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ONDCP (Drug)
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July 24



DATE: January 17, 1995

TO: Lee Brown
Director, Office of National Drug Control Policy

FROM: Patsy Fleming
Director, Office of National AIDS Policy

SUBJECT: Draft of the 1995 ONDCP Strategy

I am providing feedback on your most recent draft of the 1995 National Drug Control Strategy. I apologize for the delay in responding. We did not receive the document in time to provide comments by January 13.

Overall, I was pleased to find that you specifically mentioned AIDS more often in this draft in discussing the consequences of drug use and the linkages necessary for comprehensive treatment. However, I was disappointed that, after acknowledging the tremendous impact of drug use on our health care system, you did not analyze the public health issues as thoroughly as those for public safety. For instance, you did not include a public health objective in your list of 8 objectives for the strategy and the statistics cited in the Drugs and Health section, page 40, are wonderful, but they stand alone. Issues of homelessness and HIV infection, for example, are as relevant to drug use as violence is and deserve comprehensive treatment as well.

The process for this year's strategy was nearly complete before I was appointed to my current position. I would like to offer the resources of this office to you as next year's strategy evolves. Please contact me at (202) 632-1090 if you would like to discuss this further.

AIDS is specifically mentioned:

3. They list facts that the strategy must respond to, one of which is the cost of drug use on the health care system. They specifically cite "over one-third of the AIDS cases are associated with the reckless, self-destructive behavior of IV drug users." (p.6)
9. In the consequences section, they state that 70% of the cost is attributable to crime with "the balance reflect[ing] medical costs (including those relating to HIV/AIDS and other illnesses) and costs attributable to deaths". parentheses in original
11. In the consequences section they have a series of bullets on the impact of hardcore drug use. The health bullet mentions heroin medical emergencies and goes on to say.. "addicts who began their drug use in previous decades are now showing up in our hospitals seeking treatment for diseases including tuberculosis, AIDS, and hepatitis that are a direct or indirect result of chronic drug use". (p. 30)
13. The drugs and health section focuses predominantly on drug-related emergencies (4 pages). The last paragraph states, "Clearly, there is a strong linkage between certain diseases and IV drug use. Illicit drug use and the behaviors related to it harm the health of users through exposure to HIV, hepatitis, and other diseases. But usually, such transmission is also associated with the high-risk sexual behavior of chronic, hardcore drug users. A recent study of crack users found that the prevalence of HIV found that high-risk sexual practices accounted for the higher prevalence of HIV infection among crack users, than those who did not use crack. According to the CDC almost one-third of AIDS cases were associated with injecting drug users. The CDC also reports that almost 60 percent of children under the age of 13 with AIDS contracted the disease from mothers who were IV drug users or the sex partners of IV drug users." [cite = Edlin, B., Irwin, K., et. al., "Intersecting Epidemics - Crack Cocaine Use and HIV Infection Among Inner-City Young Adults". The New England Journal of Medicine. November, 1994. pp. 1422-1427.]
18. In the action plan for reducing the demand for illicit drugs, (see #17) they state that the burden on the health care system resulting from infectious disease has not been reduced. "Indeed, recent reports from studies in the eastern and western U.S. indicate that crack use among young people has accelerated the transmission of HIV/AIDS and other infectious diseases." (p. 73)
19. Later in the same action plan they discuss linking treatment, health care, and other social services. In discussing the thorough assessment needed, they state that it should include, "primary medical care needs, including screening and follow-up for conditions such as tuberculosis, hepatitis, and the AIDS virus". (p. 80)
30. In the program flexibility and efficiency section, action plan has a target on comprehensive, community-based approaches. "Those not involved in the criminal justice system will be identified through various outreach programs (e.g., AIDS

outreach) for drug treatment. A neutral party will manage the individual to ensure that all services are used to assist the user in becoming drug free."

AIDS is implied or subsumed under "health":

5. In talking about being responsive to communities, they describe a "target communities" program to provide technical assistance and outreach to link criminal justice, treatment and health care services. (p. 13)
6. In a table that lists the goals of the strategy, number 3 of 14 is to reduce the burden on the health care system by reducing the spread of infectious disease related to drug use. (after p. 14)
7. In talking about drug use in America today, they say that "the addicted drug user consumes substantially more drugs and is responsible for the preponderance of crime, health, and other negative social consequences." (p. 15)
10. "Any reasonable plan to reduce the crime, violence, and health consequences of drug use in this nation must include steps to address the full range of problems associated with chronic, hardcore drug use." (p. 29)
15. In the need to target hard core users section they talk about how informing the addict of the health consequences of drug use as a prevention measure. Later in that section they talk about treatment as a means to reduce the health and crime consequences of use. (p. 42, 43)
17. In the action plan for reducing the demand for illicit drugs, a 1994 goal was to reduce the burden to the health care system by reducing the spread of infectious disease related to drug use. Although not stated, they intend for this goal to be carried forward.
23. In the action plan for reducing demand, the community anti-drug coalitions section, health care providers are among those who should be included. (p. 92)
24. The drug-free workplace of the action plan for reducing demand includes safety and personal health among those things that are threatened by drug use.
25. Providing better health care is one of the things listed under the national service program in the action plan for reducing demand. (p. 98)
27. In the enhancing drug program flexibility and efficiency section health care services are among those that treatment professionals must work with. A 1994 goal was to create safe and healthy environments in which children and adolescents can live, grow, and develop. (p. 153)
29. In the program flexibility and efficiency section, action plan, health systems are among those included in developing a comprehensive community-based approach. (p. 168)

AIDS could be mentioned:

1. Probably can't add AIDS, but the principles for the 1993 strategy did not include public health concerns or the interaction between drugs and other health problems. (p. 2)
2. In stating why they chose to focus on the chronic user, they cite the consumption and crime rates but not the public health impacts that would give a good reason for addressing the chronic user (i.e. body is more vulnerable to disease, more likely to engage in risky behaviors that spread disease.) (p. 5)
4. In listing the 8 objectives of the strategy they do not include a public health benefit or reducing the public health risk/cost objective. (p. 7)
8. In the epidemiology (Drug Use in America Today) section, they break down users only by age and new vs. old user. They could describe the health characteristics of drug users. In the trends section they could talk about the growing link between drug use and HIV infection. They have a large section on adolescents that could also mention AIDS. Later sections justify specific programs by how specific populations are served, the data on these populations should be given here. The descriptors could be money and access if they are trying to avoid race and gender.
12. In addition to referencing AIDS in conjunction with long term users, they could have at least a sentence on how drug use and AIDS interact and impact individuals and society. In addition to the public health statement, there should be a bullet on how chronic drug users are more likely to become homeless or destitute and the subsequent relationship between these conditions increased vulnerability to situations that pose health problems and desperate acts, such as survival sex. (p. 30)
14. In discussing the need to target hardcore drug use, they state, "when appropriate treatment is offered..." and then have a list that should include a decrease in other behaviors that lead to poor health and lack of resources and supports. (p. 41)
16. In talking about the treatment capacity shortage, they should have a section that discusses providing diagnoses of drug addiction in other health care settings (such as HIV clinics) and diagnoses of HIV in drug treatment clinics. They could talk about the extra barriers faced by persons with multiple diagnoses. (p. 43)
20. In the action plan for reducing demand, the linking section, they want to expand SAMHSA's linkage efforts. They could specifically mention requiring Ryan White and substance abuse grantees to link. In the previous draft they had statistics about cracksmokers and HIV as well as a statement on the economic drain of not dealing with AIDS.
21. In the action plan for reducing demand, the prevention section, they reference a "safety/health skills approach" (p. 86) "adolescents at significant risk for problem

behaviors" (p. 87) but do not specifically mention the relevance and logic of including drug prevention messages in HIV education or HIV prevention messages in drug education. Later they have a paragraph on other relevant studies, does CDC have anything? Further down, they have a paragraph that starts "because under-age drinking...has extremely serious consequences..." that could specifically state the link between intoxication and increased risk for contracting HIV. (p. 89)

22. The safe and drug free schools section in the action plan for reducing demand, provides another opportunity to show the link between drug prevention and HIV prevention. DASH's efforts, for example. (p. 90)
26. In the action plan for reducing demand, the national prevention system: a shared mandate section provides another opportunity for showing how HIV and drug prevention messages should be intertwined. Also in this section ONAP has been taken out of the list of organizations in the National Prevention System. If we weren't supposed to have been there we should be, especially if the goal for reducing infectious diseases is dropped.
28. In the improving program flexibility and efficiency section, 12 month action plan, HIV infection trends among addicts should be among data distributed at the community level. Also, ensure that HIV is mentioned in a universal grant application. Technical assistance should also include information on HIV. (p. 160, 163, 165)
31. #30 should be supported by background information earlier in the document. (p. 169)
32. The international efforts section does not mention AIDS, or even health issues. The same public health costs and benefits apply internationally as they do domestically.
33. The conclusion mentions that this strategy addresses issues of safety and fiscal benefits (health care costs included). A paragraph should be added to include quality of life and public health reasons for successfully combatting illegal drug use.

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FACSIMILE COVER SHEET

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FROM: Brenda Kunkel

DATE: 1/23/95

PAGES INCLUDING COVER SHEET: 6

COMMENTS:

Thanks for helping me pull together comments. I've sent a table of contents and my notes on reading the strategy. The notes are divided into ① specifically mentions HIV/AIDS, ② mentions health and ③ where HIV could be inserted. The numbers ~~appear~~ follow the order of ^{appearance in} the strategy.

I would like your help in crafting specific language and guidance on whether the points I've raised are valid.

Thanks
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Syringe Exchanges

Don C. Des Jarlais and Denise Paone

Chaper submitted to Macmillan Publishing Company for the
forthcoming publication of Encyclopedia of Drugs and Alcohol

Why Syringe Exchanges? The first syringe exchange (SE) program was begun in 1984 in Amsterdam out of concern for the spread of hepatitis B among injecting drug users (IDUs). While hepatitis B virus, hepatitis C virus and human T cell lymphotropic virus can all cause fatal illness and are all spread through multi-person use ("sharing") of drug injection equipment, it clearly has been the threat of human immunodeficiency virus (HIV) that has become the dominant force in implementing syringe exchange programs throughout the world. HIV is the causative agent for acquired immunodeficiency syndrome (AIDS). At present HIV infection is almost uniformly fatal, there is no permanently effective treatment for HIV infection, and a vaccine against infection (if possible) is still well in the future. HIV has now been reported among injecting drug users in sixty different countries, IDUs from all continents except Antarctica, and from both industrialized and developing countries.

One of the more disturbing facets of HIV infection among injecting drug users is the potential for extremely rapid spread of the virus through a local population of IDUs. In Edinburgh, Scotland, HIV spread from introduction of the virus into the local population to infect over 40% of the local IDUs within two years (Robertson et al., 1990). In Bangkok, the percentage of HIV infected IDUs (HIV seroprevalence) increased from 2% to over 40% in less than one year (Vanichseni et al., 1992). In the state of Manipur, India, over 50% of the local population of IDUs were infected with HIV within one year of the introduction of the virus into the group. The very rapid spread of HIV among IDUs has been associated with a lack of awareness of

HIV/AIDS as a local threat and mechanisms for rapid, efficient mixing within the population, such as shooting galleries and dealers' works (Des Jarlais et al., 1992 review in AIDS)

Once HIV becomes well established within a population of IDUs, heterosexual and perinatal transmission from IDUs become additional significant problems. In most developed countries, IDUs are the predominant source for both heterosexual and perinatal transmission of HIV.

The great need to reduce HIV transmission among and from injecting drug users has led to a wide variety of prevention programs. There is some evidence for differing degrees of effectiveness with each of these programs, although there is also evidence that "education only" programs (i.e., those which do not also include providing the physical means for behavior change) are the least effective (see Des Jarlais et al., 1992 for a review). In almost all industrialized and in some developing countries increasing legal access to sterile injection equipment has become the most common HIV/AIDS prevention strategy in regard to IDUs. This strategy has included both (a) increased over-the-counter sales of sterile injection equipment; and (b) syringe exchange programs, in which IDUs can exchange used injection equipment for sterile equipment at no cost.

Increasing legal access to sterile injection equipment has been politically controversial in several industrialized countries, notably the U.S. and Sweden, and in many developing countries. Concerns have been raised as to whether increased legal access would lead to increased injection of illicit drugs and whether increased legal

access would appear to "condone" illicit drug use or "send the wrong message" about illicit drug use (Martinez, 1992). The empirical data on these questions will be reviewed below, but first it is important to address operational issues involved in syringe exchange programs—to specify how syringe exchanges actually operates day to day before addressing pre-post evaluations of their outcomes.

Organizational Characteristics of Syringe Exchange

Programs. At first glance (and regrettably, in much of the public debate about syringe exchange programs thus far), the operation of a program would seem quite simple: one would merely select a location and provide staff who could trade new injection equipment for used. In practice, it is important to think of syringe exchanges as service delivery programs, and that the organization of the services are critical to their effectiveness. Some programs are heavily utilized, for example, the Amsterdam programs exchange approximately 6 million needles and syringes per year in a city with an estimated 3000 injecting drug users. In contrast, the first legal syringe exchange program in New York City exchanged fewer than one thousand needles and syringes per year in a city with an estimated 200,000 injecting drug users.

To date there have been only two comparative studies of the organizational characteristics of syringe exchange programs (Stimson et al., 1988 and Lurie et al., 1993), so that further research is greatly needed on this topic. The most important aspect of a syringe exchange program would appear to be whether it is "user friendly" (Stimson et al., 1988). "User friendliness" includes consideration of practical characteristics such as convenient

location and convenient hours of operation, but goes beyond that to address some of the philosophical issues involved in syringe exchange programs.

Perhaps the most important aspect of user friendliness is the non-judgmental attitude of the staff towards the participants in the exchange. Participants in a syringe exchange program are treated with dignity and respect. They are not stigmatized as morally and psychologically impaired simply because they inject psychoactive drugs. The participants are presumed to care about their health and to be capable of taking actions to preserve their health and the health of others.

User friendliness also requires that syringe exchanges offer multiple services. Other HIV/AIDS concerns need to be addressed beyond the provision of sterile injection equipment for injection-related risk reduction; sexual transmission of HIV also needs to be addressed, including distribution of condoms without cost. Moreover, the trusting relationships that gradually develop between syringe exchange staff and the participants in the exchange will also lead to uncovering of additional health and social service needs. The need for access drug abuse treatment is likely to be one of the more commonly expressed needs. The exchange should be able to respond positively to such additional needs, either through referral or through on-site provision of services. Failure to do so would undermine the trusting relationships between staff and participants. There is as yet no consensus as to exactly which additional services should be offered on-site versus through referral—or even any basic set of available guidelines for how an individual syringe exchange

program should decide which additional services to offer on-site and which to offer through referral. There is, however, a very broad range of additional services presently being offered on-site at syringe exchange programs, with some programs offering conventional drug abuse treatment, self-help recovery groups, women's support groups, tuberculosis screening and treatment and Bible study groups.

The need to provide on-site--or link to other--services also means that syringe exchange programs should be considered as a part of a system of services for preventing HIV infection among injecting drug users rather than as self-sufficient HIV prevention programs.

The effects/effectiveness of syringe exchanges—methodological issues. Studying the effectiveness of an HIV prevention program that facilitates sustained risk reduction is extremely difficult. Research ethics require that "comparison" subjects also be provided with some intervention to reduce their chances of HIV infection, and it is not easy to determine an appropriate comparison condition for a syringe exchange program. Should the comparison subjects be told/permitted to purchase sterile injection equipment from pharmacies? Should they be told to purchase sterile injection equipment through an illicit market? Should they be given bleach or some other method of possibly disinfecting contaminated injection equipment?

The logical unit of analysis in a syringe exchange evaluation would be the local population of injecting drug users rather than individual drug users. If HIV infected drug users participate in

syringe exchanges--returning their needles and syringes to the exchange rather than passing them on to other injectors--persons who do not participate in the exchange would then still be protected against HIV infection. Using communities as the unit of analysis in a clinical trial, however, would be extremely expensive, and it is doubtful that many communities would accept random assignment to experimental or control conditions.

No syringe exchange study to date has approached a randomized clinical trial. Most studies have measured HIV risk behavior prior to and after participation in an exchange, or have compared risk behavior among exchange participants to some other group of injecting drug users. Conclusions about the effectiveness of syringe exchange programs must thus be drawn from the consistency of findings across many methodologically limited studies, rather than from relying upon a single or small group of methodologically rigorous tests of syringe exchange.

Drug injection. A common concern expressed by syringe exchange opponents is that syringe exchange programs would increase the frequency of illicit drug injection. However, research studies have consistently found that use of syringe exchange is not associated with any detectable increase in drug use either on a community or individual level (Des Jarlais and Friedman, 1992; Dolan et al., 1990; Donoghoe et al., 1989; Hart et al., 1989; Lart and Stimson, 1990; Ljungberg et al., 1991; Paone et al., 1993; Stimson, 1989).

The most recent review emphasized that "there is no evidence that needle exchange programs increase the amount of drug use by needle exchange clients or change overall community levels of non-

injection or injection drug use." (Lurie et al., 1993). Of the eight relevant studies analyzed in this review, three found reductions in injection associated with syringe exchange, four found mixed or no effect, and one found an increase in injection compared with the controls. Data from the New York City syringe exchange evaluation (which were not available at the time of Lurie et al.'s 1993 CDC review, indicate a modest decrease in the frequency of injection among participants using syringe exchange. (Paone et al., in press).

Moreover although opponents have often expressed an additional concern--that syringe exchange would attract new injectors--the overwhelming number of IDUs participating in exchanges have long histories of drug injection. The mean length of time injecting illicit drugs usually ranges from five to ten years or more. Typically only 1 to 2% of syringe exchange participants initiated drug injecting within the previous year. If providing sterile injection equipment to at a syringe exchange had induced large numbers of persons to begin injecting drugs, then the numerous studies to date should have observed large numbers of new injectors participating in syringe exchange.

HIV injection risk behavior. There have been consistent findings across studies indicating declines in self-reported frequencies of injecting with potentially HIV-contaminated equipment (Hagan et al., 1991; O'Keefe et al., 1991; Oliver et al., 1992; Paone et al., 1993; Lurie et al., 1993 and GAO, 1993 for reviews). The magnitude of the reductions in injecting risk behavior is difficult to estimate because studies have used different metrics for risk behavior, in that some studies have used pre-versus post

while other some studies have compared syringe exchange participants to various other groups of drug injectors. None the less the general trend observed from participants in a syringe exchange has been a reduction in injecting risk behaviors ranging from fifty per cent to eighty per cent. No studies, however, have shown anything approaching complete elimination of injecting risk behavior among syringe exchange participants.

Syringe exchange programs probably attract drug injectors who are relatively concerned about their health, and it is possible that, even in the absence of a syringe exchange these injectors would seek alternative ways of reducing HIV injection risk, such as purchasing sterile injection equipment from pharmacies or on the illicit market. Thus, the present data do not permit a conclusion that syringe exchange programs are necessary to reduce HIV injection risk behavior. However, the possibility of alternative methods for reducing injection risk behavior also does not imply that syringe exchange is not effective in reducing injection risk behavior.

On one hand, the fact that very few new injectors participate in syringe exchange may be considered a limitation on the current effectiveness of syringe exchanges. IDUs are typically exposed to Hepatitis B and C within the first few years after they begin injecting drugs (Hagan et al., 1993); thus, new injectors may already be infected with these blood-borne viruses before they start to obtain sterile injection equipment from a syringe exchange. Moreover, in high HIV-seroprevalence cities, even new injectors may

be at very high risk for HIV infection. In New York City the estimated seroconversion rate among new injectors is 6.6 per 100 person years at risk (Des Jarlais et al., 1994). Thus, new injectors in high seroprevalence cities may become infected with HIV before they begin to participate in syringe exchanges.

Sexual risk behavior. While all syringe exchange programs address sexual transmission of HIV to some extent, fewer studies have examined the effect that syringe exchange has had on sexual-risk reduction among participants. Moreover, the findings from these few studies are more ambiguous (see Lurie et al., 1993 for a review). Very few HIV prevention programs for injecting drug users have found consistent effects on changing the sexual behavior of IDUs, particularly with "regular" sexual partners (Friedman and Des Jarlais et al., 1994). The one exception might be programs that provide HIV counseling and testing, as there is some evidence that drug injectors who know they are infected with HIV are more likely to change their behavior in order to reduce the chances of transmitting HIV to others (Vanichseni et al., 1993).

Effects on HIV and hepatitis B transmission. The present research data on syringe exchange has produced a body of consistent findings with regard to reduced drug injection risk behavior. Studies of HIV seroprevalence and HIV seroincidence among participants using syringe exchange tend to validate the self-reported risk reduction. Seroprevalence rates have usually stabilized after syringe exchanges have been implemented (Des Jarlais and Friedman, 1992; Lart and Stimson, 1990) and the rates of new infections among participants in syringe exchange have ranged from

al., 1991; Hagan et al., 1992), to less than 1 per 100 person-years at risk (Oliver et al., 1992; Hart et al., 1989), to a moderate 4 per 100 person-years at risk in Amsterdam (van Haastrecht et al., 1991). While there is as yet no definitive evidence that participation in a syringe exchange reduces the chances of HIV infection, the available HIV seroprevalence and seroincidence studies are largely consistent with this hypothesis.

The same behaviors that transmit HIV infection (multi-person use of injection equipment and unprotected sexual behavior) also transmit Hepatitis B (Alter, 1993). The epidemiology of these viruses is very similar in most countries, and injecting drug users are at high risk for infection with both viruses (Alter, 1993; Chamot et al., 1992; Margolis et al., 1991; van den Hoek et al., 1990; Zeldis et al., 1992).

Studies which have examined the effects of syringe exchange participation and new hepatitis B infection among drug user in several cities have shown actual declines (Hagan et al., 1991; Taylor, 1991; Van Haastracht et al., 1991), further validating self-reported risk reduction and indicating that syringe exchanges do have a large-scale effect on AIDS risk behavior among injecting drug users.

Discarded syringes. Syringe exchanges create an economic value for used needles and syringes—they can now be exchanged for new injection equipment. Thus, exchanges have the potential for reducing the amount of used equipment that is discarded in the community. Indeed, the one study that systematically examined the amount of discarded injection equipment before and after

implementation of a syringe exchange program did find a significant reduction in needles and syringes left on sidewalks and in the streets (Oliver et al., 1992).

The "Message" of syringe exchange programs. Objections that syringe exchanges will lead to increased illicit drug use or that they will not lead to reductions in HIV risk behavior can be addressed through empirical studies. The empirical studies to date show consistent findings of no increase in illicit drug injection and consistent reductions in HIV risk behavior (although it has not yet been possible to translate the reductions in risk behavior into empirically grounded reductions in HIV transmission rates.)

One of the most common objections to syringe exchange programs, however, is that they "condone" or "send the wrong message" about illicit drug use. The symbolism of a government providing the equipment needed for injection of illicit drugs does seem to directly contradict society's fundamental disapproval of illicit drug injection. Syringe exchange participants, of course, are not likely to misinterpret a need to prevent HIV infection as indicating a reversal of prevailing societal attitudes towards the injection of psychoactive drugs.

The important political "message" in syringe exchange programs is not that the injection of drugs like heroin and cocaine is a social good, but that previous policies on illicit drug use are not capable of coping with a public health catastrophe such as HIV infection among injecting drug users, their sexual partners and their children. The "War on Drugs" or "Zero Tolerance" approach to illicit drug use focused on reducing drug related problems by reducing the

use of illicit drug use. Reducing HIV infection among drug injectors, their sexual partners and their children through exclusive reliance upon a strategy of trying to reduce illicit drug use is, however, clearly impractical. Our ability to "treat" drug users so that they will never use drugs again is clearly limited, and letting drug injectors, their sexual partners and their children die of HIV infection is clearly inhumane.

Syringe exchange programs illustrate the possibility that it may be possible to greatly reduce some of the individual and social harm associated with drug use through means other than simply reducing drug use. Making the distinction between reducing drug related harm and reducing drug use per se is the fundamental premise of a new approach to drug policy that has been termed "harm reduction" or "harm minimization" (Strang, 1992; Heather et al., 1993; Des Jarlais, 1992). Harm reduction ideas and practices existed before HIV/AIDS and syringe exchanges (Berridge, 1993) and extend well beyond HIV/AIDS issues, but syringe exchange has come to be recognized as a prototype for the usefulness of the harm reduction approach in general.

The harm reduction perspective itself is still in a period of rapid development, so that it is not possible to definitively state its fundamental principles, but there are at least four common assumptions in descriptions of the approach:

1. Pragmatism is valued over idealism. The non-medical use of both licit and illicit psychoactive drugs is likely to continue indefinitely, so policies should be formulated on that realistic basis, rather than on the basis of a utopian drug-free society.

2. Reducing drug use, particularly very heavy (dependent, addictive) drug use, is the most desirable but not the only means of reducing the individual and social harms associated with psychoactive drug use. Syringe exchanges to prevent HIV infection are a clear example of reducing harm without necessarily reducing drug use. (Designated driver programs are another example of harm reduction--reducing the harm associated with alcohol use without necessarily reducing alcohol use.)

3. In general, drug related harm is likely to be reduced through integrating drug users into society rather stigmatizing them and treating them as social outcasts.

4. While drug addiction clearly restricts an individual's ability to control his or her own behavior, drug users are still capable of making rational choices, and should be offered choices among different ways of reducing the harm drug misuse causes them and society.

The harm reduction perspective is thus quite different from the War on Drugs-Zero Tolerance perspective. Harm reduction is also distinct from a "legalization" of all psychoactive drugs perspective. The individual and social harms of drugs are not likely to be minimized by mass marketing of drugs. Nicotine/tobacco is a prime example of how large scale harm has been created through uncontrolled merchandising of an addictive drug.

Rather than basing policy on a utopian ideal of a drug free society or an equally implausible ideal of a society that freely uses psychoactive drugs without problems, the harm reduction perspective calls for basing policy on a flexible pragmatism.

Specific harms associated with specific types of drug use can be identified and concrete steps can be taken to reduce those specific harms. Syringe exchanges to reduce HIV infection among injecting drug users, their sexual partners and their children are a prototypical example of a concrete action for reducing drug related harm. The "message" sent by syringe exchange programs thus should not be read as "drug injecting is good," but rather that drug policies need to be based on their pragmatic effects rather than on their symbolism.

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NATIONAL DRUG CONTROL STRATEGY

*Strengthening Communities'
Response to Drugs and Crime*



*February 1995
The White House*