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Needle
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NEEDLE EXCHANGE PROGRAMS DO NOT WORK

At a time when the Bush Administration has requested \$12.7 billion to fight an unambiguous war against illegal drug use, the Democratic Party has officially endorsed needle exchange programs. These programs are misguided for many reasons, but primarily because they undermine society's message that drug use is illegal and morally wrong.

On May 28, 1992, the House voted 214-157 to continue to prohibit the use of Federal funds for needle exchange programs. 150 Democrats voted in favor of these programs. The Bush Administration strongly opposed this change, with HHS Secretary Sullivan telling every member of Congress that: "There is no evidence that such programs reduce the incidence of HIV."

After a thorough review of needle exchange programs, the Office of National Drug Control Policy found that "all of the needle exchange programs studied have yielded either ambiguous or discouraging results."

Encourage Drug Use

Aggressive outreach efforts, in contrast, are effective in convincing intravenous drug users to end their high risk behavior and seek treatment. And, in convincing more drug users to enter treatment, outreach programs may also reduce the incidence of drug-related crime, by 80 percent for those treated on an outpatient basis.

Even needle exchange proponents acknowledge that these programs will not reduce drug use and may, in fact, encourage it. Thus, they defend these programs as the lesser of two evils. If forced to choose between stopping drug use and preventing the transmission of AIDS, they argue, we must choose to stop AIDS because it is invariably fatal.

Give a Needle to A Pregnant Addict?

Well, the balance of competing evils may not be so simple. For example, do we really want government officials to distribute needles to pregnant addicts, addicts with unsupervised dependent children, or addicts under the age of 18, as proposed by the proponents of the exchange program in Washington, D.C.? Is it wise to hand a needle to someone who was previously convicted of a drug-related felony, to individuals on probation, supervised release, or parole, or even to an adult male who is delinquent on child support payments?

Finally, in order to encourage a greater level of participation by addicts, the police must cooperate by relaxing various anti-drug laws in the vicinity of distribution sites. Such a policy amounts to **de facto drug legalization**, which the Bush Administration categorically rejects.

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- o ONDCP Needle Exchange Bulletin, July 1992;
- o Letter dated May 13, 1992 from Governor Martinez to Mayor Sharon Pratt Kelly on D.C. needle exchange program;
- o Background information on existing needle exchange programs;
- o Statement by House Minority Whip Gingrich on his motion to recommit the Conference Report on S. 1306, the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act, with instructions relating to needle programs, and accompanying vote;
- o Selected op-ed pieces and news articles on needle programs;
- o Bush-Quayle memorandum on inconsistencies between Democratic action on appropriations bills and Democratic platform.



Needle Exchange Programs: Are They Effective?

ONDCP Bulletin No. 7

July 1992

When President Bush took office, most Americans regarded the use of illegal drugs as the most serious problem confronting the Nation. Since that time, the Nation has made substantial progress in reducing drug use. But now, in response to the AIDS epidemic, there are those who are ready to sound a retreat in the war against drugs by distributing clean needles to intravenous drug users in the hope that this will slow the spread of AIDS. I believe this would be a serious mistake. We must not lose sight of the fact that illegal drugs still pose a serious threat to our Nation. Nor can we allow our concern for AIDS to undermine our determination to win the war on drugs.

In 1988, 14.5 million Americans and nearly two million young people, aged 12-17, were using drugs. In response to the devastation caused by drug use, the President boldly announced the first National Drug Control Strategy in a televised address to the Nation in 1989. That Strategy was a landmark document. Not only did it establish a coherent, coordinated policy for the national effort against drugs, but it committed unprecedented new resources for fighting drug use.

The Strategy is working; the use of illegal drugs by Americans is declining. Between 1988 and 1991, almost two million fewer Americans were using drugs, a drop of almost 13 percent. And by 1991, about half a million fewer young people were current users of drugs, a drop of 27 percent. Since 1985, the number of Americans using drugs has fallen by over 10 million.

Key to the success of the Strategy has been increasing Americans' intolerance of illicit drugs. But, for those already caught in the deadly web of addiction, we must act with compassion. The Administration therefore vigorously supports efforts to provide effective drug treatment to those

who want it and can benefit from it, and has increased funding for drug treatment from \$1.1 billion in 1989 to a proposed \$2.1 billion for 1993.

Our gains against drug use have been hard-won, and this is no time to jeopardize them by instituting needle exchange programs. Despite all the arguments made by proponents of needle exchange, there is no getting around the fact that distributing needles facilitates drug use and undercuts the credibility of society's message that using drugs is illegal and morally wrong. And just as important, there is no conclusive evidence that exchange programs reduce the spread of AIDS.

The Administration's concerns about needle exchange are widely shared. Recently, for example, the Congress extended a prohibition on the use of most Federal drug treatment funds to support needle exchange programs. And in June 1992, the National Association of State Alcohol and Drug Abuse Directors informed every member of Congress of its support for continuing this prohibition. Also, in February 1992, the National District Attorneys Association passed an official policy position condemning needle exchange.

The Administration will continue to work with the Congress, and with State and local officials to support alternatives to needle exchange, including expanded and improved drug treatment and aggressive outreach programs. These efforts will provide addicts with something that needle exchange programs cannot: hope and a chance for real recovery from drug addiction.

A handwritten signature in dark ink, reading "Bob Martinez", is positioned above the printed name.

BOB MARTINEZ
Director

NEEDLE EXCHANGE PROGRAMS IN THE UNITED STATES

Intravenous Drug Use and HIV/AIDS.¹

Intravenous drug users in the United States are one of the groups most at risk for contracting AIDS. AIDS prevention and education programs, which have had a measurable effect on the behavior of other high-risk groups, have not been so successful with intravenous drug users.² In fact, the Centers for Disease Control estimates that about 32 percent of the diagnosed AIDS cases in this country, involving nearly 70,000 individuals, resulted from intravenous drug use or sexual contact with intravenous drug users.³ In addition, intravenous drug use is responsible for half of the AIDS cases among women.⁴

AIDS is spread among intravenous drug users primarily through the sharing of hypodermic syringes, or "needles" and other drug-using paraphernalia (e.g., cotton and water) that have been contaminated with the AIDS virus, and secondarily by high-risk sexual behavior. Thus, intravenous drug users pose a threat not only to themselves, but to their sexual partners and offspring as well. In fact, 58 percent of all reported pediatric AIDS cases are associated with intravenous drug use.⁵

Faced with the growing link between intravenous drug use and AIDS, some cities and communities have instituted or are contemplating programs to provide clean needles to addicts in the hope that this will help reduce the sharing of needles, and hence, the spread of the HIV virus.

Needle Exchange Programs. Needle exchange programs provide free, clean needles to intravenous drug users in an attempt to reduce the likelihood that they will share needles with other users. Some programs operate from fixed locations such as city government offices or pharmacies. Others are mobile, using outreach workers in vans, on foot, and at temporary sites. Some programs provide a new needle only in exchange for an old one, while others provide at least one "starter" needle. Most programs limit the number of needles that can be exchanged at any one time. Some programs provide needles to persons only if they have a verifiable history of drug injection, and most have age limits. Most programs are privately funded; others are supported with State or municipal government funds.⁶

Needle exchange programs also differ in scope. Some only exchange needles, while others are more comprehensive and provide counseling, referral to testing and drug treatment, bleach to clean needles, and safer sex information.

Needle Exchange and the Law. In 39 States and the District of Columbia, sterile needles can be purchased inexpensively without a prescription in many pharmacies.⁷ In most of the remaining 11 States, a prescription is required.⁸ However, four of the 11 are considering legislation that would broaden access to needles. Only one State, Alabama, is considering legislation that would restrict accessibility by making it a criminal offense for those other than licensed pharmacists or practitioners to sell needles.⁹

Forty-nine States, the District of Columbia, and numerous local jurisdictions have laws to prohibit the sale and distribution of drug paraphernalia. The majority of these laws conform with the Model Drug Paraphernalia Act, which was released by the Drug Enforcement Administration in August 1979. The Model Drug Paraphernalia Act would make it a crime to possess, deliver, or manufacture needles with the intent to violate anti-drug laws. Therefore, operating needle exchange programs may be a violation of the law in many States and local jurisdictions. Furthermore, operating such programs may subject municipalities to civil liability in some jurisdictions.

What the Research Shows. Several studies on the efficacy of needle exchange programs have been conducted in the United States and abroad.¹⁰ Some of these studies have been cited by proponents of needle exchange as evidence that such programs work. However, all of the needle exchange programs studied have yielded either ambiguous or discouraging results. Moreover, the methodology used to conduct these studies has been flawed. For example:

- Many studies make long-term projections of addict behavior based on short-term results;
- Many use a small or insufficient sample size and then project results to larger populations;
- Despite claims that needle sharing was reduced, none of the studies conducted objective tests (e.g., analysis of blood types

on returned needles) to determine whether needles were shared;

- Most do not use valid comparison or control groups; and
- Most have program staff, rather than independent evaluators, conduct client interviews on which the findings of the studies are based.

There are four other significant problems with the research. First, needle exchange programs are plagued by high levels of attrition. Programs may have initial contact with intravenous drug users who are at the highest risk of sharing needles and contracting AIDS, but only as few as 20 percent may return for a second or third visit.¹¹

Second, needle exchange programs tend to attract and retain a self-selecting group of older, long-term intravenous drug users who are less likely to share needles than less experienced, more promiscuous users.¹² Therefore, positive reports on the effectiveness of exchange programs may be due **more** to the behavior of this less risky subset of the intravenous drug using population and **less** to the availability of clean needles.

Third, programs offering needle exchange often provide bleach for cleaning needles, referrals to testing and treatment, and other services. However, the research conducted to date has not isolated the specific impact that exchanging needles has had on reducing the transmission of AIDS compared with these other factors. Most researchers have simply attributed positive results to needle exchange.

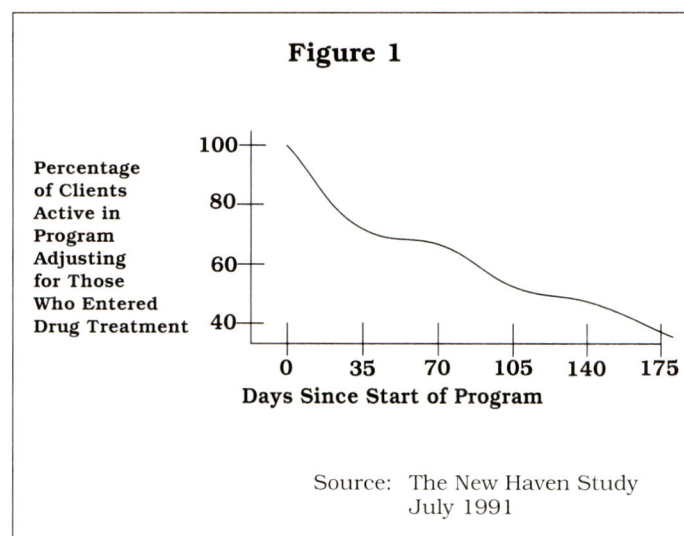
The fourth weakness with the research relates to the dynamics of addiction. No matter what addicts promise when they are not on drugs, they may still share needles when they shoot up heroin or cocaine. In many cases it is simply part of the ritual of taking drugs. More often, a drug-induced state overwhelms rational thinking. Many addicts know that they can get AIDS from dirty needles. Yet hazards to their health — even deadly ones — do not weigh heavily on their minds. Rather, they are primarily concerned with the instant gratification of drugs.¹³

To expect an individual locked in the grip of drug addiction to act responsibly by not sharing needles is unrealistic. Such a change in behavior requires self-discipline and a willingness to postpone

gratification and plan for the future — all of which are contrary to the drug-using lifestyle. The fact that addicts can purchase clean needles cheaply, without prescription, in many pharmacies in most States, but often fail to do so, is evidence of their irresponsible behavior.¹⁴ In fact, the only proven way to change an addict's behavior is through structured interventions, such as drug treatment.

The New Haven Study.¹⁵ A 1991 interim study of a needle exchange program in New Haven, Connecticut, is cited by many needle exchange advocates as evidence of the benefits of needle exchange.¹⁶ The study asserts numerous positive findings, most of which are not supported by the data.

The study states that retention rates stabilized after a high attrition rate early in the program. But, of the 720 addicts who initially contacted the New Haven program over an eight-month period, only 288 (40 percent) returned at least once to exchange a used needle (Figure 1). The New Haven study



defines the 288 returning intravenous drug users as "program participants," but does not distinguish between those who exchanged needles once and those who exchanged needles more frequently.¹⁷ The loose definition of "program participation" exaggerates the program's reported retention rate and calls into question the claim that participation in the program stabilized. In addition, the study does not provide information on the 288 individuals who remained in the program and whether they shared needles before the program started. In fact, the study reports that of the 720 addicts who contacted the program, 436 (61 percent) reported

never sharing needles before the program began (Figure 2).

Figure 2

**EXTENT OF NEEDLE SHARING REPORTED
AT INITIAL CONTACT WITH PROGRAM**

How Often Shared Works

Always (100%)	16	(2%)
Almost Always (67-99%)	16	(2%)
Half the Time (34-66%)	43	(6%)
Sometimes (1-33%)	196	(27%)
Never (0%)	436	(61%)
(Missing)	13	(2%)

Source: The New Haven Study
July 1991

The study also states that about half of the 10,180 needles distributed by the program between November 1990 and June 1991 were returned, and that an additional 4,236 “street” or nonprogram needles were brought in for exchange. However, the study fails to account for the 4,917 needles — 50 percent of those given out — that were not returned. Based on this information, the study claims that the circulation time for needles was reduced and that fewer contaminated needles were appearing in public places. However, no data are presented to directly support such conclusions.

The authors also report that 107 intravenous drug users (about 15 percent of those who contacted the program) entered treatment over an eight-month period through contact with the New Haven program, but there are no data on how many of these individuals were “program participants” (e.g., had exchanged needles more than once). Therefore, the study does not present any basis for correlating the *exchange* of needles to entry into drug treatment. Also, no data on treatment retention or completion are presented.

The study also claims that intravenous drug use in the community did not increase. Although this may be true, it is not supported by convincing data. The study indicates that 92 percent of those who initially contacted the program were experienced users who had been injecting drugs for one year or more. The study uses this statistic to demonstrate

that the availability of free needles did not entice individuals to begin using intravenous drugs. However, there is no evidence to verify that experienced users did not use needles distributed by the program to initiate new users. The study also cites an unchanged rate in drug arrests as evidence that no increase in intravenous drug use occurred due to the program. However, the New Haven program had only been in operation for two months and had been contacted by fewer than 200 addicts at the time statistics on drug arrests were recorded. Therefore, it is unlikely that the program could have had any impact on the rate of drug arrests.

The most striking finding of the New Haven study — that the incidence of new HIV infections was reduced by one-third among those participating in the program — is based on tenuous data. The study indicates that 789 needles — 581 from the program, 160 from the street, and 48 from a local “shooting gallery”¹⁸ — were tested for the presence of HIV.¹⁹ The tests found that program needles were much less likely to be HIV positive than street or gallery needles. The tests also indicated that “dedicated” program needles (e.g., those returned by the original recipient) were much less likely to be HIV positive than other program needles. Based on this information, the study concludes that “dedicated” needles were not shared, *although no tests were conducted to determine if different blood types appeared on the needles or if the blood type on the needle matched that of the program participant*. Without conducting such tests, accurate conclusions as to whether needles were shared cannot be drawn, and a reduction in the spread of HIV cannot be attributed to needle exchange.

Finally, the study projects that expanding the availability of clean needles to New Haven’s entire intravenous drug using population would also reduce the incidence of new HIV infections by one-third. The projection is based on a highly complex mathematical model involving eight different factors that are supported by numerous assumptions, estimates, probabilities, and rates. While the model may be valid, its projections are based on the tenuous assumption that the 288 intravenous drug users “participating” in the New Haven program are representative of the general intravenous drug-using population. However, the high attrition rate of the New Haven program demonstrates that such an assumption cannot be made.

FOREIGN NEEDLE EXCHANGE PROGRAMS

In recent years, other countries — most notably the Netherlands and the United Kingdom — have established needle exchange programs. Studies of these programs have also produced mixed results. Most reflect the problems noted in existing research on needle exchange. Many report anecdotal or other unquantified information. Furthermore, some base “success” on the number of needles distributed.

In Amsterdam, a program started in 1984 reported that the number of participants grew more than tenfold in four years. The program also reported that during the first four years participants shared fewer needles, the HIV prevalence rate among intravenous drug users stabilized, and instances of Hepatitis B decreased.

In England, about 120 exchange programs distribute approximately four million needles annually. These programs reportedly reach users who have not been in contact with drug treatment services, decrease needle sharing, and increase contact with other social services by participants.

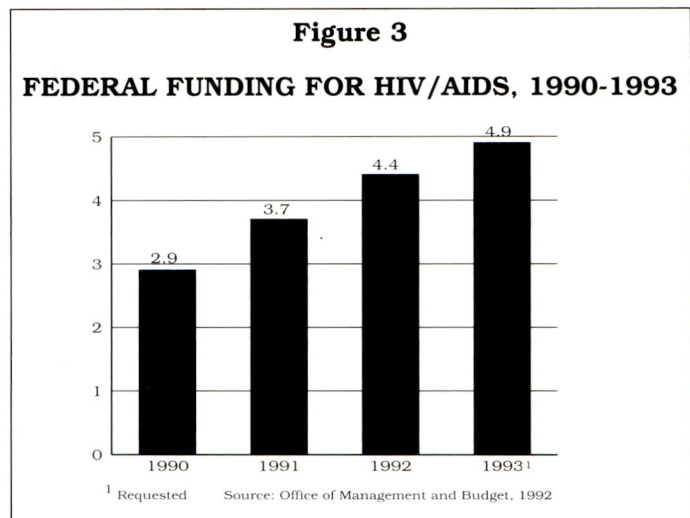
Sweden’s three needle exchange sites reported after three years that no project participant had become infected with HIV, that needle sharing had declined, and that many users not previously in contact with drug treatment had been attracted to the program.

Although generally positive, the reports on these programs are scientifically weak and present very few objective indicators of success. All claim that needle exchange reduced the number of needles shared, but none of the programs conducted the tests (e.g., blood-type tests) necessary to make that determination.

In addition, the attrition rates in foreign programs are extremely high. A 1989 study of 15 needle exchange programs in England and Scotland²⁰ reported that only 33 percent of intravenous drug users who initially contacted the programs returned up to five times. As in the United States, needle exchange programs in other countries are more likely to attract and retain intravenous drug users who are already predisposed not to share needles, and who therefore are at lower risk of contracting AIDS than other, less cautious, users.

ALTERNATIVES TO NEEDLE EXCHANGE

The challenges to society presented by drug use and HIV/AIDS require the steady development of scientific understanding and the promotion of effective interventions. Requested Federal funding for AIDS prevention, treatment, research, and income maintenance in 1993 is \$4.9 billion — a 69 percent increase since 1990 (Figure 3). The President’s National Drug Control Strategy supports using a portion of these funds for research, experiments, and demonstrations to seek out high-risk drug users; to encourage and support their entry into drug treatment; and to provide them with information on the destructiveness of their behavior and ways to change it. The Strategy also supports efforts to expand the capacity and effectiveness of drug treatment for intravenous drug users.



Outreach Programs. The most effective method of reducing the spread of AIDS among intravenous drug users is to treat successfully their drug addiction. However, Federal studies estimate that more than 40 percent of intravenous drug users have never been in treatment, even though many have used drugs intravenously for more than 10 years.²¹ Therefore, it is essential to continue efforts to aggressively recruit intravenous drug users into treatment.

Since 1987, the Department of Health and Human Service’s National Institute on Drug Abuse has funded projects in more than 40 cities to help identify intravenous drug users and persuade them to enter treatment. In these cities, squads of outreach workers contact addicts and encourage them to avoid sharing needles and other risky

behaviors and to enter treatment. Outreach workers also provide addicts with information on the threat of AIDS and dispense materials (e.g., bleach and condoms) to reduce the risk of HIV infection.

Between 1987 and 1992, outreach workers contacted approximately 150,000 intravenous drug users. Of these, 45,000 addicts (54 percent of whom reported regularly sharing needles) and 9,500 sexual partners were provided with information on treatment, counseling and methods for reducing the risk of infection. Program participants were assigned to standard and enhanced interventions. Follow-up surveys were conducted six months after the assignments were made, and the results of those surveys indicated that:²²

- 31 percent of the intravenous drug users had enrolled in formal drug treatment programs;
- 38 percent were sharing needles less frequently;
- 44 percent had begun to always clean their needles, always use a new needle, or had stopped injecting completely; and
- 47 percent had stopped injecting or reduced their frequency of injection.

The success of this effort demonstrates that outreach programs are highly effective in persuading intravenous drug users to avoid sharing needles and to seek treatment. By comparison, only 15 percent of those who contacted the New Haven program entered treatment. The Federal government will continue to support outreach programs by awarding approximately 60 grants in 1992 and 1993.

The Centers for Disease Control also administers an extensive outreach program for preventing the spread of the HIV virus among intravenous drug users. This program, which is operated through State departments of health and community-based organizations, offers intravenous drug users counseling, testing, and referral to treatment. An evaluation of the program will be completed in about two years.

Expanding Treatment Capacity. The Federal government continues to support expanded treatment capacity for intravenous drug users, primarily through the Alcohol, Drug Abuse and Mental Health Services Block Grant program, which

requires States to use at least 50 percent of their drug allotment for outreach and treatment of these drug users. Also, the Capacity Expansion Program, which was created by the Bush Administration in Fiscal Year 1992, will increase the number of drug treatment slots for areas and populations in the greatest need of treatment, including intravenous drug users. If Congress fully funds this program in Fiscal Year 1993 (the Administration has requested \$86 million), an additional 38,000 addicts — many of whom will be intravenous drug users — will be provided with drug treatment.

Medications Development. The Federal government is continuing its efforts to develop medications to treat heroin addiction. New pharmacological therapies, such as LAAM (a longer-acting alternative to methadone), depot naltrexone, and buprenorphine, are showing considerable promise in treating heroin addiction and should be available within the next few years.²³ In addition, performance standards and clinical protocols are being developed for methadone treatment programs to enhance their safety and effectiveness in treating heroin addiction.²⁴

CONCLUSION

The rapid spread of AIDS has prompted officials of some of America's cities to institute programs that distribute clean needles to intravenous drug users. Such programs are questionable public policy, however, because they facilitate addicts' continued use of drugs and undercut the credibility of society's message that drug use is illegal and morally wrong. Further, there is no compelling research that needle exchange programs are effective in preventing intravenous drug users from sharing needles, reducing the spread of AIDS, or encouraging addicts to seek drug treatment.

Research does show, however, that aggressive outreach efforts are an effective way to get intravenous drug users to end their high-risk behavior and seek treatment. Therefore, the National Drug Control Strategy will continue to support such outreach programs. It also will continue to support expanded treatment capacity for high-risk populations, including intravenous drug users; the development of medications for treating heroin addiction; and the exploration of other options that may offer intravenous drug users a real chance for recovery.

ENDNOTES

1. Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome.
2. U.S. Department of Health and Human Services. Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). *Prevention Activities of ADAMHA, Report to Congress, Fiscal Years 1989, 1990 and 1991*. Washington, D.C.: 1992.
3. U.S. Department of Health and Human Services. Centers for Disease Control. *HIV/AIDS Surveillance Report*. Washington, D.C.: March 1992.
4. U.S. Department of Health and Human Services. Centers for Disease Control. *HIV/AIDS Surveillance Report*. Washington, D.C.: March 1992.
5. U.S. Department of Health and Human Services. Centers for Disease Control. *HIV/AIDS Surveillance Report*. Washington, D.C.: March 1992.
6. Federal law prohibits the use of Alcohol, Drug Abuse, and Mental Health Services Block Grant funds — the major source of Federal support for drug treatment — to pay for needle exchange programs.
7. National Association of Boards of Pharmacy. *1991 National Association of Boards of Pharmacy Survey of Pharmacy Law*. Chicago: 1991.
8. In some States, such as California, needles may be sold without prescription for the administration of insulin or adrenaline if the pharmacist can identify the purchaser and records the purchase.
9. "State Alcoholism, Drug Abuse and Mental Health Reports," The George Washington University, May 1992.
10. Studies/Reports Consulted:
 Blumberg, M. *Needle and Syringe Exchange Programs: An Examination of the Empirical Evidence*. San Francisco: American Society of Criminology, 1991.
 Buning, E.C. "Effects of Amsterdam Needle and Syringe Exchange," *The International Journal of the Addictions* 26 1991: 1303-11.
 Christensen, B. and Ljungberg, B. "Syringe Exchange for Prevention of HIV Infection in Sweden: Practical Experiences and Community Reactions," *The International Journal of the Addictions* 26 1991: 1293-1302.
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 Ljungberg, B., et al. "HIV Prevention Among Injecting Drug Users: Three Years of Experience from a Syringe Exchange Program in Sweden," *Journal of Acquired Immunodeficiency Syndrome* 1991: 890-5.
 Nelson, K. "Human Immunodeficiency Virus Infection in Diabetic Intravenous Drug Users," *Journal of the American Medical Association* October 23/30 1991.
 Stimson, G.V. "Syringe-Exchange Programmes for Injecting Drug Users," *AIDS* 1989: 253-60.
 Stimson, G.V., et al. "Syringe Exchange Schemes for Drug Users in England and Scotland," *British Journal of Addiction* 1989: 1717-9.
 11. Stimson, G.V. "Syringe-Exchange Programmes for Injecting Drug Users." Editorial. *AIDS* 1989: 253-60.
 12. U.S. Department of Health and Human Services. ADAMHA. *Prevention Activities of the Alcohol, Drug Abuse, and Mental Health Administration, Report to Congress, Fiscal Years 1989, 1990 and 1991*. Washington, D.C.: 1992.
 13. Tims, F.M. and Leukefeld, C.G., *NIDA Research Monograph 72, Relapse and Recovery in Drug Abuse*. Washington, D.C.: ADAMHA.
 Walters, G.D. "Drug-Seeking Behavior: Disease or Lifestyle?" *Professional Psychology: Research and Practice*, 1992, 139-145, Vol. 23, No. 2.
 14. Syringes cost about \$.30 each. For example, in a recent study of pharmacies in St. Louis, Compton *et al* found the cost of a package of 10 28-gauge, 100-unit insulin syringes to range from \$1.92 to \$4.28.
 See Compton, W., et al. "Legal Needle Buying in St. Louis," *American Journal of Public Health*. April 1992, Vol. 82, No. 4.
 15. Daniels, J.C. *Preliminary Report - City of New Haven Needle Exchange Program*. Prepared by O'Keefe, E., Kaplan E., Khoshnood, K. July 31, 1991.
 16. In Fiscal Year 1992, the National Institute on Drug Abuse awarded a grant to Yale University to conduct a rigorous evaluation of the New Haven program over a three year period. Results of the evaluation will be available in 1995.
 17. Researchers estimate that intravenous heroin users on average inject two or more times a day, heavy users four to six times a day. Intravenous cocaine users invariably inject more frequently. There is very little data yet available on the number of injections an average user gets from a needle before it is discarded, although a 1989 California survey of 257 users found a mean of 22.5 uses (with 27 reporting one use and 15 reporting over 100).
 18. A "shooting gallery" is a communal injection site notorious for inadequate sterilization of injection equipment.
 19. The study does not specify the method used to select program and street needles or whether they are considered random or representative samples.
 20. Donoghoe, Martin C., et al. *Changes in HIV Risk Behavior In Clients of Syringe-Exchange Schemes in England and Scotland*: March 20, 1989.
 21. ADAMHA, Request for Applications, OTI 92-02, *HIV/AIDS and Related Diseases Among Substance Abusers: Community Based Outreach and Intervention Demonstration Program*, Washington, D.C.: 1992.
 ADAMHA, *Prevention Activities of ADAMHA, Report to Congress, Fiscal Years 1989, 1990, and 1991*, Washington: 1992.
 22. ADAMHA, Request for Applications, OTI 92-02, *HIV/AIDS and Related Diseases Among Substance Abusers: Community Based Outreach and Intervention Demonstration Program*, Washington, D.C.: 1992.
 ADAMHA, National Institute on Drug Abuse, National AIDS Demonstration Research Program, Washington, D.C.: June 1992.
 23. LAAM is a longer-acting alternative to methadone, depot naltrexone is a long-acting heroin blocker, and buprenorphine is being investigated for treating individuals addicted to both heroin and cocaine.
 24. Methadone is a synthetic medication used to treat heroin addicts by relieving withdrawal symptoms and craving for heroin for 24 hours. Methadone is only administered as part of a supervised treatment program.

Executive Office of the President
Office of National Drug Control Policy
Washington, D.C. 20500



POSTAGE
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OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
Washington, D.C. 20500

MAY 13 1992

The Honorable Sharon Pratt Kelly
Mayor
District Building
1350 Pennsylvania Avenue, N.W.
Room 520
Washington, D.C. 20004

Dear Mayor Kelly:

I was surprised and saddened to learn that your administration has decided to start a needle exchange program in the District of Columbia. While I can appreciate the difficulty with which this decision must have been made, I must express my dismay that your administration would initiate a policy that will prolong drug use and may result in more drug-related deaths.

The District of Columbia and other large cities are experiencing serious problems with the rapid spread of AIDS. Intravenous drug users account for much of the increase. But adopting needle exchange, which fosters continued drug use, is not a proven way to address this problem. The scientific evidence that needle exchange programs reduce risk-taking behavior among intravenous drug users is ambiguous, at best. Exchange programs, both within the United States and abroad, have yielded ambiguous or discouraging results, or provide insufficient data to permit clear conclusions as to their efficacy. It is troubling that the District government would be willing to gamble on the lives of many of its citizens by instituting a policy that has not even been shown to be effective.

Individuals addicted to destructive drugs like heroin need outreach programs that will encourage them to seek treatment and counseling -- not continue their drug use. Initiating a needle exchange program sends the message that the District government has given up on treatment and given up on any hope that addicts will recover. In short, it appears to be a desperate policy that ignores the fact that drug addiction, especially heroin addiction, is a serious disease -- one that often results in early death.

Page 2 - The Honorable Sharon Pratt Kelly

For these reasons, the Federal government does not support needle exchange, and Federal law prohibits the use of Federal funds for such programs. Rather, we support programs that provide hope and a chance for real recovery, including expanded and improved drug treatment. We also support aggressive outreach programs that enroll drug users in the treatment that they need. For the sake of many of your constituents, I hope that your administration and the D.C. Council adopt this same position.

Sincerely,

A handwritten signature in black ink, appearing to read "Bob Martinez", with a stylized flourish at the end.

BOB MARTINEZ
Director

Needle Exchange Programs

Underground, Legal, and Proposed

Underground Programs

California
Illinois
Louisiana
Maryland
Massachusetts
New York
Pennsylvania



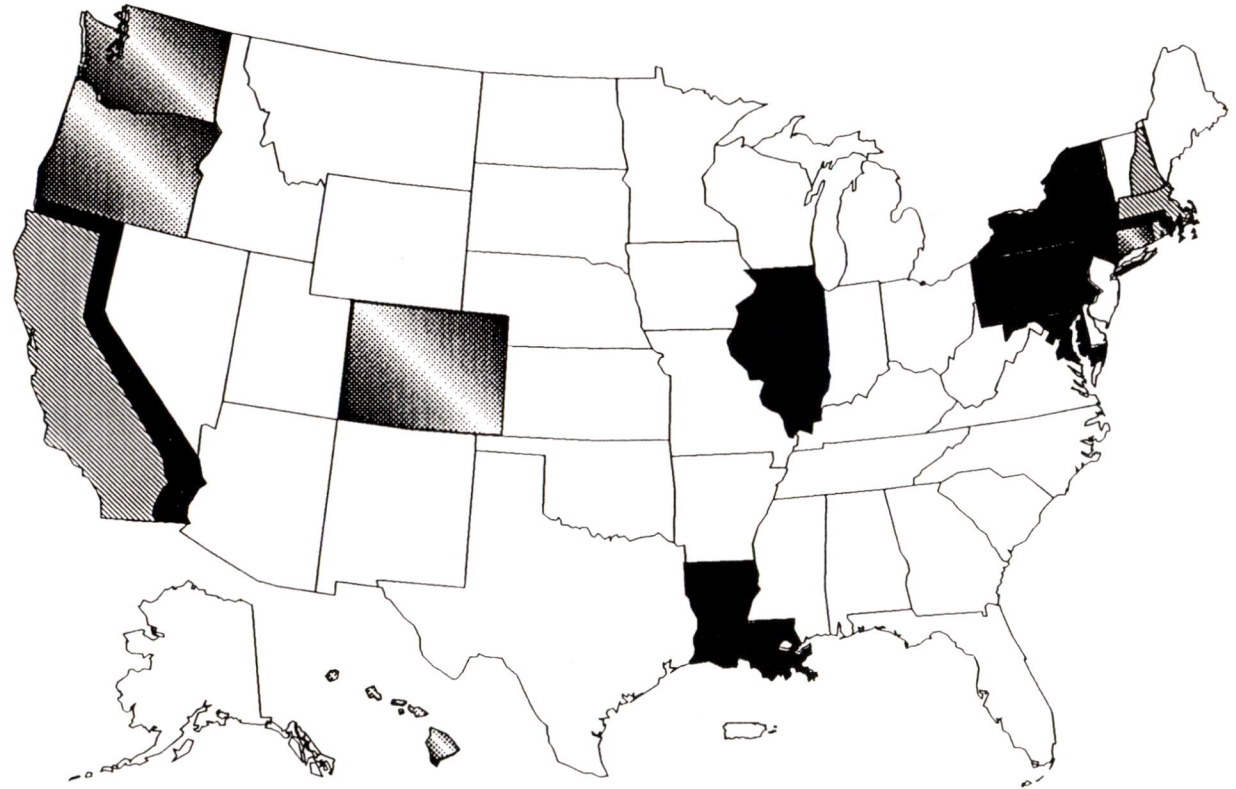
Legal Programs

Colorado
Connecticut
Hawaii
Oregon
Washington
District of Columbia



Proposed Legislation

California
Massachusetts
New Hampshire
Rhode Island



Source: Bureau of State & Local Affairs,
Office of National Drug Control Policy, July 1992

NEEDLE EXCHANGE PROGRAMS

Needle exchange programs, whether sanctioned by state and local authorities or those operated by underground organizations, exist in twelve states and the District of Columbia. Five states and the District of Columbia have state or locally supported needle exchange programs in nine cities. Seven states have illegal, underground needle exchange programs, supported by such organizations as ACT-Up, the American Foundation for AIDS Research (AmFar), and the National AIDS Brigade. Five states have authorizing bills under consideration in the State legislature.

<u>Legal Programs</u>	<u>Underground Programs</u>	<u>Proposed Legislation</u>
Colorado <i>Boulder</i>	California <i>Berkeley</i> <i>Marin County</i>	California Maryland
Connecticut <i>New Haven</i>	<i>Oakland</i> <i>Sacramento</i> <i>San Diego</i>	Massachusetts
Hawaii <i>Honolulu</i>	<i>San Francisco</i> <i>San Mateo</i> <i>Santa Clara</i>	New Hampshire Rhode Island
Oregon <i>Portland</i>	<i>Santa Cruz</i>	
Washington <i>Seattle</i> <i>Spokane</i> <i>Tacoma</i> <i>Vancouver</i>	Illinois <i>Chicago</i> Louisiana	
	Maryland <i>Baltimore</i>	
District of Columbia*	Massachusetts <i>Boston</i>	
* <i>Temporary</i>	New York <i>New York City</i>	
	Pennsylvania <i>Philadelphia</i>	

AmFAR funding needle exchange programs

NEW YORK—The American Foundation for AIDS Research (AmFAR) awarded five grants to fund needle exchange programs in the United States.

AmFAR is now the largest private funder of needle exchange programs in the country. AmFAR is taking this action to stem the alarming growth of HIV infection among intravenous drug users, their sexual partners and children.

Two of the programs are in New York City, targeted at neighborhoods with the highest concentrations of injected drug use. There are an estimated 200,000 intravenous drug users in the city. More than half of them are believed to be HIV positive.

The other programs are in San Francisco, Chicago, and Boulder, CO. All needle exchange programs funded by AmFAR include an evaluation component.

NPT

The NonProfit Times

WAIVING POINTS OF ORDER
AGAINST CONFERENCE
REPORT ON S. 1305, ADAMHA
REORGANIZATION ACT

Mr. GINGRICH. Madam Speaker, I thank the gentleman for yielding me this time.

Madam Speaker, let me say that I rise because I will have a motion to recommit which has been cleared with the gentleman from Illinois [Mr. MICHEL] and which is strongly supported by the Bush administration. The motion to recommit has nothing to do with the funding issue and no one should have any concern from the State level with a State that is involved in the funding fight.

The motion to recommit is narrowly and specifically instructing the managers to agree to a prohibition against using Federal funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Let me read from a letter today from Secretary of Health and Human Services Lou Sullivan to the Speaker:

The administration strongly objects to the conferees' removal of the prohibition against the use of State block grant funds for clean needle exchange programs. There is no evidence that such programs reduce the incidence of HIV infection. Making sterile needles available to IV drug users only encourages more drug use. We feel adamantly that the prohibition should not have been removed and we will support a motion to recommit with instructions to add the prohibition to the bill. The adoption of the prohibition would make the conference report acceptable to the administration.

Madam Speaker, let me emphasize this for just a moment. A "yes" vote will be a vote to insist that the Federal Government not pay for any clean-needle programs for drug addicts. A "yes" vote will be a vote which says we are going to stop any taxpayer money at the Federal level from going to pay for drug addicts getting needles from their Government. Let me quote again what the Secretary of Health and Human Services said: "Making sterile needles available to IV drug users only encourages more drug use."

So in Lou Sullivan's words, based on his judgment as a doctor and as the head of Health and Human Services, a "no" vote would be a vote to encourage more drug use. I do not want any Member to be confused about this, that to vote against the motion to re-

commit as characterized by the Secretary of Health and Human Services, not by me, but by Dr. Sullivan, a "no" vote allows an activity to go on which, as he says, only encourages more drug use. So I want to ask every Member of the House to join in. I believe this can be handled cleanly and simply, to pass the motion to recommit, to accept the Senate language to prohibit using Federal funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

I would strongly urge every Member to vote "yes" for the motion to recommit to cutoff any Federal money being used to give needles to drug addicts.

Again, I would strongly urge you not to vote "no," because as Dr. Sullivan characterized it, a "no" vote would "encourage more drug use."

HOUSE VOTES 145, 146, 147, 148, 149, 150

145. H Res 471. Disclosing House Bank Records. Adoption of the Gephardt, D-Mo., resolution to provide Malcolm R. Wilkey, the Justice Department's special counsel investigating possible criminal violations at the now-closed House bank, with additional bank records he has requested and to authorize a leadership group to respond to further requests. Adopted 396-5: R 153-0; D 242-5 (ND 166-3, SD 76-2); I 1-0, May 28, 1992. (Story, p. 1518)

146. HR 2507. National Institutes of Health Reauthorization/Rule. Adoption of the rule (H Res 466) to waive all points of order against and provide for House floor consideration of the conference report to reauthorize and amend the programs of NIH through fiscal 1996, including fiscal 1993 funding of \$2.2 billion for the National Cancer Institute and \$1.4 billion for the Heart, Lung and Blood Institute. The conference report would lift the ban on fetal tissue transplant research using fetal tissue obtained from induced abortions. Adopted 308-100: R 88-70; D 219-30 (ND 149-19, SD 70-11); I 1-0, May 28, 1992. (Story, p. 1534)

147. HR 2507. National Institutes of Health Reauthorization/Conference Report. Adoption of the conference report to reauthorize and amend the programs of NIH through fiscal 1996, including fiscal 1993 funding of \$2.2 billion for the National Cancer Institute and \$1.4 billion for the Heart, Lung and Blood Institute. The conference report would lift the ban on fetal tissue transplant research using fetal tissue obtained from induced abortions. Adopted 260-148: R 43-116; D 216-32 (ND 148-19, SD 68-13); I 1-0, May 28, 1992. A "nay" was a vote supporting the president's position. (Story, p. 1534)

148. H Res 379. Committee Funding for 1992. Gaydos, D-Pa., motion to order the previous question (thus limiting debate and the possibility of amendment) on the Gaydos substitute amendment to freeze funding for the operations of all standing and select committees of the House at the 1991 level of \$55 million for the second session of the 102nd Congress. The resolution would have provided for a 4.9 percent increase to \$57.8 million. Nussle, R-Iowa, attempted to defeat the previous question in order to offer an amendment that would have provided for a 5 percent cut. Motion agreed to 254-146: R 7-145; D 246-1 (ND 166-1, SD 80-0); I 1-0, May 28, 1992. (The Gaydos amendment was subsequently adopted by voice vote.) (Story, p. 1519)

149. H Res 379. Committee Funding for 1992/Funding Freeze. Adoption of the resolution to freeze funding for the operations of all standing and select committees of the House at the 1991 level of \$55 million for the second session of the 102nd Congress. The committees of the House had requested an increase to \$61.5 million. Adopted 323-76: R 78-74; D 244-2 (ND 165-2, SD 79-0); I 1-0, May 28, 1992. (Story, p. 1519)

150. S 1306. Alcohol, Drug Abuse and Mental Health Administration Reorganization. Gingrich, R-Ga., motion to recommit to the conference committee the conference report, with instructions to report it back to the House with a prohibition on the use of federal funds to buy clean needles or syringes for distribution to drug addicts to use illegal drugs. Motion agreed to 214-157: R 135-6; D 79-150 (ND 36-117, SD 43-33); I 0-1, May 28, 1992. (Hence, the conference report was sent back to conference for further consideration.) (Story, p. 1538)

KEY

- Y Voted for (yea).
- # Paired for.
- + Announced for.
- N Voted against (nay).
- X Paired against.
- Announced against.
- P Voted "present."
- C Voted "present" to avoid possible conflict of interest.
- ? Did not vote or otherwise make a position known.

Democrats Republicans
Independent

	145	146	147	148	149	150
ALABAMA						
1 Callahan	Y	N	N	N	N	Y
2 Dickinson	Y	Y	N	N	Y	N
3 Browder	Y	Y	Y	Y	Y	Y
4 Bevil	Y	Y	Y	Y	Y	Y
5 Cramer	Y	Y	Y	Y	Y	N
6 Erdreich	Y	Y	Y	Y	Y	Y
7 Harris	Y	Y	Y	Y	Y	Y

ALASKA						
AL Young	Y	N	N	?	?	?

ARIZONA						
1 Rhodes	Y	N	N	N	Y	Y
2 Pastor	Y	Y	Y	Y	N	N
3 Stump	Y	N	N	N	Y	Y
4 Kyl	Y	Y	N	N	Y	Y
5 Kolbe	Y	Y	Y	N	Y	N

ARKANSAS						
1 Alexander	?	?	?	?	?	?
2 Thornton	Y	N	N	Y	Y	N
3 Hammerschmidt	Y	N	N	Y	Y	Y
4 Anthony	?	?	?	?	#	?

CALIFORNIA						
1 Riggs	?	Y	Y	N	N	Y
2 Heger	Y	N	N	N	N	Y
3 Matsui	Y	Y	Y	Y	N	N
4 Fazio	Y	Y	Y	Y	N	N
5 Pelosi	Y	Y	Y	Y	N	N
6 Boxer	?	?	#	?	?	?
7 Miller	Y	Y	Y	Y	N	N
8 Dellums	Y	Y	Y	Y	N	N
9 Stark	Y	Y	Y	?	?	?
10 Edwards	Y	Y	Y	Y	N	N
11 Lantos	Y	Y	Y	Y	N	N
12 Campbell	?	?	?	?	?	?
13 Mineta	Y	Y	Y	Y	N	N
14 Doolittle	Y	Y	N	N	N	Y
15 Condit	Y	Y	Y	Y	Y	Y
16 Panetta	Y	Y	Y	Y	N	N
17 Dooley	Y	Y	Y	Y	Y	Y
18 Lehman	Y	Y	Y	Y	?	?
19 Lagomarsino	?	?	X	?	?	?
20 Thomas	Y	Y	N	Y	Y	Y
21 Gallegly	Y	Y	N	N	Y	Y
22 Moorhead	Y	Y	N	N	N	Y
23 Beilenson	Y	Y	Y	Y	?	?
24 Waxman	Y	Y	Y	Y	N	N
25 Roybal	Y	Y	Y	Y	N	N
26 Berman	Y	Y	Y	Y	N	N
27 Levine	?	?	#	?	?	?
28 Dixon	?	?	?	?	?	?
29 Waters	Y	Y	Y	Y	N	N
30 Martinez	Y	Y	Y	Y	N	N
31 Dymally	N	?	?	?	#	X
32 Anderson	Y	Y	Y	Y	N	N
33 Dreier	Y	Y	N	N	N	Y
34 Torres	?	?	Y	Y	N	N
35 Lewis	Y	Y	Y	N	?	?
36 Brown	Y	Y	Y	?	?	?
37 McCandless	Y	Y	N	N	Y	Y
38 Dornan	Y	N	N	N	?	Y
39 Dannemeyer	?	?	?	?	?	?
40 Cox	Y	Y	N	N	N	Y
41 Lowery	Y	N	N	N	Y	Y

	145	146	147	148	149	150
42 Rohrabacher	Y	Y	N	N	N	Y
43 Packard	?	?	X	?	X	?
44 Cunningham	Y	Y	N	N	Y	Y
45 Hunter	Y	N	N	?	N	Y

COLORADO						
1 Schroeder	Y	Y	+	Y	Y	Y
2 Skaggs	Y	Y	Y	Y	Y	N
3 Campbell	?	?	?	?	?	?
4 Allard	Y	N	N	N	N	Y
5 Hefley	Y	N	N	N	N	?
6 Schoefer	Y	N	N	N	Y	?

CONNECTICUT						
1 Kennedy	Y	Y	Y	Y	Y	N
2 Gejdenson	Y	Y	Y	Y	Y	N
3 DeLauro	Y	Y	Y	Y	Y	X
4 Shays	Y	Y	Y	N	N	Y
5 Franks	Y	N	Y	N	N	Y
6 Johnson	Y	Y	Y	N	Y	Y

DELAWARE						
AL Carper	Y	Y	Y	Y	Y	Y

FLORIDA						
1 Hutto	Y	N	N	Y	Y	Y
2 Peterson	Y	Y	Y	Y	Y	Y
3 Bennett	Y	N	N	Y	Y	Y
4 James	Y	N	N	N	N	Y
5 McCollum	Y	N	N	N	N	Y
6 Stearns	Y	N	N	N	N	Y
7 Gibbons	Y	Y	Y	Y	Y	Y
8 Young	Y	N	N	N	N	Y
9 Bilirakis	Y	Y	N	N	Y	Y
10 Ireland	Y	N	N	N	N	Y
11 Bacchus	Y	Y	Y	Y	Y	Y
12 Lewis	Y	N	Y	N	N	Y
13 Goss	Y	N	N	N	N	Y
14 Johnston	Y	Y	Y	Y	Y	Y
15 Shaw	Y	Y	Y	N	N	Y
16 Smith	Y	Y	Y	Y	Y	Y
17 Lehman	Y	Y	Y	Y	Y	N
18 Ros-Lehtinen	Y	Y	N	N	N	Y
19 Foscill	Y	Y	Y	Y	Y	Y

GEORGIA						
1 Thomas	Y	Y	Y	Y	Y	N
2 Hatcher	?	?	?	?	?	?
3 Ray	Y	N	N	?	?	?
4 Jones	Y	Y	Y	Y	Y	N
5 Lewis	Y	Y	Y	Y	Y	N
6 Gingrich	Y	Y	N	N	N	Y
7 Darden	Y	Y	Y	Y	Y	N
8 Rowland	Y	Y	Y	Y	Y	N
9 Jenkins	Y	Y	Y	Y	Y	N
10 Barnard	Y	Y	?	?	?	?

HAWAII						
1 Abercrombie	Y	Y	Y	Y	N	N
2 Mink	Y	Y	+	Y	Y	N

IDAHO						
1 LaRocco	Y	Y	Y	Y	Y	Y
2 Stallings	Y	N	N	Y	Y	Y

ILLINOIS						
1 Hayes	Y	Y	Y	Y	Y	N
2 Savage	Y	Y	Y	Y	Y	N
3 Russo	Y	Y	Y	Y	Y	N
4 Sangmeister	Y	?	Y	Y	Y	Y
5 Lipinski	Y	Y	Y	Y	Y	Y
6 Hyde	Y	N	N	N	Y	Y
7 Collins	?	?	?	Y	Y	?
8 Rostenkowski	Y	Y	Y	Y	Y	N
9 Yates	N	Y	Y	Y	Y	Y
10 Porter	Y	Y	Y	Y	Y	N
11 Annunzio	Y	N	Y	Y	Y	N
12 Crane	Y	N	N	N	N	Y
13 Fawell	Y	Y	N	N	N	Y
14 Hastert	Y	Y	N	N	N	Y
15 Ewing	Y	Y	N	N	N	Y
16 Cox	Y	Y	Y	Y	Y	N
17 Evans	Y	Y	Y	Y	Y	N
18 Michel	?	?	?	?	?	?
19 Bruce	?	?	?	?	?	?
20 Durbin	Y	Y	Y	Y	Y	N
21 Costello	Y	N	N	Y	Y	N
22 Poshard	Y	N	N	Y	Y	Y

INDIANA						
1 Visclosky	Y	Y	Y	Y	Y	Y
2 Sharp	Y	Y	Y	Y	Y	N
3 Roemer	Y	N	N	Y	Y	Y

ND Northern Democrats SD Southern Democrats

Southern states - Ala., Ark., Fla., Ga., Ky., La., Miss., N.C., Okla., S.C., Tenn., Texas, Va. Omitted votes are quorum calls, which CA does not include in its vote charts.

[illegible]

Needle exchanges: Hindrance or help?

Missed point, mixed message

Desperately looking for a quick fix to stop the spread of AIDS among intravenous drug users, activists are advocating free distribution of needles.

This is the wrong approach for two reasons:

- Giving out needles encourages drug use and sends a hopelessly mixed message.

- There is no evidence to date that having clean needles has reduced the incidence of HIV infection among drug addicts, according to Dr. Lewis Sullivan, secretary of

Robert H. Macy is incoming president of the National Association of District Attorneys. This article was written for Scripps Howard News Service.

health and human services.

One reason needle exchange programs are ineffective is that HIV is not spread by needles alone. To avoid injecting the drugs into their muscles, addicts draw back blood into a syringe to confirm they are in a vein. This bloody process spreads potentially contaminated blood into commonly shared paraphernalia, including cotton balls, spoons and water cans.

Second, the big lie in this debate is that sharing is due to a shortage of clean needles. Needles are all too available. Most addicts aren't sharing the needle but rather the drugs in the needle — drugs either purchased with another addict or offered as an expression of trust common in the IV drug culture. One addict described the process as similar to offering a sip of soda to a companion — it's uncool to wipe the rim before you drink.

If giving addicts clean needles doesn't work, what does?

Two existing strategies have demonstrated success in reducing

drug use among the IV drug-using population.

So-called "out reach" programs are working wherein squads of workers are dispatched to the streets to contact addicts and encourage them to avoid sharing needles and enter treatment. The National Institute on Drug Abuse says drug users involved in these projects have reduced their frequency of needle injection and needle sharing, and have increased the frequency of needle sterilization.

The programs have also enjoyed remarkable success in encouraging long-term IV drug users to get into treatment.

Outreach works without distributing clean needles. Indeed, treatment providers participating in the program reject such a notion as not only a waste of limited resources but also a hopelessly mixed message. One treatment provider told me that offering clean needles to addicts sounded like saying, "Please don't smoke. But if you do, try our low-tar brand."

The message sent by outreach programs and aggressive enforcement are working to the extent they are funded. Mixing the message makes no sense.

The second strategy is use of traditional law enforcement arrests and prosecutions that condition probation or early release from jail on the defendant's successful participation in treatment programs.

Despite uninformed claims to the contrary, every major study on the subject collected by the National Institute of Justice concluded that "criminal justice sanctions ... can serve a powerful role by facilitating

BURRELLE'S

NEWS EXPRESS

PAGE ____ OF ____

1/2

effective drug treatment. The leverage created permits treatment to be considered as a viable option by serious abusers."

The National Association of State Alcohol Drug Abuse Directors reports that 40 percent of all persons presently in treatment are referrals from the criminal justice system. The long-term Treatment Outcome Perspective Surveys concluded that criminal justice referrals tended to stay longer in treatment and have as good or better outcomes than similar clients who are not court-ordered.

Moreover, IV drug users' criminality is drastically reduced through court-ordered treatment. Studies report 50 percent to 80 percent reductions in crime during outpatient treatment and near zero criminality of those in residential programs.

The strong, consistent message sent by outreach programs and aggressive enforcement are working fine to the extent they are funded. Mixing the message makes no sense.

2/2

BURRELLE'S

NEWS EXPRESS

PAGE ____ OF ____

Needle swap raises a point

Will city syringes bring arrests?

By Jonetta Rose Barras
THE WASHINGTON TIMES

The law used to be simple: People caught with drug paraphernalia were arrested and prosecuted.

But advocates and critics say the District's new needle exchange legislation may make things more complex. Will a person with a city-issued hypodermic needle be arrested if that needle has drugs in it? If two persons are busted in a raid, one with a city-issued needle and the other with an illegal one, will both be arrested?

These are but two of the questions being pondered by Metropolitan Police officials in their review of the new clean-needle program.

The police department hasn't decided how it will handle the law enforcement angle when the city begins distributing the clean needles to drug abusers later this month.

"We are reviewing the law to see what impact it will have on our procedure," said Sgt. Joe Gentile, a police spokesman.

Some other cities that have similar programs leave arrests to the discretion of police.

D.C. Council member John Ray said it is "troubling" that the public health commissioner had no "discussion with the chief of police" before planning or implementing his program. He said he is concerned about several possible scenarios.

Mr. Ray said he is worried about

the black market getting hold of the city's needles and about what will happen when traces of drugs are found in a police raid.

"I think you can discriminate if there is a rational reason," he said of selective enforcement. "The bigger issue is what happens when cops raid these places and make arrests of people sitting there with legal needles and there is a little drug. I'm wondering whether judges are going to go forward with prosecuting people for possession."

The new program — which D.C. officials hope will save some users from AIDS — will allow the city to distribute needles to about 200 drug abusers awaiting treatment. It was approved temporarily by the council last month.

The needles will carry identifying markers, including numbers and colors. Persons caught with those needles will not be arrested.

But the legislation would create a loophole in the city's current drug paraphernalia law, allowing the city to distribute the needles and drug abusers to possess them.

Dr. Mohammad Akhter, the city's public health chief, said last week that he thought the head of human services, Vincent Gray, may have discussed the program with the police chief, but he "wasn't sure."

Mr. Gray could not be reached for comment.

"There will be selective enforcement," said council member Jim Nathanson, who compared the situation to a person who has taken part in a crime working with the government to get a lesser sentence.

"I don't see anything wrong with it. . . . We're dealing with a health epidemic, and we have a person who is willing to assist, who has admitted guilt and is working with the system to try to eliminate their illegal activity," he said.

Mary Jane De Frank, head of the local American Civil Liberties Union, said the organization has not taken any position on the issue of selective enforcement but that it is supporting the needle distribution plan.

Several cities have needle exchange programs, permitting drug users to turn in a needle and receive a clean, unused one in its place. But most of them are not faced with the problem of selective enforcement.

"The problem is caused by an unwillingness of the [District's] administration to have a regular exchange program," said Dave Purchase, a spokesman for the Point Defiance AIDS Projects in Tacoma, Wash., that has a 4-year-old needle distribution program for all drug users.

Seattle, which, like the District, has a law prohibiting drug paraphernalia, "worked with the police a lot," a spokesman there said, adding that in an arrest police can take all property.

Needle program criticized

Former addicts
doubt its efficacy

By Jonetta Rose Barras
THE WASHINGTON TIMES

Former drug addicts and treatment providers yesterday called the District's needle exchange legislation inadequate and raised concerns about whether the program will increase substance abuse.

They urged the D.C. Council to require that the program, authorized under temporary legislation last week, be considered a demonstration project.

"If they are all ready to go into treatment they shouldn't get needles. It has taken them a long time to make the decision. They shouldn't be discouraged," said Kemi Morten, head of Unfoldment Inc., a non-profit organization that operates a drug treatment and education program at Lorton prison.

"People need help, but they need help without giving them syringes," said Jerome Jordan, a former addict associated with Unfoldment. "I'm against giving out needles, period," he said during a public hearing before the council's Judiciary Committee.

Committee Chairman Wilhelmina Rolark has promised to move swiftly on presenting permanent legislation for a vote by the lawmakers.

The council passed a temporary measure last week authorizing the city to pass out needles to persons awaiting drug treatment. Despite its unanimous passage, council members were concerned about parts of the bill and urged quick scheduling of a public hearing.

While former drug addicts and treatment professionals raised concerns, AIDS advocates voiced strong support for the program, citing the increase in the incidences of AIDS among drug users. A comprehensive study released earlier this year found between 7,500 and 21,000 cases of people with AIDS or infected with the virus in the city. That number is expected to increase 34 percent by 1994.

"Today the city is facing a public health crisis of major proportions.

... The twofold epidemic of HIV infection and drug abuse have a devastating impact," said Public Health Commissioner Mohammad Akhter.

Dr. Akhter yesterday defended the need for the needle distribution program and accepted the five amendments made by the council during last week's voting. The amendments call for annual reports, a recording of program participants' sexual histories and a required evaluation of the program's impact.

People have to undergo a physical examination, have had a blood test and be on the waiting list for treatment before they can receive the needles, which could be distributed as often as two or three times a week, Dr. Akhter said.

About 60 to 200 people are now on the city's waiting list, he added.

"I am afraid we are going to have to do this," said Ron Clarke, executive director of RAP Inc., which has been providing long-term treatment to drug addicts for more than 15 years.

"At RAP we have said we don't support this kind of thing. But there comes a time when you have to put some things aside," he said.

Still, Mr. Clarke called the program "not well thought out" and agreed with Miss Morten's concern that sexual partners and other family members of drug users must be included in the program.

"Many of the drug users are men, and they pass on the virus to their wives or partners, and then the children contract it," Mr. Clarke said. "There needs to be some provision that talks about the family."



To: All B/Q '92 National
Surrogates
From: JIM HOOLEY
Director, Nat'l
Surrogates Division

July 27, 1992

MEMORANDUM FOR BUSH-QUAYLE NATIONAL SURROGATES

FROM: JIM HOOLEY, DIRECTOR
NATIONAL SURROGATES DIVISION

SUBJECT: MORE ISSUES INFORMATION

Attached is a summary of appropriations bills which were held up for action by the Democrats until after their convention, because Democratic markups cut funding in areas where Clinton said he wants to increase...and in areas where they complain that the President hasn't asked for enough!

SURROGATES: WE CAN HAVE SOME FUN WITH THIS. THE DEMOCRATS ARE CUTTING THE PRESIDENT'S REQUESTS RIGHT WHERE CLINTON SAYS WE HAVEN'T BEEN SPENDING ENOUGH MONEY!

July 27, 1992

NOTE TO: Addressees

SUBJECT: The Labor/HHS and Commerce/State/Justice Appropriations Bills

The FY93 Labor/HHS Appropriations Bill will be brought to the floor tomorrow. The Commerce/State/Justice Appropriations Bill is due Wednesday. These are the last two appropriations bills to hit the floor, and a safe guess is they were held close and delayed so as not to complicate the Democratic Convention. How does that work, exactly? As marked up by House Appropriations, *these bills are spectacularly inconsistent with the Democratic Platform and with Clinton's campaign proposals and rhetoric*. One, they underfund -- by huge amounts -- almost everything Clinton has said he wants to do. Two, they frequently impose cuts in Presidential requests in those areas Clinton has complained of Administration inaction. If we're smart and quick, we can use both problems to great advantage.

A quick summary follows. Perhaps our Hill colleagues can help us fill in the details.

AIDS Spending

- The Dem platform pledges to "fully fund the Ryan White Care Act."
- Fulfilling this pledge would require an FY93 appropriation of \$855 million, \$530 million more than the \$326.6 million House Appropriations markup.

Head Start

- The Dem platform pledges that "we will ... extend Head Start to all eligible children."
- House Appropriations approved \$2.7 billion in FY93 Head Start spending, enough for one year's services to 712,000 children, but a full \$5 billion less than would be necessary to fulfill the platform promise, which is consistent with Senator Kennedy's proposal for three years services to 780,000 children.
- Best of all, *House Appropriations' markup is \$27.5 million below the President's request.*

Drug Treatment

- The Dem platform promises to "make drug treatment available to all addicts who seek it."
- The Office of National Drug Control Policy estimates that fulfilling this pledge would require roughly \$800 million annually in new federal drug treatment spending.

- *The House Appropriations markup cuts more than \$88 million from the President's FY93 request for drug treatment. This cut will eliminate approximately 12,000 drug treatment slots serving a total of 30,000 people.*
- The Dem platform further endorses, without reservation, the "recommendations of the National Commission on AIDS," which commission, in turn, endorses federally-funded needle exchange programs for intravenous drug users.
- House Democrats have voted to cut federal outreach efforts to intravenous drug users by \$2.8 million. As a result, 10,000 fewer intravenous drug users will be provided outreach intervention and counseling services.

Pell Grants

- The Dem platform promises to create a domestic G.I. Bill to "make college affordable to all students who are qualified to attend, regardless of family income."
- *House Appropriations cuts \$422.9 million from the President's request for the FY93 Pell Grant program.*

Drug Education

- The Dem platform pledges to "intensify efforts to educate our children at the earliest ages to the dangers of drug and alcohol abuse."
- *House Appropriations has cut the federal Drug-Free Schools account below current levels, and \$41.5 million below the President's request.*

Drug Interdiction

- No mention of drug interdiction appears in the Democratic Platform.
- Cuts in the FY93 foreign aid appropriation will enable foreign drug producers to ship an additional 50 tons of cocaine and other drugs to the U.S., according to ONDCP estimates.

Law Enforcement

- The Dem platform promises to "restore government as upholder of basic law and order for crime-ravaged communities," and makes fleeting reference to "more community policing."
- Clinton has attacked the President for insufficient support of state and local law enforcement just within the past several days.
- House Democrats have cut funding for the Office of Justice programs, the primary means through which federal support reaches state and local law enforcement, a total of \$41.5 million below the FY92 level. Overall, funding for drug-related law enforcement at DoJ is slated for cuts as high as \$500 million, 10 percent below the President's request.