

Syringe Exchange in Allegheny County: A Legal Analysis

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Summary

Prevention Point Pittsburgh is a non-profit organization that is working to prevent the spread of HIV and other blood borne diseases through needle exchange and drug treatment programs. Prevention Point asked that the Public Interest Advocacy Clinical examine the legality of a locally authorized Syringe Exchange Program in Pittsburgh. In reaching our conclusions, we consulted the extensive scientific literature on syringe exchange and HIV, as well as the applicable statutes and case law from Pennsylvania and across the nation. **We conclude that a bona fide syringe exchange program, operated under a city's health powers or by a board of health in a good faith effort to prevent HIV transmission, does not violate Pennsylvania law or exceed the limits of local legal authority.** Other key findings include:

Syringe Exchange:

- Prevents new cases of HIV among intravenous drug users, their sex partners, and children.
- Does not promote new drug use or increased use among existing intravenous drug users.
- Would save Pennsylvania and Pittsburgh taxpayers and employers millions of dollars in taxes because it would relieve the burden of caring for uninsured patients with HIV.

Our legal analysis finds that:

- The Pennsylvania Constitution, the Allegheny County Home Rule Charter and extensive case law grant Allegheny County, through its Health Department, the power to authorize a syringe exchange program in order to protect the health of county citizens.
- **\$** The City of Pittsburgh may have the authority to authorize or operate a syringe exchange program under the general police powers conferred by the Pennsylvania Constitution and the City's Home Rule Charter. However, a conservative legal analysis suggests that the City's power to enact health measures has been superseded by the establishment of the county health department.
- Pennsylvania's drug paraphernalia law was not intended to prohibit legitimate public health measures such as syringe exchange. It was intended to combat the growing problem of retail drug paraphernalia sales conducted by "head shops."
- Syringe exchange providers lack the criminal intent required to violate the drug paraphernalia law.

I. Syringe Exchange is a Legitimate, Medically Effective Public Health Measure That Has Been Shown Not to Increase Drug Abuse

Needle exchange is a legitimate, medically effective, public health measure. Because of medical evidence demonstrating its effectiveness, needle exchange has received substantial and growing support from leading medical authorities ¹, professional organizations,² the President's HIV Advisory Council and the Pennsylvania Medical Society. The Secretary of Health and Human Services, pursuant to Public Law 105-78, certified to Congress that syringe exchange programs ("SEPs") prevent HIV and do not promote drug use.³ This section reviews the scientific evidence on the effectiveness of SEPs, their lack of harm, and their probable impact on the rate of HIV in Pittsburgh.

A. Studies Prove the Effectiveness of Syringe Exchange

HIV among injecting drug users (IDUs) has now been documented in over 60 countries in the world, and there are an additional 40 countries where injecting drug use has been reported, including widespread epidemics in southeast and southern Asia and Latin America.⁴ More new Human Immunodeficiency Syndrome (HIV) infections have been predicted to occur

¹ These include the Centers for Disease Control and the National Commission on AIDS. See North American Syringe Exchange Network (<http://www.nasen.org>).

² These include the American Medical Association, the American Public Health Association, the American Bar Association and the U.S. Conference of Mayors. Christopher S. Wren, *White House Drug and AIDS Advisors Differ on Needle Exchange*, N.Y. Times Mar. 23, 1998 at A10.

³ Sheryl Gay Stolberg, *Ban on Federal Funds for Needle Exchange to Continue*, N.Y. Times Apr. 21, 1998 at A1.

⁴ D. Paone et al., *Syringe Exchange: HIV Prevention, Key Findings, and Future Directions*, 30 Int. J. Addict. 1647 (1995).

among injection drug users (IDUs) than any other risk group in the United States.⁵ The sharing of syringes by IDUs is the leading source of HIV infection among women and children,⁶ and also a leading cause of transmission of the hepatitis viruses.⁷ The reuse of syringes is a known risk factor for acute bacterial endocarditis, subcutaneous abscesses and cellulitis, which can have serious and even fatal health consequences, and the treatment of which costs tens of millions of preventable health expenditures every year. Given the enormity of the HIV epidemic among IDUs and the critical need to reduce the spread of HIV transmission to and from IDUs, prevention efforts are essential to the public's health.⁸ Additionally, there is now evidence of a massive epidemic of Hepatitis B & C among drug users.⁹ Because of these potentially fatal diseases, there is an added need for effective public health measures targeted at drug users.

In 1997, the leading U.S. public health agencies issued recommendations for reducing the risk of disease transmission through drug use.¹⁰ In the document, the Centers for Disease Control and Prevention (CDC), the National Institute on Drug Abuse, and the Health Resources and Services Administration suggest that health care workers counsel IDUs who

⁵ S.D. Holmesburg, *The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas*, 86 Am. J. Public Health 642, 654 (1996).

⁶ P.M. Wortley & P.L. Fleming, *AIDS in Women in the United States: Recent Trends*, 278 JAMA 911, 916 (1997); Normand J, Vlahov D & Moses L, *Preventing HIV Transmission: The Role of Sterile Needles and Bleach* (1995).

⁷ M.J. Alter, LA Moyer, *The Importance of Preventing Hepatitis C Virus Infection Among Injection Drug Users in the United States*, 18 J. Acquir. Immune Defic. Syndr. S11, S19 (Supp. 1, 1998).

⁸ *Id.*

⁹ J.G. Donahue et al., *Antibody to Hepatitis C Virus Among Cardiac Surgery Patients, Homosexual Men, and Intravenous Drug Users in Baltimore, Maryland*, 134 Am. J. Epidemiology 1206 (1991); O.S. Levine et al., *Seroepidemiology of Hepatitis B Virus in a Population of Injecting Drug Users: Association with Drug Injection Patterns*, 142 Am. J. Epidemiology 331 (1995).

¹⁰ U.S. Public Health Service. *HIV Prevention Bulletin: Medical Advice for Persons Who Inject Illicit Drugs*. Atlanta, GA and Rockville, MD: U.S. Public Health Service, May 8, 1997.

continue to inject to use a new sterile syringe each time they prepare and inject drugs. This approach has been endorsed by various medical and public health organizations, including the U.S. Preventive Services Task Force, the National Academy of Sciences, the American Medical Association, and the Association of State and Territorial Health Officials. This recommendation is certainly consistent with the strong evidence that the organized provision of safe injection equipment reduces HIV transmission, and can facilitate entry into substance abuse treatment.¹¹

Throughout much of Western Europe and in Australia, users of heroin and other injection drugs have had legal access to clean needles since the mid-1980's.¹² Providing legal access to sterile injection equipment, whether through over the counter sales, syringe exchange programs or both, has become a standard public health strategy for preventing further spread of HIV among IDUs in nearly all other developed countries.¹³ Syringe exchange programs have also become common throughout the United States, including the cities of Philadelphia and New York.¹⁴ The goal of SEPs is to reduce the transmission of HIV and other blood-borne infections associated with drug injection by providing sterile syringes and other “works,” in

¹¹ D.C. Des Jarlais et al., *HIV Incidence Among Injecting Drug Users in New York City Syringe-Exchange Programs*, 348 *Lancet* 987, 91 (1996); S.F. Hurley et al., *Effectiveness of Needle Exchange Programs for Prevention of HIV Infection*, 349 *Lancet* 1797, 1800 (1997); D. Vlahov et al., *Reductions in High-risk Drug Use Behaviors Among Participants in the Baltimore Needle Exchange Program*, 16 *J. Acquired Immune Defic. Syndr.* 400, 406 (1997); R. Brooner et al., *Drug Abuse Treatment Success Among Needle Exchange Participants*, 113 *Pub. Health Rep.* 129, 139 (Supp. 1, 1998).

¹² David L. Kirp & Ronald Bayer, *The Politics, Dimensions of HIV Prevention: Needle Exchange 77* (Jeff Stryker & Mark D. Smith eds., 1993).

¹³ D.C. Des Jarlais, Samuel R. Friedman, *Research, Dimensions of HIV Prevention: Needle Exchange 63, 64* (Jeff Stryker & Mark D. Smith eds., 1993).

¹⁴ North American Syringe Exchange Network. As of November 21, 1997 there are 122 SEPs operating in the United States that offer clean syringes to IDUs.

exchange for used and potentially contaminated needles.¹⁵ There is considerable scientific research which shows that access to clean syringes can reduce blood-borne infections in IDUs, their sexual and syringe sharing partners and their children.¹⁶ Researchers studying SEPs have focused on reported changes in behavior associated with HIV transmission among SEP clients. The data show that participants in SEPs are less likely to share injection equipment and more likely to use a new, sterile, syringe for each injection as recommended by public health officials.¹⁷ In an official report to Congress, Health and Human Services Secretary Donna Shelala concluded that SEPs are “an effective component of a comprehensive strategy to prevent HIV and other blood –borne infectious diseases.”¹⁸ The National Institutes of Health

¹⁵ *Update: Syringe Exchange Programs—United States*, 46 *Morbidity Mortality Wkly. Rep.* 565, 568 (1997).

¹⁶ See I School of Public Health, University of California, Berkeley; Institute of Health Policy Studies, University of California, San Francisco, *The Public Health Impact of Needle Exchange Programs in the United States and Abroad* (1993); Steven Koester, *Copping, Running, and Paraphernalia Laws: Contextual and Needle Risk Behavior Among Injection Drug Users in Denver*, 53 *Human Organization* 287(1994); J.P. Grund et al, *Drug Use Contexts and HIV Consequences: the Effect of Drug Policy on Patterns of Everyday Drug use in Rotterdam and the Bronx*, 887 *Br. J. Addiction* 381(1992); see also Lawrence O. Gostin, Zita Lazzarini, *Prevention of HIV/AIDS Among Injection Drug Users: The Theory and Science of Public Health and Criminal Justice Approaches to Disease Prevention*, 46 *Emory L.J.* 587 (1997).

¹⁷ U.S. General Accounting Office, *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy* (1993); Holly C. Hagan et al., *An Interview Study of Participants in the Tacoma Washington Syringe Exchange*. 88 *Addiction* 1691 (1993); D. Paone et al., *New York City Syringe Exchange Exchange: An Overview*, in National Research Council & Inst. Of Med., *Proceedings, Workshop on Needle Exchange and Bleach Distribution Programs* 47 (1994) (hereinafter NRC/IOM, *Proceedings*); K. Oliver et al., *Behavioral and Community Impact of the Portland Exchange Program*, in NRC/IOM, *Proceedings* at 35; J.K. Watters et al., *Syringe and Needle Exchange as HIV/AIDS Prevention for Injection Drug Users*, 271 *JAMA* 115 (1994); D.C. Des Jarlais & S.R. Friedman, *AIDS and the Use of Injected Drugs*, 270 *Sci. Am.* 82 (1994); Merril Singer et al., *Letter, Sale, and Exchange of Syringes*, 10 *J. Acquired Immune Deficiency Syndrome & Hum. Retrovirology* 104 (1995); Preventing HIV Transmission: The Role of Sterile Needles and Bleach (J. Normand et al. eds., 1995); D. Vlahov et al., *Reduction in High Risk Drug Use Behaviors Among Participants in the Baltimore Needle Exchange Program*, 16 *J. Acquired Immune Deficiency Syndromes & Hum. Retrovirology* 400 (1997). See generally Ernest Drucker et al., *Measuring Harm Reduction: the Effects of Needle and Syringe Exchange Programs and Methadone Maintenance on the Ecology of HIV*, 12 *AIDS S217 (Supp. A, 1998)* (reviewing research studies).

¹⁸ Donna Shelala, *Report to the Committee on Appropriations for the Departments of Labor, Health and Human Services, Education, and Related Agencies, Needle Exchange Programs in America: A Review of Published Studies and Ongoing Research* (1997).

convened a panel of medical experts who agrees that, “there is no longer doubt that these programs work.”¹⁹ Every major medical and scientific organization that has studied the issue agrees that increased access to sterile syringes reduces the spread of infectious diseases.²⁰

There have been numerous scientific investigations that show fewer cases of HIV infection among SEP participants.²¹ A major study compared changes over time in HIV rates in IDUs worldwide, for cities with and without SEPs. On average, seroprevalence increased by 5.9% per year in the 52 cities without SEPs, and decreased by 5.8% per year in the 29 cities with SEPs. The average annual change in seroprevalence was 11% lower in cities with SEPs.²² Another study estimated that between 4394 and 9666 new cases of HIV could have been prevented between 1987 and 1995 had syringe exchange programs been implemented in the United States during the early stages of AIDS epidemic.²³ Any reduction of HIV among IDUs is magnified by its secondary impact: prevention of infections IDUs would have passed on to sex partners or future children.

Researchers have also examined changes in the incidence of other diseases that, like

¹⁹ National Institutes of Health, *Consensus Development Statement, Interventions to Prevent HIV Risk Behaviors* (February 11-13, 1997) (available at <http://odp.od.nih.gov/consensus/statements/cdc/104/>>)

²⁰ Organizations supporting access to sterile syringes include: the American Medical Association, American Public Health Association, Centers for Disease Control and Prevention, Pennsylvania Medical Society, National Academy of Sciences, National Institutes of Health Consensus Panel, Office of Technology Assessment of the U.S. Congress, President Bush’s and Presidents Clinton’s AIDS Advisory Commissions.

²¹ E.H. Kaplan & R. Heimer, *HIV Incidence Among New Haven Needle Exchange Participants: Updated Estimates from Syringe Tracking and Testing Data*, 10 *J. Acquired Immune Deficiency Syndrome & Human Retrovirology* 175 (1995); D.C. Des Jarlais et al., *HIV Incidence Among Injecting Drug Users in New York City Syringe Exchange Programs*, 348 *Lancet* 987 (1996); S.F. Hurley et al., *Effectiveness of Needle Exchange Programs for Prevention of HIV Infection*, 349 *Lancet* 1797 (1997).

²² Hurley, *Supra* note 11.

²³ Peter Lurie et al., *An Opportunity Lost: HIV Infections Associated with Lack of National Syringe Exchange Program in the USA*, 349 *Lancet* 591 (1997).

HIV, are spread through syringe sharing.²⁴ In Pierce County, Washington, a case control study found that cases of both Hepatitis B and C occurred significantly less frequently among SEP participants than among control subjects.²⁵ New Hepatitis B and C cases attributable to injection drug use “clearly declined” within two years after an SEP was established.²⁶

SEPs are not a panacea for the AIDS epidemic. Research has shown that if the availability of clean syringes fails to meet the needs of the IDU population in a given community, redistribution of used equipment is likely to occur and subsequently affect HIV incidence.²⁷ Many policies, including those governing access to drug treatment, the sale of needles by pharmacies, and the arrest of IDUs for possessing needles, influence the spread of HIV.²⁸ There is no doubt, however, that SEPs are an important and effective tool in harm reduction strategies to minimize new HIV infection among IDUs and their sex and needle sharing partners and children.

²⁴ Gostin & Lazzarini, *supra* note 16, at 679.

²⁵ See Holly Hagan, et al., *Reduced Risk of Hepatitis B and Hepatitis C Among Injection Drug Users in the Tacoma Syringe Exchange Program*, 85 Am. J. Pub. Health 1531, 1533-34 (1995).

²⁶ See Holly Hagan et al., *Letter to the Editor: The Incidence of HIV Infection and Syringe Exchange Programs*, 226 JAMA 1646 (1991), available in 1991 WL 4874145; Michael J. Adler et al., *The Changing Epidemiology of Hepatitis B in the United States*, 263 JAMA 1218 (1990); see also Margaret A. McDonald et al., *Hepatitis C Virus Antibody Prevalence Among Injecting Drug Users at Selected Needle and Syringe Programs in Australia, 1995-1997*, 172 Med. J. Australia 57 (2000) (reporting decline in HCV prevalence and needle sharing among SEP users).

²⁷ J. Bruneau et al., *High Rates of HIV Infection Among Injection Drug Users Participating in Needle Exchange Programs in Montreal: Results of a Cohort Study*, 146 Am. J. Epidemiology 994 (1997); J. Bruneau et al., *Assessing Harm Reduction Strategies: The Dilemma of Observational Studies*, 146 Am. J. Epidemiology 1007, 1010 (1997). Although the Montreal study is sometime cited as evidence that SEP does not work, the authors of the study themselves took the unusual step of disclaiming that interpretation of their data; Julie Bruneau & Martin T. Schecter, *The Politics of Needles and AIDS*, N.Y. Times, Apr. 9, 1998 at 27.

²⁸ R. Heimer, R.N. Bluthenthal, M. Singer, K. Khoshnood, *Structural Impediments to Operational Syringe Exchange Programs*, 11 AIDS & Pub. Pol’y J. 169, 184 (1996).

B. Syringe Exchange Does Not Encourage Drug Abuse or Endanger Community Residents

There has been concern that SEPs could promote drug use, but growing scientific evidence and practical experience indicates that this is unfounded.²⁹ There is no evidence that SEPs promote drug use, but the evidence does show that SEPs can bring “difficult to reach populations into systems of care that offer drug dependency services, mental health, medical and support services.”³⁰ Studies from both the United States and the Netherlands by the National Research Council found no evidence to suggest that new injectors are being recruited because of access to syringes through SEPs.³¹ Studies that examined the length of time exchange participants had injected drugs showed an aging population of IDUs, and not an appreciable new influx of new, younger, drug injectors.³² Additional research has

²⁹ Six governmental reports found that increased access to sterile syringes does not increase drug use and there are no reports to contradict this finding. National Commission on Acquired Immune Deficiency Syndrome, *The Twin Epidemics of Substance Use and HIV*, Washington D.C.: National Commission on Acquired Immune Deficiency Syndrome, 1991; U.S. General Accounting Office, *Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy*, Washington D.C., U.S. General Accounting Office, 1993; Lurie, P., Reingold, A., *The Public Health Impact of Needle Exchange Programs in the United States and Abroad* (prepared for the Centers for Disease Control and Prevention), Berkeley, CA: University of California, School of Public Health and San Francisco, CA: University of California, Institute for Health Policy Studies: 1993; The Clinton Administration’s *Internal Reviews of Research on Needle Exchange Programs: Previously Unreleased Documents Plus Background Material*, Washington D.C.: Drug Policy Foundation, 1993; Office of Technology Assessment, 1995; National Research Council and Institute of Medicine, Proceedings, *Workshop on Needle Exchange and Bleach Distribution Programs*, Washington, D.C: National Academy Press, 1994.

³⁰ Shelala, *supra* note 18.

³¹ AIDS: Sexual Behavior and Intravenous Drug Use (C. Turner et al. Eds., 1989); *accord* School of Public Health, *supra* note 16 at 355-56.

³² In their 1998 literature review, Drucker et al. identified four studies published between 1993 and 1997 that used the mean age of SEP participants as a measure of whether SEP were encouraging earlier use of drugs. All four of these cross-sectional studies found increases in the mean age of SEP users since SEPs began operating. Seven of the review studies found reductions in measures of drug use, such as number of daily injections, while only one found an adverse relationship (fewer SEP users than non-users in a treatment cohort were quitting). Two studies found no significant effect. See Drucker et al, *supra* note 17; E.C.

demonstrated that participants in SEPs have greater access to drug treatment and other HIV and drug prevention services.³³ The National Institutes of Health Review concluded:

Do programs encourage non-drug users, particularly youth, to do drugs? On the basis of such measures as hospitalizations for drug overdoses, there is no evidence that community norms change in favor of drug use or that more people begin using drugs. In New Haven, for example, no increase in new drug users were reported after introduction of a safe needle exchange program.³⁴

The Boston Public Health Commission reported: “We have demonstrated that, far from being a deterrent for people to seek treatment, needle exchange can actually be a vehicle for people to seek treatment.”³⁵ This information is consistent with the general theory that physiological and psychological dependency and the availability of the drug, drive drug use itself, rather than the means to administer it.³⁶

SEPs do not lead to an increase of discarded needles in their vicinities³⁷ and may even lead to improvements. The conclusion of the Washington Supreme Court, in the only decision to test a local health department’s power to conduct needle exchange, is instructive:

While the primary focus of Tacoma’s exchange program, as well as other regions’, is to halt the spread of HIV and AIDS, it has been successful on numerous levels. Prior to the Tacoma program’s initiation, public restrooms,

Buning, *Effects of the Amsterdam Needle and Syringe Exchange*, 26 Int’l J. of Addictions 1303 (1991); H.J. Van Haastrecht, J.A. Van Den Hoek et al., *The Course of the HIV Epidemic Among Intravenous Drug Users in Amsterdam, the Netherlands*, 81 Am. J. Pub.Health 59 (1991); J.K. Watters, Y.T. Cheng et al., *Syringe Exchange in San Francisco: Preliminary Findings* (Presentation at the Seventh International Conference on AIDS, Florence, Italy, June 16-21, 1991).

³³ Paone, *supra* note 4.

³⁴ National Institutes of Health, *supra* note 19.

³⁵ Zachary R. Dowdy, *Local Activists Tout Needle Exchange*, Boston Globe, Apr 4, 1998 at B1 (quoting John Auerbach of the Boston Public Health Commission).

³⁶ Gostin & Lazzarini, *supra* note 16.

³⁷ M.C. Doherty et al., *Discarded Needles Do Not Increase Soon After the Opening of a Needle Exchange Program*, 145 Am. J. Epidemiology 730 (1997); National Institutes of Health, *supra* note 19.

parks, and streets in the city were littered with used, discarded needles and syringes. Due to the needle exchange, there has been such a significant reduction in discarded needles that the problem has almost been eliminated. Moreover, police officers monitoring the program have seen no increase in the number of IVDUs or in the frequency of injection. Finally, more than 300 IVDUs have entered drug treatment as a result of the Tacoma exchange.³⁸

C. Syringe Exchange Would Save Lives and Public Money

The Pennsylvania Department of Health reports that as of September of 1998 there were 20,556 cases of AIDS across the state with 6,699 (32%) attributed to intravenous drug use.³⁹ Based on the success of SEPs elsewhere, we can assume that up to half of these cases would not have occurred had SEPS been in place ten years ago.⁴⁰

The cost of treating a single case of HIV/AIDS from infection to death is estimated to be between \$157,811-\$195,188.⁴¹ Therefore, the cost of providing the standard level of medical care to 250 people through the full course of disease comes to approximately \$489,000,000 (This estimate does not include the cost of treating abscesses and endocarditis caused by unsterile injections). Since many IDUs do not have access to adequate medical care

³⁸ Spokane Health District v. Brockett, 120 Wash. 2d 140, 147; 839 P.2d 324, 327(1992).

³⁹ Bureau of Epidemiology, State Center for Health Statistics and Research, Pennsylvania Department of Health, AIDS Factline (800) 662-6080).

⁴⁰ S.D. Holmberg, *The Estimated Prevalence and Incidence of HIV in 96 Large Us Metropolitan Areas*, 86 Am. J. Pub. Health 642, 654 (1996). It is also estimated that intravenous drug users who use needle exchange programs were two thirds less likely to become infected with HIV than those who did not. DesJarlais, D.C., Marmor, M., Paone, D., et al., *HIV Incidence Among Injecting Drug Users in New York City Syringe Exchange Programs*, 348 Lancet 987, 991 (1996).

⁴¹M.T.French et al., *Estimating the Dollar Value of Health Outcomes from Drug Abuse Interventions*, 34 Med.Care 890 (1996) (estimating the cost to be \$157,811 per individual); P. Lurie, P, A.L. Reingold, B. Bowser et al., *The Public Health Impact of Needle Exchange Programs in the United States and Abroad*, prepared for the Centers for Disease Control and Prevention, October 1993; D.R. Holtgrave, S.D. Pinkerton, *Updates of Cost of Illness and Quality of Life Estimates for Use in Economic Evaluations of HIV Prevention Programs*, 16 Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology 54, 62 (1997) (estimating \$195,188 per affected individual).

and the latest medications, and preventable HIV infection has and will continue to exert an enormous economic toll, much of this burden will be borne by tax payers and employers through higher insurance premiums.

II. Municipal Governments and Local Boards of Health Have the Authority Under State Law to Establish and Fund Syringe Exchange Programs

Local governments and local boards of health in Pennsylvania have the authority to make rules and enact ordinances deemed necessary to protect the public health within their jurisdiction.⁴² Those powers include not only those granted in express terms, but also those of necessary and fair implication.⁴³ The powers of local home rule charter governments are liberally construed by courts, with ambiguities and conflicts with state law resolved in the local government's favor wherever possible.⁴⁴ Based on the proven medical efficacy of syringe exchange and the presumptive validity that municipal health actions enjoy under Pennsylvania law, local authorities in the Commonwealth generally have the authority to establish and fund syringe exchange programs as a function of their statutory authority to protect and preserve the public health.

⁴² The Disease Prevention and Control Law of 1955, 35 PA. Cons. Stat. Ann. Section 521.3 (West 1993); Local Health Law, 16 Pa. Cons. Stat. §§ 12002. *Commonwealth v. Creighton*, 639 A2d 1296, 1299 (Pa. Commw. Ct. 1994).

⁴³ *See* 16 Pa. Cons. Stat. Ann. Section 12011(c) (stating the county board of health shall exercise its rule making power for the promotion and preservation of the public health “generally”).

⁴⁴ *See* *County of Delaware v. Township of Middletown*, 511 Pa. 66, A.2d 811 (1986).

A. Allegheny County, Through Its Board of Health, Has the Authority to Establish, Fund, and Operate Syringe Exchange Programs

The county board of health has the authority under state public health law to establish and fund syringe exchange programs. Pennsylvania statutes grant authority to local boards of health to take actions to protect the health of the citizens within their jurisdiction, including the authority to act against communicable diseases.⁴⁵ Indeed, the Local Health Administration Law places upon the county health department a duty to “prevent or remove conditions which constitute a menace to public health.”⁴⁶

The public health powers of local boards are not limited to those specifically enumerated in the relevant statutes. To the contrary, local boards of health possess broad power to act in the interest of protecting and improving public health.⁴⁷ Because of the overriding importance of protecting the public from disease, the powers of local boards are wide and liberally construed by courts. It is well established in Pennsylvania law that the promotion and improvement of public health is a fundamental obligation of national, local, and state government. The constitutional provisions relating to the security of persons and property should therefore be liberally construed. Further, general welfare clauses have always been

⁴⁵ The Disease Prevention and Control Law of 1955, 35 Pa. Cons. Ann. Section 521.3 (West 1993); Local Health Administration Law, 16 Pa. Cons. Stat. Ann. Section 12010.

⁴⁶ 16 Pa. Cons. Stat. Ann. Section 12010(c).

⁴⁷ *Commonwealth v. Creighton*, 639 A.2d 1296, 1299 (Pa. Commw. Ct. 1994); *see also Philadelphia v. Watt*, 57 A.2d 591 (Pa. Super. Ct. 1948) (stating that a municipal board of health has the authority to abate a nuisance, and a strong abuse of such authority must be shown to induce a court to interfere with the decision of such a board); (A presumption exists that the exercise of power by the municipality is valid if no restriction is found in the Constitution, the charter itself, or the acts of the General Assembly). *Fraternal Order of Police v. Pittsburgh*, 644 A.2d 246, 248 (Pa. Commw. Ct. 1994); *Norristown Fraternal Order of Police v. DeAngelis*, 611 A.2d 322, 326 (Pa. Commw. Ct. 1992).

liberally construed to accord municipalities a wide discretion in the exercise of the police power.⁴⁸

Local boards of health enjoy a special status under state law. In the performance of their duties, they exercise a portion of the police power to secure the public health.⁴⁹ Boards of health are not simply bureaucratic bodies carrying out policies set elsewhere, but essential agents of public protection, wielding the basic power of the state to foster common welfare. County boards of health have the explicit authority to make and enforce rules and regulations as may be necessary for the “promotion and preservation of public health.”⁵⁰ Because HIV and other blood borne diseases pose a serious threat to the health of the citizens of the county, and because an SEP would be an effective public health measure to address the problem, the county board of health has the presumptive authority to fund or conduct an SEP.

The county board of health has the authority under state law to authorize an SEP for public health purposes. This can be done in two ways. First, the director of the county health department can authorize a syringe exchange program. Second, the board can exercise its rule-

⁴⁸ *McSwain v. Farrel*, 624 A.2d 256, 258 (Pa. Commw. Ct. 1993); *City Council v. City of Pittsburgh*, 625 A.2d 138, 145 (Pa. Commw. Ct. 1993); *U.S. v. Westinghouse Elec. Corp.*, 483 F.Supp. 1265 (D.C. Pa. 1980) (stating that the promotion and improvement of health is a fundamental obligation of national, local, and state government, and the constitutional provisions relating thereto for the security of persons and property should be liberally construed); *Commonwealth v. Cabell*, 185 A.2d 611, 613 (Pa. Super. Ct. 1962) (stating that “general welfare clauses have always been liberally construed to accord municipalities a wide discretion in the exercise of the police power”).

Health jurisdiction includes the prevention and control of communicable, contagious and infectious diseases, and wide latitude is afforded localities to devise appropriate means to both prevention and control of activities that endanger or threaten public health. Michael E. Libonati and John Martinez, *Local Government Law*, section 14.18 at 14-55(1997).

⁴⁹ The police power is a broad and flexible power that includes the power to promote the public health, morals or safety and the general well-being of the community. *Creighton*, 639 A.2d at 1299 n.6. *See generally* pp. 15-17, *infra*.

⁵⁰ 16 P.S. section 12001 et. seq.

making power by formulating rules and regulations for the prevention of disease, the prevention and removal of conditions which constitute a menace to health, and the promotion and preservation of the public health generally. The proposed rules are submitted to the county commissioners or the joint county health commission for approval or rejection and is published within thirty days. If approved, the rules become effective ten days after that approval. Rules that are declared emergency measures become effective immediately upon approval.⁵¹

Therefore it is clear that the Allegheny County Health Department has the power to authorize a syringe exchange program in the city of Pittsburgh.

B. The City of Pittsburgh May Have the Authority to Operate and Fund SEPs

Pittsburgh arguably may establish or fund a syringe exchange program, by ordinance or otherwise, under its general police power. The police power (which includes but is not limited to law enforcement) is one of the most essential powers of government. It is a broad and flexible power, which includes the power to promote the public health, morals or safety and the general well being of the community. The police power is the government's least limitable power as it involves the inherent power of a body politic to enact and enforce laws for the promotion of the general welfare.⁵² In an extensive discussion of police power in *National Wood Preservers, Inc. v. Commonwealth Dept. of Environmental Resources*,⁵³ the Pennsylvania Supreme Court wrote:

⁵¹ 16 P.S. section 12001 et. seq.

⁵² *Commonwealth v. Creighton*, 639 A.2d 1296, 1299 (Pa. Commw. Ct. 1994).

⁵³ 489 Pa. 221, 414 A.2d 37, appeal dismissed, 449 U.S. 803, 101 S.Ct. 47, 48, 66 L.Ed.2d 7 (1980).

The “police power” is one of the “most essential powers of government...” It has been variously defined as the power “to promote the public health, morals or safety and the general well being of the community,” or as “ the inherent power of a body politic to enact and enforce laws for the promotion of the general welfare,” or as a power extending to “ all the great public needs.” The police power is fundamental because it enables “civil society” to respond in an appropriate and effective fashion to changing political, economic, and social circumstances,” and thus to maintain its vitality and order. “ The police power of the state[must therefore be]...as comprehensive as the demands of society require under the circumstances.” Of necessity, then, the police power is a broad and flexible power. Indeed, it is the state’s least limitable power.⁵⁴

Police power enactments benefit from the presumption that the legislature acts within the limits of the law. Therefore, the party challenging the constitutionality of a police power measure must establish that it is arbitrary, unreasonable and unrelated to the public health, safety, morals or general welfare.⁵⁵

Under the Pennsylvania Constitution, local governments organized under a home rule charter may exercise “any function not denied by this Constitution, by its home rule charter or by the General Assembly at any time.”⁵⁶ This includes the police power.⁵⁷

Although the City of Pittsburgh undoubtedly enjoys broad powers to protect public health and safety, which include powers large enough to embrace a recognized health measure

⁵⁴ *Id.* at 231-32, 414 A.2d at 42-43(citations omitted).

⁵⁵ *Boundary Drive Associates v. Shrewsbury Township Board of Supervisors*, 507 Pa. 481, 489-490, 491 A.2d 86, 90 (1984).

⁵⁶ Pa. Const. art. IX, § 2.

⁵⁷ *See Commonwealth v. Cabell*, 185 A.2d 611, 613 (Pa. Super. Ct. 1962) (stating that the municipality may be granted part of the governmental power of the state, so far as its local interests are concerned).

like needle exchange, a conservative legal analysis must admit some doubts as to the authority of the City in this area. Pittsburgh is served by the Allegheny County Health Department, which was established under the terms of the state Local Health Administration Law.⁵⁸ This law was clearly intended to rationalize local health administration⁵⁹ and to place all local public health functions within the county health department except in very limited circumstances.⁶⁰ If, as we suggest, SEPs are essential and valid public health interventions, it follows that the decision to authorize or operate them would be expected to lie in the first instance in the jurisdiction of the county health department. We therefore conclude that while operating an SEP would fall within the general police powers of the City of Pittsburgh, a cautious reading of state law suggests that this is a health matter more properly placed within the jurisdiction of the county and its health department. If, however, the county refused to act in this area, the City could reasonably consider invoking its police powers to fill the breach.

III. A Locally Authorized Syringe Exchange Program Would Not Be in Conflict with State Law

The general authority of local governments and boards of health to sponsor public health measures like syringe exchange is not open to question.⁶¹ Although possessed of broad powers under the Constitution, municipalities (including county governments and their health

⁵⁸ Local Health Law, 16 Pa. Cons. Stat. §§ 12001(b)(c).

⁵⁹ *Id.* §§ 12002.

⁶⁰ *Id.* §§ 12013; *see also* §§ 12013-12015.

⁶¹ For purposes of this analysis of a conflict between an SEP and state law, we will assume that the city of Pittsburgh could enact an SEP ordinance without treading upon the authority of the County.

agencies⁶²) may not act in direct and irreconcilable conflict with legislative measures enacted with the legislature's constitutional authority. While state law prohibits the distribution of drug paraphernalia, and pharmacy regulations prohibit the distribution of syringes by pharmacists without a prescription,⁶³ our analysis of Pennsylvania statutes, practice, and the experience of SEPs across the nation suggest that syringe exchange is consistent with Pennsylvania law.

The starting point for any legal analysis of a local ordinance is the broad powers accorded to the local government operating under a home rule charter,⁶⁴ and the presumption of validity attached to their actions:

Whereas previously the law held that municipalities were merely agencies instituted by the sovereign and exercising only those powers specifically granted to them, see e.g. *Philadelphia v. Fox*, 64 Pa. 169 (1870), under the present Constitution and implementing legislation, "[a] municipality which has a home rule charter may exercise any power or perform any function not denied by this Constitution, by its home rule charter or by the General Assembly at any time." Pa. Const. Art. 9, § 2. See also 53 P.S. § 1-301. Furthermore, "[a]ll grants of municipal power to municipalities governed by a home rule charter under this act, whether in the form of specific enumeration or general terms, shall be liberally construed in favor of the municipality." 53 P.S. § 1-301. In analyzing a home rule municipality's exercise of power, then, we begin with the view that it is valid absent a limitation found in the Constitution, the acts of the

⁶² See Pennsylvania Constitution Article 9, § 14 (defining municipality as "a county, city, borough, incorporated town, township or any similar general purpose unit of government which shall hereafter be created by the General Assembly").

⁶³ Pennsylvania Drug and Alcohol Abuse Control Act, 35 Pa. Const. Stat. Ann. section 780-113 (West 1993).

⁶⁴ *Creighton*, 639 A2d 256, 258 (Pa. Commonw. Ct. 1993). Although case law tends to speak in terms of municipalities, counties may also adopt home rule charters with all the power they confer. Pa. Const. art. IX, § 4.

General Assembly, or the charter itself, and we resolve ambiguities in favor of the municipality.⁶⁵

It would be the obligation of any court assessing the legality of a locally authorized SEP to analyze and resolve conflicts with state law in favor of the local government when possible.⁶⁶ Pennsylvania law mandates that the statutory grant of municipal power be liberally construed in favor of the municipality concerned.⁶⁷ Courts are not free to disregard this rule of statutory construction concerning the power granted municipalities. Once an ordinance is enacted by a municipality or local health department (establishing a syringe exchange program) under a power granted by a statute, that ordinance is endowed with a presumption of validity.⁶⁸ The presumption is particularly strong when the ordinance is designed to protect the public health. This presumption means that those arguing that a local ordinance or other action exceeds permissible bounds or conflicts with state law have the burden of rebutting the presumption and proving an irreconcilable conflict with state law.⁶⁹

These general presumptions of Pennsylvania local government law are, if anything, even stronger in matters of local health regulation. In the leading case, *Retail Master Bakers Association of Western Pennsylvania v. County of Allegheny*,⁷⁰ the Supreme Court

⁶⁵ County of Delaware v. Township of Middletown, 511 Pa. 66, 511 A.2d 811 (1986).

⁶⁶ McSwain v. Farrel, 624 A.2d 138, 145 (Pa. Commonw. Ct. 1993); County of Delaware v. Township of Middletown, 511 Pa. 66, 511 A.2d 811 (1986); In re Petition to Recall Reese, 665 A.2d 1162, 542 Pa. 114, Sup. (1995).

⁶⁷ City Council v. City of Pittsburgh, 625 A.2d 138, 145 (Pa. Commonw. Ct. 1993).

⁶⁸ *Creighton*, 639 A.2d 334, 347 (1980);

⁶⁹ *Creighton*, 639 A.2d at 1299 n.6. In local government law generally, this presumption is usually thought to be particularly strong in matters of public health., e.g. Fraternal Order of Police v. Pittsburgh, 644 A.2d, 248 (Pa. Commw. Ct. 1994).

⁷⁰ 400 Pa. 1, 161 A.2d 36 (1960).

recognized that acts of the local health department were merely exercises of the powers conferred by the Local Health Administration Law, and therefore should be treated like state statutes for purposes of assessing a conflict with another state law. Under general rules of statutory construction, “Whenever a general provision in a law shall be in conflict with a special provision in the same or another law, the two shall be construed, if possible, so that effect may be given to both.”⁷¹

These doctrines -- judicial deference, the presumption of validity, and avoidance of conflict -- tip the legal balance in favor of the legality of locally authorized SEP. It is not enough to show that drug paraphernalia and prescription laws can be interpreted to prohibit an SEP, but that such an interpretation is unavoidable, and that the legislature more probably than not intended such a prohibition. This burden cannot be met for several reasons.

A. The Prescription Regulation Does Not Apply to SEPs

Regulations issued by the state pharmacy board include the following:

(2) Sales of needles and syringes shall be made by the pharmacist only to persons showing a prescription issued by a licensed practitioner. The prescription shall be in force for a maximum of 1 year from date of its issuance....

49 Pa. Code § 27.18. Because this prescription requirement is a pharmacy regulation, and by its terms applies only to pharmacists, non-pharmacists who sell or give away syringes are not bound by the rule. It therefore does not conflict with an ordinance authorizing an SEP outside the pharmacy context.

⁷¹ 46 P.S. S 563.

B. Caselaw Has Established That There is No Conflict with State Drug Law and SEPs

The simplest way to resolve the purported conflict between a locally authorized SEP and state drug law is to reject the premise that such a conflict exists at all. In *Spokane v. Brockett*,⁷² the Supreme Court of Washington took this approach in the only case to directly consider the powers of local health officials to conduct an SEP in the face of state drug paraphernalia law. The analysis of the Court is both persuasive and consistent with the principles of deference and statutory construction contained in Pennsylvania law. In Washington there was no dispute that a syringe exchange was well within the state granted authority of local governments and boards of health to protect the public health. Opponents nevertheless argued that a local SEP would conflict with state drug law. The court held that there was no conflict: local officials seeking to operate an SEP “are acting pursuant to public health statutes. It is those public health statutes, not the criminal statute in which the drug paraphernalia act appears, with which the needle exchange program must not conflict to retain its constitutional imprimatur.”⁷³ The Court wrote:

It is undisputed the needles at issue in this case are “drug paraphernalia.” Those distributing the needles know they will be used to inject controlled substances unlawfully. Nevertheless, plaintiffs argue, the needle exchange program is authorized under the Washington Constitution, statutes granting broad powers to local health officials, and the omnibus AIDS act. Therefore, they conclude, the drug paraphernalia act, which is aimed at criminal conduct, simply does not apply to their actions. We agree, finding the SCHD’s needle exchange program

⁷² *Spokane County Health District v. Brockett*, 120 Wash. 2d 140, 839 P.2d 324 (1992).

⁷³ *Id.*

permissible under the constitution and statutes of this state.⁷⁴

Like the health officials in *Brockett*, local boards of health and municipalities are given discretion by statute to exercise the police power to protect public health. The laws that control their decisions about SEPs are the health and home rule laws, not a paraphernalia law aimed at commercial drug business.⁷⁵

Similarly, the Pennsylvania legislature has conferred broad powers on local boards of health and government to act to preserve public health. Local health officers and municipalities have the authority, even a duty, to act against disease that affects the local population.⁷⁶ Due to the important governmental function of protecting and preserving the health of its citizens from disease, public health statutes and the actions of local health boards implementing those statutes are liberally construed.⁷⁷ As in Washington, there is no evidence that the Pennsylvania legislature ever intended its drug laws to limit the public health powers of local government, generally, or with respect to the specific measure of syringe exchange. Paraphernalia law simply does not regulate health authority. Therefore there is no conflict.

C. The Paraphernalia Law Was Never Intended to Apply to SEPs

When the Pennsylvania Drug and Alcohol Abuse Control Act was enacted, HIV was unknown as a major health problem, and syringe exchange was virtually unknown as an

⁷⁴ *Id.* at 327-328.

⁷⁵ See *Retail Master Bakers Association of Western Pennsylvania v. County of Allegheny*, 400 Pa. 1, 161 A.2d 36 (1960).

⁷⁶ 35 Pa. Cons. Stat. Ann. section 521.3(a); N.J. Stat. Ann. Section 26:2-160 (West 1997).

⁷⁷ Reading Home Rule Charter, 306 Pa. Code section 11.1-105(a).

effective public health measure. Nothing in the statute or legislative history manifested any consideration of public health, let alone desire to limit local powers.⁷⁸ A statute must be read in light of the reason for its enactment or it will be applied where it was not intended to operate, thus denying municipalities the authority to deal with problems at the local level in a sensible, practical way. The Drug Paraphernalia Law was enacted to prevent drug use through commercial means.⁷⁹ The statute was not established with the intent of preventing public health measures from being implemented. There is no question that if the Act is broadly interpreted, it can be applied to the work of health care providers operating SEPs. However, this is not a sensible reading of the Act. It was passed to control commercial trade in the tools of drug use, following a national trend that was led by the federal government. Its purpose was to eliminate what had become an enormous retail trade in the equipment pertaining to illegal drug use. By 1976, between fifteen and thirty thousand “head shops” did an annual three billion dollar business in such items as rolling papers, bongos, and freebasing kits.⁸⁰ The legislative history of the Act leaves no doubt that this commercial trade was the target of Pennsylvania’s law, as it had been of the paraphernalia laws passed by other states in the same period.

According to the Pennsylvania Statutory Construction Act, “the object of all interpretation and construction of laws is to ascertain and effectuate the intent of the legislature.”⁸¹ The effort to determine legislative intent should be guided by both the language of

⁷⁸ See 1980 Pa. House Leg.J. 2598 (colloquy among Reps. Cunningham, Richardson and Pistella).

⁷⁹ See, e.g., *Commonwealth v. Potter*, 504 A.2d 243 (Pa. Super. Ct. 1986).

⁸⁰ Gostin & Lazzarini, *supra* note 16, at 611-612 (reviewing Congressional investigation of paraphernalia problem).

⁸¹ 1 Pa. Cons. Stat. Section 1921 (1991).

the statute and the express purposes of the lawmakers who wrote it. By its plain language the Act focuses on commercial activity. The determination as to whether an item is paraphernalia depends upon the application of the many factors listed in 35 P.S. section 780-102(b). These include advertising about the object, instructions concerning its use, displays, descriptive materials, and sales. Each of these factors arises in the operation of a head shop business and are irrelevant to an SEP operated by a local government or health board. Prosecutions and convictions under the paraphernalia law have been consistent with this interpretation. All of the reported cases prosecuted under the Act involve “head shops”⁸² or individuals also convicted of possession and or distribution of controlled substances.⁸³

The legislative history leaves no doubt that that the statute was designed and intended to apply to commercial head shops. In the words of Representative Cunningham, who led the debate for the bill’s proponents, “The Act is a tough enforceable bill that takes an aggressive stance against drug abuse and will enable local communities to shut down head shops where those head shops are encouraging drug abuse and making it more difficult to arrest this problem.”⁸⁴

Representative Richardson, supporting an amendment to the bill, argues that its broad language could turn everyday devices like blenders and paperclips into paraphernalia, and their owners into criminals, “this bill leaves it wide open for anyone to be stopped on the streets who

⁸² See, e.g., *Commonwealth v. Lacey*, 344 Pa. Super. 576, 496 A.2d 1256 (1985); *Commonwealth v. Potter*, 504 A.2d 243 (Pa. Super. Ct. 1986).

⁸³ See, e.g., *Potter*, 350 Pa. Super. 61; *Commonwealth v. Torres*, 421 Pa. Super. 233, 617 A.2d 812 (1992).

⁸⁴ 1980 Pa. House Leg. J at 2598.

is carrying any of these particular items.’⁸⁵ The bill’s proponents responded by emphasizing the narrow, commercial focus of the prohibition. Representative Cunningham explained:

Each of the items that has been listed here [as paraphernalia] must be used, must be shown to be sold for use in compounding controlled substances. When you see these items in a head shop, you know what they are going to be used for. The Police have got to be able to prove that they are sold for this particular use before a prosecution can take place.⁸⁶

SEPs do not sell drug paraphernalia. They provide a form of harm reducing health care to IDUs that has the strong backing of doctors and medical science. It is true that the syringes are used to inject drugs, but the purpose of providing them is to prevent disease. As the Washington Supreme Court found, in upholding the legality of local SEPs, a “drug paraphernalia act, which is aimed at criminal conduct, simply does not apply to their actions.”⁸⁷

D. Even if the Paraphernalia Analysis is Applied, Public Health SEP’s Lack the Required Intent to Violate the Law

The Paraphernalia Act provides a three-part definition of drug paraphernalia that includes (a) general terms, (b) a list of twelve examples, and (c) thirteen factors (including the intent of the actor) for consideration in making a formal determination.⁸⁸ The Act states in relevant part that drug paraphernalia is defined as:

(b) all equipment, products and materials of any kind which are used, intended for use or designed for use in ... injecting, ingesting,...or otherwise introducing into the human body a controlled substance in violation of this act. It includes, but is not limited to: (11) Hypodermic syringes, needles and other objects used,

⁸⁵ *Id.* at 2604.

⁸⁶ *Id.* at 2600.

⁸⁷ *Spokane Health District v. Brockett*, 120 Wash. 2d 140, 147, 839 P.2d 324, 327 (1992).

⁸⁸ *See Commonwealth v. Lacey*, 344 Pa.Super 576, 496 A.2d 1256 (1985).

intended for use, or designed for use in parenterally injected controlled substances into the human body.⁸⁹

By the plain language of this section, the syringes handed out at SEPs appear to fall within the definition of drug paraphernalia. However, Pennsylvania courts have refused to adopt a per se rule that any item mentioned in the statute is paraphernalia: “Precisely because a defendant is to receive the benefit of a doubt we are not persuaded by the reasoning....that objects could be classified as drug paraphernalia solely on their physical characteristics.”⁹⁰ The determination of whether an item is paraphernalia depends on the intent of the person distributing the object. Therefore, a needle may or may not be paraphernalia. For example, when a needle is used by a health care professional to care for a patient (e.g., injecting morphine, or to prevent the spread of disease, it is not drug paraphernalia.

For an item to be classified as drug paraphernalia, the prosecution must not only establish that it meets the statutory definition of Section 780-102(b), but also that the person charged with violating the act had the specific intent that the item he possessed or delivered be used with controlled substances.⁹¹ Specific intent means that it is not just foreseeable that the material will be used for drugs, but that is the purpose, object, plan, or goal of the defendant. The specific intent of the SEP worker is to prevent HIV transmission, not to facilitate, condone, or encourage intravenous drug use. Further, the goal of the SEP is to prevent the transmission of highly contagious and fatal diseases; health care workers are aware that the needles will be

⁸⁹ 35 P.S. section 780-102(b).

⁹⁰ *Lacey*, 344 Pa. Super. at 583.

⁹¹ *Lacey*, 344 Pa. Super. at 582.

used to inject illegal drugs, but that is not the intent of the provider. The SEP provider would be more than delighted if the person did not use drugs at all, which is why SEPs are used in combination with treatment and referral for drug rehabilitation.

E. Philadelphia is Operating a Municipally Funded Syringe Exchange

There is further practical support that SEP providers are not acting in violation of state drug laws. There has been long legal acceptance in the City of Philadelphia for the city's municipally funded SEP. In 1992, Mayor Edward G. Rendell authorized a city SEP⁹² operating under the health department's supervision to combat Philadelphia's public health emergency. This SEP has operated without legal hindrance to this day. The order came after careful analysis by the city's law department which concluded that the Pennsylvania Drug and Alcohol Abuse Control Act was not intended to apply to bonafide disease control measures and so does not prohibit SEPs established pursuant to the city's authority to protect public health. The Philadelphia SEP not only provides clean needles, but also offers on site health care services, such as HIV testing. The SEP has a 91% return rate of used syringes and works as a bridge to drug treatment. It has made over 1500 referrals for those seeking help.

⁹² Executive Order No. 4-92 issued pursuant to the Philadelphia Home Rule Charter section 6-205 (July 27, 1992).

IV. Conclusion

Syringe exchange is a proven method of preventing the spread of HIV and other blood borne diseases. It does not encourage drug use, but in fact encourages and facilitates drug treatment. Local governments and boards of health have broad powers under state law to take measures to prevent the spread of communicable disease in their community. Indeed, they have a duty to protect the public from such diseases. Legal concerns therefore need not stand in the way of Allegheny County authorities establishing a public health needle exchange.