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[Issues] - Needles (More) [1]

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COLLECTION:

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2018-0764-F

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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

TCA**Therapeutic Communities of America**

1611 Connecticut Avenue, NW; #4B

Washington, DC 20009

Phone: 202-296-3503; Fax: 202-518-5475

MEMORANDUM

TO: Interested Organizations

FROM: Linda R. Wolf Jones, D.S.W.; Executive Director, TCA

DATE: 4/27/98

RE: Expression of Support for General McCaffrey in His Position as Drug Czar

Attached is a letter which Therapeutic Communities of America proposes to send to President Clinton expressing support for General Barry R. McCaffrey in his position as Director of the Office of National Drug Control Policy.

There have been calls for President Clinton to oust General McCaffrey from the ONDCP position because of his opposition to the use of federal funding for needle exchange programs. **Regardless of where your organization stands on the issue of needle exchange** (understanding that some of our groups have come out in favor and others have not), needle exchange subsidies have not been and should not be the litmus test for the ONDCP Director position.

General McCaffrey has taken the time and effort to learn about, care about, and be a strong advocate for prevention and treatment. He has manifested integrity and character in his dealings with the field. He has recognized and supported us both publicly and privately. We would like you to sign onto the letter in support of General McCaffrey. Please call me at 202-296-3503 if you have any questions about this letter.

To sign on, please fill out below and fax to me at 202-518-5475 no later than Tuesday, May 5. Please type or print legibly. Thank you.

YES, WE WILL SIGN ON:

Authorized by/Contact person: _____

Organization name as you wish it to appear: _____

Phone: _____ Fax: _____

May 6, 1998

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

We, the undersigned organizations, are writing to express our strong support for General Barry R. McCaffrey in his position as Director of the Office of National Drug Control Policy.

Some of our groups have come out in favor of federal funding for needle exchange programs and others have not. We will continue to press our respective positions on that issue with him, with others in your Administration and with the Congress. However, we do not believe that needle exchange subsidies should be the litmus test for the ONDCP Director position.

We all know that drug policy is a complex and multi-faceted field. General McCaffrey has taken the time and effort to learn about and care about the demand reduction side. He has manifested integrity and character in his dealings with the field and its representative organizations. He has been a strong and vocal advocate of the need for drug prevention and treatment programs. We may not agree unanimously with his policy position, but we respect and appreciate his leadership, his honesty and his concern.

Thank you for this opportunity to express our point of view.

Sincerely,

April 28, 1998
(House)

H.R. 3717 - Prohibition Regarding Illegal Drugs and the Distribution of Hypodermic Needles
(Rep. Solomon (R) NY and four cosponsors)

The Administration strongly opposes H.R. 3717 because it is unnecessary and unwarranted. The Administration concurs in the longstanding position of the Congress that the Secretary of Health and Human Services should have the authority to determine the scientific and public health merit of needle exchange programs as they affect rates of HIV transmission and injection drug use. The Administration believes, as Congress has to this point, that the top public health leadership of the Federal government remains the appropriate place for this determination, and that the decision on which HIV prevention strategies to use should rest with State and local officials.

* * * * *

(Do Not Distribute Outside Executive Office of the President)

This Statement of Administration Policy was developed by the Legislative Reference Division (Pellicci) in consultation with HLTH (Turman/Ip), OMB Associate Director Mendelson, National AIDS Policy Office Deputy Director Todd Summers, and Deputy Assistant to the President Chris Jennings. HHS (Per Richard Tarplin, Assistant Secretary for Legislation) agrees with the proposed position. The Department of Justice (per Greg Jones) and the Office of National Drug Control Policy (per Ross Deck) have no objection.

OMB/LA Clearance: _____

H.R. 3717 was introduced on April 23rd. There have been no hearings or committee action on the bill. The House Rules Committee is scheduled to consider the bill at 2 p.m. on Tuesday, April 28th. House floor action is expected on Wednesday, April 29th.

Background

Public Law 105-78 (the Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act for FY 1998) continues the prohibition on the use of Federal funds for the distribution of needles, but allows for such funds to be used for needle-exchange programs after March 31, 1998, if the Secretary of HHS certifies that such programs are: (1) effective in preventing the spread of HIV; (2) operated in accordance with criteria established by the Secretary; and (3) not encouraging the use of illegal drugs.

On April 20th, HHS Secretary Shalala announced that "based on the findings of extensive scientific research . . . needle exchange programs can be an effective part of a comprehensive strategy to reduce the incidence of HIV transmission and do not encourage the use of illegal drugs." The Secretary noted, however, that the current law restriction on Federal funding of

needle exchange programs would not be lifted administratively. (Since 1989, the use of Federal funds for needle exchange programs has been restricted by the Congress.)

Description of H.R. 3717

H.R. 3717 states that "[n]otwithstanding any other provision of law, none of the amounts made available under any Federal law for any fiscal year may be expended, directly or indirectly, to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug."

H.R. 3717 would also repeal the provision in P.L. 105-78, which was discussed above, that would permit the use of appropriated funds to be used after March 31, 1998, for needle exchange programs.

Pay-As-You-Go Scoring

According to HLTH (Chin-Chin Ip), H.R. 3717 would not affect revenues or direct spending; therefore, it is not subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990.

LEGISLATIVE REFERENCE DIVISION DRAFT

04/28/98 - 3:30 p.m.

Organizations Supporting Needle Exchange

ACT UP, Washington
ACT UP, Philadelphia
AID Atlanta
AIDS Legal Referral Panel
AIDS Policy Center for Children, Youth and Families
AIDS National Interfaith Network
AIDS Action Council
AIDS Related Community Services
America Psychological Association
American Society of Addiction Medicine
American Academy of Pediatrics
American Public Welfare Association
American Public Health Association
American Foundation for ADS Research
American Bar Association
American Pharmaceuticals
American Nurses Association
American Psychiatric Association
American Civil Liberties Union
Association of Schools of Public Health
Association of Nurses in AIDS Care
Association of State and Territorial Health Officials
Atlanta Harm Reduction Coalition
Boulder County AIDS Project
Brotherhood Crusade
California Medical Association
California Latino Civil Rights Network
Californians for Justice
Center for Women Policy studies
Chicago Related Community
Cities Advocating Emergency AIDS Relief
Colorado Harm Reduction Coalition
Colorado AIDS Project
Committee for Children
Common Sense for Drug Policy
Community Health Network
Criminal Justice Policy
Drug Policy Forum
Drug Policy Foundation
Feminist Majority Foundation
Gay and Lesbian Medical Association
Guam Sterile Needle Exchange

Organizations Supporting Needle Exchange (Cont.)

Harm Reduction Coalition
Harm Reduction
Harm Reduction Outreach
Health Force: Women and Men Against AIDS
Hispanic Health Council
Human Rights Campaign
Legal Action Center
Lindesmith Center
Los Angeles AIDS Project
Lower East Side Needle Exchange
Lyon-Martin Women's Health
Mobilization Against AIDS
Mothers Against Misuse and abuse
Mothers Voices United to End AIDS
Mothers' Voices United to End AIDS
National AIDS Fund
National Association of Social Workers
National Black Nurses Association
National Black Police Association
National Urban Coalition
National Association of County and City Health Officials
National Association for the Advancement of Colored People (NAACP) Sacramento, CA
National Black Police Association
National Council for International Health
National Urban League
National Women's Law Center
National Alliance of State and Territorial Health Directors
National Latino/a Lesbian and Gay Organization
National Minority AIDS Council
National AIDS Treatment Advocacy Project
National Catholic AIDS Network
National Black Caucus of State Legislators
National Association of People with AIDS
National Native American AIDS Prevention Center
New York Academy of Medicine
New Hampshire Harm Reduction
National Organizations Responding to AIDS
North American Syringe Exchange Network
North American Syringe Exchange Network
Northern Exchange II
People of Color Against AIDS Coalition
People Engaged in Education and Reduction Strategies
People of Color Against AIDS Network
POZ Magazine
Project Inform
Rockford Urban Ministries

Organizations Supporting Needle Exchange (Cont.)

SFAIDS Foundation

San Francisco Medical Society

The Drug Policy Foundation

The Honorable Xavier Becerra (D-Ca) Chair, Congressional Hispanic Caucus

The Honorable Maxine Waters (D-Ca) Chair, Congressional Black Caucus

Title II Community AIDS National Network

United Church of Christ, AIDS/HIV Network Leadership Team

United States Conference of Mayors

United Church of Christ

Whitman-Walker Clinic

Womens' AIDS Network

Elected Officials

Mayor De Stefano, Jr. (New Haven)
Mayor Willie Brown, Jr., San Francisco

Rep. Neil Abercrombie (D-HI)
Rep. Gary Ackerman (D-NY)
Rep. Thomas Barrett (D-WI)
Rep. Howard Berman (D-CA)
Rep. Earl Blumenauer (
Rep. George Brown (D-CA)
Rep. Sherrod Brown (D-OH)
Rep. Benjamin Cardin (D-MD)
Rep. John Conyers, Jr.
Rep. Elijah Cummings
Rep. Carolyn Cheeks-Kilpatrick
Rep. Diana Degette
Rep. William Dellahunt
Rep. Ron Dellums (D-CA)
Rep. Anna Eshoo (D-CA)
Rep. Sam Farr (D-CA)
Rep. Vic Fazio (D-CA)
Rep. Elizabeth Ferse (
Rep. Barney Frank (D-MA)

Rep. Bob Filner (D-CA)
Rep. Greg Ganske (R-IA)
Rep. Nancy Johnson (R-CT)
Rep. John Campbell
Rep. Connie Morella (R-MD)
Rep. Melvin Watt
Rep. Nancy Pelosi
Rep. Louis Stokes (D-OH)
Rep. Robert Wexler
Rep. Mark Foley
Rep. Robert Scott
Rep. Linn Woolsey
Rep. Jim McDermott
Rep. John Lewis (Ga)
Rep. Bobby Rush
Rep. Tom Lantos
Rep. John Olver
Rep. Lucille Roybal-Allard
Rep. Loretta Sanchez

Rep. Zoe Lofgren
Rep. Shelia Jackson-Lee
Rep. Lynn Rivers
Rep. Henry Waxman
Rep. Juanita Millender-McDonald
Rep. Louis Gutierrez
Rep. Nadia Velazquez
Rep. George Miller
Rep. Jerrold Nadler
Rep. Maurice Hinchey
Rep. Ed Pastor
Rep. Jose Serrano
Rep. Patsy Mink
Rep. Eddie Bernice Johnson
Rep. Dennis Kucinich
Rep. Bruce Vento
Rep. Frank Pallone
Rep. Matthew Martinez
Rep. Maxine Waters

Law Enforcement Officials

Fred H. Law, Chief of Police (San Francisco)

Press Editorials

Chicago Tribune

Shalala Punts on a Crucial Call 3/10/98; A Potential Step Back on AIDS 9/18/97
Gaining Ground against AIDS 3/8/97

Detroit Free Press

September 9, 1997

LA Times

Needle Programs are Needed 7/8/97

Lancet

NY Times

AMA Backs Drug User Needle Exchange 6/27/97; Federal Funds for Clean Needles
2/22/97

Plain Dealer

Studies of Needle-exchange Programs ... 4/3/97

Press Democrat

One More Chance 7/22/97

Washington Post

...Offering Clean Needles 7/14/97; Needles and Classroom Candor 2/15/97

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Reasons

April 23, 1998

The Honorable Sandra L. Thurman
Director
White House Office of National AIDS Policy
808 17th St., N.W., 8th Floor
Washington, D.C., 20503

Dear Ms. Thurman:

Sandy -

The President's courageous decision not to authorize federal funding for needle exchange programs (NEPs) reflected both the continuing controversy over the efficacy of NEPs as a means to prevent the transmission of HIV and widespread concern that such programs encourage illegal drug use.

While all of us at ONDCP are encouraged by CDC studies showing that the number of new HIV cases in the U.S. appears to be declining, we share your commitment to policies that would help accelerate this decline. As you know, injecting drug use was an exposure category for 15 percent of new HIV cases reported between July 1996 and June 1997. Clearly, this problem needs to be addressed. However, NEPs are an inappropriate tactic that would undermine the President's multi-faceted, balanced *National Drug Control Strategy*.

We look forward to supporting future efforts against HIV/AIDS. Surely, our shared commitment to protecting all Americans from drug abuse and its consequences can result in mutually supportive public-health and law-enforcement strategies.

Sincerely,

Barry R. McCaffrey
Director

A sensible, prudent decision by the Administration which maintains focus of Federal efforts on supporting effective drug treatment.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY

Washington, D.C. 20503

February 12, 1998

Personal

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

The purpose of this note is to share some thoughts about needle-exchange programs. Although there are advocates within the Administration for lifting the federal ban on funding for needle exchange, ONDCP has serious concerns about the potential impact such a step would have on our drug-control efforts.

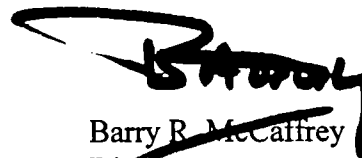
First, federal support for needle-exchange programs would weaken the anti-drug message. To date, studies assessing the effect of needle exchange on drug use have been indirect and uncertain. A consistent "no-use" message would be undermined; measurable consequences are possible in upcoming years.

Second, needle exchange could erode support in Congress for overall drug-policy efforts. A weakening of anti-drug sentiments might call into question the validity of our prevention programs. In addition, the Administration has fought hard to increase access to drug treatment, which could be jeopardized if needle exchange is seen as a cheap alternative.

Finally, lifting the current ban would be a Pyrrhic victory for needle-exchange supporters. Some members of Congress will no doubt call for punitive measures against communities that operate such programs, regardless of funding source. Lifting the ban would also invite renewed criticism that the Administration is not serious about solving the drug problem.

This information is offered for your consideration in hopes of insuring implementation of the best possible drug-control policy.

Very respectfully,


Barry R. McCaffrey
Director

Needle Exchange

With the recent confirmation hearings for Surgeon General Satcher, there has been renewed discussion regarding the ban on federal funding for needle exchange programs. Secretary Shalala regains her authority to rescind the ban on March 31, 1998. ONDCP does not support lifting the ban for the following reasons:

- **Drug treatment and outreach are the most effective means to prevent HIV.** We need to improve outreach to addicts and get them into drug treatment and HIV prevention programs.
- **Science, not ideology, should drive drug policy.** ONDCP is aware of the views of many eminent scientists that needle exchange programs can be effective in the short-term in reducing HIV transmission. However, needle exchange programs may pose a risk of increased levels of drug abuse (and therefore HIV) in the longer run. We have questions about the research and want to have a continuing dialogue with Secretary Shalala and Dr. Varmus.
- **ONDCP continues to have serious concerns about whether NEPs would contribute to higher drug use levels in the community.** This concern was raised in an Institute of Medicine report. There are still significant concerns on the part of many communities.
- **Continued drug use is dangerous.** There are real dangers in continued drug use by addicts in terms of crime in the community, the addict's own health and well-being, and potential transmission of the virus through risky sexual behaviors.
- **A mixed message is risky.** A Federal policy that demonstrated acceptance of needles exchanges by paying for them could have an impact on public perception regarding drug use. We do know that youth attitudes (i.e., risk perception, social disapproval) have a strong correlation with drug use.
- **Lifting the ban provides Congress the opportunity to add even more restrictive language to authorizing and appropriations bills, and it could hurt drug treatment funding.**

THE WHITE HOUSE
WASHINGTON

FOR IMMEDIATE RELEASE
March 22, 1998 (10:01am)

Contacts: (ONAP) (202) 255-2447/632-1090
(ONDCP) (202) 395-6618

**DRUG CZAR AND AIDS CZAR AGREE THAT
PUBLIC HEALTH POLICY MUST BE
BASED ON SOUND SCIENCE**

(Washington, D.C.) -- Barry R. McCaffrey, Director of the Office of National Drug Control Policy, and Sandra L. Thurman, Director of the Office of National AIDS Policy, issued the following joint statement:

Today, America is struggling with not just one epidemic, but with two. Tragically, the twin epidemics of AIDS and drugs are linked and impose devastating costs on individuals, families, and on our society as a whole. Together, we share a strong commitment to improving lives and to saving lives by promoting public health policies that are based on sound science.

We agree that drug treatment is the most effective tool not only in reducing the use of drugs but in reducing the sharing of needles, both of which contribute to the spread of HIV. Unfortunately, despite a 33 percent increase in federal spending since fiscal year 1993, drug treatment is only available for half of those in immediate need. We are strongly united in our desire to do everything that we can to expand the availability of drug treatment for all those in need, and to prevent the further spread of HIV among injecting drug users and people with whom they have sexual contact.

As for needle exchange, Congress has limited the use of Federal funds for sterile needle and syringe exchange projects until (1) the Secretary of Health and Human Services determines that exchange projects are effective in preventing the spread of HIV and do not encourage the use of illegal drugs; and (2) the project is operated in accordance with criteria established by the Secretary for preventing the spread of HIV and for ensuring that the project does not encourage the use of illegal drugs. The Office of National Drug Control Policy and the Office of National AIDS Policy remain dedicated to working with Secretary Shalala, and to supporting her efforts to ensure that public health policy is guided by sound science.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Why We Said No to ~~Needles~~ *Federal Funding*

This past Monday, the Secretary of Health and Human Services Donna Shalala, in close consultation with the President, made a courageous decision not to allow the use of federal funds for needle exchange programs. To date, the debate over needle exchange has been dominated by an overly constrained two-part legal test to determine whether they can receive federal funds, namely: (1) Do the programs help diminish HIV transmission rates? (2) Do the programs encourage increased drug abuse? However, the real dangers with respect to needle exchange fail to fit into these neat, legalistic boxes. By examining the full range of issues, the rationale behind the Administration's decision becomes clear.

In the end, needle exchange alone doesn't save lives; it just swaps causes of death. Even if you conclude that needle exchange prevents AIDS transmission, without treatment intravenous drug-using addicts and their sexual partners, will still die -- perhaps not from AIDS but from wound botulism, hepatitis, overdoses or violently from drug-related crime. Each year, 4,178 people die from heroin/morphine-related causes, which are the number one reason for drug-related death. Each day, another 352 people put one foot in the grave by beginning to use heroin. No matter how many "clean" needles we put out on the streets, the reality is that at one time or another -- impaired by a drug-induced high or an overwhelming craving -- virtually all long-term addicts will succumb to behavior that exposes them to HIV.

The answer to HIV and drug addiction is to focus on a cure, not look for a quick "fix." Curing drug addiction is the best way to stop HIV transmission from dirty needles -- not multiplying the number of needles on the streets that can become AIDS injectors. Needle exchanges won't cure HIV; research for a cure can, and treatment can delay the advent of AIDS. Let's not divert our focus from the real goals of prevention, treatment, and cure. AIDS "Czar" Sandy Thurman and Secretary Shalala deserve much credit for the great strides we are making against HIV. New multiple drug treatments are being used to prolong lives and dramatically reduce prenatal transmission rates. Emerging "altruistic vaccines," which allow those already infected with HIV to safeguard their partners, show great promise for denying this plague a new generation of victims. Community prevention efforts are discouraging behaviors that lead to the spread of HIV. Supporting research, treatment and education is where our efforts -- and our money -- should be invested. The \$630 million that could have been tapped into for needle exchange stopgap measures now should continue to be invested where it can do the most good: in HIV and drug treatment and prevention, and into research aimed at cures for drug addiction and HIV.

The social ills associated with needle exchange programs extend far beyond HIV transmission and drug use rates. The sad reality is that needle exchange programs are almost exclusively located in impoverished inner-city neighborhoods, not wealthy suburbs. Don't look for a needle exchange programs on tony Fifth Avenue; you won't find them there. Look for them on the tough streets of the Lower East Side of New York City. These programs become magnets, pulling in addicts, pushers, gangs, prostitution, crime and violence from surrounding

areas, making it that much harder for these communities and their residents to survive, let alone get ahead. The pervasiveness of the drug culture in these areas puts children who are already at risk in greater jeopardy. The child gunned down by a drug dealer pushing heroin in the shadows of a needle exchange program goes uncounted on either the AIDS or drug user death rolls, but he must weigh heavily in our decisions about what behavior to encourage. The impact on these families and communities, which plays no role in the narrow legal test as to federal funding for needle exchange programs, is, perhaps, the strongest reason why the federal funds should not go to needle exchange programs.

As a matter of principle, the federal government should not be in the business of buying drug paraphernalia. It is disingenuous for us to outlaw drug paraphernalia and then turn around and purchase it for addicts. The most important thing the federal government can do to attack America's drug problem is to educate our children about the dangers of drugs. We need to send a clear message to young people that drugs are wrong, and they can kill you. Actions speak louder than words; if the federal government starts handing out the tools of drug abuse, our children will learn from our deeds not our words.

The risks to our nation's children are real. The 1997 *National Household Survey on Drug Abuse* found that the mean initiation age for heroin has declined steadily from 27.3 in 1988 to 19.3 in 1995. Sending children the wrong message about heroin is especially dangerous. Attitudes drive actions, and young people's views about drugs -- including heroin -- are far too "soft" already. In 1991, 58 percent of eighth graders perceived "great risk" in occasional marijuana use; by 1997, that figure slipped to 43 percent. Even with heroin, one of the deadliest drugs, only 57 percent of eighth graders see "great risk" in using the drug. We can ill afford to confuse children about the whether or not it is okay to use heroin.

Nor can we afford to waste time in the fight against drugs and HIV by playing politics. The four million Americans addicted to drugs, and the approximately 320,000 people diagnosed with HIV/AIDS need real help now. They need treatment and a cure. The Administration's decision on needle exchange allows us all to put politics aside and get down to the business of exercising our moral responsibility to provide these people with the help they require. This Administration is 100 percent committed to saving the lives of Americans threatened by drugs and HIV. What we need is bipartisan support of the programs we are advancing that can really make a difference.

Barry R. McCaffrey
Director



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

March 23, 1998

Mr. Erskine Bowles
Chief of Staff to the President
The White House

Dear Mister Bowles:

Wanted to share my thoughts on the subject of needle exchange programs for intravenous drug users. As you know, the Director, ONDCP is charged by law to coordinate the activities of the many federal agencies involved with national drug control policy. It would not be appropriate for the Domestic Policy Council to lead the interagency process on this or other drug-related policy issues. Nor would it would be wise to force the President to have to choose between good drug policy and short-term HIV reduction.

ONDCP's position on this issue is based on three critical principles.

- ***The Paramount Importance of Drug Treatment***

The President's *National Drug Control Strategy* states that drug treatment holds the best hope for America's 3.6 million chronic drug users. Only treatment will cure the gauntlet of problems facing drug addicts, including not just HIV but also other communicable diseases and the associated social problems that come with drug abuse (e.g. prostitution, violence, homelessness, child neglect and crime). Needle exchange would only be a short-term measure. We currently have a massive treatment shortfall in America; for our 810,000 heroin addicts we have the methadone capacity for only 115,000. This in spite of the fact that addicts outside of methadone programs have a death rate between 7 and 8 times higher than do those in methadone programs. It would appear unwise to divert any funds from treatment *or funds that might otherwise be available for treatment.*

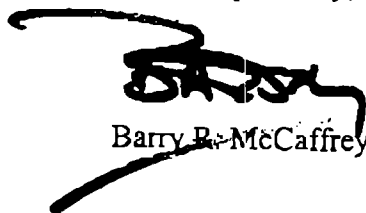
- ***The Legal Responsibilities of the Director, ONDCP***

My responsibility as Director, ONDCP in this area is clear. Should HHS or other federal agencies advocate funding needle exchange from drug funds, section 1502 (c) of title 21 of the United States Code requires that any substantial reprogramming or transfer request be approved by me. Even if drug monies are not involved, for HHS or any other agency to effect a policy change in order to support needle exchange, section 1503(b) of title 21 of the United States Code requires that I be notified in writing so that I may certify the policy change is consistent with the *National Drug Control Strategy*. While the Secretary of HHS is authorized by a separate law to make determinations pertaining to needle exchange, the actual transfer of drug funds or changes of drug policy must be certified by the Director, ONDCP.

• *The Role of Science*

We all agree that science must determine how we proceed. Two main questions must be answered prior to the approval of federally funded needle exchange programs. The first is whether or not needle exchange slows the spread of HIV and the second is whether needle exchange encourages drug abuse. The data on treatment is indisputable: the long-term outcome of needle exchange remains unclear. What is clear is that heroin use has taken a terrible upward turn among our young people. Our responsibility remains that we send an unambiguous "no use" message to them. And if they should become ensnared by drugs, we must offer them a way out of, not a means to continue, addictive behavior.

Very Respectfully,

A handwritten signature in black ink, appearing to read "Barry R. McCaffrey", with a long horizontal stroke extending to the left.

Barry R. McCaffrey



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

March 17, 1998

The Honorable Sandy Thurman
Director
White House Office of National AIDS Policy
808 17th St., NW, 8th Floor
Washington, DC, 20503

Dear Ms. Thurman:

Sandy —

Thank you for sharing your viewpoints on the issue of needle exchange programs (NEPs) this afternoon. All of us at ONDCP fully share your commitment to halting the spread of HIV, a preventable disease that infects another thirty-three Americans each day. We are only too aware that, according to the Centers for Disease Control and Prevention, 35.8 percent of new HIV cases are directly or indirectly linked to injecting drug users. At the same time, we remain committed to ensuring that the *National Drug Control Strategy's* no use message is not diluted. Each day, more than 8,000 children try illegal drugs for the first time. We cannot cut this number by 50 percent absent a steady anti-drug message.

As you know, federal law currently prohibits the use of federal funds to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug. The law also requires that the Secretary of Health and Human Services determine that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs before federal resources can be provided to these programs. ONDCP continues to rely on Secretary Shalala's leadership on this issue. We have also received briefings from Dr. Harold Varmus and Dr. Alan Leshner on research related to NEPs and the transmission of HIV among drug users and their sexual partners. In response to those briefings, ONDCP has raised a number of questions that are of particular importance as the efficacy of NEPs is considered. (I have asked John Gregrich from our Office of Demand Reduction to share those questions with your staff.)

→ In my judgment, we should not endorse the use of federal funds, including CDC funds, to support needle exchange programs. With so much at stake, drug treatment offers the better long-term policy for drug control and AIDS prevention. Lifting the ban at this time, even in part, would present serious and complex issues regarding drug use and drug control policy. There is the troubling question of how such a message would be received by our young people during this period of rising heroin use, and the concern that needle exchange programs will be considered an adequate substitute for much needed drug treatment. Furthermore, there is the simple fact that communities are not prohibited

from operating such programs; approximately 100 communities do so now without federal funding.

The narrow logic that would focus on needles or injecting as the essence of the problem fails to take into account the complex human behavior involved. As NIDA research has found, drug addiction changes and trains the brain, creating a web of destructive and high risk behaviors. The resulting crime, illness, social erosion, and death flow from the compulsive behaviors associated with addiction, not just from the act of injecting. The provision of clean needles will not contain or alter this destructive lifestyle. The only proven answer lies in treatment -- comprehensive in scope, intensive in application, and adequate in capacity. *part of comprehensive approach*

The real challenge we face is the shortfall in treatment capacity. Research sponsored by DHHS has shown that untreated opiate addicts die at a rate between 7 and 8 times higher than patients with similar characteristics in methadone programs, and that needle-sharing rates have been reduced by more than two-thirds among injecting drug users during treatment. The potential of drug treatment is impressive:

- NIDA's Drug Abuse Treatment Outcome Study (DATOS) found that participants in outpatient methadone treatment reduced heroin use by 70 percent, cocaine use by 48 percent, and illegal activity by 57 percent. The study also concluded that participants in long-term residential treatment reduced heroin use by 71 percent, cocaine use by 68 percent, and illegal activity by 62 percent. Full time work among this group increased 222 percent.
- SAMHSA'S National Treatment Improvement Evaluation Study (NTIES) found that substance abuse treatment among predominately poor, inner-city populations also was extremely effective. Use of illicit drugs dropped an average of 50 percent; arrests dropped by 64 percent, drug selling by 78 percent, shoplifting by 82 percent, and exchange of sex for money or drugs dropped by 56 percent.

Clearly, treatment has a solid record. Yet only enough capacity is available at this time to treat about half of those in severe need. Methadone capacity is sufficient for only 115,000 of the estimated 810,000 heroin addicts. As you know, the *1998 National Drug Control Strategy* advocates the continued expansion of treatment and outreach programs for the chronically addicted. Federal expenditures for treatment have increased 33 percent since fiscal year 1993. In fiscal year 1999, the Administration has proposed spending an additional \$200 million (20 percent of the proposed increase in the drug-control budget) for SAMHSA's Substance Abuse Prevention and Treatment Performance Partnership Grant in order to make treatment more available.

Our efforts to expand treatment must continue to be based on a broader, consistent "no use" message. Visits to youth treatment programs around the country have made some things painfully clear to me. One is that the importance of the message we send cannot be overstated. Heroin use has taken a terrible upward turn among our young people. As public servants, citizens, and parents we owe our children an unambiguous, "no use" message. And if they should become ensnared by drugs, we must offer them a way out not a means to continue addictive behavior.

Sincerely,

A handwritten signature in black ink, appearing to read "Barry R. McCaffrey", with a large, sweeping loop at the beginning.

Barry R. McCaffrey
Director

News from the

Office of National AIDS Policy

Executive Office of the President



FOR IMMEDIATE RELEASE

March 24, 1998 (4:26pm)

Contact: Jeff Kamen

(202) 255-2447

**STATEMENT BY WHITE HOUSE AIDS CZAR SANDRA L. THURMAN
TO OPENING SESSION OF A FOUR DAY MEETING OF THE
PRESIDENT'S ADVISORY COUNCIL ON HIV/AIDS
MADISON HOTEL 10A.M. TODAY, SUNDAY MARCH 15, 1998**

I want to begin by directly addressing a subject that is weighing heavily on the minds of every member of the President's Advisory Council on HIV/AIDS and of public health officials from coast to coast: needle exchange. This is an issue on which I have very strong and very personal feelings.

I wake every day, heartsick that another 33 Americans will have their lives torn apart by HIV as a result of I.V. drugs. Thirty-three lives that might not have been imperiled had local communities been given the support to implement needle exchange programs. These are not numbers but real lives. I have cradled them in my arms, often in their last moments. I am haunted by the responsibility to use my position to do everything I can to stop this carnage.

Needle exchange has come to symbolize a willingness to let science drive public health policy by moving forward with an HIV prevention tool that has strong scientific support. I want you to know that since my first day at the White House, I have pushed hard for a needle exchange policy based not on politics but on science.

Unfortunately, it is more complicated than that. America today is struggling not only with the AIDS epidemic but with the equally devastating impact of drug addiction. These twin epidemics feed on one another, imposing terrible costs on our country. Those of us who focus primarily on the plague of drugs are no less earnest and no less committed to saving lives than those of us who have dedicated ourselves to battling HIV. Our goals are the same, though we may at times differ on the best means to achieve them.

We will continue to work on the issue of needle exchange in an effort to do what is in the best interest of people living with HIV and AIDS, and of all Americans. And we will do so cognizant of the reality that with each passing day, more lives are lost in our battle against AIDS and in our battle against drugs.

The President clearly articulated his commitment to pushing us to do everything in our power to reduce new HIV infections until there are none. He remains firmly committed to that goal, and everyone in his administration is dedicated to being a part of that effort.

Q/A Bergman *continued*
assignment?

A. Exciting is a relative concept. The most impressive person that I have ever met was Ed Roberts, who's now dead. He founded the Center for Independent Living. He was a quadriplegic, who, in the late 1950s and early 1960s, convinced the University of California to allow totally disabled people to attend the university. He was definitely an exciting guy to be around. He could get on BART by moving his head and two fingers. That was a sight to behold.

Q. Tell us about how CBS fired Andy Rooney and then hired him back again. Is public outcry that influential?

A. Yes. It's up to you, the audience, to demand better reporting, real reporting. CBS listens to the public. Don Hewitt reads the mail. If you call him early enough, he'll answer the phone. The fact is that the networks do respond to the public when they get letters, which count more than anything else, since someone bothers to sit down and do it. Andy, bless his heart, decided that he was not going to cross the picket line, since the writers' guild had gone on strike. Everybody else was sneaking around the picket line and he just refused to cross it to be on the air. When you just say "no," a lot of times in this business, it works. ♦

Tell a Friend . . .

Most Commonwealth Club members come to us because friends have mentioned how much they enjoy the Club's programs.

If you have friends or associates who might be interested in membership, share a copy of *The Commonwealth* with them, or refer them to Rob Banchich, membership director, at 415/597-6732.

We'll be glad you did, and so will they!

WEDNESDAY JULY 2

Reducing Drug Use and Its Consequences in America

Gen. Barry McCaffrey

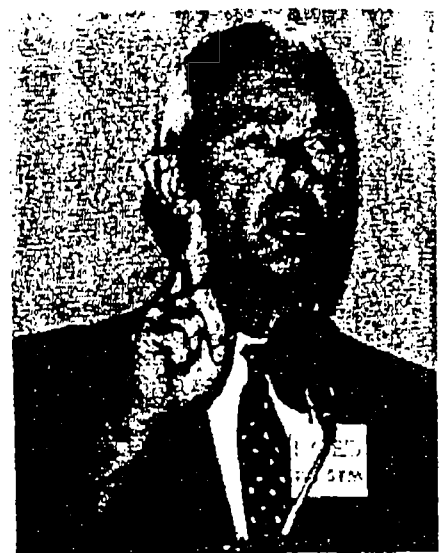
Director, White House Office of National Drug Control Policy; Member, National Security Council

One of the slogans I've adopted from the National Institutes of Health is: By the turn of the century, we need to replace ideology with science when we deal with drug addiction and its consequences. One of the challenges in most areas of organized activity in our nation is that we start with a common set of facts and then argue about alternative hypotheses and policy options to deal with the facts. With drug addiction, we begin without a common appreciation of what the facts are. We know a lot about drug abuse, but we have to get to the baseline that scholars in the scientific community have given us. From that, we can move forward with more confidence.

Heart of the Matter

We can't reach a satisfactory conclusion without a strategy, and it can't be an annual drug strategy. We have to have a 10-year perspective, and then develop five-year budgets in order to have a sensible debate. This includes the idea that by investing in sensible drug treatment programs, particularly for people involved in the criminal justice system, we can accrue enormous resource savings. But you can't have that debate unless there's a conceptual framework on which to hang your policies and budgets.

"Our problem is not that we have most of the drug addicts in the world; our problem is that we have too much money."



Gen. Barry McCaffrey

If you look at the social problems in America—the AIDS epidemic, industrial accidents, absenteeism, global competition, crime, property damage—you'll find drug abuse at the heart of it. The abuse of illegal drugs kills 14,000 Americans a year and does \$67 billion worth of direct damage to American society.

It is a nightmare. But it has gotten a lot better. Over the last 15 years, drug abuse has declined by 50 percent. America got sick of it in the 1970s. We got organized, as usual, from the bottom up. Some 4000 community coalitions

sprung up all over the country to bring together teachers, business leaders, health professionals, and law enforcement officials to address the problem. And it did get better. Cocaine use is down by 75 percent, and casual use of cocaine is down from 6 million Americans to about 1.4 million. These numbers are ambiguous at best, but what's not arguable is that cocaine use has plummeted.

That's well and good except for two problems. The most serious is that we've stopped communicating with our children about drugs. Sixty-eight million young-

Continued on page 12

Commonwealth Club of California 1997 Business Council

The Barry McCaffrey program was underwritten by members of the Club's Business Council. The Commonwealth Club is grateful for their support. A list of the members of the 1997 Business Council is listed below:

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Sollectron

McCaffrey continued

sters 18 and younger are using drugs. The extraordinarily good work done by Joe Califano and others at Columbia University shows that 39 million children age 10 and below are increasingly using alcohol, marijuana, and cigarettes. Drug use among eighth graders has almost tripled in the last five years.

So the focus of the president's drug strategy is drug prevention aimed at young Americans. We know full well, statistically, that if you can get through your 21st birthday without being addicted to cigarettes, binge drinking, or illegal drugs—primarily marijuana—you'll never have an addictive problem.

Some of us won't make it; we're not going to defeat the enemy in the war on

drugs. We have an incredible 6 percent of the population abusing drugs—20 million Americans (down from 25 million). Another 3.6 million are addicted and are causing tremendous damage. What do we do about them? That has been the principal failure of the national drug strategy in the last 20 years.

Testing and Treatment

We have inadequately made the case to responsible women and men in public life—city councils, state legislatures, and the U.S. Congress—that effective drug treatment not only has a fundamental tone of compassion for our children, our teammates, and our fellow employees. It's not only an approach that bodes well for building a generation for the future. It also makes good taxpayer sense. It is

cheaper to invest in effective drug treatment than alternative social policy.

It's my personal viewpoint that we can't decriminalize drugs. Drugs should be against the law, and law enforcement should uphold the law. But the primary focus has to be on prevention and treatment. That's why we're so impressed with the Drug Court Program. Right now, drug courts are dealing with mostly first-time, nonviolent offenders. We have to get into a dimension of coerced abstinence. We're testing the attorney general's "break the cycle" concept, and we think it will pay off.

Mandatory drug testing upon arrest is important. In New York City, 83 percent of people arrested test positive for drugs. We should be saying, "You can do treatment or incarceration or both. We'll hold you to it, and there will be both an in-prison component and a follow-up component." It costs \$24,000 a year to lock up an American, and 1.8 million Americans are behind bars—that's the highest per-capita incarceration rate of any country on earth except Russia.

I don't argue so much against incarceration as to express dismay that we have only 7 percent of the needed treatment available. We need to deal with the addicted sub-population. We can't do 28 weeks of treatment in prison, and then turn them loose on the street; we must have a follow-up component if we expect to do something about a chronic, recurring disorder that does respond to medical management.

Conceptual Framework

You can't implement a \$16 billion federal effort—\$33 billion nationwide—without a conceptual framework on which to hang it. We have five goals, which I don't think are controversial:

1. Motivate American youth to reject illegal drugs, alcohol, and tobacco.
2. Protect Americans from crime associated with drug abuse.
3. Protect Americans from the health and social cost of drug abuse.
4. Provide a sensible defense of our land, air, and sea borders. We're not going

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McGaffrey *continued*

to do that with the U.S. armed forces. That's the responsibility of federal law enforcement. We have to build appropriate law-enforcement institutions, whether it's the border patrol or a customs service, to carry out that mission.

5. Act as part of an international coalition of democracies to confront the drug abuse problem.

We're not going to solve this in the United States alone. Mexico has 94 million people; it's our third-largest trading partner, politically and culturally integrated with America. We can't defend the American people unless we act as a partner with Mexico.

It comes as a terrible shock to my Latin American colleagues when I remind them that drug abuse in Rio and Caracas is a lot worse than it is in San Francisco or Detroit. You don't have to sell cocaine at \$250 a day to an American dentist. You can sell basouko, a smoked cocaine product, to boys in a Rio favela and have them ferociously addicted and violent, destructive of their families and neighborhoods.

We do not consume half the drugs in the world. A recent U.N. report reminds us of that. Our problem is not that we have most of the drug addicts in the world; our problem is that we have too much money. That's why we have to act as a partner with the international community to address the drug threat.

We have a remarkable cooperative history with Thailand, having helped them to create one of the most honest drug police forces in the world and to grind down opium production to one percent of the regional total. This is not a hopeless proposition. ♦

CLUB TABLE—A special table is available at all Commonwealth Club luncheons for members who are attending the program alone. This table is identified by a sign reading "Club Table."

Q & A / BARRY MCGAFFREY

Answers to Questions from the Floor

Q. How can the United States have a working partnership with Mexico, when its generals keep turning out to be on the payroll of drug kingpins?

A. There's an element of creative hypocrisy in a nation that spends \$49 billion a year on illegal drugs, has four million people addicted, provides guns and money to corrupt Mexican democratic institutions, and then claims that the problem resides primarily in a transit country. We're going to work ever more effectively with Mexico over the next 10 to 15 years. Their president has committed himself to addressing this; it is the number one threat to Mexican national security. But there's no question that \$6 billion has a fundamental corrupting and threatening impact on law enforcement, judicial systems, democratic systems, and the press, in any nation. We had 600 cases of official corruption in the United States last year related to drugs. This is a human threat. Violence and corruption are twin tools in international drug crime.

Q. Is federal court opinion correct in protecting doctors' rights to recommend medical marijuana to seriously ill patients?

A. The debate over what drugs should be available to physicians in America is not a political question; it's one that ought to be decided by the National Institutes of Health and the Food and Drug Administration. There was a tremendous amount of research on the medical benefit of smoked marijuana in the 1980s. Out of it came synthetic THC, available by prescription in pill form since 1985. It probably ought to be available in other forms, such as a nasal inhalant or skin patch. We've put that whole question back where it belongs. We've asked the Institute of Medicine and the American Academy of Sciences to look at potential medical uses of marijuana. This is a scientific, medical issue; it's not one to be decided by politicians.

Q. The rich have the Betty Ford Clinic. How much of the \$16 billion in your budget will be earmarked for taking care of middle-class and poor addicts?

A. Not enough. We've gone from about \$1 billion of federal funding for drug treatment during the early years of the Bush administration to around \$3 billion in the 1998 budget. We're trying to make sure our funding is in line with the five goals of the national drug strategy, and that's hard work. We have clearly enhanced spending on prevention and treatment. The president's 1997 budget provided a 9.4 percent increase in overall funding and an additional 5 percent increase is slated for the 1998 budget. You're going to see us move deliberately, yet prudently, to make the case for increased support of effective drug treatment.

Q. Is the drug trade corrupting our financial system?

A. One of the few bits of magic I've seen in the last 15 months is the Financial Enforcement Center, a Department of Treasury task force outside of Washington, D.C. It uses a giant bank of computers to pull together information from foreign

governments, U.S. Bank Secrecy Act reports, and commercial databases to detect suspicious transactions and money laundering. This is giant enterprise. We're talking about \$49 billion a year—boxcars of hundred-dollar bills that somehow get into legal business. We've had tremendous successes, such as Project El Dorado in New York City. We're going to go after "cybercash," credit card movement of money. These are sophisticated people. They have access to very advanced legal advice: they have no respect for national sovereignty boundaries. This is an international problem, and it's going to require a cooperative solution. We're well on our way. Our hemisphere partners are passing legislation that allows them to deal with money laundering, illegal enrichment, conspiracy, witness protec-

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"Columbia is killing our children with its heroin production."

Meet America's Former Poet Laureate Robert Hass and other winners of the Commonwealth Club Book Awards



"I'd see her in the entryway looking for me, and I'd bounce the ball two or three times, study the orange rim as if it were, which it was, the true level of the world, the one sure thing

the power in my hands could summon. I'd bounce the ball once more, feel the grain of the leather in my fingertips and shoot. It was a perfect thing; it was almost like killing her."

—from "Dragonflies Mating," *Sun Under Wood*, Copyright ©1996 by Robert Hass, reprinted with permission from The Ecco Press

The 66th Annual Commonwealth Club Book Awards
Thursday, August 21, Club office
Wine & Hors d'oeuvres Reception 5 p.m. • Program 6 p.m.
Tickets \$15 for members and guests
Call Club office for reservations, 415/597-6705

Awards Endowment *continued*

the award gave him some reputation. It was an early, important prize for him." (Steinbeck won three Gold Medals—in 1935, 1936 and 1939.)

Both Cox and Lane also have a history of funding programs that recognize talented writers. Established in 1981, the Jean and Bill Lane Lecture Series at Stanford University, honoring Wallace Stegner, has brought authors of the caliber of E.L. Doctorow, Philip Roth, and Tobias Wolff to Stanford's creative writing program.

Michael Ondaatje, author of *The English Patient*, was this year's Martha Heasley Cox lecturer at San Jose State University. Other prominent authors in the Cox lecture series, established in 1983, have

included Toni Morrison, Paul Theroux, and Maxine Hong Kingston.

"A wealth of great writing originates in California, which gives us a sense of place and meaning as Californians," notes Club CEO Duffy. "The transformation of the Commonwealth Club Book Awards into cash prizes should bring additional recognition to the winning authors and their books, as well as to California as a source of literary excellence. I hope the size of the prizes will grow over time. I invite others who love good writing to follow Martha and Bill's leadership and to contribute to the endowment."

The first cash prizes, drawn from interest earned by the endowment funds, will be given to next year's winners of the California Book Awards. ♦

McCaffrey *continued*

tion, and wire tapping. You can't deal with international drug crime unless you have modern legislation, and we're moving in that direction.

Q. Isn't it discriminatory for sentences to be harsher for crack cocaine than for other drugs? Is it time to re-examine these laws?

A. Without question. The Sentencing Commission has sent new recommendations to the U.S. Congress. Here's what's unarguable: 33 percent of those arrested and 48 percent of those in prison are African American. We don't have a racial bias built into the system, but we do have a policy that has resulted in apparent racial injustice and isn't all that effective in reducing drug abuse. We need a more sensible approach. Drug abuse in America is not just an urban problem, a poor person's problem, a black problem, or a Hispanic problem. One of the highest rates of addiction, counting alcohol and drug abuse, is among health-care professionals. Ten percent of anesthesiologists may have addiction problems during their lifetimes. We need to re-examine how we combine drug treatment and penalties in the prison system; we have had a rather one-sided approach. Indeterminate sentencing combined with treatment is a more effective approach.

Q. Wouldn't it be more effective to regulate a legal industry than to suppress an illegal one?

A. Why would anyone want the problem with marijuana, cocaine, methamphetamines, and heroin to look like the one we now have with tobacco and alcohol? I don't support that and I don't think most Americans do, either.

Q. AIDS and cancer patients are suffering. What about medical marijuana?

A. The tragedy of AIDS is one that concerns every compassionate American. What medicines are appropriate for AIDS patients is best decided by health professionals. There are many conflicting needs, but I think the scientific and medical communities will do the right thing, and that's what I'm going to support.

Q. In Texas, an innocent 18-year-old boy was

Continued on page 15

McGaffrey *continued*

shot and killed by U.S. Marines on a drug stake-out. Aren't military personnel supposed to report to the DEA and be used only for surveillance?

A. Defense Secretary Bill Cohen and I have discussed this tragic incident, the first of its kind in nine years, and everything leads us to believe this was an innocent citizen going about his business. It needs to be investigated. We need to examine the rules of engagement, but we do not want the armed forces enforcing domestic law, period. The patrol involved in the shooting was there to support a border patrol operation. Their rules of engagement are to report suspicious activity—not to take any action except to defend themselves.

Q. What about needle exchange programs?

A. There are 80 needle exchange programs being studied around the country. There is clear evidence that the programs reduce the spread of HIV, but there is less clear-cut evidence that they reduce drug abuse. If the studies indicate that these programs are worthwhile, we ought to do them. But let me tell you one of the problems I have with all this discussion. Here we sit with 12 million Americans using drugs and you want me to talk about medical pot and needle exchanges. These are peripheral issues in a country that hasn't gotten serious yet about prevention and treatment programs. We have a misplaced focus. This is a complicated, legal, medical, and social issue. I don't want the health profession to walk away from the addicted. It's cheaper to spend a half million bucks on a van with two people handing out condoms, clean needles, and pamphlets than it is to do what we have to: bring in those who are addicted, offer them sensible treatment and residential care, provide follow-up programs, and try to rescue them from a life of absolute misery.

Q. What is the point of continuing the U.S. policy by which countries are certified or not each year depending on their performance the previous year in fighting drugs?

A. Federal law requires the U.S. government to report each year on whether our international partners are enforcing the

Bali—Island of The Gods

October 10-22, 1997

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1988 U.N. convention against drug use. The question is not only about countries' cooperation with us, but enforcement of this international convention. It's important to have facts when debating these issues. Columbia increased cocaine production by 32 percent last year. In the last five years, Columbia has gone from zero to 63.5 metric tons of opium production. Although the preponderance of opium is still coming out of Burma, Laos, and Afghanistan, 62 percent of the heroin seizures in America last year were from Latin America. Columbia is killing our children with heroin production. Our view is that decertification of Columbia was the right thing, even though it was a painful approach and did not include an economic blockade of some of their interests in this country. Mexico was an even more painful case, because their democratic institutions are clearly under attack by international drug crime. The best approach is to look at this problem as a common threat to the global community. We ought to be working as partners, not as antagonists.

Q. Over a million people in America are locked up for drug offenses. How would you go about setting up peace talks to settle this domestic conflict?

A. Some arguments support the notion that marijuana is a drug of low abuse potential that ought to be accepted in U.S. society. Many of us believe it is not a safe drug. We think it causes enormous problems, particularly among the young, and that smoking it is gateway behavior. It's demotivational in its impact on human behavior. We're not for it, and neither are 85 percent of the American people. I don't think our primary reaction to drug abuse should be to lock people up; that's not what we're going to do. Ours is a very common-sense approach. The American people expect prudent, balanced, direct opposition to drug abuse and its consequences. At the heart, it's not a federal problem. It's not a law enforcement problem. It's a problem for parents, teachers, ministers, coaches, and communities to confront. It's wrapped up in "What are my children doing from 3 p.m. to 7 p.m.?" Who's going to nurture our children in the afternoons, on weekends, and in summer? If we don't sort that out, we're not going to stop drug abuse. The tragedy of drug abuse is not just the \$67 billion in damages, and not even the 14,000 dead. It's the tragedy of missed human potential—that's what we're opposed to. ♦

Office of National AIDS Policy

Executive Office of the President



URGENT: "AIDS" "Needles" "Congress"

For Immediate Release
October 31, 1997

Contact: Jeff Kamen
(202) 632-1090

**White House AIDS Czar Praises, Challenges Congress on Needle Exchanges;
Hails Conference Committee Vote to Retain HHS Secretary's Power
To Remove Restriction on Funding of Needle Exchange Programs**

**"Let Science Drive this Policy," Urges Sandra Thurman
"New Public Opinion Poll Should Help."**

Programs Underway Show Cut of HIV Infection Rate & No New Drug Users

(Washington, DC) ----Sandra Thurman, the White House AIDS Policy Director, today congratulated and challenged the House and Senate after conferees voted late last night to preserve the power of the Secretary of Human Services to removed current restrictions on federal funding of needle exchange programs. There are more than 100 such programs across the nation. All studies of needle exchange programs have shown that they reduce the spread of HIV/AIDS without encouraging drug abuse.

Thurman, the principal policy advisor to President Clinton on HIV/AIDS said, "It took genuine political courage for members of Congress to let science drive this policy and I challenge them to move forward in that spirit."

A floor vote in both houses is expected soon.

"The results of the new Harris poll, which shows that 71 percent of the American people support removing current restrictions on Federal funding for needle exchange programs should help some members of Congress to remember to keep politics out of public health considerations," Thurman said in a statement released by her office.

"With last night's vote, the debate on this issue has turned a significant corner. In this bill, Congress began the process of defining essential elements of needle exchange programs worthy of federal funding. Bi-partisan support for moving forward is based on a willingness to follow the science, but it took some old fashioned guts for the lawmakers to ignore those who would play politics with this issue. What we are talking about here is simple: if the science says needle exchange programs slash HIV infection rates and don't encourage drug use, then that translates into lives saved.

"We know that there are those who are committed to stopping needle exchange programs and they are expected to try to do so legislatively over the next six months. But when you consider that the American Medical Association, the American Public Health Association, the American Bar Association and the American Academy of Pediatrics all endorse needle exchanges as a proven method for attacking the spread of this deadly disease, few questions should remain about what is good public health policy, and we will continue to explain the facts to anyone who will listen.

"Over the next several months, I will be urging Congress to continue to act based on the scientific facts and not out of ignorance or fear." ###

THE WHITE HOUSE
WASHINGTON

FOR IMMEDIATE RELEASE

March 22, 1998 (10:01am)

Contacts: (ONAP) (202) 255-2447/632-1090
(ONDCP) (202) 395-6618

**DRUG CZAR AND AIDS CZAR AGREE THAT
PUBLIC HEALTH POLICY MUST BE
BASED ON SOUND SCIENCE**

(Washington, D.C.) -- Barry R. McCaffrey, Director of the Office of National Drug Control Policy, and Sandra L. Thurman, Director of the Office of National AIDS Policy, issued the following joint statement:

Today, America is struggling with not just one epidemic, but with two. Tragically, the twin epidemics of AIDS and drugs are linked and impose devastating costs on individuals, families, and on our society as a whole. Together, we share a strong commitment to improving lives and to saving lives by promoting public health policies that are based on sound science.

We agree that drug treatment is the most effective tool not only in reducing the use of drugs but in reducing the sharing of needles, both of which contribute to the spread of HIV. Unfortunately, despite a 33 percent increase in federal spending since fiscal year 1993, drug treatment is only available for half of those in immediate need. We are strongly united in our desire to do everything that we can to expand the availability of drug treatment for all those in need, and to prevent the further spread of HIV among injecting drug users and people with whom they have sexual contact.

As for needle exchange, Congress has limited the use of Federal funds for sterile needle and syringe exchange projects until (1) the Secretary of Health and Human Services determines that exchange projects are effective in preventing the spread of HIV and do not encourage the use of illegal drugs; and (2) the project is operated in accordance with criteria established by the Secretary for preventing the spread of HIV and for ensuring that the project does not encourage the use of illegal drugs. The Office of National Drug Control Policy and the Office of National AIDS Policy remain dedicated to working with Secretary Shalala, and to supporting her efforts to ensure that public health policy is guided by sound science.

February 28, 1997

NOTE TO BRUCE REED

FROM: Eric P. Goosby, MD, Office of National AIDS Policy

SUBJECT: Additional Information on Needle Exchange Programs

Needle Exchange Programs and IV Drug Use

In studying the effects of needle exchange on drug use behaviors, the preponderance of data suggests a stable or declining level of drug use among needle exchange participants. About half of the studies show a decline in drug use. Two studies show an increase in drug use by self report; this has been discounted by expert panels as outliers. Corroborating evidence found in different studies includes: 1) rising age of participants in needle exchange programs argues against new recruits; 2) SAMHSA data showing no increase in drug users in given geographic areas; and 3) needle exchange programs refer persons to drug treatment where some are retained, no longer needing clean needles.

Most studies have some methodological weaknesses inherent to the population and effect being studied that are nearly impossible to overcome. These include: 1) reliance upon self-reported frequency of drug use that cannot be substantiated; 2) technical, ethical and logistical difficulties in randomizing one group to receive clean needles while denying another group yet expecting their continued participation in a study; and 3) isolating out the effects of needle exchange programs among the many community factors which may influence drug using behaviors in any given population.

Data quality issues received careful scrutiny by the Institute of Medicine in their 1995 report on needle exchange. The IOM panel examined patterns of evidence across all available studies, instead of relying only on the quality of each study design. The likelihood that a finding is real increases through repeated assessments across many different types of studies. In addition to research focused on individuals using needle exchange programs, other studies have examined indicator data for prevalence of drug use in communities such as unintended needle stick injuries to public and law enforcement workers. In MA and Portland OR, police and sanitation workers reported a decrease in needlestick injuries. Measures on selected population groups, such as the Drug Abuse Warning Network or Drug Use Forecasting lack precision to measure the effects of a needle exchange program, given the limited reach of most needle exchange programs and numerous variables affecting drug use patterns in a given community.

With respect to the President's new initiative to combat drug use among youth, it is important to note that almost all studies indicate that needle exchange program participants tend to be older (median age 33 to 41 years old) and are long-term users (duration of use 7 to 20 years). There is no data to suggest needle exchange programs increase new initiates into drug use, and the age of participants often increases over time.

Next Steps for HHS in Evaluating Effects on Drug Use

HHS will conduct a scientific review of the data presented at the NIH Consensus Conference in February 1997. Data presented at that conference have not yet been through the peer review process required for publication, and need close examination. A second step will be an analysis of data already collected through the NIDA demonstration projects which has not yet been specifically studied for effect on drug utilization patterns.

Congressional Climate and Community Expectations

The HHS report was released during the Congressional recess, and Hill reaction has been muted to date. This week Harold Varmus, Director of the NIH, received direct questions on needle exchange from Reps. Dickey (R-AR) and Wicker (R-MS) during a NIH Appropriations hearing. Secretary Shalala also received one question on lifting the federal funding ban prior to release of the report. Rep. Rangel once adamantly opposed needle exchange but is reported to be shifting somewhat in his stance.

Both the House and Senate have been uncomfortable with needle exchange programs, ducking the issue by punting to HHS. The exception to this was last year's prohibition on use of Ryan White treatment funds for needle exchange programs which passed unanimously. While the majority party's views would predict an unfavorable climate for needle exchange options, Senator Specter, Chair of L/HHS Appropriations Subcommittee, has come to support needle exchange programs -- Philadelphia has one of the largest. The State flexibility arguments advanced by NGA and ASTHO may also start having an effect.

Today → The AIDS community is united in seeking an end to the ban on federal funding of needle exchange programs. Aside from the most vocal proponents of needle exchange, the national AIDS organizations understand the downside of demanding the ban be lifted before the education and political work is done, and vote counts are taken. What the community wants is a willingness on the part of the Administration to let science guide policy, and to hold HIV prevention as a high priority.

Mainstream public health and state government groups (the Association of State and Territorial Health Officers (ASTHO), US Conference of Mayors, NGA, National Black Caucus of State Legislators, etc.) support lifting the federal ban in favor of local discretion; of these, ASTHO and NASTAD are the most energized and publicly visible. There is strong concern that substance abuse continue to be understood primarily as a public health issue -- a treatable disease -- and not solely through the lens of law enforcement. On the other side, the Family

Research Council has begun gearing up on needle exchange and may try to alter the terms of the debate by claiming the ultimate goal of proponents is drug legalization.

[HHS is also planning a demonstration project specifically addressing the high risk behavior of IVDUs with the goal of reducing the rate of new HIV infections. This effort combines merging outreach and prevention efforts into every service delivery system an active IVDU may access, including emergency rooms, homeless shelters, soup kitchens, health centers, etc.]

April 28, 1997

MEMORANDUM FOR BRUCE REED

FROM: Eric Goosby M.D., Office of National AIDS Policy

RE: Strategic Plan for Needle Exchange Issue

This memorandum will review where key stakeholders, Congress and HHS currently are on the ban on federal funds for needle exchange programs, and lay out strategy options for handling the issue.

HHS Secretary Shalala has indicated her readiness to move on lifting the ban imposed under the L/HHS Appropriations language -- affirming that needle exchange programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs. The February 1997 HHS report to the Appropriations Committee was moving in this direction, supporting a role in HIV prevention but maintaining some distance around data on drug utilization. Since the release of this report, the Director of NIH Harold Varmus testified before the House Appropriations Committee that -- in his personal opinion -- the data standards had been met to lift the L/HHS statutory ban. There has been no new research published since February.

Office of National AIDS Policy Sandy Thurman has publicly stated that science, not politics, must drive this issue. She is also acutely aware that politics, not science, should dictate the timing of Administration movement on this issue or else the long-term goal of actually enhancing HIV prevention will be lost. She is in accord with the contents of this memo.

ONDCP I have had two meetings with Gen. McCaffrey's staff, and I think there is room to reach an agreement on modifying the ban (see below). A discussion between Varmus and McCaffrey would contribute to ONDCP's comfort level around the data, and this can be arranged. The most compelling case for needle exchange at ONDCP would be the success of these programs as conduits for reaching and guiding IV drug users into treatment, with ultimate demand reduction.

Congress The first opportunity for Congressional action on this issue will come in May when the House Appropriations Committee marks up its bill. Reps. Wicker (R-MS) and Dickey (R-AR) are likely to lead a Republican effort to narrow or eliminate the waiver authority currently held by the Secretary of HHS, particularly if Secretary Shalala moves to lift the ban before markup. L/HHS Subcommittee Chair Porter (R-IL) has large needle exchange programs in his Chicago district, and might be helpful if convinced of the scientific integrity of efficacy data on needle exchange programs. He holds Varmus in high esteem. Given the composition of the Committee, proactively altering the language of the ban would be a high risk move. No reliable vote counts on this issue have been taken. It would be the safest course to hold further action steps on the ban until the House has completed action on the FY 1998 L/HHS/Education Appropriations bill.

The Senate is marginally more favorable on the needle exchange issue, with Sens. Spector (R-PA) and Harkin (D-IL) leading the L/HHS Appropriations Subcommittee. Both have expressed political reservations regarding taking any action on needle exchange, and a good vote count

Page 2 - Needle Exchange

would be needed before their support was guaranteed. Spector has very active needle exchange programs in Philadelphia. Both the National Governors Association (NGA) and Association of State and Territorial Health Officers (ASTHO) have more drag in the Senate, and a carefully orchestrated revision of the needle exchange ban language combined with a House-Senate conference strategy would be needed to come out with greater flexibility in use of federal funds.

The Congressional Black Caucus has not come out clearly on the issue of lifting the ban yet. Rep. Waters (D-CA) is ready to support needle exchange. Some advocates from the minority community are actively working the membership, and CBC is likely to sponsor a Hill briefing on this issue.

Community Groups The AIDS community remains split over strategies to lift the ban. Some voices in the gay press are strident in demanding that Shalala act affirmatively. A range of advocacy and research community voices continue to accuse the Administration of playing politics instead of following science and saving lives. The national AIDS groups in Washington are slowly coming around to realizing that even the Secretary's waiver authority could be lost if adequate groundwork with Congress is not laid down first. As a result, the NORA (National Organizations Responding to AIDS) Coalition is spending April-May in a grassroots and Hill educational campaign around needle exchange. The intelligence from these visits is still coming in. NORA indicated in their meetings with you and Kevin Thurm of HHS their interest in working with the Administration to achieve a good end result.

New Organizational Endorsements The US Conference of Mayors is likely to adopt a resolution supporting flexible use of federal funds for needle exchange programs in jurisdictions which want to pursue them at their June 20-24 meeting. They would join the NGA and ASTHO in making this local and states right argument. The National Medical Association, the minority counterpart of the AMA, is also drafting a resolution supporting limited needle exchange programs -- the text isn't yet available.

STRATEGY OPTIONS

1. Preferred Option Wait until the House Appropriations bill is completed. Tie Administration action on lifting the ban on L/HHS funds to the June 1997 US Conference of Mayors meeting (which POTUS is scheduled to attend) after USCM passes an affirmative resolution on local flexibility. With the nation's mayors, governors, and public health officials on record supporting local decision-making on use of HIV prevention funds, there is good political cover for allowing more flexible use of funds as long as the scientific data continues to support it. Recognizing that reasonable people may disagree on this issue, POTUS could indicate his support for local control while in San Francisco (where there's strong support for needle exchange) and the next day Secretary Shalala could lift the ban. The advocacy groups and Administration would then need to coordinate to hold a reasonable position in the Senate Appropriations process.

To help this position fly politically, several key conditions on funding need to be laid down in modified Appropriations language and Administration rhetoric:

- 1) Only HIV prevention funds (i.e. CDC) may be used for needle exchange programs, not SAMHSA drug treatment dollars. This makes sense as needle

Page 3 - Needle Exchange

exchange is being advanced primarily as an HIV prevention strategy. HIV prevention funds flow primarily to States, with smaller amounts going to the chief elected official in 7 large cities and a categorical minority CBO grant program. Use of Ryan White CARE Act funds was prohibited in last year's reauthorization bill.

2) In order for grantees to utilize federal funds for needle exchange, they must certify that:

- a) the chief elected official of the State (where State is the grantee) or of the city/county (where the City or a local CBO is the grantee) supports needle exchange programs in their jurisdiction as an effective HIV prevention measure;
- b) any needle exchange program using federal funds must provide referral access to medical and drug treatment, and provide HIV counseling;
- c) needles are provided on a replacement basis and not a free-standing distribution program; and
- d) needle exchange programs comply with established standards for hazardous medical waste disposal (minimizing stray needles in public places)

These conditions would ensure that needle exchange programs go forward only in those jurisdictions where there is local support (government, public health and law enforcement) and linkages to a broader continuum of drug treatment and medical care.

2. A fallback strategy would be stalling action until the Winter 1997 Congressional recess to lift the ban. Congressional backlash would be delayed until February, but the Administration would have to be ready to protect the policy in 1998 election year. This would be hard for Congressional Democrats.

3. A third option is to leave the ban in place and take the heat from constituent advocacy and public health groups claiming that the Administration is willing to put politics above public health. With both the New York Times and Washington Post writing editorials in support of lifting the ban, the groups can be expected to drive a media strategy and push local flexibility arguments. This will become a more difficult option over time.

MEMORANDUM

To: Bruce Reed
From: Sandy Thurman
Date: March 9, 1998
Re: Needle Exchange

This memorandum is designed to provide an update on issues surrounding the current ban on federal funding for needle exchange programs.

More data has been reported

Studies in Baltimore and Seattle continue to indicate both that needle exchange programs decrease the rate of HIV transmission and that participants who receive their referrals to drug treatment through these programs have a better retention rate than others.

Congressional Republicans appear to be losing interest in the issue

Satcher nomination

Many have worried for quite some time that the issue of needle exchange would complicate the confirmation of Dr. Satcher. While Senator Ashcroft did mention needle exchange briefly on the Senate floor, it seemed fairly clear that the issue did not resonate with other Members, the press, or the public. It did not take Ashcroft long to drop discussion of needle exchange in favor of the ethics of the AZT trials in Africa. Thankfully Dr. Satcher has now been confirmed.

Coburn amendment

The Health Subcommittee of the House Commerce Committee held a hearing last week on HIV prevention. During the hearing, Dr. Coburn asked a panel of his witnesses (the World Health Organization and county, city, and state health officials) if they believed that needle exchange was an effective public health strategy. They initially commented that they had been asked to testify on the issues of HIV testing and reporting, not needle exchange. However, when he pushed them to answer -- they all stated that scientific evidence had demonstrated that needle exchange programs are effective. This was particularly interesting given that these health officials were chosen by Coburn because "they are independent thinkers who are not in the pocket of the AIDS community". In fact, these witnesses disagree with the community on issues of testing and reporting.

Gingrich, Hasert

Recently, Reps. Gingrich and Hasert (who offered the Coburn amendment) held a press conference on the Administration's drug policy and did not mention needle exchange.

Congressional Democrats Voice Support for Needle Exchange Programs

Congressional Black and Hispanic Caucuses

The Congressional Black and Hispanic Caucuses have writted the President to express their support for needle exchange programs. Their support is based on concern over the disproportionate impact of HIV on blacks and latinosaurs arising from injection drug use.

Gephardt Support

Rep. Gephardt recently released a letter offering his support of needle exchange programs.

Public Continues to Support Needle Exchange Programs

Three public opinion polls (Tarance, Harris, and the Kaiser Family Foundation) all show strong support for needle exchange programs. Negative polling data have been released, but imply a choice between needle exchange and drug treatment that renders the results spurious. Even the Family Research Council dropped questions on needle exchange from their most recent poll on "hot button" drug issues.

HHS

It is my understanding that Secretary Shalala is now prepared to certify that, after extensive analysis, scientific data demonstrates that needle exchange programs reduce the HIV transmission and do not encourage the use of drugs. The AIDS community believes that it was first told by HHS that the strategy was to preserve the Secretary's authority and let the Congress get out of town. They were then told, to just wait until Dr. Satcher is confirmed. Having now done both -- they are again seeking clarity on the Secretary's strategy. If there is ever a "good time" for the Secretary to make such a determination, I believe it is sooner rather than.

Given that the moratorium on funding extends through March 31st, acting sooner rather than later allows the Secretary to certify the science without changing the status of federal funding of needle exchange programs. This time before the moratorium lapses provides ample opportunity to gauge public reaction, a trial balloon if you will. The White House could allow HHS to carry the water. The medical and public health groups could work with the Congress and the media in strong support of the Secretary's action. And at the end of the day, if the issue heats up (which seems unlikely) and Congress wants to extend the moratorium or ban federal funding, we could then seek to reach a compromise or simply have an up or down vote. If we loose, at least it will be clear that the Administration followed the science -- and it was the Congress who played politics with public health.

ONDCP

I understand that General McCaffrey gave the President a letter indicating his opposition to needle exchange. He argues that in order to stop the spread of HIV, we must focus on drug treatment instead of needle exchange. This is not about needle exchange versus treatment; it is about saving lives until those who need drug treatment can get it. There are currently 1.5 million drug users and only 115,000 methadone slots. The General also has expressed concern that drug treatment funds should not be used for needle exchange programs. We agree: funding should

come from HIV prevention funds, not drug treatment.

There is also concern that Administrative support for needle exchange sends a message that it is soft on drugs. This is the same baseless argument used to hold up HIV prevention funding, when it was argued that information about safer sex would promote homosexuality.

President's Advisory Council on HIV/AIDS

The President's Advisory Council on HIV and AIDS is due to return to Washington on March 15th. They believe the Administration told them that no action would occur until Congress left town, and then were told that action would be help up until after Dr. Satcher was confirmed. As you recall, at their last meeting, a resolution was proposed calling for Secretary Shalala's resignation for not "following the science on needle exchange." We managed to have the resolution withdrawn. They agreed to table consideration of the resolution until the March meeting to give the Secretary additional time. They are extremely upset with the Administration and are planning on holding a press conference and blasting us for inaction on needle exchange, as well as publicly calling for the Secretary to resign. In addition, some members have threatened to resign from the Council if this issue has not been resolved to their satisfaction.

Press

There continues to be quite a bit of press interest in needle exchange. *The Lancet* recently published an editorial in favor of needle exchange. That means that now *every* major science and medical publication *and* every major science and medical organization supports needle exchange.

APR. 23, 1998 11:57AM

NO. 892 P. 5/6

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NEWS

From U.S. Congressman

ROGER WICKER

206 CANNON HOUSE OFFICE BUILDING • WASHINGTON, D.C. 20515 • (202) 225-4306

IMMEDIATE RELEASE

**REP. WICKER SAYS BILL WILL IMPOSE PERMANENT BAN
ON FEDERAL FUNDING FOR NEEDLE EXCHANGE PROGRAMS**
Restricting legislation introduced Wednesday

WASHINGTON, DC—U. S. Rep. Roger F. Wicker (R-Miss.) joined with three House colleagues to introduce legislation to permanently ban federal funding of needle exchange programs for drug addicts.

The bill was prompted by statements made Monday by Health and Human Services Secretary Donna Shalala. The Secretary did not immediately lift the moratorium on federal support for needle exchanges, but she endorsed the activity as an effective means of drug treatment. Secretary Shalala retains the authority to release federal funds if evidence shows the practice does not increase drug usage or the spread of AIDS.

The legislation would permanently prevent federal funding for this program in the future, Rep. Wicker said. He was joined by Reps. Tom Delay (R-TX), J. Dennis Hastert (R-Ill.) and Rep. Bob Barr (R-GA). The legislation reads: "None of the amounts made available under any federal law for any fiscal year may be expended directly or indirectly to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug."

Wicker is one of the authors of the current Congressional ban and a member of the Speaker's Task Force on a Drug-Free America. "This should not be a partisan issue. Our leaders in Washington should be speaking with a clear, unified voice and the message should be that illegal drug use is wrong. Allowing federal tax dollars to be spent for needle exchanges undermines that message," he said.

"I asked Drug Czar Barry McCaffrey about this issue at a recent hearing on Capitol Hill. He said he was 'unpersuaded' by claims from needle exchange advocates that this is an effective method of drug treatment and he said further study was needed," Rep. Wicker said.

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Needle exchange programs put communities at risk for increased criminal behavior by drug addicts, and could expose children and the general population to accidental contact with discarded needles on playgrounds, parks, and other public use areas, he said.

"This Administration says it is interested in the health and well-being of our children, yet its message to the nation on needle exchange puts children in peril. I worry that Secretary Shalala's endorsement of the program could encourage teenage drug users to continue on a path toward long-term addiction. The last thing we should be doing for at-risk 16 and 17 year-olds is giving them free needles."

4/22/98

Paul Coverdell

**STATEMENT OF SENATOR PAUL COVERDELL
INTRODUCING LEGISLATION TO PROHIBIT
NEEDLE EXCHANGE PROGRAMS**

April 21, 1998

MR. COVERDELL: Mr. President, I am today introducing, along with Senators Ashcroft and Brownback, a bill to prohibit the use of federal funds to carry out or support programs for the distribution of sterile hypodermic needles or syringes to illegal drug users.

This bill would effectively continue and make permanent the ban imposed through the appropriations process which expired at the end of March. We are pleased that the Administration has decided not to use federal tax dollars to fund needle exchanges despite the expiration of the ban. But coinciding with this announcement, Health and Human Services Secretary Donna Shalala strongly endorsed needles exchanges and encouraged local communities to use their own dollars to fund needle exchange programs. This legislation is therefore needed to foreclose any temptation the Administration may feel to federally fund needle exchanges in the future.

The Drug Czar, General Barry McCaffrey, has laid out the strong case against needle exchange programs. Handing out needles to drug users sends a message that the government is condoning drug use. It undermines our anti-drug message and undercuts all of our drug prevention efforts.

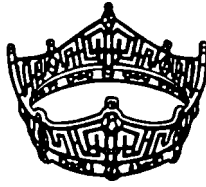
A report by General McCaffrey's office reviewed the world's largest needle exchange program in Vancouver, British Colombia, in operation since 1988. It found the program to be a failure. HIV infections were higher among users of free needles than those without access to them. The death rate from drugs jumped from 18 a year in 1988 to 150 in 1992. In addition, higher drug use followed implementation of the program.

Dr. James L. Curtis of New York, who has studied needle exchange programs was quoted in the *Washington Times* stating that the programs "should be recognized as reckless experimentation on human beings, the unproven hypothesis being that it prevents AIDS."

According to recent scientific studies, eight persons a day are infected with the HIV virus by using borrowed needles, while 352 people start using heroin each day and 4,000 die every year from heroin-related causes other than HIV. Far more addicts die of drug overdoses and related violence than from AIDS. It is wrong to aid and abet those deaths by handing out free needles to drug addicts. We should not be encouraging higher rates of heroin use.

Therefore, I hope my colleagues will join me in making permanent the prohibition on federal funding and support of needle giveaway programs.

Mr. President, I ask unanimous consent that the text of the bill be printed in the record, accompanied by the statements of myself, Senator Ashcroft, and Senator Brownback.



Kate Shindle
MISS AMERICA 1998

April 6, 1998

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington D.C. 20500

Dear President Clinton:

I am aware that your administration is once again reviewing the issue of federal funding for needle exchange programs, which affects the lives and futures of thousands of American men, women, and children each year. Once again, organizations across the country have been discouraged and frustrated at the outcome of one of these reviews. I am asking you to use federal funds to support needle exchange programs and prevent the spread of the HIV/AIDS epidemic.

It has been eighteen years since AIDS began to decimate American families, and the epidemic shows no sign of slowing. Despite recent breakthroughs in AIDS treatment, the number of new infections continues to explode. Every day, 16,000 people, somewhere, contract HIV. And as you know, the epidemic is undergoing a dramatic demographic shift. Women, minorities, and the young are being infected at unprecedented rates. Every hour of every day, two American teenagers contract HIV. And heterosexual women account for the fastest-rising group of new infections. AIDS is no longer restricted to any one social group. It's happening to all of us.

But a unique phenomenon continues to sweep our nation. It is the dynamic created by a desire to end the AIDS epidemic and a hesitance to implement the programs which will eradicate it. *We know exactly how to stop the spread of HIV.* In the absence of a cure, scientists, educators, and public health officials agree upon the need for strong and proactive programs which empower individuals to protect themselves from this virus.

Statistics regarding the prevalence of HIV infection among IV drug users are astounding. 63% of all AIDS cases among women are related to the sharing of needles—these women contract HIV either through IV drug use or through sex with an IV drug user. Similarly, 58% of pediatric AIDS cases are attributable to a parent's drug use. Clearly, drugs are killing Americans in more ways than one.

But needle-exchange programs are overwhelmingly effective in combating HIV infection. By providing clean syringes in exchange for used ones, we can easily prevent the sharing of contaminated drug paraphernalia. *Needle exchange programs prevent HIV from being spread.*

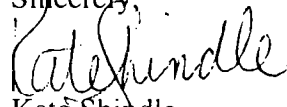
But needle-exchange programs are overwhelmingly effective in combating HIV infection. By providing clean syringes in exchange for used ones, we can easily prevent the sharing of contaminated drug paraphernalia. *Needle exchange programs prevent HIV from being spread.* In Baltimore, the HIV seropositivity rate was reduced by 40% during the program's three-year trial period. And the community benefits as well. The lifetime cost of treating *just one* person with AIDS is estimated to be \$119,000, while the median cost of running an exchange is just \$169,000—eliminating a significant financial burden on taxpayers. And by providing the opportunity for a one-to-one syringe exchange, we can all but ensure that there are no contaminated needles lying around in streets, on playgrounds, or in other places where children can find them and hurt themselves.

President Clinton, we are all familiar with the so-called arguments against needle exchange. Quite frankly, the idea that these programs promote drug abuse is unreasonable, and outdated, and has already been categorically disproven. Seven different independent agencies, including the Centers for Disease Control and the University of California at San Francisco, have shown unquestionably that there is no increase in the incidence of drug use in communities where needle-exchange programs have taken hold. In fact, the rate of use can actually decline when staff are able to counsel drug users into treatment. *No one wants more drugs on our streets.*

It's time to take action. Every 5.4 seconds, someone contracts HIV. While we bide our time and weigh our options, people are still dying. There seems to be a lot of "morality" talk surrounding HIV/AIDS prevention. Ironically, we have forgotten our moral obligation to save lives. We need to provide the information and tools which will empower all Americans to protect themselves. I am twenty-one years old, and my generation is dying.

It's time for us, finally, to have an intelligent and substantive dialogue about needle exchange. No more stalling. No more "looking into the issue." We no longer have the luxury of time. The facts are on the table. The AIDS-services community has done what you asked by providing these findings. Approximately 60% of Americans approve of needle exchange, and are watching. *Mainstream America cares about this.* Now you need to hold up your end of the deal.

There is still a lot of fear when it comes to talking about this issue, and dozens of warring factions. No one ever said ending a global pandemic would be easy. America needs money for needle exchange. We need to let scientists and public health officials determine the need for such programs on a community-by-community basis, and then we need funding to support their efforts. At this point, there is no more room for excuses. Americans are still dying, and we are to blame unless we protect them.

Sincerely,

Kate Shindle
Miss America 1998

THE WHITE HOUSE

WASHINGTON

March 24, 1998

The Honorable Barry R. McCaffrey
Director
Office of National Drug Control Policy
Washington, DC 20503

Dear Mr. McCaffrey: *Barry,*

I appreciate your taking the time to provide me with your perspective on needle exchange programs (letter dated March 17, 1998). As the recently released joint statement made clear, our offices share a deep commitment to working collaboratively to address both the drug and the AIDS epidemic. I am most emphatically in support of increasing the availability of effective drug treatment programs in this country.

However, while it is clear that we agree on the ends--reducing HIV infections and illegal drug use--there may be varying opinions on the use of needle exchange programs as a means to achieve those ends. In my judgment, this Administration is obligated both by public health science and by moral imperative to support those local communities that choose to use needle exchange programs as part of comprehensive HIV and drug addiction prevention programs.

I disagree with the assertion that certification of the appropriateness of needle exchange programs (NEPs) by the Federal government is in conflict with our anti-drug message. There is no credible evidence that needle exchange programs encourage the use of illegal drugs. On the contrary, support by this Administration for NEPs would underscore its position that drug treatment works.

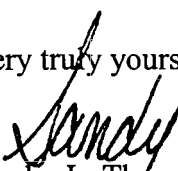
It would further make clear, as you have done so articulately in the past, that this Nation is engaged in a struggle to decrease illegal drug use, and to help--not harm--its own citizens who have become addicted to drugs. As Thomas Jefferson stated, "The care of human life and happiness, and not their destruction, is the first and only legitimate object of good government." Federal support for NEPs would constitute a clear statement that this Nation is compassionate and caring; that it is willing to put public health above politics; and that it desperately wants those addicted to drugs to be free of both the diseases of HIV and addiction.

This is not a choice between drug treatment and needle exchange; they are compatible and mutually-supportive strategies for reaching hard-core drug users while at the same time protecting them and their sexual partners from HIV. Careful examination of the over 100 needle exchange programs now operating across this country clearly demonstrates that they serve as an effective--and perhaps the best--vehicle to reach these hard-core drug users with the opportunity for drug treatment. That is what the science tells us, and we have both agreed that science should be our guide in making public health policy.

I strongly agree with your statement that a narrow focus on needles or injecting would fail to take into account the complexities of addiction. Needle exchange programs are appropriate only as a component of a comprehensive strategy that addresses both the reduction of HIV transmission and illegal drug use. This would include referrals to drug treatment, health care, and social services. That is why I believe that the Federal government must certify the science on needle exchange programs, and increase its support for drug treatment.

I look forward to working closely with you and your staff to further our shared goals of ending the epidemics of HIV/AIDS and illegal drug use. Our ability to have constructive discussions on difficult issues is critically important to furthering the interests of this Administration and of this Nation.

Very truly yours,


Sandra L. Thurman
Director
Office of National AIDS Policy

cc: Secretary Donna Shalala
Sylvia Mathews
Rahm Emanuel
Bruce Reed



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

April 10, 1998

The Honorable Sandy Thurman
Director
White House Office of National AIDS Policy
808 17th St., NW, 8th Floor
Washington, DC 20503

Dear Ms. Thurman:

Sandy
Wanted to let you know of a meeting yesterday between Director McCaffrey and Erskine Bowles to discuss needle exchange policy. Other participants included Rahm Emanuel and Bruce Reed. Mr. Bowles stated that he was keeping the President abreast of the ongoing discussion of this issue, to include providing him copies of recent correspondence between ONDCP and the AIDS Policy Office.

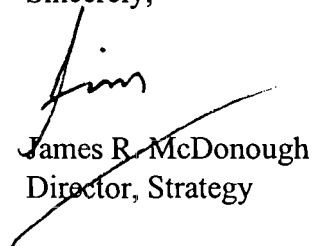
In summary, the concerns the Director has with moving forward on needle exchange at this time are as follows:

- **The science is uncertain.** It would be imprudent to take a key policy step on the basis of yet uncertain and insufficient evidence.
- **The public health risks outweigh benefits.** Each day, over 8,000 young people will try an illegal drug for the first time. Heroin use rates are up among youth. While perhaps eight persons contract HIV directly or indirectly from dirty needles, 352 start using heroin each day, and more than 4,000 die each year from heroin/morphine-related causes (the number one drug-related cause of death). Even assuming that needle exchange programs can further accelerate the already declining rate of HIV transmission, the risk that such programs might encourage a higher rate of heroin use clearly outweighs any potential benefit.
- **Treatment should be our priority.** Our fundamental moral obligation is to provide treatment for those addicted to drugs. Needle exchange programs should not be funded instead of treatment.
- **Federal dollars are not required.** State and local governments and the private sector can already fund NEPs.
- **Federal support of NEPs may undercut AIDS research, prevention and treatment.** If federal funds are allocated to NEPs, those who oppose AIDS research, treatment and prevention programs may argue why provide millions of federal dollars for these HIV/AIDS programs when the answer lies in a twenty-cents needle?

- **Federal support of NEPs may undermine other drug-control programs.** The use of taxpayer dollars to support needle exchange programs is a lightning rod issue. The President's *National Drug Control Strategy* is increasingly gaining support and making a difference. An Administration decision to alter course on NEPs and spend federal monies to buy drug paraphernalia could seriously undermine our ability to continue to carry out effective drug policies that enjoy bipartisan support.
- **Supporting NEPs will send the wrong message to our children.** By handing out needles we encourage drug use. Such a message would be inconsistent with the tenor of our national youth-oriented anti-drug campaign.
- **NEPs place disadvantaged neighborhoods at greater risk.** NEPs are normally located in impoverished neighborhoods. These programs attract addicts from surrounding areas and result in a concentration of criminal activity.

The bottom line is that General McCaffrey believes we should provide the President the opportunity to listen to the considered viewpoints of his Drug Policy Council before a decision is made to support needle exchange programs with federal funds.

Sincerely,



James R. McDonough
Director, Strategy

Enlosure
Vancouver Needle Exchange
Trip Report



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

April 6, 1998

INFORMATION

MEMORANDUM FOR THE DIRECTOR

[Handwritten signature and date: 8 APR 98]

THROUGH: THE DEPUTY DIRECTOR

FROM: STRATEGY (D.B. DES ROCHES)

SUBJECT: Vancouver Needle Exchange Trip Report

1. **PURPOSE:** To provide you with field observations on needle exchange and drug abuse in Vancouver, Canada.

2. **GENERAL:** You had directed that Dr. Adger and I visit the Vancouver Needle Exchange in light of the high incidence of HIV among needle exchange participants and the skyrocketing death rate due to drug overdose in Vancouver. Jane Sanville of ODR joined the trip because of her expertise in the field of AIDS. We spoke with law enforcement and public health officials, as well as with the scientists who studied the needle exchange and those who run the needle exchange. (Trip Schedule at TAB 1). Our visit to the U.S. Customs and Border Patrol at Blaine raised separate issues, which will be reported under separate cover.

3. **OBSERVATIONS -- FACTS:**

A. The Vancouver Needle Exchange Program (NEP) is one of the largest in the world -- it has distributed over 1 million needles annually for the last ten years, and close to 2.5 million needles last year alone.

B. The HIV rates among participants in the NEP is higher than the HIV rate among injecting drug users who do not participate.

C. The death rate due to illegal drugs in Vancouver has skyrocketed since 1988, the year needle exchange was introduced. In 1988, 18 deaths were attributed to drugs; in 1993 200 deaths were attributed to drugs. The Provincial Coroner told us that in March they were averaging more than 10 deaths due to drugs per week, and were on pace for 600 deaths province-wide in 1998 -- mostly in Vancouver.

D. With the implementation of NAFTA, the Vancouver Port Police was disbanded. Vancouver is the most active Pacific port in North America.

E. The highest rates of property crime in Vancouver are within two blocks of the needle exchange (See maps, TAB 2).

4. OBSERVATIONS--STATEMENTS:

A. The single most striking point, which all interviewees stressed, was the *lack of adequate drug treatment capacity in British Columbia*. The head of the Vancouver -Richmond Health Board stated: "I can have all the needles I want, but they won't give me a single drug treatment bed." Other health care professionals noted the fact that governmental responsibility for drug treatment has been shuffled among various ministries, and has never been a priority.

B. Every interviewee stated that *the most abused injection drug in Vancouver is cocaine*. This was cited repeatedly as a major reason for the failure of needle exchange to prevent HIV: cocaine abusers typically inject much more frequently than do heroin abusers.

C. Every interviewee cited the geographic features of the Downtown / Eastside (the major drug abuse area and the location of the needle exchange) as an exacerbating factor. Bounded by railyards and docks on two sides, it is an isolated and distinct area that contains most of the serious injection drug abuse and the drug trade, as well as associated prostitution and property crime. The area has a large number of single residence occupancy hotels, which all said contributed to the "massing effect" of addicts.

D. Every interviewee said that the average age of IV drug users has decreased in recent years.

E. Every interviewee save the Coroner pointed to the lack of turnstiles on the skytrain (elevated light rail system) as an aggravating factor, as it increased ingress for the destitute to the Downtown/Eastside area from other parts of the city.

F. The Vancouver Police interviewees stated that they had been called by other interviewees and asked what they were going to say.

G. The Director of the NEP stated that "it is ridiculous to propose that we hand out 10 million needles a year." 10 million is the number he estimated would be required to accommodate the injecting cocaine users in Vancouver with one needle per injection.

H. Jane Sanville noted that the primary investigator of the needle exchange study had been urged to suppress her research at professional conferences because it had the potential of casting a negative light on NEPs.

I. Every interviewee stated that the primary reasons for the increase in drug abuse was the available supply of cheap drugs, and that the needle exchange had either no effect or a marginal effect on overall drug abuse.

J. The Vancouver Police stated that there are inadequate drug treatment beds in the criminal justice system. Court mandated treatment is not a reality.

K. The Vancouver Police stated that there was a 24 hour drug market and similar open drug injection activity in the area immediately adjacent to the needle exchange. During a drive-

around with a detective from the Vancouver Drug Squad, we observed multiple instances of drug users injecting and purchasing drugs. A one block long alley typically had three or four people injecting, preparing to inject or moving from injecting drugs. While walking around the area, we frequently encountered discarded syringe wrappers and protective tips.

4. OBSERVATIONS-- REPORTER NOTES:

A. Everyone save the police clearly wanted needle exchange to be a success (the police seemed to feel it was a facilitator for drug use, but officially supported it), and felt that the failure of needle exchange to stop the spread of HIV was due to three factors:

1). The NEP was set up for heroin users: the prevalence of cocaine injection (which is much more frequent) meant that the NEP would be inadequate.

2). Vancouver suffers from a "nutbowl effect" -- the homeless, migrants, counter-culture types and disaffected, at-risk personalities tend to migrate there from around the country. Everyone pointed to social policies in other Canadian provinces, especially Alberta, which encouraged socially marginal people to move to British Columbia (by providing bus tickets).

3). Vancouver was on the trailing edge of the AIDS epidemic: some stated that the NEP was founded just as AIDS began to surge. It was frequently asserted that "it would have been much worse without NEP." (*Note -- it might be interesting to evaluate other NEPs in this light -- generally, NEPs in America were established on the trailing edge of the epidemic. Any claimed reduction in HIV incidence might be attributable to the normal course of the disease*).

B. The academics evaluating the NEP and the NEP itself were very close: the principle author of the Vancouver study accompanied us to the NEP and was given a telephone message that had been sent to her there. I did not take this to indicate any unethical behavior, but note merely that human scientists (anthropologists, psychologists, epidemiologists) work with humans, and thus are constantly challenged to maintain the same level of objectivity and detachment from their subjects as mathematicians and physicists.

C. All the ONDCP participants were amazed at the lack of treatment capacity in Vancouver. When we asked interviewees about this, they too were outspoken about inadequate treatment. Apparently, there is a requirement for addicts to abstain for three months prior to entering one of the few treatment spaces. Catch 22 is not just an American invention.

D. The academics who studied the NEP seemed extremely concerned by the increase in HIV among NEP participants, and devoted much of our time together to explaining how NEP frequent users were a much more marginalized and at-risk segment of society than were infrequent NEP users. When asked if there were any studies comparing NEP users and non-NEP users, the study director responded that they had no way to interview non-NEP users.

E. Property crime of all sorts in Vancouver seems to be highest in the areas around the NEP building. This is sort of a chicken-egg thing: it's hard to gauge cause and effect.

F. Public support for needle exchange seemed to exist, but only so long as the NEP was confined to Downtown-Eastside. Expansion of the NEP (by vans) was opposed at a public

meeting on the day of our departure.

G. All interviewees save the police referred to the NEP's efforts to maintain relations with the community, and their efforts to keep discarded needles away from schools, etc. However, in a private interview, an elementary schoolteacher said that children at area schools are not allowed outside at recess for fear of needles. I was unable to verify this statement.

5. CONCLUSIONS:

A. There has been a trade-off between needle exchange and drug treatment. This is the single most important lesson learned in Vancouver. The trade-off was not explicit, and was probably not deliberate. It may have resulted from normal bureaucratic politics, or the shuffling of responsibilities among ministries. **Nevertheless, it has evolved and is allowed to persist.**

- 1). Absent any mandate for drug treatment, NEPs will focus on what they can afford and do best--exchange needles.
- 2). Once the NEP was instituted, there seemed to be no imperative for the establishment or expansion of drug treatment. All interviewees stated that NEP was not a "silver bullet," but reality suggests that it is treated as such.

B. In the absence of treatment, the potential benefits of needle exchange programs are marginalized for the most at-risk. The single most common explanation given for the prevalence of HIV among NEP participants was that the NEP participants were at a greater risk than non-NEP participants. Harm reduction believes that by giving addicts the means and knowledge to safely use drugs (i.e. needles), most of the negative effects of drug abuse can be alleviated. Yet this approach still requires that the addict responsibly use the needles he is given; the HIV statistics show that he does not. For an at-risk population paternal approaches which -- as a last resort -- can supplant irresponsible behavior will probably be more effective. **With an at-risk, irresponsible population, without access to drug treatment, needle exchange appears to be nothing more than a facilitator for drug abuse.**

C. High-purity cocaine and heroin is becoming increasingly prevalent and will pose challenges across the board. Vancouver is literally swamped with drugs. Large seizures appear to have no effect at the street level. This influx of high-purity heroin and cocaine is a major cause of both the high HIV rates in Vancouver as well as the high death rate. We should examine high-purity drugs as a separate threat, and consider a national initiative along the lines of our methamphetamine initiative.

ENCLOSURES:

TAB 1	Trip Schedule
TAB 2	Crime Maps

March 30, 1998

INFORMATION
MEMORANDUM FOR THE DEPUTY DIRECTOR

FROM: STRATEGY (D.B. DES ROCHES)

SUBJECT: Vancouver Trip

1. **PURPOSE:** To provide you with background information for our trip to Vancouver to gather data on needle exchange programs and drug abuse in the city.

2. **GENERAL:** The Vancouver study of needle exchange has produced a number of findings which are of interest: a. HIV rates have increased drastically among those in the program and b. deaths attributable to drug abuse have also increase dramatically. The Director has dispatched us to Vancouver to see the situation on the ground and determine what conclusions may be drawn.

3. SCHEDULE:

April 2, 1998

1130	Lunch with Dr. John Blatherwick {(604)775-1866}, Chief of the Vancouver-Richmond Health Board, 3rd Floor, 1060 West 8th Street (near Oak and B'way), Vancouver
1300	Meeting with Steffanie Strathdee {(604) 631-5535} (Principle Investigator of Vancouver Needle Exchange Study) and others, Room 611, St Pauls Hospital, 1081 Burrard Street (@ Davie, Comox entrance) Vancouver.
1500	Tour of Vancouver Needle Exchange with Strathdee.
1600	Mtg with Deputy Chief Brian Maginnis, {(604) 665-3089} Head of Investigations and Narcotics, Vancouver Police Department, 312 Main Street, Vancouver
1700	Tour of vicinity needle exchange and drug purchasing areas with Vancouver PD.

April 2, 1998

0930 Meeting with Louise Pollock, {(604) 255-3151} Director, Downtown Community Health Center (methadone maintenance, primary drug / HIV treatment facility), 4112 E. Cordova St, Vancouver.

1200 Meeting with USCS SAC, POE Blaine, Washington

1500 Meeting with BC Provincial Coroner, (604) 660-7739

ENCLOSURES:

TAB A: Vancouver Needle Exchange Study
TAB B: Illicit Drug Statistics for British Colombia
TAB C: Vancouver / Richmond Health Board Paper on Drug Reform

Withdrawal/Redaction Marker

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. diagrams	re: Vancouver Police Department Crime Analysis Unit (2 pages)	03/00/1998	b(7)(E)

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FOLDER TITLE:

[Issues] - Needles (More) [1]

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Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

WASHINGTON

April 13, 1998

James R. McDonough
Director, Strategy
Office of National Drug Control Policy
750 17th Street NW
Washington, DC 20503

RE: Needle Exchange Correspondence Dated April 10, 1998

Dear Mr. McDonough:

I very much appreciate your sharing the perspective of ONDCP regarding the issue of needle exchange (letter dated April 10, 1998), and your impressions of the program in Vancouver. However, many of the conclusions and statements that were made perpetuate erroneous and incorrect interpretations of scientific studies.

The science is clear and convincing.

It is stated that, "the science is uncertain" and "insufficient." I strongly disagree. In fact, Dr. Varmus, the Director of the NIH, recently reconfirmed before Congress that the science was adequate to support a certification by the Secretary that needle exchange programs reduce HIV infection without encouraging illegal drug use. Nevertheless, I thought we had agreed to let the Secretary of HHS, with support from the public health experts, make these "scientific determinations."

ONDCP continues to cite studies of NEPs done in Montreal and Vancouver as evidence that they don't work. We have expressed our concern regarding the manner in which those studies have been cited, and have been subsequently joined (in an op-ed in the *New York Times*) by the authors of those studies. While both initially show a higher incidence of HIV infection among participants in the NEPs than the general population, it is because these programs specifically target those at highest risk for HIV infection. Even among this hard-to-reach population, the Vancouver NEP now shows a reduction in HIV infection. Arguing the adequacy of the science in opposition to virtually every major medical and public health organization and journal weakens the credibility of this Administration.

Public health benefits outweigh the risks.

There is no evidence that HIV transmission rates are declining, as is stated. We do know that injection drug users, their partners, and their children are increasingly impacted by this epidemic--as many as 55 to 82 new infections every day. According to the scientists, NEPs reduce HIV infections without encouraging illegal drug use. Therefore, the public health benefits clearly outweigh any theoretical risks. Clearly, an effective HIV prevention strategy with no encouraging effect on illegal drug use should be an option for those health officials who deem it to be appropriate. As for drug prevention, I wholeheartedly agree that much more needs to be done and welcome the leadership of ONDCP in this area.

Needle exchange and drug treatment are wholly compatible and mutually supportive.

I agree that “needle exchange programs should not be funded instead of treatment.” This has never been under consideration by this Administration. Quite the contrary, we have joined ONDCP in emphasizing the critical importance of increasing drug treatment services. The Congressional funding restriction currently under review by this Administration pertains to funds currently available to states and localities for HIV prevention, not drug treatment.

We will continue to work with HHS and ONDCP to support more drug treatment funding. It is worth noting that several cities with successful needle exchange programs such as Philadelphia, Baltimore, and San Francisco have been able to double their drug treatment budgets since their NEPs began.

Federal funding, and the federal imprimatur on the science, are absolutely critical.

While some state and local governments are demanding the option to use their federal HIV prevention funds for needle exchange programs, others are awaiting a public health determination by the Federal government before proceeding. Certifying that needle exchange programs are efficacious in reducing the spread of HIV without encouraging illegal drug use is a critical message to those state and local communities struggling with this issue. They are simply looking for leadership on this issue, and it is our responsibility to provide that leadership.

Congress will not abandon its investment in AIDS care, research, and prevention because needle exchange programs are funded.

We are not aware of any Member of Congress that has even suggested that AIDS funding for care, research, and prevention be reduced or abandoned in order to fund needle exchange programs. In establishing the criteria under which it felt needle exchange programs could be funded, Members of Congress indicated that they understood that needle exchange is an important but single strategy that must be seen as part of a comprehensive plan designed to deal with two complex epidemics.

What Congress has demanded is that this Administration provide direction and leadership on reducing the number of new infections so that the human and financial hemorrhaging can be stemmed.

Allowing state and local communities the option to use their HIV prevention funds for needle exchange programs in no way undermines our drug-control program.

Hypodermic syringes are not the cause of illegal injection drug use any more than matches are the cause of illegal marijuana use. However, the sharing of hypodermic syringes is directly contributing to the spread of deadly blood-borne diseases in this country. Needle exchange programs quite simply allow for the exchange of used syringes for clean ones, not handing them out on the street corner. Moreover, the scientific studies clearly show that NEPs are reaching hard-core drug users that are otherwise unreachable and offer our best and perhaps only chance of encouraging their acceptance of drug treatment.

Supporting NEPs sends a message to America that we care about our children.

The sharing of needles is the largest factor in the spread of HIV among children. NEPs offer the best hope of significantly reducing the number of babies born with HIV. That is why the Academy of Pediatrics is such a strong supporter of NEPs. Giving local communities the option to use their funds for needle exchange programs sends the message that we care about these children and their mothers. It is also a statement that we believe treatment works, and that we want drug users to stay alive so that they can avail themselves of the benefits of treatment.

NEPs are an integral component of programs that serve disadvantaged neighborhoods drowning in illegal drug use.

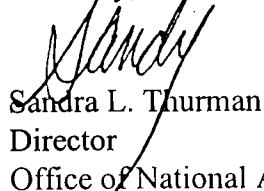
These communities are already in crisis not because of NEPs, but because of drugs, crime, poverty, violence, and AIDS. In these communities, NEPs are often the only link people have to a way out of this pernicious cycle of addiction and despair. Again, needle exchange programs increase the need for drug treatment services, health care, housing, jobs, and other services. In many cases, they have proven to be a tremendous opportunity for a range of successful interventions with a population that has heretofore remained extremely difficult to reach.

To argue that NEPs "attract addicts from surrounding areas" supports their expansion, not their restriction. Only because the programs are scarce are drug users forced to travel to different communities to get clean needles. It is certainly also true, as your staff observed in Vancouver, that it is the ready availability of illegal drugs that attracts addicts, not needles.

The bottom line is that the science is there to support the Secretary's determination. This Administration has a moral obligation to do everything it can to stop the spread of this terrible disease. Giving states and local communities the option to use their federal HIV prevention funds for needle exchange programs is an essential step if we are ever to stop this epidemic.

While on occasion we might struggle to find common ground, I greatly appreciate your dedication to stopping the devastating impact that drug use and HIV/AIDS have on our nation. I look forward to continuing to work with ONDCP to address these difficult issues.

Sincerely,


Sandra L. Thurman
Director
Office of National AIDS Policy

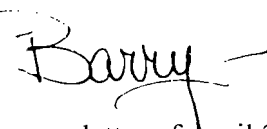
cc: Erskine Bowles
Rahm Emanuel
Bruce Reed

THE WHITE HOUSE
WASHINGTON

April 28, 1998

Barry R. McCaffrey
Director
Office of National Drug Control Policy
Washington, DC 20503

Dear Mr. McCaffrey:

 Thank you for your letter of April 23, 1998 regarding needle exchange programs (NEPs). Unfortunately, its perpetuation of factual errors and statements that directly contradict scientific determinations just made by HHS is troubling. The President is not well served when policy positions are predicated on misinformation.

The letter refers to the "continuing controversy over the efficacy of NEPs." As you well know, the Secretary of Health and Human Services with the support of the President, resolved that issue only last Monday. The position of this Administration is that needle exchange programs reduce HIV transmissions without encouraging the use of illegal drugs. We have both committed publicly to following the science on this issue, and now that the scientific determination has been made, I believe we have an obligation to respect it. I have certainly defended the Administration's decision not to fund needle exchange, despite the fact that it wouldn't have been my choice.

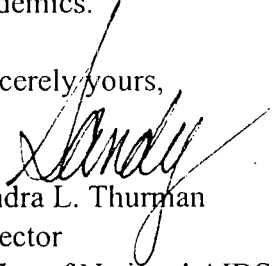
Also included in the letter are statements relative to the spread of HIV in this country, and particularly among injection drug users, that are erroneous. Unfortunately, we do not know, as is stated, that the number of new HIV infections in the U.S. are declining. Similarly, it is said that, "injecting drug use was an exposure category for 15 percent of new HIV cases." Both errors come from the use of HIV infection data published by the Centers for Disease Control and Prevention but only available for the 29 states that collect such data. As we have explained in the past, these are almost entirely low-incidence and prevalence states and using their data to characterize the spread of HIV in our country as a whole is deceptive.

Finally, continued distortions of the implications of studies completed on needle exchange programs in Montreal and Vancouver are also of great concern to me. The scientists who directed these studies, in an op-ed published in the *New York Times* (see attached), directly refuted the misinterpretation of their studies that has been used to argue that NEPs are ineffective in reducing HIV transmissions. Not only have these distortions continued but the pretext of an objective review of those programs by ONDCP staff was done to substantiate those misinterpretations.

If there is a misunderstanding about the facts that you and I have discussed at length in person, or the discussions between our staff, I am more than willing to work to clarify them. Our work together can only be effective when we adhere to our commitments to follow the science and stick to the facts.

I appreciate and admire your passionate dedication to reducing the use of drugs in this country and look forward to continuing to work with you to address the both the AIDS and drug epidemics.

Sincerely yours,



Sandra L. Thurman
Director
Office of National AIDS Policy

THE NEW YORK TIMES **OP-ED** THURSDAY, APRIL 9, 1998

The New York Times

Founded in 1851

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The Politics of Needles and AIDS

By Julie Bruneau and
 Martin T. Schechter

Debate has started up again in Washington about whether the Government should renew its ban on subsidies for needle-exchange programs, which advocates say can help stop the spread of AIDS. In a letter to Congress, Barry McCaffrey, who is in charge of national drug policy, cited two Canadian studies to show that needle-exchange plans have failed to reduce the spread of H.I.V., the virus that causes AIDS, and may even have worsened the problem. Congressional leaders have cited these studies to make the same argument.

As the authors of the Canadian studies, we must point out that these offi-

cial have misinterpreted our research. True, we found that addicts who took part in needle exchange programs in Vancouver and Montreal had higher H.I.V. infection rates than addicts who did not. That's not surprising. Because these programs are in inner-city neighborhoods, they

Canadian findings are distorted.

serve users who are at greatest risk of infection. Those who didn't accept free needles often didn't need them since they could afford to buy syringes in drugstores. They also were less likely to engage in the riskiest activities.

Also, needle-exchange programs must be tailored to local conditions. For example, in Montreal and Vancouver, cocaine injection is a major source of H.I.V. transmission. Some users inject the drug up to 40 times a

day. At that rate, we have calculated that the two cities we studied would each need 10 million clean needles a year to prevent the re-use of syringes. Currently, the Vancouver program exchanges two million syringes annually, and Montreal, half a million.

A study conducted last year and published in *The Lancet*, the British medical journal, found that in 29 cities worldwide where programs are in place, H.I.V. infection dropped by an average of 5.8 percent a year among drug users. In 51 cities that had no needle-exchange plans, drug-related infection rose by 5.9 percent a year. Clearly these efforts can work.

But clean needles are only part of the solution. A comprehensive approach that includes needle exchange, health care, treatment, social support and counseling is also needed. In Canada, local governments acted on our research by expanding needle exchanges and adding related services. We hope the Clinton Administration and Congress will provide the same kind of leadership in the United States. □

Julie Bruneau is an assistant professor of psychiatry at the University of Montreal. Martin T. Schechter is a professor of epidemiology at the University of British Columbia

January 21, 1998



Health Division



Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Route to: Richard Turman Barry Clendenin Kevin Cichetti	<u>ACTION:</u> Decision _____ Signature _____ Comment _____ As requested <u>XXX</u> Information _____	<u>Needed By:</u> Date: _____ Time: _____ <u>Copies to:</u> HD Chron, HPS Chron Post this Document on HD Intranet? <u>NO</u>
Subject: 1998 Drug Control Strategy	Phone: 202/395-4929 Fax: 202/395-7840 Room: NEOB #7001 Barbara_A._Menard@oa.eop .gov	
From: Barbara Menard		

Thank you for the opportunity to review the draft of the *National Drug Control Strategy* for 1998. HPS staff have reviewed the document and have several comments:

[Please note that because the document is not paginated in total, our comments cannot refer to specific pages, but rather to concepts that appear throughout the document.]

- **Statistics.** ONDCP cites specific “use” statistics throughout this document. Although the statistics cited seem to agree with the general use patterns with which we are familiar, we cannot confirm that all of the statistics are accurate and agree with the most recent data. On this confirmation, we defer to HHS and the OPDIVS responsible for gathering and reporting such data.
- **Use of the term “gateway drug.”** At several points in the document, alcohol, tobacco and marijuana are referred to as “gateway drugs.” We recommend that this phrase be removed, given that it is the official position of the National Institute on Drug Abuse (NIDA) that, although there is a strong *correlation* between the use of alcohol, tobacco & marijuana and the use of other illicit substances, *causality* has not yet been proven. Again, we defer to HHS on this issue.
- **Treatment gap.** ONDCP continues to cite the statistic that the current treatment gap is 3.6 million users. Upon closer examination, however, it becomes clear that this number refers to *all* of the substance abusers in the United States who could possibly benefit from treatment and are not currently receiving it. This calculation does not take into

consideration the number of substance abusers who are not actively seeking treatment, which would greatly reduce the treatment gap. Therefore, there are two “treatment gaps”: one that is theoretical (all users who *could possibly benefit* from treatment for whom there is not currently capacity in the treatment system), and the practical (all users *who are actively seeking* treatment for whom there is not capacity in the public treatment system.) We have discussed this difference with ONDCP staff, who have agreed that the estimated treatment gap currently being used is “too high” and needs to be adjusted downward to reflect the number of substance abusers who are not seeking treatment. We recommend that all references to the treatment gap in the document be modified to reflect the notion of a “practical” treatment gap, and that ONDCP and SAMHSA staff work to develop more accurate estimates of the actual treatment gap to be used in policy formulation.

- **Needle Exchange Programs (NEPs).** There is currently much debate within the Administration regarding NEPs and the presentation of the Administration’s position on such programs in the FY 1999 Budget. In the 1998 Strategy, however, ONDCP has chosen to take a hard stand against NEPs, and suggest that the Administration not support certification of the use of Federal funds for NEPs in the future. Given that this remains a very contentious issue on which many parties need to be consulted before a policy is presented, **we recommend that the *Strategy* not address the issue of NEPs at all, and we are bracketing all text referring to NEPs in Chapters Two and Four. In an effort to maintain maximum flexibility for the President and the Secretary of Health and Human Services on this issue, all language referring to NEPs currently in the strategy must be removed.**
- **Editing.** In its current form, the Strategy contains many grammatical, structural and spelling errors. It seems as if the draft has not yet received even basic proofreading, including correction of spelling, spacing and grammar mistakes. While OMB staff appreciate the opportunity to review the *Strategy* for content and agreement with the Administration’s policies, we do not have the staff or the time to focus on basic editing of the document. Given that the *Strategy* is a Presidential document that garners much public and press attention, [and that editorial errors in last year’s document were recently pointed out in the *Washington Post*], we recommend that ONDCP have the document reviewed by a professional editor prior to final publication.

Thank you again for the opportunity to review this draft. Please call with questions.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

January 14, 1998

Jacob J. Lew
Deputy Director
Office of Management and Budget
Old Executive Office Building, Rm. 252
Washington, D.C. 20503

Dear Mr. Lew:

Director McCaffrey has reviewed OMB's recommended changes to the statutory language, which loosen the criteria for the use of Federal funds for needle exchange programs. It is the Director's strong view that these changes could undermine national drug control policy and that such changes in drug control policy are subject to concurrence by the Director of National Drug Control Policy, in consultation with other agency principals.

It is ONDCP's position that sound policy in this area should include the following elements:

- The Ryan White CARE Act retain the complete prohibition on funding;
- The SAMHSA Block Grant retain the two existing criteria
 - Reduce the spread of HIV,
 - Reduce drug use;
- Other HHS programs be subject to the criteria for the SAMHSA Block Grant;
- The Secretary of HHS determine whether criteria are satisfied;
- The Secretary of HHS not establish criteria for the operation of such programs; and
- HHS continue to review the science regarding the satisfaction of both criteria.

To maintain this continuity in policy, ONDCP recommends retention of the following language.

"Notwithstanding any other provisions of this Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug unless the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and reduce the use of illegal drugs."

I hope you find this information helpful.

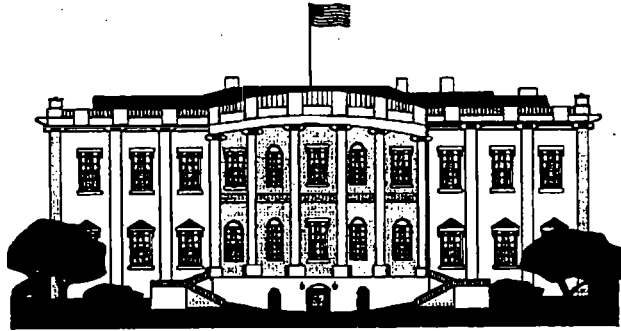
Sincerely,

A handwritten signature in black ink that reads "Janet Crist".

Janet L. Crist
Chief of Staff

EXECUTIVE OFFICE OF THE PRESIDENT

Office of National Drug Control Policy
Washington, DC 20503



FACSIMILE MESSAGE

TO: Sandy Thurmon
ORGANIZATION: _____
PHONE: 632-1215
FAX: 632-1096
DATE: 8/21 TIME: 10:00 PAGES: 2 (Including Cover)

FROM: DIANE STUMPF, OFFICE OF PUBLIC AFFAIRS

PHONE: (202) 395-6618

FAX: (202) 395-6730

COMMENTS: _____



**EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503**

August 20, 1997

**OFFICE OF NATIONAL DRUG CONTROL POLICY
COMMENTS ON NEEDLE EXCHANGE RESEARCH RELEASED AUG. 20
BY THE FAMILY RESEARCH COUNCIL**

The Office of National Drug Control Policy released the following comments in connection with a survey announced Aug. 20, in Washington D.C., by the Family Research Council regarding the issue of needle exchange programs:

"The National Drug Control Strategy focuses on the need for drug treatment to help addicts free themselves from addiction and its terrible health and social consequences. Federal treatment funds should not be diverted to short term 'harm reduction' efforts like needle exchange programs. The problem to be addressed is effective intervention to reduce the number of addicted Americans, currently 3.6 million, who suffer and cause such terrible damage to society from compulsive drug taking activity. The Office of National Drug Control Policy strongly supports drug treatment, and outreach to get addicts into drug treatment, as the proven effective means to deal with the twin epidemics of drug use and HIV/AIDS."

Contact Don Maple, (202) 395-6618

Office of HIV/AIDS Policy

Office of the Assistant Secretary for Health
U.S. Public Health Service/DHHS
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel. (202) 690-5560



☐ Room 733-E
Fax. (202) 690-6584

☐ Room 730-E
Fax. (202) 690-7560

Deliver to: Sandy Thurman

Fax: _____

Tel: _____

From: _____

Date: 9/12 : _____

This fax contains 5 pages + cover

If transmission problems occur, please call _____

Comments: _____



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

August 21, 1997

The Honorable Donna E. Shalala
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201-0004

DRAFT

Dear Secretary Shalala:

Your wisdom and leadership have been major factors in the recent health community advances made against the twin epidemics of drug use and AIDS. The Administration can be justly proud of our combined efforts. You are also absolutely right to note that our accomplishments must be tempered by awareness of emerging challenges. The dramatic reduction in overall American drug use during the past 15 years (50 percent) is offset by increases in youth heroin and cocaine use and deterioration in youth attitudes toward drugs in general. Similarly, a general reduction in new AIDS cases masks increases among minority and female populations and among injecting drug users and their sexual partners and children.

The drugs/AIDS nexus is a particular challenge. Dr. Harold Varmus and Dr. Alan Leshner recently briefed ONDCP on research related to needle exchange programs (NEPs) and the transmission of HIV among drug users and their sexual partners. Based on their reading of the research to date, Dr. Varmus and Dr. Leshner said that they may recommend a conditional lifting of the ban on the use of certain Federal funds for NEPs.

In my judgement, we should not endorse the use of Federal funds (including CDC funds) to support needle exchange programs. Drug treatment offers the better long-term policy for drug control and AIDS prevention. Lifting the ban at this time would present serious and complex issues regarding drug use and drug control policy. There is the troubling question of how such a message would be received by our young people during this period of rising heroin and methamphetamine use. In addition, ONDCP is concerned that needle exchange programs might be considered as a low cost substitute for much needed drug treatment. Finally, we are concerned about diverting Federal resources to states and communities that are not prohibited from operating such programs with non-Federal funds. More than 100 communities already support needle exchange programs without Federal funding.

Many health and law enforcement professionals are concerned about the narrow logic that would focus on needles or injecting drug use behavior as the essence of the problem. This perspective fails to take into account the complex human drug behavior

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involved. NIDA research demonstrates that drug addiction changes and trains the brain, creating a web of destructive and high risk behaviors. The resulting unemployment, crime, illness, social erosion, and frequently agonizing deaths flow from the compulsive behaviors associated with addiction, not just from the act of injecting. The provision of clean needles will not alone contain or alter this destructive lifestyle. Federal resources to provide a free 20 cent needle will not change the reckless, compulsive drug behavior that accompanies a \$200 a day habit. The only proven answer lies in effective treatment - comprehensive in scope, intensive in application, and adequate in capacity.

The real challenge America faces is the 50 percent shortfall in drug treatment capacity for our 3.6 million addicted. Research sponsored by your Department has shown that untreated opiate addicts die at a rate between 7 and 8 times higher than patients with similar characteristics in methadone programs. We also know that needle sharing rates have been reduced by more than two-thirds among injecting drug users during treatment. The positive role and record of drug treatment are clear. ONDCP strongly supports the outreach models developed by NIDA to bring injecting drug users into treatment. In particular, we must develop a greatly increased drug treatment capability for the drug dependent among the 1.6 million Americans currently behind bars at the local, state, and Federal levels.

NIDA's Drug Abuse Treatment Outcome Study (DATOS) demonstrated that participants in outpatient methadone treatment reduced heroin use by 70 percent and illegal activity by 57 percent. Treatment participation increased their full time work by 24 percent. Equally impressive, participants in long-term residential treatment reduced heroin use by 71 percent, cocaine use by 68 percent, and illegal activity by 62 percent. Full time work among this group more than doubled.

Finally, SAMHSA'S National Treatment Improvement Evaluation Study (NTIES) determined extremely positive results for substance abuse treatment among predominately poor, inner-city populations. Use of illicit drugs dropped an average of 50 percent, drug selling by 78 percent, and arrests by 64 percent. Exchange of sex for money or drugs - dropped by 56 percent, homelessness by 43 percent, and receipt of welfare income by 11 percent. Employment increased 19 percent.

Treatment has a solid record. It saves lives, reduces crime and health costs, and saves taxpayer money. Yet only enough capacity is available at this time to treat about half of those in severe need. Methadone capacity is sufficient for only 25 percent of the estimated 600,000 American heroin addicts. Methadone regulation reforms, thankfully now being developed by HHS, will have a significant impact and have the strong support of this Office. However, more resources will be required for needed drug treatment capacity expansion. The need to increase drug treatment capacity should continue to be a key part of our Administration message until the shortfall has been remedied.

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Congressional action to date on the drug control budget may result in under-funding of the prevention and treatment block grant by \$10 million in fiscal year 1998. Congress must be persuaded to join us in supporting the critical role of treatment in the long-term *National Drug Control Strategy*.

We share a common view that our efforts to expand drug treatment must be based on a broader, consistent message of "no use." Visits to youth treatment programs around the country have made some things painfully clear to me. The importance of the drug prevention message we send to young Americans cannot be overstated. Heroin use has taken a terrible upward turn among our young people. Strongly agree that the HHS-ONDCP message to our children must be an unambiguous "no use" message. If they should become ensnared by compulsive drug behavior we should offer them a way out -- not a means to continue addictive behavior.

Clearly we need to know more about the treatment of compulsive drug behavior. A number of questions that are of particular importance to the *National Drug Control Strategy* are offered in an attachment to this letter for consideration by your HHS research team. Look forward to working with you to get the treatment resources needed to control this terrible problem of injecting drug use. Fully support the HHS comprehensive strategy on the prevention of HIV/AIDS.

Respectfully,

Barry R. McCaffrey
Director

Attachment

cc: Dr. Harold Varmus, Director, National Institutes of Health
Dr. Alan Leshner, Director, National Institute on Drug Abuse
Ms. Sandra Thurman, Director, Office of National AIDS Policy

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August 21, 1997

ONDCP QUESTIONS FOR RESEARCH CONSIDERATION REGARDING THE EFFECT OF NEEDLE EXCHANGE PROGRAMS ON DRUG USE

1. The Anti-drug message. The overriding concern of ONDCP, as reflected in Goal 1 of the *National Drug Control Strategy*, is reducing youth drug use. Preliminary data from the most recent National Household Survey are a source of continuing worry regarding marijuana and heroin use by youth, and a source of renewed concern regarding future cocaine use. A consistent "no use" message must remain an integral part of Federal efforts to reduce youth drug use.

What light does the research shed on the consequences of mixed messages to youth? What does the research tell us regarding the perception by American youth of local government provision of needles for the injection of illegal drugs?

2. Monitoring drug use. Measures of the impact of needle exchange programs on the level of drug use have relied on macro indicators of drug use (e.g. DUF) and its consequences (e.g., DAWN). Some suggest that, had such macro indicators been used to measure HIV transmission, it would have been virtually impossible to reach any conclusions. ONDCP shares the concern expressed by the Institute of Medicine (IOM) that the long-term impact of needle exchange on community drug use patterns is uncertain. The continuous monitoring of local NEPs called for by the IOM will be essential, especially if local needle exchange programs increase in number.

How will existing and future research monitor and report on local drug use at the community level?

3. The specific impact of needle exchange. NIH-funded research has strongly established the effectiveness of drug treatment in reducing HIV transmission and of outreach in getting heavy users to enter treatment. However, it appears that much of the research supporting needle exchange programs seems to focus on a collection of services that includes needle exchange rather than on needle exchange effectiveness itself.

What credible local research addresses the impact of a needle exchange programs that are not combined with other services? If no such research exists, is it possible to isolate the specific impact of needle exchange from the research on multiple services?

More specifically, will research permit the development of relative cost/effectiveness measures for needle exchange programs, for outreach programs (without needle exchange), and for drug treatment?

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4. The significance of contrary findings. Research is not universally positive regarding needle exchange. Some studies seem to indicate increases in injecting, increases in drug use, and increases in HIV transmission.

What relative weight should be given to these negative studies? How should research track these possible increases in destructive, compulsive drug behavior?

5. Alternative approaches to making sterile equipment available. There is evidence of a reported reduction in needle sharing in Connecticut after state drug paraphernalia and prescription practices were modified.

What does the research say about the rates of HIV transmission among states with differing legal and practical restrictions on access to sterile needles? In other words, what does the research tell us about the relative impact of access to sterile needles compared to free provision of sterile needles? Do the Connecticut data, where needle exchange programs preceded the statewide changes, offer insights into the relative impact of each?

6. The impact of compulsive, injecting drug use on compliance with HIV medical regimes. There appears to be a basis for serious danger that HIV-infected drug users would be less compliant with complex medications regimes. Many are concerned that addicts would be more subject to accelerating illness, increased contagiousness, and potential mutation of a partially-treated virus. Does the research shed any light on this?

7. The impact of continued, injecting drug use on risk behaviors. There appears to be a serious basis for concern that continued injecting drug use would increase the likelihood of risk behaviors including needle sharing. What does the research tell us?

DRAFT



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY

Washington, D.C. 20503

July 25, 1997

Dear Mr. Yates:

Thank you for your supportive letter and interesting materials on needle exchange programs (NEPs). These programs raise challenging public health and legal issues.

While some researchers believe NEPs can be effective in reducing HIV transmission, the evidence regarding drug use where NEPs operate is less than definitive. The Office of National Drug Control Policy supports approaches that are proven effective such as drug treatment and comprehensive outreach efforts.

Encourage you to consider this approach in your fight against the dual epidemics of HIV and substance abuse. Thank you for your interest and efforts in this important area.

Best Wishes,

A handwritten signature in dark ink, appearing to read "Hoover Adger".

Hoover Adger, MD, MPH

Deputy Director

Mr. Tyrone K. Yates
Vice Mayor, City of Cincinnati
City Hall, Room 352
801 Plum Street
Cincinnati, Ohio 45202

RECEIVED

JUL 28 1997

TYRONE K. YATES

City of Cincinnati



Tyrone K. Yates
Vice Mayor

City Hall Room 352
801 Plum Street
Cincinnati, Ohio 45202
Phone (513) 352-3643
Fax (513) 352-1517
E-Mail: Tyrone.Yates@cincncl.rcc.org

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City Planning Commission

August 19, 1997

Mr. Hoover Adger, M.D., M.P.H.
Deputy Director
Executive Office of the President Pennsylvania
Office of National Drug Control Policy
Washington, D.C. 20503

Dear Mr. Adger:

Thank you for your letter of July 25, 1997 in responding to my materials in support of harm reduction efforts associated with needle exchange programs.

You write:

"[W]hile some researchers believe NEPs can be effective in reducing HIV transmission, the evidence regarding drug use where NEPs operate is less than definitive."

This is a somewhat disconcerting statement given many authoritative federal studies to the contrary of your assertion.

In fact, since June, the American Medical Association, the U.S. Conference of Mayors and the American Bar Association have recently strongly endorsed NEPs stating the exact opposite of your suggestion.

In light of the weight of numerous federal studies and the recent endorsements, will your office shift its views of the value of syringe exchange programs? Also, please forward to me any studies you have seen which indicate that the value of needle exchange programs are "less than definitive."

Sincerely,



Tyrone K. Yates
Vice Mayor

Enclosure: July 25, 1997 letter

cc: President Bill Clinton

Vice President Al Gore

Mr. Paul Helmke, President, U.S. Conference of Mayors

Mr. J. Thomas Cochran, Executive Director, U.S. Conference of Mayors

Dr. David Satcher, Director, Centers for Disease Control



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY

Washington, D.C. 20503

March 20, 1998

1545

Sandy
Dear Ms. Thurman:

We reviewed the article provided by Todd Summers to Pancho Kinney in response to the latter's questions about the last sentence in the 3d. Paragraph of our draft joint release.

I think we should go forward with the slightly reworded statement (attached). It still makes the points that you and Director McCaffrey agree are important. More importantly, we are confident that all statements in it are supported by sound science.

Sincerely,

James R. McDonough
James R. McDonough
Director, Strategic Planning

Ms. Sandra L. Thurman
Director
White House Office of National AIDS Policy

Sandy,

*Thanks for your help and patience.
Note the analysis I have attached. Think we
have to be careful to maintain credibility*

DRAFT - FOR COORDINATION

FOR IMMEDIATE RELEASE

CONTACT: _____
(202) _____

_____, March ___, 1998

**DRUG CZAR AND AIDS CZAR AGREE THAT
PUBLIC HEALTH POLICY MUST BE
BASED ON SOUND SCIENCE**

(Washington, D.C.) - Barry R. McCaffrey, Director of the Office of National Drug Control Policy, and Sandra L. Thurman, Director of the Office of National AIDS Policy, issued the following joint statement:

Today, America is struggling with not just one epidemic, but with two. Tragically, the twin epidemics of AIDS and drugs are linked and impose devastating costs on individuals, families, and on our society as a whole. Together, we share a strong commitment to improving lives and to saving lives by promoting public health policies that are based on sound science.

We agree that drug treatment is the most effective tool not only in reducing the use of drugs but also in reducing the sharing of needles, both of which contribute to the spread of HIV. Unfortunately, despite a 33 percent increase in federal spending since fiscal year 1993, drug treatment is only available for half of those in immediate need. We are strongly united in our desire to do everything we can to expand the availability of drug treatment for all those in need, and to prevent the spread of HIV, ~~now growing most rapidly~~ among injecting drug users and people with whom they have sexual contact.

As for needle exchange programs, Congress has limited the use of federal funds for sterile needle and syringe exchange projects until (1) the Secretary of Health and Human Services determines that exchange projects are effective in preventing the spread of HIV and do not encourage the use of illegal drugs; and (2) the project is operated in accordance with criteria established by the Secretary for preventing the spread of HIV and for ensuring that the project does not encourage the use of illegal drugs. The Office of National Drug Control Policy and the Office of National AIDS Policy remain dedicated to working with Secretary Shalala, and to supporting her efforts to ensure that public health policy is guided by sound science.

DRAFT - FOR COORDINATION



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

March 20, 1998

MEMORANDUM FOR Jim McDonough

From Pancho Kinney

SUBJECT. Summary of HIV/AIDS Prevention Report "The Estimated Prevalence and Incidence of HIV in Large US Metropolitan Areas" (CDC, May 1996).

DISCUSSION. Jim, you asked that I review the study faxed by Todd Summers (632-7560) of the AIDS Policy Office. As you know, he sent the article in response to my request for substantiation of the statement we currently have in our draft press release to the effect that *the rate of HIV infection is growing most rapidly among injecting drug users and people with whom they have sexual contact.*

1. I reviewed the report and concluded that we should not use this article to support this statement. The study by Dr. Scott Holmberg does not make any comparison between numbers of new HIV infections in different periods. Consequently, we cannot draw conclusions from it about changes in rates of HIV infection among any population or sub population.
2. I also found that some of the author's (Dr. Scott Holmberg) assertions are not substantiated by a later CDC study (Summary of HIV/AIDS Surveillance Report (CDC: Edition Vol. 9, No. 1) which covers U.S. HIV and AIDS cases reported through June 1997. For example:
 - a. Holmberg claims that "roughly 1/2 of new infections may be occurring among IDUs." The 1997 CDC study estimates the figure to be 15 percent (by my calculations).
 - b. Holmberg estimates "that roughly 40,000 new infections occurring each year in the U.S." The 1997 CDC study estimates the number to be 13,111 between July 1996 and June 1997 (again, by my calculations).
 - c. Holmberg states that "an estimated 19,000 injection drug users are infected each year." The 1997 CDC study estimates the number to be 2,203 between July 1996 and June 1997 (again, my calculations).

CONCLUSION. Reword the joint press release (see attached rewrite).