Testimony on HB 427
April 11, 2000

Good afternoon. My name is William Kassler, I am a practicing physician, and am here today representing the Department of Health and Human Services as the State Medical Director. I will be speaking in favor of House Bill 427. As you know, this bill will amend current New Hampshire law so that a prescription to purchase a hypodermic needle and syringe will not be needed, except for persons under the age of 18 years of age. The bill maintains the requirement that syringes can only be purchased in registered pharmacies, and would limit purchases to no more than 10 syringes per single purchase. The bill also initiates a system so that the users of syringes can learn how to dispose of used syringes properly. For clarity, I will use the term syringe to include both syringes and needles.

Before explaining why we support this bill, let me present you with a few facts. First, there are an estimated 6,000 injection drug users in New Hampshire. These individuals are at high risk for infection with HIV and other blood borne infections such as Hepatitis B and Hepatitis C every time they use a syringe previously used by another injection drug user. Each time someone injects drugs, the syringe becomes contaminated with that persons blood. If another person uses the same syringe, he or she is exposed to the previous users blood.

Nationally, about one third of the 40,000 new HIV cases are linked to injection drug use. About 20% of the 300,000 new Hepatits B cases are linked to injection drug use, and over half of the estimated 200,000 new cases of Hepatitic C are due to syringe sharing.

However, this is just the tip of the iceberg. HIV, Hepatitis B & Hepatitis C transmission that occurs through injecting drug use have a cascading effect as these infections are passed to their children and to their sexual partners who then further spread these infectious diseases in the community. Thus, reducing the risk of disease transmission among injection drug users is a legitimate medical and public health rationale for increasing access to clean syringes.

So, why does the Department believe that easing legal restrictions to syringes, as proposed in HB 427, will reduce the level of HIV infection and other blood borne diseases? First, a number of well done scientific research published in respected journals have concluded that legal restrictions are the primary reason that injection drug users share syringes. Second, as demonstrated in good scientific research, injection drug users who receive syringes from pharmacists rather than from street sellers are less likely to share syringes and less likely to attend so called shooting galleries, where syringe sharing is rampant.

In reviewing the evidence, the National Academy of Sciences concluded:

- For injection drug users who cannot or will not stop injecting drugs, access to sterile syringes remains the safest, most effective practice for limiting the transmission of blood borne infections.
- Paraphernalia laws that make it a criminal offense to possess injection equipment were designed to decrease injection drug abuse, but they also inhibit users from using sterile syringes.
- Laws requiring a prescription for the purchase of syringes promote sharing.

- Legislative bodies should repeal laws in the *(then)* nine states that require a prescription in order to purchase sterile syringes.
- There is **no** evidence that legal access to clean syringes increases drug use.
- There **is** evidence that access to clean syringes decreases HIV transmission.

Next, we support this bill because of the many public health, medical and scientific organizations that support increased access to sterile syringes as a legitimate strategy for the purpose of preventing blood borne diseases among injecting drug users. The American Medical Association in 1997 adopted the following policy, which appeared in an editorial in the prestigious Journal of the American Medical Association. "The AMA encourages the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such ... modification of laws and regulations is urgent, considering the contribution of injecting drug use to the epidemic of HIV infection."

In an article appearing in another issue of the Journal of the American Medical Association that year entitled "Prevention of HIV/AIDS and Other Blood-Borne Disease Among Injection Drug Users" the authors noted that "Over-the counter sale of syringes is likely to be a highly cost effective means of increasing the availability of sterile syringes through an extensive network of retail pharmacies , and together with the expertise of pharmacists, would help ensure wide access to syringes and professional advice."

It is important to note that only eight states (California, Delaware, Illinois, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island) still require prescriptions to purchase syringes. You should also know that two northeast states have enacted legislation similar to what is proposed in HB 427: In 1992, the state of Connecticut passed a law (HB 5015, Act 185) which permitted pharmacies to sell syringes without a prescription, and in 1993, the state of Maine (HB 587 Chapter 791) removed the requirement for prescriptions to buy syringes for people 18 years of age or older.

Following 1992, when Connecticut adopted legislation similar to HB 470, I supervised a team of scientists from the US Centers for Disease Control and Prevention, who joined the Connecticut Department of Public Health to evaluate its impact. What we found was published in two articles in the Journal AIDS, for which I was co-author. When legal restriction on both the purchase and possession of syringes was removed the following facts were documented:

- Most (83%) pharmacists sold non-prescription syringes after the law changed.
- In high drug using neighborhoods, the number of non-prescription syringes rose dramatically, while in low-drug using areas, little changed.
- Injecting drug users changed both their syringe buying practices and syringe sharing behaviors. It was found that syringe-sharing among drug-users **fell** thirty-nine percent after the laws passage.
- Most (78%) drug users surveyed **bought** syringes from a pharmacy. Fewer bought them on the street, and fewer bought them in shooting galleries.

- Needlestick injuries to police officers were **lower** after the change in the law (from six injuries/1,007 drug-related arrests before the new law to two injuries/1,032 arrests for a six-month time period after new laws.

We believe that HB 427, by making it easier for injection drug users to obtain sterile syringes, will have a health benefit for the individual injection drug user, and for their sexual partners and their children, and will have a societal benefit through the reduced transmission of the serious blood-borne infections, which cause substantial human suffering and impose major burdens on the health care system. We hope that this Committee will give full consideration to the scientific information that forms the public health foundation for HB 427, and that after consideration of this evidence the Committee will place its full support behind this bill . Thank you very much for this opportunity to speak to you about this most pressing public health matter. I will be happy to answer any questions that you may have.

Attachment E

American Medical Association
Physicians dedicated to the health of America

American Pharmaceutical Association
APhA

ASTHO
The Association of State and Territorial Health Officials

NASTAD
National Alliance of State and Territorial AIDS Directors

October 1999

HIV Prevention & Access To Sterile Syringes

Dear Colleague:

Approximately one third of all AIDS cases and one half of hepatitis C cases are directly or indirectly linked to injection drug use. Limited access to sterile syringes contributes to the transmission of these blood-borne infections among injection drug users (IDUs), their sex partners, and their children.

The United States Public Health Service recommends that drug users who continue to inject use a new, sterile syringe for each injection to prevent the transmission of blood-borne pathogens and that they obtain syringes from reliable sources such as pharmacies.

In many states, there are legal and regulatory barriers to the pharmacy sale of sterile syringes to IDUs, including prescription and drug paraphernalia laws and pharmacy regulations on syringe sales. The American Medical Association (AMA), the American Pharmaceutical Association (APhA), the Association of State and Territorial Health Officials (ASTHO), and the National Alliance of State and Territorial AIDS Directors (NASTAD) have suggested that the removal or modification of legal barriers is an important step in increasing the availability of sterile syringes through pharmacies. Connecticut, Minnesota, and Maine have made such changes.

AMA, APhA, ASTHO, and NASTAD have adopted the following policies related to pharmacy sale of syringes.

AMA (1997)	That the AMA strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription.
APhA (1999)	APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.
ASTHO (1995)	ASTHO policy states that as a possible public health strategy to reduce the transmission of injection-related blood-borne infections, states should explore the removal of legal barriers such as drug paraphernalia and prescription laws, which criminalize the distribution and/or possession of needles and syringes.
NASTAD (1997)	NASTAD calls on state and local legislative bodies to increase access to sterile needles and syringes through needle exchange programs; to deregulate possession of needles, syringes and associated injection equipment as drug

paraphernalia; to increase access to sterile syringes via sale by pharmacies; and to increase access to drug treatment for those individuals ready for such treatment.

NASTAD encourages each state health department to work with pharmacy boards and local law enforcement agencies to change local laws which would increase access to sterile injection equipment.

AMA, APhA, ASTHO, NASTAD, and the National Association of Boards of Pharmacy (NABP) believe that coordinated efforts of state leaders in pharmacy, public health, and medicine are needed to address access to sterile syringes as a means of preventing further transmission of blood-borne diseases.

We encourage you and other state leaders in these fields to meet, assess the situation in your state, and decide on appropriate approaches to these important public health issues. Other issues that may be important to consider are the availability of substance abuse treatment and options for safe disposal of syringes.

For more information, you can contact the following staff members of the organizations issuing this letter:

AMA	LJ Tan at (312) 464-4147, *litjen_tan@ama-assn.org*
APhA	Jann Skelton at (800) 237-2742 ext 7198, *jbs@mail.aphanet.org*
ASTHO	Helen Fox Fields at (202) 371-9090, *hffields@astho.org*
NABP	Jan Teplitz at (847) 698-6227, *jteplitz@nabp.net*
NASTAD	Julie Scofield at (202) 434-8090, *Jscofield@NASTAD.org*

We look forward to working with you to address these significant public health problems.

Sincerely,

E. Ratcliffe Anderson, Jr., MD
Executive Vice President
American Medical Association

John A. Gans, PharmD
Executive Vice President
American Pharmaceutical Association

Patti Shwayder
Interim Executive Vice President
Association of State and Territorial
Health Officials

Julie M. Scofield
Executive Director
National Alliance of State
and Territorial AIDS Directors

Carmen Catizone, MS, RPh
Executive Director / Secretary
National Association of Boards of Pharmacy

Attachment F

Concerning House Bill 427: **April 11, 2000**
AIDS Response Seacoast supports this Bill and urges its passage.

The multi-person reuse of syringes is a major risk factor for HIV infection. Providing access to clean, sterile equipment can mean the difference between life, HIV/AIDS and death. It is our goal to reduce the risk of HIV transmission and Hepatitis B and C.

The National Conference of State Legislatures Report states that "the lifetime cost for treating a person with HIV from infection until death is estimated at $154,402. (*JAMA*, Jan. 14, 1998)."

- An IDU with HIV infection can pass this virus on to sexual partners as well as drug using partners. Children born to a woman with HIV infection have real risks for acquiring the virus.

- **"The average total lifetime charges for care of children with HIV infection is estimated at $491,936**. This estimate is based on a child's median survival time of 120 months and the cost of both hospital-based and outpatient charges (Pediatric Infectious Disease Journal, June 1997)."

In the last 12 months **AIDS Response Seacoast served 148 clients, and of case managed HIV+ clients, 24% report injection drug use (IDU) related behaviors as their mode of transmission**. This includes men and women who are not injection users, but acquired the virus through sexual transmission, because a partner shared drug-using equipment at some point in the past.

- For example: AIDS Response Seacoast has two couples who acquired the infection in this manner. One of these individuals is close to death and will leave three young children behind.

- During the first nine months of 1999, the anonymous HIV counseling and testing sites in Rockingham and Strafford Counties tested 501 individuals. Eleven percent (11%) of the HIV+ test results were related to IDU.
- Injection drug users (IDUs) account for 21% of NH AIDS cases.

Drugs are here already; stronger and cheaper drugs keep coming in. In Foster's Sunday Citizen, on Feb.1, 1998, it was reported that there are an estimated 6000 injection drug users in NH.

- In 1998, there were three heroin overdose deaths in Dover and in 1999 there were six deaths in Portsmouth.

- NH borders Maine and Massachusetts, and is in close proximity to Boston, Lowell, Lawrence and Portland. I-93 and I-95 are often referred to as "gateways" for illegal drug trafficking.

(over)

JSI Research and Training Institute Inc., in their 1999 report and evaluation of the current HIV prevention programs in NH targeting IDU, stated that **there are no community norms here (held by IDU) for users to clean injection equipment every time before sharing**. This makes it even more important that drug-using individuals be able to access new, sterile needles and syringes.

The U.S. Department of Health and Human Services' *HIV Prevention Bulletin* (May 1997) states to advise drug users who continue to inject to "use only syringes obtained from a reliable source (pharmacies); use a new, sterile syringe to inject drugs". (Public Health Reports of June 1998, p.8)

There is no evidence that the accessibility of clean needles and syringes or even needle exchange programs increase the number of IDU or encourage the use of drugs. There is much evidence to show that these programs reduce the number of HIV infections.

- In Connecticut, HIV incidence actually decreased by one third after instituting needle exchange programs. (Public Health Reports, June 1998)

We do not advocate for the use of illegal drugs or the injection of drugs. We do support drug-using individuals in accessing drug treatment programs and for those persons who cannot or will not access treatment or who are unable or unwilling to stop injecting drugs, we encourage harm reduction strategies to reduce the risk of HIV and Hepatitis.

FYI: The **Rhode Island Senate Judiciary Committee** has passed a bill, S-2832, that would decriminalize the possession of hypodermic needles, allowing them to be purchased in pharmacies without a prescription. (Brown Daily Herald Online (www.browndailyherald.com) (04/05/00)

FYI: It pays to prevent Hepatitis C (HCV).

- According to the Centers for Disease Control and Prevention, there are at least 4 million people infected with HCV in the U.S., 85% of whom develop chronic liver disease. It is conservatively estimated that the total cost (medical and work-loss costs in the absence of liver transplants) of HCV to our society is $600 million per year. CDC *MMWR Recommendations and Reports*; 10/16/98.

- "The average lifetime cost for hepatitis C, in the absence of liver transplant, has been estimated to be about $100,000 for individual patients." 1998, the Trustees of Dartmouth College.

Speakers

SENATE PI-HHS COMMITTEE

Date 4/11/00 Time 2:00 PM Public Hearing on SB 427

Appearing in FAVOR: (Please print) **Please check box at left to speak.**

Speaking?	Name	Address	Representing
☐	~~DAVID BAILEY~~	~~BEDFORD~~	~~Pol~~
☑	JIM SPLAINE, REP.	PORTSMOUTH,	
☑	Cynthia Bouman	19 Fairway Dr. Dover	AIDS Response Seacoast
☐	Stephen DeGurski	75 High St, Exeter	AIDS Response Seacoast
☐	Leslie Lamprey	New London, NH 526-8899	NH Nurses' + Nurse Practitioner Assoc.
☑	Rep Tricia O'Keefe		Seabrook
☑	Rep Carolyn Kane		Portsmouth
☒	Janet Monahan	7 N. State St, Concord	NH Medical Soc.
☒	William Kassler	6 Hazen Dr	DHHS
☒	DAN SUNDQUIST	5 HEMLOCK ST. HAMPTON	PORTLAND, ME PUBLIC HEALTH

Appearing in OPPOSITION: (Please Print) **Please check box at left to speak.**

☐	DAVID BAILEY	BEDFORD	Police Chiefs Assoc.
☐			
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Testimony

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF COMMUNITY & PUBLIC HEALTH

6 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4501 1-800-852-3345, Ext. 4501 TDD Access: 1-800-735-2964

Donald L. Shumway
Commissioner

Kathleen A. Dunn
Director

April 12, 2000

Senator James W. Squires, Chair
Senate Committee on Public Institutions, Health and Human Services

Dear Senator Squires and Members of the Committee:

In follow-up to yesterday's hearing on HB 427, I would like to share the following information with the Committee.

At the hearing, concern was expressed about the attitudes and practices of injection drug users. If syringes were to become more widely available through pharmacies, would injection drug users obtain them; would they be willing to pay for them; and would this impact their needle sharing behaviors?

As indicated in my written and oral testimony, following Connecticut's change in syringe laws, the evaluations that were done by CDC and the State Health Department were quite rigorous from a scientific perspective, and lead to several papers published in the peer reviewed medical literature. I have included one of these articles for your review, but would like to summarize a few salient points from the Connecticut experience:

- *The proportion of IDU's who purchase syringes in pharmacies increased substantially.* According to one evaluation, that compared IDU's syringe purchase practices before and after enactment of the new law, the proportion of IDU's reporting ever having obtained a syringe in a pharmacy increased from 19% to 78%. Additional data indicate that 72% of the IDU's in one study, and 68% in another reported buying their syringes from a pharmacy.
- *The proportion of IDU's who obtained syringes from less reliable sources decreased.* According to the studies, the percent of IDU's who reported obtaining syringes on the street dropped from 88% to 74%; and from 35% to 23% for syringes obtained from a "shooting gallery". This demonstrates that when legal barriers are removed, many IDUs will choose to obtain some or all of their syringes in a pharmacy rather than from less reliable sources.
- *The proportion of syringe sharing reported by IDU's decreased.* The same study demonstrated that the proportion of IDU's who reported ever sharing a syringe decreased from 68% to 52% after enactment of the new laws; and of those reporting ever having shared a syringe there was a 39% decrease in reported incidents of sharing. This bolsters the view that removing legal barriers to obtaining syringes results in less sharing and lowered risk for HIV transmission.

In conclusion, the Connecticut experience has demonstrated a significant impact on injection drug use behavior, which in turn has been estimated to reduce HIV. A research team from Yale University, led by Dr. Edward Kaplan, tested returned syringes for the presence of HIV using a calculation that involved a return rate of syringes and the presence of HIV in syringes. A syringe exchange program was found to reduce new HIV infections by injection drug users in the program by one-third. Given the behavioral changes seen in response to Connecticut's policy change, it is entirely reasonable to presume a similar magnitude of benefit for HIV risk reduction in New Hampshire.

The issue was raised concerning the relative benefits of needle exchange versus deregulation. Over the counter sales of syringes can have a great impact for the following reasons:

- Pharmacies are a reliable source of new sterile syringes.
- Pharmacies are conveniently located.
- Pharmacies have extended hours of operations. Many pharmacies open early in the morning and remain open until late in the evening. Some operate on a 24-hour basis.
- Pharmacies are staffed by trained medical professionals. Pharmacists can provide sound medical advice about disease prevention and make referrals to appropriate community services.
- Pharmacies already have staff and supplies. Pharmacies have the existing infrastructure to offer syringe sales as part of their ongoing services without requiring additional resources for staff and supplies.
- Pharmacies are safe. Pharmacies provide a safer environment for IDU's to buy syringes then black market sources of syringes, such as drug dealers, needle dealers, and injection partners. These sources may provide used syringes that carry a greater risk of being contaminated.
- Pharmacies provide privacy. Pharmacies offer an alternative to individuals who do not want to be seen standing in line in front of a needle exchange van. Thereby risking public exposure as a drug addict.

While some worry that IDU's may shoplift, scare away customers, or encourage drug injecting and criminal activity near the store, in three studies (two in Connecticut, one in Maine) that involved surveying of pharmacists specifically asking them about negative experience associated with syringe sales, very few serious incidents were reported. In addition, pharmacists' reports of serious negative incidents related to non-prescription drug sales were minimal. In fact, State Pharmacy Boards, which play a key role in providing professional direction and guidance to pharmacies, and have traditionally taken a conservative stance when crafting regulation and practice guidelines related to non-prescription sale of syringes due to long-standing concerns about the association of such sales with illegal drug use, have gradually changed their position in response to mounting evidence indicating the positive public health benefits. Both the National Association of Boards of Pharmacy and the American Pharmaceutical Association have strongly encouraged state legislatures to revise laws to permit over the counter purchase of syringes to decrease disease transmission.

Finally, it was indicated that an evaluation of New Hampshire's experiences would be an important aspect of instituting such a program. The Department agrees and would welcome and support any amendment of the bill to require it. We would also commit, in the absence of such an amendment, to perform a rigorous evaluation using our existing resources. If I could be of any further assistance to you in this matter, please do not hesitate to ask. I can be reached at (603) 271-8560. Thank you very much for your consideration.

Sincerely,

William J. Kassler, MD, MPH
State Medical Director

WJK:sms
Enclosures

Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
10:82–89 © 1995 Lippincott–Raven Publishers, Philadelphia

Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting-Drug Users and Police Officers—Connecticut, 1992–1993

Samuel L. Groseclose, ‡Beth Weinstein, *T. Stephen Jones, †Linda A. Valleroy, Laura J. Fehrs, and §William J. Kassler

*Division of Field Epidemiology, Epidemiology Program Office, Centers for Disease Control and Prevention (CDC); *Office of HIV/AIDS, Office of the Director, CDC; †Division of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Services (NCPS), CDC, Atlanta, Georgia; ‡AIDS Division, Connecticut Department of Public Health and Addiction Services, Hartford, Connecticut U.S.A.*

Summary: To determine whether the simultaneous, partial repeal of needle prescription and drug paraphernalia laws in Connecticut affected purchasing and usage of needles and syringes (syringes) by injecting-drug users (IDUs) and risk of needlestick injuries to police officers, we conducted two serial cross-sectional surveys with IDUs recruited in drug treatment centers, correctional facilities, and health department settings. Reports of needlestick injuries among Hartford police officers were reviewed before and after the new laws. Among IDUs who reported ever sharing a syringe, syringe-sharing decreased after the new laws (52% before vs. 31% after; $p = 0.02$). Fewer IDUs reported purchasing syringes on the street after the new laws (74% before vs. 28% after; $p < 0.0001$). More IDUs reported purchasing syringes from a pharmacy after the new laws (19% before vs. 78% after; $p < 0.0001$). Eight to eleven months after the new laws were enacted, over two thirds (91 of 134) of active IDUs interviewed were aware of both new laws. Needlestick injury rates among Hartford police officers were lower after the new laws (six injuries in 1,007 drug-related arrests for 6-month period before new laws vs. two in 1,032 arrests for 6-month period after new laws). The changes in Connecticut laws were associated with decreases in self-reported syringe-sharing and increases in purchasing by IDUs of sterile syringes from reliable sources, suggesting that the simultaneous repeal of both prescription and paraphernalia laws is an important HIV prevention strategy. Key Words: Injecting-drug users—Needle prescription law—Drug paraphernalia law—Needle and syringe sharing—Needlestick injury.

Multi-person use (sharing) of syringes* is a major mechanism for transmission of human immunodeficiency virus (HIV) and other bloodborne pathogens among injecting-drug users (IDUs) (1–5). In response to the acquired immunodeficiency syndrome (AIDS) epidemic and HIV prevention interventions, IDUs in some localities have adopted safer injection practices and decreased syringe-

Presented in part in the *Morbidity and Mortality Weekly Report* 1993;42:145–8, at the IXth International Conference on AIDS, Berlin, Germany, June 7–11, 1993, and at the National Research Council's Workshop on Needle Exchange and Bleach Distribution Programs, Baltimore, Maryland, September 27–28, 1993.

At the time of this evaluation, Drs. Groseclose and Valleroy were Epidemic Intelligence Service officers with the CDC.

Address correspondence and reprint requests to Dr. Samuel L. Groseclose at Division of STD/HIV Prevention (E-63), Centers for Disease Control and Prevention, 1600 Clifton Road; Atlanta, Georgia 30333, U.S.A.

Manuscript received November 15, 1994; accepted April 18, 1995.

* We use the term "syringe" to include both needle and syringe.

sharing (6–10). Epidemiologic and ethnographic studies suggest that syringe-sharing even among IDUs knowledgeable of the means to avoid HIV infection has evolved, in part, as a response of IDUs to the restricted availability of syringes (9,11–17).

Effective July 1, 1992, Connecticut enacted new laws that removed some legal barriers to the purchase and possession of syringes as part of a strategy for reducing the spread of HIV among IDUs unable or unwilling to enter drug treatment (18). We conducted a study to determine whether changes in Connecticut's laws regulating needle prescriptions and drug paraphernalia affected syringe purchasing and usage by IDUs and police officers' risk of needlestick injuries.

Methods

Surveys of Active IDUs

We conducted two questionnaire surveys of active IDUs to assess their syringe-purchasing practices, their syringe-sharing behaviors, and their knowledge of the new syringe legislation. IDUs were enrolled consecutively and were interviewed by staff members at three health department–based HIV counseling and testing programs, three correctional facilities, and two-drug-treatment centers in four Connecticut towns—Bridgeport, Hartford, Montville, and Waterbury. Only male IDUs were interviewed in correctional facilities and they were interviewed within 7 days of being admitted or incarcerated.

To determine practices of IDUs before the new laws were enacted on July 1, 1992, we conducted an initial survey from August through November 1992. During this initial survey, IDUs were asked to describe their practices and behaviors in June 1992 (the 30-day period just before the laws were implemented and 2–4 months before the interview).

To determine practices of IDUs after the new laws went into effect, we conducted a second cross-sectional survey (follow-up survey) of different IDUs from March to June 1993 (8–11 months after enactment). IDUs interviewed during the follow-up survey were asked to describe their practices, focusing on the 30-day period before the interview.

We defined active IDUs as persons who reported using a syringe to inject drugs into their veins or muscles or under their skin. During both surveys, we limited eligibility to persons who reported injecting drugs during the month before the interview. During the initial survey, we restricted eligibility to IDUs who also reported injecting drugs in June 1992. We defined syringe-sharing as using a syringe (the IDU's own syringe or one that belonged to someone else) that the IDU knew had been used by someone else.

Police Department Data

To determine whether police officers were at greater risk for needlestick injuries after the new laws were enacted, Occupational Safety and Health Administration (OSHA)–mandated reports of occupational injuries and illnesses among Hartford police officers were reviewed for reports of needlestick injuries. We used data for drug-related violations likely to be associated with syringe use to provide some information about police drug enforcement activity before and after the new laws and to serve as a surrogate denominator for the incidence of needlestick injuries. We used Federal Bureau of Investigation Uniform Crime Reporting criteria to define a drug-related arrest as an arrest for possession of opiates, cocaine, or paraphernalia. We determined the number of needlestick injuries and drug-related arrests for the 6 months before (January 1992 through June 1992) and after (July 1992 through December 1992) the new laws were enacted.

Statistical Analysis

Data were analyzed by using Epi Info, Version 5.01b software (19). The sample means from the initial and follow-up surveys were compared by using an independent two-sample t test (20). Rates and proportions were compared by using an independent two-sample z test.

Results

Surveys of Active IDUs

Selected Demographic Characteristics and Syringe-Related Practices

During the initial survey, 187 persons were asked to participate: 124 (66%) IDUs were eligible; nine (5%) refused to participate; and 54 (29%) had never injected drugs or were no longer actively injecting drugs (ineligible). Of the 210 persons asked to participate in the follow-up survey, 134 (64%) were eligible; eight (4%) refused to participate; and 68 (32%) were ineligible. The sex and race/ethnicity of eligible IDUs interviewed during both surveys were similar (Table 1). During the follow-up survey, a significantly greater proportion of the IDUs were interviewed in drug treatment facilities than in the initial survey (68 vs. 51% in the initial survey; $p = 0.01$).

The age, duration of injecting-drug use, and frequency of injection for IDUs in our initial and follow-up survey samples were similar (Table 2). IDUs in the samples had a median age of 35 years (range: 17–56 years). IDUs reported using injecting-drugs for a median of 14 years (range: 1–33 years; Table 2). Three-percent (4 of 116) of IDUs in the initial sample and 5% (7 of 128) of IDUs in the follow-up sample reported that they began injecting drugs within the previous 12 months. Although the mean number of reported injections per month declined after the new laws (143 before vs. 124 after; $p = 0.13$), the reported number of injections did not vary significantly when data were adjusted for knowledge of the new laws or source of syringes.

More IDUs in the initial survey reported that they had ever shared syringes compared with IDUs in

TABLE 1. *Selected characteristics and practices of the initial and follow-up survey samples of active IDUs, Connecticut, 1992–1993*

Characteristic/ practice	Initial survey (total n = 124) n (% distribution)	Follow-up survey (total n = 134) n (% distribution)	p^a
Sex			
Male	98 (79)	111 (83)	0.52
Female	25 (20)	23 (17)	0.65
Race/ethnicity			
Non-Hispanic White	53 (43)	63 (47)	0.56
Hispanic	50 (40)	45 (19)	0.32
African-American	21 (17)	26 (19)	0.80
Site of interveiw			
Correctional facility	27 (22)	27 (20)	0.80
Drug treatment	63 (51)	91 (68)	0.01[b]
Health department	34 (27)	16 (12)	0.003[b]
Ever shared a needle and syringe?			
Yes	84 (68)	70 (52)	0.03[b]
Ever obtained a needle and syringe?			
On the street	109 (88)[c]	99 (74)	0.01[b]
In a pharmacy	58 (47)[c]	120 (90)	0.0001[b]
In a "shooting gallery"	43 (35)[c]	31 (23)	0.05[b]
Needle exchange	8 (6)[c]	25 (19)	0.01[b]
Other source	56 (45)[c]	21 (16)	<0.001[b]
Ever owned your own needle and syringe?			
Yes	114 (92)	133 (99)	0.004[b]

[a] Two-sided; z test.
[b] Significant at $p \leq 0.05$.
[c] Includes reported purchasing during the 2–5 months after the new laws and before the survey.

the follow-up survey (68 vs. 52%, respectively; p = 0.03; Table 1). More IDUs in the initial survey reported ever having obtained syringes on the street (p = 0.01) and from some other source (e.g., from persons with diabetes or other friends; $p < 0.0001$), and fewer reported ever having obtained syringes from a pharmacy (p = 0.0001), from a "shooting gallery" (p = 0.05), or from a needle exchange (p = 0.01) compared with IDUs in the follow-up survey (Table 1).

TABLE 2. *Self-reported practices of active IDUs interviewed during the initial and follow-up surveys, Connecticut, 1992–1993*

Practice	Initial survey (n = 124) Mean (range) [no. responding]	Follow-up survey (n = 134) Mean (range) [no. responding]	p^a
Duration of injecting drug use (years)	14 (1–33) [116]	13 (1–33) [128]	0.61
Number of injections in 30 days before interveiw	143 (2–405) [115]	124 (1–930) [130]	0.13
Number of syringes owned at one time[b]	9 (1–100) [81]	11 (1–100) [132]	0.63
Number of times a syringe reused	8 (0–63) [116]	7 (0–42) [131]	0.65

[a] Two-sided; t test.
[b] Among IDUs who reported owning at least one syringe.

Reported Syringe-Sharing

Fifty-two percent (44 of 84) of IDUs who had ever shared syringes reported at least one episode of syringe-sharing in the 30-day period before the new laws. After the new laws, a smaller proportion of IDUs who had ever shared syringes reported doing so at least once in the 30-day period preceding the follow-up survey [31% (22 of 70); $p = 0.01$; Fig. 1)]. Reported syringe-sharing did not vary by interview site. Among the IDUs reporting that they purchased syringes only in a pharmacy after the new laws, 30% (14 of 46) reported at least one needle-sharing episode in the previous 30 days.

Sources of Syringes

Fewer IDUs reported purchasing syringes on the street after the new laws went into effect (92 of 124 before vs. 38 of 134 after; $p < 0.0001$; Fig. 2). More IDUs reported purchasing syringes from a pharmacy after the new laws (23 of 124 before vs. 105 of 134 after; $p < 0.0001$).

After the new laws were enacted, pharmacies replaced street sources as the most frequently reported source of syringes. In the follow-up sample, 78% (105 of 134) of IDUs reported purchasing at least one syringe from a pharmacy compared with 28% (38 of 134) who reported purchasing at least one syringe on the street. After the new laws, fewer IDUs reported using syringes obtained in "shooting galleries" (16 of 124 before vs. 6 of 134 after; $p = 0.01$). Also, after the new laws, more IDUs reported obtaining syringes from needle exchange programs in Connecticut (4 of 124 before vs. 15 of 134 after; $p = 0.01$). Fewer IDUs reported obtaining their syringes from some other source after the new laws were enacted (56 of 124 before vs. 21 of 134 after; $p < 0.0001$).

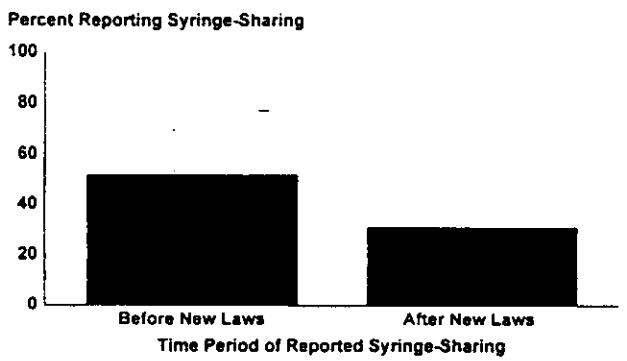


FIG. 1. Self-reported syringe-sharing before and after the new laws among active IDUs who ever shared. Connecticut, 1992–1993. Syringe-sharing was defined as at least one episode of syringe-sharing in the 30-day period before the new laws (initial survey; before) and the 30-day period before the follow-up survey (after).

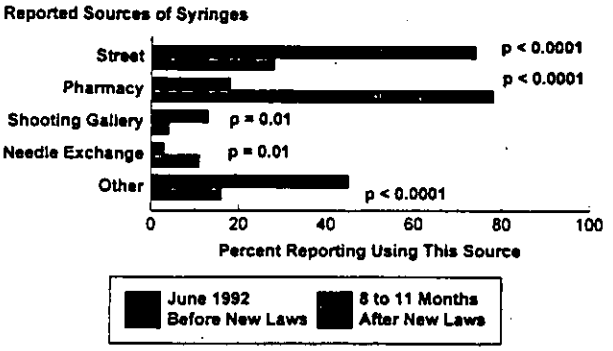


FIG. 2. Active IDUs' reported sources of syringes during 30-day periods before and after the new laws. IDUs could report multiple sources for syringes.

Reported Prices of Syringes

After the new laws, the reported street price of a syringe decreased from $2.35 (mean; range: $0.50–$5.00) before the laws to $1.79 ($0.50–$6.00; $p = 0.02$). The pharmacy prices reported by IDUs in our surveys remained unchanged at about 40 cents per syringe ($0.38 [$0.20–$0.60] before vs. $0.44 [$0.15–$1.00] after; $p = 0.07$).

Syringe Ownership and Reuse

More IDUs (99%, 133 of 134) reported owning at least one syringe after the new laws (during the 6 months preceding the follow-up interview) compared with IDUs reporting syringe ownership in the 6 months before the new laws (92%, 114 of 124; $p < 0.01$). Among IDUs who reported owning syringes, the mean number of syringes that IDUs owned did not differ before and after the new laws were enacted (Table 2). The number of times a syringe was reused before being discarded did not differ before and after the new laws were enacted (Table 2).

Syringe-Carrying Practices

Although self-reported syringe ownership increased, the percentage of IDUs reporting that they always carried syringes with them after the new laws did not increase significantly. Twenty-six percent (32 of 124) of IDUs in the initial survey reported always carrying at least one syringe on the

street before the new laws, compared with 34% (46 of 134) of IDUs in the follow-up survey (p = 0.18).

Thirteen percent (16 of 124) of IDUs in the initial survey reported that they were harassed by police for possession of clean syringes at least once during the 6-month period before the new laws were implemented. Under the new laws, the percentage was similar (14% [19 of 134] of IDUs interviewed during the follow-up survey).

Knowledge of New Laws

From 2 to 5 months after the new laws were enacted, 55% of IDUs reported they were aware that they could both purchase and possess clean syringes legally. Eight to 11 months after the new laws, 68% of IDUs reported that they were aware of the provisions of both new laws (p = 0.04; Fig. 3). During both periods, 21% of IDUs reported that they were aware they could legally purchase syringes, but did not know they could legally possess them. Less than 4% of IDUs interviewed during either survey period reported that they were aware of legal possession, but were not aware of legal over-the-counter purchase. During the follow-up survey, only 7% (10 of 134) did not know about either law compared with 23% (28 of 123) of IDUs interviewed just after enactment ($p = 0.001$). Sixty-four percent (18 of 28) of IDUs unaware of both laws in the initial survey and 60% (6 of 10) of those unaware of both laws in the follow-up survey were Hispanic. IDUs' knowledge of the new laws did not vary when the data were adjusted for interview site.

Police Officers' Risk of Needlestick Injury

Needlestick injury rates among Hartford police officers were higher during the 6 months before the law changed compared with the 6 months after (six needlestick injuries in 1,007 drug-related arrests before vs. two in 1,032 arrests after [two-sided $p = 0.27$; z test]).

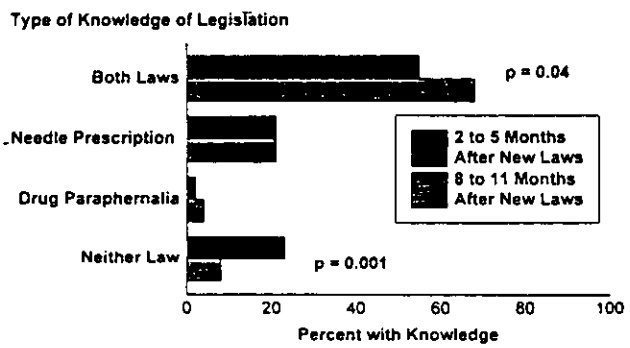


FIG. 3. IDUs' knowledge of partially repealed needle prescription and drug paraphernalia possession laws at 2–5 months (initial survey) and 8–11 months (follow-up survey) after the new Connecticut laws.

DISCUSSION

In the first year after the partial repeal of legal restrictions on both the purchase and possession of syringes in Connecticut, over two thirds of active IDUs interviewed were aware of both new laws, and many reported changes in their syringe-purchasing practices and their syringe-sharing behaviors. After the new laws went into effect, IDUs reported more purchasing of syringes in pharmacies, less purchasing on the street, and decreased syringe-sharing. These results are similar to those reported by IDUs in France after restrictions on the sale of syringes were removed (21,22). Increases in pharmacy sales of nonprescription syringes in Connecticut pharmacies after the new laws support the IDUs' self-reports of increased pharmacy purchasing (18).

The 39% decrease in syringe-sharing reported by IDUs in our samples (likely an underestimate because of the insensitive syringe-sharing definition) represents a significant reduction in risk that may lead directly to a decrease in the transmission of HIV and other bloodborne pathogens. Safer injection practices may have resulted from increased access to sterile syringes. In Washington State, where purchase of syringes in pharmacies is legal, IDUs who obtained syringes primarily from pharmacies were less likely to share injection equipment than were those with other primary sources (23). Other studies have suggested that increased access to sterile injection equipment may explain the stable HIV seroprevalence in Australia, New Zealand, and the Netherlands; the decline in prevalence of hepatitis B surface antibody among IDUs in Australia, the Netherlands, and Tacoma, Washington; and the lower HIV seroprevalence among diabetic IDUs (7,24–28).

Eight to 11 months after the new laws in Connecticut, 77% of the active IDUs we surveyed reported purchasing syringes from a pharmacy in the previous month; only 28% reported purchasing syringes on the street. In Washington State, where a prescription is not required, 66% of IDUs entering drug treatment reported buying syringes in a pharmacy as the primary method of obtaining syringes; 10% reported street purchasing as the primary method of

obtaining syringes (23). However, in Baltimore, Maryland, where purchasing syringes in pharmacies is legal but a law regulating paraphernalia is in effect, only 54% of IDUs had ever purchased from a pharmacy and 50% of those surveyed reported purchasing in the street as their main method of obtaining syringes (29). Although IDUs in Connecticut appear to have shifted their primary method of obtaining syringes after the new laws, data from Baltimore indicate that the absence of a needle prescription law does not necessarily result in purchasing sterile syringes in pharmacies by the majority of IDUs. Availability of sterile syringes in jurisdictions where purchase in pharmacies is legal may be limited because of racial bias or the pharmacist's unwillingness to sell syringes to IDUs (18, 30–34).

Findings from our evaluation and other studies suggest that barriers still exist which decrease the likelihood that IDUs will carry their own syringes with them, thus increasing the likelihood of unsafe syringe sharing (9,31,35). Even though IDU's knowledge of the new laws increased, the percentage of IDUs reporting that they always carried a syringe on the street increased only slightly (from 26 to 34%). Hispanic IDUs were less likely to know about both new laws, suggesting that language or cultural barriers limited knowledge. After the new laws, the percentage of IDUs reporting they had been harassed by police for possession of clean syringes did not decrease.

Police practices regarding the relative importance of syringe possession as a criminal offense may vary by individual officer–IDU interaction and by locality (Lieutenant Tom O'Connor, Hartford Police Department and Lieutenant Richard Walsh, Wethersfield Police Department, personal communications) (32). In focus groups with active IDUs in Connecticut, IDUs reported different police practices regarding possession of syringes. For example, an officer might request that the IDU dispose of the syringe safely in the presence of the officer with no further consequence; or another officer might arrest the IDU for paraphernalia possession pending further investigation (S. Groseclose, 1992, unpublished data). Different police responses to finding a syringe on an individual ensure that IDUs will continue to receive conflicting feedback regarding their ability to carry a clean syringe legally. Regardless of knowledge of the new laws, an IDU's perception that he/she can be harassed or arrested for possession of a clean syringe may continue to discourage the IDU from carrying a syringe—increasing the likelihood of unsafe syringe-sharing.

Another possible effect of the new laws could have been to increase the risk of needlestick injuries to police officers after the new laws were enacted. Although the officers' risk of needlestick injury may depend on factors that we did not measure, OSHA reports of needlestick injuries among Hartford police decreased after the new laws. Increased risk of needlesticks has not been observed in other localities where access to syringes has been increased (7,36). Interviews with AIDS outreach workers and police officers from several Connecticut towns did not indicate any significant increase in the number of discarded syringes in their communities after the new laws were enacted (S. Groseclose, 1993, unpublished data).

Our study has several limitations. Because our active IDU samples were not randomly selected, their representativeness is uncertain. Our samples from health department programs and drug treatment and correctional facilities may overrepresent ethnic and racial minorities. However, these communities are disproportionately affected by HIV and are, therefore, appropriate for evaluation. The poorly defined IDU population makes construction of a valid sampling frame almost impossible. Because the intervals for recall were not equal, self-reported data from our initial and follow-up surveys may be subject to differential recall bias. As with most self-reported behavioral data, the effect of social desirability on IDUs' self-reported behavior is difficult to assess. However, various studies have suggested that IDUs' self-reports of recent drug use and of arrests and hospitalizations correlate well with objective data (37,38).

This evaluation did not directly measure the impact of the legislation on HIV transmission. However, the proportional decrease in reported syringe-sharing of 39% that we report here would be expected to translate into cases of HIV infection prevented—the goal of increasing access to sterile syringes.

Although stopping drug use is the most effective means of HIV prevention among IDUs, many IDUs are unwilling or unable to stop (39,40). Therefore, multifaceted interventions must encourage risk reduction and entry into drug treatment. The National Commission on AIDS recommended the removal of legal barriers to the purchase and possession of syringes as part of a strategy for reducing the spread of HIV among IDUs unable or unwilling to enter

drug treatment (41). Our data suggest that when legal restrictions on both the purchase and possession of syringes are removed, IDUs will change their syringe-purchasing practices and their syringe-sharing behaviors in ways that can reduce HIV transmission.

Acknowledgment: The authors thank the counselors and administrators of the Hartford Dispensary; Bridgeport Regional Network of Programs; Chemical Dependency Unit, Community Health Services, Hartford; Hartford Police Department; AIDS Program, Hartford Health Department; AIDS Program, Bridgeport Health Department; AIDS Program, Waterbury Health Department; Town of Wethersfield Police Department; Bureau of Addiction Services, Connecticut Department of Public Health and Addiction Services; and the Health Services Division, Connecticut Department of Correction. In addition, Henry R. Rolka, M.S., and P. Imani Thompson, Ed. M., provided valuable assistance during this evaluation.

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Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology
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Letters to the Editor

Sale and Exchange of Syringes

To the Editor: Findings from our ongoing study of patterns of AIDS risk among out-of-treatment injection drug users (IDUs) in Hartford, CT support and extend the data presented by Linda Valleroy and Sam Groseclose. As part of a National Institute on Drug Abuse project, we have interviewed 571 male and female active IDUs (verified by urine drug testing) recruited through street outreach. This data contributes to the evaluation of the Hartford Needle Exchange Program (NEP).

The Hartford NEP is coordinated by a community consortium under the direction of the Hartford Health Department. Services are provided through a mobile van and include one-for-one exchange of (up to ten) syringes, as well as HIV prevention education, assisted referral for drug treatment and health services, and distribution of prevention materials (e.g., condoms, bleach, prevention literature). The Hartford NEP exchanges approximately 3,000 syringes per month.

Our study has collected data from cross-sectional samples of IDUs during three time periods: (a) September 1992 to March 1993, following the enactment of state legislation decriminalizing needle possession and allowing non-prescription pharmacy sale of syringes for the first time in 14 years; (b) April 1993 to March 1994, following the start-up and initial implementation phase of the Hartford NEP; and (c) April 1994 to March 1995, the second year of NEP operations, by which time the program was well-known among drug injectors. The number of participants interviewed in each of these time periods was 179, 167, and 225 respectively.

Over the three time periods, there was a progressive reduction in the barriers to sterile needle access for IDUs. For each of these periods, there was a corresponding significant increase ($\chi^2 = 13.03$; $p = 0.04$) in the percentage of IDUs reporting that they purchase syringes from a pharmacy (63.1%, 71.2%, and 76.8%, respectively). Between the first and second NEP periods, there also was a significant increase (from 51.2% to 64.9%) in the percentage of IDUs reporting use of the NEP ($\chi^2 = 8.1$; $p = 0.08$). By the second NEP period, 50% of the IDUs surveyed reported that they get more than half to all of their syringes from the NEP.

These changes have contributed to a reduction in needle-related HIV risk behavior. There was a progressive drop (from 22% to 19% to 10%) across the three time periods ($F = 2.01$; $p = 0.05$) in the proportion of drug injections among study participants involving a previously used (and potentially HIV and/or hepatitis infected) syringe.

In sum our findings show increased syringe purchase from pharmacies and increased NEP use through time, and an associated drop in the relative frequency of HIV risk behavior (i.e., multi-person use of syringes) among IDUs. These findings confirm the beneficial effects of the 1992 changes in Connecticut's syringe purchase and drug paraphernalia laws, as well as the usefulness of needle exchange. We strongly recommend that states/counties with prescription requirements for syringe purchase and/or criminal penalties for possession or distribution of syringes repeal these laws. There is a critical need to continue the process of increasing access to sterile needles among IDUs. Needed changes include deregulating syringe sale and possession, implementing needle exchange, increasing the capacity of existing NEPs to serve all of the IDUs in their catchment area, recruiting shooting galleries as sterile syringe sites, promoting the ability of IDUs to discard syringes after every use, and exploring new avenues of sterile syringe exchange, such as vending machines.

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In Eastern Connecticut, IDUs Purchase Syringes from Pharmacies But Don't Carry Syringes

To the Editor: In July 1992, new State of Connecticut laws went into effect that allowed the purchase of up to ten syringes without a prescription and possession of up to ten syringes. In two towns in Eastern Connecticut (New London and Willimantic) between March and November 1994, the Eastern Connecticut Health Outreach Project (funded in part by Grant RO1 DA08014 from the National Institute on Drug Abuse) interviewed injecting drug users (IDUs) who were not currently in drug treatment programs about purchasing and carrying syringes.

Pharmacies have become the leading source of syringes for Eastern Connecticut IDUs. Of the 147 respondents who had injected during the 30 days prior to interview, 79 (53.7%) obtained syringes primarily from pharmacies (see Fig. 1A). However, while 131 (89.1%) of respondents reported "no difficulty" obtaining sterile syringes, 33

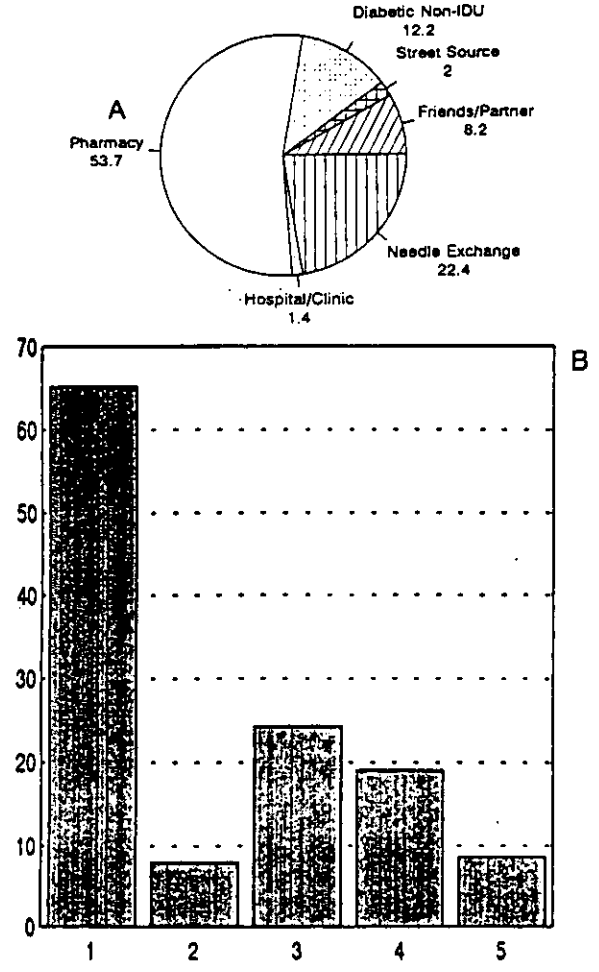


FIG. 1. Obtaining and carrying syringes. A: Primary sources of syringes for IDUs over the past 30 days. B: Reasons IDUs give for not carrying syringes with them. More than one answer possible. 1, fear of police; 2, fear of family; 3, not intending to inject; 4, injects in one place only; 5, other reasons.

(22.4%) reported obtaining syringes primarily from potentially unreliable sources such as diabetics, partners, and needle dealers.

Our data on IDUs' willingness to carry syringes are less encouraging. At the time of interview, only 37 of 158 respondents (23.4%) had syringes in their possession, and only 48 of 159 (30.2%) reported that they normally carried them. If IDUs are not carrying their own syringes, they may use other IDUs' syringes.

The primary reason (see Fig. 1B) given for not carrying syringes was fear of arrest (64.9%), a concern that did not significantly vary by gender, ethnicity or race. This fear is well-grounded. At least seven study participants reported recent arrests for possession of new syringes, used syringes, or for possession of other injecting equipment such as cookers. A sample of 66 local police reports in the Willimantic Chronicle and the New London Day from January to December of 1994 revealed that more than one-tenth (11.3%) of all reported arrests (35 of 310), and about one-fourth (28.5%) of drug-related arrests (35 of 123), included drug-paraphernalia possession charges.

IDUs' strategies for avoiding arrest for possession of syringes may increase the risk of HIV transmission. For example, we observed IDUs hiding syringes in public places (e.g., bushes) where they could potentially be found and used by other IDUs. We also observed a child find such a syringe.

In Eastern Connecticut, the current enforcement of the drug paraphernalia law for possession of syringes and the resulting concerns among IDUs about arrest for possession of syringes may increase the frequency of multiperson use of syringes and the possibility of transmission of HIV and other blood-borne infections among IDUs.

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Committee Report

Date: April 11, 2000 Time: 2:00 pm

The Senate Committee on Public Institutions/Health Human Services held its hearing in Room 102, LOB, Concord, New Hampshire.

BILL NO.: HB 427 TITLE: relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

Members of the Committee present: Senator Squires
Senator Wheeler
Senator Pignatelli

Those appearing in favor:

Name and Address	Representing
See Attached.	

Those appearing in opposition:

Name and Address	Representing
See Attached.	

REPORT OF THE COMMITTEE:

- ☒ Ought to Pass
- ☐ Ought to Pass w/ Amendment
- ☐ Inexpedient to Legislate
- ☐ Rereferred
- ☐ Interim Study
- ☐ Continued Hearing
- ☐ Postponed Hearing

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: APRIL 18, 2000

THE COMMITTEE ON Public Institutions/Health Human Services

to which was referred House Bill 427

AN ACT relative to the laws requiring a prescription to possess hypodermic needles and modifying the drug paraphernalia laws applying to syringes.

VOTE: 5-0

Having considered the same, report the same without amendment and recommend that the bill: **OUGHT TO PASS.**

Senator Katie Wheeler
For the Committee