



Issue Brief: Syringe Access Policies for California Syringe Exchange Programs

The California Department of Public Health, Office of AIDS advises syringe exchange programs (SEPs) to adopt needs-based distribution policies with the goal of ensuring that program participants have a new, sterile syringe and other injection equipment for each injection.

Restrictive syringe access policies such as variations on one-for-one exchange or the imposition of limits on the number of syringes participants may acquire per transaction are not supported by public health evidence and may impose harm upon SEP participants.

This recommendation follows the U.S. Public Health Service guidance that advises people who inject drugs to use a new, sterile needle and syringe for each injection.

This Issue Brief does not supersede legal requirements for SEP operation established in California state laws or by county or municipal laws.

Issue

Syringe exchange programs (SEPs) have operated in California since the 1980s, and California law allows local governments and the California Department of Public Health (CDPH) to authorize SEPs. Because most California SEPs have been approved by county or municipal bodies, there is significant jurisdictional variation in operating regulations, including policies that govern how program participants may obtain new syringes.

The U.S. Public Health Service recommends that people who inject drugs (PWID) use a new, sterile syringe for every injection,¹ which is reiterated in the CDPH *Guidelines for Syringe Exchange Programs*.² This issue brief reviews public health evidence surrounding various models of syringe distribution for disease prevention among PWID and recommends that SEPs eliminate restrictions on access in order to meet the objectives described in U.S. Public Health Service and CDPH guidance.

Evidence Regarding Syringe Access Policies

California SEPs currently employ several different models of syringe distribution, including (a) strict one-for-one exchange in which used syringes are required to be returned for an equal number of new syringes, (b) “one-for-one-plus” models which provide a fixed number of additional syringes (e.g. 10) beyond the number returned, (c) limits on the total number of syringes that may be acquired during a single transaction, and (d) needs-based distribution that provides an unlimited number of syringes based on how many PWID request. Policymakers have sometimes instituted restrictive syringe access policies in the belief that such policies would reduce syringe litter or serve as a means of changing behavior among PWID.³ These concerns have not been born out in research on syringe distribution policies.

Research has found that needs-based policies are not associated with unsafe syringe disposal.⁴ Syringes obtained from SEPs are more likely to be safely disposed than syringes obtained from other sources.^{5,6,7,8,9} Syringes are more likely to be safely disposed in cities with SEPs compared to those without; a study comparing cities with and without SEP found that PWID were 34 times more likely to safely dispose of used syringes if they had access to an SEP,¹⁰ and the establishment of SEPs in Baltimore was associated with a 50% decline in syringe litter.¹¹ In locations where syringe litter remains a concern, strategies for improving access to safe disposal – such as increasing SEP hours and locations¹² or installing publicly accessible sharps disposal – are appropriate public health responses. In addition, while all SEPs encourage

participants to dispose of syringes safely, other factors may impede PWID's ability to return used syringes. Notwithstanding the public health provisions of California drug paraphernalia law,¹³ police often target people based on syringe possession,¹⁴ which may deter PWID from carrying syringes for safe disposal and increase disease risk.^{15,16,17,18} Moreover, confiscation of syringes by police or other agencies, for example during homeless encampment sweeps, result in PWID being unable to return used syringes in order to obtain new equipment from restricted exchange programs.^{19,20,21}

Public health research has consistently found that restrictive models increase syringe re-use and sharing among program participants. Studies have found that difficulty accessing syringes is associated with receptive syringe sharing,^{22,23,24} which puts PWID at greater risk of viral and bacterial infections including HIV, viral hepatitis, and skin and soft tissue infections.^{25,26,27,28,29} Restrictive syringe access policies contribute to syringe scarcity, which has been found to increase the amount of time that infectious syringes circulate in the community³⁰ and the likelihood that PWID will acquire syringes from potentially non-sterile sources.³¹ Women, young people, African American and Hispanic PWID have been found to be at greater risk of experiencing syringe scarcity.^{32,33}

In California, participants of needs-based SEPs have been found to have 57% lower odds of reusing syringes compared to participants of SEPs with restrictive syringe access policies.³⁴ In another California study examining syringe coverage, PWID with the greatest access to syringes were half as likely to report receptive syringe sharing, and were nearly 40% less likely to share other injection equipment.³⁵

Several studies have examined the public health impact of policy changes to move from one-for-one to needs-based syringe access. In Vancouver, a change in local syringe exchange policy to adopt a needs-based model was associated with a greater than 40% reduction in syringe sharing as well as a decline in HIV incidence.³⁶ These results were replicated in Hawaii, where syringe sharing and HIV prevalence declined after a cap on the number of syringes dispensed per transaction was discontinued.³⁷ Similarly, comparisons of U.S. cities with needs-based versus restricted syringe access policies have found that needs-based SEP results in greater syringe coverage and greater relative decline in HIV incidence.³⁸ In contrast, a move toward more restrictive syringe access policy in Baltimore resulted in large decreases in the number of syringes both distributed and returned and the number of SEP participants.³⁹ Partial easing of restrictions (e.g. increasing limits on syringes per transaction from 10 to 30) has not been found to significantly increase syringe access among PWID.⁴⁰

Conclusion

In summary, the U.S. Public Health Service and CDPH/OA recommend that PWID use a new, sterile syringe for each injection in order to prevent disease transmission and other harms associated with injection drug use. Scientific studies of different syringe exchange models have consistently found that needs-based syringe distribution is most likely to achieve that objective. Research has not found needs-based syringe distribution to be associated with increases in unsafe syringe disposal. Restricted syringe access models, in contrast, result in lower coverage and increase syringe re-use and sharing and do not increase safe syringe disposal.

A commitment to high quality harm reduction services is central to *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*,⁴¹ and needs-based syringe access policies are essential to ensuring that PWID have the tools they need to protect themselves. **CDPH/OA recommends that California SEPs employ a needs-based syringe access model in their work.** Doing so reaffirms that California values the lives and contributions of people who inject drugs in our communities and that publically supported SEPs exist to foster safety, health, and wellbeing among the people they serve.

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